

ORIGINAL RESEARCH ARTICLE

Quality of family planning counseling: An evaluation in the context of premarital counseling services carried out within a provincial health directorate in Turkey

DOI: 10.29063/ajrh2022/v26i10.12

Figen B. Birinci¹ and Rahime A. Er^{2*}

Kocaeli Provincial Directorate of Health, Akçakocabey Healthy Life Center, Kocaeli, Turkiye¹; Kocaeli University, Faculty of Medicine, Department of History of Medicine and Ethics, Kocaeli, Turkiye²

*For Correspondence: Email: raay@kocaeli.edu.tr; Phone: +902623034716

Abstract

Good quality family planning (FP) counseling meets the reproductive health needs of individuals and couples by supporting autonomous decision making. Survey-based assessments cannot catch nuances of FP counseling. This study aimed to evaluate the quality of FP counseling offered to couples in Turkiye (Kocaeli)- which is a primary example of a developing country. This study was conducted with health workers providing at least six months pre-marriage counseling services in five institutions. Data were obtained by information form, individual face-to-face interviews, and observation. Most of the 17 participants kindly welcomed, made simple explanations without making medical terms by making face-to-face and eye contact during the counseling. While some participants were able to provide information about contraception methods, other participants were not able to explain by showing an example of each method. This study's findings demonstrated that the quality of FP counseling in Turkiye is still sub-optimal. The time allocated to FP counseling was short and there was no given information about all methods of contraception. To increase the quality of FP counseling services offered by health providers, the existing FP guidelines and training packages must be reviewed. (*Afr J Reprod Health 2022; 26[10]: 101-110*).

Keywords: Family planning, reproductive health counseling, quality

Résumé

Des conseils de bonne qualité en matière de planification familiale (PF) répondent aux besoins de santé reproductive des individus et des couples en soutenant la prise de décision autonome. Les évaluations basées sur des enquêtes ne peuvent pas saisir les nuances du conseil en PF. Cette étude visait à évaluer la qualité des conseils de PF offerts aux couples à Turkiye (Kocaeli) - qui est un exemple principal de pays en développement. Cette étude a été menée auprès d'agents de santé fournissant au moins six mois de services de conseil pré-nuptial dans cinq institutions. Les données ont été obtenues par formulaire d'information, entretiens individuels en face à face et observation. La plupart des 17 participants ont été gentiment accueillis, ont donné des explications simples sans faire de termes médicaux en faisant face à face et dans les yeux pendant le conseil. Alors que certains participants ont pu fournir des informations sur les méthodes de contraception, d'autres participants n'ont pas été en mesure d'expliquer en montrant un exemple de chaque méthode. Les résultats de cette étude ont démontré que la qualité du conseil en PF en Turquie est encore sous-optimale. Le temps alloué au conseil en PF était court et il n'y avait aucune information donnée sur toutes les méthodes de contraception. Pour augmenter la qualité des services de conseil en PF offerts par les prestataires de santé, les directives et les modules de formation en matière de PF doivent être revus. (*Afr J Reprod Health 2022; 26[10]: 101-110*).

Mots-clés: Planification familiale, conseil en santé reproductive, qualité

Introduction

Family planning (FP) and reproductive health counseling is an accepted approach for increasing the awareness and acceptance of contraception¹. In many countries, models for the provision of FP and reproductive healthcare services are very similar in

different settings. There is ample evidence that structured and high-quality FP counseling supports the individual's informed and voluntary decision-making, increasing adoptions and modern FP methods' use^{2,3}. Furthermore, it has been argued that although FP services predominantly target women, FP programs targeting only women may

have limited success^{1,4}. In addition, men play important and complex roles in FP. One of the obstacles in meeting the FP needs of married women is their spouse⁵. Therefore, a great deal of effort has been made to educate and involve men in FP^{1,4-6}. Since the mid 1990s, there has been a consensus that FP services should be provided not only to women but also to men or couples together, which has brought with it efforts to develop different strategies in this regard⁷. However, very few programs that include men in FP have been effective. The challenge that arises regarding this issue is how to ensure the effective participation of men in FP services and how to support the decision-making process of the couples⁶.

