Post Abortion Women's Perception On Contraceptive Counselling Provided By Service Providers: *A Qualitative Study In Kisumu County, Kenya*

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Summary

BACKGROUND

Contraceptive Counselling is the process in which service providers engage with Patients to help them identify a suitable contraceptive method and in a follow up interaction until the effectiveness of the process is achieved. Establish good rapport between the service providers and the recipients.

Contraceptive uptake among post abortion patients is affected by the perception the women have on contraceptive counselling by the service providers. Contraceptive knowledge is high and its usage is low among post abortion patients.

AIM

The main aim of this study was to explore how patients seeking post abortion care perceived contraceptive counselling provided by service providers in Kisumu County, Kenya.

METHODOLOGY

A sample of 20 post abortion patiens participated in the In-depth interviews where open ended questions with probes were used to collect data. The interviews were conducted in two facilities, Jaramogi Oginga Odinga Teaching and Referral Hospital and Kisumu East District Hospital (Kisumu County Hospital) (both in Kisumu County, Kenya).

The interviews were recorded and verbally transcribed. NVivo version 11 was used to sort out the data. Thematic analysis was used to analyse data. The sorted data was coded and structured in nine themes with regard to quality of care in contraceptive services. Choice of contraceptive method, information provided to recepients, interpersonal relationship, continuity and follow up, technical competence, affordability of contraceptive services, partner preference, myths and misconceptions, suggestions and concerns was emphasized.

RESULTS

The patients were able to obtain information about the various methods of contraception enabling them to make informed choices as a result of the discussions with the service providers. The good interpersonal relationship of the service providers with the respondents established good rapport and reduced the stigma. Respondents were now able to revisit clinics after abortion without fear and contraceptives provided free of charge after discussions with the respondents who felt comfortable using them. Partners were important in contraceptive decision making, such that those who had partners found it easy to decide.

CONCLUSION

The Respondents perceived contraceptive counselling positively indicating the friendliness of the service providers that made them feel confident with the contraceptive counselling and comfortable to discuss abortion with them. Respondents did not like the term abortion because it demoralized them.

Keywords

Contraceptive counselling, Contraceptive experience, Missed Opportunities, Contraceptive Uptake, Physicians and Midwives, Post Abortion Care.

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Introdution

It is estimated that between 70,000 - 100,000 women die annually due to complications related to unsafe abortions [21] WHO has defined unsafe abortion as a procedure for terminating pregnancy either carried out by an individual without the necessary skills or in an environment that does not conform to minimal medical standards, or both [1]

Unsafe abortion as a result of unwanted pregnancy remains a persistent public health challenge to women's health globally [14].

It is responsible for 13 per cent of the maternal deaths. In addition, about 8.5 million women suffer from complications of unsafe abortion and a large number of unsafe abortions take place in low income countries of which Africa is leading [20].

Unsafe abortions contribute to about 35 - 80 per cent of maternal deaths in Kenya [25].

A study in Kenya indicated that 45 per cent of women aged 19 years and below experienced severe post abortion complications [12]

The Post Abortion Care (PAC) model consists of three aspects:

1. Emergency treatment of complications
2. Post abortion contraceptive counselling
3. Service linkages to other reproductive health care services [25]

Any improvement in PAC such as timely treatment of incomplete abortion and provision of contraceptives would improve the health of women and their families [23].

To minimize the problem of unwanted pregnancies and repeat abortions there should be a constellation of services linked to emergency post abortion treatment. Particularly contraceptive services [23]

Post abortion counselling plays an important role in decision - making towards utilization of contraceptives after abortion. The counselling is at times carried out by service providers at the Post Abortion Care settings.

A study in Western Kenya indicated that, of around 40 per cent of PAC- seeking women who received

contraceptive counselling only 30 per cent accepted to use a method [8, 13]

Studies from Uganda among young women and men as well as among contraceptive service providers show multiple obstacles to contraceptive use, such as misconceptions and fears related to contraception, gender power relations, socio-cultural expectations and contradictions, short term planning and health service barriers [15]

It is important for the researcher to find out how the respondents have perceived the services provided to them during the post abortion care particularly counselling on contraceptive use and prevention of repeat abortions.

