

**STRATEGIES TO ENHANCE INDIGENOUS MEN'S SUPPORT FOR THE  
UTILISATION OF LONG-ACTING REVERSIBLE CONTRACEPTIVES  
AMONGST RURAL WOMEN IN UGANDA**

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## DECLARATION

I declare that “Strategies to Enhance Indigenous Men’s Support for the Utilisation of Long-Acting Reversible Contraceptives amongst Rural Women in Uganda” is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



**3<sup>rd</sup> May 2023**

.....  
Arineitwe Ronald Kibonire

.....  
Date

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## DEDICATION

*I dedicate this thesis to the following:*

*My late father Narisinsio Kiboneire (1938-2015)*

*My siblings: Emily, Elina, Julius, Mackiline, and Gladys*

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## TABLE OF CONTENTS

DECLARATION.....	i
ACKNOWLEDGEMENTS .....	ii
DEDICATION .....	iii
TABLE OF CONTENTS .....	iv
LIST OF FIGURES.....	ix
LIST OF TABLES .....	ix
ANNEXES .....	x
LIST OF ABBREVIATIONS AND ACRONYMS.....	xi
ABSTRACT .....	xiii
<b>CHAPTER 1 .....</b>	<b>1</b>
<b>ORIENTATION OF THE STUDY .....</b>	<b>1</b>
1.1 INTRODUCTION.....	1
1.2 BACKGROUND .....	1
1.3 STATEMENT OF THE RESEARCH PROBLEM.....	3
1.4 PURPOSE OF THE STUDY .....	4
1.5 RESEARCH OBJECTIVES.....	5
1.6 THEORETICAL FRAMEWORK .....	6
1.7 SIGNIFICANCE OF THE STUDY .....	9
1.8 DEFINITION OF TERMS .....	9
1.8.1 Strategy .....	9
1.8.2 Indigenous men .....	9
1.8.3 Support.....	10
1.8.4 Utilisation .....	10
1.8.5 Long-Acting Reversible Contraceptives.....	10
1.8.6 Rural women .....	10
1.8.7 Uganda.....	10
1.8.8 Family planning .....	11
1.8.9 Unmet need for contraception .....	11
1.8.10 Unsafe abortion .....	11
1.9 BRIEF LITERATURE REVIEW .....	11
1.10 RESEARCH PARADIGM .....	13
1.11 STUDY METHOD .....	14
1.11.1 Research design.....	14
1.11.2 Study setting.....	15
1.11.3 Study population.....	16

1.11.4	Sample selection techniques .....	16
1.11.5	Sample size .....	18
1.11.6	Data collection methods and procedures.....	18
1.11.7	Piloting of the data collection tools .....	19
1.11.8	Mitigation measures to prevent spread of COVID-19 .....	19
1.11.9	Data analysis .....	20
1.12	RIGOUR.....	21
1.12.1	Credibility.....	21
1.12.2	Transferability .....	21
1.12.3	Dependability.....	22
1.12.4	Conformability.....	22
1.13	ETHICAL CONSIDERATIONS.....	22
1.13.1	The participants .....	22
1.13.2	Respect for autonomy.....	23
1.13.3	Informed consent.....	23
1.13.4	Principle of beneficence.....	23
1.13.5	Privacy.....	23
1.13.6	Confidentiality .....	24
1.13.7	Principle of justice.....	24
1.13.8	Permission to conduct the study.....	24
1.13.9	Steps taken in case of adverse events .....	24
1.14	SUMMARY.....	25
<b>CHAPTER 2.....</b>		<b>26</b>
<b>LITERATURE REVIEW .....</b>		<b>26</b>
2.1	INTRODUCTION.....	26
2.2	DEFINITION AND HISTORY OF CONTRACEPTION .....	27
2.3	HISTORY OF LARCS (IMPLANTS AND INTRA-UTERINE DEVICES (IUDS)) .....	27
2.3.1	Origin of IUDs .....	27
2.3.2	History of Implants .....	30
2.3.3	Nexplanon.....	31
2.3.4	Jadelle .....	32
2.4	MODERN CONTRACEPTIVE METHODS.....	32
2.5	LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS).....	33
2.5.1	Mode of action of LARCs .....	34
2.5.2	Indications of LARCs .....	35
2.5.3	Contraindications for LARCs.....	36
2.5.4	Advantages of LARCs.....	37
2.5.5	Disadvantages of LARCs.....	38
2.6	A GLOBAL PERSPECTIVE ON CONTRACEPTIVES .....	38

2.6.1	Global contraceptive method mix.....	39
2.6.2	The global prevalence of LARCs .....	40
2.7	AN AFRICAN PERSPECTIVE ON CONTRACEPTIVES .....	47
2.7.1	Contraceptive method mix in Africa. ....	47
2.8	UGANDAN PERSPECTIVE .....	53
2.9	BELIEF SYSTEMS.....	57
2.9.1	Religious beliefs on contraception .....	58
2.9.2	Indigenous beliefs on contraception.....	62
2.9.3	Beliefs on western contraception .....	65
2.10	SUMMARY.....	66
<b>CHAPTER 3</b>	.....	<b>68</b>
<b>RESEARCH DESIGN AND METHODOLOGY</b>	.....	<b>68</b>
3.1	INTRODUCTION.....	68
3.2	RESEARCH APPROACH.....	68
3.3	RESEARCH DESIGN .....	70
3.4	RESEARCH METHODS .....	71
3.4.1	Study setting .....	71
3.4.2	Research Population.....	74
3.4.3	Sampling.....	74
3.4.4	Approaches in purposive sampling .....	74
3.4.5	Inclusion criteria.....	76
3.4.6	Exclusion Criteria .....	76
3.4.7	Data collection approach .....	77
3.4.8	Development of data collection tools .....	78
3.4.9	Piloting of the data collection tools.....	78
3.4.10	Recruitment of the participants .....	80
3.4.11	Interview Process .....	81
3.5	COVID-19 RISK MITIGATION PLAN .....	83
3.6	ANALYSIS PROCESS .....	84
3.7	RIGOUR AND TRUSTWORTHINESS .....	85
3.7.1	Authenticity .....	86
3.7.2	Credibility .....	87
3.7.3	Transferability .....	88
3.7.4	Dependability .....	88
3.7.5	Conformability.....	89
3.8	ETHICAL CONSIDERATIONS.....	90
3.8.1	Institutional research approval .....	91
3.8.2	The participants .....	92
3.8.3	Debriefing .....	96
3.9	SUMMARY.....	97

<b>CHAPTER 4</b> .....	<b>98</b>
<b>ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESULTS</b> .....	<b>98</b>
4.1 INTRODUCTION.....	98
4.2 DEMOGRAPHIC DATA .....	98
4.3 EMERGING THEMES.....	99
4.4 THEME 1.0: UNDERSTANDING OF FAMILY PLANNING. ....	101
4.4.1 Category 1.1: The meaning of family planning.....	101
4.4.2 Category 1.2: Family Planning methods .....	103
4.5 THEME 2: PERCEPTION OF LARCS .....	105
4.5.1 Category 2.1: Perceived side effects of LARCs .....	105
4.6 CATEGORY 2.2: POSITIVE PERCEPTIONS .....	113
4.7 CATEGORY 2.3: FEARS RELATED TO CONTRACEPTIVE USE .....	114
4.7.1 Separation of couples and single mothers .....	115
4.7.2 Adultery.....	116
4.7.3 Challenges with removal or management of side effects.....	117
4.7.4 Fear of losing their land to non-Baganda tribes .....	118
4.7.5 Disabled children .....	119
4.7.6 Complications in subsequent deliveries .....	120
4.7.7 Excessive weight leads to less productivity. ....	121
4.7.8 Conceiving while using a LARC.....	123
4.7.9 Producing twins after using LARCs methods.....	124
4.8 CATEGORY 2.4: DESIRES BY MEN.....	125
4.8.1 Balance gender among the children .....	125
4.8.2 To get the desired number of children. ....	126
4.9 THEME 3: BELIEF SYSTEM ON LARCS .....	127
4.9.1 Cultural beliefs .....	128
4.9.2 Belief in natural methods .....	128
4.9.3 Power-relations between men and women .....	130
4.9.4 Source of labour for the family .....	131
4.9.5 Expanding and strengthening the clan.....	133
4.9.6 Preference for boys for wealth inheritance.....	134
4.9.7 Wealth from dowry .....	137
4.9.8 Religious beliefs.....	138
4.9.9 Fear of losing a leadership position in the church .....	138
4.9.10 Fear of contravening the teachings of the faith.....	139
4.10 DIFFERENCES IN FINDINGS BETWEEN RUBANDA AND KIBOGA PARTICIPANTS .....	143
4.11 SUMMARY OF FINDINGS.....	144
4.11 CHAPTER SUMMARY.....	145



<b>CHAPTER 5</b> .....	<b>146</b>
<b>THE DEVELOPMENT AND VALIDATION OF STRATEGIES THAT ENHANCE POSITIVE PERCEPTIONS ON LARCS</b> .....	<b>146</b>
5.1 INTRODUCTION.....	146
5.2 STRATEGY DEVELOPMENT AND VALIDATION PROCESS.....	146
5.3 PURPOSE OF STRATEGY DEVELOPMENT .....	147
5.4 PROCESS OF STRATEGY DEVELOPMENT .....	148
5.4.1 Phase 1: Preliminary broad interventions and the targeted strategies ...	148
5.4.2 Phase II: Finalisation of the strategies .....	152
5.4.3 Details of the final strategies .....	159
5.5 STRATEGY ONE: STRENGTHENING SOCIAL AND BEHAVIOURAL CHANGE COMMUNICATION (SBCC).....	160
<b>CHAPTER 6</b> .....	<b>184</b>
<b>SUMMARY, CONTRIBUTIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS</b> .....	<b>184</b>
6.1 INTRODUCTION.....	184
6.2 BACKGROUND .....	184
6.3 STATEMENT OF THE STUDY PROBLEM.....	186
6.4 THE PURPOSE OF THE STUDY .....	186
6.5 STUDY OBJECTIVES.....	187
6.6 RESEARCH DESIGN AND METHOD .....	187
6.7 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS .....	188
6.7.1 Limited knowledge of contraceptives, including LARCS.....	188
6.7.2 Perceptions of rural indigenous Ugandan men regarding the use of LARCS .....	188
6.7.3 Belief systems that rural indigenous Ugandan men have regarding the use of LARCS.....	189
6.8 STRATEGIES TO ENHANCE INDIGENOUS UGANDAN MEN'S SUPPORT FOR THE UTILISATION OF LARCS AMONGST RURAL WOMEN IN UGANDA.....	189
6.9 RECOMMENDATIONS.....	191
6.9.1 Public health practice .....	191
6.9.2 Recommendations for Policymakers .....	195
6.9.3 Recommendation for health sciences higher education and training institutions .....	196
6.9.4 Recommendations for further research .....	196
6.10 CONTRIBUTIONS OF THE STUDY .....	197

6.11	LIMITATIONS OF THE STUDY .....	198
6.12	SUMMARY.....	200
	<b>REFERENCES.....</b>	<b>202</b>
	<b>ANNEXURES.....</b>	<b>243</b>

## LIST OF FIGURES

Figure 1.1:	Schematic diagram for the Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) (Conner & Norman, 2015:148) .....	7
Figure 1.2:	Schematic presentation of the application of the Theory of Planned Behaviour (Bintoro, et al., 2021:1195).....	8
Figure 2.1:	Estimated numbers of women of reproductive age (15-49 years) using various contraceptive methods worldwide (United Nations, 2019: 3) ....	40
Figure 3.1:	Map of Uganda showing the location of Kiboga and Rubanda Districts (adapted from Google Maps 2023) .....	72
Figure 3.2:	The Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) (Conner & Norman, 2015:148).....	85
Figure 5.1:	The process of strategy development and validation(Researcher's own initiative).....	147

## LIST OF TABLES

Table 3.1:	Number of participants per district and how data was collected (Researcher's own initiative) .....	82
Table 4.1:	Themes emerging from both focus group and individual interviews for Rubanda and Kiboga Districts.....	99
Table 4.2:	Differences in Perceptions and Beliefs between Rubanda and Kiboga Districts .....	144
Table 5.1:	Preliminary broad interventions and the targeted strategies for each .	150
Table 5.2:	Category of experts and key stakeholders consulted.....	152
Table 5.3:	Summary of developed strategies of LARCs for men in rural Uganda (Framework adopted from UNICEF, 2016:8).....	154

## ANNEXES

ANNEX 1: Ethical Clearance Certificate (UNISA).....	243
ANNEX 2: Letter of approval from TASO, Uganda .....	245
ANNEX 3: Letter of approval from UNCST, Uganda .....	247
ANNEX 4: Administrative clearance from Kiboga and Rubanda districts .....	249
ANNEX 5a: Permission letter .....	250
ANNEX 5b: Information sheet .....	251
ANNEX 6: Covid-19 Mitigation plan.....	252
ANNEX 7: Informed consent form for focus group and individual interviews-English .....	253
ANNEX 8: Informed consent form for focus group and individual interviews-Luganda .....	255
ANNEX 9: Informed consent form for focus group and individual interviews-Rukiga .....	257
ANNEX 10: Interview guide for individual interviews and focus Group - English....	261
ANNEX 11: Interview Guide for Luganda FGD.....	263
ANNEX 12: Interview Guide for Luganda Individual Interviews .....	265
ANNEX 13: Interview Guide for Rukiga FGD .....	267
ANNEX 14: Interview Guide for Rukiga Individual Interviews .....	269
ANNEX 15: Translated Transcription for English, Rukiga and Luganda.....	271
ANNEX 16: Profile of Experts and Key stakeholders consulted .....	302
ANNEX 17: Language editing certificate .....	305

## LIST OF ABBREVIATIONS AND ACRONYMS

BBC	British Broadcasting Corporation
CCP	Centre for Communication Programmes
CDC	Centres for Disease Control and Prevention
COVID-19	Coronavirus disease 2019
FCDO	Foreign Commonwealth and Development Office
FDA	United States Food and Drug Administration
FGD	Focus Group Discussion
FP2020	Family Planning 2020
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
I:	Individual Interviews
ICF	ICF International Inc
IEC	Information, Education and Communication
IRB	Institutional Review Board
IUD	Intrauterine Device
K	Kiboga Bukomero Sub-County
KD	Kiboga Dwanilo Sub-County
LNG-IUS	The levonorgestrel-releasing intrauterine system.
mCPR	Modern Contraceptive Prevalence Rate, Modern Methods
MOH	Ministry of Health
R	Rubanda Nyamweru Sub-County
RM	Rubanda Muko Sub-County
SIDA	The Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Disease
TASO	The AIDS Support Organisation
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UBOS	The Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNCST	Uganda National Council for Science and Technology

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHTs	Village Health Teams
WHO/RHR	World Health Organisation Department of Reproductive Health and Research

## ABSTRACT

Worldwide, unintended pregnancies remain a critical public health challenge, with 74 million women in low- and middle-income countries getting these pregnancies yearly. The African continent alone contributes about 25% of all unintended pregnancies globally (Bain, Zweekhorst, & Buning 2020). Even though not all unintended pregnancies are unwanted, they can lead to many health problems for mothers and children, like malnutrition, sickness, neglect, or abuse, as well as maternal and infant morbidities and mortalities. Globally, many women die due to complications related to childbirth, either during or after pregnancy. Contraceptives, especially for long-acting reversible methods (LARCs), are among the best interventions to reduce maternal death. LARCs help the mother delay pregnancy and allow for longer intervals in childbirth spacing. However, utilising LARCs globally and in Uganda remains low because of limited male partner support.

The purpose of this phenomenological qualitative research study was to elicit an understanding of the perceptions and beliefs of rural indigenous Ugandan men towards the use of LARCs by rural women. Ultimately the study designed strategies to enhance the uptake of those methods. Purposive sampling was used to identify 65 participants for focus group interviews and 30 for individual interviews comprising married men aged 20 to 49 years. The study was conducted in the Rubanda and Kiboga districts of Uganda. The researcher used semi-structured questions for individual and focus group interviews.

The data analysis was done by transcribing the interviews, sorting the field notes, organising, and storing the data, listening to recordings, reading field notes and interviews and then coding and categorising the data to build themes emerging on the phenomenon.

The study established negative perceptions and belief systems among rural indigenous Ugandan men regarding the use of LARCs by their rural women, and these acted as barriers to utilisation. These perceptions included side effects, fears, desires, and cultural and religious beliefs. The study recommends strengthening social, behavioural change communication, strengthening service provision for LARCs and monitoring and evaluation systems for LARCs. Additionally, policymakers should

provide a conducive environment for LARCs services provision, and the Ministry of Education and Sports, through health training institutions and universities, should prepare pre-service and in-service healthcare workers to provide LARC services.

**Keywords**

Long-Acting Reversible methods (LARCs), beliefs, perceptions, indigenous men, rural women, strategies, barriers, Uganda.

## CHAPTER 1

### ORIENTATION OF THE STUDY

#### 1.1 INTRODUCTION

Contraceptives have been used for long time by human beings. The practice has not been easily accepted by most societies. Some people cite religious reasons for their reservations on the use of contraceptives while others claim that it is against their culture. It is therefore important to understand the perceptions of modern indigenous men from Uganda regarding the use of contraception.

This chapter presents the background to the study, a description of the study problem, theoretical framework, literature overview, the purpose of the study, research objectives and questions. The chapter also outlines the research paradigm, study approach and ethical considerations.

#### 1.2 BACKGROUND

Worldwide, unintended pregnancies remain a critical public health challenge, with 74 million women in low- and middle-income countries getting these pregnancies yearly. African continent alone contributes about 25% of all global unintended pregnancies (Bain, Zweekhorst, & Buning 2020). Some of the factors associated with unintended pregnancies include lack of male partner support, non-use of contraceptives, maternal low levels of education levels and poverty (Alene, Yismaw, Berelie, Kassie, Yeshambel, & Assemie 2020:7).

Even though not all unintended pregnancies are unwanted, they can lead to a lot of health problems for both the mothers and children, like malnutrition, sickness, neglect, or abuse, as well as maternal and infant mortalities (Gharaee & Baradaran 2018:877-878). Other effects of unintended pregnancies include high fertility rates, school dropout leading to low education levels, and the feature employment opportunities leading to poverty (WHO 2019). Estimates indicate that about 61% of unintended pregnancies end up in unsafe abortions, which is one of the leading causes of maternal mortality and morbidities in low and middle-income countries (Bearak, Popinchalk, Ganatra, Moller, Tunçalp, Beavin, Kwok & Alkema 2020: e1157). The challenges resulting from the effects of unintended pregnancies can last for generations.



About 86.8% of unintended pregnancies, especially those in low- and middle-income countries, are due to the non-use of modern contraceptives (Mohamed, Hamed, Yousef, Ahmed, 2019:6-7; Bellizzi, Pichierri, Menchini, Barry, Sotgiu, Bassat 2019:4).

According to estimates, without using modern contraceptive methods, unintended pregnancies could result into 25 million unsafe abortions and 47 000 maternal fatalities annually (Bellizzi, Mannava, Nagai, Sobel 2019:4-5;). Global estimates indicate that in 2017 there were 295,000 maternal deaths (WHO, 2019:32). Out of the reported global maternal deaths, Sub-Saharan Africa (SSA), where Uganda is located, and Southern Asia accounted for 86% of the total of these mortalities. SSA alone accounted for about 66% (WHO 2019:32). In comparison, the maternal mortality rate in the US was 17.9 per 100,000 (Hawkins, Ghiani, Harper, Baum and Kaufman 2019:165-174).

Maternal complications resulting from pregnancy and childbirth contributed up to 75% of all global maternal deaths. These complications arise from severe bleeding (mainly after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications from delivery and unsafe abortion (WHO, 2019:32). Reducing the number of unintended pregnancies could prevent about 60% of maternal mortalities and 57% of the child death, especially in low and middle-income countries (Bellizzi, Mannava, Nagai & Sobel 2019:1;).

About 48% of pregnancies in Uganda are unintended, with 60% occurring in teenagers aged 15-19 years. In addition, Uganda still has a high fertility rate of 5.4 (Ministry of Health Uganda 2022). The burden of unsafe abortions is about 60%, most resulting from unintended pregnancies (SAAF 2022). The maternal mortality ratio is 336 per 100,000 live births, one of the highest in SSA (UBOS & ICF 2018:305). Unsafe abortions are one of the leading causes of maternal mortality and morbidity in Uganda (Inzama, Kaye, Kayondo & Nsanja 2022:1-7).

Kigezi region, South-Western Uganda, where Rubanda district is located, has the second-highest maternal mortality ratio of 541 per 100,000 live births, only second to the Karamoja region with 588 per 100,000 live births (UBOS 2017:63). Additionally, North-Central Uganda where Kiboga, another study district is located has maternal mortality ratio of 410 death per 100,000 live births higher than the national average ratio (UBOS, 2017: 63, i & iv; Kakande, Galande, Makombe, Nyegenye, Basaala, Mutyaba 2019:18). Therefore, preventing unintended pregnancies is one of the critical

approaches to reducing maternal death. Reducing unintended pregnancies is achieved by reducing the unmet need for family planning by increasing access to modern contraceptive methods (WHO 2015: 20-21).

Modern contraceptive methods include short terms, long-acting contraceptives (LARCs) and permanent methods. Examples of short-term modern contraceptives include combined oral contraceptive pills, Progestin-Only Pills, Emergency Contraceptive Pills, Progestin-Only Injectables, monthly Injectables, Combined Patch, and Combined Vaginal Rings as well as Progesterone-releasing vaginal rings (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programmes(CCP) (2018:1-309). Other short-term contraceptive methods include male condoms, female condoms, spermicides and diaphragms, cervical caps, fertility awareness methods, and withdrawal and lactational amenorrhea (Office on Women's Health 2023). The long-acting contraceptive methods, the most effective reversible contraceptive methods, include implants, copper-bearing Intra-Uterine devices (IUDs), and Levonorgestrel intrauterine devices (WHO/RHR & CCP 2022:131-191). The permanent contraceptive methods are female sterilisation(tuboligation) and male vasectomy (WHO/RHR & CCP 2022:221 and 241).

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

The uptake of the most cost-effective LARCs in Uganda is generally low, and the usage is estimated to be 21.4%, with implants contributing 17.3% and Intrauterine devices comprising only 4.1% of the family planning method mix (FP2020 2020). The low uptake of LARCs is partly attributed to the opposition of rural indigenous Ugandan men to the use of LARCs by rural women (UNFPA 2020:2; Monitor 2021). There are reports of a woman killed by her husband for using a LARC in Western Uganda, which reflects mainly the negative attitudes towards preventative methods in other regions (Muhimba 2022). The low LARCs uptake impacts the health of women and children born into large families. Uganda is a developing country with limited resources. The large families exert pressure on the country's provision of social services such as education and health, compromising the quality of the services that the Government of Uganda could provide to its population.

Rubanda and Kiboga, the two study districts, have the highest maternal mortality ratios and high fertility rates, even when the uptake of contraceptive services, including LARCs, remains low (UBOS 2020:18). In Rubanda district, the uptake of LARCs is at 14%, with a rural total fertility rate of 4.8 and maternal mortality of 541 per 100,000 live births. Additionally, Kiboga, another study district located in the Central 2 sub-region (also referred to as Central North), has a LARCs uptake of 9.2%, a rural total fertility rate of 6.3, and maternal deaths of 410 per 100,000 live births (Uganda Bureau of Statistics, 2017: 63, i & iv; Kakande et al 2019: 18).

The low uptake of LARC could partly be related to low male involvement in maternal and child health, including family planning, in the two districts due to individual, community, and institutional factors (Muheirwe & Nuhu 2019:9). The community factors include social and cultural values that are not supportive of male involvement in maternal and child health services. The researcher assumes that the indigenous men in Rubanda and Kiboga districts could have negative perceptions and belief systems about LARCs, just like men in other parts of the world have shown (Sarfraz, Hamid, Kulane, & Jayasuriya, 2023:3–12). These perceptions and belief systems could also be making the indigenous men in the two districts not support the use of the LARCs by their women (Willcox, King, Fall, Mubangizi, Nkalubo, Natukunda, Nahabwe, Goodhart & Graffy 2019:367; Andardi, Rahim, & Achadi 2022:366-367).

Therefore, this study strove to generate an informed understanding of the perceptions and beliefs of rural indigenous Ugandan men in Rubanda and Kiboga districts towards using LARCs and, in lieu thereof, develop strategies to enhance the utilisation of LARCs. Based on this statement of the research problem, the researcher developed the following purpose of the study.

#### **1.4 PURPOSE OF THE STUDY**

The purpose of this qualitative study is to generate an informed understanding of the perceptions and beliefs of rural indigenous Ugandan men towards using LARCs and ultimately develop strategies that could enhance their utilisation by rural women in Uganda. The increased uptake of LARCs could result in a significant reduction in unintended pregnancies, and unsafe abortions could eventually cause a decrease in maternal morbidities and mortalities in Rubanda and Kiboga districts and Uganda.

## **1.5 RESEARCH OBJECTIVES**

The following objectives were developed relative to the purpose statement above. The objectives of this study were designed to:

### **Phase one**

Explore the perceptions of rural indigenous Ugandan men regarding the use of LARCs by rural women to design strategies that increase their support for LARCs uptake by rural women.

Establish the belief systems that rural indigenous Ugandan men hold onto regarding using LARCs to develop strategies to enhance their support for utilising the same contraceptive methods by rural women.

### **Phase two**

Develop strategies to enhance indigenous Ugandan men's support for increased utilisation of LARCs amongst rural women in Uganda.

### **Phase three**

Validate the strategies developed through consultation with experts in the field.

## **Research Questions**

In alignment with the objectives above, the research questions were formulated as follows:

### **Phase one**

The main research question was:

What are the perceptions of rural indigenous Ugandan men regarding the use of LARCs by rural women?

### **Secondary questions:**

What barriers or facilitators enable indigenous Ugandan men to oppose or support their partners' use of LARCs?

What belief systems do rural indigenous Ugandan men hold about using LARCs, which make them not supportive of the same contraceptive method by their rural women?

### **Phase two**

What strategies can be developed to enhance indigenous Ugandan men's support for increased utilisation of LARCs amongst rural women in Uganda?

### **Phase three**

How can the strategies developed in phase two be validated?

In alignment with the above objectives and the research questions, the researcher used the following theoretical framework to anchor the study.

## **1.6 THEORETICAL FRAMEWORK**

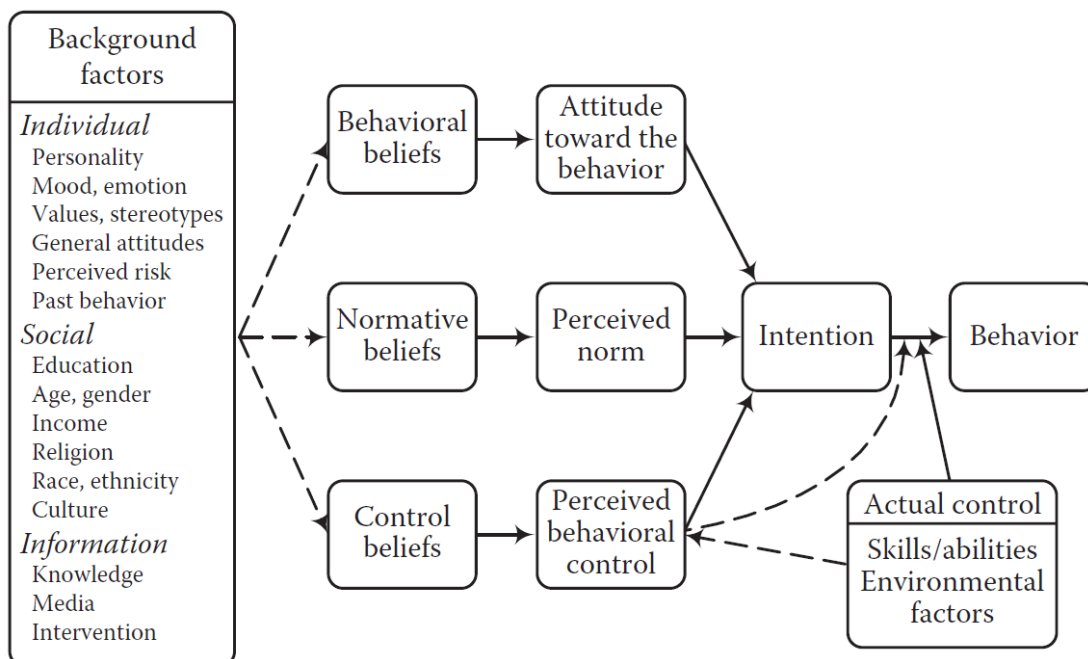
A theoretical framework is a set of ideas and premises that a researcher develops to support a study. It is rationally developed, connected, and based on one or more theories (Varpio, Paradis, Uijtdehaage, and Young 2020:7). A theoretical framework is an essential tool that guides a research study (Merriam & Grenier 2019: 52). A theoretical framework informs the researcher of the problem he has identified, the purpose and significance of the study, and how this research is in line with what is already known (Heale and Noble 2019:36). Additionally, the theoretical framework provides a basis for the research questions, the literature review, and the methodology and analysis that the researcher uses.

In this study, the researcher is guided by the Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB) which assume that individual motivation factors determine the possibility of executing an action (Glanz, Rimer and Viswanath 2015:95). The TRA and TPB operate from the conviction that human social behaviour is determined by the information or beliefs people have about that specific behaviour. The TRA and TPB further concede that the decision to execute or not execute a behaviour is dependent on the beliefs people hold about the outcome of that action (Glanz, et al 2015:122). The TRA and TPB have been selected to guide this study because both emphasise constructs that deal with personal motivational factors as

attributes of the likelihood of performing certain behaviours (Conner and Norman 2015:148).

According to Glanz et al (2015:96), the TRA and TPB explain a large proportion of the variance in intention and predict a number of different health behaviours and intention, including smoking, alcohol and substance use, health service utilisation, exercise, sun protection, breastfeeding, HIV/sexually transmitted diseases (STDs) prevention, contraceptive use, mammography and other cancer screening, safety helmet use, nutritional choices, donating blood and seatbelt use as the orientation of these theories is demonstrated in Figure 1.1.

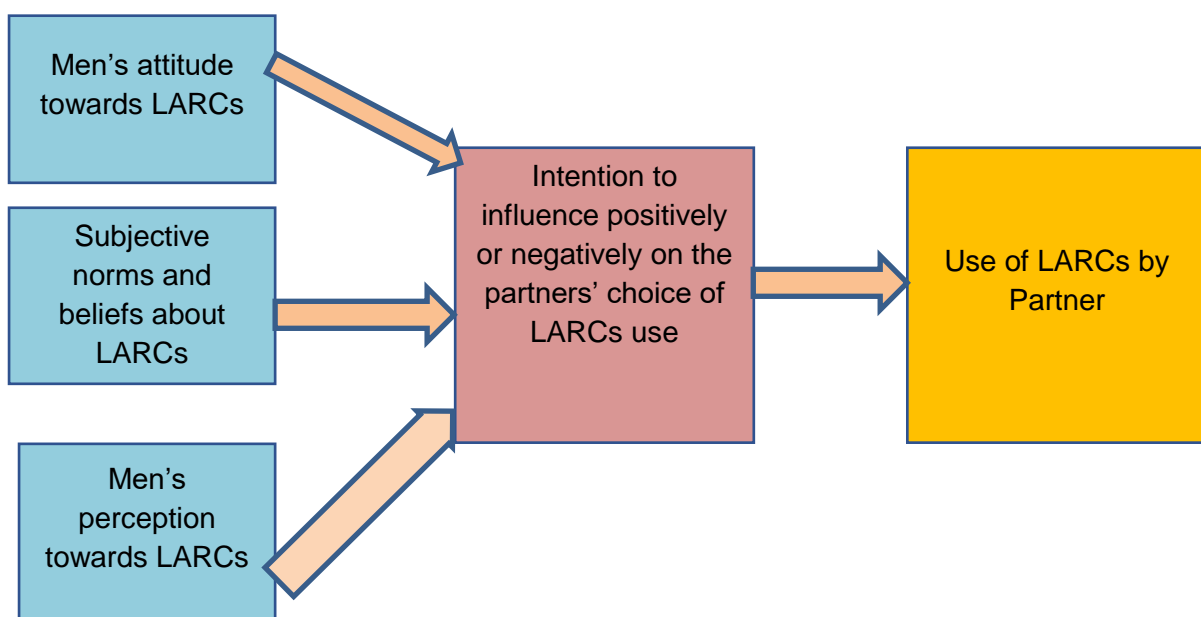
According to the TRA, the beliefs and knowledge that people have determine their social behaviour and these beliefs may be attributed to previous experiences with a specific phenomenon (LaMorte 2019:3). Irrespective of how beliefs about a certain behaviour are developed and sustained, they still offer a direction on whether to execute or not execute that behaviour. In this study, the attitude and normative perception about a behaviour determine the behavioural intention to use a contraceptive method (Bintoro, Murti, Sutisna and Suwanto 2021:1196).



**Figure 1.1: Schematic diagram for the Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) (Conner & Norman 2015:148)**

Applying the TRA and TBA to this study (as shown in Figure 1.2), the intention by Ugandan men to support the uptake of LARCs by their wives is determined by their beliefs and perceptions regarding the LARCs and the control they have over their wives. If Ugandan men have positive beliefs and perceptions about LARCs, they are likely to have a positive attitude towards the use of LARCs by their wives and are more likely to be supportive or to influence their wives to take up the LARCs as contraceptive choices. On the other hand, if Ugandan men have negative beliefs and perceptions about the use of LARCs, they are likely to have a negative attitude towards the same methods of family planning and depending on the level of control they exert over their wives, they are likely to discourage them from taking up LARCs as methods of choice for contraception.

Therefore, TRA and TPB are best suited for this study that seeks to generate a deep understanding of perceptions and beliefs that the rural indigenous Ugandan men have regarding the use of LARCs. In lieu, the study develops strategies emanating from the study to enhance the uptake of LARCs in rural Uganda.



**Figure 1.2: A schematic presentation of the application of the theory of planned behaviour (Bintoro, et al 2021:1195)**

## **1.7 SIGNIFICANCE OF THE STUDY**

This study generates an understanding of the perceptions and belief systems of rural indigenous Ugandan men in the Rubanda and Kiboga districts regarding using LARCs. These perceptions and belief systems, as summarised in 4.11, act as barriers to men's support for the uptake of LARCs by rural Ugandan women.

Therefore, the findings from this study, the developed strategies, and the recommendations benefit the health workers by providing evidence that helps them tailor and structure their demand generation and service delivery interventions that address the negative perceptions and belief systems. Additionally, the recommendations benefit policymakers in designing appropriate policies that promote positive perceptions and belief systems. The recommendations also help academia by identifying further research. Lastly, communities, community leaders, and gender activists benefit from the recommendations of this study by having a supportive environment that promotes positive perceptions and belief systems.

Eventually, with the appropriate policies and interventions in place, the indigenous rural men could become more supportive of LARCs use by rural women, leading to increased uptake. The increased LARCs uptake can lead to reduced unintended pregnancies, unsafe abortions, and finally, a reduction in maternal morbidities and mortalities in Rubanda and Kiboga districts and Uganda.

## **1.8 DEFINITION OF TERMS**

### **1.8.1 Strategy**

A strategy refers to a tactic that one utilises to accomplish specific goals (Loh, Long & Spurgeon, 2019:31; Rumelt 2011:13). In this study, strategy refers to the plans and stratagems through which men in Uganda could be encouraged to support the use of the LARCs by their women.

### **1.8.2 Indigenous men**

The term "indigenous people" (men) refers to a distinct group of people who have inhabited a particular geographical region for many decades and possess, practice, and defend a vast body of knowledge and capabilities that distinguishes them from



other groups (Hoppers 2005:2; Mafongoya and Ajayi 2017:17). The indigenous men in the study specifically refer to the original inhabitants of Rubanda and Kiboga districts who do not believe in the use of LARCs.

### **1.8.3 Support**

Support entails agreeing with and encouraging someone because of an implicit desire for them to succeed (Cambridge Advanced Learner's Dictionary & Thesaurus 2022). In this study, support means enticing the men and negotiating with them to concede to their wives using LARCs as contraceptive methods of choice. There are various forms of support that men can provide to their partners, such as emotional support, financial support, or assistance in accessing healthcare services.

### **1.8.4 Utilisation**

The term refers to using something (Collins Dictionary 2023). In this study, utilisation is specifically connected to the use of LARCs by rural women in Uganda. In the context of this study, utilization specifically refers to the use of LARCs by rural women in Uganda as a method of contraception.

### **1.8.5 Long-Acting Reversible Contraceptives**

LARCs are long term family planning methods whose effects in preventing pregnancy after coitus are reversible when the woman stops using those methods. They include Implants and Intrauterine devices (Curtis & Peipert 2017: 462).

### **1.8.6 Rural women**

Rural women are resourceful economic agents who contribute to family income and the growth of communities in a multitude of ways (ILO 2012). In this study, rural women stay in the villages and generally succumb to their husbands' demands. The rural women in Uganda, particularly in the context of this study, may face specific challenges and barriers related to accessing healthcare services and making decisions about contraceptive methods.

### **1.8.7 Uganda**

Uganda is an independent state in East Africa between the Democratic Republic of Congo, Kenya, South Sudan, Tanzania and Rwanda. It is a member of

Commonwealth Nations. The surface area measures 241,068 square kilometres and the capital is Kampala (Ingham, et al 2023). The population of Uganda is estimated at 43,252,966 people with the following ethnic compositions: Baganda 17%, Ankole 8%, Basoga 8%, Iteso 8%, Bakiga 7%, Langi 6%, Rwanda 6%, Bagisu 5%, Acholi 4%, Lugbara 4%, Batoro 3%, Bunyoro 3%, Alur 2%, Bagwere 2%, Bakonjo 2%, Jopodhola 2%, Karamojong 2%, Rundi 2%, non-African (European, Asian, Arab) 1% and other 8% (Country Reports 2023).

### **1.8.8 Family planning**

Family planning enables people to choose when and if they want to have children by providing them with the knowledge, resources, and tools they need. It involves a variety of contraceptives, including implants and intrauterine (LARCs), tuboligation and vasectomy (permanent methods), pills, and barrier contraceptives like condoms. It also incorporates other methods, like abstinence and the calendar technique. Information on family planning helps with infertility treatment and how to get pregnant when it is desired (UNFPA 2023).

### **1.8.9 Unmet need for contraception**

Unmet needs refer to the discrepancy between women's intentions regarding conception and their use of contraception. It also refers to women who report not wanting any more children or wanting to delay having another child, who are fertile and sexually active but are not using any form of contraception (WHO 2023).

### **1.8.10 Unsafe abortion**

Unsafe abortion is the term used to describe a method of ending an unintended pregnancy that is either performed by individuals who lack the necessary skills, in a setting that does not meet the bare minimum of medical standards, or both (WHO 2023).

## **1.9 BRIEF LITERATURE REVIEW**

Globally, many women and couples want to postpone or avoid pregnancy, but sometimes their need for the contraceptive services is not met. In 2020, out of 1.9

billion women of reproductive age (15-49 years), 57.9% needed family planning globally, of which 44.8% relied on a modern contraceptive method while 4.4% used traditional contraception (United Nations 2019:2). To complicate the problem further, 9.1% of the women globally were not using contraceptive methods, even though they desired to postpone or avoid pregnancy (United Nations 2019:2).

The contraceptive uptake varies across different regions of the world. The current global trends in contraceptive prevalence rate (mCPR) and unmet needs for family planning by 2020 are as follows: mCPR 59.4% and unmet need of 7.4% for New Zealand, mCPR 42.3% and unmet need of 9.3% for Central and Southern Asia, 60.1% and 6.0% for Eastern and South-Eastern Asia, 60.4% and 6.3% for Europe and North America, 58.7% and 8% for Latin America and Caribbean, 35.9% and 10% for North Africa and Western Asia (United Nations 2019:15-17). For Oceania, excluding Australia and New Zealand, the mCPR and unmet need for family planning were 28% and 17.1%, respectively. SSA had an mCPR of 27.8% and an unmet need for family planning 16.6%, respectively.

In Uganda currently, the mCPR is 35% for all women with an unmet need for family planning at 30.5% (UBOS & ICF 2018:112). In the Kigezi region of Uganda, one of the two study districts where Rubanda is located, has an mCPR of 43% and an unmet need for family planning among married women or sexually active unmarried women that currently stands at 19.9%. The North Central Uganda where Kiboga, another study district is located, has an mCPR of 42% and an unmet need for family planning of 24.1% (UBOS and ICF 2018: 112&127). The unmet need for family planning means that some fertile women are not using effective modern family planning methods, which puts them at risk of having unintended pregnancies. Consequently, some unintended pregnancies could end in unsafe abortions and maternal morbidity and deaths.

Some of the factors associated with unmet need for family planning include fear of side effects, religion, partner-level of education and ethnicity (Guure, Maya, Dery, Vrom, Alotaibi, Rezk & Yawson, 2019:11). Other factors associated with unmet need for family planning include husbands' refusal and perceived lower risk of conceiving, religious and cultural beliefs (Gahungu, Vahdaninia & Regmi 2021:11). The consequences of unmet need for family planning include unintended pregnancies,

most of which end up in unsafe abortions, leading to maternal morbidities and mortalities (Bearak et al 2020: e1157). In the following segment, the study discusses the research paradigm.

### **1.10 RESEARCH PARADIGM**

According to Denzin and Lincoln (2018: 195) a paradigm is “a basic set of beliefs that guide research action.” In another view, a paradigm is also understood as “a set of theoretical ideas and technical procedures that a group of scientists adopt, which are rooted in a particular world of view with its language and terminology” (Holloway and Galvin 2016:230). Paradigm is also defined as “set of shared beliefs, that informs the meaning or interpretation of research data” (Kivunja and Kuyini 2017: 26). The full application of the chosen paradigm is discussed and justified in Chapter three.

In this study, the researcher used the naturalistic (constructivist) paradigm. According to constructionist theorists, there is no single truth out there and they contend that reality is dynamic, and knowledge is constructed because of individuals taking part in generating and sharing it (Williamson and Johanson 2018: 32). The constructivist theory stresses the significance of the researcher being a part of the study other than an etic observer. The foundation in constructivist research is that we experience the world differently through our perceptions which are impacted by our preconceptions, beliefs, and values (Williman 2018: 24).

The constructivist paradigm was deemed suitable for this study because the researcher also shares the conviction that there is no single truth out there about the beliefs and perceptions men have towards LARCs. The reality about perceptions and beliefs about LARCs by one family might be different from those that another family may have. The constructivist paradigm allows for exploring diverse perspectives, multiple realities, and contextual nuances (Adom, Yeboah, and Ankrah 2016:6–8). The constructivist paradigm aligns with the goal of generating an informed understanding of a phenomenon (Burns, Bally, Burles, Holtlander & Peacock, 2022: 2–10).

For this study therefore that sought to generate an informed understanding of perceptions and beliefs the rural indigenous Ugandan men hold regarding the use of LARCs to develop the strategies to enhance the uptake of LARCs in rural Uganda,

constructivist paradigm is arguably the most appropriate. The following section provides an overview of the research methodology as applied in Chapter three.

## **1.11 STUDY METHOD**

The study aimed to understand rural indigenous Ugandan men's perceptions and beliefs about the use of LARCs and to develop strategies to increase their support for the use of LARCs by rural women in Uganda. Therefore, a qualitative research approach was suitable for this study. "Qualitative research attempts to understand and make sense of the phenomenon from the participants' viewpoint" (Merriam & Grenier 2019: 6).

In this study, the choice of qualitative research was made because of the need to explore the men's perceptions and belief systems from their lived experience perspective regarding the use of LARCs by their rural women. The perceptions and belief systems are better understood using a qualitative approach. The choice of qualitative approach for this study is justified by Mohajan (2018: 2), who states that qualitative research aims at exploring people's beliefs, perceptions, and experiences that give meaning from their own perspectives. For this study, in-depth individual interviews and focus group discussions were conducted to gather rich and detailed information about participants' perceptions, beliefs, and experiences. In alignment with the chosen research methodology, which is qualitative, the following research design was chosen.

