A QUALITATIVE EXPLORATION ON USE OF LONG ACTING REVERSIBLE CONTRACEPTIVES AMONG MARRIED WOMEN AT MZIMBA SOUTH DISTRICT HOSPITAL

MASTER OF SCIENCE DEGREE IN REPRODUCTIVE HEALTH

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A thesis submitted to the Faculty of Nursing, Kamuzu College of Nursing, The University of Malawi in Partial Fulfilment of the requirement for the award of

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Declaration

I, Chisomo Phethi, hereby declare that this thesis titled **'A qualitative exploration on use of long acting reversible contraceptives among married women at Mzimba south district hospital**' is my own original work. It is being submitted to the Faculty of Nursing in partial fulfilment of the requirement for the Master of Science Degree in Reproductive Health.

I declare, to the best of my knowledge, that it has not been submitted before, in part or in full, for any degree or examination at this or any other University within or outside Malawi. The work of other people in this thesis has been indicated and acknowledged as complete references.

CHISOMO PHETHI
Full Legal Name

Signature

5th April 2021
Date

Certificate of Approval

We, the undersigned, hereby certify that this thesis is the student's original work and effort and has been submitted with our approval.

Signature _____ Date _____

Angela Chimwaza, PhD (Professor)

Main Supervisor

Signature _____ Date _____

Matthews Ngwale, PhD (Former Senior Lecturer)

Co-Supervisor

Dedication

This work is dedicated to the LORD God, the Almighty who has provided me with the grace to complete my postgraduate studies and my entire family for their support throughout my studies.

May God bless you all!!

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I would like to give thanks to the following:

- My husband Zondiwe Jere, for the support and selflessness you have shown me throughout my postgraduate studies. May the Almighty God richly bless you.
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- To my parents, may the Lord forever bless you for your love and care.
- Friends and family members for the love and support.

May God bless you all!!

Abstract

Long acting reversible contraceptives (LARC) are safe, cost-effective, and highly effective in the prevention of unplanned pregnancies for almost all women in the reproductive age group. Nationally, most married women 30% (4839) use Depo Provera with a high discontinuation rate of 41%, while 12% (1936) use Implants and 1 % (161) IUD, with a discontinuation rate of 8% for both. Records at Mzimba South District Hospital for the 2016-2017 fiscal year on the use of Implants and IUD among married women remains very low. Literature on quantitative studies indicates lack of knowledge, dependence on a provider for information, partner disapproval, myths, and misconceptions as some of the underlying factors to low uptake of Implants and IUD and yet did not capture detailed reasons as to why married women do not use Implants and IUD. The aim was to explore factors influencing the use of LARC among married women at Mzimba South District Hospital and a descriptive exploratory qualitative design was used. A purposive sample of 10 married couples was used. Data were analysed manually using thematic content analysis. The study findings generated 5 themes: inadequate knowledge of married women and their partners on Implants and IUD, source of information about Implants and IUD, reasons for partner approval/disapproval to use of Implants and IUD, reasons why married women do not use Implants and IUD for family planning, myths, and misconceptions among couples on use of Implants and IUD, perceptions of couples on use of Implants and IUD. Several factors influenced the use of Implants and IUD such as inadequate knowledge, myths and misconceptions, men's approval, cultural beliefs, provider bias, health problems and side effects. Comprehensive contraceptive counselling on LARC is essential in knowledge acquisition hence promote LARC uptake among couples at the facility level. Keywords: **long acting reversible contraceptives, married women, factors, Implants, and Intra-Uterine Device.**

Table of Contents

List of Figures

List of Tables

List of Abbreviations

COMREC: College of Medicine Research and Ethics Committee

CPR: Contraceptive Prevalence Rate

FP Family Planning

KCN: Kamuzu College of Nursing

LARC: Long Acting Reversible Contraceptives

MOH: Ministry of Health

NSO: National Statistical Office

SSA: Sub Saharan Africa

WHO: World Health Organisation

Operational Definitions

Contraceptive methods: These are methods or devices used to prevent pregnancy**.**

Contraceptive prevalence rate: The percentage of women who are currently using or whose sexual partner is using at least one method of contraception regardless of the method used. It is usually reported for women aged 15-49 years.

Couple: Two people who are married or otherwise closely associated sexually.

Family planning: The practice of controlling the number of children in a family and the intervals between their births particularly by means of artificial methods.

Implants: A plastic single or double rode device 4 cm in length and 2mm in diameter that comes in the preloaded and disposable applicator.

Intrauterine device: A small T shaped plastic device wrapped with copper wire that is inserted into the uterus by a trained provider following a pelvic examination.

Long acting reversible contraception: It is a term used to describe methods of contraception that are highly effective in protecting a woman from getting pregnant for an extended period more than monthly administration.

Married woman: a female in a continuing marital relationship.

Modern contraceptives: Refers to short acting, long acting and permanent methods of contraception that exclude the traditional methods.

Reproductive age: Refers to the age range of 15 to 49 years.

Unintended pregnancy: Pregnancy that comes when an individual is not prepared.

Unmet need for family planning: The percentage of women currently married or in the union who desire to stop or postpone childbearing but are not currently using any family planning method.

CHAPTER 1

1.0 Introduction and Background

This chapter discusses two areas: the introduction and background of the study. The introduction describes the problem to be addressed that includes the nature of the research, the purpose of the research and the significance of the problem. While the background gives a compilation of review of literature based on the analysed problem, steps and methods needed to arrive at the design and implementation of results.

1.1 Introduction

Family planning (FP) is a way of controlling birth in order to allow individuals or couples to attain the desired number of children as well as spacing of pregnancies (Godana et al., 2015). It is achieved through the utilization of contraceptives which include traditional contraceptives and modern contraceptives namely, long acting reversible contraceptives [LARC] (Implants, Intra Uterine Device & Depo Provera), short acting contraceptives (oral pills, condom, form tablets and cervical cup) and Permanent contraceptives (tubal ligation for females and vasectomy for males). As for Malawi, all these methods are provided in health facilities belonging to Government, some Christian Hospital Association (CHAM) facilities and the private sector (Banja La M'tsogolo, Adventist Health Services).

The goal of FP Programme in Malawi is to reduce the unmet need for family planning through the provision of voluntary comprehensive services to all thereby, promoting good health and social-economic development (Ministry of Health, 2017). The FP programme advocates for the availability and use of highly effective contraceptives such as LARC methods, as a strategy to limit the occurrence of unplanned pregnancy and reduce fertility (David Hubacher et al., 2008) Literature also suggests that if FP was used as demanded worldwide the following; 188 million

pregnancies, 1.2 million newborn deaths and 233,000 maternal deaths would be prevented (UNFPA, 2017). According to Amentia (2015), 99% of all global maternal deaths occur in Africa and if FP were utilized, one in every three maternal deaths would be prevented. Currently, maternal mortality in Malawi is at 439/100000 live births (National Statistics Office & ICF, 2017) from 510/100,000 in 2010.

The United Nations (2015) indicated that 64% worldwide of married women use some form of contraceptives with higher use in Asia (59%) and North America (75%) and lowest in Africa (33%). Long acting reversible contraceptives specifically IUD and Implants are commonly used by 14% of women in the reproductive age in developed countries while 2% in sub-Saharan Africa. Similarly, Malawi has only 1% of its married women utilizing IUD, and Mzimba South District Hospital 0.1%. This literature reveals low utilization of both Implants and IUD despite studies proving them safe, user-friendly, more efficacious, cost-effective and suitable for all women (Asnake et al., 2013; Blumenthal et al., 2013). In a study by Winner et al. (2012) results indicated that married women who used LARC were at risk of pregnancy by 0.27 pregnancies while those that used short-acting contraceptives was at 4.55 pregnancies yet utilization of Implants and IUD remains low (Winner et al., 2012).

According to % World Bank Population indicators, (2017) currently, Malawi has a population of 18,008,081 with a growth of 2.9) and its fertility rate of 4.4 (National Statistical Office & ICF, 2017) though with a minimum improvement from 5.7 in 2010. Its unmet need for FP among married remains high (19%) versus the global which is at 12% (UNFPA, 2017). The contraceptive prevalence rate (CPR) for modern contraceptives for married women in Malawi is 58%, while for Mzimba District is at 52% below the nation (National Statistical Office & ICF, 2017). In Malawi, if all married women use FP, CPR would increase from 59% to 78%

(National Statistical Office, 2017). There is a high discontinuation rate of Depo Provera among married women despite the majority (30%) using it. Literature shows several factors such as inadequate knowledge, provider bias, cultural beliefs, and partner approval as some of the contributing factors to low utilization of LARC methods among married women. There are gaps in these studies, as many studies were quantitative (Benedugu et al., 2019; Gbagbo & Kayi, 2018; Gudaynhe et al., 2015; Nyambo, 2013a; Peer & Morojele, 2013; Tibaijuka et al., 2017). Little is known about qualitative studies on factors that influence the use of LARC among married women and none has been done in Mzimba, hence the need to explore other influencing factors.

The study was guided by the theory of reasoned action that proposes that attitudes and norms are the main influences on intention which is a major motivator of behaviour. The behavioural intention is the best predictor for health behaviour to be performed or not (Ajzen & Fishbein, 2004). For instance, if married women are to use implants or IUD, their behaviour will be influenced by their intention (personal attributes) to prevent unwanted pregnancy.

1.2 Background

Currently, FP has become an important issue globally due to unexpected and rapid population growth which affects economic development (Joshi et al., 2015) and reproductive health services negatively. In Malawi, FP programme was first introduced in the early 1960s and then reintroduced in 1994. Back then, it was called child spacing before being called family planning because people considered it as a way to space the birth of a child but not deciding when to have it (Ministry of Health, 2007). Thereafter, the government realized that rapid population growth stifled the economic growth and development of the country and negatively affected the health status of, especially women. Malawi's move to Multi-party democracy in

1994 enhanced FP Sexual Reproductive Health Right policy and programmatic activities (Ministry of Health, 2010). Since then, there is tremendous progress that includes the introduction of LARC, new curriculum development for the training of nurses/health workers in the provision of FP and in turn, CPR has improved from 13% in 1992 to 58% in 2016 (National Statistics Office & ICF, 2017).

Malawi is a signatory to several international right declarations and other documents. It recognizes the importance of access to FP as a basic human right to improve the sexual and reproductive health rights of its citizens. These include the International Conference for Population and Development Programme (ICPD) of Action in 1994 which recommended universal access to a full range of safe and reliable family planning methods by the year 2015 (UNFPA, 2010), the United Nations (UN) Fourth World Conference on Women, Beijing, China included FP in the sexual and reproductive health rights (SRHR), and 2006, the African Union Maputo Plan of Action on SRHR. In addition, between 2000 and 2015, Malawi implemented the United Nations Millennium Development Goals (MDG's) to improve maternal indicators. For instance, Goal 5 was intended to "improve maternal health with efforts to reduce maternal deaths and ensure universal access to reproductive health." Currently, we have Sustainable Development Goals (SDGs) of which Goal 3 intends to 'ensure healthy lives and promote well-being for all at all ages so that by 2030, by ensuring universal access to sexual and reproductive healthcare services, including FP, information and education, and the integration of reproductive health into national strategies and programmes. Goal 5, intends to achieve gender equality and empower all women and girls,' (United Nations, 2015).

As for Mzimba South District, FP programme has been funded since early 2000 by several stakeholders such as UNFPA, Banja La M'tsogolo (BLM) and Adventist Health Services.

Assistance has been in the following areas: provision of short-acting contraceptives, training of trainers on LARC for 31 facilities inclusive CHAM facilities, the supply of FP items like starter packs after training, equipment, supportive supervision, and mentorship to improve poor maternal and neonatal indicators. In the 2016-2017 fiscal year, the district registered 14 maternal deaths and 215 neonatal deaths out of 15,494 live births (Mzimba HMIS Report, 2017). Upon audits, about 90% of these deaths were caused by post-partum haemorrhage related to high parity which could have been prevented using LARC. Additionally, out of 1292 female admissions in the Gynae ward, 565 were diagnosed with incomplete abortion representing 43.7 % of all admissions (Mzimba HMIS report, 2017). About 80% of women diagnosed with incomplete abortion were married. Yet utilization of implants and IUD among married women remains low despite all efforts hence the reason for exploring such factors.

1.3 Problem Statement

Despite long acting reversible contraceptives (LARC) namely Depo Provera, implants, and Intrauterine Device (IUD) being effective in the prevention of unplanned pregnancies, safe and cost-effective for women in the reproductive age group, their utilization remains low. The Malawi demographic health survey [MDHS] (2015) showed that the majority 30% (4839) of married women used Depo Provera with a high discontinuation rate of 41%. While 12% (1936) used Implants and 1 % (161) IUD, with only an 8% discontinuation rate. Similarly, records at Mzimba South District Hospital for the 2016-2017 fiscal year indicate low utilization of Implants and IUD compared to the national among married women (National Statistics Office & ICF, 2017). With a total population of 105,629 (NSO, 2016) and 23,340 women of reproductive age group, 50% of women using modern contraceptives, of which only 6% used Implants, 0.1% IUD

and 30% Depo Provera (Mzimba HMIS Report, 2017). This puts most married women at risk of unplanned pregnancies, secondary complications from births such as abortion and miscarriage.

Evidence from literature indicates lack of knowledge, provider bias on short-acting contraceptives, partner disapproval, myths and misconceptions as some contributing factors to low utilization of Implants and IUD among married women (Alemayehu et al., 2012; Amentie, 2015; Gudaynhe et al., 2015; Kamara et al., 2015). There are gaps in the literature as evidence obtained is based on quantitative studies which did not capture detailed reasons as to why married women do not use Implants and IUD (Gudaynhe et al., 2015; Nyambo, 2013a; Peer & Morojele, 2013; Tibaijuka et al., 2017). Some have examined the use of all modern contraceptives among women in the reproductive age group, which is general. Yet in Malawi, Nyambo (2013) found that being married could be a predictor of the use of LARC, as married women may not want to have children or having children that are closely spaced. Little is known about qualitative studies and none has been done in Mzimba District. In one qualitative study in Malawi, Kamara (2015) explored perceptions of couples on the use of one method, Jadelle (implant) which is one of the LARC methods and not IUD, hence the need to explore other influencing factors apart from perceptions and improve utilization of Implants and IUD.

1.4 Significance of the Study

The findings of the study will benefit families and communities in Mzimba as the identified barriers to uptake of implants and IUD will be used to develop and implement strategies to promote and improve the uptake of LARC among married women. The results will also guide teachers in nursing schools in the development and implementation of nursing curricular that aim at addressing the identified barriers. In addition, the results will be used as a reference guide for future research. Lastly, the results may inform policymakers to plan for the

development of family planning policies that will aim at promoting the utilization of implants and IUD.

1.5 Research Objectives

1.5.1 Research question.

What factors influence the use of long acting reversible contraceptives among married women at Mzimba South District Hospital?

1.5.2 Broad objective.

To investigate factors that influence use of long acting reversible contraceptives among married women at Mzimba South District Hospital.

1.5.3 Specific objectives.

The specific objectives of the study were to:

- Describe the knowledge depth of married women and their partners on the use of implants and IUD as long acting reversible contraceptives.
- Describe perceived attitudes of married women and their partners about the use of Implants or IUD as a contraceptive method.
- Determine the normative beliefs (myths and misconceptions) of married men and their partners towards the use of Implants or IUD as a contraceptive method.
- Discuss subjective norms associated with the use of Implants and IUD among married women and their partners.

CHAPTER 2

2.0 Theoretical/Conceptual Framework and Literature Review

This section presents two parts; the conceptual framework that guided the study and a review of literature that was used to provide a context for the study.

2.1 Conceptual Framework

This study used the Theory of Reasoned Action (TRA) to investigate influencing factors in the use of LARC among married women. It aimed to explain the relationship between attitudes and behaviours within human action (Fishbein & Ajzen, 1975). According to Montano and Kaspryk (2008), the theory of TRA proposes that behavioural intention is the best predictor of behaviour to be performed or not to be performed (Montano et al., 2008). It is mainly used to predict how individuals are likely to behave based on their pre-existing attitudes and behavioural intentions. It is assumed that human beings process any information they are given and make an informed decision about a behaviour (Ajzen & Fishbein, 2000)

2.1.1 Brief background and description of the Theory of Reasoned Action

The Theory of reasoned action (TRA) is one of the social psychology theories. It was first developed in 1967 by Martin Fishbein and further expanded by other authors (Shumaila et al., 2010). Fishbein was concerned with the relationship among belief (Behavioural and normative), attitudes, intentions, and behaviour to understand the relationship between attitude and behaviour. However, after several studies, it was noted there was low correspondence between attitude and behaviour and then proposed the elimination of attitude (check objective) as a factor underlying behaviour (Ajzen & Fishbein, 2004; Glanz et al., 2002).

The theory was then revised by Icek Ajzen in 1975 to expand and incorporate behaviour intention as a major predictor of one's behaviour. The theory suggests that other factors influence the stability of an intention (a plan or likelihood that someone behaves in a particular way for a specific situation) (Fishbein & Ajzen, 1975). The main determinant of behaviour is behavioural intent and subjective norms of influential people and groups that could influence those attitudes.

According to TRA, attitudes and norms are the main influences on intention which is a major motivator of behaviour. For instance, if a couple decides to use implants or IUD for family planning, the behaviour will be influenced by their intention (personal attributes) to prevent unwanted pregnancy. Additionally, influence from others like the community, cultural norms, religion may have a bearing on the use of IUD and implants as family planning methods among married women (subjective norms). Therefore, the framework was used to explain the intention (influence) of married women and their partners/husbands about using Implant and IUD or not. The theory proposes that the stronger the intention to behave in a particular way, the more likely the behaviour is performed, and the opposite is true. Since an individual's decision to engage in a particular behaviour is based on the outcomes, then the individual expects will come as a result of performing the behaviour (Ajzen & Fishbein, 2004).

The TRA has the following constructs: behaviour belief, evaluation outcomes, motivation to comply, intention, attitude behaviour, knowledge, past behaviour, and habits, subjective norms, and normative beliefs. The theory suggests that the stronger the intention, the more the person is expected to perform the behaviour.

Diagrammatic presentation of the Theory of Reasoned Action

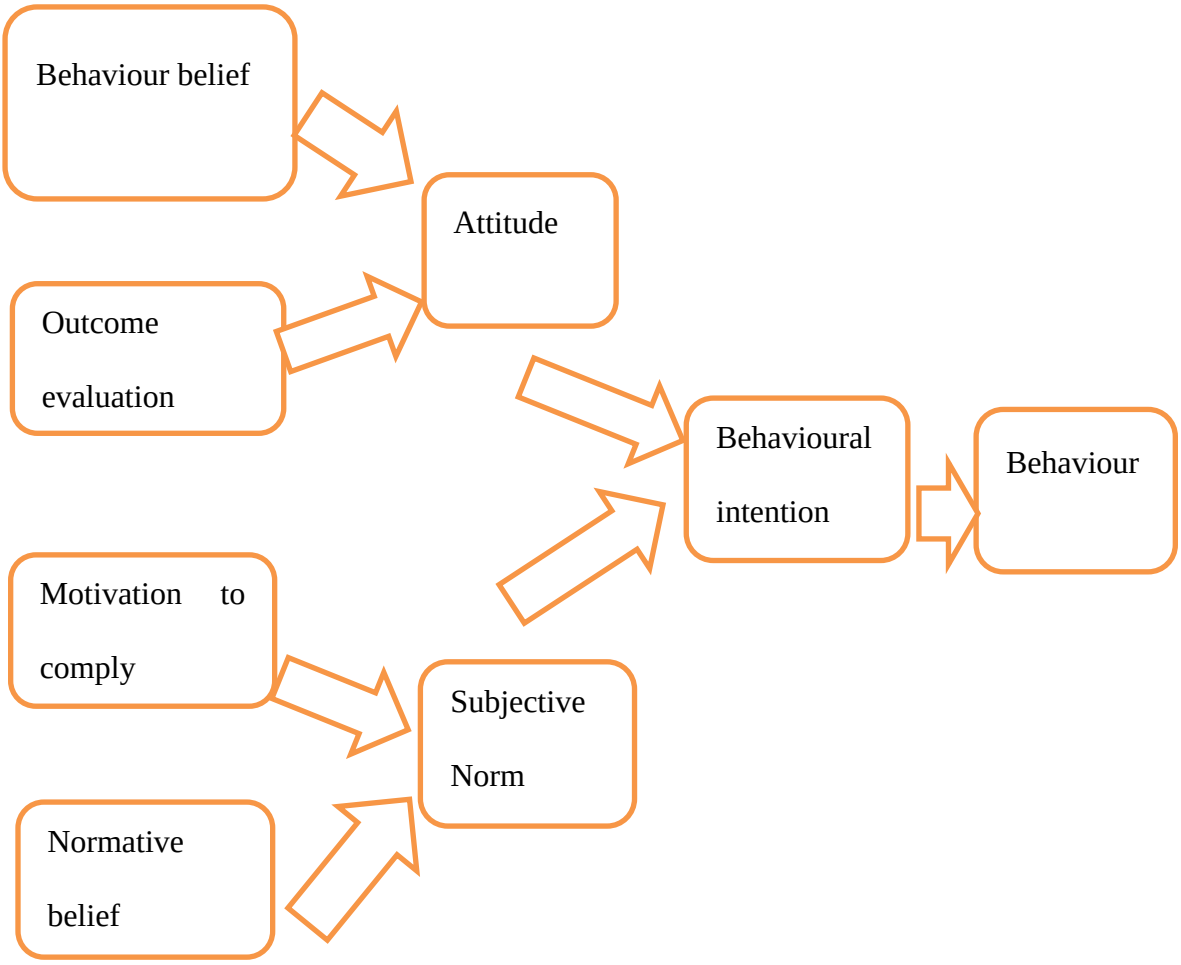


Figure 1: Theory of reasoned action (Fishbein &Ajzen 1975)

2.1.2 Description of Constructs in the theory of Reasoned Action.

2.1.2.1 Attitude.

Fishbein and Ajzen (1975) posited that attitude is the way people feel about a particular behaviour. It is about performing a behaviour and would predict behavioural intentions to enact the behaviour, which would, in turn, predict behaviour. It is also one of the key determinants of behavioural intentions. These attitudes are influenced by two factors: the strength of behavioural

beliefs regarding and the outcomes of the performed behaviour. Additionally, attitudes regarding a certain behaviour can either be positive, negative, or neutral.

