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Chapter

Government Sponsored Community-Based Health Extension Program Enhancing Contraceptive Provision in Southern Ethiopia: An Interpretive Phenomenological Exploration

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Abstract

Albeit the government efforts improving access to contraception through health extension programs in Ethiopia, gaps exhibited on experiences of the stakeholder about the basis on services provision. Therefore, perceptions about the enablers and rationale for contraceptive service were explored. Interpretative phenomenological design was employed to explore the lived experiences of stakeholders. Focus group discussions, individual in-depth interviews, and key informant interviews were employed for data collection. Data were analyzed using interpretive phenomenological analysis. The finding indicated that contraceptive service provision from the socio-economic perspectives was understood adequately, but the human rights-based rationale was shadowed. The contribution of the health extension program for contraceptive use has been remarkable. The improvement is attributed to the alignment of primary health care with the community organizations such as women development armies. The health extension program accelerated contraceptive service and given momentum for PHC. Women revealed encouraging involvement in the process of contraceptive service access and use. However, the bigger picture, and rationale for providing contraceptive services, the human rights approach, remained elusive at lower hierarchy. Hence, the study recommends that the disconnect in the broader premises of providing contraceptive services must be properly communicated across the stakeholders.

Keywords: health extension program, human rights, contraception, phenomenology, rationale

1. Introduction

The provision of modern contraceptive services in developing nations began because of the strong push from developed nations in the 1960s [1–4]. However, the lack of strong governments commitments along with limited resources and the underlying socio-cultural factors remain major impediments to the expansion of the services in many developing nations [5]. Among the notable challenges to be mentioned in the process of service provision is the access to contraceptive services affected by a lack of well-structured institutions in terms of the availability of health professionals and material inputs [6].

To narrow the gap between developed and developing nations toward contraceptive service access and use, the Primary Health Care Declaration (PHC) provides guidance that played a significant role [7, 8]. PHC has clarified a meaningful health strategy for reducing maternal and child morbidities and mortalities in developing nations [9]. Moreover, PHC has bridged the gap between institutional health service delivery and community demands through a community-based service delivery modality [10].

Ethiopia has realized that health issues require the involvement of multiple sectors and collective undertakings. Based on this understanding, the country revitalized the primary healthcare approach by identifying key stakeholders and sectors to involve in the implementation of health-related activities and actions [11, 12]. Guided by the health policy of the transitional government, the Federal Ministry of Health of Ethiopia (FMOH) has taken numerous measures to improve the health status of its population. Among the major steps that have been taken in designing and development of A 24 Health Sector Development Plan (HSDP) with its five successive five-year phases is among the several steps the government actions. After a critical evaluation of the health-based initiatives, the MOH revised its approach and incorporated government-paid community-based health service delivery, the health extension program (HEP) in 2003 [13–15].

The HEP is an innovative approach constituting a paradigm shift in Ethiopia's health service delivery creating strong links between the mainstream institutional health service and community-based health service expansion [16]. The peculiar aspect of the health extension program is that the service providers are all women except in a few pastoral villages and permanent employees of the government. They serve in the rural villages where they grew up, live and, are permanent employees of the government. This was different from the former practice which was based on volunteerism.

The HEP is expected to improve access to health care through increased availability and acceptance as workers largely share similar cultural backgrounds and speak the same language as the community they serve [17–19].

In spite of half a century or more contraceptive services in Ethiopia and encouraging engagements of the government and health workers, there are limited research outputs that reveal the depth of the lived experiences of service users, health workers, and health leaders about how service organizations and extension affect the outcome. This study sought to explore the ways that leaders in the health system, health care providers, and service users attempt to create an enabling environment for contraceptive service provision and its use. The study was conducted by aiming to describe patterns of a provision of contraceptive services and capture the perspectives of health care providers, leaders, and service users' and their lived experiences on enabling conditions of the contraceptive service organization, provision, and use.

2. Materials and methods

2.1 The research context

This study was conducted in three districts of Sidama Zone designated by Hawassa University as technology villages for research and technology transfer. The three districts were selected for accessibility. Hawassa University is located in the Sidama Zone, one of the 13 zones in the Southern Nations Nationalities and People's Regional state (SNNPRG) of Ethiopia. Sidama Zone is located in the south-eastern part of the region and is bordered by Oromia Regional state on the south, east and north and with Wolaita Zone in the west [20]. Projected from the 2007 national population census, the zone has a total of 3,471,568 people of which 1,753,142 (50.5%) are men and 1,718,426 (49.5%) are women. Close to 24% of the total population of the zone are estimated to be women of reproductive age. Household family size is estimated to be 4.7 and the annual population growth of the zone is estimated to increase 2.9% [21].

2.2 Study design

The study employed an interpretive (hermeneutic) phenomenological approach which is appropriate for understanding the life world of contraceptive service users women, health care workers (health professionals), and health leaders. It focuses on describing the meanings given by the individuals and how these meanings (the experiences of health care workers, health leaders, and service user women enable contraceptive services provision and use) influence the access to the service and use [22, 23]. The approach further considers the importance of the expert knowledge of the researcher as a valuable guide to the inquiry. The study aims to explore the life experiences related to the enabling conditions for contraceptive services and use by employing this approach. It offered a unique opportunity to establish a rich and in-depth understanding of sustainable and progressive contraceptive services establishment [24].