Turkiye is the fifth country with the highest marriage rate among the countries affiliated with the Organization for Economic Cooperation and Development⁷. The highest rate shows regional differences and rapid changes depending on variables such as income level, cultural structure, and education level⁹. It is obligatory for individuals who intend to get married in Turkiye to obtain a health report stating that they do not have any diseases that prevent marriage⁸. While examining and testing couples who apply to the institution for a health report, counseling services on infectious and genetically transmitted diseases, reproductive health, and FP are provided within the scope of Pre-Marriage Counseling (PMC)¹⁰. In order to increase the quality of PMC services and to ensure standardization, since 2013, "Pre-Marriage Counseling Instructor Training" is given to midwives, physicians, and nurses who provide PMC services. In this regard, FP training offered within the scope of the counseling services given to couples who apply for a health report before marriage is important. Couples apply to the institution together to get a health report before they get married. Therefore, perhaps the only setting where both men and women can be evaluated together about FP. FP training can be given to both woman and man at the same time, and active participation of both partners in FP is ensured. For this reason, FP counseling offered to couples in PMC settings is an important opportunity to support couples' autonomous decision-making and ensure the involvement of men in the process. Studies conducted in Turkiye have focused mainly on the knowledge and attitudes regarding FP¹²⁻¹⁴, and the

extent of the knowledge about the content and quality of FP counseling remains limited¹⁵. In addition, FP training provided for higher levels of contraceptive use needs to be evaluated. In this study using data from interviews with healthcare professionals, we aimed to better understand the quality of FP training provided during the PMC sessions. In addition, the objective of our study was to evaluate the extent to which FP counseling offered to couples supports their autonomous decision-making in choosing a contraceptive method. Thus, we targeted to reveal the obstacles in providing high-quality family planning counseling in developing countries such as ours.

Method

Study design and sample

This qualitative, descriptive, and cross-sectional study was conducted in Kocaeli, which is the second largest industrial city in Turkiye after Istanbul and the most densely populated city¹⁶. There are five institutions providing PMC services in Kocaeli Provincial Health Directorate. Preliminary survey of the five institutions showed that PMC training was provided by 19 healthcare professionals. Consequently, this study aimed at reaching all participants. Inclusion criteria was to provide premarital counseling for at least six months. First of all, institutional permission was obtained from the Kocaeli Provincial Health Directorate to carry out this study. Ethical approval was obtained from the Kocaeli University Ethics Committee (Date: July 27, 2018; approval number: 2018/11.34).

Data collection

The content of the qualitative research method includes the in-depth examination of people's perceptions, behaviors, and activities in the context of their experience. In this research method, data is collected by using observation and interview method, by recording with the help of video or audio recording, written texts, words or symbols¹⁷. In the study, this method was chosen because it allows for a detailed and unbiased evaluation of FP education offered in premarital counseling. Data were collected using interviews, observations, and information forms. The researcher [MSc midwife

holding a Reproductive Health and Intrauterine Device (IUD) Instructor Training certificate] visited five institutions twice. During the first visit, she met with the administrative supervisor of the institution and gave information about the research and learned who the health workers provide premarital counseling services in the institution are. During the second institution visit, the researcher reached out to these healthcare professionals (midwives and nurses) and informed them about the research. They were provided with the information about the rationale and purpose of the study, voluntariness of participation. They were also assured that the personal information collected would be kept confidential and would not be used in a way that could pose any risk. In addition, they were informed that the results of the study would be shared for educational and scientific purposes without using any identifying information. Informed consent was obtained from all participants for participation in the study and recording of the interviews. In addition, the contact details of the investigators were shared with the participants so that they could reach them if they had questions or wanted to be informed about the results of the study.