2.1.2.2 Behavioural intention.

Intentions were defined as the perceived likelihood of performing the target behaviour (Ajzen & Fishbein, 2004). The theory of reasoned action suggests that stronger intentions lead to increased effort to perform the behaviour, which also increases the likelihood for the behaviour to be performed. The two key determinants of behavioural intention are people's attitudes and subjective norms.

2.1.2.3 Behaviour belief.

Fishbein and Ajzen (1975) define behaviour belief as a belief that performance is associated with certain attributes or outcomes. This concept stipulates that people tend to associate the performance of a certain behaviour with a certain set of outcomes or features.

2.1.2.4 Subjective norms.

Subjective norms are one of the key determinants of behavioural intention that are referred to the way perceptions of relevant groups or individuals such as family members, friends, and peers may affect one's performance of the behaviour (Fishbein, 1967). Ajzen and Albarracin (2007), further define subjective norms as "perceived social pressure to perform or not perform the behaviour"(p.2). Fishbein and Ajzen (1975), believed that people develop certain beliefs or normative beliefs as to whether or not certain behaviours are acceptable. These beliefs shape one's perception of the behaviour and determine one's intention to perform or not perform the behaviour. However, subjective norms also take into account people's motivation to comply with their social circle's views and perceptions, which vary depending on the situation and the individual's motivation (Fishbein & Ajzen, 1975).

2.1.2.5 Normative belief.

According to Fishbein and Ajzen (1975), normative belief is belief about whether each referent approves or disapproves of the behaviour. Normative beliefs touch on whether or not referent relevant groups approve of the action. There exists a direct correlation between normative beliefs and the performance of the behaviour. Usually, the more likely the referent groups will approve of the action, the more likely the individual perform the act. Conversely, the less likely the referent groups will approve of the action, the less likely the individual will perform the act.

2.1.2.6 Motivation to comply.

Motivation is defined as doing what each reference thinks (Fishbein & Ajzen, 1975). Motivation to comply addresses the fact that individuals may or may not comply with the social norms of the referent groups surrounding the act. Depending on the individual's motivations in terms of adhering to social pressures, the individual will either succumb to the social pressures of performing the act if it is deemed acceptable or will resist the social pressures of performing the act if it is deemed unacceptable (Glanz et al., 2002)

2.1.2.7 Knowledge.

Knowledge is defined as the awareness of a situation (Ajzen & Fishbein, 2004). The theory proposes a significant relationship between knowledge and intention for one to engage in a behaviour.

2.1.2.8 Behavior.

Behaviour is defined as an individual's observable response in a given situation with respect to a given target (Fishbein & Ajzen, 1975). Fishbein and Ajzen (1975) posited that one behaviour is based on one attitude and how you believe others would have acted. A positivistic

approach to behaviour research, TRA attempts to predict and explain one's intention of performing a certain behaviour. Additionally, behavioural intention is the main motivator of behaviour.

2.1.2.9 Past behaviour and habit.

The theory of reasoned action assumes that repetitive performance may affect subsequent behaviour as a consequence of habitual processes (Fishbein & Ajzen, 1980). In addition, it also suggests that past behaviour impacts directly on present behaviour. However, in the diagrammatic presentation by Fishbein and Ajzen (1975) this concept was not included.

2.1.3 TRA Concepts Used in the Study

The following concepts were used in the study, to explore factors influencing the use of Implants and IUD among married women: behaviour, attitude, subjective norms, normative beliefs, knowledge, past behaviour, and habits behaviour.

2.1.3.1 Behaviour.

Behaviour is referred to as an individual's observable response in a given situation with respect to a given target (Fishbein & Ajzen, 1980). The theory argues that behaviour is a combination of intentions and perceptions. The stronger the intention to perform a behaviour, the more likely the behaviour will be performed and vice-versa. In this study, the behaviour was the actual utilization of either IUD or Implants which was influenced by intention. According to this study, those that had a strong intention used either Implant or IUD.

2.1.3.2 Attitude.

Fishbein and Ajzen (1975) defined attitude as a way people feel about a particular behaviour. This involves performing a behaviour and would predict behavioural intentions to

enact the behaviour, which would, in turn, predict behaviour. In this study, it was one of the key determinants of behavioural intentions which resulted in the likelihood of using Implants or IUD by married women. These attitudes were influenced by two factors: the strength of behavioural beliefs regarding and the outcomes of utilizing Implants or IUD which was to prevent pregnancy. Therefore, couples either had positive or negative attitudes towards LARC methods.

2.1.3.3 Subjective norms.

Fishbein and Ajzen (1975, p302.) define the subjective norms as a person's perceptions that most people who are important to him/her think he/she should or should not perform the behaviour in question. Subjective norm is determined by one's normative belief, whether the important referent individual approves or disapproves of performing the behaviour, weighed by his motivation to comply with the referent. Conversely, if a person believes that the referent thinks he should not perform the behaviour, he will have a negative subjective norm. While a person who is less motivated to comply with those referents will have a relatively neutral subjective norm. In this study, the married women had a sense of belief that important people in their lives such as their husbands or relatives will approve or disapprove of a (behaviour), the use of either Implants or IUD for family planning. Therefore, such a married woman to use IUD or Implant for contraceptive, firstly considered seeking approval from the significant other to use IUD or Implants. This in turn influenced whether she used Implants and IUD or not. Additionally, customarily, husbands in most African countries are considered decision makers in maternal and child health care issues (Anguzu et al., 2014), and if husbands do not approve of the use of LARC, women may not utilize Implants and IUD. Therefore, their approval or disapproval had a great influence on the use of implants and IUD as family planning methods.

2.1.3.4 Normative Beliefs.

Fishbein defined normative belief, as beliefs about whether each referent approves or disapproves of the behaviour. Belief is "the confidence in the truth or existence of something not immediately susceptible to rigorous proof'' (Fishbein & Ajzen, 1980, p68). He added that normative beliefs are an individual's beliefs about how other people who are important to them expect them to behave. Similarly, Montano et al. (2010), explained that normative beliefs are perceptions regarding what social referents or people that are important to them would think about performing the behaviour. The attitude is determined by the individual's belief about the outcome of an attribute of performing the behaviour weighed by evaluations of those outcomes or attributes (Montano et al., 2008). All these influence behaviour. In this study, the normative belief were individual's perceptions about what is culturally accepted in Mzimba about the use of LARC methods by married women. These normative beliefs can be both traditional (cultural) and religious influence to affect the intention to both use implants and IUD or not. The couples firstly assessed whether the referent (relevant groups) approves the use of either IUD or Implant before deciding and using the contraceptive methods. If they perceived culture or religion for instance disapproves use of implants or IUD, then they would not utilize such methods.

2.1.3.4 Knowledge

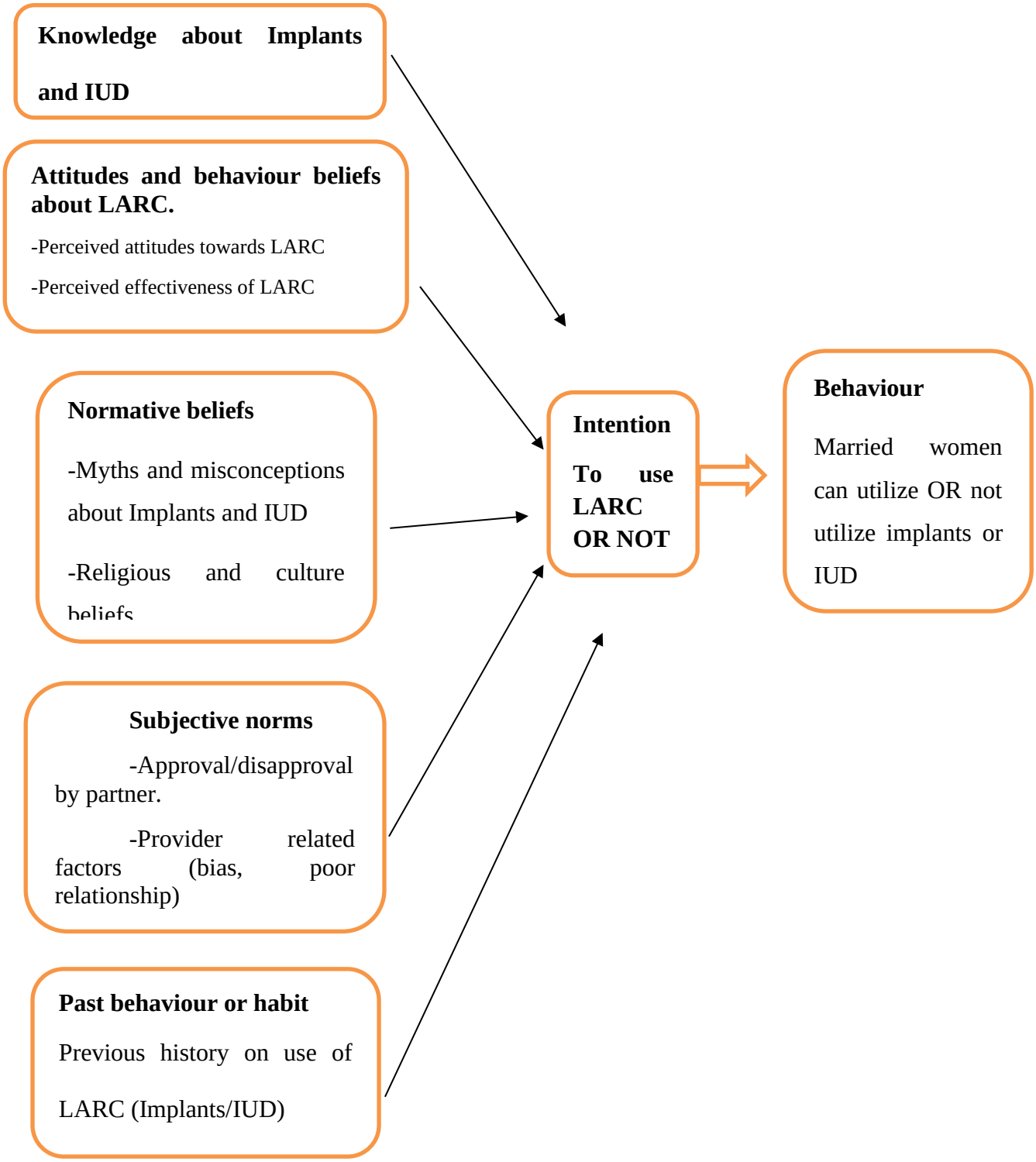
According to TRA, knowledge is referred to awareness of a situation (Fishbein &Ajzen, 1980). Other authors like (Burns, Grove and Gray, 2015) have also defined knowledge as essential content or body of information from a discipline that is required through traditions, authority, borrowing, trial and error, personal experience, role modelling and mentorship, intuition, reasoning, and research. The theory proposes a significant relationship between knowledge and intention for one to engage in a behaviour. In this study knowledge is referred to

an awareness of married women and their partners about the use of implants or IUD as long acting reversible contraceptive, relevant information on the topic namely; mode of action, duration of use, its effects and site of insertion for Implants and IUD. This was an important aspect since the utilization of the family planning methods by married women depends on the knowledge that couples have. Therefore, the knowledge among the couples was explored, to ascertain the performed behaviour which is the utilization of Implants or IUD.

2.1.3.5 Past behaviour and habit.

The theory of reasoned action assumes that repetitive performance may affect subsequent behaviour as a consequence of habitual processes (Fishbein &Ajzen, 1980). It also suggests that past behaviour impacts directly on present behaviour. In this study, the past behaviour meant the previous history of using Implants or IUD as a method of family planning for the married women, their experiences, and perceptions about the methods. This caused repetitive behaviour which was the reuse of the method either Implant or IUD, unlike starters who had no experience with these family planning methods altogether. For example, the married women that had previously used Implants as a method of choice for family planning explained their intention to reuse Implants since they knew the method and even their experience helped them to make that decision as a result of past behaviour of using Implants. Similarly, with the IUD method.

A modified model for Theory of Reasoned Action adapted from Ajzen & Fishbein, (1980).



(Adapted from Ajzen& Fishbein, 1980) which covers all the study objectives.

Figure 2: The modified model of the Theory of Reasoned Action for this study

2.2 Literature Review

2.2.1 Introduction

A review of relevant literature was conducted to generate a picture of what is known about a particular situation (Burns & Grove, 2011). It intended to provide the context of the study by giving insight into the depth of the body of knowledge for the area of study, **"a qualitative exploration on the use of long acting reversible contraceptives among married women.** It further shows related studies done worldwide, gaps identified and disparities within findings for similar studies.

The literature review was guided by the study objectives. The literature search was conducted using electronic databases for published and peer-reviewed research articles published between 2008 and 2020 because it is current information. However, a few old articles were used especially on the conceptual model since the original author wrote them around the 1960s. The Databases were used from 2017 (from the development of the proposal up to the discussion section of the thesis). This was done to locate published research data on. ; Google Scholar, Hinari, Biomedical, INASP, PubMed, CINHAL, PsychInfo, JSTOR, Science Direct & Medline-Ebscohost. Findings of the search retrieved numerous articles. The studies were narrowed using keywords including long acting reversible contraceptives, Family Planning; factors, utilization, modern contraceptives, married women, couples in the study to retrieve the right information which was specific. Africa and Malawi. These studies were conducted in developing countries (Africa and Asia). A few studies were done in Malawi and none was done in Mzimba South District.

A literature review has covered the following subheadings; LARC, knowledge and attitude of married women and their partners on the use of Implants and IUD, husband's

approval/disapproval of the use of Implants and IUD, myths and misconceptions about implants and IUD, Religious beliefs on use LARC, cultural beliefs surrounding the use of LARC, health care-related factors influencing the use of LARC.

2.2.2 Long Acting Reversible Contraceptives (LARC)

Long Acting Reversible Contraceptives (LARC) are highly effective in reducing maternal mortality by preventing unintended or closely spaced pregnancies (WHO, 2017). According to NICE (2005), LARC is defined as modern "methods that require administering less than once per cycle or month." These include injectables (Depo Provera), implants (Norplant and Implanon, Jadelle) and Copper IUDs (Blumenthal et al., 2013) The Norplant offers up to five years of protection from pregnancy, Implanon for 3 years, Depo Provera 3months whereas the Copper IUD offers up to ten years of protection (Ministry of Health, 2016). Recent scientific findings strongly encourage LARC methods because they are ideal in pregnancy prevention and spacing options (WHO, 2017). Their benefits include: safety, effectiveness, cost-effective, reversible, require little to no maintenance, and have much better compliance rates than other hormonal methods (Shegaw et al., 2014) and require little attention after insertion and prevent pregnancy for an extended period (Gbagbo & Kayi, 2018; Zenebe et al., 2017). LARC is cost-effective, because of the reduced cost that a couple incurs in a year of protection when compared to short term methods. However, LARC methods specifically, IUD and the progestogen implant are reversible and allow fertility to return immediately after stopping using them (Secura et al., 2010). They are also referred to as long-acting reversible contraception (American College of Obstetricians and Gynecologists, 2011)

2.2.3 Knowledge and attitudes of married Women and their partners towards LARC

The potential to use LARC may be influenced by the individual level of knowledge of the method (D'Arcangues, 2007). Several studies across Africa, have examined knowledge and attitudes of married men and women towards the use of LARC (Anguzu et al., 2014; Gebremariam & Addissie, 2014; Gebremichael, 2014; Kamara et al., 2015; Okanlawon, Reeves, & Agbaje, 2010; Shrivastava, Shrivastava, & Ramasamy, 2013; Tilahun, Coene, Luchters, & Kassahun, 2013; Topsever et al., 2006). These studies have revealed that both married women and their partners had relative or little knowledge about Implants and IUD. In some studies, participants expressed having no knowledge regarding Implants and IUD method. Additionally, these studies have also proved that married women and their partners have a negative attitude towards the use of LARC hence low utilization. The following research findings for countries such as Nigeria, Malawi Ghana, Kenya, Ethiopia, Uganda, and Madagascar represented in the section below.

Literature indicates that most married women and their partners know LARC methods by name and not beyond the name (FHI, 2008). Such studies include two studies done in Nigeria and Ethiopia (Gebremariam & Addissie, 2014; Okanlawon et al., 2010) which assessed knowledge and perception on long acting and permanent contraceptive methods. In northern Tigray Ethiopia, in a survey among married men and women, participants described their knowledge on LARC methods as superficial because they only knew the method's name as in IUD or implant but could not explain much about the methods as expected when one knows something (Gebremariam & Addissie, 2014). They failed to explain how contraceptive methods work in the prevention of pregnancy, their site of insertion and duration of use except for its name. Consistent with these study findings, was another study conducted in Ethiopia, Amhara

Region by ACQUIRE project (Taylor, 2008a). Before initiation of the ACQUIRE project, which aimed at promoting the use of LARC among women, a study was conducted to assess the knowledge of women on modern contraceptives. The results indicated that the participants did not know much about LARC except the name of the contraceptive method. Further findings to this study, found that participants had neither favourable nor unfavourable views on the use of implants and IUD, and yet could not describe how it works.

A study conducted in Uganda, Lubaga division, Kampala district by Anguzu et al. (2014) on women's knowledge, attitudes and factors associated with the use of LARC methods, showed contrary results. The results indicated that the women knew because they understood that LARC prevents pregnancy with a duration of protection, and most of them were aware of how the devices were inserted (administration site) for those that had previously used the method (Anguzu et al., 2014). This study indicated that participants had relative knowledge on LARC methods, and it was associated with its current use and knowledge was translated to practice. Further findings indicated that married women were the main source of information for their husbands about LARC methods upon visiting the family planning clinic. Interestingly, for a certain study, results indicated low utilization of LARC among women despite participants having knowledge about LARC and wanting to use it (Nyambo, 2013a). The difference was explained as a result of being unfamiliar with where to access LARC methods and its cost (Nyambo, 2013b). These results were different from what the two studies were done in Ethiopia and Nigeria found (Gebremariam & Addissie, 2014; Okanlawon et al., 2010)

Accessibility to FP services does not improve knowledge on Implants or IUD: Another aspect found in literature in relation to knowledge was how physical accessibility to service among women for the urban and rural areas did not improve utilization of Implants or IUD. One study

conducted in urban Ethiopia, Jimma zone on knowledge, attitudes, contraceptive practice and factors related to contraceptive use among married couples (Tilahun et al., 2013). The results revealed that most married women did not utilize LARC despite having increased physical access to FP services. These included contraceptive counselling which promoted a high level of knowledge on LARC hence improved utilization. However, it was also found that utilization in the urban area was low despite accessibility to such services compared to rural areas where accessibility was a challenge. The study demonstrated that mere physical access (proximity to clinics for family planning) and awareness of contraceptives were insufficient to ensure that contraceptive needs were met. The results in that study, further proved that access to family planning does not always translate into actual higher use of LARC in this urban setting since their contraceptive prevalence rate for LARC, remained low (13.1%) (Tilahun et al., 2013), thus depicting the knowledge application gap (Shrivastava et al., 2013). These study differences in knowledge and utilization among IUD and implants users were potentially due to rural-urban differences in socio-demographics and availability of specific LARC methods. Further, it reveals that mere easy accessibility in terms of distance to a facility for service, could not be considered a direct predictor of contraceptive usage. There might be other contributing factors apart from knowledge being affected by social demographics on the method used which needed to be explored to improve the uptake of LARC among married women.

2.2.4 Husbands approval/disapproval on use of Implants and IUD

In many African countries including Malawi, most FP programmes had concentrated more on women and less on men. They thought that childbearing functions among women were more hazardous and risky endeavours than women engaged in and could even result in their loss of life unlike with men (Amentie, 2015). In a study by Kululanga, et al. (2012) in Mwanza

district in southern Malawi, on the individual's, community's, and health workers' perception of male involvement in maternal health care, it was found that previously, maternal, and neonatal care services focused much on women than men, yet men influenced most decisions for instance in FP. This is also evident in the Uganda Lubaga study, where nearly half of the women thought that their male partners should decide on the method of contraception to use, suggesting that men played a major role in influencing the spouse choice to use LARC (Anguzu et al., 2014). Another study was conducted by Kamara, et al. (2015) on perceptions of couples who use Jadelle Implant in Blantyre District, Malawi. Findings indicated that married women whose husbands approved the use of Jadelle played a vital role in the choice of Jadelle as a contraceptive method as a result of male dominance in decision making. Similarly, two studies conducted in Kenya and Ethiopia on unmet need for FP in developing countries, (Shrivastava et al., 2013) also found that partner's approval and their support influenced the use of FP services and contraceptives respectively. The results proved the role of the male being crucial in the use of contraceptive methods.

Similarly, in a qualitative study done in Madagascar with women considering using IUD as a family planning method, the results revealed that the husband's approval to use the contraceptive methods promoted women to use IUD (Gottert, Jacquin, Rehaivondrafahita, Moracco & Maman, 2015 p.291-293). The study results showed that, for women to use IUD as a contraceptive method, they firstly needed their spouse's approval. Consistent results were found in Pakistan, Punjab Lahore by Jabeen and Umbreen (2016), who surveyed knowledge and attitudes among married women. The results indicated that approval to use contraceptive methods was influenced by joint counselling for couples. The respondents had positive attitudes towards LARC methods since the decision on contraceptive use was taken by couples jointly as the spouses were involved and could easily approve the use of LARC as per women's choice

(Jabeen & Umbreen, 2016). The women strongly agreed to a spouse's decision to use any of the methods.