2.3 Data collection

To capture in-depth information about the topic of interest: focus group discussions (FGDs), individual in-depth interviews, and key informant interviews were used. Three female research assistants with educational and professional experience were employed to fit the majority of study participants (the rural women). Recruiting the research assistants helped to bridge the gap in both language and gender. Recruitment of research assistants was done in consultation with the Regional Health Bureau, Zonal Health Department and colleagues. After recruitment and training the research assistants, health extension workers, and local women, the community leaders collaborated in the selection of study participants. A purposive sampling method was used to include well-informed participants in the study as key informants, focus group discussants, and in-depth interviewees to explore the depth of their lived experiences [25, 26].

Participants were enrolled in the study based on criteria set to suit the study requirement. These include: the women's experiences of the contraceptive services use for at least a year, their ability to elaborate on the services and factors affecting the service access in their locality, and health leaders at different hierarchies (health

institute, district, zonal, regional, and ministerial level) and the health extension workers.

A total of 82 women of reproductive age group were included and participated in the focus group discussions comprised of 7–12 participants in each FGD. For the individual in-depth interview, 19 women of reproductive age from nine kebeles were involved. A total of 18 key informants were involved in the interview based on the designated position they hold in their respective institutions (Appendix A). Semi-structured FGDs and interview guides were developed for the interview and the participants were encouraged to speak up about their experiences. This type of interview guide is assumed to be in line with the interpretive phenomenological approach that gives reasonable freedom for the participants to express their experiences of the phenomenon of interest in their ways. It further deepened discussions and reflections on the life experiences of the study participants [27, 28].

Discussions were arranged in consideration of the time and regularity and viability of rural women. All the discussions were conducted outside of market days and from 10:00 A.M. to 11:30 A.M. Data collection schedule was arranged with the study participants through the community health workers (the health extension workers and women development army leader). Consideration was given by the study team on time management as such arriving at the data collection site in time and arranging the setup in a convenient way. The seating arrangement was organized circularly so that everybody could have ample opportunity to properly see one another.

Once the study discussants took their seats, the health extension worker carried out greetings and introduced the research team. Informed consent was obtained to audio-tape and take notes during the discussion. Moderation of the discussion was done primarily by the principal investigator. The research assistant aided by translating to the women and back to the PI and taking the note. A discussion was conducted by giving adequate time that was apportioned for the women to raise issues related to the guiding questions. Care was taken to involve all participants equally so each could discuss their lived experiences. The discussion was managed by considering the standard time for the qualitative data collection and women's busy schedules. Each session lasted 60–90 minutes on average. Discussion sessions concluded with due care about the completeness of the collected data, if there were any queries from the participants and acknowledging their commitment. Participants were informed about the need to attend a subsequent meeting following the preliminary analysis of the first discussion.

The discussion session was recorded using two digital recorders to ensure accuracy and prevent equipment failure. A unique identifier was given to each focus group discussion to differentiate it from subsequent discussions and avoid confusion during transcription. Written notes were taken by a research assistant simultaneously.

Following the focus group discussion, the individual in-depth interviews were conducted with women participants by the research team in the woman's home or at the health post based on the preferences of the interviewee. For those who were interviewed at their home, the research team was guided by the health extension worker or the community leader. A signed consent was obtained from the participants by reading the form out loud to continue the interview. The study team managed the session by providing an even chance to all participants and encouraging all to talk about their life experience in detail without any fear or reservations. In such ways, the interview continued for 40 to 60 minutes until the study team agreed on the emerging ideas as

repetitions [29]. Handwritten notes were taken and an audio-tape of the interview was recorded.

Lastly, key informant interviews were conducted in the following manner. Flexible interview dates were arranged as almost all the key informants were busy with their official routines. Once the key informants were identified, an interview schedule was arranged with each interviewer either calling via phone or visiting the office in person. The key informants' interviews were arranged in the informant's office or working unit at a convenient time. The study team managed the interview reaching the site in time to ensure the functionality of materials and give adequate time for the key informants to read the consent form and sign it.

Key informant interviews began by briefly explaining the purpose of the study, the procedures for selecting the informants, and the overall process of the study. Once the research team obtained a final signed consent form from the participant, the interview was conducted. The convenience of the room and the sitting arrangement for the interview was ensured before directly embarking into the interview. By using a semi-structured interview guide, the interview was conducted flexibly and systematically.

The interview process was done by following a qualitative study data collection approach suiting this specific (interpretive phenomenology) design. The interview session was conducted as guided by the study guide questions and opportunities to probe more issues as they emerged. Adequate time was given to capture the necessary information and to ensure the documentation of both handwritten notes and recording the audio-tape. Finally, the research team thanked the informants for their time and information before departing and told them about the possibility of returning for further discussion after the preliminary analysis. All key informant interviews were conducted in similar procedures. Data collection was conducted from September 2013 to May 2014.

2.4 Data analysis

This study used the guiding principles of interpretive phenomenological methodology. It enables viewing the phenomenon along the way that reflects the significant interaction of both the data sources (participants) and the researchers as part of their "being in the world" rather than only "being' itself [30, 31]. Thus, the interinfluence and connections of the two sources are reflected in the interpretive analysis. An adapted flow diagram from the interpretive phenomenological analysis (IPA) was used to guide the analysis (Appendix B).