The aim of this study was to explore how patients seeking post abortion care perceived contraceptive counselling provided by service providers in Kisumu Kenya.

Methodology

Study Design

This was a cross-sectional descriptive qualitative study, using an interview guide that had open-ended questions. The leading prompts in the questionnaires helped to describe post abortion women´s perceptions/experiences of the post abortion contraceptive counselling and services received from service providers.

The respondents were part of a randomized controlled trial. These patients had been through abortion and were counselled for contraception and had been on contraception for the last three months and now invited to give their experiences about the contraceptive counselling they received from service providers.

Qualitative interviews with 20 post abortion responded were conducted by the author in a quiet private room at the two health facilities.

Study Area

The study took place at Jaramogi Oginga Odinga Teaching and Referral Hospital and Kisumu East District Hospital now Kisumu County Hospital in Kisumu County, Western Kenya. Compared to the whole country, western Kenya has the lowest mean age at first sexual intercourse (16.4 years) among the 20- 24 year olds [11]

The study was carried out within the Department of Obstetrics and Gynaecology, which admits about 60 patients per month with incomplete abortion.

Study Population

The study population was post abortion patients admitted for PAC, performed over the past three months previously by service providers (Midwives and Physicians).

Recruitment of Respondents

20 patients of different ages and socio - economic backgrounds were selected among those patients who for three months had received post abortion care and also received a contraceptive method of their choice in order to get a sample as broad as possible.

The study was carried out between June 2015 and April 2016. The participants were of different ages, education levels, and marital status. There were 17 midwives and 7 physicians working in the department during the data collection period.

Inclusion Criteria

These were patients who had received PAC in a gestation age 12 weeks, 3 month had passed since they had received contraceptive counselling and accepted one of the following contraceptive method;

Hormonal pills
Injectable hormones
Implant or
Intra Uterine Device.

Data Collection

The data collection tool / instrument used was an interview guide with accompanying probes to address study - specific questions.

The guide was developed in collaboration with researchers at Karolinska Institutet, Gynaecologists, Nurse - Midwives and a non-profit organisation (NGO) working in abortion care.

Before use, the guide was pretested. The interview guide focused on the six elements of quality care in contraceptive service recognized in the framework by Bruce and Jain choice of contraceptive methods:

a. Information given to users
b. Technical competence of providers
c. Interpersonal relations
d. Continuity mechanisms
e. Appropriate constellation of services
f. Appropriateness and acceptability

These elements show the aspects of services that patients experience for uptake and adherence to the chosen method of contraceptive [22].

After these sub-topics had been addressed, the respondents had an opportunity to add any information and comments they had.

Finally, they were asked about the sensitivity of the topics, whether they had found it difficult to participate in the interview. The aim of the last two questions was to strengthen the credibility of the findings.

The interviews were all done face to face and lasted between 25 and 90 minutes. They took place in quiet private rooms where contraceptive counselling was done at the two health facilities.

The interview guide was formulated in English and translated into Luo and Kiswahili languages as samples ready to be used if needed during data collection. Some participants mixed English, Luo and Kiswahili during the interviews. The data was collected in any one or a combination of the languages as the researcher was fluent in the three languages.

All the interviews were recorded using a tape recorder and were transcribed verbatim. During the interviews the researcher asked for clarifications when needed. Each participant was invited by phone call one week then a day before the interview.

Data analysis

The interviews were transcribed and analysed in English. Thematic analysis was performed according to [3].

First the interviews were read through several times to obtain a sense of the whole. Then the text was sorted and structured in themes according to Bruce and Jain's six elements of quality of care in contraceptive service [2]

The six elements recognized in the framework are: choice of contraceptive methods, information given to users, technical competence of providers, interpersonal relations, continuity mechanisms and appropriate constellation of services or appropriateness and acceptability. Five of the six elements emerged as important themes in the interviews.