In one study in South Africa rural Western Cape, by Peer and Morojele (2013) on factors associated with contraceptive use, it was a different scenario from Pakistan's study (Punjab). The results indicated that married men did not influence contraception decision making for their wives. Married women made their own decision on the choice of the contraceptive method without any interference from their partners (Peer & Morojele, 2013). It was discovered that despite men being influential in decision making in childbearing including contraception choices, that did not in any way affect the women's decision whether to use contraceptive methods or not. It was the woman's decision whether to use it or not regardless of the husband's approval. The women were autonomous in their choice of contraception method. As such it is important to explore other factors that could influence the use of LARC among married women apart from their partner's approval

2.2.5 Myths and Misconceptions about Implants and IUD.

Literature indicates that various myths and misconceptions exist among Sub Saharan Africa (SSA) countries that influence the use of LARC among married (Nyambo, 2013b) Misconceptions are views or conclusions that are wrong, misleading to most married women and prevent them from using contraceptive methods. In some context, they are called myths. Evidence obtained from various intervention studies in SSA shows that myths and misconceptions exist for use of Implants and IUD (Fiato, 2016).In Kenya, a qualitative study was conducted by Hubacher et al. (2013) on factors associated with decision making for levonorgestrel intrauterine system among post-partum women. . The study results indicated that married women had fears that the IUD would migrate to other parts of the body like the uterus.

In case they get pregnant while on IUD, there were chances of harming the foetus. The IUD would cause painful sexual intercourse especially with the strings hanging in the vaginal wall (D Hubacher et al., 2013). Some participants even believed that if they become pregnant while with an IUD in their uterus, the foetus will be harmed and be born holding Despite the centrality of religion and fertility to life in rural Africa, the relationship between the two remains poorly understood. The study presented here uses unique integrated individual- and congregational-level data from rural Malawi to examine religious influences on contraceptive use. In this religiously diverse population, we find evidence that the characteristics of a congregation leader's positive attitudes toward family planning and discussion of sexual morality, which do not fall along broad denominational lines are more relevant than denominational categories for predicting women's contraceptive use. We further find evidence for a relationship between religious socialization and contraceptive behaviour.

Another misconception that was seen in the literature about the use of IUD among women, was the belief that the IUD could cause permanent infertility which contributed to low utilization of LARC as seen in an Ethiopia study by Gebremariam and Addissie (2014). The women in this study believed that if they used IUD, they would be unable to have children or rather the use of IUD could cause barrenness. Similar findings were found, in Pakistan Pujabu, Lahore survey among Asian married women. The results indicated that married women believed that the use of IUD could steer the inability to bear children against one of the women's roles in the family 'childbearing', and that IUD was culturally considered an illegible FP method (Jabeen & Umbreen, 2016).

Similarly, in Nigeria, Uganda and Ghana studies on reasons for discontinuation of implants and IUD (Ezegwui et al., 2011; Tilahun et al., 2013), most women did not use Implants

and IUD due to the misconceptions men had that excessive menses drain women's blood and cause barrenness. Yet these were just side effects that could be treated. This also made husbands oppose the method since it made sex impossible for couples. Severe bleeding prompted men to deny their spouses to use IUD for fear that they would be deprived of sex as seen in a Uganda study (Taylor, 2008).

However, the literature also indicates that in other studies the myths and misconceptions were related to personal health concerns that participants believed to have been caused by the use of LARC methods. In a study by Blumenthal et al. (2013)on revitalizing long-acting reversible contraceptives in settings with high unmet need, the participants believed that individuals would acquire HIV/AIDS and other infections that could result in loss of life (Blumenthal et al., 2013). Further findings in Blumenthal et al. (2013) study, revealed that married women expressed fears of IUD causing abortion and rust in the uterus since it is made of metal and thereby resulting in health problems like cancers. This is similar to two qualitative studies conducted in Kenya and Uganda studies on Knowledge and attitudes towards the use of long acting reversible contraceptives among women of reproductive age (Anguzu et al., 2014; Hubacher et al., 2013). The results indicated that the participants in the focus groups had some myths and misconceptions about IUD and Implants. These included IUD causing cancer of the uterus as seen in Blumenthal's study. Other myths and misconceptions included weakening of the body that makes normal labour a challenge for women when they get pregnant, and migrate to other parts of the body like the uterus and cause prolonged bleeding.

There are also some studies done that prove lots of myths and misconceptions associated with the use of implants such as Jadelle as seen with the use of IUD as above literature. These include myths and misconceptions associated with the insertion procedure and how Jadelle

works in the body to prevent pregnancy. For instance results from Kamara's study (2015), for some women, it was believed that the insertion of Jadelle required major surgery and that insertion was very painful which caused infections to women (Kamara et al., 2015). To others, they believed the implant migrates to other parts of the body like the heart and puncture it thereby causing death. Interestingly, some married women believed that if a man sleeps with a woman who is on the implant, the power of the contraceptive would make the man weak, and lose his sexual power. This is consistent with findings from one study in Nigeria on knowledge, perceptions and attitudes towards contraceptive methods in which respondents believed that contraceptives were harmful, dangerous and can cause damage to the reproductive system (Okanlawon, et al., 2010). Such myths and misconceptions were incorrect about the use of Implants Jadelle and it influenced couples' choice to use or not Jadelle for contraception. Therefore, there is a need to explore if the same myths and misconceptions do exist at Mzimba Hospitals.

Therefore, all literature has proven that myths and misconceptions that exist among people result in some married women not utilizing the implants or IUD for family planning and they are false, hence there is a need to explore if the same myths and misconceptions could be influencing low utilization of LARC methods among married women of Mzimba.

2.2.6 Religious beliefs and use of LARC

According to the literature, religion is widely known to affect the acceptance and utilization of modern contraception including LARC among couples, thus affecting their reproductive behavioural outcomes worldwide (Nanvubya et al., 2020). This is also supported in the Theory of reasoned action (TRA) in which Shumaila et al. (2010) explained that there are factors that influence the stability of intention like the subjective norms and normative beliefs of

which some include religion, culture, myths, and misconceptions. Religion generates a mixed influence on the choice of modern contraception (Yeatman & Trinitapoli, 2008).

Previous studies done on the relationship between religion and contraceptive use in sub-Saharan Africa provide a good background for research, although they often reach quite different conclusions due to different schools of thoughts associated with religious beliefs (Yeatman & Trinitapoli, 2008). These studies considered religion as having an influence on contraceptive attitudes and behaviour in which contraceptive users considered their religious beliefs which determined whether to use contraceptive methods or not.

In Malawi, a study by Yeatman and Trinitapoli (2008) on women's relationship between religion and family planning, results indicated that it was the attitude of certain churches towards family planning and sexual molarity that influenced modern contraceptive use among women. Similar results in another Malawian study by Nyambo (2013) on factors influencing long acting reversible contractive use, found that in most cases strong religious views were associated with less contraceptive use. For instance, strong Muslims beliefs were negatively associated with the use of modern contraceptives (Nyambo, 2013a; Yeatman & Trinitapoli, 2008). Contrary results are seen in one Nigerian study by Audu (2009) on the attitude of women to contraceptive use by men. The results indicated that contraceptive use was in no anyway influenced by their religious beliefs among Muslim women but rather the side effects that they experienced was what prevented them from using these modern contraceptives. Further results indicated that these Muslim women accepted their partners to use contraceptives like condoms while they did not use any method as a result of side effects they experienced (Audu et al., 2009). Similar results were seen in another study done in South-East Ethiopia by Takele (2012) among married women on demand for long acting and permanent methods of contraceptives and factors for non-use. His

study results were similar to those of the Nigerian study (Audu et al., 2009) that religion was not significantly associated with the use of implants and IUD.

Literature also indicated that there are some variations between religious groups, for instance, Christians and Muslims on the use of contraceptives methods despite some studies showing no relationship of contraceptive use to religion as seen in the studies conducted above. For example, a study in Ghana by Doctors (2009) on the influence of changes in women's religious affiliation on contraceptive use and fertility among the Kesena-Nankana indicated that Christians were more accepting of contraceptive use than Muslims. The findings further highlighted that these religious differences in relation to contraceptive use were only to be true for certain areas rather than generalisation because there were other influencing factors to the use of LARC apart from religion itself.

Interestingly, literature further showed variations on the utilization of contraceptive methods among married women even within the same religious groups like among Christian groups. For instance, in one study conducted in Uganda by Nanvubya et al. (2020), on barriers and facilitators of family planning use in fishing communities of Lake Victoria, the results indicated that Anglicans even Muslims were more likely to use contraceptive methods than members of the Roman Catholic Church despite Anglicans and Catholics being both Christian groups. Additionally, the qualitative analysis of this study found that the religious beliefs among Roman Catholics had a negative influence on the use of family planning. Similar results were found in two studies conducted in Europe (Pinter et al., 2016) and Nigeria (Benedugu et al., 2019) which found Roman Catholic women of reproductive age not utilizing contraceptive methods due to religious influence. The study in Nigeria, further explained that the Roman Catholic Church banned the use of family planning methods to its members because family

planning was unnatural means of contraception hence their members could not use such methods (Benedugu et al., 2019)

Contrary, results were found in two studies conducted in Kenya and the USA (Hill et al., 2014; Ontiri et al., 2019) among reproductive women, the results indicated that religion was associated with uptake of LARC methods with more Roman Catholic members up taking LARC more than the Protestants. It further revealed that Catholic members were more likely to use LARC despite Roman Catholic Church beliefs discouraging its use among its members for the following reasons; the fear in its members of getting pregnant if not on any modern contraceptive method which was embarrassing to friends, congregants were convinced of the importance of using contraceptive methods to their family wellbeing and the condemnation in their religious communities (Hill et al., 2014).

Given that religion plays an important role regarding contraceptive use, it is important to explore more and ascertain how religion influences the use of LARC among married women in Mzimba.

2.2.7 Cultural beliefs surrounding the use of LARC

According to the theory of reasoned action, normative beliefs which are an individual's beliefs about how other people who are important to them expect them to behave affects the intention to use implants or IUD. Foxall, et al. (2010) describe them as perceptions regarding what social referents or people that are important to them would think about performing the behaviour. In most African countries, male dominance in families and its opposition to contraceptive use among married women are barriers to the use of family planning methods including LARC (Blackstone et al., 2017). Nonetheless, men are decision makers in the African family context, hence influence decision making on family planning, issues. Similarly, Mzimba

is patrilineal and has both Ngoni and Tumbuka men who are decision makers. Therefore, there was a need to explore if their culture influences the use of LARC among married women.

In a systematic review of literature by Blackstone, et al. (2017) on factors influencing contraceptive use in 12 SSA countries between 2005 and 2015, results on negative factors indicated cultural norms as one of the contributing factors to low utilization of LARC methods. Typically, women held low social status in the community and obtained lower levels of education hence become defenceless to decisions made by their partners. For instance, in a Zanzibar study, only 2% of the women interviewed partook in the free and accessible family-planning programs and male dominance was noted as a reason for nonparticipation, particularly in polygamous relationships.

Similarly, in Uganda Lubaga study Anguzu et al. (2014) on knowledge and attitudes towards the use of long acting reversible contraceptives among women of reproductive age in Kampala district the findings indicated that where male partner involvement was a challenge as a result of women's attitude that male partners' choice influences their contraceptive decisions, were positively associated with current use of LARC. These studies indicate that men can have a positive influential role in family planning; however, the ample evidence of women's fear of spousal disapproval suggests the need for interventions targeting cultural norms and presented in a culturally competent framework (Blackstone et al., 2017) as seen Uganda study(Anguzu et al., 2014).

However, cultural norms in relation to decision making in families are also seen as being dependent on other factors like a social network. For instance, in Ghana a study by Ezegwai, et al. (2011) on discontinuation rate and reasons for discontinuation of implant the family planning clinic of University of Nigeria Teaching Hospital (UNTH) Enugu. Nigeria indicated that social

networks played an important role in decisions regarding contraceptive and perceived acceptability of using contraceptives among men unlike in women since it did not improve the utilization of Implanon.

Similarly, in Ghana, encouragement towards contraceptive use from men's social networks was significantly associated with increased contraceptive uptake from their wives. This proves that social media played a part in promoting contraceptive use more especially in the urban setting unlike the rural where communication is a challenge. Scientific evidence has also shown that the positive influence of male partners may affect maternal and child health outcomes (Tokhi et al., 2018).

2.2.8 Healthcare related factors influencing the use of LARC

The literature review indicated that health care-related factors influence the uptake of LARC methods among married women. Several studies indicated the following health-related factors; inadequate information provided to clients, lack of knowledge and skills among providers, bias and role conflict (Azmoude et al., 2017; Gbagbo & Kayi, 2018; Hamsa et al., 2017; Kamara et al., 2015; May et al., 2011; Neucom et al., 2011; Takele et al., 2012). The section below, therefore, explains studies on how some health care factors influenced uptake of LARC among couples.

2.2.8.1 Attitude and misconceptions of family planning service providers.

According to the literature review, negative attitudes and misconceptions of family planning providers affect the utilization of Implants and IUD among women. For instance, one study conducted in Malawi by (Tang et al., 2016) mong post-partum women on the utilization of Implants found that low uptake for Implants was secondary to both patient and provider negative attitudes and misperceptions as barriers to use of Implants and IUD. This was similar to

Kamara's study (2015) in which he highlighted how attitudes of family planning providers served as motivators or barriers to the use of contraceptives among couples.

2.2.8.2 Poor Provider-client relationship

According to Topsever et al. (2006), the health care provider and client relationship had a great impact on the utilization of LARC among married women. This includes counselling. A study by Topsever (2006) results indicated that family planning counselling was critical and influential when choosing a method of family planning. The study further revealed that clients that underwent family planning counselling were able to make an informed decision about family planning methods. Similar findings were found in two studies done in Ghana, by Gbagbo and Kayi (2018) on the use and discontinuation of the intrauterine contraceptive device and western Ethiopia (Melka et al., 2015) on determinants of long acting and permanent contraceptive methods utilization among married women of reproductive age groups. The results indicated that health workers had a major role to play in encouraging positive attitudes towards using the IUD through counselling among women as it promoted IUD uptake. The results in Melk's study, (2015) found that women who attended a joint fertility counselling session with a health care provider together with their male partners were six times more likely to use LARC, and those who had a prior discussion with an FP counsellor about LARC methods were 14 times more likely to use LARC. The results further proved that there was a relationship between FP counselling and increased LARC use among women as anxieties were reduced and it created trust between FP service provider and the family planning clients.

Contrary, in northern Tigray Ethiopia, a survey among married men and women, found that low uptake of LARC was contributed by the poor relationship of health care provider and family planning clients. Participants in the study complained about health care providers not

providing adequate information during counselling sessions which contributed to a poor understanding of the methods. They further explained that the knowledge regarding LARC was superficial since participants only knew the method by names, but not much more about the method as providers could not counsel them well about the family planning methods (Gebremariam & Addissie, 2014). Participants blamed their superficial knowledge on providers of FP (counsellors), who did not provide them with information on all methods but rather focused on the short acting contraceptives of pills and injectables. That created mistrust for FP workers to performing the procedures safely and concern over the pelvic exam required for IUD hence resulted in low intention to use a LARC.

2.2.8.3 Integration of services with FP counselling.

Another area of interest found in literature was the integration of services such as ART with FP and counselling which improved uptake of LARC among couples (O' Shea et al., 2014). In Malawi, a study by Osheal et al. (2014) on family planning providers' experiences and perceptions of long-acting reversible contraception in Lilongwe, showed that integration of services with FP and counselling at ART clinic had a great impact on increased uptake of LARC among HIV clients. Initially, LARC uptake was very low (30%) compared to the time integration of FP education and on-site IUD insertion was introduced. During this intervention, more clients (95%) attending ART clinic were counselled on LARC and all services were done right at the clinic which shows how the integration improved utilization of LARC among HIV positive women. The study revealed that the integration of Counselling on family planning and ART played a major role in increased uptake of LARC methods among women as women were able to make an informed decision about the methods.

2.2.8.4 Effects of provider's age on the utilization of LARC.

Literature also indicated how negative patient-provider interactions in relation to their age and gender of the provider negatively influenced uptake of contraceptives in some cases. For instance, one study conducted in rural Ghana by Robinson et al. (2010) on barriers to intrauterine device uptake among women found that age and gender of providers influence women's likelihood of using IUD. Clients in this study preferred elder female providers to younger women (Robinson et al., 2016). To them, they trusted elder women because they seemed mature and responsible unlike young providers and culturally it was not right for issues of respect and privacy.

2.2.8.5 Provider bias.

Evidence in the literature indicated that provider bias was one of the factors that influenced the low uptake of LARC among women (O'Shea et al., 2014). However, the providers' bias was categorised in three aspects based on the following areas: lack of knowledge of the family planning client, lack of knowledge and skills for the provider in the provision of LARC and provider's cultural norms.

Two studies done in Ghana (Gbagbo & Kayi, 2018; Robinson et al., 2016)found that for some clients who were ignorant about family planning methods, there were elements of provider biases during counselling which lead to some providers either advising clients to use IUD based on their personal experiences or preference for IUD, as a result, it affected clients' choice to family planning method since they opted for the providers' choices. The clients solely made family decisions based on the providers' choice.

Lack of knowledge and skills among family planning providers also resulted in a bias towards short acting contraceptive methods. In Zambia case study on dedicated providers of

long-acting reversible contraception, results indicated that providers who lacked meaningful supervision during training lacked confidence and desire to provide the service thereby advocating for short-acting methods unlike LARC (Neucom et al., 2011). Further findings revealed that some health care providers held incorrect and outdated opinions of LARC due to limited education on the subject. Their bias towards short acting contraceptives was because they were conversant with the method as a result of long involvement and change was difficult to adapt. Consistently, findings from three Ghanaian studies (Gbagbo & Kayi, 2018; Robinson et al., 2016; Teye, 2013), also indicated providers lack of skills and number of educational tools for provider and patient, limiting options for contraception, hence more bias towards short-acting contraceptives. For instance, results showed that even some providers had incorrect information and opinions that IUD causes pelvic inflammatory infections, infertility and even not suitable for HIV women which were not true according to WHO and ACOG eligibility criteria for IUD (American College of Obstetricians and Gynecologists, 2011; WHO, 2014).

Literature also indicates that provider's bias was due to strong cultural norms among family planning providers towards mostly adolescent women using contraceptive methods. One study conducted in the Mwanza district in southern Malawi (Kululanga et al., 2012) to investigate the individual's, community's and health workers' perception of male involvement in maternal health care. In-depth interviews and focus group discussions were the methods used for data collection. The participants' responses generated two main themes namely male involvement in health facility care and outside the health facility. The participants' perception of male involvement in facility care concentrated around six sub-themes describing male involvement as; couple HIV counselling and testing; a government law; a strategy for fast services for women; unfair programme for women without partners; a foreign concept; an act of

love. We conclude that male involvement in the health facility care was fragmented and associated mainly with first antenatal care; couple HIV counselling and testing; suggesting poor integration of male involvement into the existing maternal and child health programmes and that there is a need to engender maternal health care services Green and Stanback (2012) found that providers were setting unnecessary high age and parity requirement for women to access LARC because of their own bias (Green & Stanback, 2012). The study findings revealed that the providers' strong cultural norms such as the belief that family planning was not ideal for young women prevented them from accessing the services since they were judgemental. Similarly, Chilinda et al. (2014) in their systematic review found that culture and role conflict of providers hindered most young mother to access LARC. The results further revealed that apart from family planning providers having a role in service provision, they also had other roles like parenting which prevented young women from accessing the service for fear of being advised as parents not to use family planning methods. As a result, there was a bias towards older women. That was in breach of their right to access sexual reproductive health right services (UNFPA, 2010).

2.2.9 Summary

The literature review indicated that modern contraceptives, particularly Implants and IUD (LARC) are underutilized in SSA countries due to several factors which included inadequate knowledge and attitudes of married women and their partners on the use of Implants and IUD, married men not fully involved in family planning issues despite being influential in decision making. It was also clear that both married women and their partners have myths and misconceptions about the use of implants and IUD that were misleading and impacted the choice of LARC. For instance, men who perceived LARC as causing infertility and causing the acquisition of HIV if used were more likely not to use IUD as a contraceptive method. Bad

cultural norms surrounding the use of LARC, normative beliefs like a religion on use of LARC, health care-related factors such as bias and provider-client relationship in relation to use of LARC may also have reduced LARC uptake for married women. However, there were gaps in most of these studies. These included: concentration on factors influencing all modern contraceptives among women in the reproductive age, which was general, since being married is a predictor to use of FP. More studies were quantitative and did not give full details as to why married women do not use Implants or IUD. For the qualitative studies done, many focused on either Implants or IUD. Additionally, no study had been done in Mzimba on what influenced the use of LARC among married women. Therefore, this study, concentrated on factors influencing the use of implants and IUD among married women at Mzimba South District Hospital because little was known or documented in literature about that area. In addition, there was also a gap in studies in Malawi, like Kamara, et al. (2016) who looked at perceptions among couples of which could be one of the influencing factors to low utilization.

CHAPTER 3

3.0 Methodology

3.1 Introduction

This chapter describes the methodological techniques that were used in exploring factors that influence the use of long acting reversible contraceptives among married women at Mzimba South District Hospital.

It gives an overview of the study design, setting, population, sampling method, sample size, data collection, data management and analysis, ethical consideration, study trustworthiness and conclusions.