Data analysis was conducted in two languages. The following steps describe the process: transcriptions were carried out on all the audio-taped materials verbatim, first in Amharic and then in English (Appendix C). Materials were also translated back to Amharic by a professional linguist. After that, the Amharic translation was given to the principal investigator to check for consistency.

Summary finding in the form of shortened transcripts incorporating the field notes was presented to the key informants for their further input and comments. Data immersion by the researcher immersed into the data several times through repeated reading to find out emerging codes. The analysis process utilized several rounds of indulging in the transcripts, reading and rereading, consultation with the key informants, and soliciting their inputs for the emerging descriptive codes. Inputs from the informants were incorporated into the second round of data analysis with remarks. Side notes and descriptive coding were then completed for all the materials. Data

reduction was done in a step-by-step approach, beginning with the transcripts, followed by descriptive coding, and then distilling this material into themes by bringing similar ideas and concepts together.

The overall analysis process made use of the hermeneutic circle, which means iterative back-and-forth linkage of data from both the researcher's and participants' perspectives. Guided by the study questions, the side notes, linked to the descriptive codes, themes were identified These steps were done by re-visiting the transcripts after major themes had been identified to interpret connections between the initial data and our later refinements [29, 30, 32]. Summarized reports were presented to study participants about the phenomena derived from their shared experiences. Discussions were held with participants based on the study guide questions and core concepts. Their feedback was incorporated in line with the experience of the researcher. This increased the confidence in interpretations and further enriched the understanding of the phenomena.

Data quality was assured using the steps of qualitative data quality assurance approaches generally called trustworthiness. The four closely resembling criteria for ensuring trustworthiness are credibility (truth value), transferability (applicability), dependability (consistency), and conformability (neutrality) suggested in the literature [33]. Actions carried out to ensure the trustworthiness were: (1) presenting the summary of transcripts to the study participants to give them an opportunity for further comment; (2) reviewing of the preliminary findings to ensure the early findings reflect what they know and experience; (3) sharing the preliminary summary findings with the health managers and service providers to check interpretations.

3. Results

The findings of this study are organized under the respective questions relating to health provider efforts in creating an environment conducive to contraceptive uptake and use. The aim was a better understanding of the issues of service delivery organization, processes, and content related to service availability, accessibility, convenience, trends, and the current status of contraceptive services. Moreover, the pattern of service integration, linkage among the primary health care units and the community organizations, and anticipated challenges related to services sustainability and ensuring quality were also explicated.

3.1 Trends and patterns of contraceptive service provision in connection to the HEP

3.1.1 Health managers and service providers' perspectives

Despite more than half a decade of longevity of the contraceptive service provision in Ethiopia and the study area, the progress in reaching all segments of the population was sluggish. Voluntary non-governmental organizations mainly, the Family Guidance Association of Ethiopia, started this service provision at an early age. Integration of the contraceptive services into health systems took place gradually but service expansion and increment in method mix remained low until 2005, where sharp increment took place since then. All study participants in three data collection methods expressed frankly that the current level of contraceptive services expansion and improvement in the availability of method mix was attributed to the health extension program.

As pointed out by study participants that the health extension program has brought contraceptive services closer to residents living and working places. In doing so, it has improved unconditional access to the service.

The extraordinary contribution of the health extension program in enhancing the contraceptive service access unlike the previous approach, is its propensity to extend the services to the household level through home visits and other community-based distribution options using community-based organizations such as women development armies. Another merit of the health extension workers is that they are female and recruited from the same *kebeles* where they offer service. This created a conducive environment for service-seeker women to feel comfortable when visiting the health post to access contraceptive service and when the female HEW visits their home; they express their needs without reservation. Moreover, the service-providing health extension workers share a similar culture and speak the same language and being female creates a favorable environment for women to ask whatever questions they desire. Study participants substantiated these conclusions:

> *The health extension program has improved access and utilization to communities and households. Gender parity of the health extension workers with plenty of health service users, the women is another important issue received attention. The program played incredible role that averted several barriers of contraceptive service use. These were evidenced by the convenience the program created for women in terms of time, distance language and cultural harmony. On top of the above, the program also created gender parity between the service providers and users. In the nutshell, the health extension program improved access to the services*

> *The health extension program is therefore a reason for the rapid increment in contraceptive prevalence and service coverage in the district as of the last seven years. This is so because the health extension workers provide the service both institutional and outreach models (at health posts but also house to house visitation). The health extension program significantly reduced the former distance of more than 5–10 KM to 2–3 KM walk and stretched it to the household level.*

The finding of the study has justified that the establishment of the health extension program created a strong services link within the primary health care units and the community. This further contributed to the current state of contraceptive use progress. More specifically, community mobilization using women development armies, and a one-to-five network [1] through model households are notable experiences to learn from.