### **1.11.1 Research design**

A research design is "an outline of the study" (Houser 2016:131). Research design is also defined as the logic that connects the data collected to the question of a research study (Chesnay 2017: 31). The researcher used a cross-sectional study design that employed phenomenological qualitative data collection because the design allows for the exploration of participants' perceptions, beliefs and meanings of the phenomenon. Phenomenology is an approach that seeks to get the life experiences of people and the meanings they derive from those experiences (Leavy2017: 29). Phenomenological research is an inductive and descriptive approach that enables the participants a chance to express their perceptions, interpretations, and the meanings of a phenomenon from their perspective (Schneider and Fuller 2018: 62). In this study, a

phenomenological qualitative data collection approach was used because it allowed participants to express their perceptions, interpretations, and meanings of the phenomenon from their perspective in relation to rural women's use of LARCs.

This study strove to generate an understanding of perceptions and beliefs of rural indigenous Ugandan men towards the use of LARCs in order to develop strategies that enhance their support for the utilisation of long-acting reversible contraceptives by rural women in Uganda. This constructive phenomenological approach helped the researcher to answer the research questions. The study was conducted in two locations as discussed below. In this qualitative study, in-depth interviews and focus group discussions were conducted to gather rich and detailed information about participants' perceptions and experiences.

### **1.11.2 Study setting**

This study took place in two rural districts of Rubanda found in Kigezi region in Southwestern Uganda and Kiboga in North Central Uganda as shown in chapter three. These districts were chosen because of their rural locations, high fertility rates and high maternal mortality rates which could be an indication of challenges in use of contraceptives including LARCs. Also the two districts being rural could mean that the information and services regarding contraceptive including LARCs might not be reaching the intended targets hence one of the reasons for high fertility rates. In relation to Kigezi region where Rubanda district is found, the LARCs uptake is at 14%, with a rural total fertility rate of 4.8 and maternal mortality of 541 deaths per 100,000 live births (UBOS & ICF 2018:21&305; UBOS 2018:63; UBOS 2020:62-64).

Additionally, Central 2 sub-region (also referred to as Central North) where Kiboga district is located has LARC uptake of 9.2%, a rural total fertility rate of 6.3 and maternal death of 410 death per 100,000 live births (Uganda Bureau of Statistics, 2017: 63; Kakande et al 2019:18). The maternal mortality ratio is higher than the national level which is 336 deaths per 100,000 live births while the uptake of LARCs is below 21.4%, the national the current uptake for Uganda (UBOS and ICF 2018:21&305; UBOS 2018:63. In both these regions the focus group discussions as well as individual interviews were conducted to develop and document an understanding of Ugandan men from these regions.

### **1.11.3 Study population**

According to Leavy (2017: 76), the study population is a category of elements from which the actual study sample is drawn. Population is also defined as a complete set of all those elements such as people, which have at least one characteristic in common (Williamson & Johanson 2018: 269). Additionally, study population in research is also defined as “a collective term used to describe the total quantity of things (or cases) of the type which are the subject of a study” (Williman 2018: 143-144).

The study population included key respondents who are indigenous married men between 20 to 49 years living in Rubanda and Kiboga districts of Uganda. For this study, indigenous men are those that were born within Rubanda and Kiboga districts or any Ugandan men that have lived in the respective districts for at least two years. The age group of 20 to 49 years was chosen because most indigenous Ugandan men in this age group are sexually active, married already, and their wives are likely to be of reproductive age group of 15-49 years, making them potential clients for LARCs.

### **1.11.4 Sample selection techniques**

Sampling is “the process of selecting just a small group of cases from a large group” (Williman 2018: 143). The required sample was decided through the purposive sampling method. Purposive sampling identifies participants when a researcher decides who to include in a study, as guided by the main research question (Pope and Mays 2020: 62). Purposive sampling can also be defined as a “deliberate selection of particular individuals or groups of people for observation because of their relationship to the research problem” (Roller and Lavrakas 2015: 62). Purposive sampling “means selecting participants for their ability to provide rich information” (Tolley, Ulin, Mack, Robinson and Succop 2016:56).

In this study, participants were selected based on their ability to provide rich information relevant to the research problem. The researcher sampled participants and collected data from them until data saturation, a point where no additional relevant data was provided by participants from the interviews (Cohen, Manion & and Morrison 2018: 223). For individual interviews, participants were selected based on their choice not to share their views in group discussions. Other participants for individual interviews were purposefully selected using the same procedure for the focus group

interviews but informed that they would be interviewed separately. The detailed sample technique is discussed in Chapter three.

### **Strategy for selecting the study participants**

The researcher, working with the Local council and indigenous leadership, used the selection and exclusion criteria below to recruit potential participants:

#### **Inclusion criteria**

The selection of participants considered indigenous men who were born within Rubanda and Kiboga districts or any Ugandan men that had lived in the two respective districts for at least two years. Additionally, other inclusion criteria included men aged 20–49 who were married, accepted, and consented to take part in the study. More to that, men who were willing to be tape-recorded and gave consent in their sober minds were included in the study.

#### **Exclusion Criteria**

The researcher, working hand in hand with the Local council and indigenous leaders, excluded non-indigenous Ugandan men—those who were not married and were outside the age bracket of 20–49 years. Also, men who were not residents of the Rubanda and Kiboga districts for at least two years and those who refused to sign a consent form. Additionally, men who did not agree to be recorded and potential participants with unstable mental status were excluded.

On reaching the homes, the Local and indigenous leaders introduced the researcher to the families, and after the introductions, the researcher explained the purpose of the visit to that home. The researcher informed the potential participants that they were looking to have some conversations with married men about issues affecting the health of their communities and families. Those potential participants who accepted to take part were invited to the common meeting place where the focus group discussions took place, where more detailed information was given about the study before the signing of the informed consent forms. For individual interviews, the same strategy was used, but the individual interviews mainly took place in or around the homes of participants and near the venues for the focus group interviews for those



participants that opted out of focus group interviews in preference of individual interviews.

#### **1.11.5 Sample size**

The sample size was determined from the total population of each region as determined by data saturation. Sample size is defined as the number of research participants selected to take part in the study (Leavy 2017: 76). The study sample size consisted of six focus discussion interviews with 45 participants and 20 individual interview participants for Rubanda. In Kiboga district, the sample size consisted of two focus group interviews with 20 participants and 10 individual interviews with 10 participants. Therefore, for the two districts of Rubanda and Kiboga, the total sample size was eight focus group interviews with 65 participants and 30 individual interviews. This sample size was determined by data saturation, a point at which the researcher obtained no new information from the participants.

#### **1.11.6 Data collection methods and procedures**

Creswell (2015:9) defines data collection as the means of identifying and selecting individuals for the study, obtaining their permission to study them, and gathering information by asking these people questions or observing their behaviour. Data for this study was collected using a phenomenological data collection approach whereby both focus group and individual interviews were applied through an open-ended interview guide with semi-structured questions for individual face-to-face in-depth interviews and focus group interviews. Interviews probed participants to obtain rich information regarding their views, perceptions and beliefs on LARC use.

The data collection was done in a natural setting, specifically in open places in trading centres, some secure places in the homes of participants, and some community meeting halls organised by the local council chairpersons of the respective villages. These venues were away from the interference of non-participants to ensure the confidentiality of what was discussed. The original semi-structured main research question was written in English, but the researcher translated it into Rukiga and Luganda, the two languages spoken in Rubanda in the Kiboga district. The interviews were audio tape-recorded and transcribed thereafter.

The data collection exercise was divided into two phases. The first phase involved data collection from rural indigenous men using six focus group interviews in Rubanda composed of 7-10 participants per group and two focus group interviews in Kiboga consisting of 10 participants each, giving a total of 20. This was followed by individual interviews of 20 key participants from Rubanda and 10 from Kiboga respectively for additional data per sub-county (Table 3.1 in chapter three below). Data collection is discussed fully in Chapter three.

#### **1.11.7 Piloting of the data collection tools**

Prior to actual data collection, the researcher conducted a pilot study of the research tools to ensure the quality of questions and to assess how respondents understood the questions. A pilot serves numerous purposes, the most important of which is to improve the research tools' reliability, validity, and usability (Cohen, Louis; Manion, Lawrence; Morrison&Keith 2018: 496). Piloting of the semi-structured interview tool ensured clarity of the interview questions. The piloting involved four participants for individual interviews and one focus group interview comprising 8 participants from two of the pilot sub-counties of Bubaare in Rubanda and Lwamata in Kiboga. The total number of participants for individual interviews in both pilot districts were 8 and 16 for the focus group interviews. The researcher selected the two sub-counties of Bubaare and Lwamata in Rubanda and Kiboga districts respectively for the pilot because the researcher had already secured permission from the authorities in Rubanda and Kiboga to conduct the study. The two sub-counties were different from those chosen for the main study. Data was collected from participants until saturation. The data collection interview lasted not more than one hour, 10 minutes in line with the guidance by Schneider and Fuller (2018:74).

#### **1.11.8 Mitigation measures to prevent spread of COVID-19**

During data collection, the researcher ensured that the process was in line with WHO and Uganda Ministry of Health (MOH) standard operating procedures (SOPs) for prevention of COVID-19 (MOH 2020). This was achieved by ensuring that both the research assistants and research supervisors as well as participants followed the WHO and MOH SOPs. At each of the venues for the individual interview and focus group interviews, all participants and the research team had to undergo temperature screening and the participants had a handwashing facility with soap.

During the process of data collection, it was ensured that participants in each focus group were not more than 10 in number, and they would sit two metres apart to ensure social distancing. The researcher also ensured that the focus group interview took place under the shade in the open with good air circulation. In addition, the researcher provided masks to the participants who turned up for the interviews. All participants were advised to keep their masks on as long as they were still in the meeting. More to that, the researcher had a box of sanitisers which he gave to each of the participants to sanitise their hands before, during and after interviews and they were allowed to take the remaining sanitiser in bottles provided.

At the venue for the meeting, there was also displayed MOH posters that had key messages on COVID-19 in Luganda/Rukiga languages. These guidelines were easily visible to participants. By ensuring that all the measures mentioned above were followed, the study minimised any risk of spreading COVID-19 during the process of data collection.

#### **1.11.9 Data analysis**

Data analysis is a process of deriving meaning from the data collected (Hesse-Bibber, 2017: 364). “Data analysis converts or translates the raw experience of fieldwork into the insights of scholarship” (Hightower 2019:182). Qualitative data analysis “is a process of inductive reasoning, thinking, and theorising” (Taylor, Bogdan & DeVault, 2016:168). Qualitative data analysis occurs simultaneously with data collection and data management (Cohen et al 2018: 315). For this study, the researcher conducted data analysis simultaneously with data collection in order to allow refinement of the research questions (Mohajan 2018:11). The investigator transcribed the interviews and sorted the field notes, organised, and stored the data. He also repeatedly listened to, and read the notes and recordings collected from the field interviews and then coded and categorised the data to build themes, sub-themes on the phenomenon (Merriam & Grenier 2019:15).

The Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) guide the data analysis by providing structure to develop concepts and themes. To develop concepts and themes for this study, seven components of TPB and TRA were applied: behavioural beliefs that might lead to attitude towards a behaviour, normative beliefs that could lead perceived norms, and control beliefs that might lead to perceived

behavioural control all of which could lead to an intention to perform a behaviour. The findings from the data analysis were integrated to develop strategies that could enhance indigenous men's support for utilisation of long-acting reversible contraceptives amongst rural women in Uganda. The details of the process followed are amplified and discussed in chapter four.

## **1.12 RIGOUR**

Rigour "refers to the steps a researcher adopts to ensure that the research is acceptable (Holloway & Galvin 2016: 314). Rigour of the study refers to how the study findings can be trusted by other researchers (Johnson, Adkins & Chauvin 2020: 145). Trustworthiness of a study refers to the pith and strength of the qualitative study through evaluating all the research study aspects (Grove et al 2015: 513). "Trustworthiness is also defined as a measure of validity within qualitative research" (Willig & Rogers 2017: 510) and this aspect determines the extent of confidence in the quality of an investigation and the findings of the research (Daniel 2019:102). In this study, trustworthiness was enhanced under the four criteria of credibility, transferability, dependability, confirmability (Grove et al 2015: 394) discussed in the paragraphs that follow.

### **1.12.1 Credibility**

Credibility refers to whether the research participants validate the outcomes and whether the findings make sense to other researchers (Willig & Rogers 2017: 556). To ensure credibility of the study, the researcher was in the field for a long time lasting four weeks in Rubanda and three weeks in Kiboga to engage the participants during the data collection process (Forero, Nahidi, Costa, Mohsin, Fitzgerald, Gibson, McCarthy & Aboagye-Sarfo 2018:3). The interview tools in two sites were deemed appropriate after the pretest. All field notes were collected for analysis and storage. In addition, periodic debriefing and feedback sessions with participants in the study clarified data, analysis, and findings (Forero et al 2018: 3).

### **1.12.2 Transferability**

Transferability is the ability to apply the findings of a study in different contexts (Willig and Rogers 2017:556). The researcher ensured transferability of the research findings by furnishing detailed context specific information for the readers to determine if the

findings could be applied to their respective contexts (Johnson et al 2020: 141). However, the results of qualitative studies are usually contextual and cannot be transferred.

### **1.12.3 Dependability**

Dependability means that the evidence from the study is consistent and stable such that someone not involved in the research can replicate the processes of engagement (Moon, Brewer, Januchowski-Hartley, Adams & Blackman 2016:2). Dependability is also about whether the researcher can get the same findings if the study is repeated with the same participants within the same context and coders (Forero et al 2018:3). To ensure dependability of this study, the study provided a detailed description of the research design and a thorough step-by-step reflection on the process of data collection (Forero et al 2018: 3).

### **1.12.4 Conformability**

Conformability is the assurance that the data, interpretations, and outcomes of the study are in contexts and from research participants and not from the researcher's imagination (Moon et al 2016: 3). Additionally, confirmability is the level at which the findings of a qualitative study can be confirmed or verified by other researchers (Korstjens & Moser 2018:121; Tolley et al 2016:37). To ensure confirmability, the study observed and recorded researcher and participant roles in the qualitative study process, including documenting assumptions, biases, or responses which might impact data management. The sample size of 95 participants in this qualitative study for this study gave it a better grounding, hence increasing the trustworthiness.

## **1.13 ETHICAL CONSIDERATIONS**

### **1.13.1 The participants**

Research involving human beings may lead to physical or psychological harm if not properly handled: such a study must follow research ethics guidelines (Creswell & Poth 2018: 113-114). Research ethics refers to rules and principles that govern human behaviour in a study (Nieswiadomy & Bailey 2018: 44). The study was carried out by following three key ethical principles that include respect for autonomy, beneficence, justice (Grove et al 2015: 98).

### **1.13.2 Respect for autonomy**

Autonomy “means that the participants in the research are given an opportunity and respect to make a free, individual, and informed choice without duress (Nieswiadomy & Bailey 2018: 45). To ensure this principle of respect for autonomy, the study first obtained informed consent from participants.

### **1.13.3 Informed consent**

In order to get permission to conduct the study, the researcher obtained a written informed consent (refer to Annex 5b, 7, 8 and 9) signed by the participants. Informed consent refers to the process giving full information to the potential participants about the research, including benefits and risks to enable the participant to make an informed decision whether to participate in a research study or not (Shah et al 2021:863; Schneider and Fuller 2018:132).

The study provided full information to the participants who were informed that their participation was voluntary and that they were free to participate or withdraw from the study at any time even if they had signed the consent form. The researcher further informed the participants about their rights, their expected role as well as the duration of the study. The tools containing full information and the informed consent forms were all translated into Rukiga and Luganda, the two languages spoken in Rubanda and Kiboga districts respectively. After providing the necessary information about the research study to participants, those who agreed to participate in the study were requested to sign a written consent form.

### **1.13.4 Principle of beneficence**

The principle of beneficence is about maximizing benefits and minimising harm to the research participants (Nieswiadomy & Bailey 2018:45). The study ensured that participants were protected from both physical and psychological harm by ensuring privacy and confidentiality of participation as well as measures to prevent the participants from COVID-19.

### **1.13.5 Privacy**

“Privacy refers to freedom from unwanted intrusion into one’s private affairs” (Resnik 2018:149). Privacy was ensured by guaranteeing anonymous participation (Schneider

& Fuller 2018:128), whereby the individual interviews and focus group interviews were carried out in places that afforded privacy to the participants.

#### **1.13.6 Confidentiality**

Resnik (2018:149) defines confidentiality as “a protection of private information”. Ensuring the privacy and confidentiality was critical in respecting dignity, autonomy, preventing harm as well as promoting trust. The participants were assured of confidentiality of the information shared by signing confidentiality forms and by ensuring the participants signed the same form so that they also did share the information they might have got while attending the focus group interview.

#### **1.13.7 Principle of justice**

Grove et al (2015:98) explains the principle of justice as relating to the condition that “human subjects should be treated fairly in terms of the benefits and the risks of research.” Under this principle of justice, all research participants were handled honestly in all aspects of the research study, including their recruitment, participation burden and benefits (Schneider & Fuller 2018:132).

#### **1.13.8 Permission to conduct the study**

The researcher could not proceed to collect data before getting clearance from the supervisor, Department of Health Studies at the University of South Africa, Ugandan Institutional Review Board (IRB), the AIDS Support Organisation Uganda (TASO) and then the Uganda National Council for Science and Technology (UNCST) for the final clearance for data collection. Once the researcher reached the field, he also sought authorisation from the District Health Officers and Resident District Commissioners of Rubanda and Kiboga districts for clearance. Both the district Health Officers, and the Resident District Commissioners allowed the researcher to proceed to the two sub-counties in each of the districts for data collection. In the sub-counties, the researcher first sought permission from the sub-county leadership and then the village local council leaders who also mobilised the potential participants.

#### **1.13.9 Steps taken in case of adverse events**

There were not any potential risks anticipated from this study but still the researcher prepared for psychological discomfort or any unanticipated negative effect arising from

participation in the study. The researcher prepared for referral and facilitation with counsellors at the nearby Government health counselling services. The researcher also made prior arrangement with counsellors at the nearby health facilities in anticipation of any psychological effect as a result of participation in the study. Additionally, the researcher worked with the nearby health facilities to prepare them to manage any physical harm that arose from participation in this study.

## **1.14 SUMMARY**

This chapter provided an overview of the study which included the orientation to the study, the research problem, research purpose, objectives, and research questions. It also introduced the paradigm and the theoretical foundation of the research methodology. The next chapter focuses on literature review on the history and efficacy of contraceptives. The chapter also presents types, indications, and contraindications of LARCs. More to that, the chapter presents a global, African, and Ugandan perspective of contraceptives, including LARCs. In the penultimate, this chapter interrogates the literature about belief systems, contraceptive approaches developed in western economies, religious beliefs, indigenous beliefs, and a final conclusion.

### **Structure of the study**

this study comprises six chapters as delineated below:

Chapter 1: Orientation of the study

Chapter 2: Literature review

Chapter 3: Research design and method

Chapter 4: Analysis, presentation, and discussion of the research findings

Chapter 5: The development and validation of strategies that enhance positive perceptions on LARCS

Chapter 6: Summary, contributions, recommendations, limitations, and conclusions



## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

The previous chapter introduced the scope and delimitations of the study. This current chapter focuses on literature relevant to the research topic to establish what other researchers already know about Long-Acting Reversible Contraceptives (LARCs). The literature reflects the available studies regarding LARCs utilisation globally, in Africa, East Africa, and specifically Uganda. The literature review involves searching through different sources to identify epistemic orientations about the topic to assess its usefulness, quality, debates, and the research gaps that the current study addresses (Willman 2018:52; Bairagi & Munot 2019:14). The literature review provides a logical appraisal of the relevant themes and questions that the researcher needs to interrogate (Hesse-Biber, 2017:405) in the view of other deliberations on the conundrum (Hart 2018:1).

A literature review is paramount in contextualizing and appreciating the core issues (Hart 2018:1). The primary purpose of the review was to help determine the research gap, define the research problem further, and partially answer some research questions (Librero 2012:35-6). Additionally, the literature review provides the background and a clear discussion of the theoretical basis for the research subject, thus shaping the ways in which interpreting the results generates new study implications. (Librero 2012: 35-6).

This review focuses on the history and applications of contraceptives, global and local perspectives regarding LARCs, belief systems in the context of religion, and indigenous and Western beliefs on contraceptives. The survey includes peer-reviewed publications, journal articles, academic books, professional textbooks, Governments and United Nations (UN) and other websites on contraceptives. The review relied upon UNISA online library, Google Scholar, Country and UN Health Reports, PubMed, and EBSCO search engines.

## **2.2 DEFINITION AND HISTORY OF CONTRACEPTION**

Contraception entails the practice of using various devices, sexual practices, compounds, drugs, or surgical techniques to prevent conception intentionally (World Health Organisation 2022). As a result, any device or action that prevents a woman from becoming pregnant can be classified as a contraceptive (Rakhi & Sumathi, 2011:626). Contraception enables people to have the number of children they want and to space their pregnancies as they see fit. This is accomplished through contraceptives (World Health Organisation 2022).

Contraception has been in use since time immemorial; some records dating as far back as 1550BC (The Ancient Times) show that Egyptians, Romans, and Greeks practised contraception methods (Flo Health 2022). These ancient methods used a range of sperm-blocking substances put directly in or on the genitals and home-made oral contraceptives from herbs, spices, heavy metals, barrier methods designed from animal guts, use of lint, as well as withdrawal methods. Other methods included women holding their breath during ejaculation, jumping backwards seven times after sexual intercourse, using animal dung, such as crocodiles, elephants, or mice in making vaginal pessaries, and suturing the vagina by men (Potts & Campbell 2009).

In addition, other methods included putting stones in the uterus of camels and women to prevent pregnancies (Armitage 2018). Most contraceptive methods were ineffective and harmful, especially heavy metals such as mercury, lead, and arsenic, which prevented conception and caused organ failure and brain damage among the users (Flo Health 2022). Currently, the ancient contraceptive methods have been replaced by the evolution of more effective ways that date back to the end of the 18th century and the beginning of the 19th century, as described in the next sections.

## **2.3 HISTORY OF LARCS (IMPLANTS AND INTRA-UTERINE DEVICES (IUDS))**

### **2.3.1 Origin of IUDs**

Intra-Uterine Devices (IUDs) have been in existence for more than 100 years, with the first one documented in Poland in 1909 by Richard Richter. This IUD was a ring developed from the gut of silkworm (Margulies 1974:662; Shoupe 2016:1; Dittrick Medical History Centre 2021). The ring type was later modified by a scientist from

Germany between 1920-30 and then by a Japanese physician in 1934. Subsequently in 1949, the German scientist who had moved to live in the US developed a stainless-steel ring IUD. Eventually, the United States Food and Drug Administration (FDA) approved this IUDs in 1968 (Shoupe 2016:1). Following the approval of the IUD, there were modifications of different versions of IUDs on the US market, including Lippes Loop, the Tatum-I, the saf-T-Coil, the Gynekoil, and the Copper 7 (Strasser, Borkowski, Couillard, Allina, Wood & and Susan 2016:5). These versions of IUDs were made of plastic which allowed them to be inserted and return to their shapes after reaching the uterus. These IUDs also had nylon strings to enable easy removal and for ten years, from 1960, over 12 million women used the IUDs, of which three million were based in the USA (Shoupe 2016:1).

After many years of IUDs on market and use, Jaime Zipper and other scientists found that adding a copper band around the IUD increased its effectiveness in preventing pregnancy by reducing the failure rate from 18% to 1% (Margulies 1974:666). Although these IUDs were effective, there was a side effect of bleeding and cramps associated with them, and this was solved by adding a progestin hormone to the IUDs, which reduced the side effects related to copper by 90% (Shoupe 2016:1). In 1971, Dalkon Shield IUD was introduced to the US market by a manufacturer Robins, and by 1974, over two million women had used this type, but the manufacturer suspended its sale in the US but continued the supply to other parts of the world until 1975 (Strasser et al 2016:8). The suspension of selling Dalkon Shield IUDs followed complications suspected of having led to the death of six women while thousands more had suffered serious infections (Hutchings, Benson, Perkin & Soderstrom 1985:77). Investigations by scientists from the manufacturer later found that the design of the IUD with multi-filament strings were responsible for the infections that affected the uterus (Shoupe 2016:1). Additionally, a study conducted by CDC in 1976 found that health complications and risks were not only related to the Dalkon but also other types of IUDs, including the copper type (Strasser et al 2016: 7).

In 1972, the clinical trials for the Copper T 380 IUD began, and 200 IUD units were approved for distribution in the United States by the US Food and Drug Administration (US FDA) in 1976 (Irving Sivin, 1992:VI). The same authority issued its Second Report on IUDs in 1978, outlining their clinical management guidelines. The marketing of

Copper T 220, primarily in Mexico, began in 1980. The US FDA approved Copper T 380A for marketing in 1984 but the first distribution was done to developing countries as a pilot amongst the women by USAID in 1985 (Shoupe 2016:1). The use of these was later withdrawn due to some of the complications.

Between late 1970s and 1980s, there was a steep fall in the usage of IUDs and other LARCs in the United States, despite the availability in 1988 of a revised version that complied with new FDA safety and production standards (Branum & Jones 2015:1-2; Copeland 2017; Corbett 2013). The drop in the usage of IUDs was blamed on the earlier damage Dalkon wreaked with numerous complications and deaths. Meanwhile, in the 1980s and 1990s, Copper IUDs continued to be sold and used in Europe, where the Dalkon Shield was rarely used (Strasser et al 2016:7). By 1986, only one type of IUD called Progestasert, a hormone-releasing variety, was available on the US market after all other IUDs had been pulled off from the United States market (Ramirez & Starrs 1987:28-34) and this could be related to the complications arising from the type that were used.

The levonorgestrel-releasing intrauterine system (LNG-IUS) called Levonova, later marketed as Mirena (Mirena®), was introduced in 1990 and following two international, multicentre studies carried out in 1990 and 1994, this type of IUD demonstrated a 5-year cumulative pregnancy rate of 0.5%-1.1% compared to 1.4%-5.9% for the copper IUD (Danielsson, Kubba, Caetano, Faustmann, Lukkari-Lax, Hockenheim, 2021:614). In 2000, FDA approved a newer hormonal IUD which was similar to Mirena and in 2013, a new and smaller version of 3- years called Skyla was approved by FDA (Shoupe 2016:2). On the 2nd of March 2015, a newer IUD liletta was introduced, considering affordability, like Mirena but approved for a three-year use. Subsequently, in 2020, the US Food and Drug Administration approved Mirena for six-year use. There are currently two hormonal IUDs: Mirena LNG-IUS 20 µg/24 hr., which works for five years, and Skyla LNG-IUS 13.5 mg, which works for three years (Hacker et al 2016:331).

The World Health Organisation's Scientific Committee on the Safety of IUDs concluded in 1987 that IUD usage in both developed and developing countries should be encouraged as a reversible contraceptive method (Irving Sivin 1992: VI). In the same year, the Centres for Disease Control and Prevention (CDC) in the United States

published guidelines for IUD and these included the indications, contra-indications, safety of the methods, duration of use and informed choice through counselling. In 1988, GynoPharma, Inc launched the ParaGard 380/Copper T 380A IUD in the United States, followed by a six-year extension of the IUD's effectiveness in 1989 (Reproductive Health Access Project, 2013). The FDA extended the duration of effectiveness of Copper T 380A from six to eight years in 1991. Currently, this device can protect a woman for up to 12 years (Hacker, Gambone & Hobel 2016:331).

From the history of IUDs above, it can be established that they have always had challenges related to side effects, with some complications, including death, reported, resulting in low uptake of the same methods. It can be concluded that the current low uptake of IUDs in Uganda, particularly in Kiboga and Rubanda, could also be related to the historical challenges of this contraceptive method. Although IUDs have undergone a lot of modifications to make them more effective, their use in Uganda remains low probably due to the perceptions and belief system related to historical challenges. In the next segment, the study discusses the history of implants.

### **2.3.2 History of Implants**

Implants have evolved over the years from Norplant because of an intersectoral research collaboration that began in the 1960s, with support from the Population Council (Harrison & Rosenfield 1998:108). The method of preparing the approval of Norplant started in the 1980s, and the population council worked on the strategy to introduce it in 1982. The population council then began clinical trials and pre-introduction studies in low and developed countries such as Chile, Dominican Republic, Finland, Sweden, and the United States (Harrison & Rosenfield, 1998:109). By involving both the low developed and developed, this could have been intended to minimise the risk of unethical questions arising from these studies.

Norplant was in 1983 licensed to a pharmaceutical company called Leiras OY in Finland for manufacturing and distribution (Ilegbusi 2022:2). As a result, Finland was the first country to approve the Norplant's manufacture and its use after licensing in the same year. In 1984, the WHO, upon the request from UNFPA, did the evaluation of Norplant and results demonstrated that it was an effective long-term method of contraception and suitable for women who wanted to avoid pregnancy for an extended period (Sivin, Nash & Waldman 2002:2-5).

Following the evaluation of WHO affirming that Norplant was as effective method, in 1985, several countries mainly in Africa and Asia also approved this method. These countries included Nigeria, China, Haiti, Kenya, Nepal, Ghana, Indonesia, Philippines, Sri Lanka, Sweden, Zambia, and Ecuador (Harrison & Rosenfield 1998:109). The approval of Norplants in United States in 1990 after it was done in many developing countries (Gladwell 1990; Hilts 1990). The researcher is of the opinion that delay to have the Norplants approved in United states of America could be because FDA wanted to first do their own evaluation even after WHO had evaluated to ensure safety for the Americans which was not the case with developing countries. The assumption is that the quick approval by developing countries could have been rushed without proper evaluation of the effects of Norplant use hence there were some several complications.

The International Planned Parenthood Federation (IPPF) added Norplant to the list of contraceptive commodities available to its affiliate member Associations around the same time (Sivin, Nash & Waldman 2002:2-5). Over 55,000 women by 1988 had used Norplant in clinical trial studies that had been going on in 41 Countries across the world; 24 of them had approved the use of Norplant by 1992 (Kane, Farr &, Janowitz 1990:49). Additionally, a total of about 300,000 women had used the same methods by 1989 in those Countries where the method had been approved for distribution which included both developed and developing countries (WHO1990:5). Other countries including South Africa also approved the Norplant between 1991 and 1994 (Sivin et al 2002:5).

Although Norplant has been accepted and approved in several countries, it was taken out of the US market by 2002 due to several issues associated with the contraceptive method, including coercion of women, especially those convicted of drug, child abuse and implant removal challenges (Strasser et al 2016:10). The issues that led to removal of Norplants from the US market could be having a connection to low use of implants(LARC) currently experienced in Uganda. These methods were, however, re-introduced to the market as discussed below in the different types.

### **2.3.3 Nexplanon**

The implants were re-introduced in the US Market after approval by FDA in 2006 as a single rod called Implanon. They followed the clinical trials showing a shorter insertion

and removal time of one and three minutes respectively (Shoupe 2016:2). In addition, the same researcher alludes that the approval in the USA happened eight years after the single-rod implant had been introduced in other countries. Since the introduction of Implanon, it underwent modification in 2010 to what is now called Nexplanon (Implanon NXT), which has an easy-to-use inserter and a barium marker that makes detection through imaging possible.

#### **2.3.4 Jadelle**

The process of introducing Jadelle, another type of implant that works for five years, commenced in 1990 with a clinical trial in eight countries of which some were African states (Sivin et al., 2002:13-14). Furthermore, Sivin et al (2002) add that in 1995, the scientists from Population Council submitted Jadelle's application for approval to the US FDA. The permission was granted in 1996 as a three-year method, followed by the same acceptance in Finland in 1997. In 2000, Jadelle use as a contraceptive method was extended from three to five years in Finland, Indonesia, and Population Council also requested Thailand and FDA to increase Jadelle use to five years. The approval for Jadelle as a five-year method by FDA in the USA came in 2001, and in the same year other countries also followed.

Based on the above history of IUDs and implants as LARCs above, it shows that their uptake hasve had challenges dating back in the 1970s. Although there are modifications that have been made on both IUDs and implants since then, the use of the methods is still low. Could it be due to some challenges originating from the history of IUD and implants use described in the paragraphs above that the men do not support their wives use of the LARCs? This study therefore intends to find some of the reasons in form of the perceptions and belief systems the indigenous men have so that strategies that can be designed promote their support of the LARCs uptake can be developed.

### **2.4 MODERN CONTRACEPTIVE METHODS**

The World Health Organisation Department of Reproductive Health and Research WHO/RHR&CCP (2018:1-309) listed the following contraceptive methods considered modern. They include hormonal and non-hormonal methods. The hormonal methods include combined oral contraceptive pills, Progestin-Only Pills, Emergency

Contraceptive Pills, Progestin-Only Injectables, monthly Injectables, Combined Patch, and Combined Vaginal Ring. In addition, there was an additional Progesterone-releasing vaginal rings, implants, and Levonorgestrel intrauterine devices. The non-hormonal methods consists of copper-bearing Intra-Uterine device (IUDs), female sterilisation, and vasectomy.

Furthermore, other non-hormonal methods listed as modern are male condoms, female condoms, spermicides and diaphragms, cervical caps, fertility awareness methods, withdrawal, and lactational amenorrhea. Among the contraceptive methods listed, some of them, such as fertility awareness and coitus interruptus, are also regarded as indigenous methods, which are considered ineffective (Moroole, Materechera, Otang-Mbeng, & Aremu 2020:176; Callahan & Caughey 2018:801). The fertility awareness method has a failure rate of two to five percent for ideal users and 12 to 24% for typical users; lactational amenorrhea is up to 98% effective if properly used (2% failure rate); and coitus interruptus has a failure rate of about 22% effective (Bitzer & Mahmood 2022:22–25). The following section assesses the types of contraceptives in use.

## **2.5 LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS)**

Long-acting reversible contraceptives are methods of contraception that do not have to be used or applied more than once a cycle or once a month (World Health Organisation 2019). These contraceptives are family planning methods that provide effective birth control for a long time without user intervention (Nurse Practitioners in Women Health, 2022; Family Planning NSW 2022). Intrauterine devices (IUDs) and contraceptive implants are examples of effective LARCs with a failure rate of 0.1% for hormonal IUDs, 0.8% for Copper T IUD (ParaGard) and 0.4% for implants (Callahan & Caughey 2018:801).

Currently, there are six types of LARCs available globally, which are classified under two categories. Intra-uterine devices come in three varieties and an implant which also has three versions (WHO/RHR&CCP 2018:131-2). These types are described in the following section.



## **Implants**

According to WHO/RHR and CCP (2018:131-2), implants are "small plastic rods, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body." In addition, this contraceptive is an implantable medical device used for the purpose of birth control. There are three types of implants: Jadelle, which has two rods and has Levonorgestrel (LNG) that is effective for five years; Levoplant (Sino-Implant) (II), which contains two rods and has Levonorgestrel used to prevent pregnancy for up to four years. The third type is Implanon/ Nexplanon (ENG) which has one rod and contains etonogestrel, preventing pregnancy for up to three years.

There are IUDs that are hormonal and non-hormonal (WHO/RHR and CCP 2018:155 & 181). These include Levonorgestrel releasing IUD (Mirena) and hormone Z-releasing IUD (Skyla), while an example of non-hormonal IUD is the Copper bearing ParaGard T 380A. Both the implants and IUDs are long-lasting, reversible, and efficacious in as much as they do not require the clients to do anything once the methods are in use (Hacker et al 2016:330; Callahan & Caughey 2018:813).

### **2.5.1 Mode of action of LARCs**

#### **Implants**

According to Hacker, Gambone and Hobel (2016:330), the primary mechanism of action of all subdermal implants is to prevent ovulation and inhibit sperms from penetrating the mucus of the ovum. This modality of functioning prevents sperms from ascending to the upper genital tract. Also, the implants prevent the fertilised ovum from implanting in the uterus by thickening the uterine endometrium.

#### **Intra-Uterine Devices (IUD)**

Although the mechanism of action of IUDs is not fully understood, it is tacit that they act by killing sperm (spermicidal), thereby stopping fertilisation (Callahan & Caughey 2018: 813-814). The other mode is that the IUDs also elicit an inflammatory reaction that engulfs cells, immobilises and kills the sperms (Mohit, Sadique, Mohapatra, Nijjar, Sharma, Shakshi, Sharma & Rakesh 2021:136). Additionally, the IUDs inhibit sperms and blastocyst transport by reducing tubal motility and this action does not affect

ovulation nor does it act as medical abortion (Hacker et al 2016: 330). These researchers also posit that hormonal IUD augments the action of progesterone, which prevents implantation and thickening of the cervical mucus membrane and atrophies the endometrium. The copper element in Copper T IUD (TCu-380A) impairs sperm movement and capitation, which minimises sperms from reaching the fallopian tube to fertilise the ovum (WHO/RHR & CCP 2018: 155&181).

### **2.5.2 Indications of LARCs**

The term indication refers to approved drug or medication use (Ogbru 2022). Therefore, the indications for LARCs are the approved uses for these methods of contraception.

#### **Implants**

The indications are that implants can be used by women who want a highly effective, long-term method of contraception and have serious or minor estrogen-related side effects from estrogen-progestin contraception methods (French & Darney 2015). These can also be used by women who prefer a non-coitus-related method of contraception or prefer a method that does not require repeated adherence (Callahan & Caughey 2018:813).

Additionally, the other indication is that the implants can be used by women who have decided not to have any more children but are not yet ready to use a permanent method of contraception. They can also be used by women who have a history of anaemia or heavy menstrual bleeding. Equally, these implants are amenable to women who plan to breastfeed. More to that implants can be used by women who have chronic illnesses and whose health could be jeopardised by pregnancy (WHO/RHR & CCP 2018: 135 & 158)

#### **Intra-Uterine Devices (IUDs)**

According to WHO/RHR and CCP (2018:158), IUDs are safe, and nearly all women can benefit from them. Most women can safely and effectively use IUDs. These include women who have or have not had children, are married or unmarried, are of any age, such as adolescents and women over forty years old, and have recently had an abortion with no evidence of infection (Callahan & Caughey 2018:813-814).

The IUDs can also be used by breastfeeding women, those engaged in strenuous physical labour, and those with a history of ectopic pregnancy. In addition, the IUDs can be used by women who have had the pelvic inflammatory disease (PID) and those who have vaginal infections or are anaemic. Whether with symptoms or not, women with HIV/AIDS who are on antiretroviral drugs can also use IUDs (Lanzola & Ketvertis 2022).

### **2.5.3 Contraindications for LARCs**

Contraindications are medical reasons why a particular intervention or treatment for a health condition should not be used (Deuter, Bradbery & Turnbull, 2020: 323). LARCs (implants and IUDs), like any other contraceptives, have contraindications as described in the following section.

#### **Implants**

These are contraindicated in conditions such as severe liver cirrhosis or severe liver tumours, women with serious blood clotting problems in the lower limbs or lungs, unusual vaginal bleeding as well as in women who have a history of hypersensitivity to any components of implant and those with undiagnosed abnormal uterine bleeding (WHO/RHR & CCP 2018:136).

#### **Intrauterine devices**

According to WHO/RHR and CCP (2018:158-160 & 185-187), the IUDs are contraindicated in women who are pregnant or suspect to be pregnant and those with sexually transmitted infection at the time of insertion, such as cervicitis, vaginitis, or any other lower genital tract infection. The other contra-indications include women with a congenital uterine abnormality that obscures the shape of the uterine cavity and makes insertion difficult (Melville 2015:73). IUDs are also not recommended for women with acute pelvic inflammatory disease or a history of pelvic inflammatory disease, except if a subsequent successful intrauterine pregnancy has occurred (Callahan & Caughey 2018: 814).

Furthermore, women with a history of septic abortion or postpartum endometritis in the last three months, as well as those with a confirmed or suspected uterine or cervical malignancy or neoplasia, are not permitted to use IUDs (WHO/RHR & CCP 2018:158-

160 & 185-187). The IUDs are also contra-indicated in women with abnormal uterine bleeding of unknown origin and those with any condition that increases the risk of pelvic infection.

In addition, women who have a history of previously inserted IUDs that have not yet been removed and those who are hypersensitive to any device component are also contraindicated from using IUDs. Levonorgestrel IUD is also contraindicated in confirmed or suspected breast cancer or other progestin-sensitive cancer, benign or malignant liver tumours, and women with acute liver disease as well as women with Wilson's disease and those sensitive to copper (Lanzola & Ketvertis 2022).

#### **2.5.4 Advantages of LARCs**

The advantages of LARCs speak to the benefits the woman gets when she uses these methods of contraception (Oxford University Dictionary 2022). The LARCs have several known advantages and disadvantages, according to WHO/RHR and CCP (2018:132-165). The paragraphs below highlight the advantages of LARCs.

LARCs are effective with a failure rate of less than one percent and last for a more extended time, three years for Implanon to five years for Jadelle and up to 12 years for IUDs. The methods are reversible, and once removed, fertility can return immediately. They do not interfere with the rhythms of sexual intercourse and can be inserted at any time if the woman is not already pregnant; these methods do not require the user to remember to take anything.

In addition, LARCs are readily available from different public and private providers (Callahan & Caughey 2018:816&834). For the Copper T (Cu-380A) IUD, the method does not affect the woman's fertility or hormonal balance. The IUDs can be used as emergency contraception; however, they must be inserted within five days of having unprotected sex. The implants may cause lighter or no menstrual periods, with lower abdominal pain associated with pre-menstruation. The IUDs can help prevent endometrial cancer and cancer of the Cervix (WHO/RHR & CCP 2018:132-165).

Since LARCs have various advantages in addition to offering a long period of protection against unwanted pregnancies, their uptake is expected to have been high, but this is not the case. The uptake of LARCs (IUDs and Implants) is still low compared

to the short-term methods, as they constitute only 19% of the total global method mix (United Nations, 2019:5), while the uptake in Uganda for LARCs currently stands at 21.3% (UBOS 2020: 24).

### **2.5.5 Disadvantages of LARCs**

LARCs have disadvantages that may impede functionality and effectiveness. These disadvantages of LARCs include; their administration and removal require skilled personnel who may not be readily available (Callahan & Caughey 2018: 816&834). Additionally, the insertion of LARCs can be uncomfortable and painful, making the users fear using the methods. LARCs are also susceptible to promoting infection after the method has been provided (WHO/RHR & CCP 2018:132).

If a woman has a sexually transmitted infection (STI) and an IUD is inserted, this could lead to a pelvic inflammatory disease (PID). In addition, this method could cause slightly prolonged and heavier menstrual bleeding, while some women may also find their periods irregular. In rare cases, the insertion of an IUD could lead to perforation of the uterus, leading to other complications such as peritonitis and meningitis (Terrence Higgins Trust 2021).

The low uptake of LARCs globally and in Uganda could be partly due to fears associated with the side effects described above. Additionally, low LARCs utilisation could be related to the limited capacity of health workers to provide the services, including managing the side effects and providing proper counselling on LARCs to clarify possible perceptions and beliefs. More to that, the limited knowledge of the potential users, low male support, and lack of commodity security could also be possible barriers to the uptake of LARCs by rural women.

## **2.6 A GLOBAL PERSPECTIVE ON CONTRACEPTIVES**

Globally in 2019, about 1.1 billion women needed contraceptives out of a total number of 1.9 billion (57.9%) women within the reproductive age of 14-49 years (World Health Organisation, 2020). In the same year, it was established that out of the women who needed contraceptives, only 842 million (44.3%) were using a modern contraceptive, while 190 million women were not despite their desire to avoid pregnancy (United Nations Department of Economic and Social Affairs Population Division 2019:2).

In the developing regions, about 214 million women have an unmet need for contraception because of limited access to family planning services, limited contraceptive method mix choices, an uneasiness about using the contraceptive methods due to side effects, opposition by culture or religion, poor quality of services and gender-based barriers such as lack of decision-making powers by women (World Health Organisation 2021).

It was reported that in Asia out of 1.16 billion women within the reproductive age, those whose need for family planning is met with a modern contraceptive method are 77.3%, while those with an unmet need stood at 9.2% and an mCPR of 46.0% (United Nations Department of Economic and Social Affairs Population Division 2019: 11). Additionally, in Europe, which has 164 million women of reproductive age, the demand satisfied by modern contraception is about 79.3%, with unmet need at 7.4% and a current contraceptive prevalence of 50.3%.