However, appropriate constellation of services did not appear as an aspect in the interviews. NVivo version 11 was used to sort the data. During the analysis, some themes that could not be fitted in the Bruce-Jain framework emerged. These were: affordability of contraceptive services, myths and misconceptions, clients' suggestions and concerns, and partner preference

Ethical Consideration

The study (registration number KU/R/COMM/51/588) received ethical approval by the Kenyatta University Ethical Committee, Kenya and Regional Medical Ethics Committee in Kisumu County, Kenya. Permission to conduct the study was also received from the County Government of Kisumu and National Commission for Science, Technology and Innovation (NACOSTI) permit number NACOSTI/P/18/12719/26081.

Each woman was given information about the study and its benefits after which she gave informed consent before the interview started. Participation was voluntary and the woman could stop the interview at any time if so wishes without any penalty.

Participants were assured of anonymity at all times. Confidentiality was maintained and the data was kept safely under lock and key and could only be accessed by the researchers themselves.

Results

Characteristics of Interviewed Participants

Table 1; shows the characteristics of the 20 interviewed participants. Among the seven (7) who had not had any pregnancy, this was their first pregnancy

Table 1: *Respondents Who Participated In The Qualitative Study*

Respondents' INTERVIEW Number	Age	No. of pregnancies	Use of FP	Marital status / cohabiting	Was the pregnancy planned	Was the abortion Induced	History of abortions
1	22	0	No	Married / cohabiting	No	No	0
2	30	3	Yes	Married / cohabiting	Yes	No	0
3	28	0	Yes	Single	Yes	No	0
4	22	1	Yes	Single	No	No	0
5	24	0	Yes	Married / cohabiting	Yes	No	0
6	30	0	Yes	Single	No	No	0
7	24	3	Yes	Married / cohabiting	Yes	No	0
8	22	0	Yes	Single	No	No	1
9	37	2	Yes	Married / cohabiting	Yes	No	0
10	22	1	Yes	Single	No	No	1
11	30	1	Yes	Married / cohabiting	Yes	No	0
12	20	1	Yes	Single	No	No	0
13	23	2	Yes	Single	No	Yes	0
14	18	2	Yes	Married / cohabiting	Yes	No	0
15	23	0	Yes	Married / cohabiting	Yes	No	0
16	23	0	Yes	Single	No	No	0
17	19	1	Yes	Single	No	Yes	0
18	26	1	Yes	Married / cohabiting	No	No	0
19	22	1	Yes	Married / cohabiting	No	No	0
20	23	3	Yes	Divorced	Yes	No	0

Quality Of Post Abortion Contraceptive Counselling and Services

1. Five of the six elements in Bruce and Jain´s framework that appeared as important themes in the interviews:
   - Choice of contraceptive methods,
   - Information given to users,
   - Technical competence of providers,
   - Interpersonal relations,
   - Continuity mechanisms.

2. Four additional themes that emerged during analysis were
   - Affordability of contraceptive services
   - Myths and
   - Misconceptions
   - Respondents'suggestions and concerns

   Partner preference are presented below.

The findings are presented with illustrative quotes.

Theme 1

Choice of Contraceptive Method

In line with the recommended practice of voluntary uptake of contraceptives with individual selection of contraceptives, all the participants in this study confirmed that, they had selected family planning methods out of their own free will.

No participant reported coercion of any form from health care providers when it came to selecting a contraceptive method.

The women participants regularly reported that, health providers clarified and created awareness of the different Contrceptive Methods available. Both within and outside that facility before asking them to select a method (a chart was provided showing all the family planning methods that were available for the participant to choose from).

Participants who selected a long acting contraceptive that were not available at the facility were given a short term method as they waited for their choice of method to become available or to undergo procedures for long term contraceptives.

