



**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 5

**Factors Underlying the Use of
Long-Acting and Permanent
Family Planning Methods in Nigeria:
A Qualitative Study**

**Stella Babalola and Neetu John
Johns Hopkins Bloomberg School of Public Health
Center for Communication Programs (JHU-CCP)**

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Acronyms and Abbreviations

CHO	Community Health Officer
FMC	Federal Medical Center
FP	family planning
IUD	intrauterine device
LA/PMs	long-acting and permanent methods
LGA	local government area
MCH	Maternal and Child Health Clinic
NKST	Nongu u Kristu u ken Sudan hen Tiv
NPC	National Population Commission
NURHI	Nigerian Urban Reproductive Health Initiative
PHC	primary health care
STI	sexually transmitted infection
UCH	University College Hospital
USAID	United States Agency for International Development

Summary and Recommendations

The data analyzed in this report were derived from a multimethod qualitative study conducted in Benue and Oyo States of Nigeria in July and August 2011. The findings reveal the myriad of challenges associated with demand for, and provision of, long-acting contraceptive methods (the intrauterine device [IUD] and the hormonal implant) and permanent contraceptive methods (tubal ligation and vasectomy) in Nigeria. The following is a summary of the findings.

Perceptions about Ideal Family Size

There was almost universal agreement among study participants about the importance of limiting family size. Current economic realities, as well as the perceived need to plan for the future of their children and families, were important drivers of this perception. A family of four was considered ideal. Son preference and the widespread belief that daughters are of less value than sons are some of the factors fueling preference for large families. For example, a woman who has no sons is not considered fertile, no matter how many daughters she has had. Moreover, concerns about relationship insecurities often motivate a woman to continue childbearing beyond the number of children she considers ideal. Larger families are often looked upon as burdensome, while families smaller than three children are highly suspect and are not perceived to be a choice. Moreover, a woman who has two or fewer children is often labeled as a “prostitute,” interested only in enjoying sex without the burden of childbearing.

Knowledge and Attitudes about Family Planning

There is noticeable awareness about family planning (FP) methods, although considerable misinformation about specific methods persists. Nonetheless, study participants often associated FP with peace of mind. A key factor hindering the use of FP is the fear of side effects. For example, participants feared that some methods might cause excessive bleeding, infertility, or cancer. Other beliefs may also hinder the adoption of FP methods for the purpose of limiting the number of births. For example, there was a common belief at the study sites that if a woman does not give birth to all of the children in her womb, she may develop cancer. Some men feared that women become promiscuous when they practice FP. There was also a common belief that a couple should not use FP methods early in their childbearing years, to avoid infertility.

Perceptions about LA/PMs

Knowledge about long-acting and permanent methods of contraception (LA/PMs) varied by method and across study groups. Study participants from both states were familiar with the IUD and recognized its effectiveness and advantages. However, misinformation about the method abounds, including its perceived side effects and the belief that it is harmful to a woman’s sex partner. There was a widespread belief that the IUD makes the user more prone to sexually transmitted infections (STIs) and infections of the pelvis. This belief was common not only among community members but also among service providers. The belief that the IUD increases the risk for STIs was given by some service providers as a reason for not

recommending the method for women who are in a polygynous relationship or who might be unfaithful to their husband.

Compared with the IUD, the implant was a lesser known method. Some study participants had not even heard of the method. Many of those who were aware of the method had concerns about its side effects. Participants perceived the method to be linked with excessive weight gain or weight loss and amenorrhea. Nonetheless, the study participants who demonstrated awareness about the method perceived it to be more effective than short-acting methods and even than the IUD.

While there was widespread awareness about female sterilization, knowledge was limited. Misinformation about what the procedure entailed was common. The method was generally perceived as one that a woman would select not out of choice, but rather out of necessity, in cases where another pregnancy could threaten her life or when other methods had failed.

Male sterilization was a relatively unknown method. Participants likened male sterilization to castration; men who had undergone the procedure were believed to be incapable of enjoying sex or satisfying a woman sexually.

In general, perceived high levels of child mortality were a serious concern that made permanent FP methods less than appealing.

Poor versus Nonpoor Communities

There were significant commonalities between poor and nonpoor communities in the study states. For example, in Oyo State, there were no differences in ideal family size between poor and nonpoor communities; similarly, in Benue State, both safety and effectiveness ratings were comparable in poor and nonpoor communities. Nonetheless, there were some noticeable differences between these two types of communities. For example, participants from the poor community in Benue State were more likely to express a preference for larger size families, compared with their peers from the nonpoor communities. In both study states, there was more precise knowledge about LA/PMs in the nonpoor communities than in the poor communities. Finally, compared with their peers from the nonpoor communities, participants from the poor communities were more likely to express concerns about specific LA/PMs.

Desired Attributes of FP Methods

The attributes that potential users would consider to make them decide to adopt a method varied between Benue and Oyo states. In Benue State, the tangible and intangible costs of a method (for example, its affordability and ease of use) and its collateral benefits (including perceived beauty-enhancing qualities and noninterference with sexual intercourse) are important attributes that could positively influence the decision to adopt a method. In Oyo State, collateral benefits and safety of methods appeared to be the most important considerations. The data further showed that the better understanding study participants have about a method, the more likely it is that they would indicate a preference for that method.

Experience with LA/PMs

Early adopters of the IUD were generally satisfied with their method. Most did not experience the side effects that participants in this study generally associated with the method. Similarly, many lapsed users had had a positive experience with the method and only had it removed when they were ready to become pregnant again. Some users experienced minor side effects in the first few months of IUD use, but these side effects did not lead to a decision to abandon the method. A few previous users, however, related that they experienced serious difficulties (including prolonged menses and abdominal pain) that led to the decision to discontinue use.

Many women using implants experienced perceived or real side effects, although these did not necessarily lead them to abandon the method. The complaints generally had to do with prolonged menstruation, weight gain, chest pain, and infections.

There is limited information on experience with permanent methods, since only three study participants were using female sterilization and no early adopter of male sterilization was part of the study. Service providers reported that they had yet to encounter a male client desiring male sterilization. The women who had had female sterilization appeared to be satisfied with their method. However, one woman complained that she experienced backache and weight loss after the procedure.

Contraceptive Decision Making

Typically, the decision to use a contraceptive method was jointly taken by the couple after discussing the issue between the two of them. Knowing how to negotiate contraceptive use with her husband was a skill that study participants saw as a necessary attribute for a woman in this regard. However, a woman sometimes makes a unilateral decision to use a contraceptive method covertly if the husband opposes FP use. Contraceptive decision making was often based on the experiences of friends, relations, and acquaintances who were current users. In the final analysis, potential users rely considerably on the advice of service providers in the choice of the method to use. The study did not uncover any differences in decision-making process for short-acting methods versus LA/PMs. The participants, however, stressed that mutual understanding and joint decision making between the man and his wife are of utmost importance when they are considering a permanent method.

The Role of Men

Men play a key role in the decision to adopt a contraceptive method and which method will be adopted. This study has shown that when the husband comes to the health facility with his wife, his resistance to contraception is likely to be broken and the couple are likely to adopt a method. Nonetheless, compared with women, men were less knowledgeable about LA/PMs. Moreover, in general, men demonstrated less favorable attitudes toward FP than did women. Lack of support from the husband not only hinders contraceptive use but may also lead to premature termination of use of a long-acting method. Moreover, whereas some women use contraceptive methods covertly, such behavior may result in serious marital disharmony if the husband learns of it.

Availability and Quality of Services

The study revealed several issues with availability and quality of services. In general, providers understood clients' expectations about quality but admitted that it was sometimes difficult for them to meet these expectations. For example, clients desire to have a wide range of methods from which to choose. In reality, long-acting methods were not always available at the study clinics, and permanent methods were not offered at most of the clinics. The unavailability of a desired method can lead to discouragement and the decision to postpone use. There were problems with supplies and equipment, often forcing providers to charge shadow fees and/or source for methods in the black market, with the attendant uncertain quality and the possibility of compromising the health of clients. Some facilities did not have electricity, and those that did may only have had power intermittently. Moreover, some of the clinics were in a poor state of repair. Providers complained of high workload due to an insufficient number of trained providers. This problem also leads to increased waiting time for clients. There were also problems with provider training: Many FP service providers lacked the necessary training to provide LA/PMs.

Early Adopters versus Others

In terms of perceptions about family size, fatalistic attitudes (as evidenced in responses such as “up to God,” “as many as God gives,” or “God is the provider of children and He will care for them”) were less common among early FP adopters than among the other study participants. In other words, compared with nonusers of LA/PMs, early adopters were more likely to perceive an internal (as opposed to external) locus of control over family size. The data also show that early adopters were more knowledgeable about contraceptive methods in general and about LA/PMs in particular. Early adopters were also more likely than the other study participants to perceive that long-acting methods were safe and effective. However, in terms of perceptions about safety and effectiveness of permanent methods, early adopters were not very different from the other study participants.

Preferred Sources of Information and Advice

Providers and satisfied clients are the most important and trusted sources of information and advice about FP in general and about specific methods in particular. Mass media, including television and radio, were seen as useful sources of information but were not considered to be of prime importance.

Recommendations

The findings from this study have important implications for demand generation and service provision. Below are recommendations to strengthen the FP program in Nigeria:

1. Effectively increasing demand for FP methods in general, and for LA/PM in particular, will require promoting smaller family size and changing negative attitudes toward couples with a small family. Targeted messaging should promote smaller families (fewer than four children) as the ideal. It is important to de-link the ideas of promiscuity, prostitution, and selfishness from couples who choose to have a small family. Culturally appropriate messages should also seek to increase understanding about how couples can achieve a

- smaller family size. LA/PMs should be positioned as effective and safe methods for couples to achieve their reproductive health goals.
2. It is equally important to address gender issues around FP. Efforts to change attitudes toward and build community support for women who choose to use contraceptive methods are relevant. Also relevant are interventions designed to address relationship insecurities that prevent the use of LA/PMs.
 3. Efforts to promote long-acting methods should center on increasing knowledge and correcting misinformation about the methods. It is important to address the concern expressed by some respondents about a link between use of the IUD to HIV in communication materials and during counseling. Messages need to emphasize these methods' greater effectiveness compared with short-acting methods and their association with fewer and relatively minor side effects. Improving counseling to enable users to understand the side effects of the methods and how to deal with these side effects should be part of a comprehensive intervention package.
 4. Positioning permanent methods as an ideal choice for couples who want to stop childbearing requires efforts to educate the community about the methods, clarify what the procedures entail, and elucidate their side effects. Messages that position the decision to adopt a permanent method as an act of love and responsibility toward one's children and spouse are relevant.
 5. The finding in this study that most users of LA/PMs do not experience serious side effects has important implications for programming. Interventions that show satisfied users talking about their experience and encouraging others to adopt the method can be very effective.
 6. Potential users are more likely to adopt a method that meets their expectations about its benefits. Most attributes that study participants deemed important (e.g., requiring the minimum number of visits to a health facility, having minimal side effects, being easy to use, not interfering with sexual relations, helping the user to look young for longer, etc.) are naturally associated with LA/PMs. It is important that efforts to promote these methods emphasize these attributes.
 7. Women typically bring up the idea of contraceptive use in the couple. However, the husband's opposition often hinders or delays the decision to use a method. Programmatic efforts to strengthen women's skills at negotiating contraceptive use are relevant. Women need to know how to approach discussions about contraceptive use, in general, and about LA/PM use, in particular, with their husbands. Women also need to be equipped with evidence-based and convincing arguments to counter husbands' resistance to contraceptive use.
 8. Since men are the key decision makers in their household, programmatic efforts should target them specifically. Programmatic efforts are needed to address the ideational and cultural factors that prevent men from embracing LA/PMs and from acting as a champion for their wives in the use of these safe and effective methods. Appropriate strategies should seek to educate men about these methods, promote positive attitudes toward the methods, and mobilize men to become advocates for the methods in their families and in the community. Efforts that promote couples counseling for LA/PMs are relevant.
 9. While helping to generate demand, efforts to promote LA/PMs should include a complementary focus on supply-side issues. Methods should be made available to clinics and stock-outs minimized. The regular availability of supplies and quality equipment needs

to be ensured. Shortages of trained staff should also be addressed, possibly through strategies such as task shifting and use of dedicated providers. In-service and refresher training for current providers should be considered. Efforts should also be made to introduce training on LA/PMs into the curricula for medical and nursing/midwifery students.

10. Potential users of LA/PMs rely extensively on service providers to guide them in the choice of appropriate methods. Providers, however, have their own biases and misinformation about certain methods. Indeed, study participants cited service providers as the source for some of the misconceptions they had regarding LA/PMs. It is important to increase service providers' knowledge about LA/PMs, correct their misconceptions, and strengthen their technical competence to provide the various methods. It is equally important to strengthen providers' interpersonal skills, so they can provide adequate information to clients, debunk myths and rumors, address clients' concerns, and help potential clients make an informed decision without pushing specific methods.

Background

In spite of its vast natural resources, Nigeria has among the worst indicators of health and social well-being in the world. Infant and child mortality rates, life expectancy at birth, the maternal mortality ratio, the female literacy rate, and the total fertility rate all paint an alarming picture that underscores the need for urgent and drastic corrective measures. For example, with an estimated maternal mortality ratio of 840 deaths per 100,000 births, Nigeria accounts for about 10% of the world's maternal deaths, even though the country only constitutes 2% of the world's population (WHO, 2010). The average Nigerian woman has 5.2 births in her lifetime. This high level of fertility is the direct result of multiple factors, including universal marriage, early childbearing, and (especially) low contraceptive use. The results of the 2008 Nigeria Demographic and Health Survey (DHS) show that only 10.5% of women of reproductive age were using a modern contraceptive method, while 4.9% were using a traditional method (NPC & ICF Macro, 2009). Unmet contraceptive need is huge, with less than half of the total demand for family planning (FP) currently satisfied.

Long-acting and permanent methods of contraception (LA/PMs) are safe and cost-effective for women who desire to delay or limit births, yet they are largely underutilized. These methods are the intrauterine device (IUD) and the hormonal implant (the long-acting methods) and female sterilization and vasectomy (the permanent methods). In Nigeria, these methods contribute only about 10% of modern contraceptive use. Moreover, as the data in Table 1 show, most Nigerians are ignorant about these methods. This is regrettable, considering that LA/PMs can help to significantly reduce unmet need for FP in Nigeria.

Table 1: Percentage of women of reproductive age reporting awareness of specific LA/PMs, Nigeria, 2008

Method	%	
	Men	Women
Female sterilization	36.5	23.9
Male sterilization	20.5	7.9
IUD	18.1	24.9
Implant	10.7	10.1

Source: NPC & ICF Macro, 2009

Between July and August 2011, the RESPOND Project conducted a qualitative study on knowledge of and attitudes toward contraceptive methods in Nigeria. The study focused in particular on LA/PMs and sought to document the factors that influence LA/PM use. It is expected that the findings will be useful for governmental and nongovernmental agencies in developing effective strategies for promoting the use of LA/PMs and thereby increasing contraceptive use in Nigeria.

Study Objectives and Methodology

The use-dynamics study in Nigeria is part of a multicountry qualitative research effort designed to contribute to the global evidence base on the dynamics of contraceptive use or nonuse, with a special focus on LA/PMs. The two other countries involved in the study are Malawi and Cambodia.

Specific Study Objectives

The specific objectives of this study were to:

1. Deepen global understanding of decision making related to LA/PMs by focusing on:
 - Clients who have chosen to use an LA/PM (especially in low-use settings)
 - Individuals with an unmet need for FP, for whom LA/PMs might be appropriate
 - Service providers who are expected to help clients make informed choices regarding LA/PMs
 - Influential individuals at the community and national levels who affect policy and programs and their implementation
2. Deepen understanding of differences between the decision to use a long-acting method and the decision to use a permanent method and among users of different long-acting methods
3. Support policy dialogue at the country level

Methodology

Data Collection Methods

This study covered six urban locations in two states of Nigeria: Benue and Oyo. In Benue State, the study took place in the following sites: Adikpo, Mkar, and Makurdi. The three study sites in Oyo State are Adeoyo/Yemetu, Apata, and Oniyanrin, all within the Ibadan metropolitan area. Data collection methods were qualitative and included focus group discussions (FGDs), in-depth interviews, key informant interviews, free-listing interviews to elicit the terms people use to describe contraceptive methods, and pile-sorting exercises to understand how people group those terms together. Table 2 (page 4) provides details of the various methods used to collect data in this study.