3.2 Study Design

Study design refers to the overall plan for addressing a research question including the specification for enhancing the study's integrity (Polit & Beck, 2017). This study used an exploratory descriptive qualitative design. According to Polit and Becky (2017), a qualitative methodology was chosen because it best suits this study, and it describes more details about the study by understanding peoples' decision making processes. In addition, the design helped to uncover more information on the area under study as it seeks to describe and give a narrative account of how several factors influenced their choice to use implants or IUD for family planning.

3.3 Study setting

The setting describes the physical location where the individuals of interest live, experience life, and where data collection for the study will take place (Polit & Beck, 2010). The study took place at Mzimba South District Hospital because it is the only main district hospital offering all methods of family planning, five days in a week to high numbers of clients. Also

being a government-owned health institution that is surrounded by two Catholic CHAM health facilities (Mzambazi and Katete), which do not offer FP methods due to religious reasons, this results in high clientele seeking services at the facility. Apart from Mzimba being a District Hospital, the study setting was suitable for the study as most participants stayed around it which was convenient for data collection. These factors made the researcher get more information and clients for the data collection. Their partners were booked for interviews in places that were convenient for them within Mzimba Boma. This arrangement was made considering that most married men did not go with their wives for family planning services. For most women (n-7) in the study, interviews were done at the district hospital in my office for privacy's sake while others were done at their convenient houses on request.

3.4 Study Population

According to Polit and Beck (2017), the target population refers to the entire population in which the researcher would like to generalize the results. The study population was the following:

- Married women for both initial and subsequent visits had consented to their husband's participation in the study. They were the right target population because the study explored factors influencing married women. Their marital status 'married' was ideal since marriage predicts the use of family planning methods. The age range was between 18-49 years old because the legal age for giving consent in a study is 18 and the reproductive age range ends at 49 years for most women.
- Married men aged 18 years old and above whose wives had consented to their participation in the study. Married men were included because they are also involved

in decision making pertaining to family planning which may influence the use of Implants and IUD among married women.

3.5 Sampling Method

Sampling refers to the selection of a group of people that are representative of the population being studied (Burns et al., 2015) the sampling method used for the study was purposive sampling. This sampling method involves selecting participants according to the judgment of the researcher that they will give the required information (Brink et al., 2012). The researcher wanted to target married women and their husbands within the inclusion criteria, with a selection of different age groups (younger and older inclusion) mixed levels of education and if working or not who were willing to participate were considered. Additionally, those married women attending a family planning clinic for contraceptive methods on the day of data collection so that they narrate factors that are influencing the use of LARC.

3.6 Sample Size

A sample is a part of the target population selected in such a way that the individuals in a sample represent the characteristics of the target population (Burns et al., 2015). Since there is no sample size calculation in qualitative research, an appropriate sample size for the qualitative study is one that adequately answers the research question (Marshal, 1996). This is achieved when there is data saturation. According to Brink et. al (2012) data saturation occurs when additional participants do not give different or new information. In this study, twenty participants were recruited (10 married men and their wives). Data saturation was determined after 14 (7 couples) participants were interviewed as participants did not give different information and 6 more participants (3 couples) were added making a total of 20 participants interviewed.

3.6.1 Inclusion criteria.

The inclusion criteria refer to the criteria that specify the characteristics that delimit the study population (Polit & Beck, 2017). It tries to identify persons who qualify as a member of the study. The inclusion criteria were as follows;

- Married women and their husbands who were healthy and not sick because healthy people are considered stable considering the interview would take about 30-45 minutes. This would allow them to give more information since they were capable.
- Married women that had come for any method of contraception of age range 18-49, whether initial or subsequent on the day of data collection and consented to their husbands to be interviewed as they are a couple.
- Expressed willingness to participate in the study.
- Married women who attended FP Clinic at Mzimba South District Hospital
- Understood Chichewa, English or Tumbuka

3.6.2 Exclusion criteria.

The exclusion criteria refer to the criteria specifying characteristics that the study population does not have (Polit & Beck, 2010). The exclusion criteria were as follows:

- Married women and their husbands who did not understand Chichewa, Tumbuka or English were excluded from the study.
- Couples that were mentally sick.
- Expressed unwillingness to participate in the study.
- Those who did not attend the Mzimba South district Hospital family planning clinic.
- Married women and their husbands who were less than 18 years old because they were not old enough to provide free consent to partake in the study.

- Married women who did not give consent about their husband's participation in the study.

3.7 Data Collection

3.7.1 Data collection instruments.

It refers to the device used to collect data (Polit & Beck, 2017). Data collection was guided by an interview guide (Appendix 1, p113) with open-ended questions. The interview guide included questions on personal details, knowledge about each method, beliefs, past behaviour and habits, subjective norms**.** The interviews were conducted among couples attending FP clinic.

3.7.2 Data collection process.

The principal investigator was in charge of all the interviews and the FP coordinator was oriented to assist with the recruitment of participants by the Principal investigator. The following recruitment strategies were applied; the use of screening questions which helped to filter qualified participants for the study such as consideration of all age ranges, parity, being FP client either new or subsequent.

During interviews, consent was sought to record the interviews from the participants and that data will only be used for this research purpose which includes keeping data fresh for analysis. On average, the interviews lasted for 30 to 45 minutes for each participant. Married women were interviewed separately from their husbands to allow openness. The tool was developed in line with the objectives of the study and the concepts in the theory of reasoned action (TRA) such as subjective norms, normative beliefs, attitudes, and knowledge.

The interview guide was translated to Tumbuka and Chichewa as these are commonly spoken languages in Mzimba. During data collection, all participants chose Chichewa and

English for the interviews and therefore, the interview guide for the Tumbuka version was not used. Additionally, an independent person (FP Coordinator), well conversant with Chichewa and Tumbuka assisted in the translation of the interview guide before data collection, back-to-back in order to avoid loss of meaning to the interview guide since more languages were used. Before data collection, the interview guide was reviewed by a Reproductive Health expert in research methodology to ensure trustworthiness (Polit & Beck, 2010). Pre-test interviews were done at the FP clinic at Mzimba South District Hospital on two couples by the researcher. The participants for the pre-test were approached randomly at the MCH FP clinic. Upon giving consent to their partners, interviews were conducted. The researcher had chosen the same site to pre-test the research tool (interview guide) since she was sure there was not going to be any contamination of data since the clients used for pre-testing were gone by then. A pre-test helps and gives an interviewer an insight during the in-depth interviews to questions that are misunderstood. Similarly, in this study, pre-testing of the instrument was done to refine the interview guide to test if the tool was reliable and accurate. The responses that were generated from the pre-test informed the researcher on how to conduct the actual study. Minor corrections were done mainly on the technique of getting more information through probing which helped the researcher to come up with more information during the actual data collection.

Field notes were also collected during interviews especially on questions to do with participants' perceptions about the use of Implants and the IUD method among married women. These included emotions from the participants who expressed concerns with health workers attitudes when providing family planning methods. These included a high tone, shyness and facial expressions which showed discomfort and anger.

3.8 Data Management and Analysis

3.8.1 Data management.

Data management refers to the activities involved in the preparation for data analysis (Polit & Beck, 2010). Data was recorded after gaining permission from the participants. In this study, the audio recorded (Tablet recorder) narrative data were transcribed verbatim in Chichewa by the researcher and then translated into English after each interview and back-to-back translation was done to avoid loss of meaning of the data collected. Each participant had a file with an identification code number where all interview guides containing each participant's demographic data was put together including Chichewa, Tumbuka and English of the narrative data, field notes taken during the interview and consent forms. The files and the tape recorder were locked in a drawer of the researchers' table and only be accessible to the researcher ready for analysis.

3.8.2 Data analysis.

According to Polit and Beck (2017), qualitative data analysis refers to working with data, organising it, breaking it into manageable units synthesising it, searching for patterns, discovering what is important and what is to be learned, and deciding what to tell others. Data analysis was done manually using thematic content as described by Braun and Clarke (2006) with six steps as follows: familiarization of data, generating initial codes, searching for themes, reviewing themes, defining & naming themes and producing the report. It was also be done concurrently with data collection in order to improve data quality in cases where some information was missed in the course of the interview.

Once all the interviews were done, data was organised by listening to the recorded interviews repeatedly so that the researcher got familiar with the data and got the true meaning.

The recorded data was transcribed and proofread against the recorded interviews. Then coding was done to categorise the data. At the same time, all similar data were grouped to ease the coding process. Based on the meaning of the coded data, themes and sub-themes were developed. Similar themes with their sub-themes were grouped further from all the interviews and further descriptions were made. Another independent person (deputy FP coordinator) from FP clinic helped in encoding the data to validate if the data was giving a true reflection of the original data and verify if there was an agreement.

3. 9 Enhancing Trustworthiness of the Study

Trustworthiness is one way researchers can persuade themselves and readers that their research findings are worthy of attention (Braun & Clarke, 2006). Lincoln and Guba (1985) refined the concept of trustworthiness with the following criteria: credibility, transferability, dependability, and conformability. This study achieved all criteria for its trustworthiness and have been explained below section.

3.9.1 Credibility.

This refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2010), while Guba and Lincoln (1985) claimed that the credibility of the study is determined where core researcher and readers are confronted with recognisable experience since it addresses the fit between correspondences. It is also important because it helps to evaluate if the research was worthy. In this study, credibility was achieved through prolonged engagement with each participant for 30-45 minutes which assisted to gain an adequate understanding of the study area hence established a relationship of trust. It also used persistent observation for the scope which is the depth of the matter by probing and asking for clarification where answers given were not clear.

3.9.2 Dependability.

Dependability is the stability of the data over time and other conditions (Polit & Beck, 2017). Showing that the findings and consistency could be repeated (Nowell et al., 2017). If the research would be repeated in the same context, with the same methods and participants, similar results would be obtained (Guba & Lincoln, 1989). This was achieved through an inquiry audit where the researcher was not involved in the research process to examine both the process and product of the research study. The examiners evaluated the accuracy of whether or not the findings, interpretations and conclusions support the data collected and its presentation. This allowed an outsider to challenge the results. The research process was recorded and reported in detail from the design, data collection and analysis.

3.9.3 Confirmability.

Confirmability is the degree of neutrality or the extent to which the findings of the study are shaped by the respondents and not the researchers' bias, motivation or interest (Guba & Lincoln, 1989). The methods used in the research process shall be presented in detail as possible to prove that the results are perspectives and ideas of the informants as proposed by Polit and Beck (2017). This was achieved by declaring any bias the researcher encountered through the research process. Before the conclusion of the study, results were presented to examiners both internal and external for scrutiny.

3.9.4 Transferability.

Transferability involves showing that the findings of the study have the practicability in other content (Nowell et al., 2017). It is in preference to external validity or generalization in a positive paradigm. This was achieved through the thick description of a way of achieving a type of external validity. Describing a phenomenon in sufficient detail so that conclusions can be

transferred to other time, settings, people, or situations. This included sufficient descriptive data in the research report including the research methods and context in which this study was conducted.

3.10 Ethical Consideration

To ensure that human beings were protected in this study ethical principles such as; informed consent, respect for autonomy, confidentiality and anonymity, avoiding harm and justice guided the study (Burns et al., 2015). During the research and after, several ethical considerations were followed as follows; firstly, approval to conduct the study was sought from COMREC which is a research committee. Secondly, permission from the Acting Director of Health and Social Services for Mzimba South District was sought because data collection was done there (See Appendix p.112).

The following rights were observed and respected throughout the study; participants had the right to information about the study. The researcher explained information about the study to participants. A written Information sheet was read to all participants to enable them to understand the study. The Information sheet included the purpose of the study, duration, methods, and procedures for collecting data, any risks or discomforts arising from the study. The participants had the right of withdrawing from the study at any time without being penalised or deprived of getting any health service due to their refusal. Participants had the right to privacy whereby interviews were conducted in a closed room, private and confidential. Their right to protection was also observed. The researcher explained if any risks could cause any harm to the participants be it physical or psychological. The researcher sought consent from participants upon giving them all information about the study. This was achieved through a consent form which they signed, or thumb printed. Additionally, their decision whether to partake in the

research or not to was respected. For instance, from the twenty-six participants that were approached to participate in the study, three male husbands refused to partake in the study regardless of their wives consent due to personal reasons. These included being uncomfortable to partake in the study, one participant thought he was old to be talking about family planning issues since as a family he was not planning for another baby hence no need of using LARC and not just being interested. The participants were also not forced or coerced in any form to participate if they felt not to, because it was their right to refuse in any involvement of the study.

The researcher also observed the respect of human right by giving participants all information about the study so that an informed decision is made. They also had the right to withdraw at any point without experiencing compromised or hindered them from receiving care even for those that refused to partake in the study. They got their method of choice.

3.11 Constraints and Limitations

The study was done at Mzimba district hospital hence the results apply to Mzimba only. Other health facilities were not reached because the research had to be done within the academic period due to time constraints.

3.12 Dissemination of Study Findings

Dissemination of study findings and possible recommendations will be done locally at Mzimba District Hospital to both staff and management team. Copies of the report submitted to Kamuzu College of Nursing, COMREC and Mzimba South District Hospital. Additionally, a copy of the thesis will also be made available at KCN Library for both campuses and the researcher intends to publish the study.

3.13 Conclusion

This chapter has given a step-by-step presentation of the methodology that was used in the study. The study design, inclusion criteria, the sampling process, the data management, data analysis and ethical considerations.

CHAPTER 4

Presentation of Findings

4. I Introduction

This chapter presents the findings of the study which are categorised in two sections: the demographic data and the identified themes from qualitative data.

4.2 Demographic Data

Table 1 contents present the descriptive characteristics namely age range, tribe, religion, occupation, and a number of children. In summary, most of the participants were young with an age range of 25-30 years old and had at least one to three children. Most of the participants belonged to the Tumbuka tribe and were Presbyterian by religion. On employment, the majority in which more men were a working-class with formal employment. Seven female participants were housewives while three were working class. The data also showed that the majority were educated with at least a secondary education. Demographic data were analysed manually using descriptive statistics.

Table 1: Descriptive Demographic Characteristics of Participants

Demographic data	Married Men	Married Women	Total
Age Group			
20-25		1	20
26-30	3	8	
31-35	4	1	
36-40	3		
Tribe			
Tumbuka	7	5	20
Ndali		1	
Lomwe			
Ngoni			
Chewa	2	3	
Yao			
Sena			
Tonga	1	1	
Religion			
SDA			20
CCAP	4	4	
Catholic		1	
Pentecostal	2	1	
Church of Christ	2	2	
Assemblies of God	2	2	
Occupation			
Civil Servant	6	2	20
Farmer	1		
NGO	3		
Not working		7	
Businessman/woman		1	
Number of Children			
1	5	5	20
2	2	2	
3	2	2	
4	1	1	
5			

4.3 Identified Themes from Qualitative Data

Five themes emerged from the qualitative data. These were derived by analysis of words so that word repetitions, key indigenous terms, and keywords in the contexts were identified. The following were identified themes and subthemes.

THEME	SUBTHEMES
Theme 1. Inadequate knowledge about Implants and IUD.	• Family planning methods prevent pregnancy • Variations of the level of knowledge • Knowledge gap on site of insertion, how Implants or IUD works to prevent pregnancy and its duration of use. • Sources of information about Implants and IUD.
Theme 2: husband's approval/disapproval to use of Implants or IUD.	• Approval based on; benefits, safety and comfortability of the wife
Theme 3: why women do not use Implants or IUD.	• High blood pressure in women • Effects of cultural beliefs (value of children. • Inadequate knowledge and skills among FP providers.

Theme 4: Myths and misconceptions about Implants and IUD.	• Women take time to conceive. • Loop strings cause pain during sex • Loop cause men no to accomplish anything on a woman • Loop and Implants migrate to other parts of the body and cause death. • Loop cause cancer of the womb. • Implants cause miscarriage.
Theme 5: proposed solutions to address problems faced by women.	• Promotion of LARC for healthy living • Promotion of male involvement in FP issues by traditional leaders • Hospitals to create systems that will help all ages in accessing services. • The hospital to develop special programs to reach out to the communities. • Service providers to be providing drugs to address side effects • Involvement of traditional leaders in FP and promotion of utilization of LARC. • Health workers to engage in community sensitization • Improved service delivery

4.4 Theme 1: Inadequate knowledge about Implants and IUD

The study findings showed that generally, the participants had inadequate knowledge about Implants and IUD in the following areas: site of insertion, how it works and the duration of use. They only knew these long acting reversible contraceptives by name and that they prevent pregnancy in women once in use, as seen in the following responses from participants about each method.

4.4.1 Knowledge about Implants

Most participants knew implants as one of the family planning methods that prevent a woman from getting pregnant. One female participant (002F) said that "it is a type of family planning that prevents a woman from getting pregnant even if she sleeps with her husband without protection and as for the baby, the woman can breastfeed without any problem". Similar views were shared by another female participant (001F) who reported that "Implants is a good method which helps the women not to get pregnant".

Even married men appreciated implants as being one of the best methods in controlling family size. A male participant (007M) said, "It is also one of the best family planning methods if you are planning not to have children soon. At least from 3 to 5 years".

Only male participant (001M) said he did not have information on what Implants are. "No, I do not know".

4.4.2 Variations on detailed knowledge between married women and their husbands on Implants.

Despite having information, the study findings also indicated that apart from the majority of participants having general information about Implants there were variations in their

knowledge between married women and their husbands in terms of details on how Implants prevent pregnancy. The women seemed more knowledgeable in their responses compared to their partners, as all married women in the study knew that use of Implants would prevent pregnancy. At least, the women were able to explain something about Implants, some mentioned where it is inserted and the duration of use while for the men they could not explain much. This was so because most married men were not involved in family planning issues as they did not accompany their wives for family planning services at the hospital where information is provided. One female participant emphasized male involvement in family planning issues to improve knowledge acquisition and involvement in family planning issues.

She narrated;

> *I think the family planning approach should be for both husband and wife or for men it should be a deliberate move so that men are involved in family planning as well. This can help them to have more knowledge about the methods and promote the use of family planning among their wives. Even accompany us to the clinic since many do not do that (005F).*

4.4.3 Loop (IUD) prevents pregnancy.

Findings from the study indicated that most married women and their husbands knew the intrauterine device (IUD) as a family planning method that prevents women from pregnancy. For example, one female participant (005F) explained that "I heard that this method protects a woman from giving birth and not to fall pregnant". Similarly, another married woman had to say this, "Loop (IUD) is a method of family planning".

One female participant associated the method's effectiveness with having fewer side effects compared to other family methods which proved she had more knowledge on IUD. She narrated;

> *It is a good contraceptive method (IUD) because most women complain a lot about these other methods as they cause loss of libido in women. At times they even do not have the desire to be with their husbands sexually. However, in my understanding, most women say it is a good method because it does not cause loss of libido (002F).*

Two male participants completely did not have any information as to what an IUD was, and even heard of it. For instance, one participant (007M) acknowledged his ignorance, by saying, "I have never heard about Loop (IUD), so I cannot know exactly how it works". A similar response was given by another male participant (005M) who indicated not knowing IUD. However, he blamed it on the significant other who only shared information about Implants. He complained, "I have no idea of IUD as the one who was guiding and advising us told us to opt for implants on the arm. So, I wouldn't lie to you about the IUD method''.

The following subthemes indicated a knowledge gap among men and married women about Implants and IUD.

4.4.4 Not knowing where Implants and IUDs are inserted.

Despite most of the participants knowing the name of the method and that Implants and IUD are the family planning methods that prevent pregnancy in married women, many could not show the exact site of insertion for both the methods.

Implants: Most of the participants explained that the Implant is inserted on the woman's arm. Like one male participant (007M) said, "I have to be honest, I just know it's inserted on the hand, right hand on the shoulder maybe". While three women that had implants as their choice of family planning method showed the right site of insertion for their implant and they pointed out where the Implant was inserted. One participant (002F) said, "They taught us during clinic where they insert it. They insert it on the arm [she showed the inner upper left arm]".

It was also found that the three married women that knew the exact site of insertion for Implants, had the Implant as their method of choice for family planning and that two of them had previously used Implants. Interestingly, their husbands were unable to indicate the exact site of insertion for the Implant on their wives' body except mentioning that it is inserted on the arm and not which arm specifically. Two male participants knew where exactly the Implants are inserted.

IUD: The study findings indicated similar responses from participants on-site of insertion for IUD as shown with Implants. When participants were asked to explain anything, they knew about the IUD method, their responses indicated a knowledge gap. Most of the participants said they did not know where Loop (IUD) was inserted in the woman's body. Only a minority of the participants (n-4), two-man and two married women at least mentioned the site they thought an IUD was inserted but only one was correct about the exact site for insertion. These were their responses for the three participants who said, it is inserted or tied in the uterus.

One woman (006F) said, "IUD is a method of family planning that is inserted in the womb of a woman".

Another male participant (007M) said, "If I am wrong correct me, Loop (IUD) is about tying the pipe that helps a woman to conceive and I think that is what is called Loop."

Another male participant (002M), he knew IUD being a ring that is inserted in the vagina of a woman. He explained, "Eee… this method involves the insertion of a ring in the vagina".

For the two female participants that knew the right site of insertion which was the uterus they also had it as their method of choice.

4.4.5 Not knowing how Implants or IUD works to prevent pregnancy.

The study findings indicated a knowledge gap on the mechanism of action for both Implants and IUD in the prevention of pregnancy in married women. When participants were asked how the use of LARC methods worked in the woman's body in order to prevent pregnancy, they could not explain except just mentioning that these prevent pregnancy, many mentioned that the use of Implants would prevent pregnancy.