Furthermore, in Latin America and the Caribbean, which have an estimated 175million women aged 15 to 49 years, the demand for contraception met with modern methods is about 82.6% while the unmet need for family planning is about 7.9%. In this specific regional block, the modern contraceptive prevalence is about 54.4%.

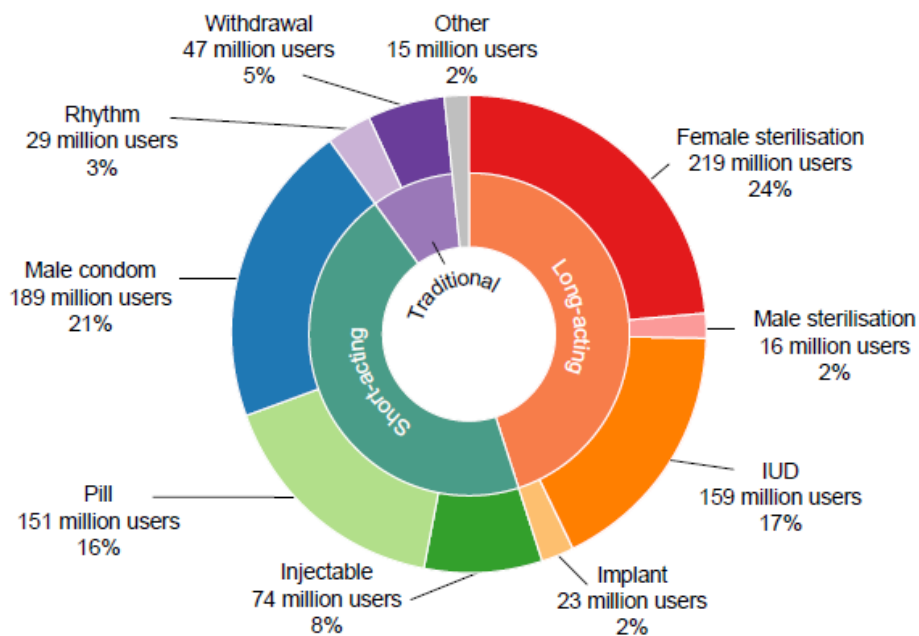
### **2.6.1 Global contraceptive method mix**

Globally, the uptake of contraceptive methods differs from one continent to another. The most used contraceptive is female-female sterilisation, with 219 million users (24%) of the method mix. This is followed by male condoms with 189 million users (21%), IUDs at 159 million (17.4%), and pills that constitute 151 million users (16%). Implants are among the least used contraceptive method globally (2%) (United Nations 2019: 5).

Although globally, IUDs (one of the two LARCs) are among the effective contraceptive methods utilised, they are least used in Africa, accounting for about 2.6% and specifically in Uganda, their use is at 4.0% of the total method mix (United Nations 2019:15). Additionally, implant use (another LARC) in Africa is about 3.7%, while in Uganda, they constitute about 17.3% of the total contraceptive method mix (FP2020 2020). Therefore, the overall uptake of all LARCs (IUDs and implants) combined in Africa stands at about 6.3% of the total method mix, while in Uganda this uptake stands

at 21.3% which is considerably low. The factors associated with the low uptake of implants and IUDs will be explored further in the subsequent sections to below.

As shown in Figure 2.1, three types of contraceptive methods can be used: traditional, short-acting, and long-acting. The examples of each are as follows: Traditional methods include rhythm, withdrawal, and the use of hubs. Short acting comprise condoms, injectables and pills. Long-acting has two categories: those that are reversible (LARC) such as implants and IUDs and long-acting no reversible (permanent), comprising female sterilisation (tubal ligation) and male sterilisation (vasectomy).



**Figure 2.1: Estimated numbers of women of reproductive age (15-49 years) using various contraceptive methods worldwide (United Nations, 2019: 3)**

The prevalence of different contraceptive methods varies across other regions of the world; for example, female sterilisation is dominant in Asia at 39% and Latin America (at 31%). The pill is more prevalent in the Middle East and Northern Africa at 32%, while the injectable contraceptive is dominant in Sub-Saharan Africa, where it takes a majority share of 36% of all the methods mix (Bertrand et al 2020:674).

### 2.6.2 The global prevalence of LARCs

Despite LARCs being the most effective methods of contraception (WHO 2020:1), their use remains low globally in comparison to all other contraceptive method mix

usage that stand at about 19% of all methods, including those using traditional contraceptive methods (United Nations 2019:3). The use of LARCs in Asia is 11.2% of the all the total methods mix compared to 8.5% in Europe and about 10% for North America (United Nations 2019:17).

In Oceania, LARCs use is at about 6.5% of the total method mix, while Latin America and the Caribbean is about 6.1% compared to Africa which is at 6.3% (United Nations 2019:15-24). From this literature and trends in use, the uptake of LARCs is lower in Africa comparatively. This calls for studies to identify the barriers impeding the uptake of LARCs and the need for interventions that could increase utilisation in Africa since LARCs have significant advantages over short-term contraceptives.

In Africa, short-term contraceptive methods continue to dominate the FP method mix. In Sub-Saharan Africa, LARCs (IUDs and Implants) uptake stands at 5.2%, with middle Africa contributing about 1.0%. North Africa has an uptake of approximately at 11% according to the United Nations (2019:17-19). The situation is not different across countries in East Africa, where short-term contraceptive methods dominate the contraceptive method mix as LARCs lag at about 7.2%. Considering the many advantages of LARCs, they should be superior choices from the contraceptive method mix.

A study in Indonesia by Damayanti, Nisa, Ariawan, Titaley, Dachlia, Wahyuningrum, Storey (2019:1452) found a low prevalence of LARCs. The same study identified some factors associated with the use of LARCs such as the availability of services, encouragement to use LARCs services, and perceived distance to the facility where services are offered. Furthermore, the same study established other associated factors such as knowledge about LARCs, the wish not to have any more children, and making a joint family planning decision with husbands.

The joint family planning decision between the woman and her husband is a positive step if the husbands support LARCs use but where the husbands hold negative perceptions and beliefs, the joint decision-making definitely leads to a woman not taking up a LARCs service. This calls for an investigation into the beliefs and perceptions that men have regarding LARCs so as to overcome the related barriers.



Another study conducted in Indonesia by Harzif, Mariana, Malik, Silviaa and Lovita (2019:7) found that LARCs uptake was positively related to women's age and the affordability of contraceptive methods. Additionally, the study identified other associated factors such as awareness about a contraceptive, beliefs, the health workers' expertise in the provision of contraception, and encouragement from health workers. However, in the same study, education level, wealth, family status, the attitude of women, dissemination of information about LARCs, and support of husbands, friends, and community leaders were not significantly related to the uptake of LARCs. In contrast to the above study, Damayanti et al (2019:1452-1457), found that encouragement to use a LARCs and joint decision-making with a husband were associated with increased use. This could mean that the use of LARCs differs from country to country owing to different reasons.

Khatri, Khadka, Amatya, Shrestha, and Paudel (2019:73-76) conducted a study in Nepal that established low uptake of IUDs. Their use depended on partner support, education status of women and their partners, knowledge of the method's safety and efficacy, and counselling on IUD. However, this study differs from the study by Harzif et al (2019: 7), which found that education levels and partner support were not significantly related to the use of LARCs.

In relation to Uganda, it is assumed that men are not supportive of their wives' use of LARCs due to the negative perceptions and belief systems these men have. This prompted the researcher to investigate those perceptions and belief systems in order to develop strategies that promote their acceptability to LARCs use by their rural women.

A study conducted by Katri et al. (2009:73-76) supports the study by Damayanti et al. (2019:1452-1457), which found that knowledge about LARCs has a positive association with increased uptake. Both studies do not show what makes male partners support the utilisation of LARCs. The study asserts that knowledge about LARCs without addressing the perceptions and beliefs that men and women have cannot translate into utilisation of LARCs in any part of the world.

Zendeheel, Jahanfar, Hamzehgardeshi and Fooladi (2020:9-10) conducted a study in Iraq establishing that men and women have knowledge about contraceptive LARC

methods, but the majority do not believe them reliable and more women than men thought it is better not to use LARCs and DMPA. The same authors also verified that younger women with younger partners with an education beyond a high school diploma were less likely to use LARCs. This could be because younger women perceive LARCs as unsuitable for younger people like them and the belief that they can manage their current families. Similarly, Holton, Rowe, Kirkman, Jordan, McNamee, Bayly, McBain, Sinnott, and Fisher (2016:130-131), conducted a study in which knowledge of LARCs was high among adults, but the majority did not think LARCs were reliable FP practices. Younger respondents were more likely to perceive LARCs as reliable contraceptive methods, and religion was insignificant in LARCs uptake amongst these youngsters.

In the same study above, it was also confirmed that men without partners were more likely to use LARCs, and this could be attributed to these men not wanting to have children that are unplanned. This calls for studies that seek to understand the perceptions that men have such that these perceptions could be adapted to develop strategies that enhance the use of LARCs through men's support of the same methods.

A study by Caetano, Blienkendaal, Engler, and Lombardo (2020:368), conducted in 14 Europe countries (Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Poland, Portugal, Spain, Sweden, Switzerland and UK) found high knowledge about LARCs among the women but low uptake of the same methods. The same study found that although there was high knowledge, women's concerns on suitability, reversibility, effectiveness, the ease of using the technique and the side effects were factors that influenced use and the uptake of LARCs. Furthermore, the same study found that limited knowledge regarding LARCs could lead to misconceptions and low utilisation rates of the methods. It can be inferred that having adequate knowledge about LARCs does not translate into utilisation because of other reasons stated above.

Another study by Bhandari, Pokhrel, Gabrielle and Amatya (2019:5-6) in Nepal found low uptake of LARCs that was approximately 4.7%. The same study verified that the use of LARC was adversely affected by factors such as women's age, little or no education in the cohort of husbands. Indigenous communities like Janajati had such

husbands in the poorest category. Additionally, the study confirmed that LARCs usage was positively influenced by women whose husbands were skilled workers, had fewer than two children, and wished to have more children in the future.

In another study conducted in the United States by Qureshey, Chen, Wagner, Chauhan & Bartal (2022: s486) it was found that the United States, though not a third world country, had low LARCs utilisation at 9.4%. The authors identified factors that are significantly associated with their uptake as being younger than 20 years at first birth and being in the age bracket of 20-24 years. The other factors negatively associated with LARCs utilisation included feeling optimistic about conceiving on time and being sexually inactive. In Pakistan, a study by Sarfraz, Hamid, Rawstorne, Ali and Jayasuriya (2021:9), illustrated that women who chose to use LARCs and continued using the methods even when they experienced adverse effects and societal pressures did so with the backing of female family members and partners.

However, a study conducted in China by Luo, Gao, Anguzu and Zhao (2018:8) confirmed that the intention to use LARCs was associated with marital status, frequency of sexual activity, number of children, the timing of the subsequent pregnancy, and previous history of LARCs use. The same research established that women who did not use LARCs due to perceived adverse effects, lacked knowledge about LARCs, and were convinced that the method impairs future fertility and harms the body.

In the same context, White, Bowen, Coley, Marvel, Walters, Vater, Fennimore and Miller, (2018:27-30) in Delaware, the United States, confirmed that most parents in the study were unfamiliar with LARCs. However, they were aware of their advantages although they were concerned about potential adverse effects, both real and perceived. Therefore, even with sufficient knowledge about LARCs, the perception about the side effects could be a barrier to their uptake by women.

From the above literature, it could be inferred that the young women might perceive themselves as not fit to use LARCs or not at risk of getting unintended pregnancy because of limited experience of pregnancy. It can also be inferred that low levels of education of the husband could mean that they lack knowledge on LARCs and therefore are not supportive of their wives using of the same methods. However, for

those with husbands who are skilled, it could mean that they have some adequate education and informed understanding of LARCs and their benefits hence the positive perception of LARCs that could make them accept use of LARCs among their women. Additionally, being indigenous could also mean that those people believe in the indigenous contraceptives and do not support LARCs that are not indigenous contraceptive methods, hence the low uptake of the same methods.

More to that, if the women have intentions of conceive in the future, they do not perceive LARCs as the appropriate method for them hence they do not choose that method. This inference is also true of women who feel they are sexually inactive who also might think LARCs are not the right choices for them. Further, with the support of male partners, even if the women experience side effects from LARCs, they are likely to continue using the methods as demonstrated in the study above, suggesting the men play a significant role in the uptake of LARCs by women.

A study done in India by Kumari and Khetwal (2020: 152-153) identified barriers to contraceptive uptake including illiteracy, male child priority, limited choice of contraceptive method, gender-based barriers, and male dominance, users, and providers' bias, in addition to fake information on the efficacy of contraceptive methods. However, another study in Indonesia by Wulandari et al (2021:481-482) identified challenges that inhibited the multiparous women from contraceptive utilisation such as old age, lack of education, living in urban locations, unemployment, and low wealth. This suggests that some people in communities do not use contraceptives because they keep scouting another gender of the child, especially boys to inherit family property in future. Similarly, male dominance in decision-making in the home is a barrier to the high uptake of LARCs, especially where men have poor perceptions and beliefs about those contraceptive methods.

According to Kang and Peng Li (2018: 256), in a study done in China, it was found that postpartum contraceptive uptake, especially LARCs, was low (9.9%). The same study also identified predictors for LARCs usage as not breastfeeding, normal vaginal delivery, and unwillingness to have another child. It was also established that the advantages of LARCs have not been comprehended, and breastfeeding is still considered to be a reliable method of contraception.

Therefore, it can be inferred that in the Ugandan setting where the postpartum LARCs utilisation is still low, the same predictors as above could also be causative rationale. However, the study did not probe the qualitative reasons why the uptake of postpartum LARCs is low, explaining why this research seeks to understand the perceptions and beliefs of men regarding LARCs so that strategies could be developed for the support and understanding of indigenous Ugandan men towards their usage.

Dansereau, Schaefer, Hernández, Nelson, Palmisano, Ríos-Zertuche, Woldeab, Zúñiga, Iriarte, Mokdad and Bcheraoui (2017:4-6), conducted a study in Mexico where they found some generational and cultural disparities in accepting contraceptive methods. In certain groups, contraceptive usage was severely restricted by gender norms and religious opposition to contraceptives. The same study also found that men had significant influence over family planning decisions in many families in Mexico but were ignored mainly by outreach and education initiatives owing to their work schedules. The study also identified acute physical adverse effects as a deterrent to usage amongst the Mexican women. The simplicity of use, cheap maintenance, and few side effects consider the implant was a novel and highly accepted method of contraception but was perceived as being prone to stock-outs.

Relatedly, in Papua New Guinea, a study by Gupta, Bernays, Black, Ramsay, Bolnga and Kelly-Hanku(2020:5-9) found that men encouraged their wives to use family planning. However, lack of community awareness about contraceptive implants hampered their use. The same study further established that men thought family planning was a women's responsibility, although they had a big say in choosing methods the women should use. Younger males were more open to biomedical knowledge, and showed willingness to utilise implants compared to older men.

In another study in the United States, diversity in the availability of LARCs among publicly funded health institutions, with about 21% of health centres not offering LARCs on-site or relying on informal referrals to provide these services to clients demonstrates that even in rich countries, access to LARCs remains a hurdle (Bornstein, Carter, Zapata, Gavin & Moskosky 2018:408).

## **2.7 AN AFRICAN PERSPECTIVE ON CONTRACEPTIVES**

In Africa, 57.8% of all women of reproductive age which is estimated to be 319 million women, have contraceptive need met by a modern method, with 15.6% of women having an unmet need for contraception (United Nations Department of Economic and Social Affairs Population Division 2019:11). The modern contraceptive use among women of reproductive age in Africa is approximately 26.1%. The contraceptive prevalence and dominant method mix varies across the different regions of Africa. Available data shows that Southern Africa has the highest contraceptive prevalence of any method at 49.7%, followed by Northern Africa with 33.1%, Eastern Africa with 32.5%, Southern Africa with 22.7% and lastly West Africa with 22.0% (United Nations 2019:15-18). The low contraceptive prevalence especially the LARCs in most regions of Africa is an indication of some challenges ranging from social cultural, religious and individual and methods related factors as discussed under the sub-sections below.

### **2.7.1 Contraceptive method mix in Africa.**

The contraceptive prevalence in Africa is 29.4%, with the injectable contraceptive as the dominant one at 8.4%. This is followed by pills and 5.8%, and male condoms at 3.8% (United Nations 2019:15). The LARCs implants and IUDs constitute 6.3%, with implants having a contraceptive prevalence of 3.7% and IUDs of 2.6%. This contraceptive method mix varies across the different regions of Africa. Sub-Saharan Africa has injectables as the dominant contraceptive method with 9.6%, followed by implant and male condoms, each with 4.5% of the total method mix, pills with 3.7%, and IUDs with a prevalence of 0.7%.

Furthermore, in Eastern Africa, the dominant contraceptive method is injectables with 14.3%, followed by implant 6.4%, pills at 4.3% and male condoms at 2.4%, 0.8% for IUDs and female sterilisation with 1.5 % of the total method mix. The scenario also shows that the LARCs uptake is indeed low in Africa (6.3%) and Uganda(21.3%) as illustrated in the literature. This provides a rationale for establishing in-depth reasons for the low uptake of LARCs.

According to Bolarinwa and Olagunju's (2019:24) in a study done to explore the knowledge and factors influencing LARCs' use among women in Nigeria was about 14.8% of the total method mix which was low uptake. However, the finding from

Nigerian study is different from what was done in Ethiopia by Gujo and Kare (2021:4), which found a higher LARCs uptake of 37.8% among women. Stonehill, Bishu and Taddese (2016:350-358) conducted a study in Ethiopia about the determinants of LARC uptake and found that the woman's age, religion, and the ability of the woman to make her own decision in addition to her occupation and marital status were the influencing factors.

A study conducted by Bolarinwa, Nwagbaraa, Okyere, Ahinkorah, Seidu, Ameyaw and Igharo (2022:495) in 26 sub-Saharan African (SSA) countries found the use of LARCs in 26 countries in SSA to be relatively low at about 21.73%. The study also revealed that the education level of women (secondary or higher education), those cohabiting and those that had four or more children were more likely to utilise LARCs as opposed to women with no education, unmarried or those who did not have biological children.

A study in Southern Ethiopia by Gujo and Kare (2021:4) revealed that LARCs utilisation was a bit higher at 37.8% as compared to the utilisation in SSA. In this study, Age, having three or more children, being employed, having a high monthly income, and women who had family discussions were all associated with the use of LARCs. These could imply that the low LARCs utilisation in most parts of Africa is a result of men being against the same methods of family planning and therefore preventing their wives from using those methods. However, for women that are educated and those that have more children are more likely to defy their husbands' opposition to LARCs.

In Kenya, another study done by Ontiri, Ndirangu, Kabue, Biesma, Stekelenburg and Ouma (2019:6-7) revealed low LARCs uptake of about 20.6%. Women's levels of education (tertiary level), religion (protestants), age at which the woman had her first child, and desire to have no more children were all associated factors in this study. However, lack of support from the husbands and perceptions that men felt that IUDs during sex were barriers to the uptake of LARCs because most women do not like to do things that are not supported by their partners. While the literature above shows a lack of partner support and the perception about IUDs, it leaves out the Implant which is also LARCs and which the men cannot feel during intercourse. The literature also did not show the beliefs systems men have that make them unsupportive of LARCs in general.

In another study that was done in Sub-Saharan Africa by Blackstone, Nwaozuru and Iwelunmor (2017:85-90) it was revealed that the uptake of contraception was favoured by higher education levels, being in employment, and having a discussion with a male partner. In a similar study conducted in Kenya by Jalang'o and Njoroge (2017:3-5), the factors associated with postpartum contraceptive use were younger age, marriage, higher level of education, and employment status, as well as receiving the methods at a public health facility. The same study also revealed that women perceived the quality of family planning services at public health facilities to be of better quality than the local chemist shops.

In a study conducted by Hibstu and Alemayehu (2020:4), in Ethiopia found LARCs usage was at approximately 33.5%. This study identified media exposure, women's wish to have one child, and husbands' support as positive predictors of LARCs use. In contrast, the same study also showed that un-educated husbands and women who were not employed were not in favour for LARCs use. A study that was conducted in Ethiopia by Woldu, Ermolo, Lemu and Gejo (2020:3-4) revealed good knowledge of LARCs among women at about 71.4% and a high LARCs usage among postpartum women at about 36.5%. The same study found that previous use of LARCs and having ever discussed with a health professional were positively associated with the use of LARCs. The reasons for no use of LARCs alluded in the same study included fear of adverse effects and inaccurate information.

The literature above has shown that the fear of side effects of LARCs is a barrier to the uptake of the methods. The literature also shows that women who have previously used LARCs can use them again if they did not experience the adverse effect in their previous usage. The level of education is equally a contributory factor to the low uptake of LARCs.

Another study conducted in Malawi by Phethi (2021:97) found that limited knowledge, myths, misconceptions, men's refusal, cultural beliefs, service providers' bias, and perceived health challenges, in addition to fear of side effects, were barriers to uptake of implants and IUDs. Additionally, another study by Boivin, Carrier, Zulu and Edwards, (2020:7-10) found that some misconceptions such as fear of infertility or damage to the structures of the body were a barrier to the uptake of contraceptives such as IUDs and implants. Another study in Tanzania by Msoka et al (2019:1-18) verified the



obstacles to the uptake of vasectomy services as religious beliefs, social norms, inadequate knowledge regarding vasectomy, and expectations related to the gender roles of men in the society.

While the study above acknowledges the role of myths, misconceptions, and beliefs, these are in relation to women and not men. This justifies the need to explore in detail all the perceptions and the beliefs men have regarding the use of LARCs so that strategies could be developed to promote indigenous men's support for LARCs use in Uganda.

Sinai, Omoluabi, Imoh, and Jurczynska (2019:1258-1264), conducted a study in Nigeria and confirmed that most women felt disempowered to decide on contraception. Another study in the same country by Durowade, Omokanye, Elegbede, Adetokunbo, Olomofe, Ajiboye, Adeniyi, Sanni (2017:123-127) identified barriers to contraceptive uptake as a desire to have more children and fear of contraceptive adverse effects. The other obstacles identified included cultural and social barriers such as husbands' refusal, providers requiring the husbands to consent to the methods, religious leaders exerting pressure to use traditional methods, and natural or perceived high cost of the FP services. Additionally, the study found that contraceptive uptake was positively associated with education, religion, and marital status. However, the same study also identified that awareness about contraceptive methods does not lead to the uptake of the same techniques.

In Ethiopia, a study conducted by Tigabu, Demelew, Seid, Sime and Manyazewal (2018:9) found that contraceptives were readily available. Still, most mothers were influenced by their religion not to use the family planning methods as the case in a Nigerian study by Durowade et al (2017:123). The study also found limited knowledge about contraceptive methods and low contraceptive utilisation. Related research done by Sundararajan et al (2019:4) in Tanzania indicates that religious traditions and dynamics of gender affect the adoption and acceptance of contraceptive methods. The study found that no matter their gender or religious affiliation, all participants wanted to adhere to their religious beliefs.

Another related study done in Nigeria by Akinyemi et al (2020:4) found social-cultural challenges to community-based injectable contraceptive scale-up. These included

patriarchy and men's anxieties of losing control over their wives, traditional and religious beliefs associated with fertility and myths about contraceptive use. Indeed, literature in most parts of the African continent amplifies very consistent and similar obstacles as impediments to the increased uptake of FP methods.

A study conducted in South Africa by Jonas, Kalichman, Morroni and Mathews (2020:4) concluded that most men believe that contraception should be the responsibility of both men and women. This specific study concluded that the general support for family planning methods was higher than in most of the other African countries, but the number of men who supported their partners in using the implants was still low. The study also verified that men's reports that their partners wanted another baby in the future, knowing that the implant was safe for women who have never produced any children, knowing that implants can prevent pregnancy for three years, and having a positive attitude about the implant's long-lasting effectiveness were all strongly linked to support of their partner's future use of the contraceptive implant.

From this diverse literature, it can be inferred that the uptake of LARCs is significantly influenced by the support of the male partners, justifying further exploration of the beliefs and perceptions that deter men from supporting use of LARCs by their women.

Another study conducted in Ethiopia by Gashaye, Tsegaye, Abebe and Woldetsadi (2020:12-13) identified that professional support, favourable attitude towards LARCs use, high economic status, and history of abortion were more linked to LARCs uptake unlike in the South African study cited above. Additionally, the same study alluded to the advantage of less frequent visits, having good knowledge of LARCs, and interest in limiting births as significantly associated with LARCs utilisation in Ethiopia.

According to another study done in South Africa by Ranape (2020:71-72), women perceived LARCs as an advantageous and effective contraceptive method. The study also identified challenges that influenced the uptake of LARCs as negative perceptions based on the women's experiences and that of their friends or family members.

Additionally, adverse health consequences such as changes in menstruation and skin, discomfort, and weight gain, contribute to women's choices of short-acting contraceptives over LARCs. The same study also highlighted challenges to LARCs

uptake as lack of skills by healthcare providers, staff shortages, longer waiting times at clinics for LARCs insertion and removal, ineffective counselling on LARCs and misinformation about the mechanism, side effects, as well as limited scepticism over LARCs.

A similar study conducted in Mozambique by Galle, Vermandere, Griffin, de Melo, Machaieie, van Braeckel and Degomme (2018:5-8) confirmed that few women received information about LARCs (22% on IUDs and 33% on implants) at the time of consultations, but still, the uptake was less than 1%. This study indicated that low uptake of LARCs could result from health workers not discussing these contraceptive methods with their clients at the time of consultations. The study findings above suggest misconceptions about contraceptive methods, including LARCs, which could be attributed to low support by men, leading to low uptake of the methods.

Another related study by Adeagbo, Mullick, Pillay, Chersich, Morroni, Naidoo, Pleaner and Rees (2017:823-825) in South Africa found that nurses lacked experience administering Implanon NXT services, especially removals. They attributed their lack of confidence in implant services, especially removals, to the short, cascade-style training they received. The method was perceived negatively by nurses. They also found that adverse effects, notably irregular bleeding, was the most prevalent cause of early removals. The study also established that men were not supportive of their spouses who utilise implants. The study also found that providers needed assistance with counselling on implants and clear guidelines for treating adverse effects.

The studies done in South Africa as well as in Mozambique all confirm that the low uptake of LARCs could be related to the lack of healthcare information provision to the clients. Additionally, lack of male support for use of LARCs was highlighted as a challenge.

A study done in Ghana by Titiati (2017:49) verified that awareness of contraceptives among lactating mothers was very high at about 98.4%, while the contraceptive prevalence rate (CPR) was low at 46.5% among respondents. The study also found that most respondents used injectables and implants, mainly acquired from the hospital. The common reason why lactating mothers used contraceptives was to space births, while most of them selected the specific methods due to convenience.

Significant factors that negatively influenced contraceptive use among lactating mothers were the belief that using contraceptives is a woman's business. In this regard, the belief system of either the individual or partners can have an effect on the uptake of LARCs.

According to Mason, Otieno, Odhiambo, Sappenfield, and Mehta (2020:45), in a study done in Kenya, women who had partner discussions about their future relationship were more likely to use provider-prescribed contraceptives than those who did not. The same study found that men who reported discussing condom use were less likely to report provider-prescribed contraceptive use.

These studies from Kenya and the south Africa show how men are influential in their partners' choice of contraception and where they are supportive, the uptake becomes high while the reverse is true. It is therefore clear that if there are strategies developed to make men more supportive of LARCs, the uptake of the same methods would increase as a result of encouragement elicited amongst the male partners.

## **2.8 UGANDAN PERSPECTIVE**

In Uganda, where the current study occurs, the LARCs prevalence is at 21.3% for the total contraceptive methods mix (the contribution of a methods to the total uptake) among married or in-union women (FP2020, 2020). The Kigezi and North Buganda regions of Uganda have LARCs utilisation of 14% and 9.2% respectively (UBOS 2020:24) which is lower than general usage in Uganda. This prevalence is still low considering the effectiveness of LARCs. Based on the information above, Rubanda and Kiboga are situated on the outskirts of the country, and it could be assumed that information disseminated does not reach these regions.

To improve the quality of family planning services in Uganda, the Ministry Health of Health in 2016 adopted the World Health Organisation Medical Eligibility criteria 2015 wheel for contraceptive use. This resulted into the development of Uganda medical eligibility criteria wheel 2016 for contraceptive use. The Uganda Medical eligibility creteria wheel provides a Ugandan context specific guidance on the indications and contraindications for all modern contraceptive methods (Uganda Ministry of Health 2016).

The guidance provided by the use of Uganda Medical Criteria Wheel is essential in ensuring that clients in need of contraceptive services are provided with safe and appropriate methods. This reduces that possibility of experiencing the side effects and complications arising from the use of particular contraceptive methods including the LARCs. Despite the adoption of this medical eligibility wheel, the uptake of LARCs by the rural community is still not satisfactory as discussed in the paragraphs below.

In Uganda, Wasswa, Kabagenyi and Ariho (2021:11) in a multi-level mixed effects analysis of individual and community level factors revealed that low modern family planning utilisation was associated with not being educated and married being young. Other factors associated with low uptake of family planning including LARCs were being Muslim, living in poverty, having a higher parity, being older at first birth, living far from a health facility, and having a low level of education in the community. High levels of poverty in the community, a lack of working women, increased average age at marriage, and high average age at first sexual encounter were all factors that led to low contraceptive use. In previous studies, religion, age at first sex, poverty as well as higher parity contributed to low uptake of the LARCs. Some religions such as catholic and islam are not supportive of modern contraceptives use while other like protestants do support. Details related to religions and contraceptives are discussed under subsection 2.9.1. Additionally, age could be related to the perceived risks of conceiving, with younger women being perceived as not being at risk of conceiving compared to older women hence low usage of LARCs.

Anita, Nzabona and Tuyiragize (2020:3) discovered that sterilisation services in Uganda were underutilised at only 2%. The same study established the associated factors for low utilising sterilisation services as age over 30 years, middle class, parity of at least four children, and making the contraceptive choice by the husband, or mutual decision making. The low uptake of the sterilisation could be attributed to the myths as well as the misconceptions regarding sterilisation. The misconceptions and myths related to sterilisation include importance or reduced sexual drive for both men and women. These misconceptions are not only on sterilisation but other contraceptive methods including LARCs which could all be contributing to the low uptake of the same methods.

According to Thummalachetty, Mathur, Mullinax, DeCosta, Nakyanjo, Lutalo, Brahmbhatt and Santelli (2017:3-6), it was found that men in Uganda had little knowledge about contraceptives, and most of them feared the associated adverse effects. Men's concerns about various family planning methods were primarily related to the methods' efficacy, side effects on women, and consequences on children. Men's attitudes toward contraceptive methods, particularly LARCs, could therefore logically affect their spouses' use of the same contraceptive methods. If the men's attitude towards LARCs is positive, they might be supportive of LARCs use by their women and if their attitude is negative, they might be unsupportive of their partners' use of the methods.

The finding of the study by Thummalachetty et al (2017:3-6) above relates to those of another study done in Uganda by Sileo, Wanyenze, Lule and Kiene (2017:1555-1560), which found that male support for women's reproductive health services boosts service usage across the reproductive health care continuum. The same study verified that knowledge about contraceptives, partner variables, beliefs, convictions about contraception, fertility goals, male involvement in women's health, peer variables, healthcare system, and structural issues about standard of care in combination influence men's participation. These two studies done in Uganda highlight the importance of male support in reproductive health service usage, the perceptions and beliefs in the uptake of family planning services.

Another study conducted by Willcox, King, Fall, Mubangizi, Nkalubo, Natukunda, Nahabwe, Goodhart and Graffy (2019:159-178) in Uganda identified the barriers to the uptake of immediate postpartum family planning (implants and IUDs). These barriers included the need to open conversations on contraceptive methods, the belief that women require time to recover before the insertion of a LARCs, worry that the baby might not live, and adverse effects. The barriers were more severe than those identified in low-income settings. In related research done in Uganda by Anguzu, Sempeera and Sekandi (2018:3-4), utilisation of LARCs was low at only 8.5%. Similarly, perceptions and beliefs held by men are key barriers contributing to low uptake of LARCs. Therefore, there is need to explore further the men's perceptions and beliefs that make them unsupportive of their partners' use of LARCs.

According to Bryce, Budongo, Baganizi, Paccione, and Kahn (2016), the uptake of LARCs was found to be 2.0%, with most women using injectable Depo-Provera. The same study established common LARCs usage barriers such as inconsistency in the supply of LARCs and service provider biases towards injectable Depo-Provera, especially with young clients. Other reasons for the low uptake of LARCs identified in the same study included having fewer children and the belief that injectable Depo-Provera was a better method of family planning. A similar study in the same country by Tibaijuka, Odongo, Welikhe, Mukisa, Kugonza, Busingye, Nabukalu, Ngonzi, Asiimwe and Bajunirwe (2017:4) found the low prevalence of LARCs was approximately 23%. Some choose the LARCs as they offer protection against pregnancy for a longer time, being an effective technique, and for better spacing of children. The same study found that reasons for not choosing a LARCs were the need for a method that the client could control and the desire for another child in the future. It is assumed that provider bias could be due to limited skills and competencies in providing the LARCs. This makes providers more inclined towards injectable methods that are easier to administer.

Asiimwe, Urunzy and Okurmu (2019:1) confirmed low prevalence of LARCs use at approximately 18.2%. The same study found that current family planning and notions that family planning is only for married couples were independently linked with use of LARCs. The same study further showed that the providers had perceptions that included user preferences and contraceptive affordability. The challenges to LARCs uptake were stock-outs, high client turnover, and provider absenteeism. The study highlights the role played by perceptions, availability of providers and contraceptive commodities in the uptake of LARCs by women.

According to Zimmerman, Sarnak, Karp, Wood, Moreau, Kibira and Makumbi (2021), in Uganda contraceptive use was lower among women who were convinced that the methods affected future fertility or created marital strife. However, contraceptive use was higher among those who were optimistic that it would preserve their beauty. The study also found that women who firmly believed it was right to use family planning before having children were less likely to stop using it than those who disagreed, confirming that perceptions and beliefs influence the uptake of contraception.

It can therefore be assumed that some community members including the indigenous men and women in Rubanda and Kiboga also might hold their own perceptions and beliefs about use of LARCs. The perceptions and beliefs held by the indigenous men could be responsible for their lack of support for the uptake of LARCs by their rural women. Relatedly, the perceptions and beliefs held by rural women could also promote or limit their acceptability to use the LARCs. This calls for further investigations to find those perceptions and beliefs that indigenous men have in the two districts of Rubanda and Kiboga, so that strategies could be developed to enhance the support of men towards LARCs use.

Another research done in Uganda by Zimmerman, Sarnak, Karp, Wood, Ahmed, Makumbi and Kibira (2021) found that contrary to IUDs and implant users, injectable and pill users were more likely to discontinue or switch contraceptives due to side effects. The study further verified that women who experienced bleeding-related side effects were more likely to quit or change contraceptive methods.

However, another study in Uganda by Sarnak, Wood, Zimmerman, Karp, Makumbi, Kibira and Moreau (2021:8) indicated that discontinuing contraception doubled when women did not talk to their spouses about pregnancy avoidance before starting contraception. The same study further showed that partners did not influence method switching, as well the likelihood of future contraceptive usage which was approximately three times higher among non-users who had partner acceptance at baseline than among those who did not.

From this literature, it is logical to deduce that once there is male communication and partners' support towards the use of family planning, there is likelihood of many women taking up the contraceptive methods. The two studies also highlighted the role played by side effects and partner communication in the non-use of contraceptive services.

## **2.9 BELIEF SYSTEMS**

A belief system is a philosophy or set of concepts that assist in interpreting experiences. These beliefs might be religion, political allegiance, philosophy, or spirituality, and these are developed and impacted by various variables. "Belief systems are the stories we tell ourselves to define our personal sense of reality"



(Nescolarde-Selva, 2016:148). A belief system is a collection of beliefs or concepts that assist us in understanding, organising, and making sense of our daily environment (Gurteen, 2022).

### **2.9.1 Religious beliefs on contraception**

Religion can influence the uptake of contraception, and it is defined as "a specific fundamental set of beliefs and practices generally agreed upon by a number of people or sects" (<https://www.dictionary.com>). However, different religions have different beliefs on contraception.

According to the theory of economic growth and stagnation (Prettner & Strulik, 2016), social norms, fertility, and education have a combined influence on long-run economic growth, sexual intercourse, and the use of contemporary contraception methods may contradict established social norms such as religious beliefs.

Chavdar, Andeva, and Kedeva (2017:121-122) conducted a study in Republic of Macedonia and found that religious affiliation and the intensity of religious sentiments continue to influence the reproductive behaviours and decision-making of the people in significant ways. This concurs with a study in Nigeria by Akinyemi, Harris and Kawonga (2020:4-6), which confirmed that due to entrenched beliefs that children are a blessing from God, there is subsequently no regulation accepting contraceptive use. From this literature, it can be understood that some religions are barriers to contraceptive use.

#### **Christian views on contraception**

The Catholic religion believes that contraception should be natural and not artificial. "Contraception works against the natural gift of fertility, treating pregnancy as if it were a disease and fertility as if it were a pathological condition" (Sacred Heart of Jesus Catholic Church 2022). "The Catholic Church teaches that any sexual acts that are closed to pregnancy are morally illicit and bans the use of condoms, hormonal birth control pills and sterilisation" (O'Loughlin, 2016). Before 1930, both the Catholic and protestant churches agreed that modern contraception was sinful (Catholic Answers 2022). Following the 1930 Lambeth conference and the growing pressure, the Anglican denomination changed its view on contraception.

They allowed contraception under certain circumstances and later wholly altered and allowed the use of contraceptives across all situations. All other protestant churches have followed and agreed with the Anglican denomination (Catholic Answers 2022:1).

Contraception restrictions are not infallible and are subject to change. According to Cline (2019), the stringent anti-contraception stance associated with Roman Catholicism originated from Pope Pius XI's 1930 encyclical *Casti Connubii*. Previously, birth control was debated, but it was usually rejected. The rejection was because sex was only valued for reproduction, and preventing reproduction would promote immoral sex. Today, the Catholic Church is the only religious organisation that clings to this limited norm on contraception. Contraception, other than the natural method, is against the Catholic faith.

Most protestant groups, theologians, and churches allow contraception and may even advocate it as a moral virtue. A study done in the United States by Liu, Hebert, Hasselbacher and Stulberg (2019) reported that participants who worked in secular and protestant systems had minimal restrictions on contraceptive care. However, from the same stage, health providers that had worked in Catholic systems reported several restrictions on contraceptive provisions. Although many doctors in a Catholic health system found creative ways to provide the methods, others claimed to be coerced to establish bogus diagnoses in patients' records to cover up the contraceptive methods that could be adopted.

Additionally, Cline (2019) indicates that Protestantism is one of the world's most decentralised religious traditions. He further says that contraception is becoming unpopular among conservative evangelicals who, oddly, depend significantly on Catholic teachings. However, from literature above, it can be assumed that protestants are more open to use all contraceptives unlike the Catholic religion that is against the use of contraceptive methods other than the natural one.

Most American Catholics believe that contraception is acceptable and is not a moral issue (Pew Research Centre 2016:25). However, bishops in African countries with large populations of Catholics have not accepted the impact family planning can have on reducing maternal mortality rates. They claim that contraception is part of the culture that causes death and increases sex practices, especially among the youth

(National Catholic Reporter Publications 2018). It can therefore be assumed that Catholics in the developed world are more liberal to the use of other non-natural contraceptive methods unlike those from Africa.

### **Judaism views on contraception**

Contraception has been the subject of heated dispute in ancient Judaism because there was no authoritative body mandating orthodox teachings (Cline 2019). A typical example is the prescription of birth control methods to prevent pregnancy while the woman is still nursing her baby, thus protecting the baby's life. "The methods of contraception allowed under Jewish law do not damage the sperm or stop it from getting to its intended destination. These are the contraceptive pill and the IUDs (BBC 2022).

Regarding birth control, two fundamental Jewish values come into play, the right to marry, reproduce and have children and the prohibition against wasting man seed (Isaacs 2022). According to the majority of rabbinic sources, women may use contraceptives, but only specific methods. Judaism believes that contraceptive methods must allow regular sexual relations and "no seed" should be squandered. Additionally, hormonal birth control tablets and other techniques are usually permitted but contraception using condoms is not (Yen 2021). It can therefore be concluded that other than the barrier methods of contraception, the other methods are acceptable in Judaism, including hormonal methods.

### **Islamic beliefs on contraception**

Several Muslims consider procreation a religious obligation, and the conception and upbringing of children is one of the goals of marriage (Ayat 2022). However, a majority of Islamic academics agree that Islam permits contraception if a pregnancy would potentially harm a woman's life (BBC 2022). Islam also allows contraception if there is a need to allow couples to space out their children, particularly if a woman is already caring for a child, such as a breastfeeding one. In addition, contraception is also allowed under Islam if there is a possibility of a child being born with a disability and in situations where the family cannot afford to raise a child, and in circumstances where the couple is not ready to have a child yet (Roudi-Fahimi 2004: 5).

Contraception is acceptable in the Islamic religion if both partners agree to the decision. However, when the husband does not agree to use of birth control by his wife, the woman is not allowed to use it (Yen 2021). Islam does not allow permanent methods of vasectomy and tubal ligation, as well as the use of IUDs (Durul-Fiqh 2021:1). The Quran indirectly recommends breastfeeding as a form of contraception for a period of two years. Breast-feeding provides women with a level of contraceptive protection because they cannot ovulate while exclusively breastfeeding (Yen 2021).

According to a study done by Egeh, Dugsieh, Erlandsson and Osman (2019:28-30) in Somalia, it was established that breastfeeding, using non-harmful contraception, and *coitus interruptus* are all acceptable methods permitted by Islam. The study also found that the selected contraceptive technique should be agreed upon by both husband and wife, with Muslim healthcare providers assisting the couple in searching for their method of choice. Using contraception to limit the number of children is considered non-Islamic, and also using a barrier method such as condoms was thought to encourage extramarital sex and hence outlawed.

In a study done in Southern California by Shabaik, Awaida, Xandre and Nelson (2019:981), it was found that most American Muslim women believed that their religion allows the utilisation of reversible contraceptive methods. Another study done among two Muslim communities in Kenya found that misunderstanding of the teachings of Islam on family planning was likely to determine uptake of contraceptives and cultural beliefs together with limited power of women to make their family planning and fertility choices were a key barrier to contraceptive uptake (Abdi, Okal, Serour & Temmerman 2020:9-10).

In a related study in Tanzania by Sundararajan, Yoder, Kihunrwa, Aristide, Kalluvya, Downs, Mwakisole, Downs (2019:8-9), the way people interpreted their religious traditions influences the acceptability and utilisation of contraceptive services. Another study in Sub-Saharan Africa found that religion can affect fertility as well as contraceptive utilisation (Turner & Götmark, 2021:101). When a woman's financial and emotional resources are not yet established, she might also use Islamic contraceptive rules to justify delaying pregnancy, which was a strong strategy for women according to Arousell, Carlbom, Johnsdotter and Essén (2019:62).

According to a study done in Uganda by Mathys (2018:38-41), religion is one of the barriers to contraceptive uptake and some religious leaders admit the need to space the children and guide their members against the teachings of their religions in private. This is supported by another study done in Uganda by Otim (2020:9) which verified that religion was one of the predictors of non-use of contraception. Another study also in the same country by Kabagenyi, Kakande, Owayezu (2020:14), found that demand for family planning was influenced by religion, with Catholicism having a higher odds of demand for contraceptive services. From the literature above, it can be deduced that while Catholic religion prohibits non-natural family planning use, some of the followers still demand and use those contraceptive methods.

According to Adedini, Babalola, Ibeawuchi, Omotoso, Akiode, Odeku (2018:509), in a study done in Nigeria, there was a higher contraceptive uptake among women who had been exposed to family planning messages by religious leaders compared to those that had not. However, another study done in Nigeria indicated that the religious leaders encouraged women to use natural contraceptive methods other than the modern ones that are considered more effective (Sinai, Omoluabi, Jimoh & Jurczynska 2019:1260).