Focus group discussions

In each of the six study communities, we conducted four FGDs—one each among early adopters, lapsed users, postpartum women with an unmet need for FP, and married men. Using the guide shown in Appendix 1, the FGDs explored people's attitudes and community norms regarding FP, with a special focus on LA/PMs. The data collected through the FGDs served as the basis for developing the free-listing interviews and pile-sorting exercises. Trained and experienced moderators conducted the FGDs. The discussions were recorded,

after obtaining permission from the participants to do so. A note-taker was also present during each FGD.

Table 2: Numbers of FGDs, in-depth interviews, key informant interviews, free-listing interviews, and pile-sorting exercises conducted, by location and subgroup

Method	Location						Total
	Benue State			Oyo State			
	Adikpo	Makurdi	Mkar	Adeoyo/ Yemetu	Apata	Onianrin	
FGDs							
Early adopters	1	1	1	1	1	1	6
Lapsed users	1	1	1	1	1	1	6
Postpartum women	1	1	1	1	1	1	6
Married men	1	1	1	1	1	1	6
In-depth interviews							
Service providers	2	2	2	2	2	2	12
Key informant interviews							
Ministry of Health	-	2	-	-	-	1	3
Facility heads/ managers	1	2	1	1	1	1	7
Free-listing							
Early adopters	7	7	14	14	7	7	56
Lapsed users	7	7	14	14	7	7	56
Postpartum women	7	7	14	14	7	7	56
Married men	7	7	14	14	7	7	56
Pile-sorting							
Early adopters	6	7	7	8	7	7	42
Lapsed users	7	7	7	8	7	7	43
Postpartum women	7	7	7	8	7	7	43
Married men	7	7	6	7	7	7	41

In-depth interviews

At each study site, the researchers conducted two in-depth interviews among service providers, for a total of 12. The in-depth interviews explored the dynamics of FP use from the providers' perspective, as well as from a supply-side perspective. The tool for the in-depth interviews is attached in Annex 2.

Key informant interviews

The study team conducted key informant interviews with 10 people. The persons interviewed included senior officials of the Ministry of Health, health facility administrators, and senior service providers. The key informant interviews helped to identify, within the broad research objectives, key issues and questions to tailor the study to the Nigeria context.

Free-listing interviews

A total of 224 people (112 from each state) were selected to participate in individual free-listing exercises, using a structured questionnaire. Eligibility criteria for participation included residing

in the study location, belonging to any of the four study groups (early adopters, lapsed users, postpartum women, or married men), and consenting to participate. In the free-listing interviews, the aim was to define the cultural domain (a set of items that belong together or share some similarities) relevant to the dynamics of FP use and to map the structure of this domain. The interviews used direct questions to generate a list of terms related to what and how the respondent thinks about ideal family size and about users of specific FP methods. In addition, we asked those currently using a method what they particularly liked about their method; those not using a method were asked to list the qualities that they would expect to see in a method that they would choose to use. Results of the free-listing interviews are not reported here; however, they provided input for the pile-sorting exercises. The free-listing tools are included in Annexes 3 and 4.

Pile-sorting/rating exercises

We conducted individual pile-sorting exercises with 169 people from both states (82 from Benue and 87 from Oyo). Four pile-sorting/rating exercises were conducted with each participant: pile-sorting of contraceptive methods; pile-sorting of the desired attributes of contraceptive methods; rating of contraceptive methods by level of effectiveness; and rating of contraceptive methods by level of safety.

Participants in the four data-gathering approaches described above did not overlap.

Study Participants

Study locations

The study targeted various groups in urban areas of Oyo and Benue states, focusing on selected health facilities with a relatively high caseload of LA/PMs. Rural facilities were excluded from the study, since none had a sizable number of LA/PM users who could qualify for participation in the study.

Benue State is situated in the middle belt of Nigeria. The current population is estimated to be around 4.2 million (NPC, [no date]). The state has a total of 614 primary public health facilities and 15 public secondary health facilities (NBS, 2007). Contraceptive prevalence was only 11.6% (NPC & ICF Macro, 2009). Benue is a multiethnic state; the main ethnic groups are the Tiv, Idoma, and Iggede. The study targeted nonpoor communities in Adikpo and Makurdi and a poor community in Mkar.

In Benue State, the choice of study sites was a bit problematic, since physicians in most state facilities had been on strike for many months prior to the study. Therefore, study sites included one mission-run facility, Nongu u Kristu u ken Sudan hen Tiv (NKST) Hospital, a Christian Reformed Church facility in Mkar; one state-run facility (General Hospital, Adikpo); and one federal government facility (Federal Medical Center [FMC] Makurdi).

FMC Makurdi is run by the federal government of Nigeria. It has a catchment population of about 300,000 people and is open around the clock, seven days a week. It is a secondary-level facility and offers several services through its various departments, including obstetrics and gynecology, surgery, internal medicine, and pediatrics. It has more than 120 providers and serves as a referral center for other health facilities in the state. FMC Makurdi has a well-

equipped FP unit that operates from 8 a.m. to 4 p.m., five days a week, with a pool of 20 service providers. It offers a wide range of FP services, including provision of LA/PMs.

NKST Hospital Mkar is a secondary-level, mission-owned facility serving a population of about 180,000. The facility offers a wide range of maternal and child health services and has a strong collaboration with international development organizations in Nigeria. With a staff of 10 nurse-midwives, the facility offers a wide range of FP services and is open from 7 a.m. to 3 p.m., Monday through Friday.

Adikpo General Hospital is a public health facility owned and managed by the Adikpo Local Government Area (LGA). It serves a population of about 100,000 people. The facility has two mid-level providers, who offer a wide range of maternal and child health services, including FP. The facility is open from 8 a.m. to 2 p.m., Monday through Friday.

Oyo State is located in southwestern Nigeria; the predominant ethnic group there is Yoruba. The state population is about 5.6 million (NPC, [no date]). Oyo State has 690 public health facilities, 653 of which are primary health facilities (NBS, 2007). Contraceptive prevalence was at 15% in Oyo State in 2008 (NPC & ICF Macro, 2009). Ibadan, the capital of Oyo State and one of the largest metropolitan areas, was the focus of the study. The study targeted three communities within the city: Apata, Adeoyo/Yemetu, and Oniyanrin. Adeoyo/Yemetu can be considered a poor community, while the other two are nonpoor.

In Oyo State, three health facilities were included in the study: Primary Health Center (PHC), Oniyanrin; Maternal and Child Health Clinic (MCHC), Apata; and Adeoyo Maternity Hospital, Yemetu (see Table 3).

Table 3: Study communities and health facilities in each state

State	Study community	Health facility	Poor/nonpoor status
Benue	Adikpo	General Hospital	Nonpoor
	Makurdi	Federal Medical Center	Nonpoor
	Mkar	NKST Hospital	Poor
Oyo	Adeoyo/Yemetu	Adeoyo Maternity Hospital	Poor
	Apata	Maternal and Child Health Clinic	Nonpoor
	Oniyanrin	Primary Health Center	Nonpoor

MCHC Apata is a maternal and child health clinic with a catchment population of about 200,000. It is a primary-level facility run by the government of Oyo State. The facility offers maternal and child health services, including antenatal care, postnatal care, and FP services. Child health services offered include child growth monitoring services, immunization, and management of minor illnesses. The facility has 10 staff members, including two nurses assigned to the FP clinic. The clinic is open Monday through Friday from 7 a.m. to 4 p.m.

Adeoyo Maternity Hospital, a secondary-level facility run by the Oyo State government, provides a wide range of health services but focuses mainly on maternal and child health. The facility has a functional and well-equipped FP unit with four nurse-midwives and four support staff. The facility is open from 8 a.m. to 4 p.m. daily.

Oniyarin Primary Health Center is run by the Ibadan North West LGA. It is a primary-level facility staffed mainly by five nurse-midwives. The FP clinic within the health facility is staffed by two nurse-midwives and three community health officers (CHOs). The facility is one of the few in Ibadan that has a community liaison officer on its staff, thereby making it easy for service providers to reach out to the community. This clinic is open Monday through Friday from 8 a.m. to 4 p.m.

Participants

The study population consisted of five main categories: (1) early adopters of LA/PMs; (2) lapsed FP users; (3) postpartum women with an unmet need for FP; (4) married men; and (5) service providers.

The study team worked with service providers to select the various categories of respondents. For **early adopters**, service providers referred to the study team any client who came to the clinic on the day of the study and who was currently using an LA/PM and was aged 25–44. The study team then explained the objectives of the study to the client, verified her eligibility, and obtained her consent to participate in either an FGD, the free-listing, or the individual pile-sorting.

Lapsed users of a modern FP method were women aged 25–44 who were previously using a modern method, were not pregnant, were not recently postpartum, and were not currently using a method. They were recruited from the community through information obtained from the health facility. The health facilities selected for this study had a high FP client load, and the providers were able to link the researchers up with some of their discontinued users. The lapsed users were mixed in terms of the method they had been using: Whereas some were previously using a long-acting method, others were using a short-acting method. Women who met the eligibility criteria and who consented to participate were invited to the health facility on a specific date for the FGD, free-listing, or pile-sorting.

For **postpartum women not using an FP method**, the recruitment points were the postnatal and well-child (for growth monitoring, immunization, etc.) clinics. At the study health facilities, postnatal and well-child clinics meet on specific days. The research team targeted these clinic days and worked with service providers to recruit eligible women. The FGDs, free-listing, and pile-sorting were held on the same day if there were enough eligible women. If not, the women already recruited were asked to return to the facility on a later date.

Married men aged 25–44 years were recruited with the help of community leaders from the communities located within the catchment area of the health facility. Using a screening tool, potential male participants were identified and were asked to consent to participate in the study.

The **service providers** who participated in this study worked at the study health facilities and consented to participate in the study. They included nurses, nurse-midwives, and CHOs.

A total of 617 people participated in the study—202 focus group discussants, 224 free-listing participants, 169 pile-sorting participants, 12 service providers interviewed in-depth, and 10 key informants. The basic characteristics of the participants are provided in Table 4. By design,

three-quarters of the study participants were women. Approximately half were from Benue State and half from Oyo State.

Table 4: Characteristics of study participants (all study sites)

Characteristic	No. of participants	%
Location		
Adikpo	95	14.9
Makurdi	98	15.4
Mkar	122	19.1
Adeoyo/Yemetu	127	19.9
Apata	95	14.9
Oniyarin	101	15.8
Sex		
Male	147	23.0
Female	491	77.0
Category		
Early adopters	149	23.4
Lapsed users	151	23.6
Post-partum women	149	23.4
Married men	146	22.9
Service Providers	33	5.2
Key Informants	10	1.5
Total no. of participants	638	100

Data Analysis

FGDs and key informant interviews

Analysis of the FGDs and key informant interviews started in the field. At the end of each day of fieldwork, the research teams met to debrief, update their notes, and identify the salient findings from the interviews and FGDs. In addition, all audio recordings were transcribed and translated into English. The transcripts reflected verbatim transcription of the recorded FGDs and key informant interviews.

Each transcript was read multiple times by the principal investigator, Dr. Stella Babalola, and a research assistant. A coding scheme was developed based on the objectives of the study and the relevant themes that emerged from the transcripts. Thematic coding was performed on all transcripts using Microsoft Word, differentiating among groups by poor/nonpoor status, place of residence, and user status. Quotes that represented the common themes or particularly significant findings were selected from the transcripts for inclusion in this report.

Free-listing interviews

Results from the free-listing served as a basis for identifying the items and structure of cultural domains related to FP in the study locations. We analyzed the data using Anthropac software (Borgatti, 1996). We examined both the content of a respondent's free-list and the order in which the items were listed. Through the content of the list, we were able to identify the items that participants mentioned most often. The order in which an item is listed can be used to generate the average rank of individual items. Assuming that the best-known items tend to be mentioned first, the more often an item is mentioned, the lower its rank (since it will tend to

appear toward the top of the participants' lists). Both the frequency of an item and its average rank are used to compute the item's salience. Using Anthropac, we identified the most salient terms used by the respondents to describe the various dimensions of FP. **The items thus identified through free-listing were then used in the pile-sorting and ranking exercises.**

Pile-sorting and ranking

Data from the pile-sorting and ranking exercises were used in multidimensional scaling using Anthropac. Multidimensional scaling is a powerful tool for exploring the perceived similarities and dissimilarities of items. In this report, the results of multidimensional scaling are displayed as a visual representation.

Perceptions about Ideal Family Size

Perceived Ideal Family Size

In general, participants across the districts and socioeconomic brackets saw limiting family size as an essential aspect of modern life. Economic considerations and the importance of investing in children's education and future were key considerations in this regard.

Although the participants' perception of ideal family size ranged from a minimum of two children to a maximum of eight children, a family of four children was most commonly seen as the best option. Discussants had different perspectives on what made a family with four children ideal. Some emphasized economic considerations as a major limiting factor:

Now there is no money and the economic situation in Nigeria is bad. ...if you have more than four [kids,] to take care of them will be difficult and you won't be able to give them the best.

—Postpartum woman, Makurdi, Benue State

Others focused on the importance of the “training” and educational needs of their children. Providing a good education for children is something that most participants cherished. In the opinion of most participants, achieving this goal is a major duty of parents:

We should be able to train them with good education, but when having six, eight children and you cannot train them, the children will blame the parent for not taking care of them. It is better to give birth to the number that you will be able to take good care of.

—Lapsed user, Apata, Oyo State

The participants also emphasized the negative effects of having too many births on the health of the woman. Many participants understood the health consequences of repeated births for the woman:

If woman has many children, she will not be healthy and strong and it will reduce the life of the mother.

—Early adopter, Adikpo, Benue State

The reason is that if you have more than four children it will affect the parents, healthwise, especially the wife.

—Married man, Oniyarin, Oyo State

A small minority expressed broader societal issues as compelling reasons for maintaining smaller families:

The reason is that our community's situation does not support giving birth to many children.

—Married man, Oniyarin, Ibadan, Oyo State

Interestingly, public messaging around ideal-sized families appears to have influenced some participants' opinions of what should be the ideal family size:

According to the lecture we received, we were told to give birth to four children so we can take care of them very well.

—Postpartum woman, Adeoyo Yemetu, Ibadan, Oyo State

However, some male participants and study participants from low-income communities disagreed with the notion of a perfect-sized family for all. They believed that ideal family size would vary, depending on an individual's unique life situation. Participants who subscribed to this view strongly believed that financially capable individuals could justify having larger families, as they would be able to support them adequately:

There is no number that is not good if we can take good care of them.

—Married man, Adeoyo Yemetu, Ibadan, Oyo State

The data suggest that fatalism and religious beliefs, as well as fear of “infertility,” sometimes discourage planning on family size. However, these beliefs were less prevalent, and only a minority expressed their thoughts on these issues openly.:

Some will mock you, and tell you that in the Bible, God said you should give birth to many children.

—Early adopter, Mkar, Benue State

Despite popular support for limiting family size, many study participants considered a family of two children to be inappropriate. Such families were often looked upon with suspicion, and the parents' motives for maintaining such a small family were suspected. Some accused them of deviating from the norm and trying to imitate “white people”:

It is only white people that give birth to two children, they will look at you and say you want to be like the white and your mother-in law will not like you. You will be left alone.

—Early adopter, Makurdi, Benue State

Such couples were also alleged to be “misers,” “crazy,” or “poor” and hence incapable of looking after larger families, although a few associated them positively with the “educated” and “rich”:

Some rich people don't give birth to more than two kids so as to train them well.

—Lapsed user, Adeoyo Yemetu, Oyo State

Moreover, in such scenarios, while the man may be accused of being lazy, greater blame and suspicion falls on the woman. The state of the woman's health and her motives become the subject of gossip in the community. A woman often is suspected of being barren or is accused of promiscuity, pointing to the existence of a sexual double standard and gender norms that negatively affect women:

They may be of the opinion that because the wife wants to start prostitution, that is the reason why she stopped having more children after the two.

—Early adopter, Apata, Ibadan, Oyo State

The data show a few differences among groups regarding perceptions around ideal family size. It appears that attitudes were somewhat more favorable to families larger than four children in Benue State than in Oyo State. Moreover, in Benue State, study participants from Mkar (the

poor community) were more likely to state a preference for larger-sized families. In contrast, in Oyo State, there were no noticeable differences between the poor and nonpoor communities. In addition, the study did not detect any differences in family size ideals or in the reasons provided to justify specific family sizes between early adopters and the other study groups. Nonetheless, fatalistic attitudes (as evidenced in responses such as “up to God,” “as many as God gives,” and “God is the provider of children and He will care for them”) were less common among early adopters than among the other study participants.