Face-to-face interviews were conducted with healthcare professionals who gave consent to participate in the study. These interviews were carried out without disrupting the functioning of the institution. In other words, if the midwife or nurse was interviewing with a couple who came for premarital counseling, this interview was expected to end. A separate environment was not prepared for interviews with the participants. Interviews within the scope of the research were carried out in the environment organized by the institution to provide premarital counseling services to couples. The role-playing technique was used during the interviews in which the researcher's spouse also joined. During the interview, the participants (midwife or nurse) were asked to imagine the researcher and her spouse as a couple who applied for a health report for marriage procedures and provide the PMC service that they routinely provided to couples. The participants were not given a time limit regarding the duration of the interview and no intervention was made during the interview. Only the questions directed by the participant to the researcher and her spouse were

answered. Interviews were recorded using a voice recorder with the permission of the participants in order to listen and evaluate the recordings again. During the interview, data related to the counseling environment, such as the participant's body language, eye contact, and distance between the participant and the researcher and her spouse were observed and noted. After the interview was completed, the study participants were asked to fill in a 10-question information form that was prepared to obtain demographic (gender, age, marital status, education, and whether or not they had children) and occupational (occupation, duration of working in that occupation and in the current institution, whether or not they had received PMC training, and how long they provided this training). In addition, the participants were asked to indicate the challenges they encountered in the provision of PMC services and their suggestions regarding the effective provision of this service at the end of the information form.

Two nurses could not be contacted because they were on maternity leave, and all 17 healthcare providers who were interviewed agreed to participate in the study. Interviews with the research participants, which started on October 8, 2018, were completed on December 31, 2018. The duration of the interviews with the participants within the scope of the study varied between 2 minutes and 12 minutes.

Data analysis

The evaluation of the study data started from the moment of its collection. The recordings were transcribed in a computer environment at the end of each interview. Notes on the observations made during the interview were also added to the text. Further, two researchers worked together to evaluate the FP training given by the participants in line with the Marriage Counseling Skills Learning Guide (MCSLG) based on the records and observations. MCSLG is a 27-item guide developed by the Republic of Türkiye Ministry of Health, General Directorate of Mother-Child Health and Family Planning to standardize and increase the quality of PMC services provided in Türkiye (Appendix 1). Each item in the guideline was evaluated as "needs improvement" (performing the step incorrectly or not performing it on time),

Appendix 1

Steps of the marriage counseling skills learning guides

1. Welcoming the applicant couple politely
2. Providing the necessary privacy
3. Introducing oneself
4. Learning the names of the applicant couple
5. Using appropriate body language
6. Making eye contact
7. Adjusting the required distance for communication
8. Being face-to-face with the applicant couple during communication
9. Not engaging oneself with other activities during the counseling session
10. Performing the counseling session as if one is chatting
11. Asking the ages and occupations of the couple
12. Learning about their fertility goals
13. Giving information about contraceptive methods
14. Explaining each method with an example
15. Asking if they are a carrier of thalassemia
16. Providing information about thalassemia
17. Describing the thalassemia carrier screening test
18. Asking about their blood types
19. Providing information about sexually transmitted infections
20. Providing information about the tests that can be performed
21. Making careful and simple explanations
22. Using short sentences that do not contain medical terms
23. Encouraging the couple to ask questions
24. Paying attention to whether the couple wishes to discuss something else
25. Understanding and trying to address the couple's needs, concerns, and fears
26. Filling in the records
27. Referring to the laboratory

“adequate” (performing the step correctly and in sequence but with deficiencies), “mastered” (performing the step correctly and in sequence without stopping or needing help), and “no observation made” (the researcher did not observe the step)¹⁸. After all the interviews were completed and the data were collected, the personal and professional data of the participants and the percentage distribution of the evaluations regarding the FP training they provided were obtained. Mean values for age, duration of working in the profession and institution, and duration of providing PMC training were calculated using the SPSS 20.0 program.

Results

Table 1 summarizes the characteristics of 17 participants. The ages of midwives and nurses

ranged from 28 to 55 years, and their duration of working in the profession ranged from 5 to 34 years. The duration for which the midwives and nurses provided PMC training was between 6 months and 13 years.

Marriage counseling skills of the participants

While the participants were mostly evaluated as “mastered” in the 19 steps of MCSLG, the rate of participants who were considered “adequate” was higher in three steps. In addition, the rate of those who could not be observed or whose data could not be obtained was higher in five steps. The data obtained from the guide were discussed under four headings (Table 2).