There were women who reported ever using contraceptives. Although these women reported that they were aware of existing methods of contraceptives and often selected the methods that they had previously used.

They confirmed that health providers still provide information on different methods of contraceptives to them. Some of the responses from the women were as follows:

"She [counsellor] asked me if I had used contraceptives before and I told her I have never. Then she told me there are some methods like injection, tablets, then she asked me which I would prefer and I said injection"
(IDI 18 -KEDH)

"I already knew all of them [Contraceptive Methods] ...the first one I had was [implant] after I delivered my first child. So [implant] was my choice"
(IDI 16-JOOTRH)

According to the women the health care providers respected their decision-making processes and were supportive in terms of the flexibility they exhibited in incorporating respondenting partners in decision making.

Allowed time for decision making on Contraceptive Methods while providing condoms and other short term solutions and accommodating women preferences.

Note the following responses from some women:

"They wanted to inject me immediately but I refused because I was still bleeding... I intended to stop bleeding before I return for injection ... after the bleeding stopped I went to be injected"
(IDI 02-JOOTRH)

"Yes, they told me to select a family planning method for 6 months, so I chose condoms because my partner refused injections"
(IDI 19 - KEDH)

Nearly all participants reported that they were given a broad range of contraceptive choices to select

from and that they were provided with the methods of their own choice. Therefore, they were happy with the outcome.

A few participants however, reported that, some service providers wanted them to choose a particular method because of their health conditions after abortion or the method was medically contraindicative.

Respondents made informed choice on specific methods during the first counselling session. But sometimes the method first chosen was changed during a follow up.

Typical situations that resulted in a change were side effects associated with a Contraceptive Method or change from a short term to a long term method once the method became available.

A Woman confessed that:

" ....some new methods
brought problems of bleeding
which made my partner uncomfortable
and became troublesome
and also brought problems to my body.
I started slimming, bleeding could start
after every two weeks,
numbness of the hands , back pains,
and I ould not work as before;
therefore, decided to stop''
(IDI, 13, JOOTRH)

Theme 2:

Information provided to Participants

The service providers had samples of Contraceptive Methods that they used to explain to the participants. Women commonly reported that the information provided during Contraceptive Counselling sessions included details on the two aspects of Contraceptives.

How Contraceptive Methods work and possible side effects. While participants reported that, they were given information on the different methods, discernible difficulties were noted in some women's recall of information provided during counselling. Especially the technical names of Contraceptive Methods.

Although the women could describe most Contraceptive Methods, they rarely recalled the names of methods like Implants, and Coils correctly. Instead referred to these methods using the anatomical sites in which, these methods were placed or how they are used. They said:

"Yes I was shown pills,
I was shown a drug to be placed on the arm
and also a pill to taken through the mouth
and another one to block ovaries"-
(Idi 04- Kedh)

"They first started by advising me
and asking about the method I would like
to use and I chose Depo...
another one is a coil.
I have forgotten
some of the names but they told me
there is one for the arm for about 5 years.....
Condoms they told me is another method"-
(IDI-08 KEDH).

Theme 3:

Interpersonal relations

The women reiterated that the relationship with the provider was an important aspect when assessing the quality of Contraceptive counselling.

Among the provider attributes that were valued by the women were responsiveness, genuine concern in the respondent's situation. Also clarity in communication during counselling.

The majority of the women confirmed that, they were well received while the healthcare provider took time to make them comfortable. Some of the women complained that, the healthcare providers took time to introduce themselves.

The majority of the women said that the reception was sufficient, those doctors and nurses were concerned about their condition.

However, three women complained that, the doctors were too busy to attend to their needs. This is in terms of the healthcare providers' attitude. Some participants also claimed one of the nurses was rude and that her responses were abusive and not supportive.

The majority of the women expressed that, they were attended to immediately. In some cases where the waiting time was long, the healthcare service providers had apologized and given reasons for lateness. Then the participantsv could say that they understand, that the workload was heavy.