Perceived Causes and Consequences of Having More than the Ideal

Despite strong beliefs around limiting family size and economic considerations, many families ended up with larger families than they desired. Desires concerning the sex composition of the family and fear of child mortality were most commonly cited as barriers to achieving a couple’s goal vis-à-vis smaller family size:

Some will continue to have children because they want a male child. They can have up to six, and there will be many children on ground, and I have seen people that were looking for a male child and have children up to 10, and they are all girls.

—Lapsed user, Adeoyo Yemetu, Ibadan, Oyo State

If any of the children die, you can decide to have more children.

—Lapsed user, Mkar, Benue State

In addition, lack of knowledge about FP and religious beliefs were also seen as among the causes of having more than the ideal number of children.

Some don’t know how to control childbearing. The nurses have been teaching us about family planning, if they meet the nurses; they will teach them better on family planning.

—Postpartum woman, Adikpo, Benue State

Some people believe that it is God that gives children, so they have as much as possible and they are ignorant of family planning.

—Postpartum woman, Makurdi, Benue State

Knowledge and Attitudes Regarding Family Planning

The data revealed a noticeably high level of awareness about FP methods among the various study groups. Almost invariably, when asked what a couple could do to delay or avoid getting pregnant, the first response in all groups was that they should “do family planning”:

If you don’t want to have more children, your husband can use condom, or you can use any family planning method.

—Early adopter, Makurdi, Benue State

With prompting, the groups then went on to mention specific FP methods. Various FP methods were mentioned across the groups, including modern, traditional, and natural methods. The modern methods most often mentioned included condom, the pill, injectables, and the IUD. The implant, vasectomy, and female sterilization were the least-mentioned methods. The traditional methods frequently mentioned were incisions (therapeutic tattoos, typically done by a traditional herbalist using a blade to make marks on the woman and then rubbing in a herbal mixture), a traditional ring that a woman wears on her finger during

intercourse, herbal concoctions, and a fetish bag that is hung in the bedroom. Participants also mentioned natural methods, including withdrawal and calendar methods.

Most groups viewed the condom, the pill, and the IUD as the methods ideal for spacing and vasectomy and female sterilization as the methods indicated for stopping childbearing. However, there was no consensus about the role of abstinence, the implant, and injectables. Whereas some groups classified these methods as ideal for childspacing, others believed that they should only be used for the purpose of stopping childbearing.

Husband and wife don't want to give birth or they decide to space it, they can see a doctor who will give her injection.

—Postpartum woman, Makurdi, Benue State

If they want to stop childbearing, they can turn her womb or take [an] injection that will last them for up to 20 years [apparent misinformation about injectables].

—Lapsed user, Apata, Ibadan, Oyo State

At all of the sites, awareness about methods was higher among women than among men. As expected, current and lapsed users displayed a higher level of awareness than any other study group. For example, in Benue State, the implant was mentioned only by current and lapsed users. Early adopters from Adikpo (Benue State) made the distinction between an internal method (specifically, the IUD) and an external one (specifically, the implant).

Data from pile-sorting shed further light on community understanding about the methods. Figures 1 and 2 present results for poor and nonpoor communities in Benue and Oyo states. In all study communities and for all study groups, the participants tended to group male and female sterilization together and very distinctly from the other methods. Knowledge about the methods appears to be better in the nonpoor communities than in the poor communities. In Oyo State, the participants from the nonpoor communities distinguished between the short-acting and the long-acting methods in their pile-sorts. In addition, the participants from these communities tended to see the condom as distinct from other methods. In contrast, participants from the poor community did not distinguish between the short-acting methods and the long-acting methods.

Figure 1: MDS of contraceptive methods—Oyo State

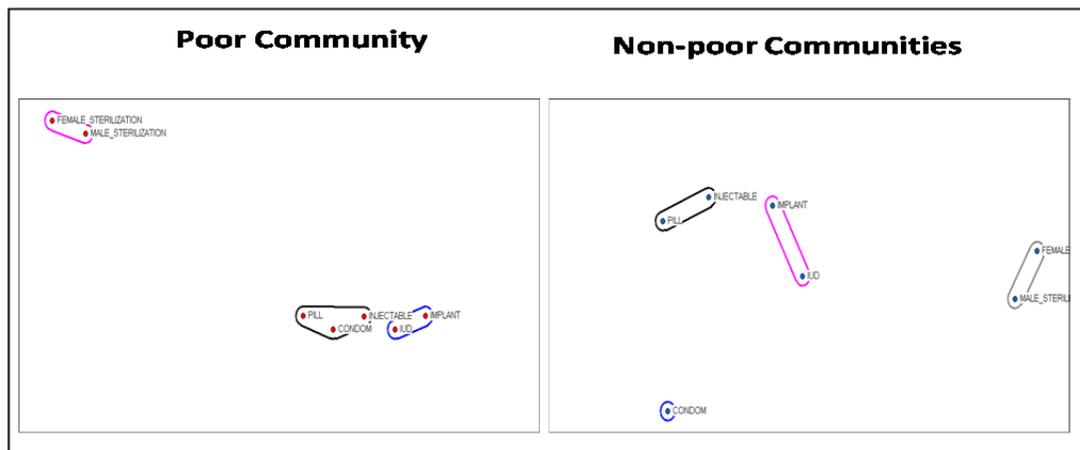
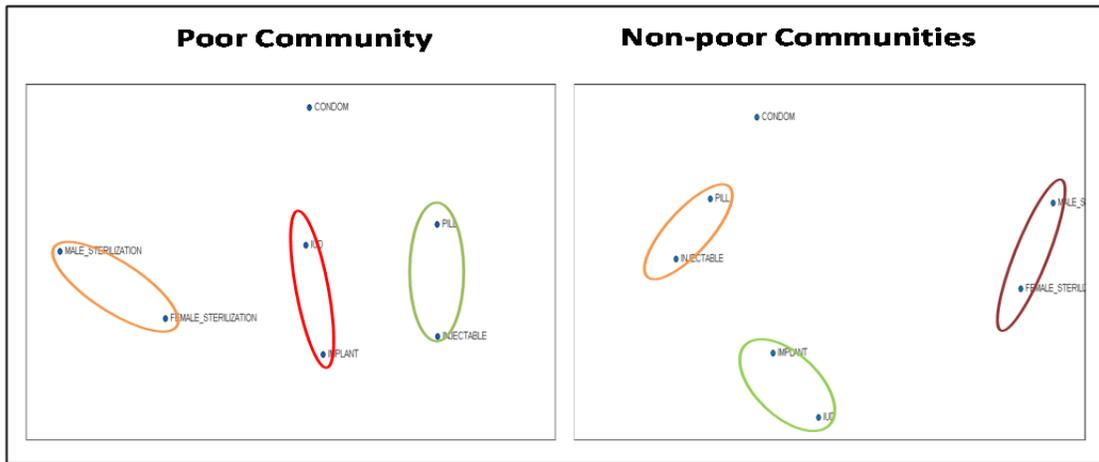


Figure 2: MDS of contraceptive methods—Benue State



In Benue State, participants from both the poor and the nonpoor communities placed the long-acting methods close together. They also placed the pill and injectables close together and the condom apart from all of the other methods. However, participants from the nonpoor communities in this state tended to make a greater distinction between permanent methods and the other methods.

There was significant concern about modern FP methods among the study groups. Some believed that couples should not use an FP method early in their childbearing years because of the risk of infection, which may interfere with childbearing:

Some people if they do family planning early, it will cause some infections, some infection that can stop partners from giving birth to as many as you want.

—Early adopter, Mkar, Benue State

Some also feared that FP methods were not always effective.

I know of a family that wants to stop childbearing. After going to the hospital for family planning, the wife still took in and gave birth. In this case, are we going to fault the doctor or other health personnel there or that family planning does fail?

—Married man, Apata, Ibadan, Oyo State

Desired Attributes in a Method

Participants had a range of expectations for contraceptive methods. A major attribute that participants highly desired was lack of side effects. In essence, potential clients look for a method that “suits their body” and has minimal side effects:

If they say there is one that doesn't cause headache or body ache, I will do it. If they say that it is good and it goes well with their body, we can do it.

—Postpartum woman, Apata, Benue State

We will go to hospital and they will explain all and their side effects and we will choose the one that doesn't have much side effect.

—Postpartum woman, Makurdi, Benue State

Service providers echo this concern about side effects. Some of the service providers interviewed explained how clients came to the clinic specifically asking for a method that will not harm them. According to the providers, some clients request a method that does not have any side effects. Learning that most methods have some potential side effects, clients are likely to settle for a method with minimal and easily managed side effects.

Not surprisingly, people were comfortable opting for methods they had either used themselves or seen others use over the years and knew to be associated with minimal side effects. Familiarity with a method was often a reason for preferring that method. For example, men preferred condoms because of their familiarity with the product and its ease of use. Similarly, some women felt that the implant would have been a preferred method if people were more familiar with its advantages.

Moreover, methods introduced recently were often viewed with suspicion, with individuals often looking for others to take the lead and start using the product before they would try it. In the words of a lapsed user from Makurdi:

Because injection is one of the family planning methods that people are aware of, but the new ones are still scary to them. They will want others to try it first and see what comes out of it.
—Lapsed user, Makurdi, Benue State

Often, counseling from health professionals about specific methods was not enough, and many discussants liked to consult early adopters about their experience with specific methods. A lapsed user expressed her sentiments in this way:

If there is someone we know in the community who is using the method without side effect, we can decide to do it also.
—Lapsed user, Adeoyo Yemetu, Oyo State

A method's effectiveness as well as its duration were also important considerations. Most women who came for FP services were already determined to avoid another pregnancy and were looking for a method that would enable them to achieve this objective. Service providers explained that some of the women who come for FP have already experienced one or more induced abortions and are determined to avoid another unwanted pregnancy:

I have enough children and I want the one that will last longer, that is why I chose this one, it lasts longer.
—Early adopter, Adikpo, Benue State

One quality they are looking for is how the method will work and how effective it will be to prevent them from getting pregnant. The major problem we have observed in this community is that about ... 8 out of 10 women that come for family planning have experienced abortion ... they wouldn't want to have that experience again, so they are looking for the effectiveness of the method.
—Service provider, Mkar, Benue State

In addition, given the importance of children in the communities, a method that allows a quick return to fertility was highly desired. In the words of a lapsed user:

Like the implant, if they tell me about it and that if I use it for maybe five years it will not affect me and that if I want to be pregnant again they can remove it, then I can choose the method.
—Lapsed user, Mkar, Benue State

Protection from STIs was another consideration for some individuals, but not for all. Men were often more vocal about this consideration. In the words of a man from Adikpo:

Like me, is condom that I am used to because it prevents diseases.
—Married male, Adikpo, Benue State

Women often favored a contraceptive method that they believed would enhance their appearance, either by making them younger looking with radiant skin or by increasing or decreasing their weight. It should be said that women do not like a method that makes them either too fat or too thin. Observing the beauty-enhancing effects of a method on a woman may make other women opt for that method:

If some women take the injection, they will be beautiful and neat, so that when you see them, you will say this particular one is the best.
—Postpartum woman, Mkar, Benue State

For that injection, why I did it is because I saw some friend that do it and was fat, and my husband has been complaining about my stature, I did it to be fat, but instead of getting fat, I just keep on getting slim.
—Lapsed user, Onianrin, Oyo State

In contrast, negative remarks about the appearance of a woman who has just adopted a method may make the woman decide to abandon the method. A service provider told the

Weight fluctuations associated with a method are enough of a reason to decide to abandon a method.

Around four months ago, we had a client, she came in frowning her face, she wouldn't smile, I tried to make her smile, but she said "just come and remove this thing." I said why, she said she is now too thin and everybody is saying it also... Then I sat her down and educated her in the mode of action of the family planning methods and I begged her that she should give it one month and after then she can come for the removal. I told her to listen to me, that what I will do now is to look for the one that we have removed from another woman and put it inside nylon, then you will take it home and show all the people that said you have done rubbish family planning that you have removed it. After four weeks of showing them, come back and tell me, and on that day [if you still want to] I will remove it. The next visit, she came and told me that they were now pulling her cheeks that she is fine now, that she is beautiful. I said so from now on, keep your lips sealed, do not tell them you have any family planning, and till now she is still doing fine.
—Service provider, Apata, Ibadan, Oyo State

story of one of her clients who almost abandoned IUD use due to remarks about her weight from people around her (see Box). The story illustrates the challenges that providers face when working with a predominantly low-literacy population in an atmosphere permeated with myths and rumors about contraceptive methods. It also shows the tactics (not always commendable) to which providers have recourse when dealing with such situations.

Some other attributes that participants favored were easy accessibility and not having to return several times to the health facility. Service providers shared how long-acting methods are often preferred

because women do not have to travel to health facilities as often, especially women living in remote areas. Methods that help to save time and minimize repeated travel to the health facility are likely to be preferred by some clients:

Like some of them will say because of the time factor, they come to the hospital, they go for two, three months, they are not there, they come after, they want to take the injection, but if they are taking oral pills and they forget and have intercourse with their husband.... So because of that they don't want to take pills or other methods.

—Service provider, Mkar, Benue State

It's because ... some of them don't have the time to come to the clinic often, they say they want to come to the clinic maybe once in six months or once in one year, so they prefer IUD majorly, except those that don't want their husband to know, those are the ones who are taking injectables.

—Service provider, Oniyanrin, Ibadan, Oyo State

In addition, the study participants particularly appreciated a method that does not interfere with intimate relations. Some participants gave this desire for noninterference with sexual intercourse as a reason for not liking the IUD and for preferring implants and injectables. For example, in describing her reasons for preferring implants, a woman explained that it is important to her that the method does not get in the way of sexual relations with her husband:

Because it is easy to carry about, it is not too expensive, and it can last for years, it doesn't disturb anything sexual activities. If you put it, it is on the arm, there, you can have sex as much as you want and it will not disturb the man. So I think men like it most, and woman too.

—Lapsed user, Adikpo, Benue State

Discreetness of use is another factor that participants mentioned as a desirable quality in an FP method. This is particularly important for women who are covertly using a method without the knowledge and approval of their husband. Service providers explained that the desire for discreet use was a major reason that some women choose to use injectables and one that may also make implants appealing for many women, once this method becomes easily available:

Obviously women use injectable mostly. Most women will go on injectable because they think it's confidential. If you take injection, nobody will know if you are using a method or not... Recently, with the availability of this Jadelle [an implant], a lot of women are coming for it, but it's not everybody.

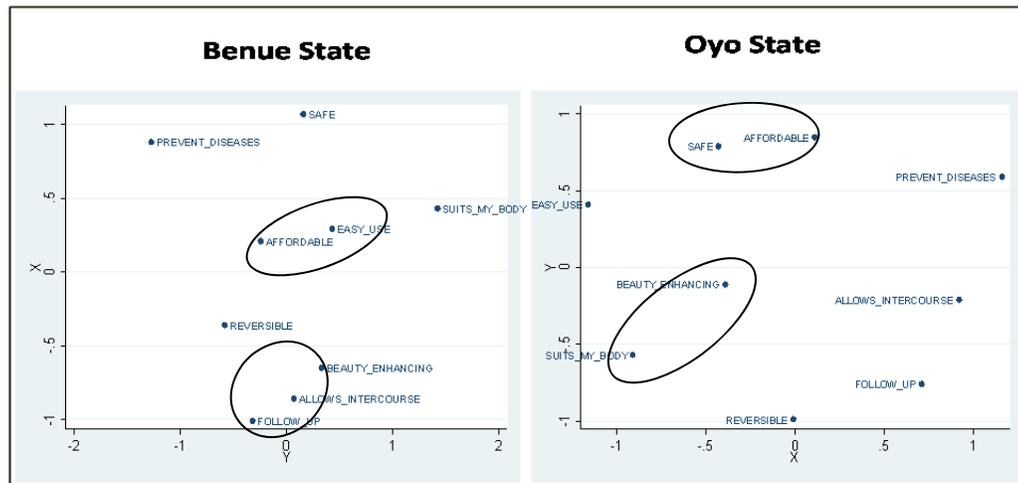
—Service provider, Mkar, Benue State

In general, motivations to use LA/PMs include the perception that one had had enough children and the desire to “rest” and not have another child for many years. In other words, the women using LA/PMs see the methods as a way of meeting their need to stop childbearing or put a long interval between births.

Data from the pile-sorts provide an interesting perspective on the attributes that potential and actual users consider important in choosing a contraceptive method. The data (shown in Figure 3, page 19) indicate that there were differences between the two study states in the ways in which study participants conceived desired attributes of contraceptive methods. In Benue

State, people associated two themes with desired attributes: (1) the collateral benefits (“beauty-enhancing,” “not interfering with intercourse,” and “allowing adequate follow-up”), and (2) tangible and intangible costs (“affordable” and “ease of use”). In Oyo State, the picture is less clear, but it appears that desired attributes are linked with collateral benefits and safety.