Communication

The eleven steps of the MCSLG are aimed at assessing the counselor's communication skills. All 17 participants were evaluated as having mastered the following steps of MCSLG: they did not engage in other activities during counseling, almost all of them (n=16, 94.1%) welcomed the applicant couple politely, the majority of them maintained the necessary distance for communication, faced the applicant couple during communication, used appropriate body language (n=15, 88.2%), and made eye contact (n=14, 82.4%). Most of the midwives and nurses (n=12, 70.6%) providing PMC service did not perform the steps of learning the names of the couple, and more than half of them missed the step of asking the ages and occupations of the couple (n=11, 64.7%) and introducing themselves (n=9, 52.9%).

Provision of information

The nine steps of the MCSLG are under the informing heading. Almost all of the midwives and nurses in our study (n=16, 94.1%) used short sentences without medical terms and explained the thalassemia carrier screening test, more than half of them carefully made simple explanations during the counseling (n=11, 64.7%), encouraged the couple to ask questions, and also paid attention if the couple wanted to discuss another topic (n=10, 58.8%); they were evaluated as having mastered in the aforementioned steps. It was found that one third (n=6, 35.3%) of the counselors in our study

Table 1: Participant characteristics

	n or mean (years)	%
Gender		
Female	17	100.0
Age	42.6±8.9	
Marital status		
Single	3	17.6
Married	14	82.4
Number of children		
None	2	11.8
One	3	17.6
Two	12	70.8
Education		
Vocational school of health	5	29.4
Associate degree	5	29.4
Undergraduate	7	41.2
Occupation		
Midwife	10	58.8
Nurse	7	41.2
Duration of working in occupation	22.4±9.6	
Duration of working in current institution	10.9±9.4	
Pre-marital counseling training		
Received	11	64.8
Not received	6	35.2
Duration of given pre-marital counseling training	4.5±4.2	

did not give any information and nearly half of them (n=8, 47.1%) gave incomplete information about sexually transmitted infections to the counselees.

Privacy

Fourteen participants (82.4%) were considered to have mastered the step of ensuring privacy. All interviews were conducted in a separate room where only the participant, the researcher and her spouse were present. The interviews were completed without any interruptions or breaks.

Family planning education

The three steps of the MCSLG are included under this heading. Six participants (35.3%) had mastered the step of providing information about contraceptive methods, 7 participants (41.2%) were considered adequate, 2 participants (11.8%) needed improvement, whereas 2 participants (11.8%) did not provide information about contraceptive methods. In the explanation of FP methods, 3 participants (17.6%) had mastered the step of explaining each method with an example and 10

participants (58.8%) were considered adequate, whereas 4 participants (23.5%) did not give any examples of FP methods. The majority (n=14, 82.4%) of the participants were considered to have mastered the step of learning the fertility goals of the applicant couple. All participants were considered to have mastered filling in the records and appropriately referring clients to the laboratory, which constitutes the last two steps of the MCSLG. Eleven study participants provided information about the difficulties they encountered in the provision of PMC services. The most frequently cited difficulty was the individuals were not open to education and, therefore, they could not provide education. Other cited difficulties were unsuitable counseling environments and the insufficient number of healthcare personnel providing counseling services. In addition, participants stated that they did not receive PMC training, and the PMC service was short due to the high number of applications, there was a lack of communication between the couples themselves, and brochures and materials related to the training were insufficient. The researcher observed that cleaning, heating, and lighting conditions of most settings were suitable, there were seats and a table for the counselor and the counselees to sit. Besides there were materials, guides, brochures, posters, and banners related to the FP service in the place where the counseling service was provided.

Discussion

FP services in Turkiye focus on women as a target, thus, methods for contraception are often used by women¹⁴. PMC services are an important opportunity in terms of providing FP training to men and women together as well as male involvement in FP. In this respect, it becomes necessary to evaluate the effectiveness of FP training provided within the scope of PMC services. This study has primarily provided in-depth information in terms of evaluating the effectiveness of FP trainings provided within the scope of PMC services in Kocaeli, Turkiye and revealing the relevant problems. In this section, the study data related to FP training are discussed. Seven items of MCSLG were excluded from the discussion since they were related to other subjects (information about blood type assessment, thalassemia, sexually

Table 2: Evaluation of the counseling provided by the participants according to the marriage counseling skills learning guide (N=17)