All the study participants consensually remarked that the health extension program and the service organization have functional linkages manifested through collaborative undertakings at the community level. The strong collaborative undertakings between the health extension workers, the women development armies, and a one-to-five community network ensured the expansion of contraceptive service within their catchment area. Such interlinks or collaboration among stakeholders not only improves access to services but also is a clear indication for female empowerment as the service providers, advocators, and community leaders lead contraceptive service programs. This was further substantiated by citations from the study participants and a district-level manager explained the issue as follows:

Health system organization in the study area is a witness for the observed strong linkage and collaborative undertakings. The health professionals from the health center provide supportive supervision to the health post and in a similar passion the health extension worker do so for the women development army. The supportive supervision is for all the health extension packages including the family planning services.

Similarly, another experienced health extension worker has given her experience in this regard by clearly indicating:

By its very nature the health extension program is from the 'community to the community', that has strong linkage between the service providers, users and leaders. The relationship is eventually took a shape of strong family and created mutual trust. We, the health extension worker provide service with a sense of serving our fellow women. A woman being the first contact point in the household has been another ease condition for the expansion of services both in the household and the community. On top of the women development army a one-to-five network system, we also use other community organizations such as 'edir' and 'kuteba mehiber [2]'. We work collaboratively with all these organizations, networks and systems. Generally, we have established a strong working relationship starting from an individual woman to the community level.

3.1.2 Service user women's perspectives

Experiences of service user women toward contraceptive service availability and accessibility in the era of health extension programs are congruent with the health service manager and service providers' articulations.

Women explained that, unlike the previous high-level health institutions, now they comfortably express their feelings and get services including advice easily through understanding. They never fear or feel ashamed of telling their feelings as the health extension workers are from the same localities. When the health extension workers visit clients' houses, women easily talk to them and even invite them to have coffee or food. Because of such interaction, the extension workers feel at home and well-acquainted with the service users. This was not the case before the inception of the health extension program.

Daname, a woman in the focus group discussion who has used contraceptive services from various sources elaborated on the service access difference and the convenience now and previously:

I paid 270 ETB for contraceptive service (surgical implant) at Yirgalem hospital before the access to contraceptive service improved. I also waited for five days to get service in addition to paying a service charge as stated above. Now the situation is different. Service accessibility was greatly improved. As the former discussants mentioned, we got service here at our kebele by our children. This is a big change. We share our feelings without hiding anything from the health extension workers. We don't have a problem with waiting for long hours for services, no need to go daily to queue up for services, no one tells us to bring your card from the card room. We receive services at one stop shot.

Similarly, another woman in one of the focus group discussions vented:

More specifically, the establishment of a health post in our kebele has created a better chance to access health services both for ourselves and our children. We were troubled

> *to access the health services for our children before the establishment of this health post. It was customary to move here and there looking for health services previously. We were forced to take them to medically unproven services and exposed them to unsanitary/unhygienic services. Past years were known for us for the huge deaths of our young children others remained disabled. Appreciation should be paid to the government and our God who brought this time. We got relief and our children are growing well and healthy (Baliessie, a mother of 5 children and 30 years old).*

Loetie, a 25-year-old woman who used contraceptive service for 5 years explained her lived experience as how she has benefited from the service as:

> *Remarkable change is seen here when compared to the earlier time. Instead of waking far distance to access contraceptive service, this time I am accessing contraceptive service here in my kebele with a short walk distance. Before the health extension program, one was experienced walking long distances and required to pay for contraceptive service. Thus, the long-distance walk, time and financial barriers hampered from service users in the pre-health extension era. Grace be to the Almighty God and appreciation to the government; we receive health information daily. The health extension workers provide services and information in all the packages, with due focus on how to keep our hygiene, different types of contraceptive methods available in the health posts and elsewhere, inform the benefits of contraceptive use about spacing pregnancies thereby improving the health status of both mothers and children.*

Furthermore, women expressed their views on the contribution of the health extension workers in creating health services demand and access in their respective kebele. They are the first to bring contraceptive information and services; by the way, this remains the reason for the improved prevalence of service use in their kebele. Women further witnessed that their know-how and skills for health service use are improved since the establishment of the health extension program.

This is further supported by the excerpts from other participants:

> *Before the health extension program, I knew nothing about what contraceptive service mean and why it exists. We hardly find health services in our locality until the establishment of the health post in our kebele. Mostly we were ignorant about health services such as contraceptive use and vaccination. Immediately following the establishment of the health post in our kebele, the worker started to inform us about various health extension packages including contraceptive use and related benefits. They showed us the difference between unplanned and planned fertility and mechanisms to control fertility, (Dalbe, a 27 years old used contraceptives for 7 years).*

A one-to-five network means a model woman in one of the five neighboring households: act as a team leader (due to her outstanding performance on the health extension program) for all development-related affairs in that team.

4. Discussion

4.1 Toward an enabling environment for contraceptive use

The perception of participants in the study regarding the environment in relation to contraceptive service is discussed in this section and includes: (1) the service

organization that includes accessibility, availability, acceptability, and convenience (2) the premises of rights approach for service provision and (3) special contributions of health extension program as an innovative primary health care strategy toward contraceptive service.

4.2 Contraceptive service organizations (content and process)

The study has indicated that until recently, the access and availability of services were weak in the country. The findings confirmed this claim, as, at the early stages of the health extension program, only oral contraceptive pills were available at health posts. Currently, couples of methods are available including short-term methods and long-term methods at the health posts provided through a health extension program. However, the availability of more methods is not uniform across the health institution. It increases when one goes up in the hierarchy of health services delivery institutions.