Figure 3: Qualities considered key in method adoption



Perceptions about LA/PMs

The Implant

In Benue State, there is relatively limited familiarity with implants, particularly among nonusers in Makurdi and Adipko (Benue State), where the method was not available at the time of the research. Relatively few women at these study locations in Benue State were aware of the method:

For me, I am hearing of it for the first time.
—Postpartum woman, Makurdi, Benue State

This match type of family planning is new, so we are not that familiar with it so much, but we know that it is effective.
—Lapsed user, Adikpo, Benue State

Study participants from Mkar, as well as early adopters and a few lapsed users from the two other study locations in Benue State demonstrated some level of familiarity with the method. These women were able to describe the implant and were aware that it is effective until its expiry date or until it is removed. Most early adopters in Mkar were currently using the implant. A few other early adopters in Benue had actually used the method in the past but had abandoned it due to side effects.

In Oyo State, awareness about the implant was rather limited across most groups. A few people had heard about the method but were not very familiar with it:

We don't know it [implant] but have heard about it, they said it use to last longer like five years.
—Early adopter, Apata, Ibadan, Oyo State

Given the low level of familiarity with the method, it is probably not surprising that there is a lot of misinformation about it. For example, a few participants who had heard about the method were not sure where exactly the device is inserted:

The implant can be the one they put in the arm or in the vagina.

—Lapsed user, Yemetu, Ibadan, Oyo State

Moreover, the belief that the implant is only for women who were done with childbearing was very common. Incidentally, some participants mentioned service providers as the source of this misinformation:

When I was in Jos, when I gave birth to my first child, my husband asked me to go and do it and I told him it is good for only women who have finished giving birth, so when we went to the hospital my doctor told us that it is good for those women that no longer want children.

—Postpartum woman, Makurdi, Benue State

The method is perceived to be associated with several side effects. Most of the perceived side effects were attributed to the experience of an acquaintance or friend who had used the method or to what participants had generally heard about the method. The following contribution by a postpartum woman in Makurdi aptly illustrates the role of vicarious experience in helping people form views about the side effects of implant:

I have a friend that put it in her arm, since the time she put it she don't see her menstruation.

—Postpartum woman, Makurdi, Benue State

There was some concern that the method makes women gain or lose weight excessively. It was not uncommon, during the FGDs, for someone to report that they knew a woman who had to have the implant removed due to weight gain or weight loss.

They said it makes one to be thin.

—Lapsed user, Apata, Ibadan, Oyo State

I don't know that one, but the bad thing about it is that it makes the woman fat.

—Married man, Mkar, Benue State

Nonetheless, the participants recognized some of the advantages of the method, including its effectiveness, the fact that it can be used discreetly, and the minor nature of associated side effects. Incidentally, the perceived advantages of the method were generally based on what they heard from satisfied users:

Someone told me that she was using the injectable at first, but it came with different aches and sicknesses for her, so she had to change to implant, and since she has done the implant, there has been no pain or sickness. She also told me that immediately [after] she removed it and had intercourse with her husband, she became pregnant.

—Postpartum woman, Yemetu/Adeoyo, Ibadan, Oyo State

And it is more comfortable ... because as they put it under the arm, there is no disturbance like the other one that we are talking of infection and all that but not on this one.

—Lapsed user, Adikpo, Benue State

Study participants generally rated the implant better than short-acting methods and the IUD. Compared to the pill, participants preferred the implant because it does not require remembering to take tablets daily. Condoms are believed to be liable to burst and therefore are believed to not be as effective as the implant. Injectables are thought to have too many side effects and to not be as safe as the implant. The implant is considered better than the IUD due to the belief that the IUD may make a woman susceptible to infections:

Like the injection method, people will say it makes them look like they are pregnant with twins, the one on the private part they will complain that it disappears inside the woman; the one that they fix on the arm, there is nothing vanishing inside the woman, stomach ache, pain, it is very easy.

—Postpartum woman, Oniyanrin, Ibadan, Oyo State

Participants in the pile-sorting exercise who were familiar with the implant were asked to rate the method for safety and effectiveness. The data showed that many (45/70) of the participants in Benue State and most (62/77) in Oyo State rated the method highly (a rating of 6 or 7 out of 7) on safety. In Benue State, there was no significant difference in the safety rating of the method between poor and nonpoor communities, but early adopters were more likely than the other study participants to rate the method highly on safety. In contrast, women from the poor community in Oyo State tended to rate the implant higher on safety than did their peers from the nonpoor communities, but there were no differences in safety ratings between early adopters and other participants. In terms of effectiveness rating, there were no significant differences by poverty status or between early adopters and the other participants in Benue State. In contrast, in Oyo State, early adopters were more likely than other participants to rate the implant high on effectiveness.

The IUD

The IUD is relatively well-known among the study participants. It is typically referred to as the “coil” in Oyo State and as the “rubber” in Benue State. Most study participants were familiar with the device and were able to describe it:

It is inside nylon, when you remove it, it looks like a T shape and it has a tail.

—Lapsed user, Adikpo, Benue State

Nonetheless, one early adopter admitted that although she had an IUD inserted, she had never seen the device before:

I have used it [before]... but I don't know how it looks like because I did not see it.

—Early adopter, Makurdi, Benue State

The perceived advantages of the method had to do with its long-acting properties, its effectiveness, the fact that it does not interfere with menses, a woman's prompt return to fertility upon its removal, and its minimal side effects, such as weight gain.

It is very effective. If it is not removed, then there can't be any pregnancy.

—Postpartum woman, Apata, Oyo State

If a woman is using it, the woman will not be too fat, because it does not make her eat much like other methods.

—Lapsed user, Makurdi, Benue State

A few participants understood that the side effects of IUD were not serious and were easily resolved:

Coil do change one's system initially, it causes heavy flow during menses and also cause pain in the lower abdomen that will be suppressed by Panadol extra.

—Lapsed user, Yemetu/Adeoyo, Ibadan, Oyo State

Nonetheless, there were concerns about the IUD, and respondents had a lot of misinformation about it. Myths and rumors abounded regarding the effectiveness of the method and its side effects. For example, a few participants were confused about the part of the body in which the IUD is inserted, while some believed that it could cause cervical infection (especially if the woman does not practice good hygiene, referred to by the respondents as not being neat), cancer, or high blood pressure. A few others believed that the IUD could lead to weight gain and excessive bleeding or amenorrhea. Others were concerned that since the device is artificial, the body may react to it in some unspecified ways.

There is also the widespread belief that IUD may harm the man during intercourse.

The bad thing is for anybody that is using that rubber [IUD] is that, if the person is not neat, she will quickly contract infection, and the infection can damage her womb.

—Postpartum woman, Makurdi, Benue State

Sometime the woman will see her menstruation twice a month. Anytime man is making sex with the woman he will be feeling the rubber [IUD].

—Married man, Adikpo, Benue State

Another common concern about the IUD is its association with stomach or waist pain. This side effect was mentioned in many groups, including among current LA/PM users.

The woman has problem of stomach pain.

—Married man, Adikpo, Benue State

What I know about IUD is that when people do it, they complain too much. So it frightens me, because they complain about stomach ache every time, but they do tell them to use tetracycline with flagyl every time, and I can't take drug every time, some people also bleed.

—Lapsed user, Oniyanrin, Ibadan, Oyo State

Curiously, many participants in both states cautioned that users of IUD should stick only to their husbands in order to avoid contracting STIs and to prevent method failure. The idea that the IUD is not for women who engage in sexual relations with multiple partners was mentioned in almost all of the groups. Indeed, most participants believed that the IUD, made the user more prone to infections than are users of other nonbarrier methods.

If you put the rubber [IUD], you can't have fun with any man except your husband, so that the rubber [IUD] won't have problem like sickness.

—Postpartum woman, Adikpo, Benue State

When I first did it, they said it will not allow me to be pregnant only if one is faithful to her husband and not have extramarital affair.

—Early adopter, Oniyanrin, Ibadan, Oyo State

Many participants attributed the belief that IUD users were more prone to STIs to what they were told by service providers. Interviews with service providers actually revealed that many service providers held this belief. The belief that the IUD increases the risk for STIs was given by some service providers as a reason for not recommending the method for women who are in a polygynous relationship or who might be unfaithful to their husband.

Some of them when they put the IUD, they complain of vaginal discharges, and you know with IUD on, you will not be able to move around too much and it is not good to have multiple sexual partners, so some of the women are scared of IUD.

—Service provider, Adikpo, Benue State

[There are some clients I will not give IUD to] like a woman in a polygamous family because if there is an infection, it will go round the family, and they can't stay with it. I won't give women that are not neat because of infection, and also women that are not faithful to their husband.

—Service provider, Makurdi, Benue State

Lack of trust in relationships and dynamics concerning socially accepted gender norms may be some of the factors fuelling the pervasive belief that the IUD makes women more susceptible to STIs and is less effective in extramarital affairs. A discussant in Adikpo provides a possible explanation:

And some men, if they realize that it will prevent their wife from moving from one man to another, they will take it, because they will not like their wife to be moving from one man to another. If the service provider there says that you should stick to your husband, the person will like it.

—Postpartum woman, Adikpo, Benue State

Another common view is that the IUD tends to become dislocated and get lost in the abdominal cavity, thereby causing complications for the woman. According to some participants, if the device shifts into the abdominal cavity, it will require a major surgery to remove it.

Sometimes when you make love, the man's penis might push it inside your stomach and it may start itching and it also brings out water from some people's vagina.

—Postpartum woman, Mkar, Benue State

There were also some concerns about the IUD's lack of effectiveness. The fear about effectiveness is linked with its perceived ability to shift position in the womb.

Another thing is that, the rubber [IUD] is not hundred percent effective, at times, the woman might put it and it will leave its position so if it leaves its position, and the woman did not know, if she now meets a man, she can be pregnant.

—Postpartum woman, Adikpo, Benue State

Some believed that the IUD requires surgery to insert and remove, an attribute that makes it less than desirable. In Nigeria, people view surgery as risky and something that should be allowed only as a last resort.

I don't like the coil method because it is usually inserted by operation and will need another operation to remove it, if the woman is not strong healthwise, it may lead to her death.

—Married man, Apata, Oyo State

Most of the participants' concerns about the IUD were due to lack of knowledge about the method. It is therefore probably not surprising that most of the concerns and misinformation about the IUD came from postpartum women and lapsed users in all locations and from early adopters in the poor communities (Mkar in Benue and Adeoyo/Yemetu in Oyo State). By and large, early adopters of LA/PMs (regardless of the method they were using) were more knowledgeable about the method and had more favorable attitudes toward it than women in the other study categories. In addition, knowledge about the method was generally higher in Oyo State, where the method is more commonly used.

FGD participants were asked to compare the IUD with short-acting methods, such as the condom, injectables, and the pill. Most participants rated the IUD better than the pill or injectables. According to them, the IUD is more convenient to use and does not require remembering to take a pill on a daily basis or returning to the health facility every two or three months for an injection. The IUD was also perceived to be more effective and have fewer side effects than the other two methods.

The tablet makes some people fat and makes them to see irregular menstruation, but IUD for the people that use it don't give complaint of any problem.

—Postpartum woman, Makurdi, Benue State

What I know is that if it is well inserted, it will be better than injection or tablets. One can easily forget the tablet or injection but the coil method [IUD], once it is inserted, [that is it].

—Married man, Apata, Ibadan, Oyo State

For some study participants, the preference for the IUD was based on personal experience with the other methods. Some participants had experienced serious side effects while using the other methods, which had made them discontinue use.

I prefer IUD to pills, because pills caused me to have hypertension.

—Early adopter, Mkar, Benue State

Injection disappointed me, but since I have done the coil, I have my peace.

—Early adopter, Oniyanrin

Only a few participants rated the IUD lower than other methods. The main reasons advanced for this attitude were that the IUD made women prone to infections and might cause pain.

As for me, I like condom because it won't make me have any infection, unlike IUD, that makes one bleed and have infection.

—Lapsed user, Mkar, Benue State

The pile-sorting and ranking data showed that in terms of safety, the IUD was more highly rated in Oyo State than in Benue State. Curiously enough, in both states, participants from the poor community tended to give the method a higher safety rating than did their peers from nonpoor communities. In Oyo State, early adopters gave the IUD a higher safety rating than did the other participants. In contrast, there were no significant differences between the early adopters and the other participants in Benue State.

The same pattern was found for the perceived effectiveness of the method. On average, study participants rated the IUD higher for effectiveness than for safety. In both states, there were significant differences in effectiveness ratings by poverty status, with participants from poor communities being more likely than their peers from nonpoor communities to rate the IUD highly on effectiveness. In contrast, whereas in Oyo State early adopters were significantly more likely than the other participants to rate the IUD highly on effectiveness, there was no difference between the two categories of participants in Benue State.

Female Sterilization

Female sterilization was often referred to as “turning the womb,” “tying the womb,” and “removing the womb.” Three of the participants in Benue State had undergone the surgery, but none of the participants in the other locations had used the method.

There was some level of misinformation about the method among the participants. For example, what the procedure entailed was not clear to most participants. For some, it entailed actually removing the womb, tying it somewhat, and putting it back in place. Others believed that the method involved turning the womb upside down.

Some participants believed that if a woman has not given birth to all of the children in her womb, female sterilization could make her sick.

That one [female sterilization] they said if you do it, and you are not up to age or still have children in your body, it may lead to sickness.

—Early adopter, Makurdi, Benue State

Most participants understood that female sterilization is for women who no longer desire to have additional children. The method was generally perceived to be very effective. One woman in Adikpo, Benue State, described it as the “most powerful method of stopping child birth.” Some participants articulated some advantages of female sterilization, all tied to its highly effective nature: peace of mind, no more worrying about unwanted pregnancies, looking smart and young, maintaining marital harmony, and living longer.

You will not conceive again, you are just to enjoy yourself. The stress of taking drugs every day is not there again, the fear of IUD dropped inside will not be there.

—Postpartum woman, Makurdi, Benue State

The advantage is that it helps to prolong your life.

—Postpartum woman, Apata, Ibadan, Oyo State

However, a few people thought that the method could fail, a fact that they attribute to lack of skill on the part of providers.

... Some people will do it and later you will see that the woman has taken in again, if the womb is not tied very well, the woman will take in again... if you tie it, it may be some time later, the woman will be pregnant and you will do it again.

—Lapsed user, Adikpo, Benue State

[I know] someone that did it but later got pregnant in her fallopian tube and they had to operate on her; there is serious problem there.

—Lapsed user, Onianrin, Ibadan, Oyo State

In general, selection of sterilization was perceived not as one that a woman makes out of choice, but as a last resort when another pregnancy could threaten her life and when other methods have failed.

Maybe if she goes for other methods it will affect her or if she gets pregnant it will cost her life, so they want permanent solution, or it can be because the woman use to deliver through operation so they will prefer this method.

—Postpartum woman, Makurdi, Benue State

Most participants were not in favor of the method, particularly because of its irreversibility. Many believed that a couple with no medical issue should not consider the method until they have had many children, the woman is nearing menopause, and the man is very old. There were concerns that some of a couple's children could die and they may see the need to replace them. Other arguments given for not favoring female sterilization included situations (e.g., divorce or death of a spouse) in which the woman remarries and desires to have another child with her new husband or in which a man may become rich and want another child.

Then maybe you have three children and you lost one, remaining two, and you feel that you are still young and want to conceive again but with the method of tying of womb, you cannot do so again.

—Lapsed user, Makurdi, Benue State

Study participants associated female sterilization with a number of side effects, including excessive weight gain or loss and stomach problems (thought to be due to the fact that the woman “still has children in her womb”). Some participants claimed to have learned about the link between incomplete fertility and side effects of female sterilization from a health provider.

After the operation, some may have stomach upset. If they go back to the hospital, the doctor will tell them that they still have more babies in their womb, that is why the stomach upset occurs.

—Post-partum woman, Mkar, Benue State

Since female sterilization involves surgery, the fear that something could go wrong during the procedure, leaving the woman maimed or dead, is pervasive. The perceived high monetary cost of the procedure and the long recovery period were other perceived disadvantages of the method.

A few study participants believed that female sterilization was preferable to short-acting or long-acting contraceptive methods. The only reason given by these study participants had to do with its perceived effectiveness and the attendant peace of mind it provides. The data suggest that the belief that female sterilization is preferable to other methods was more prevalent in Benue State, particularly in nonpoor communities, than in Oyo State.