Implants: Many mentioned that use of Implants would prevent pregnancy, but most participants (n-17) could not explain how Implants work in a woman's body to prevent pregnancy. The following were some of their responses when asked on the mechanism of action for Implants; one female participant (001F) said, "I don't know". One man (001M) said, "No, I don't know anything". A similar response from another male participant (002B) said, "On that, I cannot explain much".

Only a few participants (n-3) were able to explain how pregnancy is prevented when using Implants. Their explanations included that Implants prevent pregnancy by delaying ovulation, thickening the cervical mucus thereby delaying sperm mobility and causes the endometrium to thin.

One male participant (009M) narrated, "Implants help women not to become pregnant by stopping ovulation, making vaginal mucus thick and delay sperm mobility and the uterus does not prepare for the fetus". A similar response came from one female participant (005F) who had to say this, "Aaaa…these chemicals stop the hormones for a woman to fall pregnant".

IUD: Similar observations were made under the IUD method as most of the participants (n-18) lacked information on the mechanism of action for Loop (IUD) in the prevention of

pregnancy. The participants knew that Loop (an IUD) would prevent a woman from pregnancy but did not know what exactly happens to prevent pregnancy. These were some of their responses.

One male participant (003M) verbalised that, “no idea on that one”. A similar response was given by one female participant (004F) who said, “There, I do not have more information”. The two participants who knew how Loop (IUD) works explicitly explained how an IUD works.

One of the male participants who had information on the mechanism of action for IUD explained;

> *It prevents a sperm from reaching the ovum. That’s when one has IUD when they insert it, it makes a T where there is cooper, and that cooper releases these chemical elements that prevent the sperm from reaching the ovum. In that way, it prevents women from pregnancy (004M).*

Another woman (005F) explained that “Aaaa…these chemicals stop hormones for the woman to get pregnant while using Loop (IUD)”.

4.4.6 How long one uses Implants and IUD.

Most of the participants did not know the duration of use for both Implants and IUD. They could not explain how many years would the use of Implants or IUD protect a woman from pregnancy? Below were some of the responses from participants per method.

Implants: The study findings indicated that most participants (n-18), had little information about the duration of use for Implants, except for two participants. The two participants knew the duration of use for the two types of implants commonly found and used in Malawi, (Jadelle, which is for five years and Implanon, for 3 years). These were their responses.

One male participant who knew about implants said, “I know two, Implanon and Jadelle whereby the other is for three years and the other five years”. One female participant said, “On the time, it works for 3 years Implanon and the other type for 5 years”.

IUD: Similarly, with the IUD method, most of the participants did not know the duration of use for Loop (IUD) to prevent pregnancy. This was evident by a response from participants who could not explain the duration of use for IUD. For instance, one female participant (003F) said that “what I know about this method is that a person can stay with this method for a long period. I heard like five years”.

Only two participants were able to explain that the use of IUD by a woman could prevent pregnancy for 10-12 years, it is non-hormonal with few side effects and long-term family planning methods.

One married woman (006F) said that, “the method is used for 10-12 years and that it is non-hormonal and has no side effects”. A similar response was given by one male participant (004M) who explained that “I know it’s one of the long-term family planning methods. Aaaa… that more women use. And it can stay up to ten years.”

4.4.7 Source of information about Implants and IUD.

Source of information about Implants and IUD was one of the subthemes which emerged as participants explained how they got to know about Implants and IUDs among married women and their partners. The findings indicated that participants get information about Implants and IUDs from the hospital, social groups (WhatsApp) notice board, radio, and wives. The study findings also indicated that the main source of information for participants was the hospital.

However, there were variations in the sources of information about Implants and IUDs between married women and men. When participants were asked where they get information about these methods, all married women mentioned family planning clinic as their source of information while their husbands explained that information was acquired through, their wives, social groups (WhatsApp), radio, friends, and notice boards.

Married women: All married women, explained that they get information about different family planning methods including Implants and IUD mainly during their visit to the family planning clinic. Health workers give health education talks on different family methods that women can use to prevent pregnancy, advantages of the methods, their side effects and duration of use.

These were some of their responses; one female participant (001F) narrated, “We have learnt a lot of family planning methods that can prevent pregnancy and problems that women face when using these family planning methods for example, how implants prevent pregnancy when to use it, its advantages and many more”.

Another female participant explained that;

> *During today’s clinic, we have learnt that IUD is a good method because it has few side effects unlike other methods, and it was a fruitful health education session because they emphasized the importance of using it. The counselling was adequate because they talked about the importance of using IUD (002F).*

4.4.8 Providers give adequate information

Apart from female participants mentioning the family planning clinic as their source of information, the study findings indicated that the majority acknowledged **‘adequacy’** to the information that was provided by the service provider during their visit to the clinic for both

Implants and IUD. They said the information was adequate because it gave them an understanding of the different methods, their advantages, and disadvantages.

A minority of the participants seemed unsatisfied with the provided information during their visit to the clinic, and described the information as **'inadequate,'** since it did not address all areas that could give them more information. Therefore, participants suggested the following areas be emphasized during health education so that family planning clients could have a better understanding of these methods. For instance, with **Implants** they suggested the following information to be added to health education for them to have a better understanding about Implants**;** 1) side effects like pelvic bleeding, loss of libido and weight gain. 2) How Implants work. These were the responses for the two women.

One woman (004F) said, "But I just want to know why many people when they insert Implant, bleed a lot and others even gain weight. But before having it everything is ok. For some it makes the woman lose interest in sex?"

Another female participant said, "I would like to fully understand how it (Implant) works in a woman's body to prevent pregnancy?"

However, one of the two participants who mentioned information about Implants being inadequate also talked about the negative attitude of some family planning providers at the clinic. She complained about the information not being enough since they could not explain much about the methods.

She explained;

> *Their attitude. They do not elaborate more. So I only know they insert it on the arm and it's up to you to select which one you know. And if I was given a chance*

to know more about Implants, I would like to know how Implants works and what guarantee I may have that it will work for me without problems? (005F)

Regarding **IUD**, the participants narrated that the health workers explained some methods that married women would use in order to prevent pregnancy including IUD. However, the information was inadequate. When participants were further asked about additional information that they would have loved health workers to give them about IUD to have a better understanding of IUD, three participants had suggested the following areas:

Clients to be allowed to remove IUD before ten years: Two participants suggested the possibility of having the IUD removed before 10-12 years after insertion, as young women would love to have a baby after few years of IUD use. The duration of IUD which was 10-12 years was too long for them because they are young and would like to have babies for instance every 2 to 3 years. They suggested that it could be better if the couples could go back and have the IUD removed voluntarily before the stipulated removal time. These were their responses:

One female participant (003F) said, "Aaaa… in my thinking some desire to remove it before time to have another baby, yet during counselling, we are told to remove after a specific time, thus 10-12 years". A similar response was given by another woman (004F), "I think the women should be given a chance to remove it even before 10-12 years of use as long as they want to have another baby. 10 years is too much for young couples, but 2 or 3 years can work I think".

How IUD works and side effects: The three participants were also interested in knowing how an IUD works and its side effects as additional information they wished to hear from health workers. This was evident by the responses from the three women;

Yes, I would like to know about it (IUD) because it is a long term and many people say it (IUD)does not have side effects when the woman has it, for example, she does not bleed a lot (heavy menses) compared to use Implants which has hormonal effects such as heavy bleeding. In that way, I will have a better understanding of the loop and maybe use it in future (004F).

Two other women reported wanting to know more about the advantages and disadvantages of using IUD. The following were their responses; "I would love to be taught how loop works and advantages as a well as disadvantages of this method" and another woman said, "Maybe for us to be told the effects of a loop would assist".

4.4.9. Men get information about Implants and IUD from their wives.

Most of the male participants, mentioned, 'my wife' as their main source of information for family planning when asked where they gave information about Implants and IUD method. One of the male participants (007M) shared this, "I heard from my wife when she returned from hospital to access a family planning method".

For the other sources of information for male participants, these were their responses; one participant (007M) shared this, "I heard about IUD in social media groups and offices on how people can be protected from unplanned births in their families". A similar response was given by another male participant (005M) who said, "Just hearsays from a grouping we chat on WhatsApp. These are groups for men where they could openly share issues affecting their families".

Another male participant (002M) got the information from a different source apart from the hospital and friends. He said this, **"**People talk about these methods and the hospital gives health education and some through notice boards like here at the hospital, I have seen some poster on the notice board about family planning methods".

4.5 Theme 2: Husbands Approval/Disapproval on use of Implants or IUD by their wives (subjective norms)

According to the study findings, most of the male participants approved the use of either Implants or IUD as a family planning method, when asked if they approved these family methods for their wives. Except for one participant who disapproved of his wife using any of the two methods. This was in line with the fourth study objective, which was to discuss subjective norms (approval and disapproval) associated with the use of Implants and IUD among married women and their partners. Below were their reasons for approval which were based on the following areas;

4.5.1 Reasons for husbands' approval.

When the husbands were asked to explain their reasons for approval, it was noted that their responses for both methods were similar and based on the following: benefits of using the method, comfortability of the wife and safety to use.

Benefits: The male participants that approved the use of Implants and IUD for their wives based their approval on some benefits associated with its use which included prevention of pregnancy, child burden and better planning of their families. Below were their responses specific to the method.

"There is a benefit that she will not fall pregnant soon whilst the child is still young said one of the male participants (001M). A similar response was given by another male who had to say this.

> *I do approve because I have a specific reason. Because when I want to have a child, I should have a better plan. And we discussed it and we agreed to have the method for five years and I gave her a go-ahead on the method. And she is using it. (006M)*

And another male participant (007M) added, “I approve because if you look at the life of a woman and factors that are associated with marriage life, you will find out that most of the child burden is done by a woman”.

Comfortability of the wife: Comfortability of the partner was also another reason for husbands to approval to use of IUD and Implants by their wives. To them, if the woman said she was comfortable to use and agrees to use a method, then the husband automatically approves. Two of the participants approved the use of Implants and IUD of their wives based on comfortability. For instance, one participant (004M) said, “Aaaa…. personally, I don’t have any problem with the family planning methods provided she is fit for such a method she chooses and is comfortable with”. A similar response was given by another man when asked if he approved the use of Implants or IUD by his wife and he said (005M), “I gave her a go-ahead on the method she will be comfortable and whatever she did was agreed and approved”.

Safety of the method: For some husbands, the safety of the method to the women mattered most and that contributed to approving to use of the method. One participant explained, ‘‘for the safety of my-wife I would agree as long as it is safe for her and that we can live with it and have no problem (005M).’’

4.5.2 Reasons for husband’s disapproval.

Except for one participant, he disapproved of the use of Implants or IUD for his wife because he did not have adequate information as to its side effects in relation to health which resulted in him having fears. He explained;

> *I will disapprove till I learn of the effects in relation to health. Yeah, I have no knowledge of what works and effects and as such, I have not dug deep into it. So, I was saying, the challenge is I am very much concerned with the health of*

my wife the fact that it may have negative effects on her unless I understand how they work I will not approve that. (005M)

4.6 Theme 3: Reasons why married women don't use Implants or IUD (subjective and normative beliefs)

The study findings indicated that indeed subjective norms and normative beliefs played a part in married women not using Implants or IUD as family planning methods. These included the following reasons: health-related problems that women experienced during their pregnancy like high blood pressure specifically for Implant, health-related problem such as use provider bias, inadequate knowledge, and skills for providers (subjective norms), cultural beliefs (Normative beliefs) that people have towards these methods.

4.6.1 High blood pressure in women

Few women expressed having health-related problems such as high blood pressure during their pregnancy, which made them illegible utilization of Implants. They explained that after the delivery of their babies, they opted for condoms which one of the short terms because they were told they are illegible to use Implants due to high blood pressure. One woman narrated;

It is because when I delivered, I had high Blood Pressure. So, I heard, it (Implants) affects Blood Pressure……Use of Implants cause high BP in some women. So, the nurse said maybe you can have another method since it is just like Depo Provera with similar effects of causing BP. And they advised I can try this Loop (IUD). It is just that I do not want to use IUD (004F).

A similar response was given by another woman (001F). She had to say this, "I was diagnosed with Blood pressure. They advised me to wait for four months before using Implants and then try the other family planning method because of the problems I have, increased blood pressure".

4.6.2 Effects of cultural beliefs, “value of children’’

Findings from the study indicated that some cultural beliefs exist among people in Mzimba such as children are seen as assets for farming which made married women not use Implants or IUD as family planning method. When participants were asked about cultural beliefs that discourage women not using Implants or IUD, the majority of participants did not know any cultural beliefs associated with the use of implants or IUD except for three participants of which one was a woman and two were men who mentioned the ‘value of children.’ Culturally they considered children to be assets for the family hence valued them and, in that way, the woman’s role in the family was to produce more children hence not encouraged to use family planning methods.

For the three participants that mentioned the value of children as one of the cultural beliefs among Tumbukas and Ngonis, they explained that children are considered assets for their families, and they are proud of that. They believed that once someone bears more children in his family, they could assist in farming and yield more for their families and enrich themselves. For that reason, most families discouraged married woman to use family planning methods including Implants and IUD.

Responses from the three participants on the value for children were based on other people’s shared beliefs that exist among Tumbukas and Ngonis in Mzimba, and not necessarily their personal experiences. For instance, one male participant (002M) complained about pressure from parents based on their cultural beliefs and how it influenced the low uptake of FP. He explained, **“**On cultural beliefs, the parents are a major problem since they focus on having many grandchildren because they believe the use of family planning delays childbearing and they

pressurise them not to use. The more children one has, the more he is respected because they are assets to farming".

Another male participant explained that;

> *What I know is as we chat, we normally say married men need to prove that they have children. So, in a way, we would say sometimes if you use some of the methods, it may end up that you completely stop bearing children, so such fears come especially. Though I have not stayed long in Mzimba probably, I would think children are regarded as asserts more especially the fact that most of the areas they tend to focus on farming activities, so when you look at children you look at, the more I have, the more power I have (003M).*

One woman (005F) explained, "I heard that men stop women because they want to have more children since they are the Ngonis and they believe in having more children".

4.6.3 Provider's bias towards short –term contraceptives (subjective norms)

The study findings indicated provider bias towards short-acting contraceptives as one of the contributing factors to low utilisation of Implants and IUD as expressed by two participants. These were their responses; one male participant explained this,

> *'Another contributing factor to the low utilization of LARC is the providers themselves. Often, they are more biased to short acting than these long-term methods and as a result women just get such methods. And also, they have trust in health workers such that what they tell them is taken to be the best and they don't object but rather get such short-term methods (004M)".*

Another female participant said, "Health workers are more biased, no wonder they don't explain much about these other methods. So, people go for short term since it's what they are taught".

4.6.4 Inadequate knowledge and skills among family planning providers.

The study findings also revealed that inadequate knowledge and skills among family planning providers also contribute to low utilization of Implants and IUD. Two participants explained that the information provided by service providers was inadequate and this could be due to a lack of knowledge and skills among providers. One male participant explained;

> *"At times lack of knowledge and skills in the provision of LARC also contributes to bias towards the short term. Honestly, the insertion of IUD is no easy job one needs skills. So, most nurses are afraid to perforate the uterus and no wonder they tell clients we are not providing that method you can get another method (004M)".*

Another female participant (009F) said, "The providers don't explain much about these methods since they do have knowledge and skills, especially Loop. That is why we go for the common methods".

4.7 Theme 4: Myths and misconceptions about Implants and IUD (Normative beliefs)

Study findings indicated that married women and their partners had several myths and misconceptions about the use of Implants and IUD among married women that resulted in low utilisation of the two methods. Their responses were both from their personal experiences as well as what they heard from others. The following subthemes emerged as myths and misconceptions that the participants had and are presented as per method:

4.7.1 The woman takes long time to conceive.

One of the female participants thought that once the women were using Loop (IUD) it delays fertility hence not conceive. She (003F) explained, "What I heard about this method is that when you are on IUD, it takes a long time to conceive".

4.7.2 Loop strings cause pain during sexual intercourse.

For some participants, two men and one woman they believed that Loop (IUD) strings can cause them pain during sexual intercourse and therefore most men disapproved of its use by their wives. These were their responses;

One male participant (002M) explained, “Especially for men, they believe if a woman has IUD, the ring can cause pain during sexual intercourse”.

Another male participant explained;

> *…When somebody has been inserted an IUD, it gets missing. So, they are afraid that it may go to some parts of the body. They also believe that maybe the string may scratch their penis despite not having used it before. They have fears …. And yes, there is low uptake of IUD due to such myths and misconceptions (004M).*

Another female participant narrated, ‘Loop causes pain during sexual intercourse for the man, no wonder most men do not approve its use.’’

4.7.3 Loop cause a man to jump and accomplishes nothing on the woman

One female participant explained that she heard that when a woman is on Loop (IUD), the partner cannot ejaculate and therefore does not accomplish anything on the woman. He cannot get her pregnant. She narrated;

> Yes, I have heard some women saying that if a woman is on IUD, during sexual intercourse the man would just jump without accomplishing anything on the woman. He cannot make her pregnant. Others prefer the natural method, and this misleads most women instead of using modern contraceptives which can help them limit family size which is manageable (002F).

4.7.4 Loop migrate to other body parts and cause the death of the woman.

Another misconception about the IUD method (loop) that people had was that the IUD might move inside the uterus and cause death. The three participants explained that this can result in many married women not using it for family planning. These were some of their responses;

A female participant (002F) narrated, “They think that when IUD is inserted, it can get inside the uterus and it will kill them”. A similar response was given by another male participant (007M), he said, “The IUD strings get lost and migrate to other parts of the body which can cause death, you know?”

4.7.5 Sex is unenjoyable.

For the three participants in the study, they explained that the use of IUD made sexual intercourse unenjoyable because of the strings hence most men discouraged their wives to use Loop (IUD). Below was one of the female participant’s (004F) explanations;

She narrated, “Other people say when you are using IUD, it’s like the man will not enjoy sex because you will just be feeling the strings. So, you will not enjoy sex and they don’t use it”.

Similar responses were given for Implants. Two female participants explained that the use of Implants made sex unenjoyable as one of the misconceptions that people have. She explained, “Sex is unenjoyable with Implants”. (008F).

4.7.6 Loop causes cancer of the womb.

One female (005F) participant explained that Loop (IUD) causes cancer of the womb among women and that discouraged most women to use it as a family planning method, “Some

say, Loop is bad because it causes severe bleeding, and cancer of the womb. That is why most people do not use it as a family planning method".

Similar responses were given for the use of Implant. The minority men mentioned that the use of Implants in women causes cancer in women. And that that is one of the reasons why most women do not use Implants. These were their responses; one male participant (004M) explained, "Most of the times they don't use because of the rumours, misconceptions that somebody has that family planning method, they don't menstruate, they think that those menses are accumulating somewhere, and may cause cancer". Another female participant (005F) said, "Some people believe that when you use Jadelle or Implanon you might end up having cancer".

4.7.7 Implants cause miscarriages.

One of the reasons that came out from the married women (n-1) why many do not use Implants, is because of the misconception that the women have. They believe once a woman is on Implants as family planning and decides to have another child, it will be difficult to fall pregnant. And once she gets pregnant, she is likely to experience a lot of miscarriages because of the Implant. She explained;

> *For those that do not like Implants in general, some say that these methods delay one from getting pregnant. The time you decide to get pregnant it becomes difficult to fall pregnant. In others, they experience a lot of miscarriages and they also loss of libido to their husbands (003F).*

4.7.8 Implants migrate to other parts of the body and cause death.

Four participants, (two male and two females) believed that Implants could migrate to other parts of the body and cause death. One female participant (005F) explained,

"Some say once inserted on the arm it moves towards the heart as a result a person dies".

4.7.9 Side effects of Implants

The study findings indicated that eight participants explained that the side effects that women experience while on Implants made them not use the Implants. The following side effects contributing to low utilization of Implants by married women; Prolonged menses, missed monthly periods, lack of libido, weight gain and weight loss, spotting. Below were some of the participants' responses on side effects that women experience and as to why the utilization of Implants remains low among women.

One female participant (002F) explained about menses and how missed menses could cause cancer of the womb upon accumulating in the uterus.

> *Yeah…. Commonly most of the times, when women are on this type of family planning the common side effects are, they tend to experience some effects. They do not have menses, some tend to experience prolonged menses, but the worry comes because they do not do menses. There is a misconception that once a woman does not have the monthly periods then, the menses do accumulate in her body and therefore can cause cancer in her.*

Another male participant (004M) explained:

> Initially, women naturally by the end of the month, need to menstruate. If they do not, they face misconceptions maybe I am pregnant or if I am not pregnant maybe. If they are not pregnant, where do these menses go? They think they just accumulate in the abdomen and causes cancer of the womb.

Prolonged menses: Three of the participants explained about prolonged menses as an effect of using Implants and that it discourages married women to use them.

One of the female participants (004F) narrated;

> *Yes, I have heard one. It causes heavy menses they said that they used that method before. And as a result, they could not stop their monthly period. They argued that for a year they could not do their menses. But once they started having them, they could not stop because of the family planning method (004F).*

A similar response was given by another woman (002F), many people complain about bleeding.

One male participant (003M) said, "These Implants cause women to bleed heavily and it can cause complications such as anaemia and destructs even their sexual life".

Weight gain and weight loss: Weight gain was one of the side effects of using Implants, which one female participant (004F) mentioned. She explained that "Others they lose weight, others gain weight, and they don't like using it".

4.8 Theme 5: Proposed solutions to address challenges faced by married women using Implants and IUD

The following proposed solutions were made by participants in order to address challenges that married women face in accessing and utilizing Implants and IUD; promotion of LARC use for healthy living, Promotion of male involvement in family planning issues in the community by traditional leaders and service providers, Government to create systems that will help all ages in accessing family planning services like the adolescents, the youth and adults, the hospital to develop special programs to reach out to the community that would enhance improved utilization of LARC, Service providers to provide drugs to address side effects that women experience when on LARC, Involvement of traditional leaders as custodians of culture in issues of family planning and promote utilization of LARC, Health workers to engage in community sensitization.