Agreement is established among stakeholders (services providers, users, and health managers) of the availability, accessibility, convenience, and use of contraceptive services in the study area. One can conclude that there are some improvements in coordination and communication among stakeholders concerning the service processes and contents. Except for a few, all the participants' experiences showed that contraceptive service availability, accessibility, and quality are improving. Some peculiarities were experienced concerning the injectable contraceptive method availability of specifically injectable contraceptives.

The lack of a particular method, an injectable contraceptive (which is more likely accepted by users), may pose a challenge to further expanding and sustaining contraceptive services [34]. Switching from one method to another ought to be due to defined medical reasons or the choice of the client, but the current shortage-related switching is another hindrance that may overshadow service quality and expansion. The shortage of widely acceptable contraceptive methods could hamper service expansion and negatively affect the good feedback toward the HEP. The irregularity in availing of preferred methods may contrast with the established service norms, which state that the service delivery should provide adequate attention to sociocultural and personal experiences [35–37].

The study examined the processes that support the provision of high-quality contraceptive services and revealed that most contraceptive users' access services from health posts. As indicated, the prime source of contraceptive services in the community is the health extension worker with close supervision from the health center. Therefore, maintaining the quality of such service is dependent on regular updating of the competence of the health extension workers through continuous refresher training and supportive supervision. These must be coupled with the provision of materials that help with spot references such as job aid, guidelines, manuals, and standard operating procedures. The availability and use of reference materials are examined in this study from the perspectives of service providers and managers.

The higher-level health service managers argue that they have prepared and distributed standard supportive documents in the form of manuals, flipcharts, and leaflets as requested by the regions. Similarly, most of the health extension workers indicated the availability of reference materials adequately and useful in guiding their service provisions. However, few of the service providers had shared their feelings that the materials are inadequate or incomplete for fulfilling the level of competency

required for service provision. The study revealed that reference materials (and that the materials are comprehensive and easy to understand and use) by the service providers helped to provide contraceptive services efficiently. Service providers' competency is crucial for initial service start-up and subsequent continuation of service provision. The findings from USAID-Deliver [38], argue that proper method choice and sustained use are dependent on the information clients receive from providers.

Government-sponsored health extension program is one of the significant indicators for the established links to the contraceptive uptake. The establishment of the health extension program remained a unique landmark for the rapid services uptake and quality improvement. This is further evidenced that more than half a decade-long service remained sluggish in its progress but has shown tremendous improvement since the establishment of this program. As has been indicated in much empirical evidence [39, 40], the service coverage showed tremendous improvement in contraceptive prevalence.

From the perspectives of the service providers, health services managers and users, the study scrutinized their view of which factors contributed to the remarkable improvement in contraceptive use and any defined connection to the new innovative community-based health extension program. Their lived experiences indicated that the health extension program has made a unique contribution to rapidly improving access to and convenience of these services for women. As indicated in the participants' experiences the health extension program improved services access by bringing them closer to women where they live, and work compared with the former strictly institutionalized approach of service delivery.

The availability of the services in each *community organizations* created the opportunity for women to easily access the services tackling challenges related to distance and requirements of permission from their husbands. In circumstances when women maintain the secrecy of their service use from their husbands, they go to the health post as if they are going to a neighbor's house. Studies support this finding that any service to be promoted and used by the target group should fulfill certain conditions including physical, financial, and socio-cultural aspects. Bringing services closer to the potential users increases the possibility of actual use [41, 42].

Another peculiarity of the health extension program concerning contraceptive service is that the program has removed many obstacles and barriers that hampered women's potential for service use. When the behavior of health professionals welcomes the service users (cultural and linguistic congruence) clients are more likely to use services [43, 44]. Thus, this study finding is in congruence with the above one as the health extension workers are almost all women recruited from the *community* which they serve and share the same culture and language. This has removed the gender, language, and cultural barriers between service providers and service users.

The contextual similarity between the health extension workers and service user women not only created a unique opportunity for the early services adoption but also for the continuous use. Women evidently expressed their experiences in this regard by comparing their pre-health extension program service inquiries. Formerly, the service was far from their residential area and male-dominated. Moreover, they were requested to pay for services and in most cases looked for a translator to explain their feelings to the health professional. As a result, they were highly discouraged from the health institutions to seek services [17–19].

The peculiarity of health extension programs in improving access is their conformity to the local community context. The contraceptive service extension to the household through home visits by female health extension workers is favorably welcomed by the community. Program. This is connected to cultural aspects and the domestic work patterns in which most rural women stay home doing domestic duties, and thus, are easily accessible for a health extension worker to provide services during their home visits.

The study further showed another crucial perspective of the health extension program the participants' life worlds related to contraceptive service, its alignment to the multidimensional aspects of the health systems from the health principles and philosophical ascertainments. The organizational arrangement of the health extension program shows strong links from the community level to the mainstream health institution. This further indicated and assured the need for close collaboration across the wide dimensions of actors to ensure the success of the program. The health system closely works with partners at various levels to fill gaps either technically or materially. Many study findings show that health service delivery approaches that do not leave room for inter-sectorial cooperation and that do not ensure community involvement is never satisfactorily accessible, acceptable, or sustainable [19, 39, 43, 44].