People can forget to take the pills, so the turning of the womb is better.

—Early adopter, Makurdi, Benue State

As men do not like condoms, the best thing to do is to get a reasonable number of children and tie the womb to enjoy your life again. Condom causes pain and can burst.

—Lapsed user, Makurdi, Benue State

For most participants, female sterilization did not compare favorably to any other method. The main reasons advanced for this position were its permanent nature and perceived associated complications.

I have seen the woman they turn her womb but after they turn it, she became lame and later she died, and I have seen two people who were affected by the turning of womb, so I prefer the tablet.

—Postpartum woman, Makurdi, Benue State

Data from the pile-sorting and ranking confirmed that female sterilization was generally perceived to be very effective. Participants from Oyo State were more likely than those from Benue State to give the method a high rating (6 or 7 out of 7) on effectiveness. There was no noticeable difference in effectiveness rating by poverty status or between early adopters and the other participants in either state. The pile-sorting and ranking data also confirmed that people had concerns about the safety of female sterilization. In contrast to its generally high rating on effectiveness, many participants rated female sterilization relatively low on safety. In Benue State, there were no differences in the method's safety rating by poverty status or between early adopters and the other participants. In contrast, in Oyo State, there were no differences between early adopters and others, but participants from the poor community were considerably less likely than their peers from the nonpoor communities to rate the method highly on safety.

Male Sterilization

Awareness of male sterilization was very low across all the study groups. Some admitted that they were not at all aware of the method. By and large, male sterilization appears to be the least known of the LA/PMs.

I don't know that they normally operate a man to prevent him from impregnating a woman.

—Postpartum woman, Apata, Ibadan, Oyo State

... it is the first time that I am hearing that man is also treated as a goat.

—Married man, Adikpo, Benue State

Most of those who were aware of the method had misconceptions about it. For example, some believed that the method involved giving a man some injection to “kill off the sperm.” A few others believed that it involved tying the man's penis in much the same way as the woman's womb is tied or removing the testicles.

It is an operation for man that they will tie their penis as they do tie woman's womb, there is something they tie in the penis.

—Lapsed user, Makurdi, Benue State

However, some participants believed that male sterilization is a riskier procedure than female sterilization:

It is riskier than that of women; it can even lead to death.

—Married man, Oniyarin, Ibadan, Oyo State

Some believed that a man who had undergone male sterilization would not be able to satisfy a woman sexually, thereby causing marital infidelity and disharmony. A few participants likened

male sterilization to castration. Others were of the opinion that such a man will not be able to ejaculate or even have any desire for sex.

Male sterilization is not good; people say that it doesn't give any satisfaction, and the man will not have the strength to please his woman.

—Early adopter, Adipko, Benue State

The disadvantage is that the man will be like a living dead; his manhood will no longer be as strong as before.

—Lapsed user, Yemetu/Adeoyo, Ibadan, Oyo State

Like female sterilization, male sterilization is considered a last resort suitable only in cases when the woman is not able to use any other methods, when the woman's health may be adversely affected by another child, or when the man is at least 70 years old and already has many children and grandchildren.

It may be because all family planning methods [do not] work for the woman, so husband will go and tie his own organ based on their agreement.

—Postpartum woman, Makurdi, Benue State

There was little doubt in the minds of the participants that the method is highly effective. “*Rest of mind*” was an expression often used by participants in connection with male sterilization. Many participants appreciated that sterilization would allow the couple to have sexual intercourse without worrying about pregnancy. Some participants saw it as a way of preventing out-of-wedlock children.

The advantage is that if he has a girlfriend outside, he won't be able to impregnate her, and the wife's mind will be at rest that he won't bring any child from outside.

—Lapsed user, Apata, Ibadan, Oyo State

As in the case of female sterilization, the perceived irreversibility of male sterilization was a major source of concern among study participants. Male sterilization was perceived as an extreme measure because it does not allow for a change of mind. Participants gave several scenarios that might necessitate the couple to revisit their decision, including improved economic conditions, death of children, and death of the spouse and later remarriage.

Some time back, there was one man who did it in my area, he had two children, and he wanted more children, he started disturbing his wife and later says he will marry another wife, that is how problem started for their family. At times, if they say they will go back (reversing it), it is a problem, it causes disturbance in the family.

—Lapsed user, Adikpo, Benue State

The nonpermanent methods were generally preferred to male sterilization, due mainly to the nonreversible nature of male sterilization.

To me, the tablet is better, because anytime you want to give birth, you stop taking tablet, but for the tying of man organ, it can lead to impotency.

—Postpartum woman, Makurdi, Benue State

Data from the pile-sorting and ranking confirmed the information from the FGDs. Most participants in Benue State (87%) and almost all participants in Oyo State (98%) rated male sterilization high on effectiveness. There was no significant difference in effectiveness rating by poverty status in Oyo State, but in Benue State, women from the poor community appear more likely than the others to perceive that the method is very effective.

As in the case of female sterilization, many participants in both study states (45%) did not perceive male sterilization to be very safe. In Oyo State, perceptions about the safety of the method did not vary significantly by sex of the participant or between early adopters and other participants. In contrast, participants from the poor community (36%) were considerably less likely than those from the nonpoor communities (72%) to perceive that the method was very safe. In Benue State, there were no significant differences by poverty status or between early adopters and the other participants.

Perceived Norms about FP Use

Perceptions about Preferred and Commonly Used Methods

Study participants had varying perceptions of the most popular contraceptive methods in their communities. The methods that were perceived as most commonly used varied between study states as well as across communities within the same state.

Oyo State

In Apata, while postpartum women viewed the IUD, implant, and injectable as the most popular methods, the lapsed users saw the pill, condom, and injectables as the most commonly used. Men, on the other hand, believed the condom to be most frequently used in their community, because it was “cheap” and prevented STIs. According to service providers, most clients come to the clinic asking for injectables. The providers explained that injectables are believed to be a discreet method and some women wanted a method they could use covertly without their husband’s knowledge. After counseling, however, most of these clients settled for the IUD.

People in this area prefer the IUD and injectables; those are the two that they do go for. During counseling, they prefer the injectables mostly. But on the day of examination we counsel them more and some will now go for the IUD.

—Service provider, Apata, Oyo State

Service providers in Apata also shared that there is a growing demand for long-acting methods and mentioned that lately, implants were gaining popularity, although they were not easily available.

Some women do specifically come for implant, so far we tell them we don’t have it here, that they should go to another place, some will go and some will say no ma, I am not going, I want you to give me the ones that you have here, and then we use to give them what we have.

—Service provider, Apata, Oyo State

In Adeoyo/Yemetu and Oniyanrin, the condom and injectables were the most preferred methods. However, according to service providers, most of their clients at the two sites were

moving away from injectables to IUDs and implants, because of the counseling provided by service providers, as well as the fact that these methods were now available practically free of cost. In the words of a service provider:

Majorly, people come for the IUD... followed by the injectables; now that the implant is free, I think since June, people have started opting for it, since it lasts longer and that one too is easily reversible and then return to fertility is high, so I think because of finance they have not been choosing that method but since June I think we have started recording cases of clients asking for it.

—Service provider, Adeoyo Yemetu, Oyo State

Benue State

In Makurdi, according to the postpartum women, the IUD and condom were the most commonly used methods. Lapsed users, on the other hand, indicated that the IUD and injectables were most popular. The men voted for condoms and injectables. According to the service providers, most clients coming to the clinics opted for IUDs and implants.

Because of the economic problem, people prefer the implant and IUD, and also because of the long-acting period, nobody wants to give birth to plenty children again.

—Service provider, Makurdi, Benue State

In Adikpo, postpartum women considered the condom to be the most popular method, whereas lapsed users listed condoms, pills, injectables, and female sterilization as the commonly used methods. Men, on the other hand, thought that both condoms and injectables were the most popular. Service providers, however, confirmed the popularity of injectables, and more recently implants. In their opinions, clients preferred these methods because, in the case of injectables, the method is easy and discreet to use, and in the case of the implant, it is a long-lasting method.

As at now, what they prefer most is injectable and the new implant. Most of them run away from the pills because they are traders and can forget to take it. Generally, they are very poor at taking drugs, so they prefer the injections that will come once in two or three months.

—Service provider, Adikpo, Benue State

In Mkar, condoms and injectables were seen as the most popular methods among community members. On the other hand, service providers reported that they serviced the majority of their clients with the IUD and the implant.

The IUD, this is because it is a long-acting method, most especially the married women and some of them the Jadelle.

—Service provider, Mkar, Benue State

Barriers to the Use of LA/PMs

Participants identified several barriers to the use of modern contraceptive methods in general and to the use of LA/PMs in particular. The barriers mentioned ranged from fear of side effects, lack of knowledge, and cultural and religious beliefs to gender dynamics and relationship insecurities.

Fear of side effects associated with specific methods, coupled with a lack of adequate knowledge, was an important barrier to use. These factors encouraged many couples to opt for the more familiar natural or short-acting methods, as opposed to LA/PMs.

While some fears associated with specific methods were based on actual experience, often people had misguided notions because of a lack of information. Particularly damaging are myths and rumors about side effects. A previous user who has a negative experience can help spread misinformation about methods and foster negative attitudes toward them. For example:

Their friend can confuse them that they should not take IUD, the thing has happened to my friend, so all those, what they are hearing out there can confuse them from choosing the method, maybe one person has had a problem with it before, maybe one of their friends got pregnant with the IUD, that thing can confuse them or maybe the thing expelled, it can confuse them from using the method.

—Service provider, Adeoyo Yemetu, Oyo State

The influence of peers was particularly strong. Service providers shared how despite counseling, it was often difficult to remove suspicions about specific methods from the minds of potential users. What users learn from people in their peer group about any given method has a powerful influence on their decision whether to continue with a method. In the words of a service provider:

After counseling, they will accept the implant, they go home with it to discuss with their friends and other women, and unfortunately it's not even women that have used the method, they will just listen to their peers talk and then they will come back with it and tell you that they want it removed. So some of them, even though the method is for five years, they come back within one year and say, I want it out. You ask them, do you want to be pregnant, they will say no, but I'm afraid, they are saying this. So it's like all the counseling you were doing for them at the initial time did not even enter their mind. So it's like they are not yet convinced about how effective and how good the method is for them.

—Service provider, Adeoyo Yemetu, Oyo State

Cultural as well as religious beliefs were additional barriers to contraceptive use. Some religious organizations do not allow their followers to use contraceptives, as this is against the tenets of their faith. Other religious groups are not in favor of specific methods. For example, the participants believed that the Catholic Church particularly frowns upon the use of the IUD, equating it with abortion.

For some, it is because of their religion, some churches will tell them God doesn't like it. Like Faith Tabernacle, one of my friends attends there, they don't allow her to take anything, and the Catholic Church doesn't allow.

—Postpartum woman, Makurdi, Benue State

As already noted, pronatalist beliefs, such as that children are “gifts of God,” were very prevalent in the communities, with support not just from religious groups but also from traditional beliefs. In the words of a lapsed user:

Like the villages when you tell them to go for family planning, they will tell you that God says you should give birth, and fill the earth, so they will continue to give birth, and some don't even know that there is anything like family planning.

—Lapsed user, Adikpo, Benue State

Some service providers also had reservations about female sterilization and were often reluctant to recommend sterilization for certain categories of women, including young women and those who do not already have a large number of children.

In this part of the world, you know as Africans we cherish having children. An African woman who ... has come to tell you I want to go on sterilization after counseling ... [you] will still tell her to go and think over it, then by tomorrow you may change your mind, because this is irreversible here, maybe abroad they have been reversing it, but here in this part of the world, in Nigeria, we are yet to advance to the level of reversing it.

—Service provider, Adeoyo Yemetu, Oyo State

Costs associated with contraceptives were not a big part of the discussion among the study participants, perhaps because most contraceptives were available free of cost in public facilities. However, a few service providers discussed hidden costs associated with long-acting methods.

Sometimes we used to have and when we have, we give them free because we are supposed to give free to clients. In as much as we will not just insert it like that with our bare hands, we need to buy gloves and then we pay for gloves. In as much as we need to have sterilized our instruments, they are the one to buy Jik [a bleaching agent], Dettol and tissue papers that we use, and these things are chasing some people away... Some will say please I cannot buy all those things and they will go. That is the only problem we are having with the IUD.

—Service provider, Apata, Oyo State

Gender issues also surfaced in the discussion on barriers to use. Men often acted as major barriers to contraceptive use and suspected the motives of their wife if she desired to use contraception or feared that the method may result in complications. Pressure from the husband may force a woman to discontinue method use against her wishes. A service provider shared a tale of a woman, who was forced to remove her IUD due her husband's wishes.

A client came for removal; before then, her husband had come without her consent and said that their child was 4 and that he was ready for another baby but his wife would not agree. Unfortunately, when she came, I was not around, and they said she came and she removed the IUD of her choice and volition, she removed it. Later, she came back to me about two weeks after that time and she said she did not want it to be removed.

—Service provider, Apata, Oyo State

Lack of support from the husband is a major reason why some women opt for covert use of contraception. A woman convinced about her need for spacing or limiting may come to the clinic asking for a discreet method. Moreover, this type of behavior may lead to domestic violence or may place the provider at risk from retaliation from the husband if he learns about his wife's decision.

Some of their husbands do not want them to do it, thereby they do it behind the man secretly, but when the men get to know, they will come here and fight the nurses.

—Service provider, Apata, Oyo State

Experience with Use of FP Methods

Many study participants talked about their satisfaction with the method they were currently using, while some reported negative experiences with a method, which had made them switch methods. The negative or positive experiences covered all types of methods, including short-acting, long-acting, and permanent methods. In the following paragraphs, we will discuss the participants' experiences with each of the LA/PMs.

The IUD

Early adopters of the IUD were generally satisfied with their method. Most did not experience the side effects that participants in this study generally associated with the method. Similarly, many lapsed users had a positive experience with the method and only removed it when they were ready to become pregnant again.

Since I have done it, my mind has been at peace and my husband wasn't aware of it, there was no complaint at all, and they told us that if we don't want to do it again, we can remove it, but it gives me rest of mind and it did not affect me.

—Early adopter, Oniyanrin, Ibadan, Oyo State

What I know is that when I did mine [had an IUD inserted], I had it for seven years, then I had it removed. There were no problems

—Lapsed user, Apata, Ibadan, Oyo State

Serpentine path to a decision to use a long-acting method

What I saw in it is that the coil is good, it is very effective, because before I had my second child, I went to see one old man who gave me some powdered stuff and told me to buy a razor blade, mark the lower part of my tummy, and apply the powdered stuff on the cuts. It was in the moonlight and I did the incision round, and I told my friend to do the back for me, she asked me why, and I told her that it was for protection and I did not tell her the truth and I didn't tell my husband too. When she was through with it, I rubbed the powdered stuff on the cuts and I mixed the rest with pap and drank it. I did everything as told but I still get pregnant. Before I went for the coil, I went to the chemist, they gave me one drug to use, I did so but I was still pregnant. When I narrated my story to my friends, they asked me why didn't I do the coil, but I was afraid that the coil that do fall inside. That was how I went for it. When I got there, I saw a woman that did it for seven years and we were chatting and she said she ought not to remove it but her husband has impregnated another woman outside. I was afraid and those nurses told me to put my mind at rest and as soon as they finish, I got out of the place and there was no problem at all.

—Early adopter, Oniyanrin, Ibadan

For some current or previous users, the path to the decision to use an IUD was not simple and involved disappointments with other methods. In many cases, a woman who perceives the need for FP will start with a traditional or natural method. When these methods fail, she is likely to try one of the short-acting modern methods before graduating to a long-acting method. A current user from Ibadan tells her story in the box on page 33.

Some users experienced side effects (specifically pain and excessive bleeding) in the first few months of IUD use. However, these side effects did not lead to a decision to discontinue use. It appears that in such cases, the provider had conducted adequate preinsertion counseling and informed the user about what to expect.

A few previous users, however, related that they experienced serious difficulties with the method that led to the decision to discontinue use. These difficulties had to do with undisclosed illnesses that the user associated with the method, prolonged menses, and abdominal pain.

I have done it before, but I couldn't stay for up to a month before removing it. When I used it, it changed all my systems, I fell sick, and my husband did not like it, so I had to remove it.

—Lapsed user, Apata, Ibadan, Oyo State

I used IUD and I stopped because I was having severe waist pain.

—Lapsed user, Makurdi, Benue State

One woman in Apata stated that she became pregnant while using the method because it “shifted.” Another woman related how she experienced several miscarriages after removing an IUD. According to her, she had to take medications to make her “womb strong again” before she was able to conceive. While possibly outliers, stories like these, coming from actual users, may act as a serious hindrance to IUD acceptance.