Additionally, Dansereau, Schaefer, Hernández, Nelson, Palmisano, Ríos-Zertuche, Woldeab, Zúñiga, Iriarte, Mokdad, Bcheraoui (2017:4-6) in a study done in Mexico found that religious objections to contraception severely hampered usage. Similarly, a study done in Zambia found that being a protestant, African traditionalist, or Muslim was linked to low usage of contraception (Lasong, Zhang, Gebremedhin, Opoku, Abaidoo, Mkandawire, Zhao and Zhang (2020:4). Based on the literature above, it can be concluded that different religions affect contraceptive utilisation differently with Catholics and Islam being the most rigid toward non-natural contraceptives use while the protestants are flexible.

### **2.9.2 Indigenous beliefs on contraception**

The term "indigenous people" refers to a distinct group of people who have inhabited a particular geographical region for many decades and possess, practice, and defend a vast body of knowledge and capabilities that distinguishes them from other groups (Hoppers 2005:2; Mafongoya and Ajayi 2017:17).

Indigenous people are in charge of and keep alive different cultures and ways of relating to others and their environment (United Nations 2022).

In Africa, contraceptives were used way back before the advent of modern contraceptives. These indigenous methods continue to be used and involve over 40 variations or techniques (Moroole et al 2020:174). Despite the colonial legacy emphasising western contraception, African indigenous contraception plays a reproductive function among populations (Rossier & Corker 2017: 1-2).

According to one African point of view, indigenous methods of contraception are considered to be both physical and spiritual, which includes the use of drinking herbs and wearing inhibitions, periodic and postpartum abstinence, breastfeeding, withdrawal, burying menstrual effluxions, placing curses of sterility on the mother, polygamy, waistband, burial of the umbilical cord, padlock on labia, alcoholic drinks, eating soil; thigh sex, inserting the foot of the baby in the vagina, inserting certain plants in the vagina, and wearing amulets (Moroole et al 2020:175).

Additionally, some other forms of traditional contraceptives involved the woman holding her breath during sexual intercourse and sneezing or blowing her nose immediately after ejaculation (Quarini 2005:28). Some also involved a woman calling out in a loud voice while jumping backwards after intercourse which they believed would expel the sperm from the body (Quarini 2005:29). Amulets and magical spells were also used to ward off conception (Johnson 2021:1-13).

According to Ngozi and Kabera (1991:116-23), traditional contraceptives used in Uganda included putting the baby's foot in the opening of the vagina, putting plants in the genitals, wearing amulets and charms, burying the umbilical cord and placenta after birth, and drinking herbs. These methods were meant to prevent pregnancies and to space them out. In Nigeria, traditional contraceptives were amulets of leather pouches which they enclosed with pieces of paper with incantations written on them (Johnson 2021:1-13). The rhythm method was also used, and this was fully developed after the timing of ovulation was confirmed (Quarini 2005:29).

A study done in Nigeria established that women used to drink various concoctions after sex, especially a mixture of salt and water as well as fizzy drinks, traditional herbs boiled in water, and used water with Qur'anic verses (Sinai, Omoluabi, Jimoh &

Jurczynska 2019:1258). Additionally, in a study by Odivwri (2016:1-9), the other most common traditional contraceptives used in Nigeria were waistband, the ring, gin concoctions, abstinence after childbirth, and prolonged breastfeeding. Women widely misunderstand modern contraceptive methods due to perceived adverse side effects.

Bationo, Ngangue, Soubeiga, Pafadnam, Barro, Pilabre, Kabore, Adognibo, Drabo, Bationo, Ngangue, Soubeiga, Pafadnam, Barro, Pilabre, Kabore, Adognibo, Drabo (2022:51) found the commonly used indigenous contraceptive methods in Sub-Saharan Africa include abstinence, withdrawal, breastfeeding, and rhythm.

According to Mothiba, Lebeso and Davhana-Maselesele (2012:228-239), traditional contraceptives used by South Africans included safety pins; the burial method; eating soil; thigh sex; having more than one woman; drinking ashes; anointed water or oil; abstaining from sexual activity after giving birth and for a certain period; and using a waistband. Additionally, they use breastfeeding and herbs as traditional contraceptive methods. It can therefore be deduced that indigenous people prefer using traditional birth control methods for contraception, to space their children, and as an emergency strategy.

In Nigeria by Akinyemi and Harris and Kawonga (2020:4-6), showed that social-cultural challenges to community-based injectable contraceptive scale-up included patriarchy and men's worry of losing control over their wives, traditional and religious beliefs associated with fertility, and myths about contraceptives use. Additionally, participants indicated opposition to contraceptive use due to traditional beliefs associated with the methods.

Another research conducted in Uganda by Kabagenyi et al (2016:3-7), illustrated that the persistence of socio-cultural practices and beliefs encouraging childbirth were barriers to the uptake of modern contraceptive services. Those beliefs and practices included polygamy, extending family lineage, replacing the dead, gender-based violence, power relations, and twin myths. Other barriers are continued reliance on traditional contraceptive practices, as well as misconceptions and fears about modern contraception. Therefore, from the above literature, beliefs and social-cultural practices are barriers to modern contraceptive uptake including the use of LARCs.

According to research conducted by Sedlander, Bingenheimer, Thiong'o, Gichangi, Rimal, Edberg and Munnar (2018:351) in Kenya, found the belief that contraceptives cause infertility and when they are taken at a young age or prior to having children, were thought to weaken a woman's womb or harm her fertility, making it difficult for her to conceive or carry a baby to term in the future. Similarly, people in Egypt believed that oral contraceptive pills could lead to cancer and that IUDs may puncture the uterus and go to the heart (Eshak 2020:420).

A study done in Kenya by Selander (2018:350-353) found a belief that using modern contraception at a young age or before delivering a child renders women infertile. According to this notion, the most prevalent methods in society were associated with infertility, especially after women who used them were unable to conceive. According to Durowade, et al (2017:123-127) in Nigeria, traditional believers had the least contraceptive utilisation. This supports the theory of economic growth and stagnation (Prettner & Strulik 2016: 21) which found that in the traditional steady state, there is a stagnant economy with high fertility, and limited education, where modern contraception is not practised. This is contrary to a study by Lawton, Makowharemahihi, Cram, Robson and Ngata (2016:58) which verified that indigenous teenage Maoris actively sought family planning before and after pregnancy, although health system challenges led to missed chances of satisfying these young women's needs for effective contraception.

From this literature, it can be concluded that even with the inception of modern contraceptive methods, many people in African countries including Uganda still believe in and use traditional contraceptive methods.

### **2.9.3 Beliefs on western contraception**

Western contraceptives are founded on scientific and technological advances and are administered by modern health providers in clinics or hospitals (Hubacher & Trussell 2015: 421). Modern contraception techniques include sterilisation for both males and females; the LARCs such as IUDs and subdermal implants; short-term methods such as oral contraceptives; condoms for both males and females; injectables; emergency contraceptive pills; patches; diaphragms and cervical caps; spermicidal agents that include gels, foams, creams, and suppositories as well as vaginal rings and sponges.



According to Prettner and Strulik (2016:21) modern contraception is practised, fertility is low, and education and economic growth are high. However, the transition from the traditional regime to the contemporary is not always without challenges. Improving the value of education has been suggested as an approach to boost contraceptive usage and kick-start long-term development.

Therefore, men's support for the use of LARCs by their partners partly depends on the belief systems they hold about the same methods. These belief systems could be religious, cultural, indigenous, or western. If men have Catholic and Islamic religious beliefs, they are likely not to believe in the use of modern contraceptives, including LARCs, and therefore will not support their partners to use of those methods. More to that, men who hold indigenous or cultural belief systems are more likely to support their partners to use of traditional contraceptive methods and will not support their rural women's use of modern methods, including LARCs.

## **2.10 SUMMARY**

In the reviewed literature above, different studies show that the uptake of contraceptive LARCs remains low globally compared to short-term contraceptives. Studies also confirm that men have a big say in their partners' use of contraceptives in general. In addition, other studies have shown that women who had discussions with their partners took up a contraceptive method and the continuation rate was high. Some studies have shown that cultural and religious beliefs play a role in the utilisation of contraceptive services. Also myths and misconceptions about contraceptives including LARCs and perceived adverse effects and benefits of contraception determine uptake. However, there is no study that has assessed the influence of men's perceptions and beliefs on the uptake of LARCs among women. This leaves a gap which is the main focus of this current study.

This chapter provided a review of the literature by highlighting contraceptive LARCs including the history, global perspectives, African perspectives, Ugandan perspectives of contraception and LARCs. The chapter also provided the types of LARCs, and belief systems about contraceptives and LARCs in the context of religion, and indigenous and western beliefs on contraceptives.

It can be concluded that, based on the information and the literature above, men have been excluded from the contraceptive development. However, they are key in making decisions for their women regarding contraceptive use including LARCs. Although today there are several methods available for men to use, men are still resistant to using them. This chapter ended with a summary and the conclusion. The next chapter traces research design, including population, sampling, data collection and analysis processes, ethical considerations and rigour of the study.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

The previous chapter presented the literature review on contraceptives including LARCs under the themes of history of contraceptives, types of LARC's, global perspectives, African perspectives, Ugandan perspectives as well as belief systems (Western approach, religious beliefs, Indigenous beliefs). This chapter zooms on research designs and methods as applied in this study.

#### **3.2 RESEARCH APPROACH**

This study used qualitative research methodology, defined as an approach that generates descriptive data, such as individuals' written or spoken words, as well as observed actions (Taylor et al 2016: 7; Creswell & Poth 2018:41; Leavy 2017:124). The choice of qualitative research was appropriate for this study because it aligns with the research objectives and allows for a deeper understanding of the beliefs and perceptions of the participants. This research approach enables the investigator to get thorough knowledge of a phenomenon by analysing the meanings that individuals attribute to their lives, activities, events, circumstances, people, and things (Leavy 2017:124).

According to Creswell and Poth (2018:96) qualitative researchers often collect data on-site, in the location where participants encounter the phenomenon or problem under investigation, suggesting that the study does not bring participants into a laboratory (which is an experimental environment), nor do they distribute instruments for them to complete, as is the case with survey research. According to other various authors, the qualitative researcher is a key instrument and collects the information directly from individuals by speaking with them and seeing how they act in their environment (Taylor et al 2016:5; Creswell & Poth 2018:98; Flick 2018:6). In this study, focus and individual interviews using open-ended questions in the communities where the men live in their natural environment were applied to generate the data directly by listening and seeing them was conducted.

Flick (2018:5) states that qualitative researchers are interested in the significance that individuals place on events in their lives. In this case, the researcher aimed at understanding people from their own points of view and reality as they perceived it in this phenomenological research. The researcher empathised with and identified with the participants to understand their perspectives regarding perceptions and beliefs about LARCs (Taylor et al 2016:7-8).

Rather than gathering data to test predetermined models, hypotheses, or theories, qualitative researchers build ideas, insights, and understandings from patterns in the data (Taylor et al 2016:5). A qualitative methodology takes a holistic perspective of environments and people; individuals, situations, or groups are not reduced to variables, but are considered as in the totality of their worldviews. In this study, the qualitative researcher examined participants in the context of their past and current circumstances (Creswell & Poth 2018:96). Additionally, qualitative researchers are interested in how individuals think and behave in their daily lives (Tolley, et al., 2016:4). According to Flick (2018:15); Creswell and Poth (2018:97), qualitative researchers place an emphasis on maintaining a close relationship with the empirical world. In the current study, all views from the participants were considered worthy of investigation. The qualitative researcher contests the belief that people's strong views are more legitimate than the weak perceptions (Taylor et al 2016:9).

Taylor et al (2016: 11) states that there is something to be learnt by the qualitative researcher in every situation and group. There is no part of social life that is too uninteresting or minor to study. At the same time, all situations and individuals are distinct. In applying this to the current study, it was ensured that all views of participants were captured, and all participants were given equal chance to express their views regarding the open-ended questions from the interview tools.

In addition, qualitative research is a fluid, emergent, and iterative process and the research design is never set in stone, but rather facilitates the interaction of data gathering and discovery (Tolley et al 2016: 6; Creswell & Poth 2018: 97). Qualitative research is iterative in nature, meaning that findings develop continually. In this study, the investigator was constantly engaged in the research process, seeing how participants reacted to the issue and evaluating data for new insights that could result

in refining the approach, revising the questions, or changing the direction of the study to follow new clues (Flick 2018: 5).

According to Kothari (2018:5) the qualitative research method is concerned with the subjective evaluation of attitudes, beliefs, and behaviours. In light of this, the study sought an informed understanding of perceptions and beliefs of the rural indigenous Ugandan men towards the use of LARCs. This led to the development of strategies that enhance men's support for utilisation of long-acting reversible contraceptives by rural women in Uganda.

### **3.3 RESEARCH DESIGN**

According to Creswell and Poth (2018:38); Denzin and Lincoln (2018:58); Sekaran and Bougie (2016:95), research design entails the complete research process, beginning with the formulation of a problem and progressing through the research questions, data collection, analysis, interpretation, and report writing. The design chosen is determined by the nature of the problems that the research objectives seek to answer (Williman 2018: 26).

This study applied the phenomenological approach because it enables an in-depth understanding of beliefs and perceptions of LARCs use amongst the Bakiga and Baganda men from their lived experiences in their families and communities. Phenomenology also enables the participants a chance to express their perceptions, interpretations, and the meanings of a phenomenon from their perspective (Schneider and Fuller, 2018: 62). This strategy delved into the people's lived experiences and the meanings that they draw from those experiences (Leavy 2017: 129). Phenomenological research design, being an inductive and descriptive method, allowed participants to share their thoughts, interpretations, and meanings of a phenomenon, in this case LARCs, from their own point of view (Schneider & Fuller, 2018: 62).

Furthermore, in using this approach the researcher also gained a better understanding of rural indigenous Ugandan men's perceptions and beliefs about the use of LARCs. Understanding the perceptions and belief systems of indigenous Ugandan men helped the researcher understand the partner related barriers that lead to the low uptake of LARCs by rural women.

The gained understanding of rural indigenous Ugandan men's perceptions and beliefs about the use of LARCs led to the development of strategies to increase their support for the utilization of long-acting reversible contraceptives by rural women in Uganda.

### **3.4 RESEARCH METHODS**

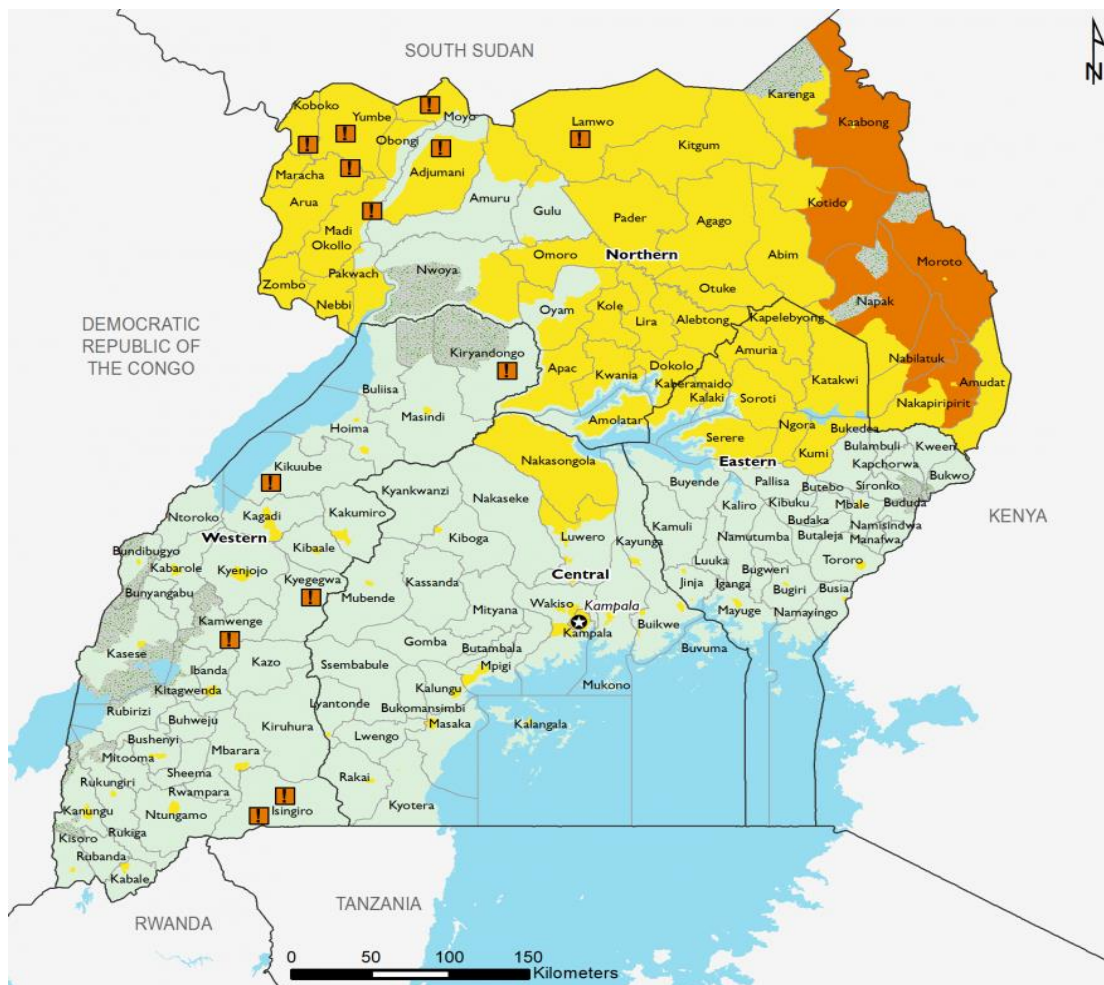
This section discusses the study setting, study population, sampling techniques, and the data management and analysis procedures.

The research methods describe the processes used to organise a study, collect and analyse data in a methodical manner (Polit & Beck 2017: 743). In addition, research methods refer to the behaviour and instruments used in selecting and constructing research (Kothori 2018: 7).

#### **3.4.1 Study setting**

A research setting is the physical location where the investigator accesses participants for the purposes of developing a viable relationship with them, and collecting data directly linked to the objectives of a study (Taylor et al 2016: 32). Data in this study was obtained in a natural context where the participants lived (Polit & Beck 2017: 464; Creswell & Poth 2018:46).

This research was conducted in two rural districts of Uganda which are Rubanda in South-western Uganda and Kiboga District in North-Central Uganda (Fig. 3.1) below.



**Figure 3.1: Map of Uganda showing the location of Kiboga and Rubanda Districts (adapted from Google Maps 2023).**

These two districts were selected due to their rural setting and the indigenous beliefs held by the majority of the people in these districts. Furthermore, choice of the two districts align with the research objectives especially their rural nature, majority of the population being indigenous, high fertility and maternal mortality rates, high unmet need for family planning, limited LARC uptake, and minimal male engagement in family planning.

More to that, the two districts were chosen because of their distance between each other which could be about 600 km as shown in Fig 3.1 above. The other reason was that the researcher wanted to collate views of men without any contamination due to proximity of the districts. These two districts are also far from the capital where family planning is done differently from these rural settings.

Therefore, studying the two specific districts of Rubanda and Kiboga provided insights into the beliefs and perceptions of rural indigenous Ugandan men and facilitated the development of strategies to enhance their support for LARC utilization by rural women. Therefore, the choice of the two rural districts of Rubanda and Kiboga contributed to achieving the research objectives.

### **Demographics of Rubanda and Kiboga districts**

Rubanda district found in Kigezi sub-region has a LARCs uptake of 14%, a rural total fertility rate of 4.8 and maternal mortality of 541 deaths per 100,000 live births. Additionally, Kiboga is another study district located in Central 2 sub-region (also referred to as Central North) has LARC uptake of 9.2%, a rural total fertility rate of 6.3 and maternal death 410 death per 100,000 live births (Uganda Bureau of Statistics, 2017: 63, i & iv; Kakande, et al., 2019: 18).

Rubanda district is located in South-Western Uganda, and it has a population of 206,600 of which 52.5% are females and 47.5% are males (UBOS 2020). The district is bordered by Kisoro in its Western border, Rukungiri and Kanungu districts in the North, Kabale district in the Eastern border and the Republic of Rwanda in its South. The district covers a land area of 660.2 sq km and the altitude ranges between 1,219 metres (3,999 ft) and 2,347 metres (7,700 ft) above sea level. The population is predominantly the Bakiga, but also the Batwa (Pygmies), the Banyarwanda and the Bahororo tribes (Rubanda district local Government 2021).

The second research setting is Kiboga District in the Central region of Uganda. The district population is 169,700 with males constituting 51.7% and females 48.3% of the population (UBOS 2020). The district covers a land area of 1586.9 sq km and is bordered by the Nakaseke District in the northeast and east, Mityana District in the Southern part, Mubende District in the south-eastern and Kyankwanzi District to the northwest. The major tribes in Kiboga include Baganda, Basoga, Bagisu, Bagwere, Bakiga, Banyankole, Banyarwanda, Lugbara, Banyoro, and Batooro. Lugand (Kiboga 2021).



### **3.4.2 Research Population**

According to Leavy (2017: 76), the study population consists of elements from which the actual study sample is drawn. The term population as also defines a complete set of all those elements such as people, which have at least one characteristic in common (Williamson & Johanson 2018: 269; Williman 2018: 143). The study population for Rubanda district was 98,135 men, while Kiboga district had 87,735 men. From this population, indigenous married men aged 20 to 49 were considered. This was because most indigenous Ugandan men in this age group are sexually active, and their wives are likely to be in the reproductive age group of 15 to 49 years and at risk of getting unintended pregnancies, making them potential clients for LARCs. The study population was also relevant to the research objectives, and their perspectives on LARC utilisation by their wives could provide valuable insights to guide the development of strategies for enhancing the uptake of LARCs. The total sample size drawn from this population was 95 men, of whom 65 were from Rubanda and 30 from Kiboga district.

### **3.4.3 Sampling**

Sampling means “the process of selecting a small group of cases from a large group” (Williman 2018: 143). Additionally, sampling is a specific strategy for getting a small number of participants to represent a specified population (Kothari 2018: 55). This study used the non-probability, purposive sampling approach because the researcher wanted to get information about aspects of the phenomenon that are yet unclear (Boswell & Cannon 2017:186; Silverman 2013:355; Creswell & Clark, 2018:269). For this study, participants were recruited on the basis that they were married men with children, whose wives were potential clients for contraceptive use LARC use (Tolley, Ulin, Mack, Robison & Succop 2016:56; Pope & Maysc 2020: 62). Purposive sampling was also applied on the inclusion criteria described in 3.4.5 and the actual sample size was determined by data saturation - a stage when no new information emerges from the participants (Creswell & Poth 2018:496).

### **3.4.4 Approaches in purposive sampling**

Creswell and Clark (2018:269) describes three approaches of purposive sampling as: maximal variation sampling is when a wide range of people are chosen who are likely to have different views about the study. More to that, extreme case sampling entails

the researcher picking persons who give particularly uncommon, difficult, or insightful experiences while homogeneous sampling is when the researcher identifies persons belonging to a subgroup with distinguishing traits.

In this study, the researcher used the non-probability purposive sampling, necessitating critical consideration of the parameters of the population under investigation (Silverman 2013: 355). Researchers used the non-probability purposive sampling approach because of its convenience in getting participants for the study, less time-consuming and inexpensive than other sampling techniques. This sampling approach also enabled the researcher to easily identify study participants, as long as they met the inclusion criteria.

The researcher, working with the local council and indigenous leaders, identified homes that had potential participants using the registers and in accordance with the inclusion and exclusion criteria discussed in 3.4.5 and 3.4.6 below. The researcher guided by the local leaders, visited the homes of potential participants that had been identified from the registers of local councils. After introductions, the researcher explained the purpose of the visit to the potential participants, and those who accepted to take part in the study and met the selection criteria were invited to the venue for the focus group interviews. The same procedure was followed for participants for individual interviews, but for them, they had the option to be interviewed in their homes if they found it appropriate to do so there.

The maximal variation approach was also used to select the sample, which was achieved by selecting participants from two distant sub-counties that were more than 20km apart in each of the two districts of Rubanda and Kiboga. In addition, the two distant districts, which are also about 600 kilometers apart and each have a different dominant tribe. The maximum variation approach was used to ensure the non-contamination of participants and enable the researcher to get different perspectives from two distinct settings and distinct populations.

### **3.4.5 Inclusion criteria**

The following inclusion criteria was adopted:

- Indigenous Ugandan men, that is a distinct social and cultural community with a common ancestry to the land and resources on which they currently live, once occupied, or were forcibly removed from (The World Bank 2022). For this study, these were men born within Rubanda and Kiboga districts or any Ugandan men that had lived in the two respective districts for at least two years. This criterion was important in ensuring that participants who were well versed with local set up including the culture, behaviors and belief systems were recruited.
- Men who were aged 20-49 years and were married. The explanation for this inclusion criteria was given in the sections above.
- Men who accepted and consented to take part in the study and were willing to be tape-recorded and gave consent in their sober mind.

### **3.4.6 Exclusion Criteria**

The following criteria was used in the study:

- Men who refused to sign a consent form because it would be unethical to forcefully include them as study participants.
- Men who did not agree to be recorded were excluded because the researcher needed voice-recorded messages to be used during the data analysis process.
- Non-indigenous Ugandan men who were not residents of Rubanda and Kiboga districts. Including non-residents and non-indigenous people would most probably bring in the perspectives of other setups, which would contaminate the study findings. Also, men who had not lived for at least two years in Rubanda and Kiboga districts were excluded for the same reasons.
- Non-married men and those below 20 years of age or above 49 years of age were excluded because they had no experience with the study problem under investigation and lacked adequate experience to share during the interviews.

- Potential participants with unstable mental status because the research required consent from a stable mind, and therefore it would be unethical to include mentally unstable participants.

Data was collected in two phases: focus group discussions and individual interviews. In Rubanda district, the sample size included six focus group interviews comprising 45 participants and 20 participants for the individual interviews from the two sub-counties of Muko and Nyamweru. For Kiboga districts, the total sample size of two focus group interviews consisted of 20 participants and 10 for individual interviews from the sub-counties of Bukomero and Dwanilo (refer to Table 3.1 below). This sample size was determined by data saturation, a stage where there was no new information emerging from the participants (Cohen et al 2018: 253). The two sub-counties per district and two distant districts were selected for the study to have participants from two different perspectives for triangulation purposes. Creswell and Poth (2018: 328) define triangulation as the process of collecting and interpreting data on a phenomenon using numerous ways or perspectives in order to arrive at an accurate portrayal of the truth. The term "triangulation" also refers to the use of many methods or data sources in a single study (Taylor et al 2016:98); hence, in this study, data was collected using both focus group discussions as well as individual interviews.

#### **3.4.7 Data collection approach**

In this section, the research presents the data collection process and instruments used. The data comprises information or facts gathered during study (Nieswiadomy & Bailey 2018:65) while data collection is defined as a systematic procedure of obtaining, measuring, and analysing reliable data from a range of sources to solve research problems, answer questions, assess results, and forecast trends and probability (Creswell & Poth 2018: 148).

The qualitative data collection entails selecting and producing verbal (or visual) material for the purpose of analysing and understanding phenomena, social fields, subjective and collective experiences, and the meaning-making processes that go with them. Qualitative data gathering in this study was used to identify and explain a phenomenon in the field, as well as structures and processes in routines and practices (Flick 2018:7).

The researcher made arrangements with the men in both districts especially for the focus group discussions (FGD) through their indigenous leaders. The FGD as well as the individual interviews were used on the assumption that some men might not be free to voice their opinions with others (FGD) while others might not have any reservations. During the FGD, some men opted not to be part and preferred individual approach. The same questions were used during the interviews for both districts and approaches. This approach allowed for consistency in data collection and facilitated meaningful comparisons between the two districts.

#### **3.4.8 Development of data collection tools**

Prior to data collection, tools were developed. These included open ended focus group and individual interview guides (Sekaran & Bougie 2016:113; Cohen, et al., 2018: 474), information sheet for consent and informed consent form. The open-ended interview guides allowed the participants to speak freely on the subjects that they believed were important to them, using their own words and articulating their experiences in depth using stories and narratives and examples (Leavy 2017:19). The open-ended questions are a popular choice for individual studies or sections of a questionnaire that require participants to provide candid, personal feedback (Cohen et al 2018: 475).

The development of research tools prompted the researcher to translate them using local language experts into Rukiga and Luganda, the two languages spoken in Rubanda and Kiboga districts respectively for easy understanding by the study participants and research assistants. The English version was developed and approved by the supervisor as well as ethics committee of the institution (UNISA). The locally translated versions were taken for language editing by local language experts and approval by the local Ethics Committee in Uganda, the AIDS support Organisation and then for final approval by the Uganda National Council for Science and Technology.

#### **3.4.9 Piloting of the data collection tools.**

Piloting of the research tools was conducted to ensure the quality of questions and to assess how much the participants understood the questions. A pilot serves numerous purposes, the most important of which is to improve the research tools' reliability,

validity, and usability (Cohen et al 2018: 496). The piloting involved four participants for individual interviews and one focus group interview comprising eight participants from Bubaare in Rubanda and Lwamata in Kiboga. The total number of participants for individual interviews in both two pilot districts was 8 and 16 for the focus group interviews. Bubaare and Lwamata in Rubanda and Kiboga districts respectively were selected because they share similar characteristics in terms of ethnicity and rurality and the researcher had already secured permission from the authorities to conduct the study in the two districts. However, the two sub-counties selected for piloting were far from the study sub-counties in each of the two districts to avoid contamination of the actual perspectives of the participants.

Piloting started with the researcher providing information on the consent sheet to the participants recruited for the focus group and individual interviews. The information sheet was translated in Rukiga and Luganda languages and it was read to the participants who met the inclusion criteria. The researcher asked participants if they had any questions, and after providing adequate information to potential participants, the researcher distributed a written informed consent form also translated in the local languages of Rukiga and Luganda.

The researcher then requested that those participants who wished to participate in the study sign the consent form for the pilot study. All the selected participants signed and were interviewed. The pilot interviews were recorded, transcribed, and then coded for themes. The pilot interviews took one hour and fifteen minutes for Rubanda and one hour and twenty-four minutes for Kiboga districts. In the pilot process, the researcher found that the question about perceptions needed more probing so as to get detailed information from participants. Also, during the pilot process, the researcher realised that questions that would provide information on the belief systems needed proper clarifications in order to get the right information from participants. Furthermore, the researcher found that some participants were dominating the conversation and needed control while others were not active and needed to be prompted first before giving their views. The findings from the pilot guided the researcher to prepare possible probing questions and clarifications that were appropriate for the main study interviews.

### **3.4.10 Recruitment of the participants**

To recruit participants, the researcher first got a letter from the Uganda National Council for Science and Technology and the President's Office authorising the researcher to proceed with data collection in the respective districts. The researcher proceeded with the letter to request permission from the Resident District Commissioners (RDCs) of Rubanda and Kiboga to conduct research in their areas. This permission from the RDCs was very important for security clearance, as they are the heads of security in the districts in Uganda.

After getting permission from the RDCs, the researcher proceeded to the District Health Offices in the two districts to inform the District Health Officers about the study since it was health-related and needed permission at that level. The investigator then proceeded to Muko and Nyamweru Sub-counties in Rubanda district and Bukomero and Dwaniro sub-counties in Kiboga districts for another level of permission to proceed to the village level since they supervise the activities of the villages in those sub-counties, including security and health issues. While in the four sub-counties, the researcher sought permission from the Sub-County local council as well as the indigenous leaders.

The permission of local council leadership and that of indigenous leaders was key since they are responsible for monitoring all activities in their respective villages. The village local council chairpersons as well as the indigenous leaders also helped in identifying the participants, guided by the inclusion criteria. The local council leaders provided the registers of homes with potential participants, and the researcher selected the homes randomly from the lists provided. This was done to minimise bias by the local leaders in selecting the participants. In addition, the village council leaders assisted the researcher in securing appropriate venues where the individual interviews and focus group interviews took place, which were under the tree shade in a playground or in open, secure places in trading centres and community halls within the respective villages.

### **3.4.11 Interview Process**

An interview is a discussion between two or more persons that is guided and deliberate with the aim of collecting specific information (Sekaran & Bougie 2016:114; Nieswiadomy & Bailey 2018: 70). In addition, interviews and observations are the most prevalent methods for generating data in qualitative studies (Boswell & Cannon 2017: 187). The potential participants were mobilized by four local councilors who are the indigenous leaders of four villages (two each from Rubanda and Kiboga) who are the gatekeepers and had to meet with the researcher first to explain the study. This was because indigenous peoples would not come to any gathering unless called by their chiefs (leadership).

At the venue for the interviews, ethics issues were re-iterated in the information sheet written in Rukiga and Luganda languages. In Rubanda district, Muko sub-county, there were 5 focused group interviews where two groups had eight participants each, another group had nine members while another one had 10 participants. In the same sub-county, the researcher conducted 10 individual interviews making a total number of 50 participants for both individual and focus groups interviews. Still in Rubanda district, Nyamweru sub-county, only one focus group interview of 10 participants and five individual interviews were conducted. In Kiboga districts, the researcher held two focus group interviews each consisting of 10 participants and five individual interviews for the two sub-counties of Bukomero and Dwanilo.

During the interviews, researchers ensured a structured and guided discussion while allowing participants to freely express their opinions and experiences. To ensure the comfort of the participants, the researcher dressed casually and interacted with them freely in their local languages before, during, and after the interviews. Additionally, the researcher explained to the participants that he was a man like them and reassured them that what was discussed would not be shared with any other person outside the confines defined by the study. The researcher further explained to the participants that participation was voluntary and that whoever did not feel comfortable participating could withdraw at any time. Also, by providing an option for those participants who would not be comfortable participating in a focus group to take part in an individual interview, the choice made the participants comfortable. This approach created a comfortable and respectful environment for the participants.



The researcher stopped the interviews after reaching the data saturation. Each of the focus groups lasted between one hour to one hour fifteen minutes while the individual interviews lasted between fifty minutes to one hour five minutes. The entire data collection process lasted for 21 days. Below is a summary of participants from the four sub-counties in the two districts of Rubanda and Kiboga (Table 3.1).

**Table 3.1: Number of participants per district in the generation of data (Researcher’s own initiative).**

Study area	No. of Focus Group Interviews	Individual interviews	Total participants
<b>Rubanda District</b>			
<b>Muko</b>	5 FGD (35 participants)	15 interviews	50 participants
<b>Nyamweru</b>	1FGD (10 participants)	5 Interviews	15 participants
<b>Kiboga district</b>			
<b>Bukomero</b>	1FGD (10 participants)	5 Interviews	15 participants
<b>Dwanilo</b>	1FGD (10 participants)	5 Interviews	15 participants

The data collection was done in a natural setting in the community where participants live. The data was collected including the homes of men, the places of work such as gardens, trading centres, social gathering playgrounds within the community.

To commence the interviews, the researcher began by greeting as well as introduction and proceeded to ask the participants questions for biographic data such as age, occupation, language, telephone contact, village, parish, sub- county, district, tribe, marital status, duration of stay in the district, number of children.

The questions were written in English, and the researcher translated them into Rukiga and Luganda, the two languages spoken in Rubanda and Kiboga districts. The researcher can speak both languages fluently. Probing questions were used as in the interview guide to continue the conversation and get detailed information on the subject matter (Hesse-Biber 2017:129). The probing questions helped in providing clarity into the phenomenon of contraceptives and perceptions and beliefs about LARCs in particular. The researcher allowed the respondents to elaborate on the subject at hand (Nieswiadomy & Bailey 2018:211).

Once the researcher confirmed that no more information emerged from the participants, he thanked them for their participation. The researcher also promised the participants that once the study was concluded, he would communicate the findings to them. Both the individual and the focus group interviews were recorded with permission of the participants.

### **3.5 COVID-19 RISK MITIGATION PLAN**

During the process of data collection, the researcher ensured that the process was in line with WHO and Uganda's Ministry of Health (MOH) standard operating procedures (SOPs) for the prevention of COVID-19 (Ministry of Health-Uganda 2020). The researcher ensured that research participants adhered to the WHO and MOH SOPs. At each of the meeting venues for the individual and focus group interviews, all participants underwent a temperature screening before the interviews began. The researcher had a box of sanitisers for each of the participants to sanitise their hands before, during, and after interviews. As a bonus, they were allowed to go with the remaining sanitiser.

In addition, the researcher ensured that participants in each focus group were not more than 10, and they sat two metres apart to ensure social distancing. Most of the focus group interviews took place under the shades in the open with very good air circulation, and those that took place in the community halls had participants socially distanced and windows as doors were well opened to ensure air circulation. Masks for each of the participants were provided, and the researcher ensured that they put them on. The research team also followed the same COVID-19 prevention guidelines to ensure that they did not spread or acquire COVID-19 from the study team. At the venue for the meeting, the researcher displayed MOH posters that had key messages on COVID-19 in Luganda and Rukiga languages secured from the nearby health facilities. The key messages were as shown below:

- Wash your hands frequently with soap and water or with an alcohol-based hand rub.
- Maintain social distance to protect yourself and others from getting sick.
- Avoid touching your eyes, nose, and mouth with your hands.
- Practice respiratory hygiene.

- Clean and disinfect frequently touched objects and surfaces regularly.
- Stay home if you have a fever, cough, or difficulty breathing, and seek medical care early.
- Stay informed and follow the advice given by your healthcare provider.
- It is normal to feel sad, stressed, confused, scared, or angry during the COVID-19 outbreak, but you can help yourself in several ways.

These guidelines were easily visible to participants at the venues for the focus group and individual interviews, minimising any risk of spreading COVID-19 during data collection.

### **3.6 ANALYSIS PROCESS**

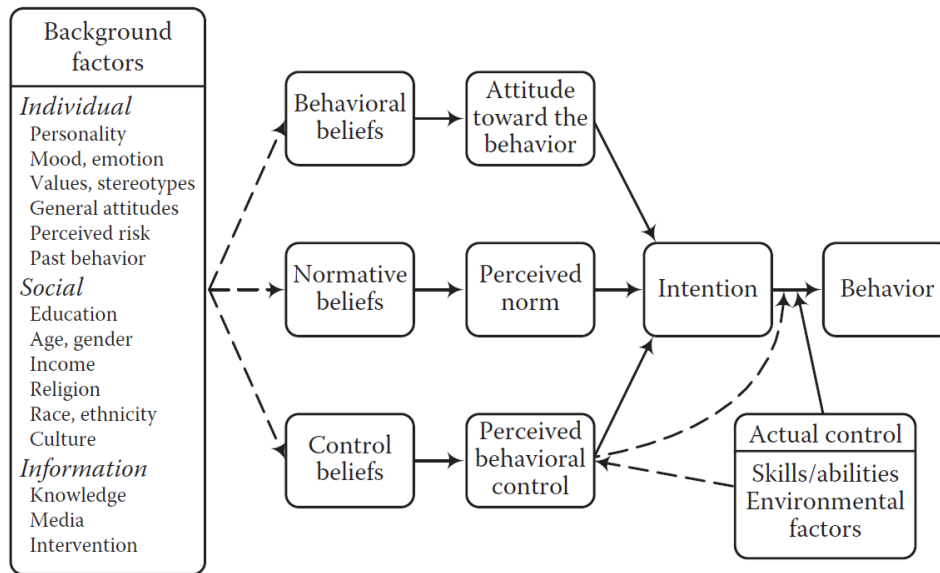
Data analysis refers to the systematic organising and interpretation of research data (Polit & Beck 2017: 725). It entails sorting, questioning, reasoning, and building themes from data (Hesse-Biber 2017:336). For this study, the data was transcribed from the individual and focus group interviews recording into text format by carefully and repeatedly listening to the recorded interviews in a quiet environment free from distractions.

The researcher was exhaustive in transcribing all the details from the recorded interviews (Edmonds & Kennedy 2017: 322). After transcription, the researcher did memoing, a process of keeping track of what the researcher learns from the data (Hesse-Biber 2017:341). This was done to keep track of the concepts, and how they relate within the data for the purposes of guiding the development of codes and themes. After the memoing, the researcher coded data manually, checking the data for themes, concepts, and categories, then labelling comparable chunks of text (Edmonds & Kennedy 2017: 325; Hesse-Biber 2017: 343-344).

An independent researcher from one of the organisations involved in research in Uganda was also used as co-coder of the study themes. Once the researcher generated the themes, categories, and sub-categories under each of the three emergent themes were collated by a co-coder who also coded and came her own themes, categories and sub-categories. Through discussions with the researcher, a consensus on the common themes, categories, and sub-categories was reached.

In total, three main themes emerged from the with eight categories and 34 sub-categories.

The Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) were applied to guide data analysis by providing structure, concepts, and themes.



**Figure 3.2 The Theory of Planned Behaviour (TPB) and Theory of Reasoned Action (TRA) (Conner & Norman, 2015:148)**

Guided by these theories, the researcher used some of the components to develop the themes. The components of the theory the researcher used include the background information, beliefs, and perception components of the theory. These components guided the research in coming up with the three themes during the data analysis. The three themes include the understanding of family planning, which is related to knowledge under information in the background factors of the theories, and the perceptions and belief systems that also directly appear in the theories. The intention component of the theories reflects the men’s support for the use of LARCs by rural women. The researcher ensured rigour throughout the study process to achieve trustworthiness.

### 3.7 RIGOUR AND TRUSTWORTHINESS

Rigour refers to the steps a researcher has taken to ensure that the research is being carried out in an acceptable way (Holloway & Galvin 2016: 314). Additionally, rigour also refers to how the study findings are trusted by other researchers (Johnson, Adkins

and Chauvin 2020: 145). Furthermore, trustworthiness of a study is defined as the strength of the qualitative study through evaluating all the research study aspects (Grove et al 2015: 845). In addition, Daniel (2019:102); Willig and Rogers (2017:510) define trustworthiness as ways in which other researchers determine the extent of confidence in the quality of an investigation and the findings of the research. In this qualitative study, the researcher enhanced trustworthiness under the five criteria that included: authenticity, credibility, transferability, dependability, confirmability (Boswell & Cannon 2017: 189)

### **3.7.1 Authenticity**

Authenticity in research means that the research's conduct and appraisal are credible and authentic, and that the research is beneficial and contributes to the niche (Creswell & Poth 2018: 409). To ensure authenticity in this study, the researcher used both individual and focus group interviews. The researcher gave participants an option of either participating in the focus group or in individual interviews so as to give freedom to those men who were not comfortable expressing their views in the group. The researcher also establish rapport with the participants by ensuring that he dressed appropriately in order not to intimidate the participants. He also re-assured the participants that he was a fellow man like them and requested them to feel free while expressing their views during the interviews.

Furthermore, the researcher used only local languages the Rukiga and Luganda in two districts of Rubanda and Kiboga respectively. All those actions gave participants comfort and willingness to share their experiences. Additionally, the researcher gave every participant adequate time to express their views on contraceptive and LARCs without interference from other participants or the researcher himself (Cohen et al 2018: 253). Moreover, the researcher documented the methods used including the theoretical perspective as well as the duration and length of the study (Lincoln & Guba 1985:5).

Moreover, the researcher took a lengthy and very rigorous time with the study participants so as verify issues that appeared vague to get clarity of the participants' responses. More to that, the researcher described the nature, the number of participants and the setting with in which the research was conducted (Creswell & Poth

2018:409). Furthermore, the researcher provided the details of how the study settings were selected, how the study participants were selected and his role during the study.

Additionally, the investigator provided the details of how data interpretation and analysis was done and presented (Taylor et al 2016: 217). Lastly, the researcher the researcher conducted the member check during the and after the individual and focus group interviews to ensure the data collected was agreeable by the participant (Lincoln & Guba 1985: 5). This was done by restating and summarising the views of participants and then reading them for the participant to determine their accuracy. The researcher completed member checks by sharing all the findings with the participants after the data collection.

### **3.7.2 Credibility**

Credibility refers to whether the research participant agrees with the outcomes and whether the findings make sense to other researchers (Willig & Rogers 2017: 556). Credibility is concerned with having faith in the accuracy of the results, as well as having a thorough knowledge of the context and paying attention to all important viewpoints (Tolley et al 2016: 36).