Evaluation heading	Mastered		Adequate		Needs improvement		No observations made	
	n	%	n	%	n	%	n	%
Communication								
1. Welcoming the applicant couple politely	16	94.1	1	5.9				
3. Introducing oneself	8	47.1					9	52.9
4. Learning the names of the applicant couple	5	29.4					12	70.6
5. Using appropriate body language	15	88.2	2	11.8				
6. Making eye contact	14	82.4	3	17.6				
7. Adjusting the required distance for communication	15	88.2					2	11.8
8. Being face-to-face with the applicant couple during communication	15	88.2					2	11.8
9. Not engaging oneself with other activities during the counseling session	17	100						
10. Performing the counseling session as if one is chatting	10	58.8	6	35.3			1	5.9
11. Asking the ages and occupations of the couple			6	35.3			11	64.7
25. Understanding and trying to address the couple's needs, concerns, and fears	8	47.1			2	11.8	7	41.2
Provision of information								
15. Asking if they are a carrier of thalassemia	1	5.9					16	94.1
16. Providing information about thalassemia	11	64.7	4	23.5			2	11.8
17. Describing the thalassemia carrier screening test	16	94.1	1	5.9				
18. Asking about their blood types	11	64.7					6	35.3
19. Providing information about sexually transmitted infections	1	5.9	8	47.1	2	11.8	6	35.3
20. Providing information about the tests that can be performed	8	47.1					9	52.9
21. Making careful and simple explanations	11	64.7	6	35.3				
22. Using short sentences that do not contain medical terms	16	94.1			1	5.9		
23. Encouraging the couple to ask questions	10	58.8					7	41.2
24. Paying attention to whether the couple wishes to discuss something else	10	58.8	1	5.9			6	35.3
Privacy								
2. Providing the necessary privacy	14	82.4	3	17.6				
Family planning education								
12. Learning about their fertility goals	14	82.4					3	17.6
13. Giving information about contraceptive methods	6	35.3	7	41.2	2	11.8	2	11.8
14. Explaining each method with an example	3	17.6	10	58.8			4	23.5

transmitted infections, and tests to be performed) within the scope of PMC.

According to our study findings, it was determined that most of the midwives and nurses did not introduce themselves to the applicant couple, learn the names of the applicant couple, and ask about their age and occupation. Self-introduction of healthcare professionals is important and necessary for building trust between the counselee and the counselor, enabling the counselee to express themselves more comfortably¹⁹. Building trust is an essential part of a successful FP training process. If counsees feel comfortable, they would be able to express their needs and questions more clearly²⁰. In addition, if the counselor learns the names of the counsees and call them by their names, this will make them feel respected and cared for. Since the age of the individual is important for using certain FP methods, it is already necessary that the ages of the individuals to be provided with FP training are found out. This is because the content of the FP training to be given will vary according to the age of the individuals. In addition, previous study has revealed that the FP method used by individuals in Turkiye varies according to their education level and occupation²¹. In our study, the fact that most of the midwives and nurses did not introduce themselves and learn the names, ages, and occupations of the couple suggests that the FP training provided within the scope of the PMC services is not specific to the individual. It also shows that there are deficiencies in terms of conducting the trainings with mutual interaction in line with the needs and requirements of the individuals.

It was found that most of the midwives and nurses who participated in our study greeted the applicant couple politely, communicated at an appropriate distance, face-to-face, established eye contact, and did not engage in other activities during training. One of the basic principles of good FP counseling is a strong interaction and communication built by the counselor with the counselee. Regarding the communication skill that forms the basis of counseling, what the counselor says and what they do not say, i.e., the counselor's body language is very important. It was indicated that the counselor should also establish eye contact with the male, especially while providing