It is possible that some of the side effects that users attribute to specific methods have nothing to do with the method. For example, a woman who has an IUD inserted and then develops a fever is very likely to link the fever with the device. A service provider explained the challenges she faced managing the fears and misinformation of some clients.

... women when they are using IUD and they have catarrh [a cold] or they have chest pain or they have headache, they will come back to you and say “I took this method this is my experience” ... Some of them will come back and tell you that “I have waist pain, my legs are weak, I cannot even move them well, it's like I'm having a stroke.” So they feel that the thing travels in their body, so some of them when we explain to them ... and we refer them to the hospital, we will say they should go for general treatment because family planning is not immunization that will prevent them from being sick. So when we give them the counseling, they will now go to the hospital and get treatment. When we observe the problem is minor, like malaria and other infections, we just treat them and they recover. Some of the women for IUD they will say the husband is experiencing strokes, that it is shocking them in their waist.

—Service provider, Mkar, Benue State

The Implant

There were few users of implants among the study participants, due principally to the fact that at the time of the study, implants were not available at the three study sites in Oyo State and at one study site in Benue State. Nonetheless, the data suggest that many women using implants experienced perceived or real side effects, but that these did not necessarily lead them to abandon the method. The complaints generally had to do with prolonged menstruation, weight gain, chest pain, and infections.

I did my own 29 of June and my menses started the next day, it lasted for eight days with pain in my navel instead of the normal three days, I don't know if it is because of this method that I did.

—Early adopter, Makurdi, Benue State

I started having serious chest pains.

—Early adopter, Mkar, Benue State

In contrast, reports from service providers indicate that complaints about the implant were not common and that most clients are satisfied with the method. A provider in Makurdi described how in the past, women with newly inserted implants used to return to the clinics with a variety of complaints, but that currently providers saw few such cases.

The... implant... others go back to tell people that it does not give them problem like other methods, because in the past they do come back to complain about bleeding, headache, and waist pain, but with the implant they don't complain about these things again.

—Service provider, Makurdi, Benue State

Permanent Methods

There is limited information on experience with permanent methods, since only three study participants were using female sterilization, and no early adopter of male sterilization was part of the study. Service providers reported that they had yet to encounter a client requesting male sterilization. They attributed this lack of interest in male sterilization to misinformation about the method, cultural norms about masculinity, and cultural practices such as polygyny.

The family will tell him “do not follow your wife to do that, if she says you are not the father of the children you have, what will be your own gain? But if you don't do permanent one and she says you are not the father of the ones you have, you can still meet with another woman even at the age of 70.” That is why it is rare for men to do permanent methods.

—Service provider, Apata, Ibadan, Oyo State

Personally, I have not witnessed it, and men in this locality will never choose that method, as you understand that men believe in marrying more than one wife. So, when they do vasectomy, it means they are not fertile again.

—Service provider, Mkar, Benue State

The women using female sterilization appeared to be satisfied with their method. However, one woman complained that she experienced backache and weight loss after the procedure. Evidence from interviews with service providers in Benue State buttressed the point that female sterilization is safe and associated with very few and typically minor side effects.

I have been working here for like five years now; no one has ever come to lodge a complaint after having female sterilization.

—Service provider, Makurdi, Benue State

Contraceptive Decision Making

The study participants generally agreed that both the husband and the wife have a key role to play in the decision about whether to use a method. Typically, the idea to practice FP comes from the wife, often as a result of a talk she heard at the health facility or a discussion she had with friends. The woman will then choose the right moment to discuss the issue with her husband and try to obtain his blessing. The idea of the couple discussing and reaching a mutual decision came out in all of the group discussions.

They will call themselves and discuss it that they should space or stop having children so that they can train the ones they have.

—Postpartum woman, Makurdi, Benue State

It depends on the rapport between them. The wife can call the husband and try to pet him and tell him that she want them to stop childbearing, considering the number of children they have on ground, and the husband will agree that whatever she likes.

—Married man, Apata, Ibadan, Oyo State

Commonly, after discussion, the couple jointly decides in favor of using an FP method. With the husband's approval and based on information received from the media, friends, and other sources, the woman will then go to the health facility for counseling about appropriate methods.

I discussed it with my husband he said I should go and do it.

—Early adopter, Adeoyo/Yemetu, Ibadan, Oyo State

The path to contraceptive decision making is not always so straightforward or simple. It often happens that the husband resists the idea of the couple's using a modern method for several reasons, including lack of knowledge about methods, myths and rumors about methods, and perceived association of FP with a woman's infidelity. Lack of support and consent from the husband may prevent the woman from practicing FP or at least delay the decision to use a method. Cultural and religious norms dictate that the wife should obey her husband in all things. Study participants shared that going against the will of the husband regarding FP may lead to serious marital disharmony.

Most women don't discuss things like that with their husband, because men can be so hostile, then the woman becomes scared.

—Early adopter, Makurdi, Benue State

The Bible makes us to realize that the husband is the head of family to the wife and also said wife obey your husband. So there is nothing the husband cannot tell the wife. He will tell her that this is how I want us to do it.

—Married man. Adeoyo/Yemetu, Ibadan, Nigeria

At times, a joint visit to the health facility may be all it takes for a man who initially opposes FP to change his position and agree for his wife to use a method.

Some do go to the hospital with their husband and they disagree before they agree on it.

—Postpartum woman, Makurdi, Benue State

It is common for a woman to make a unilateral decision to use a contraceptive method covertly if the husband does not agree or if she anticipates that the husband will not favor contraceptive use. The justifications for covert use of contraceptive methods in such cases included economic hardships, the perceptions that the husband was not responsible, and health difficulties experienced by the woman. Some early adopters who participated in the study shared that they were using a method without the consent or knowledge of their husband.

My husband said he doesn't want it because he said if I do it, I will be fat and will not be able to control it.

—Early adopter, Makurdi, Benue State

Some men will not give their consent ... I had done it [IUD] before I told him and he was angry immediately and ask me why?

—Early adopter, Adeoyo, Ibadan, Oyo State

Friends and relations (typically a brother or a sister, rarely parents or parents-in-law) play some role in contraceptive decision making. For example, they may suggest to a couple to consider using a contraceptive method, particularly if they see that the couple already has many, closely spaced children. However, it appears that in such cases, the advice has more weight if it comes from a man's friends or relations than if it comes from a woman's.

They can talk to them and say these children you have are enough so that you can take proper care of them. Like my husband, it was his brother that helped me in talking to him, and he agreed.

—Postpartum woman, Adikpo, Benue State

In addition, friends and relations may be asked to advise in cases where a couple disagrees on whether to practice FP or if they are confused about which methods to use.

Yes, they can call their family friends to come and advise them, if you have a friend that has done it before, after the discussion between the husband and wife, they can seek the experience of the friend.

—Married man, Adikpo, Benue State

The study participants agreed that the decision about the specific method to adopt should be made based on the advice of the service provider. Potential users may go to a health facility with ideas about which method they would prefer to use or not to use, based on what they have learned from satisfied or dissatisfied users. Nonetheless, they rely on service providers to guide them in the choice of which methods to use.

Availability and Quality of Services

Service availability varied by location and by type of institution. While all study clinics offered various types of short-term methods and the IUD, they differed in the extent to which they provided implants and permanent methods. In Ibadan, only the FP clinic at Adeoyo offered the implant at the time of the study. The other two clinics in Ibadan were either out of implants or had yet to start offering the method. Clients who indicated interest in the method were referred to a tertiary institution, such as the University College Hospital (UCH). Unfortunately, clients referred to the tertiary institution for the method did not always go for the services. The reasons are multiple but essentially have to do with transportation and perceived cost of services at that institution.

The only thing that we want to be doing now is the implant, we are no more using the Implanon, but we're using the Jadelle, but they said they will bring it to us because we got up to two to three clients that they want to do it. We now referred two of them to UCH but one is still in our center as at today to do Jadelle, but because we don't have it at hand, we can't do it for her, and she said she'll come back, because some of them want free things anyway.

—Service provider, Oniyarin, Ibadan, Oyo State

In Benue State, implants were offered at all three study clinics, although not all service providers had received training to provide this method. For example, one service provider in Adikpo stated that she had not been trained to provide the implant.

Qualified medical doctors offered permanent methods on-site in the study clinics in Benue State. In Oyo State, clients are referred to a secondary or tertiary institution. The providers interviewed expressed the concern that due to the high workload of gynecologists at the referral institutions, provision of permanent methods is very low on their list of priorities. As a result, clients referred for permanent methods may have to wait several months before receiving services.

The challenge they face is that in the gynecology department, many people go there with gynecological problems, you now send someone who wants to have a permanent device to be done there by the same personnel that still care for such people that I have mentioned before. Such clients might need to take a turn, that is, just to be on the queue, and it may take some time, and that is why before a client leaves here, we still give some back-up method, since we don't know whether the client is going to be given a time that will go well with her, so that she doesn't get pregnant before [obtaining the methods] she really wants.

—Service provider, Adeoyo/Yemetu, Ibadan, Oyo State

Service providers understood clients' expectations about quality and admitted that these expectations were not always met. The providers shared how when clients received good-quality care, they would not only stick with their method but would also bring their friends and family to the health facility for services.

Providers explained that clients want a wide array of contraceptive methods from which they can choose the one most suitable. When preferred methods are out of stock, clients are discouraged and sometimes leave the facility without any method. Providers sometimes resort to sourcing for contraceptives in the “black market” to avoid stock-out, possibly compromising quality of service.

Sometimes we run out of stock but not too frequently; when that happens, I will go into the market to get some so that we will have the methods, because we are mindful of our clients' appointment dates... I used to tell the community that the IUD is now costly because we used to get it from black market in Makurdi.

—Service provider, Adikpo, Benue State

Providers also noted that there are not enough competent service providers to attend to clients in a timely manner. Some trained FP providers had been transferred to other units within the health facility or to other facilities entirely, without any effort to replace them. Some FP providers lack the training to provide the services effectively.

The services are not always available like the postpartum IUD. The only person that was trained has resigned. For the permanent methods also, the doctors that are coming in now ... they are not trained specifically in minilaparotomy. So some of the women, because of this, they always don't want to go for the method, because the procedures they are using are not in accordance with what should be done.

—Service provider, Mkar, Benue State

Often, FP service providers were called upon to assist in other units of the health facility, further straining available resources for FP services. The result is that clients end up spending a long time waiting for services, and some may even leave the clinic in frustration without receiving the services they come for.

... at times, we have too many clients.

—Service provider, Apata, Ibadan, Oyo State

Necessary supplies (gloves, sterilizing lotion, syringes, and gauzes) and equipment (e.g., sterilizing machine, examination bed) are often not available at clinics, presenting another challenge to quality of care. At times, clients are asked to pay for supplies or to bring them when they come to the clinic.

We don't have enough consumables, although the NURHI [a Gates Foundation-funded project] people do supply Jik and the lotion that we use and the gloves, but we have exhausted all those things. Though what we do here is free, we do send patients to go and buy gloves, so these are the challenges we have, and we still need more instruments.

—Service provider, Adeoyo/Yemetu, Ibadan, Oyo State

Inasmuch as we need to sterilize our instruments, they [clients] are the one to buy Jik, dettol and tissue papers that we use, and these things are chasing some people away, you know that fingers are not equal. ... Some will say, please, I cannot buy all those things, and they will go, only God knows where they are going to, maybe to the quack nurses or herbal family planning methods, that is the only problem we are having with the IUCD.

—Service provider, Apata, Ibadan, Oyo State

Some clinics were in a poor state of repair, and the physical environment was not conducive to the provision of quality services. For example, providers in Apata, Ibadan, complained that the roof leaked when it rained, causing discomfort to clients and providers. Moreover, some clinics do not have electricity, and those who do only enjoy an intermittent supply.

Community Perceptions about Service Providers

Study participants had a positive attitude toward service providers and appreciated their services. Service providers were perceived to play other roles in the community besides providers of FP services. Study participants saw in service providers a catalyst for increasing community awareness about modern methods and for building community support for FP. In the words of one woman:

What I know is that the health workers will be the ones to tell us the advantages and the disadvantages, and they are also the ones that will bring the awareness.

—Early adopter, Oniyanrin, Oyo State

Service providers were also perceived as the most trusted sources of information and advice on the appropriate choice of methods. Helping a potential client understand multiple methods and make an informed choice was a role that participants attributed to the provider.

They [service providers] will be the ones to advice on which method to use once the matter gets to them.

—Married man, Apata, Oyo State

Service providers are generally considered to be trustworthy and credible sources of health information. Highlighting their powerful role in the community, a lapsed user shared how community members often accept any information that is delivered by the health workers:

We do accept whatever they [service providers] say.
—Lapsed user, Adeoyo Yemetu, Oyo State

In terms of quality of services, early adopters were especially satisfied with the counseling they received. Clients were particularly appreciative of the fact that service providers took the time necessary to explain the advantages, side effects, and appropriateness of each available method to them.

Their work is best, because they give us good counseling and ask us if we have any problem, we should come to them, they are doing good in short.
—Early adopter, Adikpo, Benue State

They perform their duties diligently; they do lecture us on the entire methods, one after the other.
—Early adopter, Adeoyo Yemetu, Oyo State

In addition, allowing the client to ask questions and taking the time to answer the questions were some of the attributes that clients appreciated in a provider. An early adopter shared her thoughts:

Anytime I go there, they do give room for question or that, if there is any problem, we should tell them.
—Early adopter, Adikpo, Benue State

A few participants discussed the variability in service quality depending on the health facility and the cadre of service provider. In general, clients believed that the quality of services was better at public health facilities than at private facilities. There was also a belief that older and more experienced service providers did a better job. In the words of an early adopter:

Those who came to do it the other time were from UCH and they were Matrons, they did the job well, but the hospital we were referred to are not as competent. The elderly nurses too are good, while the private hospitals are not too good in providing the service.
—Early adopter, Apata, Ibadan, Oyo State

Despite clients' positive attitude toward the service providers, it was often challenging for service providers to effectively counsel clients about specific methods. Often clients came in with the expectation of adopting a method, and service providers had to convince them about other methods that in their professional opinion would better suit the client's needs. Low literacy levels of some clients made effective counseling somewhat challenging.

Sources of Information and Advice

The participants identified many sources of information and advice, ranging from health professionals like doctors, nurses, and health workers to drugstore managers, current users, and experienced users, as well as family, relatives, and friends. Health professionals were consistently seen as the best source of information and advice, across sites and discussant

groups. Health professionals were considered good sources of both general information about contraceptive methods as well as more specific information in response to inquiries about methods that would suit the needs of a particular user. They were also seen as the most reliable source of advice and “how to” knowledge.

The most reliable one is the hospital. There is nothing they want to say on the radio, television, or in the community that can be compared to the information gotten from the hospital.

—Married man, Oniyarin, Ibadan, Oyo State

If one should visit them, they will help with the method that fits the person involved. They will also counsel them well on family planning.

—Postpartum woman, Apata, Oyo State

Some participants ranked various types of health facilities based on the perceived credibility of the information that clients can obtain from the facilities. Government health facilities were seen as more reliable than private establishments. This view was particularly strong among study participants from the poor communities. In the words of a lapsed user:

It is good to go to a government-owned hospital than going to the private hospitals.

—Lapsed user, Adeoyo Yemetu, Oyo State

A large proportion of the discussants considered experienced users as the next best source of information after health professionals. They were often the first source of information for people moving toward adopting use. The experience of these users is very powerful in helping a woman considering FP use to decide whether to practice it and which method to adopt. Satisfied users play a key role in encouraging potential users to adopt a method.

When they first started doing it [IUD], people were afraid that it might affect the womb, but when I saw someone that did it for seven years, it makes my mind to be at rest, then I went for it and there was no problem.

—Early adopter, Oniyarin, Oyo State

Similarly, a negative experience of an acquaintance or friend goes a long way toward discouraging potential users.

That coil method, I have seen someone that do it and after she removed it, she did ... not give birth again and she said she cannot advise anybody to do it. I wanted to do it but since my husband heard, he did not allow me to do it.

—Postpartum woman, Oniyarin, Ibadan, Oyo State

While mass media like television and radio were seen as sources of information, they were not of prime importance. Only a handful of discussants mentioned these media as sources of information.