To ensure credibility of the study, the researcher was in the area for at least 4 weeks and engaged with the participants before and during the data collection. This built rapport with the participants. To ensure quality of the data collection tool, the researcher pre-tested them in two different sites to ensure their appropriateness. The researcher also collated field notes during the interviews while audio recordings were managed. Also, the researcher requested participants to review and provide feedback to the interview data and emerging themes and categories (Lincoln & Guba 1985: 5).

To ensure triangulation, the researcher used different data collection methods that included focus group and individual interviews. Triangulation is a strategy that entails studying the same research questions using multiple methods to search for a convergence of research results in order to improve credibility (Hesse-Biber 2017: 304). The researcher did multiple individual interviews in addition to focus group interviews and gave the participants a chance to review and where possible amend the concepts and themes that emerged from the data analysis.

The experiences that the researcher got while collecting and analysing data, was always recorded as a diary, and was included in the discussion of the findings in chapter 5 (Fain 2017:191)

### **3.7.3 Transferability**

Transferability is the ability for the study findings to be applied in different contexts (Willig & Rogers 2017:556; Boswell & Cannon 2017:189). Additionally, Olson et al (2016:86) define transferability as the extent to which results from one qualitatively researched setting may be applied to another qualitatively investigated setting. For this study, transferability of the research findings, was achieved by the researcher furnishing detailed context specific information for other researchers to determine if the processes and findings can be applied to another similar situation (Johnson et al 2020: 141).

The detailed context specific information the researcher provided included description of the sampling procedure and the details of the study participants, and the sample size used, the study setting in which the study was conducted as well as the data collection process and the study findings (Creswell & Poth 2018:416). This was done so that other independent researchers could determine how transferable the findings were due to similarity in the study characteristics (Boswell & Cannon 2017:189-190).

### **3.7.4 Dependability**

Dependability means that the evidence from the study will be consistent and stable such that someone not involved in the research can easily follow by reading the content (Moon, Brewer, Januchowski-Hartley, Adams & Blackman 2016:2). Dependability is also about whether the researcher can get the same findings if the study is repeated with the same participants within the same context and coders (Forero, et al., 2018:3). The study's dependability is when other investigators follow the researcher's actions throughout the investigation and reach comparable findings (Boswell & Cannon 2017: 190).

To ensure dependability of this study, the researcher provided a detailed description of the research design and provided a thorough step by step process of data collection used in the study (Forero et al 2018: 3). This was done by the researcher properly

recording where the data was collected, how it was kept, and how it was processed, which offers a snapshot of the flow of information toward the study's final result (Boswell & Cannon 2017: 190). The dependability of this study was also illustrated by doing an audit. An audit is a practice in which a third party examines the study, challenges the techniques utilised, assesses the data's adequacy, and provides input to help in improving the study (Nieswiadomy & Bailey 2018: 71).

In this case, the researcher shared all analysed data with the supervisor and an independent researcher from another University school of public health, who provided feedback and confirmed that they were appropriate. The independent researcher was also used as the co-coder of the study themes.

### **3.7.5 Conformability**

Conformability is the assurance that the data, interpretations, and outcomes of the study are in contexts and from research participants and not from the researcher's imaginations (Moon et al 2016: 3). Confirmability is also defined as the level at which the findings of a qualitative study can be confirmed or verified by other researchers (Korstjens & Moser 2018:121). Conformability "means a way of knowing that, even as a co-participant in the inquiry, the researcher has maintained the distinction between personal values and those of the study participants" (Tolley et al 2016:37). Conformability was tackled by compiling a full record of the data collection and analysis strategies employed (Gray et al 2017: 648).

The researcher also observed and recorded his own roles in the qualitative study process, including documenting assumptions, biases, or responses which could impact the process of data management. The researcher also reviewed the analysed data with study participants and other experts that included his researcher supervisor and another researcher from Makerere University school of Public Health to mitigate the effects of researcher bias (Boswell & Cannon 2017:224). This approach increased confirmability of this study.

The researcher availed the study for outside scrutiny and verification through leaving an audit trail for other researchers to verify. "An audit trail is a record that enables you and others to track the process that has led your conclusions" (Tolley et al 2016: 213).



In order to leave a good audit trail, the study documented and stored the following items:

- Uncoded transcripts, audio recordings, and field observation notes.
- Data reduction and analysis outputs: code list, theoretical comments on working themes, matrices.
- Data rebuilding and synthesis products: diagrams and comments demonstrating how various topics are related, as well as a final report.
- Process records; methodological memos, trustworthiness notes, audit reports documentation
- Resources pertaining to goals and dispositions: research procedure, personal notes on motivations and study goals.
- Information on instrument development: interview guidelines, data collecting methodology.

The sample of 95 respondents offered a solid grounding, hence increasing the trustworthiness. This qualitative study was carried out in compliance with the trustworthiness criteria explained above.

### **3.8 ETHICAL CONSIDERATIONS**

Ethics are principles and rules that assist us discern among what is right and wrong (Johnson & Christensen 2014:180). Ethics is defined as “that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions” (Dictionary.com 2022). Research ethics refers to rules and principles that govern human behaviour in a study (Nieswiadomy and Bailey, 2018: 44). The researcher considered the broad ethical issues that come with doing research with human subjects (Creswell & Clark 2018:20).

Researchers therefore use research ethics to help them perform ethically sound investigations (Johnson & Christensen 2014:180). In any study, the researcher should strive to protect the rights of the study participants (Nieswiadomy & Bailey 2018: 42). It is a researcher's obligation to conduct research in an ethical manner; failing to do so jeopardises the scientific process and could have unfavorable consequences. To conduct a study ethically, the investigator must do it competently, use logistics

honestly, acknowledge those who give direction or support, accurately share the findings, and evaluate the relevance of findings to the field of investigation in particular and society at large (Brink et al 2018: 27-29).

Research involving human subjects may lead to physical or psychological harm if not properly handled (Creswell & Poth 2018: 113-114). The research team and participants must be properly informed about the research's objective, methodology, and anticipated possible uses, as well as what their involvement in the study and what risks, if any, are involved (Johnson & Christensen 2014: 164-165).

### **3.8.1 Institutional research approval**

This study was in line with the research ethics requirement, by acquiring clearance from the supervisor, and then from UNISA College of Human Science Ethics Committee under number NHRE REG NO: Rec-240816-052. This was followed by seeking approval from a Ugandan Institutional Review Board (IRB) at the AIDS Support Organisation Uganda (TASO) under registration number TASO-2021-56 which was granted after carefully reviewing the protocol and the research tools that included the individual and focus group interview guides, and the consent form. Both the information sheet for consent and the consent forms were translated by the professional translators for Rukiga and Luganda. Following the approval from TASO, the study applied for authorisation at the Uganda National Council for Science and Technology (UNCST) under reference number REF-HS2152ES, where the final clearance for data collection was granted (Nieswiadomy & Bailey 2018: 45).

The study also sought authorisation from the Resident District Commissioners of both Rubanda and Kiboga districts using the clearance letters from TASO and UNCST, who also granted clearance to proceed to sub counties of Muko and Nyamweru in Rubanda and Bukomero and Dwanilo in Kiboga districts for data collection. While in the sub-counties, the researcher sought permission from the sub-county leadership that included the Local Council III chairperson and the then village leadership that included the Local Council I chairperson. After getting the permission, the researcher moved with the Local Council I chairpersons, who also recruited participants then the data collection commenced.

### **3.8.2 The participants**

The researcher carried out this study guided by three key ethical principles that include respect for autonomy, beneficence, justice (Grove et al 2015: 98). These are human rights that must be respected in research, including the right to self-determination and privacy, anonymity, and confidentiality.

#### **3.8.2.1 *Respect for autonomy***

Autonomy “means that the participants in the research are given an opportunity and respect to make a free, individual and informed choice without being under duress (Nieswiadomy & Bailey 2018: 45). According to this principle, individuals are autonomous, which means they have the right to decide for themselves (Brink et al 2018:32). This means that an individual has the freedom to choose whether or not to participate in research without fear of punishment or discrimination. He or she also has the right to withdraw from the study at any time, decline to provide information, and request clarification on the study's goal (Nieswiadomy & Bailey 2018: 44-45). This right must be respected by the researcher, who must refrain from employing any kind of force or coercion (Johnson & Christensen 2014: 164).

To ensure this principal of respect for autonomy, the researcher followed a selection criterion whereby only participants who were aged 20 to 49 years were selected. Working with the local council chairperson, only those participants of sound mind were selected as participants for the study. The participants that met the selection criteria were taken in a quiet place free from distraction and community meeting grounds, under the tree shades, community meeting halls and homes of some participants to avoid too much sunshine. Once at the meeting venues, the researcher introduced himself to the selected participants after which he informed the about the study that he was conducting for the researcher PhD studies and how it would benefit the communities, the districts, and the country. The researcher further provided each of the potential participants the information sheet that was translated in both Rukiga and Luganda for study sites in Rubanda and Kiboga respectively. The information sheet contained all the detailed information about what participants needed to know about the study (refer to Annex 5b).

In addition to the above, the researcher explained the consent information sheet which included the rights of the participants such as right to choose whether or not to engage in research without fear of retribution or discrimination. He further informed the participants that they had a right to withdraw from the study at any time they wish that they have a right to decline to provide information, and request clarification about the study's research purpose. Once the researcher finished explaining the information in the consent sheet, he requested participants to ask any question or clarification where they might not have understood, and the research team answered the questions. The researcher then asked those that wanted to participate in the study to sign the consent form which they did, and the copy of the information sheet was left with them for further reading.

### **3.8.2.2      *Informed Consent***

To proceed with the data collection using focus group and individual interviews, the researcher had to first get permission from the study participants by requesting them to sign a written informed consent (Annex 6). Informed consent refers to the process whereby researcher gives full information to the potential participant about the research including benefits and risks if any to enable the participant to make an informed decision whether to participate in a research study or not (Shah et al 2021:863-4; Schneider & Fuller 2018:132).

The researcher provided full information to the potential participants about the study including the benefits and any risks. The researcher informed participants that their participation was voluntary and that they were free to participate or not and that they had a right to withdraw from the study at any time even if they have signed the consent form. The researcher informed the participants about their rights during the study, their expected role in the study, the duration of the study that it would not take more than one hour. After providing the necessary information about the research study to participants, the researcher requested those that would like to participate in the study to sign a written consent form which they did while those that refused to sign the consent form were excluded from the study.

### **3.8.2.3      *Principle of beneficence***

The principle of beneficence is about maximizing benefits and minimising harm to the research participants (Nieswiadomy & Bailey 2018:45). The research participants should not be harmed physically, emotionally, psychologically, professionally, or individually because of the study (Cohen et al 2018: 127). The principle of beneficence in relation to the study subjects or participants demands the researcher to actively endeavour to do good and impart benefit while actively seeking to cause no damage to research subjects (Gray et al 2017:1271). In this study, the researcher protected the participants from both physical and psychological harm by ensuring their privacy, confidentiality and anonymity of participation (Burkhardt & Nathaniel 2014: 525) as explained below.

### **3.8.2.4      *Privacy***

"Privacy refers to freedom from unwanted intrusion into one's private affairs" (Resnik 2018:149). The right to privacy refers to an individual's ability to choose when, how, and under what conditions personal information is shared with or concealed from others (Grey et al 2017: 335). The researcher ensured privacy by guaranteeing anonymous participation (Schneider & Fuller 2018:128). The right to privacy was given utmost importance in this study, whereby all study participants were interviewed in an environment that offered privacy (Brink et al 2018: 35). Even though the individual and group interviews were held at community meeting places, playgrounds, and some participants homes, the researcher ensured that the meetings were away from public viewing or hearing and free from any interference. The free environment was ensured by the local council leaders, who prevented potential disruptions from approaching the interview venues.

By recording only the provided codes rather than the research participants' names, the researcher ensured the confidentiality of the data they provided. Additionally, the researcher stored the interview data securely in lockers at his home and did not provide access to third-party members outside the confines of the study. Also, the researcher gave the participants the choice of participating in individual interviews or focus group interviews, depending on how free they were to share their views in a focus group discussion.

Informants were given the flexibility to choose when, how much, and their freedom to share information or withhold information at any time during the interview process.

### **3.8.2.5 Confidentiality**

“Confidentiality refers to protection of private information” (Resnik 2018:149). Ensuring the privacy and confidentiality is key in respecting dignity, autonomy, preventing harm as well as promoting trust. The researcher assured the participants of confidentiality of the information shared by signing confidentiality form and by making sure the participants sign the same form so that they also do not share the information they might get while attending the focus group interview. The researcher also made sure that none of the members outside the participants in the focus group or individual interviews were able to listen to what was discussed during the interview session.

### **3.8.2.6 Anonymity**

Anonymity refers to the fact that even the investigator is unable to trace a participant's identity to their responses (Gray et al 2017:339; Fain 2017:19) define anonymity as “a condition in which the identity of subjects remains unknown, even to the researcher, to protect subjects participating in a study and to promote objective results”. The researcher explained to participants the measures used to secure their identities and information received under the privileged settings. Individuals' identities were kept anonymous, and access to information obtained on a subject was restricted.

The use of code numbers for participants' identities helped to ensure anonymity (Fain 2017: 37). Participants were not required to write their names anywhere during the interviews, instead they were assigned codes to represent participants. However, on the consent form, they were made to indicate both names and sign, but these consent forms were kept securely and not utilised by the researchers during the interviewing process, so there was no possibility of linking the participants' responses to the respective consent forms.

### **3.8.2.7 Principle of justice**

Grove et al (2015:98) explains the principle of justice that “human subjects should be treated fairly in terms of the benefits and the risks of research”. This principle states that everyone should be treated equally and given what they are entitled to (Gray et al

2017:342). Justice is a core principle of research ethics that requires that the benefits and liabilities of research must be shared evenly. Under the principle of Justice, the researcher ensured that all research participants were handled honestly in all aspects of the research study, including their recruitment, participation burden and benefits (Schneider & Fuller 2018:132). This principle states that everyone should be treated equally and given what they are entitled to or owed (Gray et al 2017: 342).

To ensure the principle of justice was followed, the researcher considered equity and fair distribution in selecting the study participants. All participants that met the inclusion criteria were given an opportunity to participate as long as the required number from had not exceeded the required sample size from that study site. The researcher also interacted fairly with participants throughout the interview process, giving each and every one a chance to participate in the discussions.

### **3.8.3 Debriefing**

To increase dependability of the study findings, the researcher did a debrief at sessions after conducting individual and focus group interviews. (Johnson & Christensen 2014:209) states that “debriefing refers to an interview conducted with each research participant after he or she has completed the study”. Debriefing is a period after the study in which the participants are given time to reflect on the events that occurred during the research (Leavy 2014: 680).

In this this study, the researcher held a debriefing session with research participants to provide more information about the study, get more clarifications about the emerging themes and some aspects that needed more clarification from participants as well as sharing with the participants the issues that had emerged from the data collected. De-briefing was done in an interactive way.

During the debrief, the researcher also provided additional information of family planning methods and LARCs including their benefits to the mother, the father, the family, the community, and the country. He further clarified common myths and misconceptions about. The researcher answered all the questions from the participants during the debrief session. At the end of the debrief, the researcher thanked the participants for taking part in the study and promised to share the findings from the study when the whole research is completed.

### **3.9 SUMMARY**

This chapter described the qualitative, cross-sectional phenomenological study design and methods used to collect data on perceptions and belief systems of indigenous Ugandan males towards the usage of LARCs by rural women in Uganda. The chapter also discussed the study population, sample and sampling techniques, data collection techniques, pretesting of the survey questionnaire, the process of data collection and analysis, as well as the ethical considerations. Further, it described credibility, dependability, confirmability, and transferability, and how each of these was addressed and implemented by the researcher, as well as how ethical principles were considered. The next chapter fourth chapter presents the data analysis and interpretation, as well as discussion of results.



## **CHAPTER 4**

### **ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESULTS**

#### **4.1 INTRODUCTION**

The previous chapter focused on research methodology that included the design and methods. This chapter focuses on the demographic data, data qualitative analysis in form of themes categories and sub-categories, and finally discussion of findings. The discussion is a precursor to the development of strategies in Chapter 5. This chapter offers a combined presentation of themes even though data was collected from two districts. This decision was reached after realising that there is a consistent pattern in the themes.

#### **4.2 DEMOGRAPHIC DATA**

This study was conducted in two districts of Rubanda found in South-Western Uganda and Kiboga in North-Central Uganda. There were 45 participants for focus group interviews in Rubanda District and 20 participants for individual interviews. In Kiboga District, there were 20 participants for focus group interviews and 10 for individual interviews. The age range of participants in both districts was between 21 to 49 years with an average age of 34.6 years. The participant with the highest number of children was 49 years, having born 13 children from Kiboga District while in Rubanda District the equivalent participant was 48 years, with 12 children.

Peasant farmers made up the majority of participants in both the Rubanda and Kiboga Districts, followed by motorcycle transporters (boda-boda riders) and very few local small businessmen. In Rubanda District, all 65 participants were "Bakiga" men, while in Kiboga District, a majority of the men (26) were "Baganda," with the rest being non-Baganda, and these included one Munyoro, one Mutoro, one Musoga, and one Munyarwanda. In Rubanda district, all the participants spoke Rukiga, while in Kiboga, the Luganda language was spoken by all participants, even though some of them were not Baganda. In Rubanda district, 35 participants out of 65 were Catholics, followed by 26 protestants, three Muslims, and the rest being born-again Christians. In Kiboga, out of 30 participants, 16 were Catholics, nine were protestants, three were born-again Christians, and three were Muslims.

### 4.3 EMERGING THEMES

In this study, the researcher listened attentively to the audiotapes in order to comprehend and analyse the interviews. This procedure was performed several times to grasp the nuances in the expressions. The researcher then transcribed these words and phrases for study. Three themes emerged, and these include the understanding of family planning, perceptions, and belief systems. Each of the themes has categories that total up to eight and a total of 33 sub-categories under them, as shown in Table 4.1 below.

Although data collection happened in two different districts using two approaches (focus group discussions and individual interviews), the themes that emerged were the same with few outliers which are illustrated in Table 4.2 below. Table 4.1 shows the common themes for both regions from the dual data collection methods. These common themes as shown in Table 4.1 below emerged despite the fact that these two districts are about 600km apart as shown on the map in Chapter 3.

**Table 4.1 Summary of themes emerging from both focus group and individual interviews for Rubanda and Kiboga Districts**

Themes	Categories	Sub- categories
1. Understanding of FP	<b>1.1 Meaning</b>	1.1.1 <i>Child spacing</i> 1.1.2 <i>Planning for children</i> 1.1.3 <i>Few children</i>
	<b>1.2 FP methods</b>	1.2.1 <i>LARCS</i> 1.2.2 <i>Natural</i> 1.2.3 <i>Permanent methods</i> 1.2.4 <i>Short term FP methods</i>
2. Perception of LARCs	<b>2.1 Associated /perceived side effects</b>	2.1.1 <i>Prolonged bleeding</i> 2.1.2 <i>Low libido</i> 2.1.3 <i>Effect on body organs</i> 2.1.4 <i>Infertility</i> 2.1.5 <i>Paralysis of arms</i>
	<b>2.2 Positives</b>	2.2.1 <i>Proper planning for family</i> 2.2.2 <i>Adequacy of resources</i>
	<b>2.3 Fears</b>	2.3.1 <i>Separation and single mothers</i> 2.3.2 <i>Adultery</i>

		<p>2.3.3 <i>Challenges with removal or management of side effects</i></p> <p>2.3.4 <i>Fear that land could be usurped by other tribes</i></p> <p>2.3.5 <i>Complications in subsequent deliveries</i></p> <p>2.3.6 <i>Excessive weight gain</i></p> <p>2.3.7 <i>Conceiving while on a FP method</i></p> <p>2.3.8 <i>Possibility of twins after using some FP methods</i></p>
	<b>2.4 Desires</b>	<p>2.4.1 <i>Balanced sex of children</i></p> <p>2.4.2 <i>To get the desired number of children</i></p>
<b>3. Belief systems</b>	<b>3.1 Cultural</b>	<p>3.1.1 <i>Belief in natural methods</i></p> <p>3.1.2 <i>Power-related reasoning</i></p> <p>3.1.3 <i>Source of labour for the family</i></p> <p>3.1.4 <i>Expanding and strengthening the clan</i></p> <p>3.1.5 <i>Gender preference for boys for the inheritance of wealth</i></p> <p>3.1.6 <i>Wealth gained from dowry.</i></p> <p>3.1.7 <i>Preservation of or strengthening the clan</i></p>
	<b>3.2 Religious</b>	<p>3.2.1 <i>Fear of losing leadership position in the church.</i></p> <p>3.2.2 <i>Not to contravene the teachings</i></p>

Table 4.1 above presents the themes from the participants in form of categories and sub-categories that were generated from wide information from individual and focus group discussions in both Rubanda and Kiboga Districts. The detailed analysis and discussions about each theme, category and sub-categories are presented in the paragraphs below.

The following abbreviations are used in verbatim vignettes from participants to show the participant number, district, and Sub-Counties from which they came.

**FGD:** Focus Group discussion

**I:** Mean Individual interviews

**R:** Refers to participant from Rubanda District, Nyamweru Sub-County

**RM:** Means participant from Rubanda District, Muko Sub-County

**K:** Refers to Participant from Kiboga District, Bukomero Sub-County

**KD:** Means participant from Kiboga District, Dwanilo Sub-County

Participants will also be referred to using their codes for example R 1 to mean participant number 1 from Nyamweru sub-county Rubanda district, K 2 to mean participant 2 from Bukomero Sub-country in Kiboga district.

#### **4.4 THEME 1.0: UNDERSTANDING OF FAMILY PLANNING.**

This theme considers the meanings that men attach to the term family planning and contraceptive methods. This understanding can be defined as the ability to comprehend and make meaning out of the concept (Oxford Dictionary 2019) and in this context, an understanding of the ways the rural indigenous regard family planning as discussed below.

##### **4.4.1 Category 1.1: The meaning of family planning**

According to UNFPA (2022), “family planning is the information, means and methods that allow individuals to decide if and when to have children.” It aids in the avoidance of unplanned pregnancies, hence lowering maternal morbidity and the number of pregnancy-related deaths (WHO 2020). Moreover, family planning is not about producing a few children but a number that is manageable, with the right spacing at the right time. In this respect, therefore, family planning is equally about plotting for the number of children and the family.

The findings from this study demonstrate that a few men defined family planning in the following ways.

*“Family planning is spacing between children” (FGD K5)*

*“Me I understand family planning as giving little spacing between the children” (FGD-K8)*

*“Family planning means using [the] injections to stop the women from producing” (FGD R1)*

*Family planning is preventing a woman from producing many children (I K15)*

*“[FP] helps in bringing up children well, and proper management of finances” (FGD RM 2)*

*“Giving a child adequate space of either 2 or 5 years so that they are well brought up and prevention of unintended pregnancies” (FGD R7).*

*“Family planning means producing one or two children but not more than three” (I RM43).*

*“Family planning is producing few children that are not many to disturb in caring for them” (I KD 2)*

Based on these submissions, it can be inferred that some participants in this study thought family planning means producing only a few children, which is partly incorrect. However, a number of men in both Kiboga and Rubanda Districts seem not to understand family planning well and therefore could not answer that question when it was put to them by the researcher. There were variations across the sub-counties in both Rubanda district, with a reasonable number of men (46%) in the Muko sub-county having a slightly nuanced understanding of family planning compared to those in the Nyamweru sub-county (27%). In the Kiboga district, the knowledge of contraception was the same across the two sub-counties of Bukomero and Dwanilo where the majority (51.7%) of men evinced a sound understanding of the meaning of contraception.

The findings from both Kiboga and Rubanda contradicts with findings from studies done in Nigeria by Adeoye and Olatunji (2020: 4); Judith et al (2020:58) and another study done in Namibia by Alagba (2019:53), Akamike et al (2020:4) which found that most men had good knowledge about contraception.

However, they are in agreement with the findings of the studies done in Uganda by Thummalachetty et al (2017:3-6) and another one done by Dougherty et al (2018:3) which found that men had little knowledge about contraceptives and LARCs respectively also in relations to the discussions below in 4.4.2.

When men have inadequate understanding of family planning, this situation creates fertile ground for myths, misconceptions, and rumours about family planning methods. The wrong information about family planning could affect the way men perceive it, and this might also negatively affect the beliefs they hold related to the method they use. Therefore, the perceptions and beliefs the men have due to their limited knowledge about family planning, including the LARCs, could limit their support for the rural women's use of the methods.

#### **4.4.2 Category 1.2: Family Planning methods**

According to WHO (2022), contraception (family planning) methods are devices, sexual practices, compounds, drugs, or surgical techniques used to prevent conception intentionally. When participants were asked about contraceptive methods, a few of them (45%) in Rubanda and 49.3% in Kiboga were able to name at least two modern contraceptive methods, with injectable and withdrawal being the most mentioned. Only few men (10%) in Rubanda and 14% in Kiboga mentioned any of the LARCs. Still, a reasonable number of men (38%) in Rubanda and 27.2% in Kiboga were unable to name any contraceptive methods.

*“For me the examples of family planning that I know include the coil that they put in the womb, capsules, and implants” (FGD R7)*

*“I know there is natural methods where you use safe days and withdraw. The woman can also use tablets as family planning methods” (FGD K5).*

*“For me, I know cutting tubes for men and women” (FGD KD4)*

*“There is family planning type of capsules for 3 and 5 years” (FGD R7).*

*“Me I know injections of 3 and 5 years that can be used for family planning” (I R14)*

*“The family planning methods I know are IUDs, pills and implants” (FGD RM13)*

*“Family planning means producing one or two children but not more than three” (I RM43).*

It was evident from this study that knowledge of contraceptive methods and LARCs, in particular, was limited among men since many of them did not know about LARCs. This finding disconfirms the findings from another study done in Uganda by Dougherty et al (2018:3) which found that the majority of men knew at least one contraceptive method. However, the above study as well as the current study confirm that injectables were the most known contraceptive methods, while in both studies, a limited number of men knew about LARCs. These findings relate to another study done in Uganda by Thummalachetty et al (2017:3-6) and another one done by Dougherty et al (2018:3) which found that men had little knowledge about contraceptives and LARCs, respectively. This is contrary to the study done by Zendehdel et al (2020:9-10) in Iraq which found that men and women had knowledge about contraceptive LARCs.

More to that, the finding in the current study relates to a study conducted by Katri et al (2009:73-76) in Nepal which illustrated that low uptake of IUDs was related to limited knowledge of the method's safety and efficacy. Additionally, this study's findings confirm the findings from Katri et al (2009:73-76) and are also supported by Damayanti et al (2019:1452-1457), which found that knowledge about LARCs has a positive association with their uptake. When men have limited knowledge about LARCs, their support for the uptake of the same methods by their rural wives could be low, just as the Damayanti et al study has demonstrated above. The limited knowledge of family planning, including LARCs, among men could be due to inadequate targeted social behavioural change communications both at the community and health facility levels. This could be partly due to the limited understanding of LARCs by community health workers (the village health teams) as well as the health workers.

When knowledge about contraceptives is low, particularly LARCs, it leaves room for myths, misconceptions, beliefs, and negative perceptions among men, which could lead to less support for these methods. This could result in them discouraging their wives from using contraceptive methods, leading to low utilisation and uptake by rural women.

However, increasing men's understanding of and attitudes regarding the LARCs may enhance their willingness to support their partner's usage of the same methods (Jonas et al 2020:4). However, the fact that more women have adequate knowledge about LARCs does not necessarily translate into the utilisation of these contraceptive methods, probably due to other barriers that could include lack of partner support (Agyemang et al 2019: 4). Therefore, increasing the knowledge of family planning among men, including LARCs, requires strategies whose details are discussed in Chapter five.

## **4.5 THEME 2: PERCEPTION OF LARCS**

Perception is an opinion that is often shared and based on how things seem but is not necessarily correct or true (Cambridge Dictionary, 2022). Perceptions in this case refer to how indigenous men in Uganda view the use of LARCs by their rural women. This section discussed the different categories and sub-categories in relation to men's perceptions about LARCs as found in the study. Under this theme, three categories emerged that included perceived side effects, positive perceptions, and fears. Understanding indigenous Ugandan men's perceptions about LARCs provides the basis for addressing the specific uptake barriers that can lead to designing strategies that could increase the uptake among rural women.

### **4.5.1 Category 2.1: Perceived side effects of LARCs**

Five sub-categories emerged under this category, and these include prolonged vaginal bleeding, low libido, effects on body organs, infertility, and paralysis of the arms. Fear of side effects by men was one of the barriers to the uptake of LARCs (Willcox et al 2019: 159-178). However, the documented undesirable effects of LARCs are indicated in the sections that follow.

#### **4.5.1.1 Side effects of implants**

The side effects of implants include changes in the bleeding patterns. The regime could become irregular, lasting more than 8 days and sometimes for over the first year, irregular, infrequent, and sometimes no bleeding at all later (Melville 2015: 67). Other side effects are headaches, abdominal pains, breast tenderness, acne, weight change, breast tenderness, mood changes or changes in libido, nausea and dizziness,



infection at the site of insertion or removal, abscess, expulsion, and severe lower abdominal pain (WHO/RHR & CCP 2018:124; Tracy 2017:151)

#### **4.5.1.2 IUD side effects**

The major side effects of IUDs include changes in bleeding patterns such as prolonged or heavy monthly bleeding, irregular bleeding, lower abdominal cramps and pains during menstruation, and anaemia. The male partner may feel IUD strings during sex, while the woman experiences severe lower abdominal pain, uterine perforation, and IUD may partially or fully come out (WHO/RHR & CCP 2018:149; Tracy 2017:151; Melville 2015:172). Understanding the side effects of LARCs is key in determining whether the perceptions of men are based on the real side effects or myths and misconceptions in regard to their opposition to LARCs use by rural women. According to the findings of this study, the following side effects were expressed by the participants.

#### **4.5.1.3 Prolonged vaginal bleeding**

Prolonged vaginal bleeding means monthly periods associated with prolonged bleeding or an extremely heavy period that lasts over seven days. Participants indicated that LARCs cause continuous vaginal bleeding among women that use them and submitted this as one of the reasons they did not support their partners using LARCs. In the following quotations, participants gave their responses.

*“When our women use an implant or a capsule (IUD), they make them bleed non-stop. As a man, you can imagine what we feel spending a long time without touching your wife. I cannot allow my wife to use family planning method” (FGD R 7).*

*“I also hear that women bleed too much if they use those methods” (I RM 43)*

*I have heard that women who use capsules bleed nonstop and this can make them become very weak and unable to do work at home and in the garden (I RM 39).*

*“A woman using a family planning method does not see the monthly periods and when they finally come, she will bleed for all the months she*

*missed. This kind of bleeding can kill her and therefore I cannot allow my wife to use a LARC method (I K15)".*

*"Family planning users can bleed very profusely and become weak nonstop and as a man, you find you are starved" (FGD-KD 9).*

These findings are consistent with a study done in China by Luo et al(2018:6); Mwaisaka, Gonsalves, Thiongo, Waithaka, Sidha, Agwanda, Mukiira, and Gichangi (2020: 5) which found irregular vaginal bleeding as a strong barrier to LARCs uptake, leaving the men starved of sex for a long time. The majority of men believed in this and gave it as a reason why they did not recommend their wives using the LARCs. According to Melville (2015:67) about 20% of implant users experience amenorrhea, while up to 50% experience intermittent, regular, or protracted vaginal bleeding. Users of Implanon are more likely to experience infrequent or no menstrual bleeding than experience irregular bleeding (WHO/RHR & CCP 2018:110).

The IUDs users might also experience some prolonged and heavy monthly bleeding or intermittent bleeding (Casanova et al., 2019:566). Although prolonged vaginal bleeding is a known side effect of LARCs, it can be well managed by service providers if the women experiencing it visited health facilities (WHO/RHR & CCP 2018: 149). However, when men perceive LARCs as a method that will starve them sexually, the majority cannot accept their wives using such a method. This could be the reason for the low use of LARCs in the two regions that are settings in this study.

#### **4.5.1.4 Low libido**

Low libido is a reduction in sexual desire. The findings from Rubanda and Kiboga districts verified that men perceive LARCs as a method that lowers libido for both women and men. Participants indicated that LARCs make women's sexual desires lower, subsequently lowering the frequency of sexual intercourse with their husbands. In other cases, some men also end up having their libido lowered. Most participants from both districts expressed their unwillingness to accept the use of LARCs by their women due to the perceived loss of libido as a consequence. The quotations below are representative of the responses of some respondents which align well to the finding under this sub-category.

*“The LARCs make our women impotent and unresponsive when aroused in preparation for doing the adult game of the bed” (FGD-R1).*

*“When a woman is using the capsule in the arm and in the womb, she becomes less interested in sexual intercourse and when you touch her, it is as if she is a log in bed” (I-K11).*

*“When a woman is using family planning, it also affects their husband’s libido which reduces” (I-RM 44)*

*“The LARCs make our women impotent and unresponsive when aroused in preparation for doing the adult game of the bed with her husband” (FGD K 2).*

*“If a woman uses family planning that is long acting in nature, when she wants to produce, she will not get pregnant. We have seen women failing to conceive after family planning” (FGD KD 2)*

The loss of libido by women is associated with women using DMPA, Implants and vaginal rings but not hormonal IUDs or non-hormonal IUDs (Boozalis et al 2016:570). However, the concern over loss of libido by men is consistent with a study done in Sweden by Omar et al (2022:3) and another one conducted among Somali men who raised fears that modern contraceptive use could affect future fertility. As a result of these side effects, male partners find it undesirable for their women to use all the LARCs even when this effect is not experienced by all the women.

There is, however, no literature confirming loss of libido in men whose wives use LARCs. This could be just a psychological belief held by men due to limited knowledge about LARCs (Yolandie Kriel 2019:13). A study by Caruso et al (2022: 6) found higher interest in sexual intercourse in Implant users which disproves the views of participants that LARCs cause low libido in women users. This is also supported by the study done Guida, et al (2019:2-3) which found improvement in sexual life among LARCs users. The concern of low or no libido is, however, related to findings of studies by Guen, et al (2021:7); Akamike et al (2020:5); and Mwaisaka et al (2020:5) which was one of the reasons for rejecting hormonal contraceptives in Western countries. There is need to educate both men more on LARCs, including the benefits and possible side effects

and where their partner can get help for the management of the side effects in case they arise. If the issue of low libido among men is not managed psychologically and medically, both men and women could continue shunning the use of LARCs, and their utilization may remain low despite the many benefits in reducing unplanned pregnancies.

#### **4.5.1.5      *Effects on body organs***

Under this sub-category, it emerged that a number of men think that LARCs affect the organs of women and theirs too. The participants indicated that the use of LARCs makes the reproductive organ of their women very small and sometimes they are unable to penetrate during a sexual encounter. They also indicated that LARCs make their penis smaller, weaker, and unable to satisfy their women. The participants of this study also thought that when a woman used implants or IUDs, the methods disappear into the stomach and the heart which could cause other problems such as cancers, “pressure” (hypertension), and other swellings in the body. Below are the vignettes from selected participants.

*“We have heard some women using the capsule in the arm which disappears and ends up in the heart where it causes heart diseases and pressure” (I-K15).*

*“Some of the women who use a capsule that is put in the womb end up causing swellings in the stomach and ... cancer” (FGD-R10)*

*“When a woman uses family planning, they become very weak and cannot manage to do day-to-day work like digging in the gardens and going to look for firewood and fetching water. I cannot allow mine to use any family planning because of those bad outcomes” (FGD-RM 13).*

*“When a woman uses family planning, especially the long-acting ones, they burn the eggs, and they get destroyed and she cannot produce again” (I-K13).*

*“Women who use long-acting family planning do not produce again when they stop the method because all the eggs in a woman are already destroyed” (FGD R1)*

*“Family planning, especially those that work long, is destroying the eggs of women rendering them unable to produce again” (FGD K9)*

This finding resonates with what Boivin, Carrier, Zulu and Edwards (2020: 4) found in their study, in spite of the fact that there is not much published literature to support this assertion. The incorrect information that men have makes them reluctant to support the use of LARCs by their women (Kumari & Khetwal 2020:152-153). Some participants expressed fears that LARCs can burn the women “eggs” hence rendering them never to produce again. This finding correlates with the findings from a study by Boivin et al (2020:4) which found similar fears by men of contraceptives burning the egg. The findings in Rubanda and Kiboga districts resonate with those from a study done in Ethiopia by Endriyas, Alano, Mekonnen, Ayele, Kelaye, Shiferaw, M., Misganaw, Samuel, Hailemariam and Hailu (2018:8) which found that participants feared using LARCs for various reasons such as disappearance of implants in the body to IUDs perceived as causing cancers and damage to the genitals.

However, it is not true that LARCs affect the body organs of both man and women. These are just the perceptions the men which they base on to oppose the use of LARCs by the rural women.

#### **4.5.1.6      *Infertility***

Infertility refers to inability to conceive and have a baby which could happen either in men or women. Under this sub-category, the majority of men believe that using LARCs leads to a delayed return to fertility or permanent infertility. For this reason, most men indicated a preference for short-term or natural family planning to LARCs. Even though the LARCs are reversible, it appears many men lack that enlightenment, hence the negative perceptions they have based on the wrong information. Below are some of the submissions from men under this sub-category as indicated below.

*“Some women take longer to get pregnant when the period of using the long-term family method is done which is not good when a man wants another child” (FGD-KD1).*

*“Family planning that work for a long period of time make women not to produce again even when they stop using them” (I R13)*

*“Women who use long-acting family planning do not produce again when they stop the method because all the eggs in a woman are already destroyed. This is bad when they still have few children ...making family planning bad” (FGD-R1).*

*“Long-acting family planning make the women not to produce again even when they stop using the method. They are not good for those who still want to produce” (FGD RM 8).*

*“Child may die and if there is a need to produce another one and the woman has been on a long-acting family planning it may be hard to reverse the process” (I KD15)*

The finding of the current study is in line with those of a study by Boivin et al (2020:4-10) conducted in several African countries which identified that men’s fear of infertility caused by internal toxicity preventing population growth, internal movement of a family planning method, burnt eggs, internal accumulation and blockage of menstrual blood, and behavioural effects preventing sexual activity. Relatedly, the current study arrived at similar findings to one conducted in Malawi by Phethi (2021:97) which verified the fear of side effects as a barrier to the uptake of Implants and IUDs. The fear of barrenness and delayed conception from the current study concurs with the findings of a study done in Ethiopia by Sedlander et al (2022:5) which found the husband’s support for contraception was closely related to the belief that they cause infertility, in tandem with the study done in Uganda by Thummalachetty et al(2017:3-6) which found that men were concerned about infertility caused by IUDs.

The available literature shows that both Implants and IUDs do not cause infertility, nor do they delay the return to fertility after stopping their use since they are reversible contraceptives (WHO/RHR & CCP 2018:166,179,183 &152). Since a significant number of men seem not to understand the reversibility of LARCs, it could be the reason why they do not support their wives using the same contraceptive methods as supported by the study done by Damayanti et al (2019:1452-1457) and Luo et al (2018: 8) who found that non-use of LARCs by women was due to fear of impairing future fertility and harming the body by the same method.

The findings from the current study also agree with Zimmerman et al (2021: 249), in a study done in Uganda which confirmed that contraceptive use was lower among women who were convinced the methods affected their future fertility. The finding in the current study also relates to those in studies done in California and Kenya by Cabral, et al (2018:181) and Mwaisaka et al (2020: 5) which verified that fears of infertility among the participants are significant barriers to use them. Similarly, a study done in China by Feng et al (2022:5) found that the concern about future infertility was a major barrier to the uptake of IUDs.

#### **4.5.1.7      *Paralysis of arm***

According to Healthline Media (2022), “paralysis is a loss of muscle function in part of your body.” In this case, paralysis of the arm means loss of muscle function in the arm rendering it nonfunctional. In the Rubanda District, participants reported paralysis of the arm as one of the fears they have, making them non supportive of LARCs use by their women. However, all the participants that mentioned paralysis of the arm they had not witnessed any case of paralysis but only what they had heard from rumours from other people. The statements of selected participants are presented below.

*“Like capsules when administered on the arm, some women complain of paralysis on several occasions” (FGD RM 3)*

*“We have heard about women who used family planning of inserting in the arm and they [have] since failed to use the arm properly” (I RM 44)*

The concern of paralysis of the arm by men replicates the findings of a study done in Ethiopia by Tebeje and Workneh (2017: 8), who found that the perceptions of some clients were that LARCs could cause paralysis of the arms where the method is inserted. The misconception about paralysis was also the same in a study done in Ethiopia by Obsa et al (2021:4) but this study involved women and not men participants. Additionally, the perception that implants cause paralysis is also supported by another study done in Papua New Guinea by Gupta et al (2020:8) which arrived at the conclusion that men had heard rumours and misconceptions that women who use implants become very weak and could not move the arm even after the implant is removed. Therefore, since more recent studies have found the same claim of paralysis of the arm like the current study finding, it could be an area for further

research to prove or disprove if the fear is a genuine one or just a misconception by men.

#### **4.6 CATEGORY 2.2: POSITIVE PERCEPTIONS**

The previous section 4.5 discussed the negative perceptions of LARCs, this section discussed the positive perceptions. The finding from the current study illustrates that there are some men who hold positive perceptions about contraceptives and LARCs. They indicated that LARCs are good for the proper planning of the family, for a reasonable time which allows the mother time to prepare for the next baby while also allowing the baby to grow well. A number of men indicated that long-term family planning allows a family to have enough food for the children and secure school fees for their children. Out of men with positive perceptions about LARCs, there are those who were willing to discuss with their wives the same methods of contraception.

However, some men that mentioned the benefits of LARCs still had reservations over the perceived side effects of these methods. Generally, there was no difference in the two districts of Rubanda and Kiboga. Some men interviewed were able to list various benefits of family planning and LARCs in particular. However, a number of participants were hesitant to concede if they would allow their wives to use LARCs, instead indicating a preference for using short-term methods before attempting LARCs. The following vignettes are illustrative.

*“The methods of family planning that last long are good in order to provide a proper education for the children” (I-K15).*

*“Longer-acting family planning is good as it helps the family in preparation, especially finances for the children” (FGD-RM24)*

*“Long-term contraceptives are good because women reduce the frequent visits they would make to the hospital if they were using short-term methods (FGD K2).”*

*“Due to the low incomes of our families in Buganda, I have no problem with using family planning that lasts longer” (FGD-K9).*



*“Long-term contraceptives are good because women reduce the frequent visits they would make to the hospital if they were using short-term methods” FGD(K3).*

*“I support capsules for 5 years. However, women using such often fall sick” (FGD-R1)*

*“I support LARCs, especially for 5 years however I appeal that more methods are availed in case an individual is incompatible with the ones available” (I-RM 46)*

*“I support IUDs because they can be removed before their timeframe in case there is a need for a child before that time has elapsed” (FGD-RM 20).*

*“Long-acting reversible contraceptives are good, but they come with issues like low libido in women” (I-KD 16).*

*“Long-acting reversible contraceptives are good but there are associated issues like over bleeding in women which makes men starve from sex for a long time” (I-K11).*

The quotations above indicate the findings as mentioned by the participants during the interviews. In confirming the findings in Rubanda and Kiboga Districts, other studies done in South Africa, Nigeria and Kenya have also shown that not all men have a negative perception about LARCs. A study in South Africa by Kriel et al (2019: 9-10) shows that some men are supportive of contraceptive and encourage their partners to use LARCs. This also corroborates the findings from Nigeria and Kenya by Akamike et al (2020:6) and Abdi et al (2020:7) which concluded that some male partners were in support of contraceptive use by their wives. According to the findings of the current study, even men with positive perceptions of LARC are not supportive of their use by rural women. This could be due to their cultural or religious beliefs, the cost of accessing the methods, or the fears discussed in the paragraph above.

#### **4.7 CATEGORY 2.3: FEARS RELATED TO CONTRACEPTIVE USE**

Under this category of fears related to contraception use, eight sub-categories emerged, and these are related to the fact that contraceptives more especially LARCs lead to single mothers, separation, adultery, the free insertion of method but high charges on removal, fear of losing their land to non-Baganda, possibilities of disabled children, women failing to produce normally and complications in subsequent deliveries. The fears expressed by men affect their support for LARCs use by rural women, especially if there are no efforts to address those fears. These fears, therefore, can act as barriers to the use of contraceptive services by rural women because of the lack of support from indigenous men.