counseling to couples¹⁸. In two studies conducted in Turkiye, similar to our study, midwives²² and nurses²³ who provided counseling services had high communication skills. Conversely, in another study, it was determined that a small number of midwives and nurses were sometimes able to perform nonverbal communication skills adequately²⁴. In addition, it was determined that the nurses who gave counseling training in Spain had the greatest difficulty with communicating effectively²⁵. Almost all our study participants used short sentences that did not contain medical terms. More than half of them provided counseling services using simple explanations. Most women in Turkiye demand that FP training be given in an explanatory and understandable ways such that they can easily ask questions to the counselor²⁶. Conversely, very few (5.1%) healthcare professionals believe that FP training should be given in a short and simple way²⁷. The participants offered FP counseling in understandable terms and encouraged the counselee to ask questions, which was a positive finding in terms of supporting the couple to understand and grasp the information given. Quality FP counseling should promote a couple's awareness of the broad array of contraceptive options and focus on meeting their reproductive needs²⁸. Individual-centered FP counseling depends on learning the fertility goal of the counselee, informing the counselee about the positive and negative aspects of all FP methods, and supporting the counselee to choose the FP method freely without guidance²⁹. Learning the fertility goals of the couples is necessary to determine the content of the FP training to be offered to the couples. In our study, most of the healthcare professionals obtained information by asking about the fertility goal during the interview. This finding suggested that the participants would determine the content of the FP training in line with the couple's fertility goal. However, one third of the participants did not explain each FP method with an example. In the area of family planning specifically, persons' selection of a new contraceptive method is influenced by whether providers mention or recommend specific methods³⁰. The fact that the counselor did not explain the FP methods with examples was considered an obstacle in choosing the FP method freely for the couple. During the interview, some participants also provided

guidance on the FP method. While some of the participants said that condom was the appropriate FP method, some of them did not recommend this method saying that the protection obtained from condoms was low. In addition, some participants talked about FP methods for the woman first, and finally said “*If you do not wish to use birth control, your spouse could use it.*” These results show that improvements are needed to increase the quality of FP training provided within the scope of PMC services, which is one of the few settings where couples can be trained together in Turkiye. In previous studies conducted in Turkiye, it has been reported that many couples who do not want to have children do not find FP services sufficient and are not satisfied with the service provided^{26,31}. An effective and successful FP counseling increases the use of contraceptives^{15,20,32}, whereas inadequacies in training cause dissatisfaction of the counselees³⁰. In the study, considering that the longest interview takes about 12 minutes, it is difficult to provide an effective FP training that is specific to the applicant couple and will meet the needs of the couple within these periods. For this reason, the quality of the training given by healthcare professionals who provide FP counseling should be improved.

In our study, only one-third of the participants asked the male counselee’s name and age during the interview. In addition, a similar proportion of participants did not make eye contact with the male counselee and only gave information about FP methods for women. Despite the great importance of male participation in FP, health professionals in our study continued female-dominated FP counseling. Studies conducted in Iran and Jordan have similarly revealed that FP counseling is carried out in a way that predominantly targets women^{2,3}. In many countries, men’s participation in FP services is not sufficient and there are attempts to increase men’s use of FP methods³³. A study conducted in Ethiopia revealed that efforts to achieve FP goals were most successful when they involved not only women but also men³⁴. Another study from Ethiopia found that FP educational intervention which includes both spouses be useful to foster contraceptive method⁴. Our study has shown that men should be

encouraged and their participation in FP programs should be increased in Turkiye similar to many other countries.

Our study had certain limitations. The first limitation was regarding the study population and sample size; since our study was conducted only in Kocaeli province, it cannot be said that our results represent Turkiye as a whole. The second limitation was regarding the data collection method. The study participants were asked to provide the PMC service that they routinely provided to the researcher and her spouse. However, the fact that the participants knew that this was requested for study purposes may have affected the counseling service they provided.

Conclusion

In conclusion, our study provided detailed information on the FP counseling offered to couples about to get married in Turkiye. However, this study allowed us to understand the obstacles in providing high quality FP services offered to the couples in Turkiye. One of these obstacles is the short period of time allocated for PMC services. Another obstacle is the failure to provide information about all FP methods and to explain the methods with an example. Another obstacle is that the male counselee is not approached in FP counseling and information is given only about FP methods for women. Furthermore, the success of FP training targeting only women is low. Our study results have revealed that there is a need for improvement in two main areas to increase the quality of FP counseling: informing the couple about FP methods in line with their needs and supporting the couple’s joint decision-making by involving the male partner more effectively.