Here is what respondents had said:

"I found two sisters,
one of them was very kind to me,
but one was very rude
Well very rude that at times
she could just come and abuse you.
But one was very kind with me
she treat me very well and advised me more."
(IDI-03 KEDH)

".....It was a bit too long (waiting time),
because there were some people to be attended to,
so I had to wait."
(IDI-10 JOOTRH)

All the respondents reported that, the counselling room was conducive for the interviews. Quiet, well ventilated with good lighting and privacy. In fact some respondents said that, whenever there was any disturbance, counselling was stopped, sorted out before resumption.

The participants confirmed that, they were able to talk freely and openly, That, during sessions, the facilitators, would allow them to raise any question on unclear issues.

In some cases, the healthcare service provider had allowed their partners to attend sessions. This women found it supportive.

The respondents indicated as follows:

"It was quite private, so everything
I need to express myself since there was
no one to hear me or see anything"
(IDI-10- JOOTRH)

".....when he came back we were there 3,
people in the counselling room.
Myself, my husband and his sister."
(IDI-03 KEDH)

Participants stated that the healthcare workers were empathetic and engaged in an honest and open conversation. Some women were impressed and indicated that they would refer their friends to the same doctors to seek for contraceptive advice.

Some participants expressed that they had received good interaction from the doctors contrary to the negative ideas their friends had told them prior to the visit.

According to the participants the doctors and nurses were generally compassionate, caring, and understanding as evidenced in the transcripts.

Most women said that:

"The visit was okay but was worried that,
if I came here I would get a doctor
who harasses people but I am surprised
the interaction was very good"
(IDI-11 JOOTRH)

"The reasons why I feel motivated is
because the people who are dealing with me
were so patient, they are so caring, loving
and they counsel people well."
(IDI-12 JOOTRH)

There were mixed feelings about being free to open discussions on family planning and post abortion. Most women, especially young ones, said they were a bit hesitant to discuss family planning openly because they thought they would be victimized / stigmatised also afraid of what would happen in future such as loss of fertility.

However, the older ones, especially those who had children, appeared to be more comfortable discussing family planning. Some also reported that the level of assurance that they had received from the healthcare Service provider allowed them to be free to discuss their thoughts.

"But I was not totally free,
because am still a student. I don't know
what will happen."-
(IDI 11- JOOTRH).
"Yah, she told me to be free, and
she told me to see her like my mother
and what happened to me

(that abortion) is a normal thing.
Then she told me not to be worried
but feel free."
(IDI 12 JOOTRH)

Theme 4:

Continuity and Follow-Up

All respondents mentioned that they were given follow - up dates on a card. The majority of the participants said that, beside being given return-dates, they were even reminded with phone calls from the facility prior to the visit.

Telephone reminders were a unique aspect of the study that promoted continuity and follow up of contraceptive use.

The participants appreciated the fact that health care providers called them to check on their condition and reminded them to attend clinical appointments. Several respondents described situations where they would have missed clinical appointments. If it was not for telephone reminders from the facility staff.

Some participants who had difficulties traveling to the facility mentioned that the hospital provided them with money for transport.

However, some respondents reiterated that, it was in their own interest to come back to the facility for further treatment whenever there was any problem. They said:

"I was looking at those dates
they wrote to me,
I was given an appointment
which I kept on checking.
I wanted to miss but they made
a phone call and told me not to miss.
The second one I defaulted ,
it was on Sunday,
and they called me to come the next day...
it was good it reminds me even if I forget"
(IDI-04, JOOTRH)

Apart from the phone reminder cordial interactions and expressing genuine concern in the welfare of participants prompted them to return for follow up care.

"The reason why I feel motivated
to attend appointments was...
because the people who are dealing with
me are so patient, they are so caring,
loving and they counsel people well"
(IDI-14, KEDH)

Theme 5:

Technical Competence

In general, the participants regarded the quality of clinical services provided in the facility as good. They also commended the counsellors providing information on contraceptives as highly knowledgeable.