Below are the specific fears expressed by participants in the current study.

#### **4.7.1 Separation of couples and single mothers**

Participants felt that LARCs could cause the separation of couples as a result of domestic violence, especially when the woman used the method without approval from her husband. This is echoed in the following submission: *“A woman using family planning (LARCs) becomes less interested in having a sexual meeting with her husband and when a man tries to eat things by force, a fight erupts, and the woman ends up separating from the husband to become a single mother” (I-K 13)*

Some participants also thought that the use of LARCs leads to low libido in women when the men want to have sex with them, and they refuse. As a result, the men could end up abandoning such women and finding solace in alternative women and those abandoned end up as single mothers. The following vignette captures this sentiment: *“When your woman is using a family planning method that takes long in the body, her power in bed reduces and this can cause a man to look for another woman leading to separation of the couple” (FGD KD 3).*

To avoid such a scenario, participants mentioned that they would rather not allow their women to use a LARC in favour of short-term and natural contraceptive methods.

Some of the participants felt that when women are using LARCs, they end up having very few children and should they disagree with their husbands, the women move on. This is because they are still attractive as they have not produced many children, hence easily find other men to remarry. For this reason, participants were not in favour

of their wives using LARCs. This assertion came out in Kiboga District but was not as voiced in Rubanda District. This could be attributed to the fact that the Bakiga men despise women who are separated from their husbands, unlike Buganda cultures where separation is something normal.

*“Women who use long-acting family planning may leave marriages because they don’t have many children there and they are still attractive to other men” (FGD K4).*

*“A woman easily leaves the marriage if they don’t have many children with the man” (FGD K5)*

This current finding correlates with the one study conducted in Ethiopia by Sedlander et al (2022:6) which established that women feared using contraceptives because they believed they would become infertile leading to their husbands abandoning them. This is, however, different from the finding in the current study where men are the ones fearing that their wives would leave them for new men. Similarly, a study done in Nigeria found that some men send away women using contraceptives from their homes, leading to separation (Akamike et al 2020:6). Separation is also identified in another study done in Kenya by Mwaisaka et al (2020:5) which found the same fears among men.

#### **4.7.2 Adultery**

Adultery is defined as voluntary sexual intimacy between a married person and another person who is not their lawful spouse (Dictionary.com 2022). The findings from the current study indicate that men feel that once their wives use LARCs, they know they are safe from getting pregnant from extra-marital sexual affairs. Participants from both Rubanda and Kiboga Districts, therefore, felt that LARCs can lead to adultery amongst the women. The same assertion is also true for men who think that once their women use LARCs, the perceived low libido of the men leads them to go for other women who are sexy and therefore able to satisfy them. Participants indicated that this has resulted in both men and women acquiring sexually transmitted diseases including HIV/AIDS.

*“Because the woman knows that she cannot be impregnated by another man when she goes out while using a long-term family planning method, this encourages her to continue cheating” (FGD R4).*

*“Women who are using a long-acting family planning method, tend to be cheaters because they are not worried of being impregnated by other men. So, family planning encourages cheating and I do not support it”(FGD RM 35).*

*“A woman who is using a family planning method especially those that take long with engage in going out for other men because she knows she will not get pregnant since she is protected” (FGD-KD 1).*

*“A woman who is using a long-term family planning method is very tricky; she can easily sleep with other men as she is sure she can never get pregnant” (I-K14).*

The fear of adultery by men in this study relates to the finding in another study by Obare et al (2020: 1748-1762) done in Kenya which indicated that participants feared using contraceptives because they thought their partners would suspect them of infidelity. In the same study women had the same fear that using contraceptives would drive their male partners into extra-marital affairs. The fear of infidelity is also identified by Mwaisaka et al (2020: 6).

Therefore, participants of the current study had reservations in allowing their women to use the LARCs to avoid adultery and cheating in their families. This finding from Rubanda and Kiboga Districts also is supported by findings from a study done by Bekele et al (2021:9) that found allowing women to use contraceptives would make them healthy, pretty and attractive to other men. Due to this belief, men in Rubanda and Kiboga Districts cannot allow their wives to use LARCs.

#### **4.7.3 Challenges with removal or management of side effects**

Participants in this study were concerned about their wives using LARCs because they are inserted for free at health facilities. However, when they get problems while using the same methods, they are not helped at the same health facilities. They confirmed that the health providers at the health facilities tell them to wait for people

(organizations) that inserted them. This is also true for women who wanted to remove the LARCs.

As a result, men indicated spending a lot of money to have their women get managed for side effects and removal of the devices. This made the participants discourage their wives from using the LARCs. This finding is related to that of a study done by Adeagbo et al (2017:823-825) in South Africa which found that nurses lacked experience with Implanon NXT removals, leading to low uptake of the same method. Lack of LARCs removal services was also verified by women in a study done in Kenya (Brittona et al 2021:3-4). This, therefore, could mean that the fears that men have are also shared by their women and all contribute to the low uptake of LARCs.

The quotation below reflects some sentiments expressed by participants.

*“When they are calling women to come for family planning to the health centres, they tell them that the services are free but when they get problems and they want the methods removed, they are asked a lot of money or referred to places which require payment” (FGD K 5).*

*“I cannot accept that my wife uses a capsule in the arm because when time for removing them comes, the health workers at the health centre cannot help as they want money” (I-RM 49).*

*“Usually, women who get family planning services get them for free from Marie Stopes but when women get problems and they want to remove them, they cannot be helped by the health workers at the health centres. We end up spending a lot to remove them from private clinics” (FGD-RM 5).*

It can be deduced that this practice also contributes to the low uptake of LARCs unless the health care providers at the health facilities are well trained in the recommended method.

#### **4.7.4 Fear of losing their land to non-Baganda tribes**

According to some participants in Kiboga District, they felt the government of Uganda was encouraging the Baganda to use LARCs so that they produce few children while

other tribes that live in the same district continue without limitations. They thought this could lead to their tribe having a very small population that could lead to their land and wealth being taken over by the non-Baganda tribes, especially the westerners (Banyakore, Bakiga, Banyarwanda). Some participants indicated that there were many organisations promoting family planning in central Uganda where Kiboga is located, and they thought there were sinister intentions to reduce the population of Baganda in Uganda. Therefore, some Baganda in Kiboga District do not support the use of LARCs so that they could keep their population numbers high. This assertion was from participants in the two sub-counties of Bukomero and Dwanilo in the Kiboga district. Some of the quotations are stated below.

*“You see the problem they are telling us Baganda to use family planning (LARCs) when the Banyankole and Banyarwanda are busy producing as many children as they can. They will end up taking our land as many non-Baganda are already owning a very big chunk of land in our district” (FGD-K7).*

*“Why do they want us to use a long-term type of family planning (LARCs) when other tribes in our sub-county are producing like rabbits? Don't you think there is a motive for stealing our land as it is already happening? We cannot support such methods of family planning” (FGD-KD 5).*

*“The population of Baganda is still small and therefore no need to use family planning, especially those methods that work for a long time” (I-K15).*

This finding in Kiboga district is not supported by any available literature from studies done both within and outside Uganda. This could be a myth that has spread through the region based on ethnicity and tribal distrust.

#### **4.7.5 Disabled children**

According to the findings from both Rubanda and Kiboga Districts, participants feared that their wives could bear disabled children because of LARC use. They stated that some of the women that have used family planning end up not having normal babies.

As a result of that, they indicated that they cannot support the use of LARCs as they all desire having healthy children in their families and communities.

*“As a man, I cannot allow my wife to use a long-term family planning because when she is to produce again, she may end up producing a disabled child” (FGD-RM 19).*

*“Some women who use a coil and capsules produce lame babies and therefore I cannot encourage my wife to use them” (I-KD 14)*

*“Long-acting family planning are not good as they cause disability. Therefore, as a man, I encourage my wife to use natural family planning to avoid problems of such children who are difficult to care for” (FGD-R8).*

The fear of producing disabled children arising from the use of LARCs is verified in findings from a study done in Tanzania by Kassim and Ndumbaro (2022:5). Similarly, the findings of the study done in Kenya by Mwaisaka et al (2020: 5) confirmed the perception that contraceptives could cause disabilities in children born after their use. Therefore, it could be possible that men use these fears to oppose the use of LARCs by the rural women even when there is no literature to show that disability can come as a result of using contraceptives including LARCs.

#### **4.7.6 Complications in subsequent deliveries**

The participants from both Rubanda and Kiboga Districts indicated that they feared that when their wives use long-acting contraceptives, they could lead to complications in the subsequent deliveries. Participants indicated that the pregnancy complications arising from LARC use often lead to women getting operated on during delivery or even other complications like excessive bleeding before or after delivery. Participants thought that for those women who use LARCs, it becomes hard to push a baby normally through the vagina hence explaining the many caesarian sections where men indicated spending much money to have the operation done. When men have misinformation and limited information about LARCs, they are more likely to oppose their use by their female partners (Kriel 2019: 13). Below are some of the sentiments from selected participants in both Rubanda and Kiboga Districts.

*“Since family planning causes women to bleed a lot, it means there will be complications to subsequent pregnancies” (FGD-K4).*

*“There are complications in the succeeding pregnancies, leading to producing weak babies who eventually die” (FGD-RM 13)*

*“Some women who use long-acting family planning end up getting complications in the next pregnancies and end up being operated, they become weak and can never function normally at home” (FGD-RM 15).*

*“There are difficulties during labor which lead to operations while giving birth” (I-KD 15).*

However, the available literature shows that it is not true that women who use LARCs end up getting complications in the subsequent pregnancies (WHO/RHR & CCP 2018:128-131and156). This finding from the current study concurs with a study in Uganda by Thummalachetty et al (2017:5) in which men showed a concern that IUDs could cause future complications in subsequent pregnancies and birth. This also relates to the findings of a study done in Kenya which verified that men feared that the use of IUDs complicated deliveries among their partners (Mwaisaka et al 2020:5-6). The findings from the current study in Rubanda and Kiboga Districts confirm those from another study done in Uganda (Waniale et al 2020:5) where participants indicated that contraceptive use could be the cause for the many caesarian sections happening in their region. There is however no literature to show that contraceptive use leads to complications.

#### **4.7.7 Excessive weight leads to less productivity.**

The participants expressed a concern that women that use LARCs become overweight and get problems with mobility and become very weak to do the work at home and in the garden. This assertion was given by participants from both Rubanda and Kiboga Districts. As a result, men thought that their women’s use of LARCs will lead to a lack of food at home and there is no one to do the work that a woman is supposed to do. Therefore, men think the use of LARCs could increase the burden on them because their women are not as productive as they would be without using those family



planning methods. Due to the fear of additional burden, most men prefer their women to either use short-term or natural contraceptives.

*“Women who use long-acting family planning (LARCs) get excessive weight which leads to less productivity in doing chores and this makes men suffer with no one to do work of the woman at home” (FGD-RM 28).*

*“When women use LARCs, they tend to be overweight leading to laziness at doing work at home” (FGD-RM 14)*

*“I also here that family planning brings a lot of bleeding, and excessive weight gain making a woman unable to go and dig” (FGD R2).*

*“Because of weight gain in women using long-acting methods, they end up developing to pressures (Hypertension)” (FGD-KD 6)*

*“I have seen very big women and I hear it is because they have been using family planning for long” (I-K12).*

Some studies show that some LARC users report some weight gain while other studies have shown that there is no scientific relationship between LARCs use and weight gain. According to some literature, there is no causal link between the use of implants and IUDs and weight gain (Melville 2015:66 & 72). Similarly, a study done by Romano and Braun-Courville (2019:409-414) found that ENG Long-Acting Implant does not cause weight gain. However, a study done by (Rohan 2020:102S; Lazowitz, et al 2019: e10; Edwards et al 2020:461-470; Beksinska et al 2021: 3-5) found weight gain among the users of ENG implant and hormonal IUDs but not with Copper IUD use.

The perceived cause of weight gain among women using LARCs could be an assumption based on women being at peace of mind because of knowing that they are free from getting unwanted pregnancies.

#### **4.7.8 Conceiving while using a LARC.**

Perceived methods failure was another concern expressed by participants in Rubanda District, that even when women are using LARCs, they go ahead and conceive. In addition, participants, expressed that the methods do not work properly yet they have other health effects on the body including on the unborn babies. Men felt that such babies who are conceived while the mother is using a LARC may end up getting birth defects and are born with disability. As a result, this deters the men and their wives from using LARCs instead prefer to use shorter contraceptive methods like the three-month injectable, pills and natural methods. Some quotation from the participants is below.

*“You see, we hear that they are some women when using a capsule(implants) or a coil (IUD) they still get pregnant, and they end up producing babies who are disabled” (FGD-RM 13)*

*“My wife told me that there is a woman who was using capsules and she still got pregnant which affected her health. She had to be operated on to remove the baby at birth which was very expensive” (I-RM 49).*

LARCs are considered to be the most effective contraceptive methods, according (WHO/RHR & CCP 2018:110) who report the failure rate of implants to be 0.0005% (5 pregnancies in 10,000) and less than one pregnancy per 100 women who use an IUD (6 to 8 per 1,000 women). Different studies indicate some implant failures among women taking certain treatments such as Rifampicin for Tuberculosis, antiretroviral drugs such as efavirenz for HIV/AIDs treatment as a result of drug interactions (Surya & Kusnawara 2020:91 - 98; Kreitchmann, et al 2022:67-74; Pfitzer, et al., 2020:6-9). Other studies have found failure rates just like what the participants expressed. In a study done by (Moray et al 2021:5), it was found that the failure rate for LARCs was 0.2% in a study done in the USA while the implant failure rate was found to be 0.5% (Bawah et al 2021:6) in a study done in Ghana. Literature also shows that Implants and IUDs do not cause any birth defects (WHO/RHR & CCP 2018:129&156).

Based on the failure rate as expressed by the WHO, the failure rate among LARC users is insignificant. Therefore, what the participants said might be a misconception.

#### **4.7.9 Producing twins after using LARCs methods.**

As expressed by some of the participants in Rubanda District, they are of the opinion that when their female partners use LARCs, some of them end up delivering twins after discontinuing the methods yet there is no history of twins in those families. To them raising twins is a costly venture that puts a lot of pressure on those families hence the reason why some men do not support their partners to use LARCs. The quotation from a participant is shown below.

*“Some women produce twins after using some long-acting family planning methods yet there is no history of twins in the family” (FGD-RM 17)*

*“Men as a man, I cannot support my wife to use a long-term family planning method because she might produce many children at ago” (I-RM 44).*

There is no current literature to support this notion that LARCs use can lead to twin pregnancy and eventual delivery of twin babies in those women. However, some old literature shows that there was a much higher rate of monozygotic twins in pregnancies that happened within 6 months of stopping birth control (Macourt et al 1982: 22-28). Similar findings from another study showed a link between the number of women who stop using oral contraceptives and the number of monozygotic twin births 18 months later (Murphy et al 1989:277). Another study done in Nigeria found that Copper T IUCD rarely fails, resulting in a twin pregnancy (Koledade et al 2020:155-158). However, there is no other recent evidence that shows any other relationship between LARCs and twin pregnancies. The fear that men expressed was mainly a result of rumors from their peers as none of the participants reported their partners conceiving twins after using LARCs.

It is worth noting that some of the fears expressed by the participants in Rubanda and Kiboga Districts are not related to what previous studies have shown, as discussed in the paragraphs above under Section 4.7. Such fears could be explored in conducting

further research to find the actual magnitude of the low support of men for LARCs use by rural women.

#### **4.8 CATEGORY 2.4: DESIRES BY MEN**

A desire is “a strong wish to have or do something” (Oxford Learner's Dictionaries 2022). In this study, most participants from the two districts had desires that make them not support the use of LARCs by their female partners. These desires included the need to have balanced gender among the children and the desire to have the required number of children including heir.

##### **4.8.1 Balance gender among the children**

In both Districts of Rubanda and Kiboga, participants expressed their desires to have both boys and girls as one of the reasons they oppose their wives from using LARCs. They stated that sometimes you find a couple has only girls or boys yet if they allow their wives to use LARCs they may lose an opportunity to produce the missing gender of children. Participants, therefore, preferred their wives to first have all the required sex of both girls and boys before they can think of using LARCs. The following quotes illustrate the desires of participants on gender.

*“You see you find you have only girls and there are no boys in your family if you allow the woman to use a long-acting family planning method, she might fail to produce again so she better uses a short-term or a natural method” (FGD-RM 17).*

*“As a man, I need to have a mixture of both boys and girls and yet I currently have only girls. If I allow my wife to use family planning, I lose the opportunity to have boys and the village mates will make fun of me for not knowing how to produce boys” (I KD 15).*

*“Like now I have only two girls, how do I allow my wife to use a long-acting family planning method? Suppose she does not produce again? It means I will have no boys or if I want one, I have to go outside to produce there. That is why I do not support those methods” (FGD R5).*

*“If I have my cows and my land and yet I have only girls and few boys, how do I allow my wife to use a long-acting contraceptive method? If she chooses to use them without my knowledge, I go for a young woman willing to produce for me” (FGD KD 7).*

Men as heads of the house, always prefer to have both boy and girl children for various reasons. If there are only girls and no or few boys, some men would want to have boys as well as that one itself is a barrier for LARCs use (Abdi et al 2020:6). In addition to desire for boys, some men just like to have many children both boys and girls in order to feel like real men in their communities (Kriel et al 2019:8). The same applies to a family that has boys and no girls or few of them, such a family will prefer to also have girls for various reason including doing household chores, for dowries and working on family land for food production.

#### **4.8.2 To get the desired number of children.**

According to the findings from both Rubanda and Kiboga districts, men expressed the unwillingness to allow their women to use LARCs if they still have few children than those they desire to have. Some participants mentioned that when some women use family planning, they become comfortable because they are free from disturbances that come along with childcare. When men want to have more children to their desired numbers, those women who are already comfortable using LARCs will not accept having more children. Participants also indicated that such women who are comfortable with LARCs end up cheating with other men. Men also indicated that it is because the women know they are free from the risk of getting pregnant by those side lovers. The purported cheating by women and not giving the men more children might lead to gender-based violence according to participants. So, some men thought it is better for them not to allow their women to use LARCs in order to keep their families free from gender-based violence.

*“When women use long-acting family planning, they get used to it and become comfortable such that when a man wants more children, they refuse because they have taken long without producing” (FGD RM 48).*

*“You see some women of these days think that if they produce more children, they grow old very quickly and do not look attractive, so they*

*want to use family planning yet as a husband you feel you still need more children” (I R12).*

*“As a man, I cannot allow my wife to use a long-acting family planning method except when we have finished producing” (FGD K6).*

*“Some women are tricky these days, they want to produce very few children and when they get other men, they run away with them because they know they still have more eggs to produce for the new men” (I KD 15).*

Every family desire to have a particular number of children, and this was expressed by participants from both Rubanda and Kiboga Districts. Several studies conducted in Bangladesh by NazmulHoq (2020:6), another one in Ghana by Takyi et al (2021:6), and one in Nigeria by Akamike et al (2020:6) indicated the need to attain a family size before using LARCs was a priority. In both studies, both women and men alluded to having a modest family before using a contraceptive method. The need for desired children is also supported by another study done in the Solomon Islands by Harrington et al (2020: 291) and another one done in South Africa by Kriel et al (2019: 8), which found that socio-cultural expectations require a woman to produce both boys and girls. Furthermore, a study in Tanzania by Kassim and Ndumbaro (2022:4) also concurs that if the woman has produced only girls, she needs to continue producing until she gets boys. As a consequence, therefore, the use of LARCs is not supported by men, especially those who believe they have not produced the desired number of children or the other gender opposite to what they have.

#### **4.9 THEME 3: BELIEF SYSTEM ON LARCS**

Nescolarde-Selva (2016: 148) defines the belief system as a philosophy or set of concepts that assist us in interpreting our daily experiences. Under this theme, two categories of cultural and religious emerged with cultural beliefs having seven sub-categories while religious beliefs have two sub-categories. In the African context, the belief systems form the roots of the family. In most of the African countries, the ancestral lineage can determine the number of children and gender that is required. This is to preserve the clan names.

#### **4.9.1 Cultural beliefs**

Cultural beliefs are notions that are acquired and disseminated throughout various social groupings of people (Weller 2005:579). In this category, seven sub-categories emerged that included Belief in natural methods, power-related reasoning, source of labour for the family, expanding and strengthening the clan, gender preference for boys for the inheritance of wealth, wealth gained from dowry and preservation of or strengthening the clan.

#### **4.9.2 Belief in natural methods**

According to participants in both Rubanda and Kiboga Districts, men do not encourage their partners to use family planning and LARCs because their ancestors never used the same methods. The participants claimed that their fore parents used natural contraceptives which worked very well without bothering their women with adverse effects of contraceptives and all the undesirable complications that come with the use of LARCs. The participants, therefore, believed that natural contraceptive methods are better, and work well compared to LARCs.

Similarly, some participants stated that they would rather encourage their partners to use the indigenous natural methods of family planning such as withdrawal, abstinence, herbs tied around the waist area and drinking concoctions to prevent pregnancies. The participants also believed that their female partners should get permission on whether to use contraceptive methods or not.

*“According to my culture we value a boy child therefore like me a man with only girls will keep producing until when he gets boys” (FGD R4)*

*“For my case, the Bakiga culture guides us and recognize one as a man to be having many children both boys and girls. Therefore, I don’t want my wife to use any family planning method let it be for a short time or the one that last long time” (FGD R10).*

*“According to our culture and clan, they advise we men to produce many children and to have boys that will look after our wealth as heir. So, we are supposed to have many children” (FGD R7)*

*“Our ancestors never used these long-acting methods that are currently in the system instead they depended on nature which still worked for them without getting any problems” (I KD12)*

*“We need family planning methods that can keep the woman in her normal state when they use them and therefore natural methods are better” (I K14).*

*“Our parents and grandparents tell us that they never used family planning and they were able to take good care of all their children. Why should we give long-acting family planning methods that can expose our women to diseases?” (FGD RM 38)*

*“I am a Muganda, and I need to follow my culture, which does not support FP and there is no way I can support my wife to use LARCs” (FGD KD2)*

*“According to the Bakiga culture, a man should have as many children as possible and therefore if you use a long-acting family planning method, that will not be possible to get many children” (FGD R37).*

In a Tanzanian study, Kassim and Ndumbaro (2022: 5-6) found that women preferred using herbs because they had fewer side effects than contemporary contraceptive methods, including LARCs. This finding supports the preference for natural contraceptive methods over LARCs. Additionally, this study underscores the findings from a study done in Nigeria, which confirmed that men preferred natural methods to modern contraceptives because they believed that they were free from side effects (Akamike et al 2020: 6). Similarly, the current study's findings confirm those of another study done by Bekele et al (2021:9) that found similar beliefs in the natural method in Ethiopia in 2021.

According to this belief, participants agreed that women should first seek permission from their husbands before using any contraceptive methods other than natural ones. This also confirmed the patriarchal control that men have over women. Female contraceptive use should be a woman's choice without needing to get permission from the husband because women are the ones affected more by not using contraceptives,



including LARCs. Therefore, there is no justification for men to control the use of LARCs by women.

In consideration of the failure rate of Natural methods, which is very high compared to LARCs, more women should be opting for LARCs other than natural methods, which is not the case. As shown by the findings of this study, men could be deciding for women to take up less effective contraceptive natural methods instead of encouraging them to take up more effective LARCs methods. The failure rates of natural methods that men are expressing to support are as follows: fertility awareness method has a failure rate of two to five percent for ideal users and 12 to 24% for typical users; lactational amenorrhea has 2% failure rate, and coitus interruptus has a failure rate of about 22% effective (Bitzer & Mahmood, 2022:22–25). For LARCs, Intrauterine devices (IUDs), and contraceptive implants, they are very effective methods with a failure rate of 0.1% for hormonal IUDs, 0.8% for Copper T IUD (ParaGard), and 0.4% for implants (Callahan & Caughey 2018:801).

#### **4.9.3 Power-relations between men and women**

Power relations are defined as the ability to have an influence on another person's behavior (Lindsey 2016: 225). Participants in both Rubanda and Kiboga Districts were convinced that a man is the head of the family and has the last word on whether his wife should use LARCs or not. Since men have their fears and beliefs regarding LARCs use, most of them stop their willing wives from using the methods sometimes to show them that they have power over the decisions in the home. Some men indicated that if the women go to get LARCs without their permission, they have to take them back to the health facilities to have them removed because they did not authorize the women to get those methods. Below are some of the quotations from the participants' views.

*“As a man, I am the head of the family, and I am supposed to be the one to allow my wife to use or not use a contraceptive method” (FGD-R 5).*

*“You see women escape and go to put that family planning thing without telling us, men. So, to avoid problems that come with the use of those family planning methods I have to take mine back to the facility to remove*

*it. I should be in the know before she uses any family planning method”  
(FGD RM 46)*

*“I am a decision maker regarding all home issues and therefore I have to be the one to give permission to my wife to use LARCs. That permission will only come when I feel I have enough children” (I KD15).*

The findings from this study based on the submissions above are similar with those from a study done by Augustine and Godwin (2018: 8-9) which found that due to male dominance, women sometimes have no voice in contraceptive use. Similarly, finding concurs with studies done in Papua New Guinea, South Africa, and Nigeria (Gupta et al 2020: 7; Kriel et al 2019: 8-9; Akamike et al 2020: 6) which found that women are required by culture to consult their husbands for approval before using implants. There are some instances where men damage LARCs to make the methods ineffective or even crudely remove from their partners forcefully (Kriel et al 2019:8-9). All the above shows the dominance the men have over their wives especially in the rural setting.

Therefore, the men's dominance can translate even to the use of LARCs by rural women, where men believe they must permit them to use a contraceptive method and which method they should. Therefore, most rural women, even if they have the correct information on the benefits of LARCs, will not use them if their husbands have not permitted them. Therefore, even when these men's dominance is not good, it can still be used positively, especially in increasing the uptake of LARCs, when the dominant men are well-sensitised to the benefits of those contraceptive methods. The dominance of men some results in gender-based violence including forceful, cruel removal of LARCs by the husband where some where a woman gets that method without the permission (Monitor 2021).

#### **4.9.4 Source of labour for the family**

The participants expressed that the more children they have, the more labor they provide to the family for food production if the family has enough land. Therefore, some participants indicated that they are not in support of their wives using LARCs because they take many years and are not sure if their women will produce again. They also indicated that this might reduce their chances of having as many children as possible

to provide labour for food production for generating cash in the homes. Some of the quotations from participants are stated below.

*“If a family has many children and they go to cultivate, they dig a very big area for food production, and you will find such a family had enough food and money from selling excess food” (FGD R2).*

*“As farmers here in Rubanda, if you have many children, they provide you with the labour force you need to produce food for selling and for eating. So, if you are using family planning, you miss out on those good things” (I RM43)*

*“You know as Bakiga we depend on farming, when you have many children, you can cultivate big land and produce a lot of food for the family and for selling. Therefore, many children are good to bring riches to the family. If I allow my wife to use a family planning method that take long, I will miss out on the benefits of children” (I R11).*

*“The more children the family has, the more food they can produce as they are able to cultivate a lot of food for home consumption and for selling. This is possible especially with more land” (FGD RM 34).*

*“I am a coffee farmer and I need labor to help in this venture, I need many children who will help me to plant and manage the coffee and for this reason, I only support my wife to use short-term family planning methods and not LARCs” (FGD K 5).*

Families in Africa consider many children as a source of labor as supported by a study done in Nigeria by (Akamike et al 2020: 5) which states that families preferred to have many children to provide labour. This finding is also consolidated in another study done in Ethiopia where many children were preferred as a source of labour for the family (Endriyas et al 2018: 3). However, it is not a must that having many children translates to direct labour for the family. Instead, many children especially in many parts of Uganda where there is already a problem of limited land can be a danger to the family and the community. In some cases, the many children can end up being engaged in unlawful activities like abusing drugs, rape, theft and dropping out of

schools or not even attending any school at all. As a consequences, many the families with big children end up in object poverty (O'Leary 2023). Therefore, the issue of having many children for family labour should not be reason enough for families not to use LARCs.

#### **4.9.5 Expanding and strengthening the clan.**

In this sub-category, participants expressed the need to expand and strengthen their clans as the reason why men do not support the use of LARCs by their women. In the Kiboga District in addition to expanding the clan, men stated that they also need to expand the Kiganda tribe to counter the non-Baganda who are producing many children in their districts. Some participants from Rubanda mentioned that a man is viewed as being great by the family size he has in terms of children and wives while participants from Kiboga District expressed that a true Muganda is required to produce many children as required by the Buganda culture. The quotations below highlight the views of men from both the Rubanda and Kiboga Districts.

*“I am from the Bahimba clan and in this area, we are only one family so men and my brothers need to produce many children to expand our clan so that when [we] are at the bar we are not overlooked and beaten. Therefore, we cannot allow our women to use long-acting family planning” (I R11)*

*“I also have to be seen as contributing to expanding my clan and therefore it is not in order for my wife to use long-acting family planning. I will be considered a man when I have many boys to enlarge our clan” (FGD RM 22).*

*“Family planning is not good, especially the long-acting ones because even in the past, the power of a man was seen in the number of children he has, and it is still the same in our Kiganda culture so I cannot go against my culture” (I K 11).*

*“I also want to produce and preserve the clan so that I am counted as having contributed to the size of the clan. So, I cannot allow my wife to use a family planning method” (FGD R10)*

*“I do not support the use of FP because the population of Buganda is low” (FGD KD5)*

These submission from both Rubanda and Kiboga Districts are supported by a study done in Ethiopia by Bekele et al (2021: 9) which found that cultural leaders were against the use of family planning in preference for big family size to cope with inter and intra-clan competition and other dynamics. Expanding the clan becomes a principal motive for not allowing their wives to use LARCs. This is also supported in studies conducted in Tanzania and South Africa where women submitted that men do not want them to use contraceptives because they feel they have a responsibility of enlarging their clan by producing many children (Kassim & Ndumbaro 2022: 4; Kriel et al 2019:8-9). However, indigenous men need to understand that the challenges of big families outweigh the recognition they get for increasing on the clan size. In Uganda, few clans contribute to the care of children born by the members. Therefore, those men who want to contribute to the clan side will suffer alone with little or no support from the other clan members.

#### **4.9.6 Preference for boys for wealth inheritance**

Wealth was raised by participants as a reason for not allowing their women to use LARCs. They expressed that they needed many children, especially boys to inherit the riches in their families and therefore if their partners use the LARC, this becomes impossible. Participants said this was because LARCs take a long time and they cannot guarantee that their partners would have children again after using them. This notion is held by men who thought they have enough assets such as land, domestic animals and other properties that generate income for the families.

*“That if a man has not produced a boy, he is not considered a man and won’t have a say in public gatherings thus keep producing in order to have boys to inherit property” (FGD RM 22).*

*“According to our culture and clan, they advise men to produce many children and to have boys that will look after our wealth as heir” (FGD R7)*

*“As a man, you have to have a boy that will inherit your property and therefore if I do not have boys among my children, I cannot allow my wife to use a long-acting family planning. She must continue producing until when we have boys” (I R15).*

*“Culture says every child comes with their own blessing so everyone should produce what they can... both boys and girls” (I K12).*

*“As a man, I should have both boys and girls and if the boys are few, I have to continue producing until when I have a good number of boys. According to our culture, if the man does not have boys to inherit his things, then he is not considered a man” (FGD K7)*

*“A true Buganda family should have a boy in the family who will be heir to his father when he is no more. There, I have only girls and no boy, my wife must continue producing until when God blesses us with boy child” (FGD KD4)*

The findings of the current study are supported by those of another study done in Indonesia by Sari (2020:81) which revealed that gender preference by couples reduces the utilisation of contraceptives. The preference for boys is associated with the non-use of family planning methods just as the findings of this study have shown. Relatedly, study done in Bangladesh found that women with more boys were more likely to use a contraceptive method compared to those that had more girls (Hoq 2020: 4). It could mean that women who have produced boys are satisfied that they have the to use a contraceptive method. However, those women who do have more girls still want to get boys and they think if they use a contraceptive method, they will miss out on this choice the same way the current study findings suggest. Similarly, low contraceptive utilisation due to a desire for boys over girls was also confirmed in a study done in India (Sowmya et al 2020:1077-1081).

Additionally, the preference for boys was also found in a study done where contraceptive use was high in families that had the last born as boys compared to those who had girls as the last born (Khan et al 2021:3). According to a study by Pathak and Arya (2018: 1338), families having at least two male children preferred a permanent method of contraception compared to those who had female children.

According to Uddin et al (2016:8) in a study done in Bangladesh, women preferred not only to have one or two sons but also at least a daughter. This view could also be held by their male partners as is the case with the findings of the current study.

Similarly, according to a study finding in India by Deya et al (2021:3), couples with fewer than four children who had an equal or higher number of girls than boys compared to those who have no girls were less likely to use a modern planning method. In relation to the current study, there is a preference for a boy child and as long as a couple does not have the desired number of boys, they are less likely to use long-acting contraceptive methods.

In another study done in Uganda, women who had at least one son were 23 times more likely to use a modern family planning method compared to those that had no boy child (Kyosiimire 2020). However, another study in Kenya found no correlation between son preference and family planning utilisation (Agili 2019:7). Additionally, in concurrence, a study done in Ethiopia by Edberg et al (2018:4) showed that there was a need for children who would inherit the family lineage, although it was not specific whether the preferred children were boys or girls (Kriel et al 2019:8). The preference of boys for wealth inheritance is also corroborated by study findings from Papua New Guinea by Gupta et al (2020:7) and Laksonoa et al (2020:7) which verified that men believed in having a boy for the inheritance of the family wealth and it was one of the reasons why they would not allow their women to use LARCs.

The findings of boy preference in the current study and the many related studies above show the importance of the boy child over the girl. This shows how male dominance has been promoted over time, right from birth. The belief in wanting to have many boys for inheritance has caused problems for many indigenous Ugandan families. Instead of peacefully inheriting the property, the boys fight for the same property, sometimes causing death.

Moreover, some indigenous families, especially those with girls only, keep producing to get boys, sometimes without success. However, many children already born as couples look for girls suffer the consequences of not using family planning and miss out on the benefits of LARCs. These consequences of big families include poor health of the mothers and children due to many deliveries, sometimes leading to death; the

children are poorly looked after with limited food; and many of those girl children do not attend school. Even where these families get the boys with the aim of inheritance, by the time they are grown up, no wealth remains for them to share as they have already exhausted the whole of it. As a result, many girls from these families get married early, resulting in teenage pregnancies and the consequences of early marriages and teenage pregnancies. In most cases, such families end up in abject poverty without any wealth for the boys to inherit.

#### **4.9.7 Wealth from dowry**

Another reason given by some participants in the Rubanda District for not allowing their partners to use LARCs was a need for dowry from their daughters. Some participants submitted that when one has many daughters and they all happen to get married, the family amass many cows in the form of dowry and other gifts which improve the wealth of the family. Therefore, allowing women to use LARCs denies the families opportunities of having many girls in the families; hence less dowry in future resulting in limited family wealth.

*“When I have many children especially girls and I am lucky they get married, I get cows and that is wealth in the family. So, if I allow my wife to use family planning, you cannot get enough girls and that means few cows” (FGD R9).*

*“While I do not believe in getting cows from girls, I know my friends who think that when you produce many girls you can get a lot of dowries when they finally get married. Such men can never allow their wives to use LARCs” (FGD RM3).*

*“If you produce many girls in the family and they become old, they will get married, and the family will get many cows and goats which are a source of wealth to the family. If the woman uses family planning, she will produce very few children and few cows” (I R 15).*

The belief that many girl children are a source of wealth in the form of bride price corroborate the findings from a study done by Harrington et al (2020:291) which found that bride price obligations require women to produce children and use of



contraceptive is against the socio-cultural expectations. There is a logic that because a man paid bride-price, some participants in Rubanda District were convinced that women should produce many children both boys and girls for the purpose of recovering the dowry by marrying off the girls in line with a study done in South Africa (Kriel et al 2019:8).

However, many families produce children to have more girls for dowries and end up getting poor-quality children who are poorly fed, poorly, or not schooled. Such children are sometimes married off very early before the consent age of 18. Even the dowries they get from such children are very inadequate and cannot pull such families from poverty as they expected in comparison with families that use contraceptives and plan well for their children. Therefore, the importance of contraceptives, including LARCs, outweighs those of dowries.

#### **4.9.8 Religious beliefs**

Religious beliefs are unique conceptualisations in religion and frequently have to do with the existence, traits, and worship of a divine being; following a divine direction in the spiritual world and in human life; or deontological justifications for moral principles and practices that based on the teachings of a spiritual teacher or group (Stands4networks 2022). Under this category, two sub-categories namely fear of losing a leadership position in church and not contravening the teachings of the church emerged from the focus group discussion as some of the barriers the impeding the use of LARCs by their wives.

#### **4.9.9 Fear of losing a leadership position in the church**

In the Rubanda District, some men expressed feared losing leadership positions in the church if they supported LARCs use by their partners. The participants indicated that some of them as well as their partners hold powerful leadership positions in the church, and they do not want to be perceived as faltering in their religious convictions. These views were mainly expressed by participants of the Catholic faith and born-again Christian in the two sub-counties of Rubanda District. Below is an aggregate of their sentiments:

*“My wife is a leader in the born-again Church and if they know that she is using family planning, they will immediately stop her so for this reason, I cannot encourage her to use a LARC” (FGD RM 31).*

*“As a Muslim leader, I can only support the use of natural family planning as I will be risking my leadership role in Islam and therefore anything to do with artificial methods is against Islam” (I KD 14)*

*“As a born-again Christian, if I allow my wife to use a long-term family planning method, I will be bashed for killing the unborn life. I therefore fear that I will be chase...they will chase me away from being a senior member of the church” (I RM 50)*

There is no available literature related to the belief of losing leadership positions in Church by participants or their wives if they used LARCs as established in Rubanda District. However, this fear could be directly related to the belief of not wanting to contravene the teachings of their religion. When men or women who are considered religious in the Catholic Church use contraceptive methods including LARCs, the Church would take such men or women as not following the true teachings of the Church and could lose the leadership positions they hold in Church.

#### **4.9.10 Fear of contravening the teachings of the faith**

Participants from both Rubanda and Kiboga Districts stated that they do not allow their wives to use contraceptives because it is against the teachings of their faith. This assertion is held by mainly Catholics, Muslims, and born-again Christians but not Anglican participants. They reasoned that using family planning is similar to murdering the unborn baby, yet the Church and Islam encourage their congregants to produce, practice the word and teach against murder. Some participants showed their unwillingness to support their wives' use of contraceptives including the LARCs except for the use of the natural methods which they believe are God-sent methods. However, in both Rubanda and Kiboga Districts, there were divergent views with some Muslims, Catholics, Anglicans, and born-again Christians stating that the use of LARCs depends on someone's economic status and not religion. The testimonies below illustrate the diverse views:

*“As Catholics, I do not encourage the use of FP by women because it is against the teaching of the bible, and it is tantamount to killing the unborn baby” (GFD-RM 27).*

*“It is against the teaching of Islam to use modern contraceptives other than natural ones and there I cannot support my wife to use a LARC” (I-KD 15*

*“The priest or sheikhs cannot help at your home when you are suffering to provide for the many children you have. Therefore, the necessity to use LARCs should be according to the income of the household” (I-KD 13).*

*“As an Anglican, I follow the teaching of the Bible that tell us to produce and fill the world. For that reason, I do not allow the use of long-term Family Planning.” (FGD R10).*

*“As a Catholic I believe that the use of any family planning even the long-acting one is murder and sin and hence won’t want to commit a big sin by allowing my wife to use a long-acting family planning method” (FGD R4).*

*“As Catholics, we only believe in the natural family planning and therefore I cannot allow my wife to use a long-acting family planning method”(FGD-K12).*

These findings from Rubanda, and Kiboga Districts are supported by related studies done in Uganda, East Africa, and globally. According to Mathys (2018:38-41), religion was one of the key barriers to contraceptive uptake in Uganda, although some religious leaders accepted spacing the children in opposition to the teachings of their religions in private. This is supported by another study done in Uganda by Otim, (2020:9) which confirmed that religion was one of the predictors of non-use of contraception. In agreement, Kabagenyi et al (2020:14), found that the demand for contraceptives was influenced by religion, with the Catholic having a higher odd of demand for contraceptive services.

According to findings from studies done in Kenya and Somalia, some Muslims are against the use of modern contraceptives, preferring to use natural methods (Abdi et al 2020:5; Gele et al 2022:4) as contraceptive use is against Islamic practices. The current study finding relates to those from a study done in Republic of Macedonia by Chavdar et al (2017:121-122), which verified that religious affiliation and the intensity of religious sentiments continue to significantly influence reproductive behaviours and decision-making in the utilisation of contraceptives including LARCs. This also agrees with the findings from another study done in Nigeria by Akinyemi et al (2020:4-6), which showed the entrenched religious beliefs that children are a blessing from God and the use of any contraceptive methods goes against the grain. According to Yen (2021), contraceptives, other than the natural method, is against the Catholic faith.

A similar finding in Augustine and Godwin (2018:7) states that some Catholics preferred to use natural methods to be in line with their religious teaching. In both Rubanda and Kiboga Districts, the opposition against LARC use by men was strong among the Catholics and Muslims than in Anglican participants. This finding consolidates the notion that most Anglican groups, theologians, and Churches allow contraception and may even advocate it as a moral virtue.

Similarly, the findings in Rubanda and Kiboga Districts relate to those of a study done in the United States by Liu et al (2019:193–199) which illustrated that participants who worked in secular and Anglican systems had minimal restrictions on contraceptive care. In addition, in Ethiopia, Bekele et al (2021:9) confirmed that Muslim participants were against using contraceptives since they believed that it was against the teachings of their religion.

In contrast, the current findings differ from the beliefs of most American Catholics who believe that contraception is acceptable and is not a moral issue (Pew Research Centre 2016:25). Bishops in African countries with large Catholic congregants have not accepted contraceptive use including LARCs in reducing maternal mortality rates. They claim that contraception is part of the culture that causes death and increases sex practices, especially among the youth (National Catholic Reporter publications, 2018).

According to Yen (2021), contraceptive is allowed in Islam when both partners agree but when the husband does not, then the woman is not allowed to use the method. In Somalia, it was confirmed that breastfeeding, using non-harmful contraceptives, and *coitus interruptus* were all acceptable methods according to Muslims. However, the same study reaches a contradiction were using contraceptives to limit the number of children was non-Islamic and using a barrier method such as condoms was thought to encourage extramarital sex and hence outlawed (Ageha et al 2019:28-30),

Contrary to the findings in Rubanda and Kiboga Districts, Americans believe that their religion allows the utilisation of reversible contraceptive methods (Shabaik et al 2019:981). The findings in the current study corroborate those of a study done among two Muslim communities in Kenya which found that misunderstandings of teachings of Islam on family planning were likely to determine the uptake of contraceptives.

Limited power of women to make their family planning and fertility choices were a key barrier to contraceptive uptake (Abdi et al 2020: 9-10). A related study done in Tanzania by Sundararajan et al (2019:8-9) found that the way people interpreted their religious traditions influence the acceptability and utilisation of contraceptive services. Similarly, another study done in Sub-Saharan Africa found that religion influences fertility as well as contraceptive utilisation (Turner & Götmark 2021:101).

When a woman's financial and emotional resources are fluid, she might use Islamic contraceptive rules to justify delaying pregnancy, which is a strong weapon for women, (Arousell et al 2019:62). In addition, a study in Nigeria indicated that religious leaders encouraged women to use natural contraceptive methods other than the modern ones (Sinai et al 2019:1260).

According to Dansereau et al (2017:4-6) and Akamike et al (2020:5) it was found that religious objections to contraception severely hampered usage of LARCs. Similarly, a study in Zambia by Long et al (2020:4) found that being an Anglican or Muslim was linked to low usage of Contraception. However, the Zambian study differs from the current findings in the sense that most Anglican participants were not against the use of LARCs although both studies agree that Islam marginalised contraceptive use.

### **Barriers that enable indigenous Ugandan men to oppose their partners' use of LARCs.**

The study findings in Rubanda and Kiboga districts revealed the various barriers that make indigenous Ugandan men not supportive or LARC use by their rural women. Limited knowledge about contraceptives, particularly LARCs resulting in negative perceptions and beliefs.