Acknowledgements

The authors would like to thank all the participants in this study and Ahmet Suat Birinci for his support as of interviewer.

Competing interests

The authors declared that they have no conflict of interest.

Funding

The authors declare that they received no funding or grant to conduct the study.

Authors' contributions

FBB and RAE conceived and designed the study and analysed the data; FBB collected the data; RAE led the writing of the manuscript and critically reviewed the manuscript; Both authors read and approved the final manuscript.

Data availability

Data will be made available upon request

References

1. El-Khoury M, Thornton R, Chatterji M, Kamhawi S, Sloane P and Halassa M. Counseling women and couples on family planning: a randomized study in Jordan. *Stud Fam Plann.* 2016; 47(3):222-228.
2. Abdulreshid M, Dadi HB. Assessment of family planning counseling provided for postpartum women and associated factors. *Int J Repro Med.* 2020. Available: <https://www.hindawi.com/journals/ijrmed/2020/2649340/#copyright>
3. Okour AM, Saadeh RA and Zaqoul M. Evaluation of family planning counselling in North Jordan. *Sultan Qaboos Univ Med J.* 2017; 17(4):e436-e443.
4. Tilahun T, Coene G, Temmerman M and Degomme O. Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health.* 2015; 21(15):682.
5. Di Giorgio L, Moses MW, Fullman N, Wollum A, Conner RO, Achan J, Achoki T, Bannon KA, Burstein R, Dansereau E, DeCenso B, Delwiche K, Duber HC, Gakidou E, Gasasira A, Haakenstad A, Hanlon M, Ikilezi G, Kisia C, Levine AJ, Maboshe M, Masiye F, Masters SH, Mphuka C, Njuguna P, Odeny TA, Okiro EA, Roberts DA, Murray CJ and Flaxman AD. Perceptions of and barriers to family planning services in the poorest regions of Chiapas, Mexico: a qualitative study of men, women, and adolescents. *Reprod Health.* 2017; 14(1):129.
6. Lundgren RI, Gribble JN, Greene ME, Emrick GE and de Monroy M. Cultivating men's interest in family planning in rural El Salvador. *Stud Fam Plann.* 2005; 36(3):173-188.
7. Maluka SO and Peneza AK. Perceptions on male involvement in pregnancy and childbirth in Masasi District, Tanzania: a qualitative study. *Reprod Health.* 2018; 15:68.
8. Organization for Economic Cooperation and Development. Marriage and Divorce Rates, 2019. Available: https://www.oecd.org/social/family/SF_3_1_Marriage_and_divorce_rates.pdf
9. T.C. Ministry of Family, Labour and Social Services General Directorate of Family and Society Services. Advanced Statistical Analysis of Family Structure in Turkey, 2018. Available: https://www.aile.gov.tr/media/35869/taya-18_turkce_kitap.pdf
10. Official Gazette of the Republic of Turkey. Turkish Civil Law, 2001. Available: <https://www.mevzuat.gov.tr/MevzuatMetin/1.5.4721.pdf>
11. Republic of Turkey Ministry of Health. Pre-Marriage Health Report Circular. Ankara, 2002.
12. Çalıkoğlu EO, Bedir B, Yılmaz S and Aydın A. Health knowledge of medical students about family planning and sexually transmitted diseases. *FPPC.* 2017; 2(2):12-17.
13. Oltuluoğlu H and Başer M. The evaluation of birth control methods and causes of method preference among married women in Malatya. *J Inonu Uni Med Faculty.* 2012; 19(3):167-174.
14. True HY, Oktay G, İşgüder CK, Özsoy SZ, Cakmak B, Delibaş IB and Yıldız NC. The overview of women by age groups on the family planning and the evaluation of preferred methods: a tertiary center experience. *Dicle Med J.* 2016; 43(3):413-418.
15. Büyükbayrak EE, Kars B, Karageyim Karşıdağ AY, et al. Comparison of attitudes related with family planning methods before and after effective family planning counseling. *Turk J Obstet Gynecol.* 2010; 7(3): 228-234.
16. Turkish Statistical Institute. Address Based Population Registration System Results, 2020. Available: <https://data.tuik.gov.tr/Bulten/Index?p=Adrese-Dayali-Nufus-Kayit-Sistemi-Sonuclari-2020-37210>
17. Bachman R and Schutt RK. Qualitative methods and data analyses. In: Bachman R, Schutt RK (Ed.). *Fundamentals of Research in Criminology and Criminal Justice. 3rd edition. Los Angeles:* Sage Publications, 2015, 170-206. Available: https://www.sagepub.com/sites/default/files/upm-binaries/59781_Chapter_8.pdf
18. Republic of Turkey Ministry of Health Public Health Institution Department of Women's and Reproductive Health. Pre-Marriage Counseling Guide. Ankara: Ministry of Health Publication. 2014. Available: https://sbu.saglik.gov.tr/Ekutuphane/kitaplar/Evlilik_onesi%20DanismanlikRehberi.pdf
19. Bozkurt KMN. Determination of counseling processes, skills, problems and self-efficacy levels of family counselors. Master Thesis for Social Service, Hacettepe University, Ankara, Turkey, 2019.
20. Slater AM, Estrada F, Suarez-Lopez L, de la Vara-Salazar E and Campero L. Overall user satisfaction with family planning services and associated quality care factors: a cross-sectional analysis. *Reprod Health.* 2018; 15(1):172.
21. Güllü A and Taşçı Turan E. Investigation of the opinions of men about the newly developed contraceptive