The majority of the women were happy with the level of knowledge they received from the healthcare providers and some thought that it was worth sharing these positive aspects with other women in the villages since they had carried misconceptions about the healthcare providers.

Some women said that the healthcare workers corrected the inaccurate information and misconceptions (discussed later in this chapter) they had, had. The message, the women said was put in a simple way that they clearly understood.

They concluded that, the health-care workers answered their questions well and some even went further to probe for more information. The majority of the women said they were anxious of the methods and side-effects of contraception. Especially after having abortion and a miscarriage, they had been advised adequately with doctors giving them hope with their explanations.

(IDI-11 JOORTH)- Translation: -Yes I asked.
There are questions I asked.
I asked on whether to continue with
family planning when my partner was
not around and the doctor told me
to continue regardless.

"He talked in the language I could understand
and everything he said he made sure
I understood and would be able to answer."
(IDI-10 JOORTH)

Theme 6:

Affordability of Contraceptive Services

There were concerns among the women about financial charges that were required for certain contraceptive methods.

Most facilities that provided subsidies for contraceptives attracted patients with financial constraints and patients considered these facilities as offering better quality healthcare. It was noteworthy that financial charges were only levied on implants that require surgical intervention but no charges were made for oral, injectable and barrier methods of contraceptions .

"...Not actually forcing you but
at times they remove it,
they always charge some money
for that procedure."
(IDI-5 KEDH)

Theme 7:

Partner Preference

The majority of the participants said that the partners plays a key role in their usage of contraceptives especially after having an abortion.

Some participants were of the opinion that their partners had a lot of misconceptions about different methods of contraception and needed to be present during counselling so that the choice would be made as a couple.

Others mentioned that, in their choice of contraceptives they had to consult their partners on which method to use. Some partners were present during the counselling session and the participants considered it easy to make the choice in such cases.

One woman mentioned that her partner was of the opinion that she needed to use herbal medicine to wash her "stomach" (The woman meant that she was going to be given herbal medicine to clean her uterus) rather than choosing a family planning method immediately after abortion.

"Me and my partner consulted each other
trying to bring up positive part
of condom and relating
to other family planning methods
... contraceptive methods"
(IDI-13 JOOTRH)

"My partner it seems he is
so much reluctant .....
By then he was not even working,
then I went and now he told me to stop.
I stopped one week, and
then we used this herbal drugs,
to wash my stomach"
(IDI-12 JOOTRH)

Theme 8:

Myths and Misconceptions

Some statements from the particpants provided strong evidence of widespread firmly held beliefs about negative effects of contraceptives. Many of which can be considered myths. There were further suggestions that participants were likely to accept information regarding contraception passed through gossip and such misinformation was difficult to shed off contrary to information given by the health care provider.

A number of respondents mentioned that, by using contraceptives, they would be referred to as harlots.

Others said contraceptives would cause bleeding that could result in death or give birth to children with disability (without legs and hands).

Others reiterated that, the main cause of miscarriage was using contraceptives. Besides there were women who mentioned that they could not use the IUCDs because the removal later on would completely damage the vaginal wall thus causing infertility.

Additionally, some said that contraceptives was only suitable for those who had already had a first child and that it would take some women up to two years to regain fertility after stopping contraceptive use.

"one can use that drug to stop ...
what I wanted because that bleeding is in our family,

even there are some who died from it…
They always say
ladies who do family planning
before giving birth are harlots or prostitutes….
When you use pills you are likely
to be having continuous non-stop
monthly periods and family planning
can make a woman give birth to
a kid with no legs nor hands.
If you are still single and use
contraceptives society see you
as a prostitute…"….
(IDI-12 JOOTRH)

"There are some people who
use those methods, end up losing fertility
and you get some problems in your life.
What I hear from outside,
they say, contraception can make
someone to…
like what my partner told me
if I use contraception any of those methods,
I would be like unfaithful to him
because I will just go round sleeping with men.
And others say you can end up
not getting any child in future. …"….
(IDI-10 JOOTRH)

Theme 9:

Suggestions and Concerns

A few participants suggested that, the facilities needed healthcare workers who were more mature and experienced in dealing with cases of post abortion in a professional way.