- The negative perceptions about LARCs that include side effects of LARCs, fears of the outcomes of the LARC use, the desires that men have especially for bigger family side, for balancing the gender and boys for inheritance.
- The beliefs systems about LARCs such as cultural and religious beliefs that discourage the use of contraceptives.
- The gaps in LARCs service provision at the facility and community level. These include stock out of LARC commodities, LARCs services not available except on outreach days by partner outreaches. Additionally, absenteeism of health workers who are supposed to provide LARCs services including the insertion, removal services and management of side effects and long distances to where health facilities that offer LARC services.

### **Facilitators that enable indigenous Ugandan men to support their partners' use of LARCs.**

The facilitators of indigenous Ugandan men's support of utilisation of LARCs by the rural women include addressing the above barriers through the strategies and their actions discussed in chapter 5

## **4.10 DIFFERENCES IN FINDINGS BETWEEN RUBANDA AND KIBOGA PARTICIPANTS**

Although the themes and categories of that emerged from the study in both districts of Rubanda and Kiboga were similar, there were some differences in the sub-categories. These are indicated in table below (Table 4.2).

**Table 4.2: Differences in perceptions and beliefs between Rubanda and Kiboga districts**

<b>Rubanda</b>	<b>Kiboga</b>
<b>Perceptions</b>	
1. Conceiving while using a LARC	Fear of losing land to non-Baganda tribes
2. Producing twins after using LARCs	Separation and single mothers
<b>Belief systems</b>	
3. Wealth from dowries	
4. Fear of losing leadership positions in church	

Most of the participants from the two districts of Rubanda and Kiboga had similar perceptions and belief systems. However, table 4.2 above depicts the outliers from participants in the two districts. These differences have been discussed in table 4.1 above.

#### **4.11 SUMMARY OF FINDINGS**

The perceptions and belief system among rural indigenous Ugandan men in Rubanda and Kiboga districts were the same regarding the use of LARCs. Some of the perceptions act as barriers to utilisation of LARCs by their women which has maintained those method mix low compared to short term contraceptives. These barriers have since led to subsequent high maternal mortality and morbidity in two districts of Uganda where the study was conducted. These perceptions and beliefs among indigenous Ugandan men have regarding LARCs are summarised below.

The perceptions included those associated and perceived side effects such as prolonged bleeding, low libido, effect on body organs, infertility, paralysis of arms and the positive perceptions such as proper planning for family and adequate resources. Other perceptions are those under fears that included fears Separation leading to single mothers, adultery, challenges with removal or management of side effects, fear for land taken by other none Baganda tribes, complications in subsequent deliveries, excessive weight gain, conceiving while on a method and fear to produce twins after using some contraceptive methods. Additionally, there were desires to get balanced

sex of children in the family and to get the desired number of children as perceptions that limited support for men towards use of LARCs by their women. The belief systems identified from this study included cultural and religious beliefs. The cultural beliefs included believing in natural methods, power-related, children as a source of labour for the family, need for children to expanding and strengthening the clan, sex preference for boys to wealth inheritance, wealth from dowry, cultural recognition and preserving or strengthening the clan. The study also found the religious beliefs to include fear to lose leadership position in the church and not to contravene the teachings of the religions especially among Catholics and Muslims participants.

#### **4.11 CHAPTER SUMMARY**

To increase the uptake of LARCs by rural women in Uganda, the perceptions, and beliefs that indigenous rural men must be addressed. This requires the development of appropriate strategies to enhance men's support for LARCs use by their female partners. The next chapter five therefore focuses on the development of strategies that could increase men's support for LARCs use.



## **CHAPTER 5**

### **THE DEVELOPMENT AND VALIDATION OF STRATEGIES THAT ENHANCE POSITIVE PERCEPTIONS ON LARCS**

#### **5.1 INTRODUCTION**

Chapter four presented the study findings and subsequent discussion. In this chapter, we present the conclusions based on these findings and the development of strategies to enhance indigenous men's support for the utilization of LARCs among rural women in Uganda. The chapter begins by describing the strategy development process, which involved the application of the Delphi approach. The chapter also provides evidence by summarising the findings and describing the validation process. This chapter provides detailed strategies developed to increase indigenous men's support for LARC use among rural women.

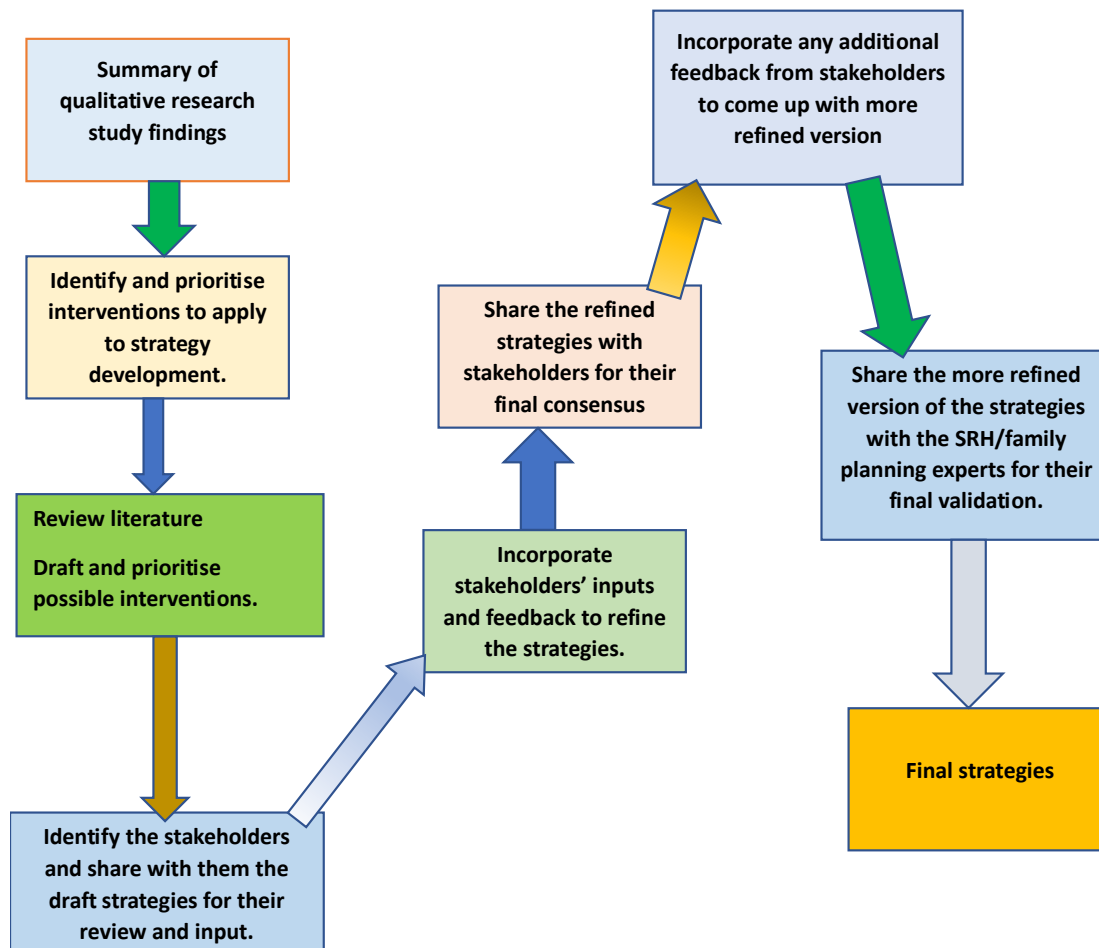
#### **5.2 STRATEGY DEVELOPMENT AND VALIDATION PROCESS**

The development of strategies followed the evidence generated from the findings generated from the qualitative data analysis. A strategy explains how someone intends to accomplish their goals based on identified needs (Loh, Long, & Spurgeon 2019:31; Rumelt 2011:13). Qualitative data analysis was used as a basis for strategy development because it provides a more profound understanding of the perceptions and belief systems of indigenous Ugandan men that make them oppose the use of LARCs by rural women. This knowledge is crucial in developing strategies to enhance indigenous Ugandan men's support for the uptake of LARCs by rural women (Leavy 2017:124).

The Centre for Community Health and Development (2022), states that a good strategy should provide overall direction, matching resources with opportunities while minimizing resistance and barriers. Additionally, a good strategy should reach those who are affected, and it should advance the mission. In the context of this study, a strategy refers to a systematic plan of action to enhance indigenous men's support for the uptake of LARCs among rural women in Uganda. These strategies were developed specifically for the indigenous men in Uganda, who are the intended population.

### 5.3 PURPOSE OF STRATEGY DEVELOPMENT

The purpose of strategy development is to address the perceptions and beliefs of indigenous Ugandan men regarding the use of LARCs. By doing so, we aim to increase the uptake of LARCs among rural women, ultimately leading to reduced maternal morbidity and mortality rates.



**Fig 5.1: The process of strategy development and validation (Researcher's own initiative)**

Figure 5.1 above illustrates the process followed in developing the strategies.

#### **Summary of key steps**

The strategy development process was a two-phased one involving summarising the key findings from the study, followed by identifying, listing, and prioritising the broad intervention strategies, reviewing the relevant literature, and drafting key strategies under each intervention area listed.

The second phase involves finalising the strategies, where the researcher identified and consulted key stakeholders in the strategy development process and then the validation of developed strategies by experts.

## **5.4 PROCESS OF STRATEGY DEVELOPMENT**

The strategy development process was a consultative one consisting of two phases, as shown in Fig. 5.1 above. A modified Delphi process was used in this process of strategy development. The Delphi approach is helpful for gathering and validating expert opinion, whether it is based on consensus or not (Fletcher & Marchildon 2018:3).

### **5.4.1 Phase 1: Preliminary broad interventions and the targeted strategies**

In phase one, the key findings from the study, as shown in Fig 5.1, were summarised. Next, the researcher identified, listed, and prioritized the broad intervention strategies. The researcher then reviewed the relevant literature on the processes followed in previous studies and interventions that have worked elsewhere. This literature review guided the drafting of the critical strategies under each intervention area listed.

#### **5.4.1.1 Summary of findings from the study**

The findings revealed that men had limited knowledge about contraceptive usage, including LARCs. There were perceptions and belief systems that the rural indigenous Ugandan men in the Rubanda and Kiboga districts held regarding using LARCs. These belief systems and perceptions of men served as barriers to the utilisation of LARCs among rural Ugandan women. The situation has contributed to the low uptake of LARCs compared to short-term contraceptives. These eventually have led to subsequent high maternal mortality and morbidity in Uganda's Rubanda and Kiboga districts (UBOS 2017:63, I & IV; Kakande et al 2019:18).

##### **5.4.1.1.1 Limited knowledge of contraceptives, including LARCs**

The study findings showed that men had limited information about family planning; a few participants were able to mention at least two modern contraceptive methods with the injectable and withdrawal methods most pronounced.

The study also found that very few men could mention any of the LARCs, while many of them could not name any of the contraceptive methods. The study revealed that men had minimal knowledge about contraceptive methods, particularly LARCs. Many of them were unaware of the existence of LARCs. This limited knowledge about LARCs could be linked to the negative perceptions and belief systems that indigenous men have regarding their acceptability for LARCs usage among their rural women.

#### *5.4.1.1.2 Perceptions of rural indigenous Ugandan men regarding the use of LARCs*

The following are the perceptions of indigenous Ugandan men from Rubanda and Kiboga districts regarding LARCs: the perceived side effects, prolonged bleeding, low libido, effect on body organs, infertility, paralysis of arms, and positive perceptions such as proper planning for family and adequate resources. Additional perceptions included fears of separation leading to single motherhood, concerns about adultery, and challenges related to removing or managing side effects. Furthermore, fear that the land or wealth would be usurped by other non-Baganda tribes, complications in subsequent deliveries, excessive weight gain, conceiving while on a method, and fear of producing twins after using some contraceptive methods were other perceptions. Furthermore, some men expressed a desire for gender balance in their children, achieving their desired number of children, which limited their support for using LARCs by their partners and hindered uptake.

#### *5.4.1.1.3 Belief systems that rural indigenous Ugandan men have regarding the use of LARCs*

The study identified cultural and religious beliefs as the belief systems held by rural indigenous Ugandan men. The cultural beliefs included believing in natural methods, those that are power-related, children as a source of labour for the family, need for children to expand and strengthen the clan, gender preference for boys for wealth inheritance, expected wealth from dowry, cultural recognition and preserving the clan's name. The study also revealed that religious beliefs included fear of losing leadership positions in the church and not contravening the teachings of the religions, especially among Catholics and Muslim and born-again participants.

### 5.4.1.2 Areas of intervention to guide strategy development

The researcher considered three intervention areas for strategy development based on the themes from the data analysis. They included addressing limited knowledge among men regarding contraceptives and LARCs, as well as addressing the perceptions and belief systems about LARCs that men had. Table 5.1 below shows the three broad intervention areas and the proposed strategies for each. The Table 5.1 below presents the preliminary broad intervention areas sent out to experts in phase one for their inputs.

**Table 5.1: Preliminary broad interventions and the targeted strategies for each**

No	Broad Intervention areas	Strategies
1	Addressing limited knowledge about contraceptives and LARCs, in particular	Community family planning group education for men
		Re-orientating village health teams to target men
		Identifying and using simple, practical training of men champions the mode of action of contraceptives
		Engage trained men champions to train fellow men in the communities on family planning and LARCs in particular.
		Train video hall attendants, bar owners and attendants
		Dedicated men's spaces and days at health facilities for dedicated information and services provided on SRHR/FP
2	Addressing the perceptions about LARCs	Increase the knowledge about FP, particularly LARCs, among men by simplifying their mode of action
		Increase the capacity of health facilities workers to manage common side effects such as prolonged bleeding and loss of libido.
		Train, equip and monitor the community health workers to manage common side effects.

		<p>Avail the supplies for management of side effects of LARCs at all levels of health facilities, including the community health-based distribution. This addresses the challenge of side-effect management</p>
		<p>Identify, train and make use of men LARC champions in dispelling rumours, myths, and misconceptions and addressing fears</p>
		<p>Identify, train and monitor community and religious leaders to work as marriage counsellors to handle cases of mistrust in families of LARC users to reduce the possibility of couple separation resulting from the method used.</p>
		<p>Strengthen and reduce corruption in land offices at national and districts, especially in the Buganda region, to minimise land grabbing by the so-called “well-connected people”. This reduces suspicions about contraceptive use among community members, increasing the acceptability of the methods, especially the LARCs.</p>
3	Addressing the belief system about LARCs	<p>Improve the knowledge of men about all contraceptive methods, including natural ones and LARCs.</p>
		<p>Identify and train men as gender champions who can train other men in the communities in gender issues and their application in daily life and the benefits.</p>
		<p>Community dialogues with crucial people in the communities, such as religious, community and political leaders and men, on issues related to their belief systems and help them to adjust to fit into the current modern world.</p>
		<p>Introduction of peer-to-peer community clubs of men to discuss reasons why women die or get complications that are pregnancy-related.</p>

Table 5.1 above illustrates the broad intervention areas and the proposed strategies as identified by the researcher before consultations experts. Following the drafting of the preliminary broad intervention areas and proposed strategies, they were shared with independent stakeholders.

#### **5.4.2 Phase II: Finalisation of the strategies**

In phase II, the researcher identified the 34 stakeholders who were consulted in the strategy development process and validation.

##### **5.4.2.1 Stakeholders' identification**

In developing strategies, 34 experts and key stakeholders were identified and selected based on their expertise in sexual reproductive health and rights, family planning, social and behavioural change communications, gender and their importance in the district health systems. The researcher considered the following experts and stakeholders and included them to validate the proposed strategies: the National level, regional and district-based Family planning experts, the national, regional and district-based Social Behavioural Change Communication (SBCC) experts and Gender experts, including those from Rubanda and Kiboga districts.

In addition, other key stakeholders included the family planning service providers, the village health teams, the community leaders, representatives of village health teams, the female potential family planning users and religious leaders in both Rubanda and Kiboga districts. The consultation also included men participants in the two study districts to get their inputs and views regarding developing strategies that could enhance their support towards using LARCs by their women. The summary of the experts and key stakeholders consulted is shown in Table 5.2 below.

**Table 5.2: Category of experts and key stakeholders consulted.**

<b>No</b>	<b>Category of stakeholders</b>	<b>Number consulted</b>
1	National-level family planning experts	5
2	National-level SBCC experts	4
3	Regional/District level family planning experts	7
4	District-level SBCC experts	2
5	Religious leaders	4

6	Community leaders	4
7	Village Health team members	4
8	Representatives of men participants	4
TOTAL		34

A total of 34 stakeholders were consulted in developing the strategies. These stakeholders contributed independently at different times in the strategy development process. The demographics of these stakeholders are shown in Annexure 13.

#### **5.4.2.2 First level experts and stakeholders consultations**

The identification and profiling of experts and stakeholders once completed, the broad draft strategies shown in Table 5.1 above were shared electronically via e-mails, google documents and WhatsApp for feedback. The follow up was done through phone calls and WhatsApp messages for their input. Additionally, stakeholders who could not communicate through e-mails, WhatsApp or phone calls were followed up physically.

The views of men participants in the study and what they thought would increase their support for LARC use had been gathered during data collection. However, during strategy development, the representatives of men participants were also consulted throughout. After sharing the draft strategies with the experts and stakeholders, through electronic means and face to face interactions, their inputs were documented.

#### **5.4.2.3 Second level consultations with stakeholders**

All experts and stakeholders consulted gave their feedback and agreed that there was need for some improvement. The improved strategies were then shared again with the same experts and stakeholders for their consensus via the same platforms.

#### **5.4.2.4 Third level consultations with stakeholders**

This phase involved incorporating the feedback received from stakeholders into the second draft, which resulted in the final strategies. Some feedback included refining the strategic goal, addressing the LARCs service delivery gaps in the approaches, and refining the vision and recommendation to have the fourth strategy on monitoring and evaluation as shown in 5.3. The researcher shared the last strategy version with all the stakeholders for the final consensus.



The researcher used the same channels to send the initial draft strategies again. Table 5.3 below shows the final version of the strategies all stakeholders agreed upon: it has four intervention areas instead of the three in the first draft, as advised by the experts. The four intervention areas are increasing knowledge of contraceptives, particularly LARCs, among men, addressing perceptions and belief systems about LARCs, and minimising the gaps in LARCs service provision at the facility and community levels.

#### **5.4.2.5 *Fourth level validation with experts***

The experts validated the strategies after the stakeholders had agreed. These experts have got more than five years of experience in reproductive health/family planning programming. All experts consulted had medical and nursing background as well as a Masters in public health qualifications (refer to Annex 16 for more details). Table 5.3 below shows the final strategies that were validated and agreed up on by the experts.

**Table 5.3: Summary of developed strategies for LARCs for men in rural Uganda (Framework adopted from UNICEF, 2016:8)**

<b>Vision</b>	<b>A world where men are supportive of their wives using LARCs.</b>			
<b>Goals</b>	To popularise the use of LARCs among men to support their partners to accept those contraceptive methods.		To increase the uptake and retention of LARCs methods among women of reproductive age	
<b>Approaches</b>	Increase knowledge about contraceptives, particularly LARCs			
	Address the perceptions about LARCs			
	Address the beliefs systems about LARCs			
	Minimise gaps in LARCs service provision at the facility and community level			
<b>Strategies</b>	<b>Strategy 1:</b> Strengthen SBCC to empower families and community systems to support and demand LARCs	<b>Strategy 2:</b> Advocacy to build an enabling environment for LARCs provision	<b>Strategy 3:</b> Strengthen the family planning health systems for LARCs service delivery.	<b>Strategy 4:</b> Strengthen monitoring and evaluation systems for LARCs in the health care facilities.
	<ul style="list-style-type: none"> <li>Re-orientating Village Health Teams (VHTs) on LARCs</li> <li>Conduct community family planning group education for men</li> </ul>	<ul style="list-style-type: none"> <li>Promote the intersectoral corroborations at all levels</li> </ul>	<ul style="list-style-type: none"> <li>Capacity building in comprehensive LARCs counselling and service provision</li> </ul>	<ul style="list-style-type: none"> <li>Build the capacity of health workers in the documentation of LARCs and</li> </ul>
<b>Actions</b>				

	<ul style="list-style-type: none"> <li>• Identify, train, and deploy male LARCs, satisfied users, as champions</li> <li>• Recruit and train community entertainment attendants</li> <li>• Use of community and political leaders</li> <li>• Engaging the religious leaders</li> <li>• Avail the information, Education and Communication (IEC) Materials</li> </ul>	<ul style="list-style-type: none"> <li>• Make available the SRHR policy guidelines</li> <li>• Advocate for increased funding for family planning activities</li> <li>• Engage the community, cultural and religious leaders.</li> </ul>	<ul style="list-style-type: none"> <li>• Building the capacity of health workers on LARCs side effect management</li> <li>• Strengthen the supply chain systems to address the stockout of LARCs.</li> <li>• Address service provider biases on LARCs and low morale</li> <li>• Strengthen the supportive supervision at all levels.</li> </ul>	<ul style="list-style-type: none"> <li>reporting the services offered</li> <li>• Make availability of HMIS tools at Health facilities for to LARCs</li> <li>• Completeness of Family Planning data captured and reporting.</li> <li>• Improve data use for decision making</li> <li>• Improve supportive</li> </ul>
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	<ul style="list-style-type: none"> <li>• Conduct community dialogues on LARCs</li> <li>• Adapt and scale up the use of family planning games</li> <li>• Build the capacity of VHTs in side effects management.</li> <li>• Addressing the social and gender norms among men</li> </ul>		<ul style="list-style-type: none"> <li>• Policy shifts to widen LARC access through drug shops.</li> <li>• Address human resource gaps at the health facilities</li> <li>• Address financing for family planning activities</li> <li>• Deploy LARC-satisfied male and female users as champions at facilities</li> <li>• Task shifting on common side effects</li> </ul>	<p>supervision for M&amp;E</p>
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			management by VHTs <ul style="list-style-type: none"> <li>• Avail Family planning guidelines, including those on LARCs</li> </ul>	
<b>Expected outcome.</b>	Increased support and demand for Family planning services and LARCs among men through addressing the perceptions, beliefs and increased knowledge about Family planning and LARCs	Improved supportive enabling environment for family planning and LARCs provision	Increased capacity of health facilities to provide LARC services, including insertion and removal services	Improved documentation and reporting for family planning and LARC services

Table 5.3 above illustrates the summary of developed and validated strategies that can enhance the support of indigenous men towards LARCs use among their women in Uganda. The details are described in the paragraphs to follow below.

### **5.4.3 Details of the final strategies**

After the consultations with stakeholders and validation by the experts, the investigator came up with the final version of the strategies adopting the UNICEF framework, as summarized in table 5.3 above. The critical components in the final strategy include the vision and goals, the approaches, strategies, actions and outcomes (UNICEF 2016:8; Hummelbrunner & Jones 2013:1-8).

#### **5.4.3.1 *The vision and goals***

A vision statement looks ahead and imagines the ideal situation the entity wants to reach (Dictionary.com 2022). Therefore, the vision for this study is to have world where men are supportive of their wives use LARCs. This can be achieved through the following goals: to popularize the use of LARCs among men so that they support their partners to take up those contraceptive methods and increase the uptake and retention of LARCs methods among women of reproductive age.

#### **5.4.3.2 *Operationalization of strategies.***

An approach is steps towards creating a desired outcome (Dictionary.com 2022: Online). Four approaches are proposed to be used to reach the vision and goals indicated in the above paragraph (refer to Table 5.3 above).

##### **5.4.3.2.1 *Approach 1: Increase knowledge about contraceptives, particularly LARCs.***

Based on the findings, the knowledge and understanding of contraceptives, especially the LARCs, was very limited among most participants as evidence Table 4.1 and the details that follow in Chapter 4. When the researcher asked the participants about contraceptive methods, a few (45%) in Rubanda and 49.3% in Kiboga could name at least two modern contraceptive methods, with injectable and withdrawal being the most mentioned. Only a few men (10%) in Rubanda and 14% in Kiboga mentioned any of the LARCs. Still, a reasonable number of men (38%) in Rubanda and 27.2% in Kiboga could not name a contraceptive method. To address the knowledge gap, strategy one will be implemented. The actions taken for strategy one and the expected outcome of this strategy, refer to Table 5.3 and the details under section 5.5 below.

#### 5.4.3.2.2 *Approach 2: Addressing the perceptions about LARCs.*

Under the perceptions, men are hesitant to allow their women as they perceive the LARCs as having undesirable health effects on the bodies of their women. The perceptions are related fears and desires that men have. These include prolonged bleeding, low libido in their women, effect on body organs, infertility, paralysis of arms, fear of separation, fear for land or wealth being taken by other none Baganda tribes, desires to get balanced gender of children in the and to get the desired number of children in a family. To address the perceptions above, strategy one, two, three and four will be implemented with the expected outcome as stated in Table 5.4 above.

#### 5.4.3.2.3 *Approaches three: Addressing the beliefs systems about LARCs.*

Based on the findings of this study, men had belief systems that included both cultural and religious beliefs as described in Chapter 4. In order to address these belief systems, the strategy one will be applied, with the actions and expected outcome as shown in Table 5.3 above.

#### 5.4.3.2.4 *Approaches four: Minimise gaps in LARCs service provision at the facility and community level.*

According to this study findings, participants indicated poor LARC service at health facilities such as management of side effects, lack of LARCs insertion and removal services. These gaps can be addressed by implementing strategies one, two, three, and four to achieve their respective expected outcomes as shown in Table 5.3 above.

### **5.5 STRATEGY ONE: STRENGTHENING SOCIAL AND BEHAVIOURAL CHANGE COMMUNICATION (SBCC)**

One strategy to address men's limited knowledge, perceptions, and belief systems regarding contraceptives, including LARCs, is to strengthen Social and behavioural change communication (SBCC). Social and Behaviour Change Communication (SBCC) is defined as *"the systematic application of theory-based, research-driven communication strategies to address individual-level change and change within broader environmental and structural levels"* (USAID 2019).

## **The strategy goals.**

Empower the family and Community systems to support and demand LARCs services, which will be achieved by implementing the activities discussed below.

## **Strategic actions**

### ***Re-orienting Village health teams (VHTs) on LARCs***

The Village Health Team is a community-based (village) institution in Uganda whose membership is agreed upon by the community members themselves in their places of domicile to promote the good health and well-being of their communities (Ministry Of Health-Uganda 2010:11). The VHT system in Uganda is classified as Health Centre 1, which is the lowest level of healthcare delivery and functions. In Uganda, each village health team member covers at least 25 to 30 households, depending on how sparse the population is in that area (MOH 2010:12). The role of VHTs is to promote health in different fields, ranging from Maternal and child health to nutrition, water, and sanitation, among other health areas. Most VHTs have had some superficial training in contraception, which does not emphasise particular methods like LARCs. The simple training means that the VHTs lack adequate knowledge of LARCs. Therefore, as VHTs do community sensitisations, they do not highlight the benefits of LARCs to both men and women, as they are not appropriately prepared to counter the misconceptions and beliefs associated with limited knowledge about LARCs among men. Therefore, re-orienting the VHTs in LARCs is a step in the right direction, in preparation for them to spread correct information to men and women in the communities, which could eventually see men becoming supportive of LARCs uptake among rural women.

### ***Conduct community family planning group education for men.***

Forming and educating men in groups of about 8 to 10 about family planning during their free time at places near their homes or places of relaxation could be one of the interventions to increase the knowledge of contraception, including LARCs, among men. The education sessions could be facilitated by male Village health team members (VHTs) who had been re-oriented on LARCs.



The VHTs should be motivated and assigned to reach out to men whose wives are still of reproductive age. The VHTs should meet the groups for men at least twice a week to take them through different family planning methods, with a sample of some of the LARCs to show them during the sessions. In the family planning group sessions, the VHTs should always discuss LARCs and their benefits to the woman, the man, the children, and the community. The VHTs should encourage the men to share the lessons learned with their partners after the sessions. As men get more exposed to information about LARCs, their knowledge will improve and as a result, men's negative perceptions and belief systems could also improve, increasing their support for using LARCs among their rural women.

***Identify, train, and deploy male LARCs, satisfied users, as champions.***

LARCs champions actively support and promote long-acting reversible contraceptives (LARCs) and believe in their virtues and advantages (Johns Hopkins University 2022). In the community, not all men are negative about LARC because few have adequate knowledge and support from their partners to use the same methods. Such men should be used to influence their peers to support LARC use among their women. These men can be recruited, trained, and deployed as champions to increase the understanding of LARCs among indigenous rural men LARCs. The LARC champions could easily convince their fellow men because they can share their positive experiences with LARCs use with their partners (Horvath et al 2020: S866). The LARCs champions are also better because they are approachable to fellow men who may want more information about LARCs. By deploying the LARCs male champions, more indigenous men will have their myths and misconceptions addressed. They will most likely support LARCs use by their women, thereby increasing the uptake of the same methods.

***Recruit and train community entertainment attendants.***

In rural areas, many men spend a reasonable amount of time in community entertainment centres such as local bars and video halls for their leisure. Most men who spend their time in bars and video halls are prone to getting negative information about contraceptives and LARCs, in particular, because of their peers in those places.

To reach such men with correct details about LARCs, there is a need to identify and train the attendants of those entertainment places and then support them in disseminating information about LARCs to men in those places. Also, some debates, including family planning use, occur among the patrons in those community entertainment places. When the attendants in those entertainment places are trained and have adequate information on LARCs, they could disseminate the same to their guests during such debates. In doing so, they might also be able to correct the myths and misconceptions the men might have had about LARCs. This approach may improve men's knowledge of LARCs, resulting in their support for using such methods by rural women.

### ***Use of community leaders, such as cultural and political leaders***

Community leaders are responsible for their community's well-being and development (Axner 2022). The community leaders range from government leaders to cultural leaders and leaders of community groups like the self-help groups (community Ngozi), the village saving groups, and burial groups. These leaders have a lot of influence on their community members and are well respected and trusted. When such leaders are well equipped with proper information on LARCs and are supported, they can reach out to many men and help dispel men's negative perceptions and belief systems, thereby increasing their support for LARCs use by rural women. In addition, the government of Uganda is rolling out a Parish development model programme where groups of people in the communities are given startup capital for household wealth creation. All these groups have their leaders, and men dominate most of these groups. Therefore, targeting the leaders of these community groups, building their capacity with information on contraceptives with an emphasis on LARCs, and encouraging them to disseminate the same information is the best approach for reaching out to men. The targeted information should be on the benefits of using LARCs for men and women in those groups. This approach could increase the understanding of family planning, including LARCs, among men. Eventually, this could increase their support for LARCs use among their women.

### ***Engaging the religious leaders***

According to the study findings, some men indicated their lack of support for family planning and LARCs because they were against the teachings of their religions.

This finding was mainly from participants who were Muslims, Catholics, and born-again believers. Addressing this barrier requires religious leaders' engagement with various religious denominations on family planning issues (Bormet, 2020:852). Although not all the religious leaders mentioned above are against using family planning and LARCs, they fear coming out openly to support them.

Therefore, the engagement of religious leaders should start by identifying those supporting contraceptive use, equipping them with more information on LARCs, and encouraging them to share the same with their church members quietly. The church leaders should be encouraged to share information about the benefits of contraception, especially from the perspective of the benefits of LARC use to the mother, husbands, children, and family, in addition to the community, as the same approach has worked in Malawi (Lemani et al 2018:43). Once the church leaders share such information with their members, including the men, they could support family planning and LARCs in particular because indigenous men believe in their church leaders and can easily follow what they tell them.

### ***Information, Education, and Communication (IEC) Materials***

Information, Education, and Communication (IEC) tools are printed materials such as flyers, posters, leaflets, placards, banners, and billboards to bring attention to a health condition and change the behaviour of the people towards a better situation (Nancy, 2020: 451-453). IEC materials are vital to disseminating information about family planning and LARCs to indigenous men in the communities. The IEC materials should be written in the local languages of Rukiga for Rubanda and Luganda for Kiboga and placed in strategic places such as trading centres and local entertainment areas such as bars and video halls.

The IEC materials should be given to the village health team members and other key leaders in the community to distribute to their area residents, especially the men.

The IEC materials should have information that dispels common rumours and misconceptions about LARCs and emphasises the benefits of FP with LARCs. Some IEC materials should include frequently asked questions (FAQs) on FP and LARCs and have the information to dispel the myths and misconceptions arising from the study findings.

With the availability of the IEC materials in the communities, the men will have access to the correct information about LARCs. They are more likely to support using LARCs among rural women.

### ***Conduct community dialogues on LARCs.***

Community dialogues are crucial in addressing the low knowledge of family planning, including LARCs, and men's perceptions and beliefs regarding LARCs. A community dialogue is a platform in which people from various segments of the community congregate to discuss and work towards a common vision, knowledge, or solution to a specific concern or problem (Common Ground Institute 2016:7). The Village health teams should be equipped with knowledge and skills to facilitate community dialogues during family planning discussions with emphasis on LARCs. The training of VHTs will provide opportunities to counteract men's myths and misconceptions. The community dialogues should be for men only to allow them freely discuss the issue of LARCs. The community dialogues should also have the participation of the community and religious leaders so they can learn more about contraceptives and LARCs. Regular community dialogues could increase knowledge about family planning and LARCs among men, and this will also address their negative perceptions and beliefs towards LARCs. Eventually, with an increased understanding of LARCs, men could support using the same methods by their women, leading to the uptake of LARCs.

### ***Adapt and scale up the use of family planning games.***

Adapting and scaling up the implementation of family planning interactive games for men in trading centres and other community gatherings could be an activity in the right direction towards addressing the limited information of LARCs, as well as managing the negative perceptions and beliefs that men have.

Most men spend their free time in trading centres and other places such as bars, video halls, and other small gatherings where they play games such as playing cards (matatu). Studies in Uganda and Nepal showed that family planning games increased men's knowledge and involvement in family planning issues (Nguyen 2018; IntraHealth 2022). Still, the findings from the same study revealed that the uptake of family planning services increased in the intervention region compared to the non-intervention regions.

Therefore, scaling up family planning games designed to include more information on LARCs would most likely increase men's knowledge of LARCs. As a result, this could change their negative perceptions and beliefs about LARCs, thereby increasing their support for the same methods. Therefore, this could facilitate more women taking the LARCs as their preferred method.

#### ***Build the capacity of VHTs in side effects management.***

Evidence from the current study shows that the lack of proper management of side effects was a barrier to the uptake of LARC services. This barrier could be because the health workers are not adequately prepared to manage the side effects. Therefore, that could also be due to the limited attention given to the family planning clients' side effects at the health facilities by health workers. The situation is made worse because some clients of LARCs move long distances to reach the health facilities, where they fail to access the services for managing the side effects of LARCs they may have. By building the capacity of Village Health teams to manage common side effects and equipping them with necessary supplies, family planning and LARCs, clients will be able to access services nearer to their homes. Additionally, family planning clients can conveniently access the services for side effect management, as is the case with community-based family planning services currently offered by some trained village health teams in Uganda.

#### ***Addressing social and gender norms among men***

Social norms are standards of conduct shared by members of a group or society, and they govern what is considered normal and acceptable behaviour for those members (Cislaghi & Heise 2019:409).

Gender norms are beliefs embedded in people's minds and institutions that significantly impact health-related behaviours and unequal access to health care (Cislaghi & Heise 2019:412). Evidence from the current study shows that men still have gender and social norms that make them feel superior to women, which makes them dictate the non-use of LARC by their women. Social and gender norms caused men with many children to feel like real men, contributing to the clans' size and making men less supportive of their women's LARC use. Other social and gender norms, such as the preference for boys over girls and a balanced gender of both boys and girls, also contribute to the non-support of men for LARCs use by rural women. The social pressure from family members and norms that consider the man to be the head of the family and decision-maker have all been barriers to LARCs use (Alspaugh et al 2019: 69 & 79).

Additionally, considering women who use contraceptives as unfaithful is another norm identified in the current study. Therefore, addressing social and gender norms through the various SBCC channels discussed in the previous subsections should be used (Okigbo et al 2018:6-7). The interventions should also include group education for men, community dialogues involving men and community and religious leaders, interactive family planning games, and mass media campaigns with specific information targeting the identified social and gender norms. Addressing the social norms mainly through targeting men's perceptions and beliefs on LARCs could change for the better, leading to their buy-in for the same contraceptive methods, and their support for rural women to use LARCs.

### **Strategy two: Advocacy for LARCs services**

Advocacy for family planning services is another strategy to be used to get the support of men for the use of LARCs services. Advocacy is any action in which one speaks for, supports, argues for, or pleads on behalf of another (Ministry of Health Uganda 2020:12).

### **Strategic Goal**

To create an enabling environment for the support provision of LARCs services to ensure the support of men towards LARCs use by rural women.

## **The strategic actions**

Below are the strategic actions that could be implemented under Strategy 2. They include:

### ***Intersectoral corroboration at all levels***

Contraception is not only a medical activity but cuts across all human development sectors, including agriculture, gender and community development, education, and finance. As a way to increase men's support for the use of LARCs by rural women, there is a need to bring all stakeholders across the different sectors of the Government of Uganda and involve them in mobilising and sensitising men on the need to support LARC use, considering the many advantages associated with them. The engagement of the different stakeholders should start with their sensitisation on the benefits of family planning, emphasising LARCs and how men, their women, and their families stand to benefit by using contraceptive LARCs. After sensitising the stakeholders, they should be encouraged to share with men in the different forums where they meet them. The various platforms include wealth creation activities, those for water and the environment, parent-teacher association meetings, community development meetings, and political meetings, which attract many men. The different sector players should also be encouraged to sensitise the communities on the advantages of having manageable families and why it is better to have fewer families that are likely to be of quality than having large families of poor quality and poverty-stricken families.

### ***Availability of SRHR policy guidelines***

The provision of family planning in Uganda is still guided by the old SRHR policy signed in 2012, a period of more than ten years. Though there have been efforts to have the revised version of the new policy in place, the Ministry of Health has never signed and availed the updated approach to the public (Ministry of Health Uganda 2017:36). The implication is that the outdated version guides the provision family planning services in Uganda yet many advances have been made in the past ten years. Therefore, to promote family planning services, including the LARCs, there should be clear policy guidelines for family planning available to all health facilities and accessible to all health workers.

The policy guidelines should emphasise the need for men to support women's uptake of LARC use. Much as there is a male involvement strategy for 2019, it is congested as it focuses on the involvement of men in Reproductive Health, Maternal, Child, and Adolescent Health and Rights, and Nutrition, Including HIV/TB and not specific to family planning services and LARCs (Ministry of Health Uganda 2019: 161). In addition, the long-acting reversible contraceptives and the permanent method strategy for Uganda for 2017-2020 highlights men's opposition to LARCs use, but it does not provide clear strategies for getting men's support towards LARCs use by women (Ministry of Health Uganda 2017:11). Therefore, having a clear policy guideline on LARC provision and the engagement of men through addressing their perceptions and belief systems is key to enhancing the support of men towards LARC use by rural women.

### ***Engagement of the community, cultural, and religious leaders***

The community, cultural and religious leaders command a lot of respect and influence in their communities. Their influence can be a resource in addressing men's negative perceptions and beliefs regarding family planning use, particularly the LARCs (Yarinbab et al 2019; 4). According to evidence from the current study, men have beliefs and perceptions that limit support for LARC use among their women. These included the need to balance sex, preference for a boy child, desire to expand the clans, and, in Kiboga, fear of losing Buganda land to non-Baganda tribes. The religious beliefs included fear of going against their religion's teaching and losing leadership positions in the church.

To address religious and cultural beliefs, community leaders, cultural leaders, and religious leaders should be engaged across all levels, from National to village level (Yarinbab et al 2019: 4-5). The engagement of the leaders should include sensitisation on the importance of having manageable families and the benefits of using LARCs. In addition, the meetings with community, cultural, and religious leaders should also include dispelling the negative beliefs and perceptions of men above through discussions with the leaders, which should happen right from the national level to the village level where possible (Bormet 2020: 852).



Furthermore, once the support of the leaders is received, the Ministry of Health could engage them to conduct more sensitisation of their community members, especially the men, on the advantages of having manageable families and how they can achieve that through the use of LARCs by women. Once the leaders do the sensitisation, their community members are likely to listen to them, and in so doing, the support of men towards using LARCs by their rural women could be achieved, leading to more uptake of the same methods.

#### **Approach 4: Minimise gaps in LARCs service provision at the facility and community levels.**

Under this approach, two strategies will address LARCs' service provision gaps. These include strengthening the family planning systems of LARC service provision and the Monitoring and Evaluation systems for LARCs, as described in the following paragraphs.

#### **Strategy One: Strengthen the Family Planning Service Provision Health Systems for LARCs**

##### **Strategic goal**

To enable all LARCs services, including insertions, removals, and management of side effects, at all health facilities.

##### **The strategic actions include:**

##### ***Capacity building in comprehensive LARCs counselling and service provision***

Training health care providers in family planning services, especially LARCs, is key to increasing access to the services. The findings in the current study show that men were against using LARC services because they are not readily offered at nearby health facilities outside the outreaches by implementing partners. As a result, some men discourage the use of LARCs by their women (Lemani et al 2018: 43). To have the support of men for LARCs, the Ministry of Health should ensure both the insertion and removal services and management of side effects are made available at the nearby health facilities (Ministry of Health Uganda 2017:19).

Achieving this strategic action requires building the capacity of health workers from the health centre two levels up to the hospital level so that women can easily access the LARC services when needed. The capacity building could be done using the onsite mentorships of health workers on comprehensive counselling with an emphasis on LARCs, the management of side effects, and addressing myths and misconceptions about LARCs and other contraceptive methods (Horvath et al 2020: S866–S867). The availability of LARC services in nearby health facilities would encourage men to support the same contraceptives as they know their women can quickly get the services, including insertions, removals, and side effects, and they would also help rural women to use those methods.

### ***Building the capacity of health workers on LARCs side effect management***

One of the findings from the current study shows that men were not supportive of their women's use of LARCs because those who get side effects do not access the services for their management. The most familiar side effects mentioned by men included prolonged bleeding, dryness of the vagina during intercourse, and loss of libido. Therefore, building the capacity of health workers at all levels of facilities and supporting them with the required supplies to offer services for side effect management will increase the support of men for LARC use by their women.

### ***Strengthen the supply chain systems to address the stockout of LARCs.***

Currently, the Government of Uganda has an overreliance on donor support for family planning commodity procurement, with few contraceptive commodities procured by Government funds (Ministry of Health Uganda 2014:15; Ministry of Health Uganda, 2021:36). Without proper financing for Contraceptive commodities, including LARCs, there are always shortages of those supplies, in addition to some essential supplies required in the provision of family planning services, such as LARCs (IUDs and implants), not being adequately catered for (Ministry of Health Uganda 2021:38). Such supplies include sterile gloves, drugs for providing local anaesthesia in the case of implant insertion and removal, and a lack of LARC insertion and removal sets.

Also, the challenges come with implementing one facility, one warehouse policy where public health facilities are supposed to order their supplies from national medical stores while private and not-for-profit health facilities order from joint medical stores. However, the challenge is that some district and health facility staff do not adequately plan to procure some contraceptive commodities, such as LARCs, due to limited skills and negligence. Additionally, the order fulfilment rates for some contraceptive commodities, such as LARCs, are inadequate at the National and Joint Medical Stores, the two national stores responsible for supplying drugs to Uganda.

Consequently, health facilities receive fewer contraceptive commodities, sometimes leading to stockouts. Additionally, drugs for managing side effects, such as Ibuprofen, are provided in limited stocks, yet general patients also use them for other treatments. This situation leaves Ibuprofen for the side effect management of LARCs stocked out, and women who need it when they have side effects of LARCs cannot access the drug. Hence, the health workers send women with side effects such as prolonged bleeding to buy the drugs from private pharmacies and drug shops. Therefore, the cost involved in purchasing such drugs or paying in private clinics to have the service for side effect management, as the evidence suggests from this study shows, is what the men do not like in addition to the bleeding that limits the sexual encounter among the couples.