Summary and Recommendations

Summary

This report has examined community perspectives on long-acting contraceptive methods (IUDs and implants) and permanent methods (tubal ligation and vasectomy) in two states in Nigeria: Benue and Oyo. The study targeted various categories of people—early adopters, lapsed users, postpartum women in need of a contraceptive method, married men, and service providers. The study also used a multimethod approach: Data were collected using FGDs, in-depth interviews, free-listing, and pile-sorting. The findings reveal the myriad challenges associated with demand for and provision of LA/PMs in Nigeria.

Perceptions about Ideal Family Size

There was almost universal agreement among the study participants about the importance of limiting family size. Current economic realities, as well as the perceived need to plan for the future of their children and families, were important drivers of this perception. A family of four was considered ideal. Although larger families were often looked upon as burdensome, the decision to have fewer than three children was not perceived as one that a couple makes out of choice. A woman who has two or fewer children is often labeled as a “prostitute,” interested only in enjoying sex without the burden of childbearing. Son preference and the widespread belief that daughters are of less value than sons are some of the factors fueling preference for large families. For example, a woman who has no sons is not considered fertile, no matter how many daughters she has. Moreover, concerns about relationship insecurities often motivate a woman to continue childbearing beyond the number of children she considers ideal. The data suggest that in spite of a preference for moderate-sized families, many couples do not use effective FP methods for reasons ranging from desires around the sex composition of the family to lack of knowledge about FP methods. Moreover, FP was often seen as inappropriate until a couple has already achieved their desired family size, or at least until they have had a certain number of children and wish to postpone the birth of another child.

Knowledge and Attitudes about Family Planning

Despite notable awareness about FP methods, considerable misinformation about specific methods persists. Nonetheless, participants often associated FP with peace of mind. A key factor hindering FP use is the fear of side effects. For example, participants feared that some methods might cause excessive bleeding, infertility, or cancer. Other beliefs may also hinder the adoption of FP methods for the purpose of limiting the number of births. For example, there was a common belief in the study sites that if a woman does not give birth to all of the children in her womb, she may develop cancer. Some men feared that women become promiscuous when they practice FP. It also was commonly believed that to avoid infertility, a couple should not use FP methods early in their childbearing years.

Perceptions about LA/PMs

Knowledge about LA/PMs varied by method and across study groups. Study participants from both states were familiar with the IUD and recognized its effectiveness and advantages. However, misinformation about the IUD abounds, including its perceived side effects and the

belief that it is harmful to a woman's sex partner. The belief that the IUD makes the user more prone to STIs and infections of the pelvis was common not only among ordinary community members, but also among service providers. This belief was cited by some providers as a reason not to recommend the IUD for women who are in a polygynous relationship or who might be unfaithful to their husband.

Compared with the IUD, the implant was less well-known. Some participants had not even heard of it, and many of those who were aware of the method had concerns about its side effects. Participants perceived the implant to be linked to excessive weight gain or weight loss and amenorrhea. Nonetheless, the study participants who were aware of the method perceived it to be more effective than short-acting methods and even than IUD.

While there was widespread awareness of female sterilization, specific knowledge about this method was limited. There was a lot of misinformation about what the procedure entailed. Sterilization was generally perceived as a method that a woman would decide to use not out of choice, but rather out of necessity, when another pregnancy could threaten the woman's life or when other methods had failed. Male sterilization was a relatively unknown method. The participants likened male sterilization to castration; men who had undergone the procedure were believed to be incapable of enjoying sex or satisfying a woman sexually.

In general, the perceived high level of child mortality is a serious concern that makes permanent methods less than appealing. Another reason why many participants did not favor permanent methods is the general fear of surgical procedures in Nigeria. Many participants felt that because these methods involve surgery, permanent methods can lead to death. Participants generally preferred long-acting and short-acting methods to permanent methods.

Poor versus Nonpoor Communities

Poor and nonpoor communities shared significant commonalities. For example, in Oyo State, there were no differences in ideal family size between these communities; similarly, in Benue State, both safety and effectiveness ratings were comparable across poor and nonpoor communities. Nonetheless, some notable differences exist by poverty level. For example, participants from the poor community in Benue State were more likely to prefer larger families than were their peers from nonpoor communities. In both study states, people in nonpoor communities had more precise knowledge about LA/PMs than those in poor communities. Finally, compared with their peers from nonpoor communities, participants from poor communities were more likely to express concerns about specific LA/PMs.

Desired Attributes of Family Planning Methods

The attributes that potential users would consider to make them decide to adopt a method varied between Benue and Oyo states. In Benue State, the tangible and intangible costs of a method (for example, its affordability and ease of use) and its collateral benefits (including perceived beauty-enhancing qualities and its lack of interference with sexual intercourse) were important attributes that could positively influence the decision to adopt a method. In Oyo State, the collateral benefits and safety of methods appeared to be the most important considerations. The data further show that the better understanding study participants had about a method, the more likely they were to indicate a preference for it.

Role of Satisfied Users

Prior users are an important source of information and advice about methods. When a woman or a couple start to consider using a contraceptive method, they are likely to seek advice from a friend or relation who has personal experience with the method. A satisfied LA/PM user is a potent source of motivation to adopt the method, whereas a dissatisfied user could help to discourage the decision to adopt a method.

Experience with LA/PMs

Early adopters of the **IUD** were generally satisfied with their method. Most did not experience the side effects that participants in this study generally associated with the method. Similarly, many lapsed users had a pleasant experience with the method and only removed it when they were ready to become pregnant again. Some users experienced minor side effects in the first few months of IUD use, but these side effects did not lead to a decision to abandon the method. A few previous users, however, related that they experienced serious difficulties (including prolonged menses and abdominal pain) that led to the decision to discontinue use.

Many women using **implants** experienced perceived or real side effects, but these did not necessarily lead them to abandon the method. Complaints generally had to do with prolonged menstruation, weight gain, chest pain and infections.

There was limited information on experience with **permanent methods**, since only three study participants were using female sterilization and no early adopter of male sterilization was part of the study. Service providers reported that they had yet to encounter a male client desiring male sterilization. The women relying on female sterilization appeared to be satisfied with the method. However, one complained that she experienced backache and weight loss after the procedure.

Contraceptive Decision Making

Typically, the decision to use a contraceptive method was jointly made by the couple after the two of them discussed the issue. Knowing how to negotiate contraceptive use with her husband was a skill that study participants saw as a necessary attribute for a woman in this regard. However, a woman sometimes took a unilateral decision to use a method covertly if her husband opposed the use of contraceptives. Decision making often occurred based on the experiences of friends, relations, and acquaintances who were current users. In the final analysis, potential users rely considerably on the advice of service providers in their choice of method. This study did not uncover any differences in the decision-making process for short-acting methods versus LA/PMs. The participants, however, stressed that mutual understanding and joint decision making between the man and his wife are of utmost importance when they are considering a permanent method.

The Role of Men

Men play a key role in the decision to adopt a contraceptive method and in which method to adopt. When the husband came to the health facility with his wife, his resistance to contraception was likely to be broken and the couple was likely to adopt a method. Nonetheless, compared with women, men were less knowledgeable about LA/PMs. Moreover, in general, men held less favorable attitudes toward FP than women. Lack of support from the husband not only hinders a woman's decision to use an LA/PM but may

also lead to premature termination of use of a long-acting method. Moreover, whereas some women use contraceptive methods covertly, such a behavior may result in serious marital disharmony if the husband comes to learn of it.

Availability and Quality of Services

The study revealed several issues with the availability and quality of services. In general, providers understood clients' expectations about quality, but they admitted that it was sometimes difficult for them to meet these expectations. For example, clients desire to have a wide range of methods from which to choose. In reality, long-acting methods were not always available at the study clinics, and permanent methods were not offered at most of these clinics. The unavailability of a desired method may lead to discouragement and the decision to postpone use. Problems with supplies and equipment often forced providers to charge shadow fees and/or obtain methods on the black market, with the attendant uncertain quality and the possibility of compromising the health of clients. Some facilities did not have electricity, and the others often had it only intermittently. Moreover, some of the clinics were in a poor state of repair, and clients were often exposed to the elements. Providers complained of high workload due to insufficient number of trained providers. This problem also leads to increased waiting time for clients. There were also problems with provider training: Many FP service providers lacked the necessary training to provide LA/PMs.

Early Adopters versus Others

In terms of perceptions about family size, fatalistic attitudes (as evidenced in responses such as “up to God,” “as many as God gives,” and “God is the provider of children and He will care for them”) were less common among early adopters than among the other study participants. In other words, compared to nonusers of LA/PMs, early adopters were more likely to perceive an internal (as opposed to external) locus of control over family size. The data also showed that early adopters were more knowledgeable about contraceptive methods in general and about LA/PMs in particular. Early adopters were also more likely than the other study participants to perceive that long-acting methods were safe and effective. However, in terms of perceptions about the safety and effectiveness of permanent methods, early adopters did not differ much from the other study participants.

Preferred Sources of Information and Advice

Providers and satisfied clients are the most important and trusted sources of information and advice, about FP in general and about specific methods in particular. Mass media, including television and radio, were seen as useful sources of information but were not considered to be of prime importance.

Recommendations

The findings from this study have important implications for demand generation and the provision of services. Below are some recommendations based on these findings:

1. Effectively increasing demand for FP methods in general and for LA/PMs in particular will require promoting smaller family size and changing negative attitudes toward couples with a small family. Targeted messaging should promote smaller families (fewer than four children) as the ideal. It is important to delink the ideas of promiscuity, prostitution, and selfishness from couples who choose to have a small family. Culturally appropriate

- messages should also seek to increase understanding about how couples can achieve smaller families. LA/PMs should be positioned as effective and safe methods for couples to achieve their reproductive health goals.
2. It is equally important to address gender issues around FP. Efforts to change attitudes toward and build community support for women who choose to use contraceptive methods are relevant. Also relevant are interventions designed to address relationship insecurities that prevent the use of LA/PMs.
 3. Efforts to promote long-acting methods should center on increasing knowledge and correcting misinformation about the methods. Messages need to emphasize these methods' greater effectiveness than short-acting methods and highlight their association with fewer and relatively minor side effects. Improving counseling to enable users to understand the side effects of the methods and how to deal with these side effects should be part of a comprehensive intervention package.
 4. Positioning permanent methods as an ideal choice for couples who want to stop childbearing requires efforts to educate the community about the methods, clarify what the procedures entail, and elucidate their side effects. It is important to address the potential link of the IUD to HIV in communication materials and during counseling. Messages that position the decision to adopt a permanent method as an act of love and responsibility toward one's children and spouse are relevant.
 5. The finding in this study that most users of LA/PMs do not experience serious side effects has important implications for programming. Interventions that model having satisfied users talk about their experience and encourage others to adopt the method can be very effective.
 6. Potential users are more likely to adopt a method that meets their expectations about its benefits. Most attributes that study participants deemed important (e.g., requiring the minimum number of visits to a health facility, having minimal side effects, being easy to use, not interfering with sexual relations, helping the user to continue looking young, etc.) are naturally associated with LA/PMs. It is important that efforts to promote these methods emphasize these attributes.
 7. Women typically bring up the idea of contraceptive use in the couple. However, the husband's opposition often hinders or delays the decision to use a method. Programmatic efforts to strengthen women's skills at negotiating contraceptive use are relevant. Women need to know how to approach discussions about contraceptive use, in general, and about LA/PM use, in particular, with their husbands. Women also need to be equipped with evidence-based and convincing arguments to counter husbands' resistance to contraceptive use.
 8. Since men are the key decision makers in their household, programmatic efforts should target them specifically. Programmatic efforts are needed to address the ideational and cultural factors that prevent men from embracing LA/PMs and from acting as a champion for their wives in the use of these safe and effective methods. Appropriate strategies should seek to educate men about these methods, promote positive attitudes toward the methods, and mobilize men to become advocates for the methods in their families and in the community. Program interventions should position the couple's joint decision to adopt an LA/PM as an act of love and responsibility toward one's family. Efforts that promote couples counseling for LA/PMs are relevant.

9. While helping to generate demand, efforts to promote LA/PMs should include a complementary focus on supply-side issues. Methods should be made available to clinics and stock-outs minimized. The regular availability of supplies and quality equipment needs to be ensured. Shortages of trained staff should also be addressed, possibly through strategies such as task shifting and use of dedicated providers. In-service and refresher training for current providers should be considered. Efforts should also be made to introduce training on LA/PMs into the curricula for medical and nursing/midwifery students.
10. Potential users of LA/PMs rely extensively on service providers to guide them in the choice of appropriate methods. Providers, however, have their own biases and misinformation about certain methods. Indeed, study participants cited service providers as the source for some of the misconceptions they had regarding LA/PMs. It is important to increase service providers' knowledge about LA/PMs, correct their misconceptions, and strengthen their technical competence to provide the various methods. It is equally important to strengthen their interpersonal skills, so they can provide adequate information to clients, debunk myths and rumors, address clients' concerns, and help potential clients make an informed decision without pushing specific methods.

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Appendix I

Tools for Focus Group Discussions

LA/PM Use Dynamics Study Focus Group Discussion Guide—Early Adopters of LA/PMs

Location: _____

Date: _____

Time discussion started: _____ Time ended: _____

Participants: total: _____ women: _____ men: _____

1. Introduction of Facilitators and FGD Process:

- The moderator introduces her(him)self and the note-taker
- Explains the purpose of the FGD
- Explains ground rules and format of the focus group: Use of tape-recorder; Everyone should participate freely; Everything said by anyone will be kept confidential and anonymous; No right or wrong answers; One person talks at a time; Honest responses are highly appreciated

2. Introduction of Participants:

- a. Ask participants to specify their age, marital status, profession, educational level, length of residence in study community, nickname that they would like to be called
- b. Any questions before we start?

3. Beliefs about Family Composition and Size

- a. In this locality, what does an ideal family look like? That is, what is the composition of an ideal family?
- b. You have mentioned children as members of a family. What are the benefits of having children?
- c. What is the ideal number of children for a couple to have?
- d. Why would a couple want more or fewer children?
- e. What are some of the negative consequences of having many children? [PROBE: for the mother? For the children? For the father? For the family as a whole?]
- f. How do people in this community view couples that decide to have only two children?

4. Knowledge about Family Planning Methods

- a. If a couple wants to postpone the birth of another child or if they do not want to have any more children, what can they do? [PROBE: IUD, implant, male sterilization, female sterilization]
- b. You have mentioned all these methods of preventing pregnancies. Now, let's classify them into the ones best for spacing and the ones best for stopping childbearing.

5. Perceptions about LA/PMs

Now, let us talk more about some of the methods that you have mentioned.

- a. Can you describe IUD to me? What are the advantages of using an IUD? What are the disadvantages? To what extent does IUD prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an IUD?
- b. Can you describe the implant or Norplant to me? What are the advantages of using an implant or Norplant? What are the disadvantages? To what extent does an implant/Norplant prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an implant or Norplant?
- c. What do you understand by female sterilization or tubal ligation? What are the advantages of undergoing female sterilization? What are the disadvantages? To what extent does female sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider female sterilization?
- d. What do you understand by male sterilization? What are the advantages of undergoing male sterilization? What are the disadvantages? To what extent does male sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider male sterilization?

6. Contraceptive Decision Making

- a. In this locality, if a couple wants to do something in order to postpone a pregnancy, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- b. You have mentioned that the couple would discuss the problem. I need two volunteers to demonstrate to us how that discussion is likely to take place.
- c. How about if a couple wants to do something in order not to have any more children, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- d. What would make it easier for a couple to discuss family planning and make a decision regarding use of family planning methods? [PROBE: What does a woman need to make this happen? What does a man need to make this happen?]
- e. What makes it difficult for couples in this community to discuss the use of modern contraceptive methods?

7. Personal experience with LA/PMs

- a. What circumstances led to your decision to use your current method?
- b. How was the decision to use the method made?
- c. What has been your experience with using your current method?
- d. What do you think of the service providers in the family planning clinic that you use?
- e. What do you think of the overall quality of service in the family planning clinic that you use? [PROBE: in what ways should the service be improved?]
- f. What advice would you give anyone who is interested in using a method similar to yours?

8. Sources of information and advice on contraceptive methods.

- a. Where or to whom would you go for information on family planning in general? Please rank these sources from the least to the most credible.
- b. Where or to whom would you go for information on long-acting and permanent methods of family planning? Please rank these sources from the least to the most credible.
- c. Where or to whom would you go for advice on family planning methods? Please rank these sources from the least to the most credible.
- d. What would be the best ways to bring information about family planning to your locality?
- e. Are there any special local beliefs on family planning and contraceptive methods that should be addressed in a program to promote contraception? (PROBE: Special cultural beliefs? Health beliefs? Health-seeking behaviors?)

9. Wrap up

- a. Is there anything else that you would like to tell me about any of the issues that we have discussed so far?