More so is the trust the health extension program builds at the community level. It is at this time that the health system closely functions with the local community in a sustainable manner. This is in line with the assertion that the health system is being affected and affects other systems. This is evidenced by that the health extension program functions in a network at the *kebele* level. The health extension workers participate in the *kebele* affairs and receive support from the *kebele* administration. They are members of the *kebele* command post, which is responsible for overall affairs. Furthermore, the health extension workers closely function with the women development armies, one-to-five networks, and model household women. This has established strong linkages between the health extension program and the community members at a basic level. Thus, it is through such channels that information and services flow until they reach the households and target women.

The trust and strong collaboration established between the health extension workers and the current women users of contraception has created a circular passion for the information dissemination to the current non-user women in the community. The platform of current service-user women in the community through the women development army and the one-to-five network in their neighborhood helped initiation of discussion about contraceptive use and its benefits with the current non-user counterparts by sharing their life experiences. Perry and Roger (2014) argue that if the health service delivery approach offers attention to the multiple dimensions of health determinants and involves all stakeholders, the service uptake increases tremendously. Gulzar and Ali [45] also agree that the client's family planning service use behavior is largely influenced by the relationship between the service provider and the client. This study has proved that female health extension workers have greatly improved contraceptive service uptake by extending service to households through home visitation.

The basic premise of contraceptive service provision was reemphasized that the health extension program packages were designed based on fundamental human and reproductive rights. The human rights dimension for reproductive health received little attention at its earliest time. Through the persistent struggle of the advocacy

groups coupled with a series of UN conferences, meetings, and treaties have produced an agreed-upon approach to ensure the reproductive health rights of service users. The essence that human beings have a right to enjoy the highest level of attainable health, including sexual and reproductive health, received increased attention. Women and men have the right to have means to do so without any discrimination and coercion. Such ascertainments ensure that women have the right to choose a method best suited to their condition and to withdraw from the method when it fails to do so. In the contrary to the human rights principle, failure to provide adequate information and limiting service access is an indication that the contraceptive service is not in line with the ICPD plan of action. Hardee et al. [46] argue that any family planning program must respect the ICPD plan of action and must guarantee freedom of contraceptive choice and respect, protect, and fulfill human rights.

4.3 Strengths and limitations

The study was conducted in three districts of the Sidama zone and considered only the married women currently using the services may be considered as the limitations of the. Sexual and reproductive matters are usually sensitive and considered as taboo in most rural communities, thus might have limited the depth of response during data collection. Another possible limitation is that the study has not considered current non-users' perceptions of the benefits of contraception. Men are also not considered in this study as the prime purpose of the study is to explore the experiences of women.

The study was carried out to explore the experiences of women contraceptive service users in the Hawassa University research villages, which were established to observe the impact of university-based research in knowledge generation, technology transfer, and the livelihood of the residents. The scope and patterns of this study have taken such shape with the assumption to strengthen the university-community linkage. These are some of the delimitations of this study.

4.4 Conclusion and recommendation

Based on the findings of this study, it can be concluded that the contraceptive service organizations' process and content, are encouraging and improvements made in service quantity and quality. HEP symbolized the effectiveness of community-based health services provision as the backbone of primary health care. Moreover, HEP amicably expressed the functionality of intersectoral collaboration and various community-based organizations networks hand-in-hand for the betterment of the most needy segment of the society. Women revealed encouraging involvement in the process of contraceptive service access and use in their organizations such as development armies and the one-to-five network.

4.5 Recommendations

Identifying successful strategies for the sustainable use of reproductive health services from the human and women's rights perspectives is vital not only to ensure the well-being of women and their significant others but also toward ensuring the attainment of sustainable development goals. This study, therefore, has come up with the following recommendations to ensure evidence-based service provision and propel contraceptive service use in a way that consistently respects human rights and sustainable use:

1. Strengthen the existing community networks through proper evaluation and feedback and create strategies on how to improve men's involvement in reproductive health services, including contraception, in a manner that respects, protects, and fulfills women's rights.

2. Establish mechanisms to share the experiences of women development armies, a one-to-five network to expand the inclusion of men and elders to broaden contraceptive services to the current non-user and ensure sustainability

3. Special preparation is needed to avail of the contraceptive methods without discontinuation

5. Declaration

5.1 Ethical considerations

Ethical clearance for this study was obtained from all concerned institutions both abroad and in-land. These are: the University of Saskatchewan, Canada, Hawassa, University, Ethiopia and the SNNPR Health Bureau, Ethiopia. Study participants offered their consent in written form ensuring their voluntariness to be part of the study. The study team explained the purpose of the study; its benefits and any risk in case thoroughly to prove the confidence of the study participant. Study participants were informed about communication of the study finding in various meetings, workshops and publications and verbal consents were obtained.

5.2 Consent for the publication

This manuscript is an extract from the PhD dissertation with some addition later on. All ethical issues including communication of the finding to various stakeholders were properly communicated and their consents were obtained. Study participants signed consent forms in the local language are attached under the supporting document Section 7.