- methods directed towards them. *JOWHEN*. 2020; 6(2):71-86.
22. Avcı IA, Altay B, Uğur HG, Yılmaz A and Güzel N. The effect of communication skills of the midwives working for basic health services on their status relating to training people about health. *J Anatolia Nurs Health Sci*. 2012; 15(3):161-166.
 23. Tiryaki Şen H, Taşkın Yılmaz F and Pekşen ÜÖ. Levels of communication skills of service education nurses. *J Psychiatric Nurs*. 2013; 4(1):13-20.
 24. Akcan F, Özsoy SA and Ergül Ş. An investigation of midwives' and nurses' consultation skills who work in primary health care services. *J Atatürk Uni School Nurs*. 2006; 9(4):10-21.
 25. Arranz P, Ulla SM, Ramos JL, Del Rincón C and López-Fando T. Evaluation of counseling training program for nursing staff. *Patient Educ Couns*. 2005; 56(2):233-239.
 26. Babadağlı B and Şahin S. Comparison of the knowledge and attitudes of women of childbearing age about family planning and counseling in Sakarya Maternity and Child Care Center and SSK Izmit Hospital. *J Firat Health Serv*. 2006; 1(2):51-64.
 27. Serbest N. Opinions, suggestion and preference of health workers about family planning. Master Thesis for Obstetrics and Gynecology Nursing, Marmara University, İstanbul, Türkiye, 2008.
 28. Dey AK, Averbach S, Dixit A, Chakraverty A, Dehingia N, Chandurkar D, Singh K, Choudhry V, Silverman JG and Raj A. Measuring quality of family planning counselling and its effects on uptake of contraceptives in public health facilities in Uttar Pradesh, India: A cross-sectional analysis. *PLoS One*. 2021; 4;16(5):e0239565.
 29. Dehlendorf C, Rodriguez MI, Levy K, Borrero S and Steinauer J. Disparities in family planning. *J Obstet Gynecol Am*. 2010; 202(3):214-220.
 30. Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clin Obstet Gynecol*. 2014; 57(4):659-673.
 31. Yıldızhan B, Yıldızhan R, Adalı E, et al. Evaluation of family planning methods in Istanbul Goztepe Training and Research Hospital at 2000-2004. *Van Med J*. 2008; 15(4):104-106.
 32. Apanga PA and Adam MA. Factors influencing the uptake of family planning services in the Talensi District, Ghana. *Pan Afr Med J*. 2015; 20:10.
 33. Hardee K, Croce-Galis M and Gay J. Are men well served by family planning programs? *Reprod Health*. 2017; 23;14(1):14.
 34. Berhane A, Biadgilign S, Amberbir A, Morankar S, Berhane A and Deribe K. Men's knowledge and spousal communication about modern family planning methods in Ethiopia. *Afr J Reprod Health*. 2011; 15(4):24-32.