Thank the participants for their time and contribution.

LA/PM Use Dynamics Study

Focus Group Discussion Guide—Lapsed Users of Any FP Method

Location: _____

Date: _____

Time discussion started: _____ Time ended: _____

Participants: total: _____ women: _____ men: _____

1. Introduction of Facilitators and FGD Process

The moderator:

- Introduces her(him)self and the note-taker
- Explains the purpose of the FGD
- Explains ground rules and format of the focus group: Use of tape-recorder; Everyone should participate freely; Everything said by anyone will be kept confidential and anonymous; No right or wrong answers; One person talks at a time; Honest responses are highly appreciated

2. Introduction of Participants

- a. Ask participants to specify their age, marital status, profession, educational level, length of residence in study community, nickname that they would like to be called during the discussion.
- b. Any questions before we start?

3. Beliefs about Family Composition and Size

- a. In this locality, what does an ideal family look like? That is, what is the composition of an ideal family?
- b. You have mentioned children as members of a family. What are the benefits of having children?
- c. What is the ideal number of children for a couple to have?
- d. Why would a couple want more or fewer children?
- e. What are some of the negative consequences of having many children? [PROBE: for the mother? For the children? For the father? For the family as a whole?]
- f. How do people in this community view couples that decide to have only two children?

4. Knowledge about Family Planning Methods

- a. If a couple wants to postpone the birth of another child or if they do not want to have any more children, what can they do? [PROBE: IUD, Implant, male sterilization, female sterilization]
- b. You have mentioned all these methods of preventing pregnancies. Now, let's classify them into the ones best for spacing and the ones best for stopping childbearing. Please explain why you believe that each method belongs in the category in which you have put them.

5. Perceptions about LAPM

Now, let us talk more about some of the methods that you have mentioned.

- a. Can you describe IUD to me? What are the advantages of using an IUD? What are the disadvantages? To what extent does IUD prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an IUD?
- b. Can you describe the implant or Norplant to me? What are the advantages of using an implant or Norplant? What are the disadvantages? To what extent does an implant/Norplant prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an Implant or Norplant?
- c. What do you understand by female sterilization or tubal ligation? What are the advantages of undergoing female sterilization? What are the disadvantages? To what extent does female sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider female sterilization?
- d. What do you understand by male sterilization? What are the advantages of undergoing male sterilization? What are the disadvantages? To what extent does male sterilization prevent pregnancy? How does this method compare to a method like the Pill or condom? Under what circumstances should a couple consider male sterilization?

6. Hindrances to Contraceptive Use

- a. Some couples in this locality who want to delay or avoid a pregnancy are not using any modern method of contraception. What are the reasons they are not using a method?
- b. What are the family planning methods that couples in this locality are most likely to use?
- c. Why do couples prefer these methods?
- d. Some couples use a family planning method for some time and then discontinue. What are the reasons some people who need family planning methods discontinue using the methods?
- e. Do you know a woman or a couple that decided to stop using a family planning method? Please tell us her/their story? [PROBE: Circumstances that led to the discontinuation? Consequences of discontinuing?]

7. Contraceptive Decision Making

- a. In this locality, if a couple wants to do something in order to postpone a pregnancy, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- b. You have mentioned that the couple would discuss the problem. I need two volunteers to demonstrate to us how that discussion is likely to take place.
- c. How about if a couple wants to do something in order not to have any more children, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- d. What would make it easier for a couple to discuss family planning and make a decision regarding use of family planning methods? [PROBE: What does a woman need to make this happen? What does a man need to make this happen?]
- e. What makes it difficult for couples in this community to discuss the use of modern contraceptive methods?

8. Sources of Information and Advice on Contraceptive Methods

- a. Where or to whom would you go for information on family planning in general? Please rank these sources from the least to the most credible.
- b. Where or to whom would you go for information on long-acting and permanent methods of family planning? Please rank these sources from the least to the most credible.
- c. Where or to whom would you go for advice on family planning methods? Please rank these sources from the least to the most credible.
- d. What would be the best ways to bring information about family planning to your locality?
- e. Are there any special local beliefs on family planning and contraceptive methods that should be addressed in a program to promote contraception? (PROBE: Special cultural beliefs? Health beliefs? Health-seeking behaviors?)

9. Wrap-Up

- a. Is there anything else that you would like to tell me about any of the issues that we have discussed so far?

Thank the participants for their time and contribution.

LA/PM Use Dynamics Study

Focus Group Discussion Guide—People with Unmet Need for LA/PMs

Location: _____

Date: _____

Time discussion started: _____ Time ended: _____

Participants: total: _____ women: _____ men: _____

1. Introduction of Facilitators and FGD Process:

The moderator:

- Introduces her(him)self and the note-taker
- Explains the purpose of the FGD
- Explains ground rules and format of the focus group: Use of tape-recorder; Everyone should participate freely; Everything said by anyone will be kept confidential and anonymous; No right or wrong answers; One person talks at a time; Honest responses are highly appreciated

2. Introduction of Participants:

- a. Ask participants to specify their age, marital status, profession, educational level, length of residence in study community, nickname that they would like to be called
- b. Any questions before we start?

3. Beliefs about Family Composition and Size

- a. In this locality, what does an ideal family look like? That is, what is the composition of an ideal family?
- b. You have mentioned children as members of a family. What are the benefits of having children?
- c. What is the ideal number of children for a couple to have?
- d. Why would a couple want more or fewer children?
- e. What are some of the negative consequences of having many children? [PROBE: for the mother? For the children? For the father? For the family as a whole?]
- f. How do people in this community view couples that decide to have only two children?

4. Knowledge about Family Planning Methods

- a. If a couple wants to postpone the birth of another child or if they do not want to have any more children, what can they do? [PROBE: IUD, Implant, male sterilization, female sterilization]
- b. You have mentioned all these methods of preventing pregnancies. Now, let's classify them into the ones best for spacing and the ones best for stopping childbearing.

5. Perceptions about LA/PMs

Now, let us talk more about some of the methods that you have mentioned.

- a. Can you describe IUD to me? What are the advantages of using an IUD? What are the disadvantages? To what extent does IUD prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an IUD?
- b. Can you describe the implant or Norplant to me? What are the advantages of using an implant or Norplant? What are the disadvantages? To what extent does an implant/Norplant prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an implant or Norplant?
- c. What do you understand by female sterilization or tubal ligation? What are the advantages of undergoing female sterilization? What are the disadvantages? To what extent does female sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider female sterilization?
- d. What do you understand by male sterilization? What are the advantages of undergoing male sterilization? What are the disadvantages? To what extent does male sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider male sterilization?

6. Hindrances to Contraceptive Use

- a. Some couples in this locality who want to delay or avoid a pregnancy are not using any modern method of contraception. What are the reasons they are not using a method?
- b. What are the family planning methods that couples in this locality are most likely to use?
- c. Why do couples prefer these methods?

7. Contraceptive Decision Making

- a. In this locality, if a couple wants to do something in order to postpone a pregnancy, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- b. You have mentioned that the couple would discuss the problem. I need two volunteers to demonstrate to us how that discussion is likely to take place.
- c. How about if a couple wants to do something in order not to have any more children, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- d. What would make it easier for a couple to discuss family planning and make a decision regarding use of family planning methods? [PROBE: What does a woman need to make this happen? What does a man need to make this happen?]
- e. What makes it difficult for couples in this community to discuss the use of modern contraceptive methods?

8. Use of Family Planning

- a. Have you ever used any family planning method before?
- b. If yes, what method?
- c. If you have never used any family planning method before what are your reasons?

- d. If you had an opportunity to use family planning, which method would you prefer to use and why?
- e. If you were given an opportunity to use LA/PM, would you be willing to take it and why?
- f. What do you think are the barriers to women preventing them to use a method of their choice?

9. Sources of Information and Advice on Contraceptive Methods

- a. Where or to whom would you go for information on family planning in general? Please rank these sources from the least to the most credible.
- b. Where or to whom would you go for information on long-acting and permanent methods of family planning? Please rank these sources from the least to the most credible.
- c. Where or to whom would you go for advice on family planning methods? Please rank these sources from the least to the most credible.
- d. What would be the best ways to bring information about family planning to your locality?
- e. Are there any special local beliefs on family planning and contraceptive methods that should be addressed in a program to promote contraception? (PROBE: Special cultural beliefs? Health beliefs? Health-seeking behaviors?)

10. Wrap-Up

- a. Is there anything else that you would like to tell me about any of the issues that we have discussed so far?

Thank the participants for their time and contribution.

LA/PM Use Dynamics Study Focus Group Discussion Guide—Lapsed Users

Location: _____

Date: _____

Time discussion started: _____ Time ended: _____

Participants: total: _____ women: _____ men: _____

1. Introduction of Facilitators and FGD Process

The moderator:

- Introduces her(him)self and the note-taker
- Explains the purpose of the FGD
- Explains ground rules and format of the focus group: Use of tape-recorder; Everyone should participate freely; Everything said by anyone will be kept confidential and anonymous; No right or wrong answers; One person talks at a time; Honest responses are highly appreciated

2. Introduction of Participants

- a. Ask participants to specify their age, marital status, profession, educational level, length of residence in study community, nickname that they would like to be called
- b. Any questions before we start?

3. Beliefs about Family Composition and Size

- a. In this locality, what does an ideal family look like? That is, what is the composition of an ideal family?
- b. You have mentioned children as members of a family. What are the benefits of having children?
- c. What is the ideal number of children for a couple to have?
- d. Why would a couple want more or fewer children?
- e. What are some of the negative consequences of having many children? [PROBE: for the mother? For the children? For the father? For the family as a whole?]
- f. How do people in this community view couples that decide to have only two children?

4. Knowledge about Family Planning Methods

- a. If a couple wants to postpone the birth of another child or if they do not want to have any more children, what can they do? [PROBE: IUD, implant, male sterilization, female sterilization]
- b. You have mentioned all these methods of preventing pregnancies. Now, let's classify them into the ones best for spacing and the ones best for stopping childbearing. Please explain why you believe that each method belongs in the category in which you have put them.

5. Perceptions about LA/PMs

Now, let us talk more about some of the methods that you have mentioned.

- a. Can you describe IUD to me? What are the advantages of using an IUD? What are the disadvantages? To what extent does IUD prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an IUD?
- b. Can you describe the implant or Norplant to me? What are the advantages of using an implant or Norplant? What are the disadvantages? To what extent does an implant/Norplant prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider using an implant or Norplant?
- c. What do you understand by female sterilization or tubal ligation? What are the advantages of undergoing female sterilization? What are the disadvantages? To what extent does female sterilization prevent pregnancy? How does this method compare to a method like the Pill or condom? Under what circumstances should a couple consider female sterilization?
- d. What do you understand by male sterilization? What are the advantages of undergoing male sterilization? What are the disadvantages? To what extent does male sterilization prevent pregnancy? How does this method compare to a method like the pill or condom? Under what circumstances should a couple consider male sterilization?

6. Hindrances to Contraceptive Use

- a. Some couples in this locality who want to delay or avoid a pregnancy are not using any modern method of contraception. What are the reasons they are not using a method?
- b. What are the family planning methods that couples in this locality are most likely to use?
- c. Why do couples prefer these methods?
- d. Some couples use a family planning method for some time and then discontinue. What are the reasons some people who need family planning methods discontinue using the methods?
- e. Do you know a woman or a couple that decided to stop using a family planning method? Please tell us her/their story? [PROBE: Circumstances that led to the discontinuation? Consequences of discontinuing?]

7. Contraceptive Decision Making

- a. In this locality, if a couple wants to do something in order to postpone a pregnancy, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- b. You have mentioned that the couple would discuss the problem. I need two volunteers to demonstrate to us how that discussion is likely to take place.
- c. How about if a couple wants to do something in order not to have any more children, how would they go about making that decision? [PROBE: couple discussion? Role of friends and family members? Role of health service providers?]
- d. What would make it easier for a couple to discuss family planning and make a decision regarding use of family planning methods? [PROBE: What does a woman need to make this happen? What does a man need to make this happen?]
- e. What makes it difficult for couples in this community to discuss the use of modern contraceptive methods?

8. Sources of Information and Advice on Contraceptive Methods

- a. Where or to whom would you go for information on family planning in general? Please rank these sources from the least to the most credible.
- b. Where or to whom would you go for information on long-acting and permanent methods of family planning? Please rank these sources from the least to the most credible.
- c. Where or to whom would you go for advice on family planning methods? Please rank these sources from the least to the most credible.
- d. What would be the best ways to bring information about family planning to your locality?
- e. Are there any special local beliefs on family planning and contraceptive methods that should be addressed in a program to promote contraception? (PROBE: Special cultural beliefs? Health beliefs? Health-seeking behaviors?)

9. Wrap-Up

- a. Is there anything else that you would like to tell me about any of the issues that we have discussed so far?

Thank the participants for their time and contribution.

Appendix 2

LA/PM Use Dynamics Study In-Depth Interview Guide—Service Providers

Location: _____

Date: _____

Time discussion started: _____ Time ended: _____

1. Introduction of Facilitators and Interview Process

The moderator:

- Introduces her(him)self and the note-taker
- Explains the purpose of the Interview

2. Experience in Providing Family Planning, Including LA/PMs

- a. During your preservice training did you go through family planning service provision? (Probe for length of training, and scope of training)
- b. How long have you been working in family planning service provision?
- c. What are the common family planning methods requested by clients in this facility? Why are these methods preferred?
- d. How common do family planning clients request for LA/PMs here?
- e. For clients who report discontinuation of use of a method or LA/PM, what were the common reasons given for discontinuation?
- f. What could be some of the reasons why clients would avoid using LA/PMs?
- g. What are the challenges in providing LA/PMs here?
- h. What do you think should be done to improve family planning service provision especially the LA/PM provision?
- i. What do you think should be done to encourage uptake of LA/PM among women?

3. Wrap-Up

- a. Is there anything else that you would like to tell me about any of the issues that we have discussed so far?

Thank the participants for their time and contribution.

Appendix 4

LA/PM Use Dynamics Study Pile-Sorting Questionnaire for Nigeria

Date: _____ Location: _____

Respondent characteristics: Age ___ Sex ___ Education ___ Current method _____

1. Please put these cards in any number of piles you like. You can put one or more cards together but you cannot put all the cards in one single pile. Also, you cannot put one card in more than one pile. Please tell me why you put the cards in each pile together. [INTERVIEWER: PRESENT THE RESPONDENT WITH EACH OF THESE CONTRACEPTIVE METHODS WRITTEN ON ONE SIDE OF THE CARD: PILL, CONDOM, INJECTABLE, IUD, IMPLANT, FEMALE STERILIZATION, MALE STERILIZATION. ON THE OTHER SIDE OF EACH WILL BE A UNIQUE NUMBER BETWEEN 1 AND 7.

Pile #	Card Numbers	Explanation
A		
B		
C		
D		
E		

2. Here are some things that people in this community said that they would consider in choosing a family planning method: Suits my body; Safe; Reversible; Not interfere with intercourse; Helps to prevent diseases; Allows adequate follow-up; Beauty enhancing; Easy to use; Affordable. [INTERVIEWER: PRESENT THE RESPONDENT WITH EACH OF THE QUALITIES ON ONE SIDE OF THE CARD. ON THE OTHER SIDE OF EACH WILL BE A UNIQUE NUMBER BETWEEN 1 AND 9.

Please arrange these words in three piles as follows:

- a. Attributes you would most certainly consider in choosing a family planning method
- b. Attributes you may consider
- c. Attributes you will not consider at all

3. Please indicate how safe you think the following family planning methods are. Use a number ranging from 1 (not at all safe) to 7 (very safe).

Method	Perceived level of safety						
Male Condom	1	2	3	4	5	6	7
Pill	1	2	3	4	5	6	7
Injectables	1	2	3	4	5	6	7
IUD	1	2	3	4	5	6	7
Implant	1	2	3	4	5	6	7
Female sterilization	1	2	3	4	5	6	7
Male sterilization	1	2	3	4	5	6	7

4. Also, please indicate how effective you think each method is. Use a number ranging from 1 (least effective) to 7 (most safe). If the respondent does not know the method, leave the row blank.

Method	Perceived level of effectiveness in preventing pregnancies						
Male Condom	1	2	3	4	5	6	7
Pill	1	2	3	4	5	6	7
Injectables	1	2	3	4	5	6	7
IUD	1	2	3	4	5	6	7
Implant	1	2	3	4	5	6	7
Female sterilization	1	2	3	4	5	6	7
Male sterilization	1	2	3	4	5	6	7