5.3 Declaration of funding

The original PhD dissertation was funded by the joint contribution of Hawassa University, Ethiopia and the University of Saskatchewan, Canada. The funding was only covered fieldwork expenses such as travel cost, perdiem, fuel, and related incidentals. Additional data were gathered at the expense of the authors' personal pockets. No fund was allocated for the communication of finding such as publication. There is no interference of the funding entities in all undertakings of the study work except offering the fund for the accomplishment of the study.

Authors' contribution

The manuscript is a joint effort of all the authors. AA was responsible for conducting data collection, analysis, and the write up. LH was responsible for revising transcription, analysis, editing, and supervising all steps. MM was involved in designing the study, manuscript preparation, editing of the manuscript.

Competing interest

The manuscript is the efforts of both authors primarily dedicated to academic purposes. The financial support from Hawassa and Saskatchewan universities was in support of a PhD study. The manuscript is partially taken from the PhD dissertation with some addition of data after it. Hence, there were no competing interests either from the funding sources or the authors.

List of abbreviation

WHO	World Health Organization
PHC	Primary Health Care
MOH	Ministry of Health
HEP	Health Extension Program
HEW	Health Extension Worker
SNNPRG	South Nation, Nationalities and People's Regional Government
FGD	Focus Group Discussion
IPA	Interpretive Phenomenological Analysis
ICPD	International Conference on Population and Development

A. Profile of study participants

A. 1 FGD

Site 1

See **Tables A1–A9**.

S. No.	Age	Education	# of children	Year of contraceptive use
1	35	9	4	5
2	25	10	4	10
3	30	5	8	10
4	32	1	03	7
5	30	6	05	12
6	25	4	4	6
7	35	7	7	10
8	25	—	5	3
9	27	10+3	2	6
10	32	2	7	8
11	30	9	7	6
Mean	**29.64**		**5.1**	**7.54**

Table A1.
Profile extracted from the FGD participants' transcription document of the Waycho site.

Site 2

S. No.	Age	Education	# of children	Year of contraceptive use
1	25	7	5	4
2	30	—	8	7
3	25	6	3	4
4	25	—	4	3
5	34	8	4	3
6	30	—	8	2
7	40	6	8	6
8	20	10 completed	1	2
9	40	4	7	7
10	25	3	2	4
Mean	**29.4**	**4.4**	**5**	**4.2**

Table A2.
Profile of the participants extracted from the FGD participants' transcription document of the Ganie site.

Site 3

S. No.	Age	Education	# of children	Year of contraceptive use
1	28	—	4	3.5
2	27	—	5	7
3	23	10 completed	1	2.5
4	25	—	7	4
5	30	—	4	10
6	30	—	6	8
7	25	—	4	8
8	20	4	3	4
9	30	—	6	6
Mean	26.44		4.44	5.88

Table A3.
Profile of the participants extracted from the FGD participants' transcription document of the Degara site.

Site 4

S. No.	Age	Education	# of children	Year of contraceptive use
1	28	—	6	3
2	27	—	5	7
3	30	—	4	3
4	35	—	3	1
5	30	—	6	4
6	30	—	8	5
7	25	—	5	2
8	30	3	5	2
Mean	29.4		5.25	3.34

Table A4.
Profile of the participants extracted from the FGD participants' transcription document of the Korangoge site.

Site 5

S. No.	Age	Education	# of children	Year of contraceptive use
1	25	5	5	8
2	22	8	3	4
3	20	4	4	3
4	20	9	2	2
5	25	6	5	5
6	26	6	5	9
7	20	4	2	3
Mean	22.57	6	3.7	4.86

Table A5.
Profile of the participants extracted from the FGD participants' transcription document of the Dilarife site.

Site 6

S. No	Age	Education	# of children ever born	Period of contraceptive use	Remark
1	25	5	2	5 years	
2	25	4	5	7	
3	22	7	1	1 and half	
4	35	3	7	5 and 3/12	
5	30	—	4	4	
6	30	—	6	3	
7	22	10 completed	1	2	
Mean	**27**	**4.14**	**3.7**	**4**	

Table A6.
Profile of the participants extracted from the FGD participants' transcription document of the Konsore Fullasa site.

Site 7

S. No	Age	Education	# of children ever born	Period of contraceptive use	Remark
1	36	8	10	5 years	
2	28	5	3	1	
3	30	2	6	8	
4	30	5	4	1	
5	34	2	4	3.5	
6	32	-	4	3.5	
7	35	7	5	11	
8	30	-	2	4	
9	25	3	3	5	
10	30	7	5	9	
Mean	**31**	**3.9**	**4.6**	**5**	

Table A7.
Profile of the participants extracted from the FGD participants' transcription document of the Gassara Kuwie site.

Site 8

S. No	Age	Education	# of children ever born	Period of contraceptive use	Remark
1	25	7	2	3 years	
2	30	1	4	8	
3	35	—	5	9 and half	
4	30	—	5	7	
5	25	—	3	3	
6	38	5	4	6	
7	30	—	5	8	
8	30	—	4	13	
Mean	**30.38**	**1.63**	**4**	**7.2**	

Table A8.
Profile of the participants extracted from the FGD participants' transcription document of the Wotara Gendo site.