4.8.1 Promotion of LARC use for healthy living to couples.

All participants in the study proposed the promotion of LARC use by couples so as to promote healthy living for families. With child spacing the family would develop economically, live happily without sicknesses. These were their responses;

One female participant explained that "I would encourage them to get family planning method that will last for a long period and this will assist them to have healthy living" (004F)

Another female participant explained;

> *For the people in the village, they need surety that if they do family planning method, they will not fall pregnant and have children. Despite them believing that children are their future worth……. Some of the villagers are afraid and so there should be awareness of the methods and basic examples that have been using the methods and do not have closely spaced children so that in the end they have a healthy family and can develop (006F)*

Another male participant explained "They (couples) should go for a planning method so as to be protected from getting pregnant and live happily without having complications from childbirth" (001M)

4.8.2 Promotion of male involvement in family planning issues in the community by traditional leaders and service providers through the creation of bylaws.

Participants suggested the importance of involving men in issues of family planning by traditional leaders, religious groups, service providers and couples themselves. For the traditional leaders, they talked about the creation of bylaws that would enhance male involvement in family planning while the men themselves get involved. Below were some of the responses from two participants, on what solutions they could suggest promoting LARC use among married women;

One male participant (002M) said, “During antenatal visits, women should come along with their husbands, and for those who fail to bring their husbands to the clinic they should be delayed but prioritize the ones with their husbands according to bylaws. Chiefs should enforce that”.

Another female participant (005F) explained the importance of educating the husbands by health care workers. She narrated, “The way forward is for the husbands to be educated and get an understanding on how family planning works to let them know the time it takes for them to have another child”.

4.8.3 Government through the hospital to create systems that will help all ages in accessing family planning services like the adolescents, the youth, and adults.

Another solution proposed by the participants was the need for the government through the hospital to create systems that will help all ages in accessing family planning services. One participant explained;

> *Maybe we need to create systems that can work well. For example, consideration of ages when dealing with different groups of people like adolescents with youth-friendly services so that their problems are addressed accordingly. Similarly, with women, the providers should create a conducive environment for the women and their needs (003M)*

4.9.4 The hospital to Develop special programs to reach out to the community.

Two of the participants also suggested the need for the hospital to develop special programs to reach out to the community that would enhance the improved utilization of LARC. The following were their responses;

One male participant (003M) said, “Develop programs like plays, drama and engage in debate issues so that out of the debate activities people from the village should be able to learn and know what is right or wrong and make a decision”

Another female participant (002F) explained that “To address this challenge of women having closed spaced children, there is need to do a research by going to the communities and meet these women so that they are encouraged to use family planning methods”.

4.8.5 Service provider to provide drugs to address side effects that women experience when on LARC.

Three of the participants suggested the provision of drugs as a solution to the problem of side effects that women face when using LARC methods so as to promote its utilization. They explained that the side effects that women face and that have no solutions, always cause fear in them and as a result, they stop using such methods since it affects their life.

One female participant explained;

> *When something new comes out, there is always a need to check its advantages and disadvantages. So, there should be ways to capture and address the problems that participants are facing by the hospital personnel like maybe a woman is having prolonged menses. They can have drugs to address such a problem because if the woman continues to experience such problems it can affect the family as well. Or on the loss of libido towards the husband, what happens? What element of that method causes such problems? Then at least what can be done to address it. So that when people are using the method they should know even if I use this method there are solutions to the problems I face. Assuming there are no solutions, women will are afraid to use the method maybe they will be saying if we use this method the side effects will be minimal (003F)*

4.8.6 Involvement of traditional leaders as custodians of culture in issues of family planning and promote utilization of LARC.

Most of the participants (n-14) suggested the involvement of traditional leaders who are the custodians of culture in family planning issues such as traditional beliefs that discourage utilization of LARC methods among married women to promote its utilization.

These were some of their responses;

One male participant narrated;

> *Traditional leaders... yah because they have an element of cultural understanding and cultural beliefs how traditional leaders them being aaaa Primary custodians of culture, if they can be oriented, briefed and taught on these particular family planning methods, it can promote utilization of LARC And if they can understand and roll out to the community so that those myths and misconceptions can be stopped it is likely the community can start using the method. (004M).*

Another one also explained;

> *About our traditional leaders, they are the custodians of culture, for example, there is a need for increased awareness to them so that these individuals are briefed about the method of family planning which the hospital is providing. I assume these misconceptions can be ruled out yeah and more married women can use the methods (0010M).*

4.8.7 Health workers to engage in community sensitization.

Four participants suggested engagement of health care workers in community sensitization on issues of family planning as a way of promoting the utilization of LARC among married women;

Yeah…. Recommendations, I may even tell from ministry, aaaa…. the basic thing is they should use aaaa…. Several modalities to how the community should get hold of more information, they may choose may be the mode of an awareness campaign, so that people may know the thing. The thing is people should know it. About health workers should give information about these methods Aaaa… how the method works, the possible effects someone can have as is on that kind of method, through the campaigns. And be given a chance to decide which method to use (004M)

Another woman explained;

There is a need to provide information to women in the community about these methods. Its advantages and disadvantages because most of them prefer injection and it may happen that after 3 months they are required to go to the hospital and yet they do not have transport. However, if they go for 3to 5-year Implant it will reduce the need for transport and will assist them to settle down (005F).

4.8.8 Health workers to promote utilization of Implants and IUD through Improved service delivery.

Improvement of service delivery was one of the solutions proposed by participants (n-4) in this study. They explained that improved service delivery such as availability of resources and human resource would promote utilization of these family planning methods among married women. These were some of their responses;

One male participant explained;

I would start with the hospital, at times you may want to have such methods and find no medicines at that clinic and you go home without that method. This is a challenge to women. For the ministry of health, I would say they should look at the number of health workers qualified and look at the population that is trying

to access such a service and they should have good numbers of health workers that should tally with the population being served (007M).

Conclusion

This chapter has presented the findings according to study objectives and the themes that emerged from the qualitative data. The findings have revealed a number of factors that influenced married women not to use Implants or IUD for family planning. These were the findings; generally, there was inadequate knowledge among married women and their partners on the use of Implants and IUD specifically on-site of insertion, mechanism of action and duration of use, inadequate information from service providers for clients to make an informed decision. The participants had some information sources for family planning methods such as social groups (WhatsApp), wives, hospital, and friends. Additionally, cultural beliefs surrounding the use of LARC such as children being assets for farming, myths, and misconceptions that couples have towards the use of Implants and IUD also contributed to low utilization of the LARC. However, other married women, could not use Implants due to health-related problems such as raised blood pressure and side effects experienced while on these methods. Lastly, all participants proposed solutions that they thought could address the challenges that women faced in accessing LARC methods.

CHAPTER 5

5.0 Discussion of the Findings

5.1 Introduction to Discussion

This chapter presents the underlying meaning of this research findings by giving an interpretation of results and in light of known literature, the importance of the results and their possible implications in other areas. At the same time, it describes the possible improvements that can be made to further develop the concerns of the study. The main qualitative findings were;

5.2.1 Inadequate knowledge of couples on Implants and IUD.

This study provided valuable information that married women and their partners have generally inadequate knowledge about Implants and IUD. All participants knew the methods by the name, and that utilizing such methods would prevent a woman from pregnancy only. This result was similar to studies done among married women in Nigeria and Ethiopia (Anguzu et al., 2014; Gebremichael, 2014; Okanlawon et al., 2010). The majority did not know the site of insertion, mechanism of action since they could not describe how these methods work even for its duration of use except for those who had it as a method of their choice and had the previous history of use of the family planning methods. This is in line with the Theory of Reasoned Action by Fishbein (1967) which assumed that the repetitive performance of behaviour may affect subsequent behaviour as a consequence of the habitual process. There is a high chance for a repetitive performance subsequence behaviour which is the use of the method by individuals with a history of use (Ajzen & Fishbein, 2004). As in this study, those married women that had previously used Implants or IUD method repeated the behaviour by reusing the same methods. A similar study in Kampala Uganda by Anguzu, et al. (2014) among women on knowledge and

attitudes towards the use of long acting reversible contraceptives also found that participants did not know much about Implants and IUD except for its name and few used LARC. This means that their lack of knowledge about how a method works may have influenced choices of the method among married men and women since knowledge transfer about the mode of action of the chosen method improves efficiency and compliance to contraceptive use (Topsever et al., 2006). Additionally, the potential to use LARC may be associated with individuals' level of knowledge of the method (D'Arcangues, 2007). This means that it was unlikely of them to use LARC methods since the majority did not know the mechanism of action of these methods which promoted fears in them. This result is similar to Kamara's study in Malawi. This means that since the married women in Mzimba have inadequate knowledge about LARC methods, that is why they are not using Implants and IUD methods for family planning.

5.2.2 Sources of information about Implants and IUD

The study findings indicated variations on sources of information for Implants and IUD between married women and their partners. During interviews, husbands mentioned their wives as the main source of information apart from other sources such as social groups like WhatsApp, friends, and radio while for women it was FP clinic. Their visit to the family planning clinic resulted in married women at least being more knowledgeable about Implants and IUD since they could explain some information about these methods. This was so because they had access to information for all family planning methods which contributed to more exposure and correct information about modern contraceptives compared to their partners who could not explain much except for the method name and that it prevents pregnancy. This was evident during data collection whereby no husband was in the company of his wife for family planning, which confirms that men do not escort their wives for family planning services hence the knowledge

gap. Similar results are found in Uganda and Malawi studies(Anguzu et al., 2014; Kamara et al., 2015)in which wives were the main source of information about Implants for married men.

Dissimilar results were found in an Ethiopia study by Ezagwa, et al. (2014) in which husbands happened to be the main source of information regarding family planning including Implants and IUD, and they were more knowledgeable than their wives. This also improved the utilization of LARC methods among married women in which the men's approval was not a problem. The difference is well explained due to cultural diversity that exists among countries and levels of male involvement in maternal and neonatal issues in which those countries that had males involved in issues of family planning, utilization of LARC was high among its married women. In Malawi, studies proved that there is minimal male involvement in maternal and neonatal issues including family planning (Kamara et al., 2015; Kululanga et al., 2012; Nyambo, 2013a), as most men do not accompany their wives to the hospital where most health education about modern contraceptives is given and that resulted in knowledge gap among men compared to married women which affected utilization of LARC especially with partners approvals based on their understanding to the methods.

In this study, some men even proposed strategies that would improve male involvement in family planning issues to improve LARC uptake among women. Some studies in Malawi, Uganda and India have also proven that men that are involved in these family planning issues have more knowledge and are likely to approve the utilization of LARC and support their women in making good choices (Anguzu et al., 2014; Kamara et al., 2015; Shrivastava et al., 2013). Partners' approval and support influenced the use of contraceptives respectively, hence the need to encourage and educate men on the importance of their involvement in family planning issues. This implies that in Mzimba, married men have a gap in knowledge on LARC

methods as they depend on their wives for information which is likely to affect their approval towards the use of LARC hence the need to promote male involvement in family planning issues.

Another significant finding in this study in relation to sources of information for women which is the hospital is that it did not influence the increased utilization of Implants and IUD methods among them. The fact that married women had physical access to family planning services including counselling which promoted a high level of knowledge about LARC among them compared to men did not translate into high usage of Implants and IUD methods. All Married women at Mzimba District Hospital had access to family planning services including Implants and IUD, information on its benefits both medical and non-medical, yet the majority of married women opted for short term contraceptives. This result is similar to the Lubaga study in Ethiopia on knowledge and attitudes towards the use of long acting reversible contraceptives among women of reproductive age in which the majority of participants were on short term family planning methods despite having access to information about long acting reversible contraceptives such as Implants and IUD. This proves that mere easy accessibility in terms of physical accessibility for service and information was not considered a direct predictor of contraceptive usage. This depicts the knowledge application gap as found in India by Shrivastava et al. in the 2013 study. The women are not applying the acquired knowledge from FP Clinic which proves there could be other contributing factors apart from accessibility to a service hence the need for providers to improve on information giving.

5.2.3 Inadequacy of information about Implants and IUD provided by service providers to women.

The study findings indicated that the majority of the female participants acknowledged the sufficiency of information about LARC provided by service providers at the family planning

clinic. This was likely to influence their decision to use LARC upon understanding the method as the potential to use LARC is influenced by the individual's level of knowledge (D'arcangues, 2007). Similar results are found by Kamara, et al (2014) and Anguzu, et al. (2015) studies, in which the participants expressed adequacy of information from a service provider at the family planning clinic.

Dissimilar results in the Ethiopia study (Gebremariam & Addissie, 2014) indicate that participants expressed dissatisfaction with the information provided by the service provider and even termed it as superficial since the provider did not give more information about the family planning methods which resulted in participants not having adequate information about the LARC methods except for the name of the method. In this study, despite the majority of participants acknowledging the adequacy of information from service providers, all of them knew the method by name and that it could prevent general pregnancy. However, the majority could not explain in detail how the Implants or IUD method work, its duration of use and site of insertion. This means that the information provided by service providers was inadequate. For the few participants that expressed dissatisfaction with the information provided during their visit to the clinic, they explained that the providers concentred much on the positives rather than the negatives which are the disadvantages of using this LARC method. For instance, the side effects associated with the use of these methods and a consideration of the removal period for an IUD method to 2 to 3 years for young women who could not manage an IUD for 10-12 years since they are still young. There is a need for service providers at Mzimba to improve on information giving so as to improve utilization of LARC among married women assuming these women did not have any medical conditions that made them illegible for Implants or IUD as in the case with Mzimba.

5.2.4 Partner's disapproval/approval to use of Implants or IUD

In this study, it was found that subjective norms such as partner's disapproval to use of Implants or IUD were one of the reasons why some married women were not using Implants and IUD method. Their disapproval was based on the existing myths and misconceptions that men have towards LARC methods such as discomfort during sex, migration of the device to other parts of the body apart from the cultural beliefs that men had about Implants and IUD. To them, they were concerned with their women's health in terms of safety to use the method and the comfortability of the wife. Similar results are seen in two studies done in Ghana and Nigeria (Ezegwui et al., 2011; Gbagbo & Kayi, 2018) in which some of the reasons for discontinuation of LARC among women was due to disapproval by partners who were concerned with partners health.

For the husbands that approved the use of LARC by their partners, its approval was based on benefits, that it prevents complications resulting from childbirth with closely spaced pregnancies, as childbearing functions are very risky (Amentie, 2015). Others approved based on their wives comfortability and its safeness of Implants and IUD to use. Interestingly these results are contrary to literature for most African studies (Jabeen & Umbreen, 2016; Kamara et al., 2015; Kululanga et al., 2012; Shrivastava et al., 2013)in which partner approval to use of LARC method was based on the fact that male dominance in decision making to family planning issues was crucial. The women could not make their own choices on family planning methods except for their husbands deciding for them on what to use. Meaning if the partner approves, then the woman could use it. Similar results in two studies conducted in Kenya and Ethiopia, on unmet need for FP in developing countries, (Shrivastava et al., 2013) also found that partner's approval and their support influenced the use of FP services and use of contraceptives respectively among

married women. The results proved the role of the male being crucial in the use of contraceptive methods or the size of the family since their approval influenced women to use FP methods.

For South Africa rural Western Cape study by Peer and Morojele (2013) on factors associated with contraceptive use, it was a different scenario from these other studies whereby the woman's decision to use LARC was dependent on the man's approval/disapproval. The results indicated that married men did not influence contraception decision making for their wives. Married women made their own decision on the choice of a contraceptive method without any interference from their partners (Peer & Morojele, 2013). It was discovered that despite men being influential in decision making in childbearing including contraception choices, that did not in any way affect the women's decision whether to use contraceptive methods or not. It was the woman's decision whether to use it or not regardless of the husband's approval. The women were autonomous in their choice of contraception method as for some women in this study who independently used the method without a husband's approval. This entails the need for service providers to give correct information about LARC that will help women the liberty to independently make sound decisions about their health status based on the benefits of LARC.

5.2.5 Reasons for low utilization Implants and IUD among married women

According to this study, there were some reasons why married women did not use Implants or IUD as family planning methods. These include; health-related problems that women experienced during their pregnancy like high blood pressure specifically for Implant, health-related factors (subjective norms), cultural beliefs that people have towards these methods and myths and misconceptions in relation to side effects (normative beliefs).

5.2.5.1 Side effects of Implants and IUD

According to the study findings, one of the contributing factors to low utilization of Implants and IUD method among married women were side effects experienced by women while on these methods. These side effects were such as prolonged menses, weight gain and weight loss and loss of libido. When the women were asked why they opted for short terms family planning methods such as pills and condoms rather than Implants and IUD, they explained that they experienced a lot of side effects that affected their relationship with the partner, for instance, prolonged bleeding. The husbands were unhappy with their wives since they could not have sex with them while having prolonged menses. They disapproved of its use hence women discontinued its utilization. Similar results were found in Ghana, Ethiopia and Uganda studies (Ezegwui et al., 2011; Tilahun et al., 2013) on family planning knowledge, attitude and practice among married couples and another study on the discontinuation rate and reasons for discontinuation of Implanon. These three studies proved that low utilization of Implants and IUD was due to side effects such as prolonged menses, loss of libido, weight gain and loss and many more. All these contributed to the discontinuation of the methods. Therefore, there is a need to put in place strategies to address such challenges by engaging service providers in treating side effects to promote the utilization of LARC among married women. Since the utilization of LARC among women in the productive age has proved to be beneficial in pregnancy prevention, efficacy and effective and long term(Gbagbo & Kayi, 2018; Secura et al., 2010; Shegaw et al., 2014; Zenebe et al., 2017).

5.2.5.2 Myths and misconceptions about Implants and IUD (normative beliefs)

According to the study findings, some normative beliefs such as myths and misconceptions exist in Mzimba that influenced low uptake of Implants and IUD. The participants explained the following myths and misconceptions surrounding the use of Implants and IUD; that they migrate to other parts of the body, make sexual intercourse unenjoyable, IUD strings cause discomfort to men during sex, causes cancer of the uterus, causes bareness, miscarriage and accumulation of menses that cause cancer with Implant. These myths and misconceptions created fears in most participants since they believed anything that would cause a problem to their health should not be used or entertained, yet these were just mere misconceptions. For instance, the belief that the Implant might migrate to other parts of the body like the heart and cause a puncture even cause death demotivated them to use such methods. Similar results have been found in intervention studies done in Sub Saharan Africa (SSA), other countries like Kenya, Uganda, Ethiopia, Malawi Nigeria, Ghana and Pakistan (Alemayehu et al., 2012; Blumenthal et al., 2013; Fiato, 2016; Gebremariam & Addissie, 2014; D Hubacher et al., 2013; Jabeen & Umbreen, 2016; Kamara et al., 2015; Taylor, 2008a; Tilahun et al., 2013) in which participants explained about some myths and misconceptions and made them not to use LARC for fear of their health in terms of safety. It is therefore important that clients are given appropriate and accurate information about LARC including the myths and misconceptions so that individuals understand that individual differences, hormonal imbalance and that there are specific criteria to each method hence improve utilize LARC is promoted(Mota et al., 2015; Shrivastava et al., 2013; United Nations et al., 2015; WHO, 2017).

5.2.5.3 Impact of Cultural beliefs on the use of Implants and IUD

In this study, normative beliefs like cultural beliefs that exist among people such as the value for children and male dominance also contributed to the low utilization of Implants and IUD among married women in Mzimba. According to the theory of reasoned action, normative beliefs which are individuals' beliefs about how people who are important to them expect them to behave, affects the intention to use the IUD method (Ajzen & Fishbein, 2000; Fishbein & Ajzen, 1975). This could explain why the utilization of Implants and the IUD method was low among married women. According to the participants, Mzimba is patrilineal which promotes male dominance among married couples including decision making about FP. Women in this area, have to respect such cultural beliefs without questioning their partners. The Ngoni's value children as assets and therefore, utilization of family planning, in general, becomes a challenge since every woman is expected to bear more children for the family and therefore is not encouraged to use long term contraceptives. This study finding is similar to one study in Ghana, in which it was found that the desire to increase fertility among families, was the expectation for parents to bear more children (Gbagbo & Kayi, 2018). This in turn discouraged most women from using any family planning method. Therefore, there is a need to reach out to the community and promote the use of LARC among married women.

5.2.5.4 Provider bias towards short –term contraceptives.

Provider bias towards short methods also influenced married women in the study to opt for short methods than Implants and IUD which are long acting reversible contraceptives. The bias was a result of inadequate knowledge and skills to provide the IUD method. Some participants especially married women complained that providers did not explain much during their visit to the family planning clinic about LARC because they concentrated much time on the

short term. That compelled them to choose short-acting methods because they had little understanding of LARC to make an informed decision. Similar results were reported in a Zambian study on dedicated providers of long-acting reversible contraception, where the providers were biased towards the short term because they lacked confidence in the provision of LARC (Neucom et al., 2011). The participants explained that the providers could not explain much about LARC since they lacked experience and confidence hence concentrated much on short term methods. This also explains why many married women could not use Implants or IUD at Mzimba District Hospital due to bias and it was in breach of their right to access sexual reproductive health right services (UNFPA, 2010).

However, this study did not reveal if service providers took advantage of the client's ignorance of family planning information and then had a bias towards short term methods. And as a result, they just agreed to use short term methods. Two studies done in Ghana (Gbagbo & Kayi, 2018; Robinson et al., 2016)found that for some clients who were ignorant about family planning methods, there were elements of provider biases during counselling which lead to some providers either advising clients to use IUD based on their personal experiences or preference for IUD, as a result, it affected clients' choice to family planning method since they opted for the providers' choices. The clients solely made family decisions based on the providers' choice. It is easy for someone to decide on LARC, only when they have a full understanding of the method hence providers must improve on service provision.