The majority of the participants were concerned about the use of the terms miscarriage and abortions. They felt demoralized when the healthcare workers criticized them for aborting although it was a miscarriage.

Other participants querried the fact that certain methods of family planning, such as IUCD would take so many years in the body and that no doctor would agree to remove them before the duration was over; despide the fact that they would be payfor removal.

"You know sometimes when somebody
comes to the hospital, say like she
had a miscarriage in medical terms.
Then you don't say miscarriage,
you just say abortion.
So when you say (abortion) to
the patient maybe she will feel like
self- esteem lowered.
As if you telling her
she had an abortion …"
(IDI 10 JOOTRH)

"Once inserted, it (IUCD)
must take certain number of years
and no doctors will agree
to remove it before that particular time.
…Not actually forcing you
but at time they remove it,
they always charge
some money for that procedure."
(IDI-5 KEDH)

Discussion

The study highlights women's perceptions of post abortion contraceptive counselling rendered by service providers within the available facilities which are usually family planning clinics or provided with contraceptives by doctors.

Since fertility returns early within 7-10 days after abortion some post abortion victims get pregnant before they reach family planning clinics. PAC patients were not being followed up for contraceptive counselling after they left the Family Planning Clinics.

The study took to find how patients seeking Post Abortion Care perceived contraceptive counselling provided by service providers in Kisumu County, Kenya.

This is an essential tool to enhance contraceptive usage among post abortion patients. It is important in improving the quality of healthcare and influence change of behaviour positively as a way of promoting good care.

Counselling may sometimes result in complex decision-making processes by the recepient. This requires the healthcare worker to be supportive

and flexible in incorporating recepient's partners in the process allowing time for a final decision on contraceptive methods made by the duo.

One of the findings is that, in most cases there was freedom of choice in family planning contraceptive methods. Without any coercion, the healthcare providers played a key role in reassuring the respondents and giving them the freedom to make their own informed choice on the method of family planning.

Freedom of choice was influenced by the way the healthcare providers communicated with the respondents on different methods that were available both within and outside the nearby facility before asking them to select a method.

The results were similar to a study that was conducted in Nairobi in which 45 per cent of the participants who responded to the question agreed that they had received adequate information from the providers. That, the healthcare providers delivered routine counselling even after that visit [6]

This cuncured with a study done in Nigeria, which showed that, the women were provided PAC care and given an opportunity to have a family planning method of their own choice [5].

However, the results are different from a study done in Malawi and Dominican Republic, which showed that youths were not counselled by the healthcare workers despite them yearning for the information.

Therefore it was evident that healthcare workers play a major role in providing contraceptive counselling after abortion. This may have been motivated by the fact that, they are well trained for these services and that they are empathetic towards the provision of good quality healthcare services [9].

Provision of accurate information and the interactions participants have with the healthcare workers determines the quality of care and the outcome of care provided.

The younger recepients said, they were a bit hesitant to discuss openly issues of contraception.This was attributed to the fact that, some felt they could be victimized.

Therefore, no need for the health care workers to provide reassurance to the youths and provide them with a conducive or non-threatening environment to allow free expression but later no use.

Contrary, it was revealed that, the older women especially those who already had children appeared to be more comfortable. Discussing family planning due to the fact that, they had tried several family planning methods before and were openly able to express themselves.

The findings confirm that, the participants were knowledgeable on contraceptive methods. The associated side effects despite some participants referring to the methods using the anatomical site in which these methods were placed or administered.

This concurs with other studies conducted in Uganda, Nairobi and in Western Nigeria of which, the participants exhibited high level of knowledge on contraceptive methods [5].