Site 9

S. No	Age	Education	# of children ever born	Period of contraceptive use	Remark
1	36	8	10	5 years	
2	30	5	3	1	
3	35	2	6	8	
4	30	5	4	1	
5	30	-	4	3.5	
6	35	-	4	3.5	
7	35	7	5	11	
8	30	-	2	4	
9	20	3	3	5	
10	30	7	5	9	
11	35	5	4	5	
12	35	6	7	6	
Mean	31.75	4	4.75	5.16	

Table A9.
Profile of the participants extracted from the FGD participants' transcription document of the Basha site.

A. 2 Profile of key informants

See **Table A10**.

S. no.	Age	Sex	Education	Profession	Service YR	Position
1	30	M	BSc	Health Officer	12	District Head
2	28	M	BSc	Health Officer	2	Deputy Head, district
3	27	M	BSc	Nurse	4	District Head
4	34	M	BSc	Health Officer	13	RH coordinator, District
5	29	M	BSc	Family science	7	RH coordinator, District
6	51	M	BSc	Health Officer	31	RH coordinator, HC
7	29	F	Diploma	Clinical Nurse	4	RH coordinator, HC
8	26	F	10 + 1	Health Extension W	7	Service provide
9	30	F	10 + 1	Health Extension W	8	Service provide
10	22	F	10 + 1	Health Extension W	7	Service provide
11	25	F	10 + 1	Health Extension W	7	Service provide
12	44	M	BSc	Nurse	27	RH coordinator, HC
13	25	F	Diploma	Midwife	5	RH coordinator, HC
14	23	F	10 + 1	Health Extension W	8	Service provide
15	28	M	MD + MPH	Physician	7	Director for RH, Federal Minister of Health
16	38	M	MPH	Public health	18	Deputy Head Regional Health Bureau
17	25	F	10 + 1	Health Extension W	7	Service provide
18	23	F	10 + 1	Health Extension W	7	Service provide

N.B. The Key informants composed of service providers at community and health institution levels, health service managers at district, regional and federal levels indicating the hierarchy.

Table A10.
Key informant profile extracted from the transcription of the informants' document from the study sites such as health institutions (health post and health center) and the health services administrative offices.

B. Data analysis flow diagram adapted from IPAThe qualitative data analysis steps adapted from IPA (Smith et al., 2009, pp. 82–100) and customized to fit my study taking the following steps as indicated below in flow diagram (Figure B1).

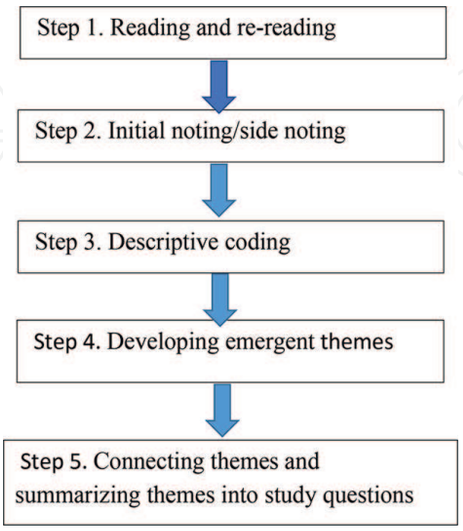

Figure B1.
It can be cited as Fig. B1. Flow diagram of data analysis adapted from the Interpretive Phenomenological Analysis (IPA).

C. A flow diagram indicating steps in translation

This study involved several participants in the overall processes with various languages background. In order to establish a common understanding and create

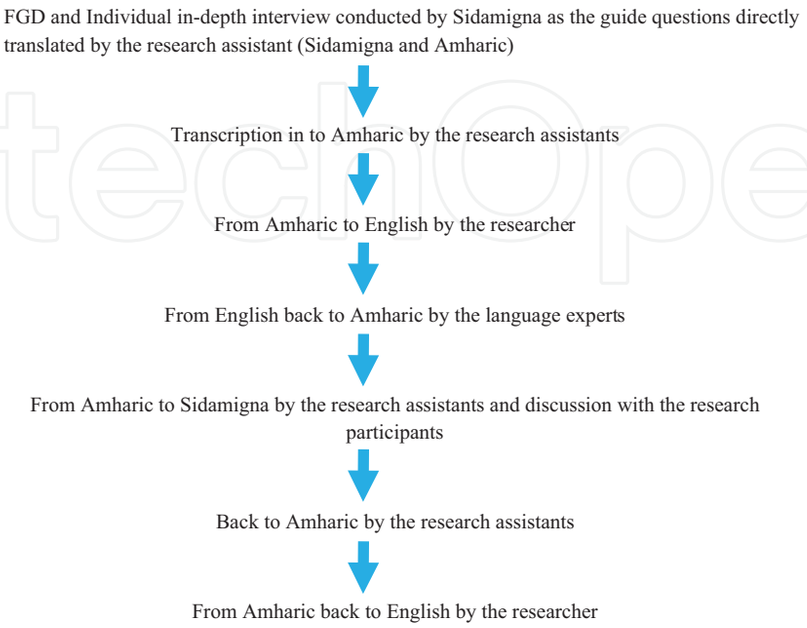

Figure C1.
This can be cited as a flow diagram developed to indicate a translation of transcription from the local language to the working language in the stepwise (developed by the researcher).

closeness in the process of the research, use of language translation from one to another has been a necessary condition. Accordingly, the following steps in translation has been taken until the final text took its recent shape (**Figure C1**)

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