5.2.5.5 Inadequate knowledge and skills among FP service providers

In this study, healthcare-related factors such as inadequate knowledge and skills among service providers also contribute to low uptake for Implants and IUD among women. According to Topsever, et al. (2006) health care provider effect has a great impact on utilization of LARC

and these include counselling. Similar findings on service provider effects and how it promotes LARC utilization were found in two studies done in Ghana and western Ethiopia, (Gbagbo & Kayi, 2018; Melka et al., 2015)in which results indicated that health workers had a major role to play in encouraging positive attitudes towards using the IUD through counselling among women as it promoted IUD uptake. Some female participants expressed dissatisfaction with the health education provided during their visit to the family planning clinic. They felt that providers needed to give them additional information to have a better understanding of Implants and IUD. This proves inadequacy of information considering that family planning counselling is critical and influential when choosing a method. Similar results were found in Ethiopia study among married women and men who described information by providers as superficial since the providers did not give adequate information but rather concentrated on the short term.

Additionally, the couples in this study did not attend counselling jointly of which literature has proven to increase LARC uptake among couples (Jabeen & Umbreen, 2016). This could explain why many did not use LARC methods. As seen in the Pakistan Punjab Lahore study where there was increased utilization of LARC among couples since counselling was done jointly. This proves that there is a relationship between family planning counselling and an increase in LARC use since anxieties are allayed and it creates a trust of couples towards service providers. This can be achieved through the provision of the right information to clients for them to make an informed choice about their health (Gbagbo & Kayi, 2018). This implies that adequate information is likely to contribute to the high uptake of IUD among women as health care providers are knowledgeable, trustworthy in maintaining the confidentiality and can advise on the method, its side effects and potential health risks. That, in turn, will make women more receptive and convinced to use the Implants or IUD as a choice FP method.

5.3 Participants perceptions about LARC

According to the study findings, the participants had positive perceptions about the use of LARC based on the benefits of LARC. These included safety, effective to the prevention of pregnancy that allows children to grow well hence promote the health of the family. Additionally, couples can manage well their families. However, for one couple, their negative perception towards LARC, was attributed to inadequate knowledge about LARC which created some fears in them such as how safe it was for the wife to use Implant or IUD when they hardly had information about it? This is a concern because one of the roles of service providers is to provide information that includes the method names. How it works, its duration of use and side effects. Similar findings are seen in Kamara's study as low and power contraceptive usage results from the ineffective conveyance of relevant information to clients by health workers during counselling. In another study findings by O'shea et. al, (2014) in Lilongwe, also indicated that lack of emphasis on LARC counselling by service providers was a result of work burden (O' Shea et al., 2014). As a country, there is a need to address the critical staff shortage by deploying more staff. It is also important to intensify one to one counselling since it allows clients to make informed choices about the contraceptive method and influence their compliance with FP.

5.4 Proposed solutions for LARC use.

The study findings indicate that women face several challenges when utilizing LARC methods that could be addressed and promote its utilization among married women. Participants explained proposed solutions to improved LARC utilization among married women. These included the promotion of the use of LARC by couples based on the advantages of LARC in the delay of pregnancy, effectiveness, and safe. This is also described by the World Health Organisation in its fact sheet where the emphasis is made on the importance of using LARC based

on its benefits such as, effectiveness, safety, long term method and cost-effective (WHO, 2017). Understanding the benefits of utilizing LARC by married women, addressing misconceptions that exist among them and its barriers, would improve utilization of LARC. Similar findings are seen in two studies done in the USA and Malawi (O' Shea et al., 2014; Yoost, 2014) in which FP clients proposed the use of LARC among women to promote quality of life in many women.

5.4.1 Male involvement in FP issues

For some, male involvement in FP issues was another suggested strategy to improve utilization of LARC among married women in the community since most men are not involved in maternal neonatal health issues as evidenced by no man in accompany his wife during FP Clinic visit (during data collection). Similar findings are seen in Kululanga's study in Mwanza Malawi in which it was found that most maternal and neonatal care services focused much on women than men, yet men influence their decisions in the choice of FP method. In other study findings in Kenya and Ethiopia found that partner approval and their support influenced the use

LARC respectively (Shrivastava et al., 2013). The results proved the role of the male being crucial in the use of contraceptive methods among women hence the need to intensify their involvement with all stakeholders such as traditional leaders in formulation of bylaws and community sensitization.

5.4.2 User-friendly services

According to the study, the age of the services providers could affect the utilization of LARC among married women. Some participants proposed that the hospitals should allocate mature and responsible providers to FP clinics so that women come in large number for instance with the use of the loop. For a youngster to insert that method into elder women, it looked disrespectful and culturally unacceptable. Therefore, those in view of this, felt that it contributed

to low utilization of other LARC methods. Similar findings in one Ghanaian study (Robinson et al., 2016) indicated that most women preferred elder female providers to young providers because they seemed mature and respectful. This could be explained why most women did not go for IUD as a method of contraceptive hence they need to provide services that are client centred.

5.3 Conclusion

Several factors influenced the low utilization of intrauterine device and Implants among married women at Mzimba South District Hospital. These included inadequate knowledge among participants, the bias of service providers, myths and misconceptions, cultural beliefs, health-related problems, and side effects. Comprehensive contraceptive counselling on long acting reversible contraceptives such as IUD and Implants is essential in promoting the uptake of these methods as well as impart knowledge among couples at the facility level so that clients make informed decisions about family planning. Service providers should also treat side effects experienced by women to allay anxiety and promote its utilization. At the community level, there is a need for the involvement of traditional leaders who are custodians of culture to discourage cultural beliefs that hinder acceptance of the utilization of LARC among women. There is also a need for various targeted messages to dispel myths and misconceptions that exist among Ngoni's and Tumbuka's in Mzimba so that uptake of Implants and IUD is increased.

5.4 Study Limitations

- The study was conducted at one district hospitals as such the findings cannot be generalized to other settings. Having multiple sites could have enriched the study findings.
- Time was another limiting factor since this thesis is an academic requirement for the fulfilment of the Master of Science in Reproductive Health, it was required to be completed within a specified period.

- The financial and material resources were limited henceforth, the study involved few participants from a single district hospital, and this made findings not be generalized to other settings.

5.5 Recommendations of the Study

a) Clinical Practice

The findings of the study showed a gap in service delivery due to inadequate knowledge and skills among service providers. Therefore, to improve family planning services, the Ministry of Health and its Partners through the Reproductive Health Department should organise on the job training for LARC and intensify supportive supervision for nurses and midwives in the family planning clinic.

b) Management

The study revealed the knowledge gap among family planning clients. The district management team should mobilize resources to reach out to the communities' e.g sensitization campaigns and stakeholder engagement in promoting LARC use among married women.

c) Nursing/ medical education

The study findings indicated a knowledge gap on LARC by service providers. Therefore, there is a need to include a comprehensive family planning module in the nursing and clinical curriculum so that students are well conversant and prepared.

d) Research

Findings in the current study showed that several factors influence the use of LARC, therefore there is a need to explore through research on change strategies that can promote the use of these methods.

References

Ajzen, I., & Fishbein, M. (2000). Attitudes and the Attitude-Behavior Relation: Reasoned and Automatic Processes. *European Review of Social Psychology*, *11*(1), 1–33. https://doi.org/10.1080/14792779943000116

Ajzen, I., & Fishbein, M. (2005). The influence of attitudes on behaviour. In D. Albarracín, B.T. Johnson, & M. P. Zanna (Eds.), The handbook of attitudes (p. 173–221). Lawrence Erlbaum Associates Publishers.

Alemayehu, M., Belachew, T., & Tilahun, T. (2012). Factors associated with utilization of long acting and permanent contraceptive methods among married women of reproductive age in Mekelle town, Tigray region, north Ethiopia. *BMC Pregnancy & Childbirth*, *12*(1), 6, doi: https://doi.org/10.1186/1471-2393-12-6.

Amentie, M. (2015). Utilization of family planning services and influencing factors among women of childbearing age in Assosa district, Benishangul Gumuz Regional State, West Ethiopia. *Science Journal of Clinical Medicine*, *4*(3), 52, doi: https://doi.org/10.11648/j.sjcm.20150403.11

American College of Obstetricians and Gynecologists. (2011). Long-acting reversible contraception: Implants and intrauterine devices. *Obstetrics & Gynecology*, *118*(1), 184-196.

Anguzu, R., Tweheyo, R., Sekandi, J. N., Zalwango, V., Muhumuza, C., Tusiime, S., & Serwadda, D. (2014). Knowledge and attitudes towards the use of long acting reversible contraceptives among women of reproductive age in Lubaga division, Kampala district, Uganda. *BMC Research Notes, 7*(1), 1-9.

Asnake, M., Henry, E. G., Tilahun, Y., & Oliveras, E. (2013). Addressing unmet need for long-acting family planning in Ethiopia: Uptake of single-rod progestogen contraceptive implants (Implanon) and characteristics of users. *International Journal of Gynecology & Obstetrics*, *123*, e29–e32. https://doi.org/10.1016/j.ijgo.2013.07.003

Audu, B. M., El-Nafaty, A. U., Bako, B. G., Melah, G. S., Mairiga, A. G., & Kullima, A. A. (2008). Attitude of Nigerian women to contraceptive use by men. *Journal of Obstetrics & Gynaecology, 28*(6), 621-625, https://doi.org/10.1080/01443610802283530.

Azmoude, E., Behnam, H., Barati-Far, S., & Aradmehr, M. (2017). Factors affecting the use of long-acting and permanent contraceptive methods among married women of reproductive age in East of Iran. *Women's Health Bulletin*, *4*(3), 1-8. https://doi.org/10.5812/whb.44426

Benedugu, L., Adenyanju, A., & Oniso, J. (2019). *Factors influencing the utilization of modern family contraceptives among women of reproductive age in Ikot Offing Ambai community* Akpabuyo local government area, Cross river State. https://lautechjournalofnursing.org/my_files/uploads/2019/09/FACTORS-INFLUENCING-THE-UTILIZATION-OF-MODERN-FAMILY-CONTRACEPTIVES-AMONG-WOMEN-OF-REPRODUCTIVE-AGE-IN-IKOT-OFFIONG-AMBAI-COMMUNITY.pdf.

Blackstone, S. R., Nwaozuru, U., & Iwelunmor, J. (2017). Factors influencing contraceptive use in sub-Saharan Africa: A systematic review. *International Quarterly of Community Health Education*, *37*(2), 79–91. https://doi.org/10.1177/0272684X16685254.

Blumenthal, P., D., Shah, M., N., Jain, K., Saunders, A., Clemente, C., & Lucas, B. (2013). *Revitalizing long-acting reversible contraceptives in settings with high unmet need: A multicountry experience matching demand creation and service delivery. Contraception*, *87*(2), 170–175. https://doi.org/10.1016/j.contraception.2012.10.002

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brink, H., Rensburg, G., & van der Walt, C. (2012). *Fundamentals of research methodology for healthcare professionals*. Juta

Burns, N., Grove, S. K., & Gray, J. (2015). *Understanding nursing research: Building an evidence-based practice* (6th ed). Elsevier.

D'Arcangues, C. (2007). Worldwide use of intra-uterine devices for contraception. *Contraception*, *75*(6), S2–S7.

Ezegwui, H., Ikeako, L., Ishiekwene, C., & Oguanua, T. (2011). The discontinuation rate and reasons for discontinuation of implanon at the family planning clinic of University of Nigeria Teaching Hospital (UNTH) Enugu Nigeria. *Nigerian Journal of Medicine: Journal of the National Association of Resident Doctors of Nigeria, 20*(4), 448-450.

Fiato, N. (2016). *Family planning in Sub-Saharan Africa: A review of interventions in the promotion of long-acting reversible contraception*, masters thesis, University of Pittsburgh, doi: http://d-scholarship.pitt.edu/27371/.

Fishbein, M. (1967). *A behaviour theory approach to the relations between beliefs about an object and the attitude toward the object*. John Wiley & Sons.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behaviour.* Addison-Wesley.

Gbagbo, F. Y., & Kayi, E. A. (2018). Use and discontinuation of the intrauterine contraceptive device in the greater Accra Region of Ghana. *Contraception and Reproductive Medicine*, *3*(1), 1-17. https://doi.org/10.1186/s40834-018-0061-1

Gebremariam, A., & Addissie, a. (2014). Knowledge and perception on long acting and permanent contraceptive methods knowledge in Adigrat town, Tigray, Northern Ethiopia: A qualitative study. *International Journal of Family Medicine* (2014), Article ID 878639, doi: http://dx.doi.org/10.1155/2014/878639 https://doi.org/10.1155/2013/878639.

Gebremichael, H., Haile, F., Dessie, A., Birhane, A., Alemayehu, M., & Yebyo, H. (2014). Acceptance of long-acting contraceptive methods and associated factors among Women in Mekelle City, Northern Ethiopia. *Science Journal of Public Health*, *2*(4), 239-245. https://doi.org/10.11648/j.sjph.20140204.27

Glanz, K. G., Rimer, B. K., & Lewis, F. M. (2002). *Health behaviour and health education theory: Research and practice* (3rd ed.). Jossy-Bass A Wiley Imprint.

Godana, W., Wondmu, F., Temesgen, G., Timer, G., Yesuf, J., Habte, M., & Abdi, M. (2015). Utilization of long acting and permanent family planning methods among women's visiting family planning clinic in Arba Minch Hospital, Ethiopia. *Journal of Health & Medical Nursing*, *15*, 62–71.

Guba, E. G., & Lincoln, Y. (1989). *Fourth generation evaluation.* Sage.

Gudaynhe, S. W., Zegeye, D. T., Asmamaw, T., & Kibret, G. D. (2015). Factors affecting the use of long-acting reversible contraceptive methods among married women in Debre Markos Town, NorthWest Ethiopia 2013. *Global Journal of Medical Research, 14*(5), 1-10.

Hamsa, T., Swamy, Bhanu, M., & Nanda Kuma, B. S. (2017). A qualitative study on determinants of the choice of contraceptives in a rural. *International Journal of Community Medicine and Public Health, 4*(6), 1943-1950. https://doi.org/DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20172154

Hill, N. J., Siwatu, M., & Robinson, A. K. (2014). My religion picked my birth control: The influence of religion on contraceptive use. *Journal of Religion & Health, 53*(3), 825-833.

Hubacher, D, Masaba, R., & Veena, V. (2013). Uptake of the levonorgestrel intrauterine system among recent postpartum women in Kenya: Factors associated with decision-making. *Contraception*, *88*(1), 97–102. https://doi.org/10.1016/j.contraception.2013.03.001

Hubacher, David, Mavranezouli, I., & McGinn, E. (2008). Unintended pregnancy in sub-Saharan Africa: Magnitude of the problem and potential role of contraceptive implants to alleviate it. *Contraception, 78* (1), 1–86.

Jabeen, C., & Umbreen, G. (2016). Long-acting reversible contraceptives: Knowledge and attitude among married women of Lahore. *Journal of the Liaquat University of Medical & Health Sciences, 15*(3), 121-127.

Joshi, R., Khadilkar, S., & Patel, M. (2015). Global trends in the use of long-acting reversible and permanent methods of contraception: Seeking a balance. *International Journal of Gynecology & Obstetrics*, *131*(Supplement 1), S60–S63

Kamara, B. O., Rodriguez, R., Chorwe-Sungani, G., & Chimwaza, A. (2015). Perceptions of couples who use Jadelle implant in Blantyre District, Malawi. *Open Journal of Nursing*, *5*(11), 994–1003. https://doi.org/10.4236/ojn.2015.511106

Kululanga, L. I., Sundby, J., Malata, A., & Chirwa, E. (2012). Male involvement in maternity health care in Malawi. *African Journal of Reproductive Health, 16*(1), 145-157.

May, K., Ngo, T., & Havig, D. (2011). *Expanding contraceptive choices for women promising results for the IUD in sub-Saharan Africa*. Marie Stopes International

Melka, A. S., Beyene, T. T., & Tesso, D. W. (2015). Determinants of long acting and permanent contraceptive methods utilization among married women of reproductive age groups in western Ethiopia: A cross-sectional study. *Pan African Medical Journal, 21*(1). https://doi.org/10.11604/pamj.2015.21.246.5835

Ministry of Health. (2007). *Preservice education family planning*. Ministry of Health, Malawi.

Ministry of Health. (2016). *Health sector strategic plan II 2017-2022*. Ministry of Health, Malawi.

Ministry of Health. (2017). *National Sexual and Reproductive Rights (SRHR) Policy*. Ministry of Health.

Montano, D., Kasorazyk, D., & Taplin, S. (2008). *The theory of reasoned action and the theory of planned behaviour.* (2nd ed). Jossey-Bass Publishers.

Mota, K., Reddy, S., & Getachew, B. (2015). Unmet need of long-acting and permanent family planning methods among women in the reproductive age group in shashemene town, Oromia region, Ethiopia: A cross sectional study. *BMC Women's Health*, *15*(1). https://doi.org/10.1186/s12905-015-0209-y.

Mwafulirwa, T., O'Shea, M. S., Hamela, G., Samuel, E., Chingondole, C., Chipangula, V., ... & Tang, J. H. (2016). *African Journal of Reproductive Health, 20*(2), 62-71.

Nanvubya, A., Wanyenze, R. K., Kamacooko, O., Nakaweesa, T., Mpendo, J., Kawoozo, B., Matovu, F., Nabukalu, S., Omoding, G., Kaweesi, J., Ndugga, J., Bagaya, B., Chinyenze, K., Price, M., & Van Geertruyden, J. P. (2020). Barriers and facilitators of family planning use in fishing communities of Lake Victoria in Uganda. *Journal of Primary Care & Community Health*, *11*, 215013272094377. https://doi.org/10.1177/2150132720943775

National Statistical Office. (2017). *2015-16 Malawi demographic and health survey*. NSO, Malawi.

National Statistics Office, & ICF. (2017). *Malawi demographic and health survey 2015-16*. NSO, Malawi, and Rockville, Maryland, USA.

Neucom, J., Chilambwe, J., Mkandawire, J., & Mbewe, R. K. (2011). Dedicated providers of long-acting reversible contraception: New approach in Zambia. *Contraception, 83*(5), 447–452. http://dx.doi.org/10.1016/j.contraception.2010.08.021

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 160940691773384. https://doi.org/10.1177/1609406917733847

Nyambo, V. (2013). *Factors influencing long-acting reversible contraceptive use in Malawi.* Masters' dissertation, University of the Witwatersrand, Johannesburg, South Africa. http://hdl.handle.net/10539/13176.

Okanlawon, K., Reeves, M., & Agbaje, O. F. (2010). Contraceptive use: Knowledge, perceptions, and attitudes of refugee youths in Oru Refugee Camp, Nigeria. *African Journal of Reproductive Health, 14*(4), 17-26.

Ontiri, S., Ndirangu, G., Kabue, M., Biesma, R., Stekelenburg, J., & Ouma, C. (2019). Long-acting reversible contraception uptake and associated factors among women of reproductive age in Rural Kenya. *International Journal of Environmental Research and Public Health*, *16*(9), 1543. https://doi.org/10.3390/ijerph16091543

Peer, N., & Morojele, N. (2013). Factors associated with contraceptive use in a rural area in Western Cape Province, *South African Medical Journal*, *103*(6), 406–412.

Pinter, B., Hakim, M., Seidman, D. S., & Kishen, M. (2016). Religion and family planning. *The European Journal of Contraception & Reproductive Health Care*, *21*(6), 486-495. https://doi.org/doi:10.1080/13625187. 2016.1237631

Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed). Wolters Kluwer Health.

Robinson, N., Moshabela, M., Owusu-Ansah, L., Kapungu, C., & Geller, S. (2016). Barriers to intrauterine device uptake in a rural setting in Ghana. *Health Care for Women International*, *37*(2), 197–215. https://doi.org/10.1080/07399332.2014.946511

Secura, G. M., Allsworth, J. E., Madden, T., Mullersman, J. L., & Peipert, J. F. (2010). The Contraceptive CHOICE Project: Reducing barriers to long-acting reversible contraception. *American Journal of Obstetrics and Gynecology*, *203*(2), 115.e1-115.e7. https://doi.org/10.1016/j.ajog.2010.04.017

Shegaw, G., Nadew, K., Tamrat, K., Zeru, G., Desta, H., & Yinager, W. (2014). Long-acting contraceptive method utilization and associated factors among reproductive age women in Arba Minch Town, Ethiopia. *Greener Journal of Epidemiology and Public Health*, *2*(1), 023–031. https://doi.org/10.15580/GJEPH.2014.1.070514294

Shrivastava, S. R., Shrivastava, P. S., & Ramasamy, J. (2013). Unmet need for family planning in developing countries: Challenges and solutions. *International Journal of Gynecological and Obstetrical Research*, *1*(2), 84–87.

Shumaila, Y., Foxall, G., & Pllister, J. (2010). Theory of reasoned action, theory of planned behaviour or technology acceptance model. *Blackwell Publishing Inch*, *40*(5), 1172–1202.

Takele, A., Degu, G., & Yitayal, M. (2012). Demand for long acting and permanent methods of contraceptives and factors for non-use among married women of Goba Town, Bale Zone, South-East Ethiopia. *Reproductive Health*, *9*(1), 26, doi: 10.1186/1742-4755-9-26.