Despite the high level of knowledge, it is still important for the healthcare worker to continue educating the recepients on a different method during post abortion contraceptive counselling. Suprisingly informed by some respondents' misconceptions about some contraceptive methods.

Some of the reasons that have been put across as imperative in allowing the respondents to learn methods, are the good relationship with the providers.This was an important aspect when assessing the quality of post abortion care and contraceptive counselling.

Eventually, attributes such as responsiveness of the healthcare workers, genuine concern in the receipients' situation and clarity in communication during counselling are paramount since they are useful in determining the quality and outcome of the care provided.

The study found that the respondents were well followed-up after PAC to ascertain the progress. Besides, the respondents were reminded of their return dates, which enhanced the number of participants who returned for counselling and services.

Similarly, to a study done in United Kingdom, which showed that follow-up was essential in improving

the post abortion contraceptive counselling. It gave the receipients the reassurance and hope that it was still possible to have another child [24].

In a study conducted in Turkey 75 per cent of the respondents who received a follow-up continued the use of contraceptive methods [4].

The study adds to the literature that telephone reminders are a unique way of promoting continuity and follow-up on contraceptive use after abortions. Facilities need to invest in it.

Besides the telephone reminders transportation for the receipients who are not able to access the facilities was significant. It was an essential tool of encouraging the respondents to go for follow up especially when they face economic challenges [12]

Likewise a study conducted in Myanmar that showed that some receipients would delay to seek PAC because of lack of transport [10].

The other essential way of increasing contraceptive use is by reducing the financial charges required for certain contraceptive methods (an example in this part of the country is the implants and IUCD methods).

This study has shown that facilities that provided subsidies for contraceptives attract receipients with financial constraints. These clients consider these facilities as offering better quality healthcare.

Respondents viewed the technical competence and knowledge of the healthcare providers in providing contraceptive counselling excellent. They valued the knowledge because the providers were able to correct misconceptions and myths around contraceptives.

Partners play a key role in the usage of contraceptives especially after an abortion. The presence of the partner was also considered effectivel in helping to reduce some misconceptions around contraceptives.

Finally the study revealed widespread and firmly held beliefs about negative effects of contraceptives. Most of this are mythical.

Studies have shown that myths and culture are some of the challenges that countries face towards increasing contraceptive use.

For instance, studies from Uganda show young women and men as well as among contraceptive service providers multiple obstacles to contraceptive use.

Such obstacles were:

a. Misconceptions and fears related to contraception,
b. Gender power relations,
c. Socio-cultural expectations and contradictions,
d. Short term planning and health service barriers [15]

Therefore it is essential for the service providers to render contraceptive knowledge during counselling to help reduce the misconceptions and myths to prevent repeat abortions and further support contraceptive use.

Conclusion

The respondents were able to obtain information on the various methods of contraception, enabling them to make informed choices as a result of the discussions. The good interpersonal relationship of the service providers with the respondents established rapport and reduced the stigma allowing them to discuss contraceptives freely.

, Respondents were now able to revisit Clinics after abortion without fear, simply because the service providers were friendly and they could discuss their problems without any reservation. Contraceptives were provided free of charge after discussions with the respondents who felt comfortable using the contraceptives.

The contraceptives that the respondents chose such as IUCDs, implants were not free. Participants were supported by the project.This is because they were out of stock in the facilities.

Partners were considered to be important in contraceptive decision making such that those who had partners present found it easy to make a decision.

Respondents suggested that, the healthcare workers should be more experienced in dealing with post abortion in a professional way. Respondents did not like the term abortion because it demoralized them.

The myths, culture and misconceptions around contraceptives, are major challenges and therefore, healthcare workers need to provide knowledge that can reduce the vice.

Several factors including good interpersonal skills, service providers′ competence to inform on contraceptives, partner support, and service provider technical competence care is essential components in good quality post abortion contraceptive counselling.

The label family planning is deterrent for young women to step in for contraception as it infers that they are women who are married and therefore contraceptive use could be a better concept more palatable and in future to both young and older women using the services.

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