Tang, J. H., Kopp, D. M., Stuart, G. S., O'Shea, M., Stanley, C. C., Hosseinipour, M. C., Miller, W. C., Mwale, M., Kaliti, S., Bonongwe, P., & Rosenberg, N. E. (2016). Association between contraceptive implant knowledge and intent with implant uptake among postpartum Malawian women: A prospective cohort study. *Contraception and Reproductive Medicine*, *1*(1). https://doi.org/10.1186/s40834-016-0026-1

Taylor, J. (2008a). *Revitalizing underutilized family planning methods using communications and community engagement to stimulate demand for the IUD in Ethiopia.* The ACQUIRE Project/EngenderHealth.

Teye, J. K. (2013). Modern contraceptive use among women in the Asuogyaman district of Ghana: Is reliability more important than health concerns? *African Journal of Reproductive Health 17*(2), 58-71.

Tibaijuka, L., Odongo, R., Welikhe, E., Mukisa, W., Kugonza, L., Busingye, I., Nabukalu, P., Ngonzi, J., Asiimwe, S. B., & Bajunirwe, F. (2017). Factors influencing the use of long-acting versus short-acting contraceptive methods among reproductive-age women in a resource-limited setting. *BMC Women's Health*, *17*(1). https://doi.org/10.1186/s12905-017-0382-2

Tilahun, T., Coene, G., Luchters, S., & Kassahun, W. (2013). Family planning knowledge, attitude and practice among married couples in Jimma Zone, Ethiopia. *PLoS One 2013, 8(4):e61335*. *8*(4).

Tokhi, M., Comrie-Thomson, L., Davis, J., Portela, A., & Chersich. (2018). Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PloS One, 13(1), e0191620*. https://doi.org/doi:10.1371/journal.pone.0191620

Topsever, P., Filiz, M., Aladağ, N., Topallı, R., Ciğerli, Ö., & Görpelioğlu, S. (2006). Counselling and knowledge about the contraceptive mode of action among married women; a cross-sectional study. *BMC Women's Health*, *6*(1). https://doi.org/10.1186/1472-6874-6-12

UNFPA. (2010). *Improving reproductive health services*. http:www.unfpa.org/rh/service.hmt

United Nations. (2015). *Transforming our world: The 2030 agenda for sustainable development sustainable development knowledge platform*. https://sustainabledevelopment.un.org/post2015/transformingourworld

United Nations, Department of Economic and Social Affairs, & Population Division. (2015). *Trends in contraceptive use worldwide, 2015.* United Nations, Department of Economic and Social Affairs, & Population Division.

WHO. (2014). *WHO. Medical eligibility criteria for contraceptive use 4th ed.* World Health Organization.

WHO. (2017). *WHO family planning contraception*. http://www.who.int/mediacentre/fact1/en/

Winner, B., Peipert, J. F., Zhao, Q., Buckel, C., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Effectiveness of long-acting reversible contraception. *New England Journal of Medicine*, *366*(21), 1998-2007.

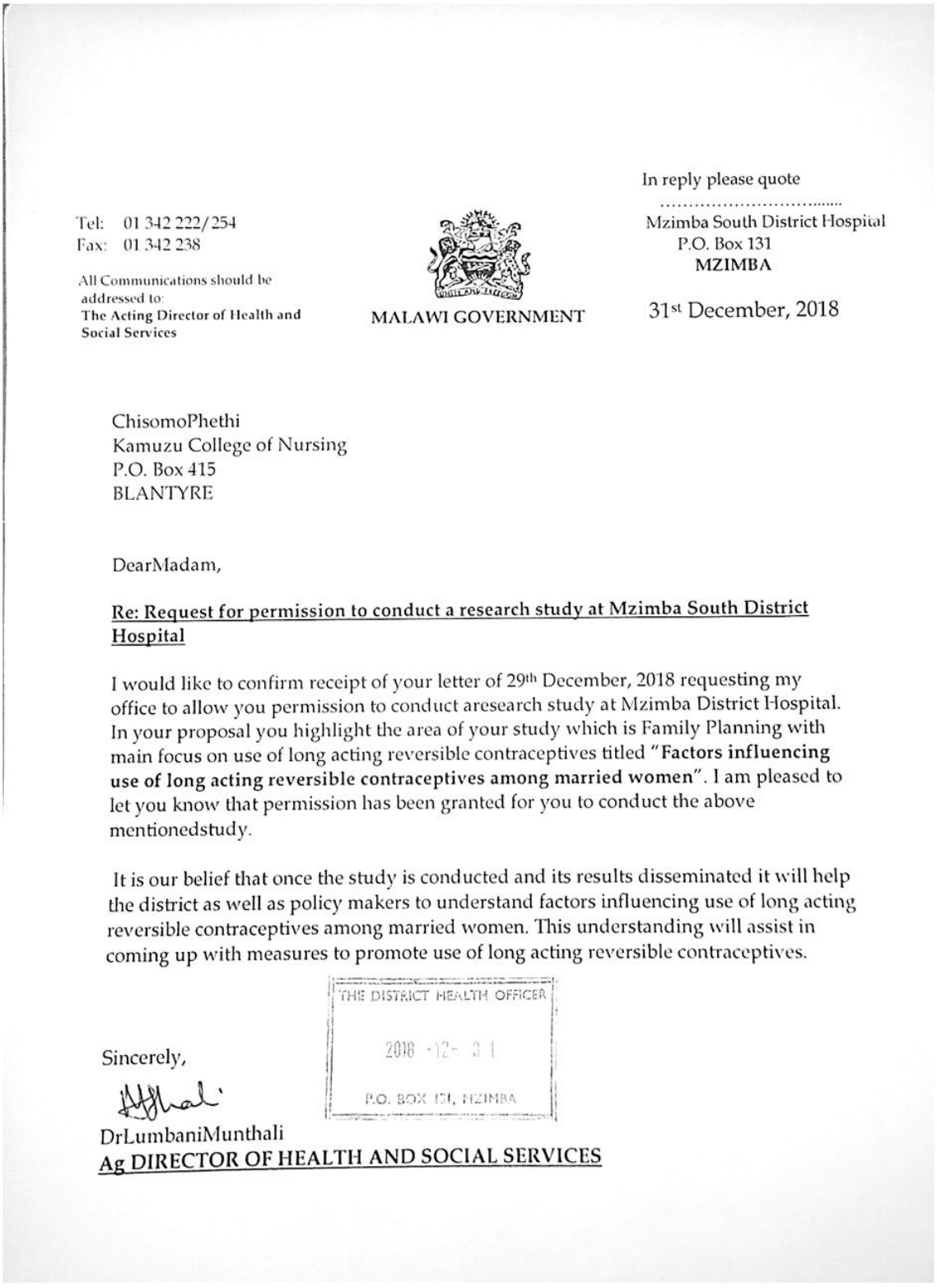
Yeatman, S., & Trinitapoli, J. (2008). Beyond denomination: The relationship between religion and family planning in rural Malawi. *Demographic Research*, *19*, 1851–1882. https://doi.org/10.4054/DemRes.2008.19.55

Yoost, J. (2014). Understanding benefits and addressing misperceptions and barriers to intrauterine device access among populations in the United States. *Patient Preference & Adherence, 8,* 947, doi: https://doi.org/10.2147/PPA.S45710

Zenebe, C. B., Adefris, M., Yenit, M. K., & Gelaw, Y. A. (2017). Factors associated with utilization of long-acting and permanent contraceptive methods among women who have decided not to have more children in Gondar city. *BMC Women's Health, 17*(1). https://doi.org/10.1186/s12905-017-0432-9

Appendices

Appendix A: Letter seeking permission to conduct the study at Mzimba District Hospital



In reply please quote
.....
Mzimba South District Hospital
P.O. Box 131
MZIMBA

Tel: 01 342 222/254
Fax: 01 342 238

All Communications should be addressed to:
The Acting Director of Health and Social Services

MALAWI GOVERNMENT

31st December, 2018

ChisomoPhethi
Kamuzu College of Nursing
P.O. Box 415
BLANTYRE

DearMadam,

Re: Request for permission to conduct a research study at Mzimba South District Hospital

I would like to confirm receipt of your letter of 29th December, 2018 requesting my office to allow you permission to conduct aresearch study at Mzimba District Hospital. In your proposal you highlight the area of your study which is Family Planning with main focus on use of long acting reversible contraceptives titled "**Factors influencing use of long acting reversible contraceptives among married women**". I am pleased to let you know that permission has been granted for you to conduct the above mentionedstudy.

It is our belief that once the study is conducted and its results disseminated it will help the district as well as policy makers to understand factors influencing use of long acting reversible contraceptives among married women. This understanding will assist in coming up with measures to promote use of long acting reversible contraceptives.

THE DISTRICT HEALTH OFFICER
2018 -12- 31
P.O. BOX 131, MZIMBA

Sincerely,

DrLumbaniMunthali
Ag DIRECTOR OF HEALTH AND SOCIAL SERVICES

Appendix B: Certificate of Approval from COMREC

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.02/19/2606 - Factors influencing use of long acting reversible contraceptives among married women at Mzimba South District hospital. Version 1.0 by Chisomo Phethi

On 28-Feb-19

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study

28-Feb-19

Dr. YB. Mlombe - Chairperson (COMREC) — Date

Appendix C: Information sheet

Study title: A qualitative exploration on use of long-acting reversible contraceptives among married women at Mzimba south district hospital

Dear participant My name is Chisomo Phethi, currently, a student pursuing a Master of Science Degree in Reproductive health at the University of Malawi, Kamuzu College of Nursing. I am conducting a study in partial fulfilment of my master's degree programme and the title is 'Factors influencing the use of long acting reversible contraceptives among married women at Mzimba South District Hospital. I, therefore, request you to participate in the study because you are the right person to give more information about long acting reversible contraceptives. Because they are Married AND ARE ON CONTRACEPTIVES

The study aims to explore factors that influence married women in using LARC (IUD and implants) to identify barriers.

You HAVE THE RIGHT TO choose to participate, refuse or withdraw from the study at any time without giving reasons for doing so and that will not have any effects on the services that you are receiving from the health care providers at this health facility. Furthermore, there are no risks in the study such as physiological or psychological risks. Additionally, it is important to let you know that you will not derive any incentives or immediate benefits from participating in the study. However, exploring the factors influencing the use of long acting reversible contraceptives will help in identifying barrier related to low use of LARC hence assist service providers, FP managers, MOH, Stakeholders and policy makers in constructing effective and efficient strategies that will promote and improve sexual reproductive health rights services.

If you consent to participate in the study, you will be interviewed individually in a private room within Mzimba Hospital for about 30 to 45 minutes.

Be assured all information given will be kept confidential and only used for research purpose. Codes and not names will be used for the study.

The study has been approved by the College of Medicine Research Ethics Committee (COMREC) and Mzimba South District hospital. If you have any questions, please do not hesitate to contact

The Principal Investigator:

Chisomo Phethi
Postal address:
Kamuzu College of Nursing,
P.O. Box 415
Blantyre. **Email address: cphethijere@gmail.com/phethi2017chisomo@kcn.unima.mw**
Cell: +265888676167/0991720944

Or you may forward your concerns, or clarifications regarding the study to;

My Research supervisor

Professor A. Chimwaza
Kamuzu College of Nursing,
P.O. Box 415
Blantyre
Email: afchimwaza@kcn.unima.mw
Cell: +265888866706

Or the following contacts for information on your rights and safety;

The Chairperson

College of Medicine Ethics Review committee (COMREC),
P/Bag 360, Chichiri,
Blantyre 3
Email address: comrec@medcol.mw

Part II: Certificate of Consent

I have been invited to participate in research about factors influencing the use of long acting reversible contraceptives among married women at Mzimba South District Hospital.

(This section is mandatory)

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. The participant was given an opportunity to ask questions about the study
2. And all the questions asked by the participant have been answered correctly and to the best of my ability
3. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Information Consent Form has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____ Day/month/year

Appendix D: Interview Guide for married woman

Code Number……..Date…….Time…….....

Name of interviewer……

Demographic and Social-economic data

How old are you?

Have you ever attended school?

What highest level of education, have you attained?

What tribe do you belong to?

What languages can you speak well enough for our conversation?

What is your religion?

What is your occupation?

How many children (parity) do you have now?

Part A: IUD (LOOP)

Knowledge on IUD

What do you know about the loop? (IUD)

Probe: How does a loop work in a woman's body to prevent pregnancy?

What are your comments on the information provided during health education today on the use of IUD (loop)?

What additional information would you like to learn or know about IUD (loop)?

Beliefs about IUD

What method of family planning have you chosen?

Probe: Why have you chosen that family planning method?

Past behaviour and habits

What has influenced you to choose the family planning method today?

Probe: a) What contraceptive method have you ever used/chosen before?

b) Why the choice of that family planning method?

Do you like or dislike IUD (loop) as a family planning method?

Probe why? What reasons do you have to like and dislike the methods?

Does your society or culture stop or encourage women to use IUD? (Opinion about the loop)

Probe: why?

Now tell me your perceptions regarding the use of IUD (loop) (Probes)

What are your expectations regarding the use of IUD (loop)?

Subjective norms

How do people, family members and country perceive the use of IUD (loop) as a family planning method among married women? (their opinions)

Overall, what would you say about the support provided to you by health workers and significant others on the use of IUD (loop) as a family planning method?

What challenges have you or others experienced in accessing the IUD method (loop) for family planning?

What do you think are the factors which **influence women** to choose or not to choose IUD (loop) for family planning?

What can be done to address these challenges?

What recommendations can you make to the traditional leaders, hospital and ministry of health to address the challenges in accessing the IUD method for married women?

What information would you share with your friends and relatives regarding the use of IUD (loop)?

B: Implants

Knowledge of Implants

What do you know about Implants?

Probe: how do Implants work (Mechanism of action) in the prevention of pregnancy in women?

What are your comments on the information provided to you during health education today about Implants?

What additional information would you like to learn or know about Implants?

Beliefs about Implants

Do you like or dislike the use of Implants by married women?

Probe why?

Does your society or culture stop or encourage married women to use Implants? (Their opinion)

Probe: why?

Now tell me your perceptions regarding the use of Implants by married women?

What are your expectations regarding the use of Implants?

Subjective Norms regarding Implants

How do people, family members and the country perceive the use of Implants as a family planning method among married women?

Overall, what would you say about the support provided to you by health workers and significant others on of use Implants as family planning?

What challenges have you experienced, or you experience in accessing Implants as a method for family planning?

What do you think are the factors **which influence** women to choose or not to choose Implants for family planning?

What can be done to address these challenges?

What recommendations can you make to the traditional leaders, hospital and ministry of health in order to address the challenges in accessing Implants for married women?

Appendix E: Interview Guide for married men

Code Number……..Date…….Time…….....

Name of interviewer……

Demographic and Social-economic data

How old are you?

Have you ever attended school?

What highest level of education have you attained?

What tribe do you belong to?

What languages can you speak well enough for our conversation?

What is your religion?

What is your occupation?

How many children do you have?

Part A: LOOP (IUD)

Knowledge on loop (IUD)

What do you know about IUD (loop)?

Probe: how does loop (IUD) work (Mechanism of action) in the prevention of pregnancy?

Where do you access information regarding loop (IUD)?

What additional information would you like to learn or know about loop (IUD)?

Beliefs about loop (IUD)

What method of family planning is your wife on?

Probe: Why is she on that family planning method?

What has influenced her to choose of method?

Past Behavior and Habits

Probe: a) What contraceptive method has she ever used/choose before?

b) Why that family planning method?

Do you approve or disapprove of the use of loop (IUD) by your wife?

Probe: why?

Does your society or culture stop or encourage married women to use loop (IUD)?

Probe: why?

Now tell me your perceptions (opinions) regarding the use of loop (IUD) by your wife

Subjective norms

How do people, family members and country perceive the use of loop (IUD) as a family planning method by married women?

Overall, what would you say about the support provided to married women by health workers and significant others on the use of loop (IUD) as a family planning method? (Opinions)

What challenges has your wife experienced or she is experiencing in accessing the loop (IUD) method for family planning?

What do you think are the factors **which influence** married women to choose or not to choose loop (IUD) for family planning?

What can be done to address these challenges?

What recommendations can you make to the traditional leaders, hospital, and ministry of health in order to address the challenges married women face in accessing the loop (IUD) method?

What information would you share with your friends and relatives regarding Loop (IUD)?

Part B: Implants

Knowledge of Implants

What do you know about Implants?

Probe: How do Implants work (Mechanism of action) in the prevention of pregnancy among married women?

Where did you get information from regarding Implants?

What additional information would you like to learn or know about Implants?

Beliefs about Implants

Do you approve or disapprove of the use of Implants by your wife?

Probe why?

Does your society or culture stop or encourage married women to use Implants as a family planning method?

Probe: why?

Now tell me your perceptions (opinions) regarding the use of Implants

Subjective Norms regarding Implants

How do people, family members and the country perceive the use of Implants as a family planning method among married women?

Overall, what would you say about the support provided to your wife by health workers and significant others regarding the use of Implants?

What challenges has she experienced, or she is experiencing in accessing Implants as a method for family planning?

What do you think are the factors **which influence** women to choose or not to choose Implants for family planning?

What can be done to address these challenges?

What recommendations can you make to the traditional leaders, hospital and ministry of health in order to address the challenges in accessing Implants for married women?

Appendix F: Interview guide: Interview Guide for Married women (Chichewa Version)

Ndondomeko yamafunso

Tsiku lofunsa mafunso……

Dzina la ofunsa mafunso……...

Nambala ya oyankha mafunso…….

Zofunika kudziwisa anthu zokhuza kafukufuku

1. Kuonesera mwini kafukufuku
2. Kufotokozera zolinga za kafukufuku
3. Kufotokozera tsatanetsatane wakafukufuku monga kusunga kwachinsinsi

Gawo loyamba: Mbiri ya oyankha mafunso

Muli ndi zaka zingati?

Ndinu antundu wanji?

Kodi ndi zilakhulo ziti mukhoza kuyankhula bwinobwino?

Mumapemphera mpingo wanji?

Kodi munayamba mwayimbapo sukulu?

Kodi mumagwira ncthito yanji?

Kodi muli ndi ana angati?

GAWO 1: NJIRA YA LUPU

Mungandiuzeko chilichonse chokhuza njira yakulera yalupu?

Nanga njira yalupu imagwira bwanji ntchito munthupi lamayi pomuteteza kuti asatengemimba?

Nanga leroku clinic yanthu mwa phunzirapo chani zonkhuza njira yalupu?

Kodi mukuganiza kuti uphungu womwe mwapasidwa lero okhuza njira imeneyi ndiokwanira?

Nanga ndiuphungu wanjiowonjezera omwe mukuganiza ukanaku thandizani zonkhu zanjira yalupu?

Ndizifukwa zanji zimene zimakupangisani kukonda kapena kudana ndinjira yalupu?

Ndinjira yanji imene mwasankha tsiku lalero?

Chifukwa?

Nanga ndichiyani chakupangisani kuti mutenge njira imeneyi?

Kodi mmbuyo mumumagwirisa ntchito njira ziti/yiti yakulera?

Ndichifukwa chani munapanga chisankho chogwirisa ntchito njira imeneyo?

Kodi palimwambo wina ulionse mderalino umene umalimbikisa kapena kulesa azimayi apabanja kugwirisa ntchito njira yalupu?

Nanga njira yalupu mumayiona bwanji panokha, pabanja lanu ngakhalenso dzikolanu?

Nanga achibale kapena anthu ogwira ntchito kuchipatala, ndithandizo (Sapoti) lanji limene amakupasani lokhu zanjira yalupu?

Ndimavuto anji amene azimayi apabanja amakumana nawo potenga njira yalupu?

Nanga ndizinthu ziti zimenezi mapangisa mayi wapabanja kusatenga njira yalupu

Nanga tingachitepo chani pothesa mavuto amene azimayi apabanja amakumana nawo potenganjira yalupu?

Ndindondomeko zanji zimene mungapeleke kwaanthu amudzi, kuchipatala ngakhale ku zomwe zingathandize kuthesa mavuto amene azimayi apabanja amakumana nawo potenganjira yalupu?

GAWO 2: NJIRA YA KULERA YA PANKONO

Mukudziwapo chani pa zanjira yakulera yapankono (implants)?
Nanga njira yapankono imagwira bwanji ntchito munthupi lamayi pomuteteza kuti asakutenge mimba?

Nanga leroku clinic yanthu mwaphunzirapo chani zonkhu zanjira yapankono?

Kodi mukuganiza kuti uphungu womwe mwapasidwa lero okhu zanjira imeneyi ndiokwanira?

Nanga ndiuphungu wanji owonjezera omwe mukuganiza ukanakuthandizani zonkhuza njira yalupu kapena yapankono?

Ndizifukwa zanji zimene zimakupangisani kukonda kapena kudana ndi njira yakulera yapankono?

Kodi pali mwambo wina ulionse mdera lino umene umalimbikisa kapena kulesa azimayi apabanja kugwirisa ntchito njira yakulera yapankono?

Nanga njira yakulera yapankono mumayiona bwanji panokha, pabanja lanu ngakhalenso dziko lanu?

Nanga achibale kapena anthu ogwira ntchito kuchipatala, ndithandizo (Sapoti) lanji limene amakupasani lokhuza njira yakulera yapankono?

Ndimavuto anji amene azimayi apa banja amakumana nawo potenga njira yakulera yapankono?

Nanga ndizinthu ziti zimene zimapangisa mayi wapabanja kusatenga njira yapankono?

Nanga tingachitepo chani pothesa mavuto amene azimayi apabanja amakumana nawo potenganjira yapankono?

Ndindondomeko zanji zimene mungapeleke kwa anthu amudzi, kuchipatala ngakhale ku zomwezi ngathandize kuthesa mavuto amene azimayi apabanja amakumana nawopotenganjira yakulera yapankono?

Nanga ndiutheng awanji umene mungapeleke kwamnzanu, achibale anu zokhu zanjiraya kulera yapankono?