To overcome this challenge of stockout of commodities, there is a need to strengthen the supply chain systems from the National stores through the subnational and health facility levels. When the challenges of contraceptive commodities stocks are solved, women can access all the LARC services at nearby health facilities without relying on outreaches. Eventually, the community could see the men becoming more supportive of LARCs use.

### **Addressing service provider biases in LARCs and low morale**

Some health workers who are supposed to be providers of LARCs have a bias towards LARCs in preference for short-term contraceptives. Even when a few men support their wives to LARCs, they are disappointed that they cannot receive the services at the health facilities because the biased providers advise women to use short-acting methods such as injectable contraceptives. As a result, men get discouraged from

further supporting their wives to use LARCs, as the evidence from the current study shows. Therefore, addressing the provider biases through value clarification on LARCs can make the providers change their biases. In addition, incentives should be provided for health workers who provide family planning services. The incentives can include sending those providers to refresher training, providing them with certificates of appreciation for the work well done, and where possible, using results-based financing funds to give the providers some allowances (Ministry of Health Uganda 2021:101).

The biases sometimes result from a lack of knowledge, skills and competencies in LARCs provision. Therefore, the issue of provider biases towards LARCs and low morale would be addressed through capacity building, as already mentioned in the above paragraphs. Once there is an attitude change among providers, they can provide the LARCs services at the health facilities on all working days. The men would also have a positive attitude towards the LARCs, as they are sure their women will get all the services for insertion, removal, and side effect management when they want them.

### **Strengthen facilitative supervision at all levels.**

Support and supervision are critical to improving Health services at health facilities, including family planning. Supportive supervision is described as directing, overseeing, and coaching employees to encourage adherence to professional standards and ensure the provision of high-quality services (World Health Organisation 2020:1). To enhance LARCs services at the health facilities; there is a need for district and health sub-district teams that include the focal persons for family planning services to regularly conduct support supervision at the lower health facilities (Ministry of Health Uganda 2017:21). This approach would enable the health workers to provide the services in those facilities, as they would know that their supervisors are keenly watching the quality of work they do in terms of service provision. Sometimes, the capacity of health workers to offer LARCs is done, but without follow-up on support and supervision, trained providers still do not provide the LARCs services, and women who want such services cannot access them (Abay et al 2021;7-9).

In addition, there is a tendency for staff to offer services without following standard guidelines for family planning provision by the health workers. Eventually, that can lead to poor-quality service provision. A study done in Uganda found that poor supportive supervision was associated with staff absenteeism and low morale, which created many workloads for the few available health workers (Mukasa et al 2019:244–256). By facilitating the supervision of the health facilities, the morale of staff would improve, as they would get support in the form of advice from their supervisors, and both the facility staff and the supervisors would be able to share the challenges and work out a solution for improving them.

Moreover, regular facilitative supervision provides continuous onsite support to LARC service providers and identifies the challenges hindering services, including LARC provision. The support visits also motivate the health workers at the health facilities to offer better family planning services, including LARCs, while following the standard guidelines for family planning and SRHR services. Once there are better LARC services at health facilities, rural women who need them can easily access them through outreach or at the facility level. Even those women who want assistance in managing effects or want to insert or remove LARCs would be able to access those services. When the LARCs services are easily accessible, that could encourage more men to be supportive because they would know that the services are readily available in case of side effects or need to remove or insert a LARC.

### **Policy shifts to widen LARC access through drug shops.**

Drug shops are small medical establishments that sell over-the-counter medicines (Mayora et al 2018:1). According to the findings from the current study, access to LARC services is still a challenge in many communities, where women have to travel long distances to where the services are offered. Travelling involves paying for transport to reach the health facilities, which men sometimes find very costly. As a result, men do not support their women's use of LARCs because they know they cannot get the services at the nearby health facilities. Addressing the challenge of distant LARCs services being, required the Ministry of Health to have a policy change to allow drug shops to offer LARCs health education and services, including insertions, removals, and side effect management. This policy change is key because the drug shops are operated by qualified staff at the minimum level of enrolled nurses and

midwives, some of whom already have the skills to provide LARCs. Those other staff in drug shops who do not have skills could be trained to offer the LARCs since the current policy allows the cadre of staff to provide LARCs.

Additionally, the drug shops are well spread in many trading centres; therefore, allowing them to offer some LARC services would significantly improve access to those methods. Already in 2021, the National Drug Authority, a drug regulatory body of the Government of Uganda, approved the provision through drug shops of Injectable contraceptives for both intramuscular (IM) and subcutaneous (SC) medroxyprogesterone acetate (DMPA) (Orr et al 2021).

Therefore, a further policy change to allow drug shops to offer LARCs would expand the contraceptive method mix and let women have easy access to the services without men spending a lot of money on women going to distant facilities for those services. This policy shift would encourage men to seek information about LARCs from nearby drug shops. Once they have the correct information, they would most likely support their partners' use of LARCs. This intervention action can be piloted first on a small scale to evaluate the success of this policy shift before scaling up the same approach.

### **Address human resource gaps at the health facility.**

Health human resources (HHR) refers to all individuals engaged in activities whose primary goal is to promote favourable health outcomes and reduce the challenge of heavy workloads (World Health Organisation 2016:10). According to evidence from the current study; participants indicated that the health workers at health facilities are few and do not prioritise clients for family planning services, especially those needing LARCs removal and management of side effects. Instead, the health workers tell clients for LARCs to wait until the partner health organisations come for outreaches. The inadequate staffing could be due to the districts' limited wage bills and the absenteeism of the already available health workers deployed at the health facilities, creating an artificial staff shortage (Mukasa et al 2019:244–256). The few available experience work pressure and stress due to high absenteeism rates attributable to clinicians and health managers, leaving a lot of workload to the few health workers that are not able to provide services seen as non-emergencies such as family

planning, including LARCs (Tweheyo et al 2019:3–4). This further discourages the indigenous men from supporting the use of LARCs by their rural women.

Therefore, the availability of adequate staffing through recruitment and deployment of new ones and minimising absenteeism can reduce workloads. This could further lead to staff providing sufficient health education and comprehensive counselling on contraceptive methods to both men and women. When health providers give proper counselling about LARCs, they address most myths and misconceptions about those methods, reducing the negative perceptions and beliefs that both men and women have regarding LARCs. So, improving the staffing of health facilities, including those on standby to offer all LARC services, would mean that women can readily access all the LARC services they need. This action could encourage more men to support their partners' LARCs use because they know there are health workers ready to offer the services to users in case of any challenges.

### **Financing for family planning activities**

Donors in Uganda fund the majority of family planning initiatives at the national and sub-national levels (Ministry of Health Uganda 2021:35). The Ugandan Government only allocates some resources that are not adequate to finance most of the family planning programmes in the country (PAI 2021:2–5). This challenge of relying on partner organisations for LARCs is evidenced by the results of the current study, which show that LARC services are available at facilities when donor-funded partner organisations, such as Marie Stopes Uganda, Reproductive Health Uganda, and others, come for outreaches (Ministry of Health Uganda 2021:34). Therefore, providing adequate funding by the government for family planning activities is key to having constant availability of services at all health facilities. Once the LARC services are available, especially at lower-level facilities, women who need them can easily access them. The outreach mainly happens monthly or bimonthly, meaning that the LARC services are not readily available outside of the outreach days. The lack of provision of LARC services is partly due to the lack of equipment like IUD insertion and implant removal sets and limited supplies like gloves needed to provide LARCs.

Additionally, limited resources cannot enable the health facilities to conduct integrated community outreach, including LARC provision. This is because of a lack of privacy

issues due to the lack of mobile outreach shelters like tents, lack of money to pay staff allowances to conduct the outreaches, limitations in the transportation of health facility staff to the outreach sites, and lack of resources for the mobilisation of communities for family planning and other services. So even where men support their wives taking up LARC services, they are discouraged when such services cannot be found or accessed in their nearby Health facilities.

Therefore, by increasing the funding for family planning activities, the required resources for mobilising men and women will be available, and the supplies needed for providing LARCs will also be available. In addition, resources for building the capacity of health workers, training the village health teams and male LARC champions, and conducting other SBCC activities, such as radio spots targeting the role of men, should be available. Eventually, we could see more sensitised men with adequate knowledge of LARCs who would most likely support their rural women's utilisation of the services.

#### **Deploy LARC-satisfied male and female users as champions at health facilities.**

LARC-satisfied users are men and women who have used the services and are happy with them and free to share their experiences with other men and women. To support health education at the health facilities that offer contraceptive services, there is a need to identify and deploy LARC-satisfied male and female users to support demand generation at the health facility level. To accomplish this, pleased users should share their experiences with LARCs and how they overcame any difficulties they may have encountered while using the methods. By sharing their experiences with their peers, LARC-satisfied users could build confidence in men to support LARC service uptake. The champions could also be vital in dispelling the myths and misconceptions and clarifying the beliefs and perceptions that both men and women have regarding LARCs, increasing men's support for LARCs.

#### **Task shifting on common side effect management by VHTs.**

Task shifting is the reasonable redistribution of responsibilities within health workforce teams, from highly trained health professionals to less qualified ones, to make better and more efficient use of the available health workforce (World Health Organisation



2008:7). VHTs are a category of community health workers already trained to mobilise their communities for health services. Some village health teams have been trained to offer injectable and oral contraceptives after the policy change and approval by the National Drug Authority (Orr et al 2021). The evidence from the current study shows that fear of side effects was one of the barriers to men's support for their women's contraceptives.

Therefore, a further policy shift to allow some VHTs to be trained in managing common side effects of contraceptives, such as prolonged vaginal bleeding, dryness during sexual intercourse, and low libido, is vital to increasing the support of men for LARC use by their rural women. This action will require amendments to the health service commission, the National Drug Act, and the health professional regulation laws (Ministry of Health Uganda 2017:22). This policy shift will give users of LARCs easy access to services in the community, just like they get community-based family planning services through trained VHTs. However, this should first be piloted on a small scale to see the viability of the intervention before scaling up. Implementing this action could further address men's worries about LARC side effects, increasing their support for using the same methods among rural women.

### **Avail Family planning guidelines, including those on LARCs.**

Family planning guidelines such as the WHO Medical Eligibility Criteria Guidelines are essential in guiding health workers in providing contraceptive services, including LARCs (World Health Organisation 2018:3). The guidelines provide clear guidance to the service providers on comprehensive counselling and the provision of contraceptive methods, including LARCs insertions, removals, and management of side effects. Using guidelines to provide services increases LARCs retention, as some studies have shown (Jacobson et al 2018:225-229; Solo& Festin 2019:380). To increase the competence of the health workers and access to LARCs services, family planning, including LARCs guidelines, should be provided to every health facility and put up in all the service provision areas in visible places. Additionally, all service providers should be oriented on the proper use of guidelines.

## **Strategy Two: Strengthen Monitoring and Evaluation Systems for LARCs**

### **Strategic goal**

To improve documentation and reporting of LARCs in the Health management information system (HMIS). A health management information system (HMIS) collects, stores, retrieves, and processes health data to help decision-making (Endriyas et al 2019:1; World Health Organisation 2004:3). The HMIS is essential to strengthening the health system and improving the quality of services in a health care system (Wandera et al 2018:9). When monitoring and evaluation system is strengthened, it provides data that key stakeholders can use to make decisions for improving LARCs services.

### **Actions to be taken.**

The following actions below should be implemented to strengthen the monitoring and evaluation systems for LARCs:

#### **Build the capacity of health workers and HMIS officers to document LARCs and report them.**

To improve the reporting of LARC services, health workers need to build the capacity to use the HMIS tools for family planning service data capture. According to Wandera et al (2018), health workers sometimes find challenges in using the HMIS tools because they are not user-friendly and can be confusing (Kagoya & Kibuule 2018:8). This leads to poor data capture and reporting for LARCs services at the health facilities, sometimes leading to under- or over-reporting of the essential services offered at the facilities. Limited training on the use of the HMIS tools is one of the main barriers leading to poor quality family planning data captured in health facilities in Uganda (Wandera et al 2019:7-8).

To improve the quality of LARC data that is collected at the health facilities, the health workers, including the HMIS officers, should be trained through onsite mentorships where they are also able to enter the data practically in the reporting tools (Ouedraogo et al., 2019:9). This is consistent with evidence from a study conducted in Nigeria

(Nwankwo & Sambo 2018:5), which found that training health workers improved data reporting for family planning.

### **Availability of HMIS tools at Health facilities for LARCs**

The availability of HMIS tools is critical to improving the quality of family planning services through documentation and reporting. A study by Kagoya and Kibuule (2018:8–10) in Uganda found that the availability of paper-based HMIS tools was inadequate at some rural Health facilities. Additionally, the action is in agreement with the findings from another study done in Ethiopia, which revealed that the lack of HMIS tools was a challenge to accurate reporting (Endriyas et al 2019:4). Therefore, to improve the quality of family planning data, including for LARCs, the districts working with the Ministry of Health, partners should provide enough HMIS tools to all health facilities.

### **Completeness of Family Planning data captured and reported.**

One of the barriers to improving family planning services, including LARCs, is poor capture of service data due to incompleteness and inaccuracies in the HMIS tools (Adamo et al 2020:806). Continuous onsite mentorship and training are vital in ensuring the HMIS tools are correctly filled to provide complete data and the flow from the service delivery points to the district and national levels through the District Health Information System 2 (DHIS2).

Full and accurate data reporting eases planning for family planning services, makes planning easy, and improves the quality of services as the correct outputs are reflected in the district and national monthly reports. Proper documentation of LARC services also eases the procurement planning for contraceptive commodities, including the LARCs, based on the accurate dates available reported in the reporting HMIS system. Proper procurement planning enables the availability of contraceptive services both at the national and sub-national levels, including health facilities, eliminating the challenge of stockouts of LARCs. When there are no commodity stockouts, it means that LARC services can be provided, which in turn encourages the men to support their women to go and access those services if they are available in the nearby health facilities.

### **Improve data use for decision-making.**

Using accurate HMIS data for decision-making is key to improving the quality of family planning services (Tamfon et al 2020:9). When correct data is available in the HMIS system, it must be regularly analysed and discussed at the health facility and district levels. It should not only stop at discussion but also be used for decision-making on improving services, including those for LARCs.

Proper use of data for decision-making can improve the quality of services offered (Ho & Wheeler 2018:169). The health facility and district-level staff should use the family planning data from the HMIS by regularly analysing and discussing it for planning purposes, including those for LARCs, instead of using it only for making reports (Adamou et al 2020:808). At all levels of health care, accurate data should be used to plan for the procurement of contraceptive commodities, the HMIS tools, capacity building, and the deployment of staff. In addition, data should be used to prepare the channel for delivering family planning services, including LARCs through integrated community outreaches or static facilities and community-based family planning services.

### **Improve supporting supervision for Monitoring and evaluation.**

Supportive supervision is an approach that improves the health system, allows health professionals to provide quality healthcare services, and improves performance (Avortri et al 2019:1). Just like supportive supervision is a key intervention in enhancing the quality of family planning service delivery, it is also key in improving HMIS data management, which, according to a study done in Mozambique, improved the performance of the health workers and the quality of services (Madede et al 2017:7). Additionally, facilitative supervision ensures the collection of quality family planning data, including that for LARCs and improves the proper use of HMIS tools through onsite coaching and mentorships (Marshall & Fehringer 2013:10; Kok et al 2018:9).

In addition, with facilitative supervision, other issues, such as contraceptive stock management issues, are addressed, as is the absenteeism of health workers at facilities, which leads to an improvement in the quality of family planning services

provided, including the LARCs. The improved LARC services mean that women who need different services such as LARC insertion, removal, and management of side effects will get them. The availability of all LARCs services could encourage indigenous men to support the rural women's use of the same services.

## **5.5 CONCLUSION**

In order to increase indigenous men's support for the uptake of LARC services among rural women in Uganda, there is a need to address the limited knowledge about those contraceptive methods. The increased awareness of LARCs would reduce men's negative perceptions and belief systems regarding using LARCs by rural women. Additionally, minimising gaps in LARC service provision through improvements in the quality of LARC services the health facilities provide will increase men's support for the use of LARCs by rural women.

The approaches should be implemented by using the four strategies that include strengthening SBCC to Empower the family and Community systems to generate demand for LARCs, conducting advocacy activities to build an enabling environment for LARCs service provision, and Strengthening the Family planning systems for LARCs service provision. Additionally, the Monitoring and Evaluation systems for family planning services, including LARCs, should be strengthened to provide reliable data for planning LARC services.

## **5.6 SUMMARY**

This chapter presented the strategy development and validation process, which involved a two-phased approach. Phase one involved summarising the key findings from the study. The next step included identifying, listing, and prioritising the broad intervention strategies, reviewing the relevant literature, and drafting key strategies under each intervention area listed. The second phase involved finalising the strategies, which involved consultation with key stakeholders in the strategy development process and validation and refining the aim, goal, approaches, strategies, and actions to ensure validity and appropriateness for Rubanda and Kiboga districts.

The successful implementation of these strategies could improve the men's support for utilising LARCs by the rural women in those two districts of Uganda. The next chapter presents the conclusions of the entire study and summarises the findings and the development of strategies to improve men's support for LARC use by rural women. It also discusses the study's contributions, recommendations, limitations, and conclusions.

## CHAPTER 6

### SUMMARY, CONTRIBUTIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

#### 6.1 INTRODUCTION

The previous chapter presented the development of strategies, their validation and operationalisation. This chapter summarises the background to the study, the problem statement, the study purpose, the objectives, the research questions, and the study design and how they were attained. In addition, the chapter further crystallizes the findings and the development of strategies to enhance men's support for the uptake of LARCs among rural women in Uganda. Additionally, this chapter discusses the significance of the study, its contributions, recommendations, and limitations.

#### 6.2 BACKGROUND

Worldwide, unintended pregnancies remain a critical public health challenge, with 74 million women in low- and middle-income countries getting these pregnancies yearly. African continent alone contributes about 25% of all global unintended pregnancies (Bain, Zweekhorst, & Buning, 2020). Some of the factors associated with unintended pregnancies include lack of male partner support, non-use of contraceptives, maternal low levels of education levels and poverty (Alene, Yismaw, Berelie, Kassie, Yeshambel & Assemie 2020:7).

Even though not all unintended pregnancies are unwanted, they can lead to a lot of health problems for both the mothers and children, like malnutrition, sickness, neglect, or abuse, as well as maternal and infant mortalities (Gharaee & Baradaran 2018:877-878). Other effects of unintended pregnancies include high fertility rates, school dropout leading to low education levels, and the feature employment opportunities leading to poverty (WHO 2019). Estimates indicate that about 61% of unintended pregnancies end up in unsafe abortions, which is one of the leading causes of maternal mortality and morbidities in low and middle-income countries (Bearak, Popinchalk, Ganatra, Moller, Tunçalp, Beavin, Kwok & Alkema 2020: e1157). The challenges resulting from the effects of unintended pregnancies can last for generations.

About 86.8% of unintended pregnancies, especially those in low- and middle-income countries, are due to non-use of modern contraceptives (Mohamed, Hamed, Yousef, Ahmed 2019:6-7; Bellizzi, Pichierri, Menchini, Barry, Sotgiu & Bassat, 2019:4). Therefore, reducing the unmet need for contraception is essential in addressing unintended pregnancies and can be achieved through increasing access and use of modern contraceptive methods (WHO 2015: 20-21).

According to estimates, without using modern contraceptive methods, unintended pregnancies could result into 25 million unsafe abortions and 47 000 maternal fatalities annually (Bellizzi, Mannava, Nagai & Sobel 2019:4-5;). Global estimates indicate that in 2017 there were 295,000 maternal deaths (WHO 2019:32). Out of the reported global maternal deaths, Sub-Saharan Africa (SSA), where Uganda is located, and Southern Asia accounted for 86% of the total of these mortalities. SSA alone accounted for about 66% (WHO, 2019:32). In comparison, the maternal mortality rate in the US was 17.9 per 100,000 (Hawkins, Ghiani, Harper, Baum & Kaufman, 2019:165-174). Maternal complications resulting from pregnancy and childbirth contributed up to 75% of all global maternal deaths. These complications arise from severe bleeding (mainly after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications from delivery and unsafe abortion (WHO 2019:32). Reducing the number of unintended pregnancies could prevent about 60% of maternal mortalities and 57% of the child death, especially in low and middle-income countries (Bellizzi, Mannava, Nagai & Sobel 2019:1;).

About 48% of pregnancies in Uganda are unintended, with 60% occurring in teenagers aged 15-19 years. In addition, Uganda still has a high fertility rate of 5.4 (Ministry of Health Uganda 2022). The burden of unsafe abortions is about 60%, most resulting from unintended pregnancies (SAAF 2022). The maternal mortality ratio is 336 per 100,000 live births, one of the highest in SSA (UBOS and ICF 2018:305). Unsafe abortions are one of the leading causes of maternal mortality and morbidity in Uganda (Inzama, Kaye, Kayondo & Nsanja 2022:1-7). Kigezi region, South-Western Uganda, where Rubanda district is located, has the second-highest maternal mortality ratio of 541 per 100,000 live births, only second to the Karamoja region with 588 per 100,000 live births (UBOS 2017:63).



Therefore, preventing unintended pregnancies is one of the critical approaches to reducing maternal death. Reducing unintended pregnancies is achieved by reducing the unmet need for family planning by increasing access to modern contraceptive methods (WHO 2015: 20-21).

### **6.3 STATEMENT OF THE STUDY PROBLEM**

The poor uptake of LARCs affects the health of women and children born into large households. Uganda is a third-world nation with limited resources. Large families strain the government's ability to provide social services such as education and health care. These large families jeopardise the quality of services in their own homes and those offered by the government of Uganda to its people.

The study aimed to gain a deeper understanding of the perceptions and belief systems of rural indigenous Ugandan men regarding LARCs and develop strategies to enhance their support for the utilization of these methods by rural women. Based on the findings, the above-mentioned problem could be minimised by addressing the negative perceptions, low knowledge of LARCs and the beliefs systems that indigenous men have. The strategies that were developed in Chapter 5 are aimed at addressing these barriers.

### **6.4 THE PURPOSE OF THE STUDY**

The purpose of this study was to understand the perceptions and beliefs of indigenous Ugandan men regarding LARCs and develop strategies to enhance their support for these methods among rural women. This purpose could be a realistic implementation of the current available strategies in combination with the developed ones in Chapter 5. The strengthening awareness campaigns and LARCs service delivery, advocacy and monitoring and evaluation could jointly assist in achieving this purpose.

## **6.5 STUDY OBJECTIVES**

The following were the objectives designed to:

### **Phase one**

Explore the perceptions of rural indigenous Ugandan men regarding the use of LARCs by rural women to design strategies that increase their support for LARCs uptake by rural women.

Establish the belief systems that rural indigenous Ugandan men hold onto regarding using LARCs to develop strategies to enhance their support for utilising the same contraceptive methods by rural women.

The perceptions and belief systems of indigenous Ugandan men regarding the use of LARCs by the rural women were fully understood during the both the focus group discussions and individual interviews (See chapter 4). These interviews were conducted in two separate districts (about 600 km apart) each with two sub-counties between 20 and 40km from each other (see chapter three: research setting)

The objective of phase two was to develop strategies to enhance the support of indigenous Ugandan men for the utilization of LARCs among rural women in Uganda.

The objective of phase three was to validate the strategies developed through consultation with experts in the field.

The developed strategies followed the adopted UNICEF framework and were validated by experts in the field of reproductive health and family planning as explained in chapter 5.

## **6.6 RESEARCH DESIGN AND METHOD**

The researcher used a qualitative research design and method. The design choice allowed the researcher to obtain emic data from participants and explore participants' perceptions, beliefs, and meanings of the LARCs phenomenon. This approach allowed the participants sharing of information about their perceptions, beliefs, and understanding of LARCs. The participants expressed their views without coercion, allowing the researcher to explore and describe the perceptions and belief systems of

rural indigenous men regarding the rural women's use of LARCs. The exploratory approach through these indigenous men was accomplished using focus groups and individual interviews.

## **6.7 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS**

The study's findings are based on the analysis of the qualitative data collected from the two districts of Rubanda and Kiboga in Uganda.

### **6.7.1 Limited knowledge of contraceptives, including LARCs.**

The study established that men have limited knowledge of family planning, particularly the LARCs. The study revealed a limited understanding of contraceptives, as a few participants (45%) in Rubanda and 49.3% in Kiboga could name at least two modern contraceptive methods, with injectable and withdrawal being the most mentioned. Only a few men (10%) in Rubanda and 14% in Kiboga mentioned any of the LARCs. Still, a reasonable number of men (38%) in Rubanda and 27.2% in Kiboga could not name a contraceptive method. The limited knowledge contributes to negative perceptions and belief systems about LARCs.

### **6.7.2 Perceptions of rural indigenous Ugandan men regarding the use of LARCs**

The men from Rubanda and Kiboga have negative perceptions that retard support for the use of LARCs by their rural women. These perceptions are related to fears of side effects on their women such as prolonged bleeding, low libido, effects on body organs, infertility, and paralysis in the arm. Other perceptions included fears of separation, adultery, challenges with removing LARCs, fear of land loss, and complications in subsequent deliveries.

In addition, men also regaled experiences of excessive weight gain by their partners that significantly affected the ways in which they view the women they married. They also expressed fear of producing twins after using the LARCs even though there is no history of twins in their families. It can be concluded that men have a limited understanding of how LARCs work. However, some men had positive perceptions of LARCs in cases where they need proper family planning for which they can provide adequately. Lastly, other perceptions included using LARCs to have a balanced

gender of children (boys and girls) in the family and to get the desired number of children.

### **6.7.3 Belief systems that rural indigenous Ugandan men have regarding the use of LARCs.**

The study confirmed that men have strong-rooted belief systems that make them averse to their women using LARCs. The study identified cultural and religious beliefs. The cultural beliefs coalesced on natural family planning methods, gender power imbalance with men's dominance, many children as a source of labour for the family, and the need for children to expand and strengthen the clan. Based on these beliefs, using LARCs among the indigenous Ugandan men was not a method of choice.

Other belief systems held by the indigenous men included gender preference for boys over girls for the ultimate inheritance of wealth, expectations of wealth obtained from dowry, cultural recognition and preserving the clan. The researcher also established those religious beliefs among men ranged from fear of losing leadership positions in the church and not contradicting the teachings of their religion, especially among Catholics and Muslim participants. Based on this data, it can be inferred that men had set and ossified beliefs regarding the gender of children, and they held negative beliefs regarding LARCs steeped in their religious understanding and teachings.

## **6.8 STRATEGIES TO ENHANCE INDIGENOUS UGANDAN MEN'S SUPPORT FOR THE UTILISATION OF LARCS AMONGST RURAL WOMEN IN UGANDA.**

The strategy development process was three-phased and resulted in four strategies. These strategies included strengthening SBCC to empower families and community systems to support and demand LARCs services; advocacy to build an enabling environment for LARCs provision; strengthening family planning health systems for LARCs service delivery; and strengthening monitoring and evaluation systems for LARCs in healthcare facilities. The strategies are intended to address the gaps that include limited knowledge about contraceptives, particularly LARCs, perceptions, and belief systems about LARCs, and to minimise gaps in LARCs service provision at the facility and community levels, as described in Chapter 5.

The process of designing and developing strategies to mitigate these gaps followed the Delphi approach and consisted of three phases, as described below:

### **Phase one**

The first phase involved summarising the key findings from the study, identifying, listing and prioritizing the broad intervention areas to guide the development of strategies. The researcher then reviewed the relevant literature and thematized the perceptions, belief systems that indigenous Ugandan men have, then drafted key strategies under each intervention area listed in Chapter 5.

### **Phase two**

In the second phase of the strategies' development, the researcher involved stakeholders in sexual reproductive health, family planning, and public health. The details of this phase are described in Chapter 5 and Annexure 13. These stakeholders had comments that contributed to modifying and refining the strategies. The researcher initially had three broad intervention approaches to address limited knowledge about contraceptives and LARCs, perceptions about LARCs, and belief systems about LARCs. After consultations with the experts and the key stakeholders, they agreed to add the fourth one that aimed at addressing the gaps in service delivery for LARCs, making a total of four strategies sent to experts for validation. The fourth intervention area was added on the understanding that addressing the limited knowledge, perceptions, and belief systems cannot be done in isolation from service delivery for LARCs.

### **Phase three**

In the third phase, the researcher sent the final document to the national and district-level experts in family planning programming in Uganda to validate the strategies, and their input was affected in the final document disseminated for evaluation. The experts included the Ministry of Health family planning focal person, family planning advisers with various donor-funded projects and experts from Makerere School of Public Health. The complete validation details are in Chapter 5. The strategies developed and validated are aimed at enhancing indigenous men's support for LARC use among rural women in Uganda.

## **6.9 RECOMMENDATIONS**

In this section, a description of recommendations derived from significant findings of the study are made accordingly. Specific recommendations addressed to stakeholders include the public health practice, Health policymakers, health sciences education and training, and further research. All the recommendations align with the strategies developed for increasing indigenous men's support for LARCs uptake among rural women.

### **6.9.1 Public health practice**

In Uganda, various implementing partners work with the districts to strengthen the health system. They have funding from several development partners such as USAID, FCDO, SIDA, and CDC. The district and health facilities also get funding directly from the Government of Uganda to support health activities, including family planning services. The funds the districts receive are inadequate. However, there are different Health implementing partners working in Kiboga and Rubanda who can support the implementation of the recommendations outlined below.

- Re-orientating Village Health Teams (VHTs) to provide them with adequate basic information on LARCs. This orientation would enable the VHTs to disseminate accurate and proper information on LARCs to their community members, especially the men. This approach would help increase men's understanding of LARCs, which could result in positive perceptions and belief systems regarding the use of LARCs. This approach could result in more men supporting using LARCs for rural women.
- The district health management teams working with the health facility staff and supported by the health implementing partners, should train and facilitate the VHTs to conduct community family planning/LARCs group education for men to increase their knowledge about LARCs.
- The district health management teams working with the health facility staff should organize and conduct regular community dialogues for men of LARCs and other aspects of family planning. Once the community dialogues for men are implemented, they would enable the health workers and VHTs to address the negative perceptions, rumours, and misconceptions about LARCs among

the men. This approach would increase the understanding of LARCs and could increase men's support for using LARCs by rural women.

- The district health management teams, working with the health facility staff and supported by the implementing partners, should identify, train, and deploy male LARCs satisfied users as champions to disseminate positive information about LARCs. The champions could achieve this by sharing their positive experiences regarding LARC use with their wives. This approach has potential to encourage more men to support the rural women's use of the LARCs. This is because men like to listen from their peers and take the information they get from them more serious than from the health workers. Therefore, if the LARCs men champions share their positive experiences with use of LARCs by their partner, then men will listen and could encourage their partners to use LARCs.
- The district health officials, working with the health facility staff with support from MoH and the implementing partners, should recruit and train community entertainment and bar attendants on family planning and LARCs. After their training, these attendants should be supported to disseminate accurate information that promotes the use of LARCs at their places of work.
- The community, cultural, religious, and political leaders are vital people trusted and listened to by their community members. Therefore, the district health management teams working with the health facility staff and health implementing partners should engage those leaders on the benefits of having controlled families and how the use of LARCs is essential to achieving planned families. When the engaged leaders have precise information on LARCs, they should be supported to share the same information in their communities they lead. This action could help address men's perceptions, religious and cultural beliefs regarding LARCs use.
- The Ministry of Health leadership, together with districts health management teams, should support the health facility staff with information, education, and communication (IEC) materials for family planning with an emphasis on LARCs.
- The health facility staff should then work with the village health teams, LARCs champions, and religious and cultural leaders to disseminate the information in IEC materials to their community members, especially the men. This would increase the men's understanding of family planning and LARCs, which could reduce negative perceptions.

- The district health management teams and health implementing partners should support the health facility staff and village health teams conducting community dialogues on LARCs. Once the community dialogues are performed, the men will better understand the efficacy of LARCs. A better understanding of the importance of LARCs would most likely reduce some negative perceptions that could lead to support for their use as contraceptives.
- The districts working together with the implementing partners should support the health facility staff and village health teams to adapt and scale up the use of family planning men games for LARCs. These games have been tested in some districts of eastern Uganda by Intrahealth International and found to increase information about family planning including LARCs among men. Additionally, the games have been found to increase the use of LARCs among the partners of men that play those family planning games. Therefore, when the districts together with the implementing partners adopt and implement such games, they could increase the knowledge of family planning among indigenous men, including the LARCs. A better understanding of LARCs would reduce the negative perceptions and belief systems that indigenous men have resulting to men being more supportive of LARCs by rural women.
- The district health management teams and the health facility staff should work with the village health teams and health implementing partners to address the negative social and gender norm that men hold onto that hinder their support for LARCs. This could be achieved by actively engaging the community members and their cultural, religious and political leaders on the importance of having family planning in reducing unintended pregnancies, unsafe abortions and maternal mortalities and morbidities.
- The district health management teams working with the implementing partners should adopt mass media channels like radios, community public address systems (Bizindalo) and video halls to disseminate information on family planning with an emphasis on LARCs. When these channels are used, they have a potential of addressing the negative perceptions and beliefs the indigenous men have regarding the use of LARCs. This could also promote the positive perceptions and address the beliefs of men on LARCs resulting into more support for the use of these methods by the rural women.



- The district health management teams working with the implementing partners should support capacity building for health workers in comprehensive LARCs counselling and service provision, including side effect management and removal services. Once the health workers are able and motivated provide LARCs at the nearby health facilities, more potential users of the methods can access the services, including those for LARCs removals and side effect management. As a result, men would not spend much money on transport for women accessing the LARCs services since they would be available in nearby health facilities. This could eventually result into more support for men towards LARCs use by rural women.
- The district health management teams should work with health implementing partners to address service provider biases on LARCs and low morale through enhanced training, value clarification and providing incentives such as on-job training without discrimination. This approach would encourage more health workers into family planning service provision including the LARCs the respective health facilities. As a result, this would ensure that the LARCs services are available all the time they are needed instead of health facilities waiting for outreach days from partners such as Marie stopes to offer the LARCs services.
- The district health management teams working with the implementing partners strengthen the supply chain systems to address the stockout of LARCs and necessary equipment for insertion and removal of LARCs, especially the IUDS at health facilities. Once all LARCs services are available at the nearby health, the support for men would increase, especially when they have been sensitised about the importance of the methods at the facility and community level.
- The district health management teams should strengthen the supportive supervision from the district and health subdistrict to the lower health facilities.
- The district health management teams with support from the health implementing partners, should address human resources for health gaps at health facilities due to staff absenteeism. This can be achieved through regular support supervision and proper monitoring of staff attendance of duty.
- The district health management teams supported by the implementing partners should avail family planning policy guidelines and the medical eligibility wheels for their facilities. These guidelines would act as a reference point for health

workers during counselling and service provision of family planning services including the LARCs.

- The districts working with the implementing partners should strengthen the systems for monitoring and evaluation of family planning services, emphasising LARCs. This can be achieved by training health facility staff in the proper documentation for LARC services in the family planning tool (HMIS 105) for appropriate reporting. The capacity building should also cover the use of family planning data for decision-making at facility and district level for proper planning of family planning interventions and not just for reporting purposes. Additionally, the districts Health management teams should improve facilitative supervision for monitoring, evaluation, and learning to ensure proper documentation of family planning services including the LARCs. This approach would ensure proper planning and implementation program for LARCs at facility and community level which are key in improving the quality of services.

### **6.9.2 Recommendations for Policymakers**

The study recommends that policymakers provide a conducive environment for LARCs services provision in the districts. The Ministry of Health should:

- Consider a policy change to allow the training of VHTs in side effects management at community level.
- Work on a policy shift to widen LARC services in drug shops just like it was done for injectable contraceptives.
- Avail the SRHR/Family planning guidelines, including those on LARCs, to the districts, who should distribute them to health facilities and ensure their proper use.
- Finalise the process of SRHR policy guidelines and avail those policy guidelines to the districts and health facilities to guide the implementation of family planning and LARCs including male engagement.
- Allocate more finances for family planning activities at the districts and the health facility level to facilities integrated community outreaches where LARCs services can be taken closer to the communities. Also, an increase in funding would enable the availability of contraceptive commodities and equipment for provision of LARCs at health facilities including removal services and drugs for managing side effects.

### **6.9.3 Recommendation for health sciences higher education and training institutions**

These recommendations are aimed at the health sciences and higher education and training to:

- The Ministry of Education and Sports, working with the Health training institutions, should review and reform the current training curriculum for nurses, midwives, and clinical officer students to include a comprehensive standalone section on contraceptives with emphasising LARCs, which should be examinable as a section on its own.
- Provide adequate training of pre-service and in-service healthcare workers in the provision of LARCs and management of their side effects. This is because most of the health workers coming out of training schools do not have skills to offer family planning services, more so the LARCs. The lack of skills in provision of LARCs services affect the quality of family planning services resulting in negative perceptions that make men have regarding those services.
- Pre- and in-service training of health workers on social and behavioural change communication for SRHR/family planning in both facility and the community component. This enables graduate health workers to handle SBCC provision that is key in dispelling men's myths, misconceptions, and beliefs regarding the LARCs.
- Train both pre-service and in-service health workers HMIS on reporting so that by the time they qualify, they are already used to filling them. In that manner, they commit to providing LARCs services, including proper counselling, removal services and side effect management.

### **6.9.4 Recommendations for further research**

There is a need to conduct further research in the following areas:

- Quantitative research to establish the relationship between the knowledge gap, perceptions, belief systems, and indigenous men's support for LARC use by rural women.
- Qualitative research to evaluate the effectiveness of the developed strategies in addressing indigenous men's support for LARC use by rural women.

- Similar research should be done in other districts with different ethnic groups in other regions of Uganda to clarify men's perceptions and belief systems regarding the use of LARCs by rural women.
- An evaluation study on the effectiveness of training the VHTs effectively manage the side effects of LARCs in the community.

## **6.10 CONTRIBUTIONS OF THE STUDY**

This research extends the body of knowledge on the perceptions and belief systems of men in the Rubanda and Kiboga districts regarding the adoption and use of LARCs by rural women. The study also provides recommendations to the districts and community health workers (village health teams). Furthermore, the study recommends implementing partners to address the knowledge gap and the perceptions and belief systems among men regarding LARCs to support these typologies of contraceptives among rural women. This study, therefore, provides critical information for increasing men's support for LARC uptake through the strategies developed and disseminated in this study.

The strategies addressing the knowledge gap among men and the perceptions and beliefs systems provide novel directions for specifically addressing the lack of support by men for LARCs use by rural women. These strategies differ from other male involvement strategies focusing on health issues and not specifically LARCs. The developed strategies could also be applied to other districts of Uganda where the context is similar to that of Rubanda and Kiboga districts to increase men's support for LARCs use among rural women. The study also contributes to research by identifying specific research gaps mentioned in the recommendations and possible trajectories for such studies in the near future. In addition, this study provides policymakers with modalities to improve men's support, such as policy shifts on service provision for LARCs to allow drug shops to offer the methods and training VHTs to manage side effects. Additionally, policy adjustments are needed to increase funding for family planning services, with an emphasis on LARCs.

The study also provides recommendations for health training institutions through the Ministry of Education and Sports on improving the curriculum for LARCs. Once the curriculum reforms are implemented, more competent service providers for LARCs

could be available at health facilities that would eventually implement some of the developed strategies. Finally, with the successful adoption and implementation of the strategic actions, there could be an improvement in the perceptions and belief systems of indigenous men towards the support of women to take up LARCs services, resulting in increased use of the same methods in Kiboga and Rubanda districts and other districts with similar contexts. Improving the uptake of LARCs by rural women could reduce unintended pregnancies, unsafe abortions, and more planned families with a manageable number of children. As a result, the cases of maternal morbidity and mortality resulting from pregnancy-related causes could be reduced in tandem with a reduction in infant and neonatal mortality rates.

### **6.11 LIMITATIONS OF THE STUDY**

Despite the study's emic findings about men's beliefs and belief systems regarding rural women's use of LARCs in Rubanda and Kiboga, it has some limitations as outlined hereunder.

- The study had a limited sample size and was conducted in a specific geographical area. However, the researcher overcame this limitation by having a relatively more representative sample of 95 participants. Moreover, conducting the study in two very distant districts and sub-counties in each district adds improved validity to the study that could be applied to similar contexts.
- The qualitative nature of this research is subjective and cannot measure how the perceptions and beliefs influence men's opposition to LARC use among rural women. This limitation was overcome by recommending additional and more extensive quantitative studies to determine the relationship between the knowledge gap, perceptions, and belief systems on the influence of men's opposition to LARCs use.
- The qualitative research design meant that the study documented the experiences of a relatively small number of participants, which has negative consequences for the generalizability of the study's findings to other contexts.
- Due to the context-specific nature of the qualitative study, the analysis and interpretation of the research data were heavily reliant on the researcher's

decisions; however, the same data could have been interpreted differently by another researcher, which could have led to different conclusions.

Despite these limitations, the results are reliable, valid, and trustworthy. This is especially true because the emic methods used to collect and analyse the data were thorough and were checked by an expert in qualitative research at every step of the data collection, analysis, and reporting process. To ensure reliability, validity and trustworthiness of the study, the researcher ensured the following:

### **Credibility**

- To ensure the study's credibility, the researcher was in the area for at least four weeks and engaged with the participants before and during the data collection. This built rapport with the participants.
- To ensure the quality of the data collection tool, the researcher pre-tested them in two different sites to ensure their appropriateness. The researcher also collected field notes while audio recordings were managed during the interviews.
- Also, the researcher requested participants to review and provide feedback on the interview data and emerging themes and categories.
- To ensure triangulation, the researcher used different data collection methods, including focus groups and individual interviews.
- The researcher did multiple individual interviews in addition to focus group interviews and allowed the participants to review and, where possible, amend the concepts and themes that emerged from the data analysis. The experiences that the researcher got while collecting and analysing data was always recorded as a diary and was included in the discussion of the findings.

### **Transferability**

- The detailed context-specific information the researcher provided included description of the sampling procedure and the details of the study participants, the sample size used, the study setting in which the study was conducted, the data collection process, and the study findings. This was done so that other independent researchers could determine how transferable the findings were due to similarity in the study characteristics.

## **Dependability**

- To ensure the dependability of this study, the researcher provided a detailed description of the research design and a thorough step-by-step process of data collection used in the study. This was done by the researcher properly recording where the data was collected, how it was kept, and how it was processed, which offers a snapshot of the flow of information towards the study's final result.
- The dependability of this study was also illustrated by doing an audit to examine the study, challenge the techniques utilised, assess the data's adequacy, and provide input to help improve the analysis. In this case, the researcher shared all analysed data with the supervisor and an independent researcher. The independent researcher was also used as the co-coder of the study themes.

## **Conformability**

- Conformability was tackled by compiling a complete record of the data collection and analysis strategies employed.
- The researcher also observed and recorded his roles in the qualitative study process, including documenting assumptions, biases, or responses that could impact the data management process.
- The researcher also reviewed the analysed data with study participants and other experts, including his research supervisor and another researchers from Makerere University School of Public Health, to mitigate the effects of researcher bias. This approach increased the confirmability of this study.
- The researcher availed the study for outside scrutiny and verification by leaving an audit trail for other researchers to verify.

Therefore, even though they are limitations of this study, the results show strong evidence that indigenous men have negative perceptions and beliefs about using LARCs. As a result, they dissuade their rural women from using LARCs, justifying the need to mobilise their support for LARC use which this study addresses.

## **6.12 SUMMARY**

This chapter presented the outline of the study findings, the strategies and critical recommendations, and different research areas for further investigation. Additionally, the chapter highlighted the study's limitations, significance, and contributions. Once

the developed strategies, as detailed in Chapter 5 and the suggestions highlighted in Chapter 6 are addressed, there would be increased knowledge of LARCs among men. This could further lead to more positive perceptions and new orientations among the indigenous men regarding using LARCs. As a result, more indigenous men are likely to support the use of LARCs by rural women in Uganda.



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## ANNEXURES

### Annex 1: Ethical Clearance Certificate (Unisa, TASO and UNCST)



#### COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

29 November 2021

Dear Mr Arineitwe Ronald Kibonire

**Decision:**  
**Ethics Approval from 29 November 2021 to 29 November 2026**

NHREC Registration # :  
Rec-240816-052  
CREC Reference # :  
12749966\_CREC\_CHS\_2021

**Researcher(s): Name: Mr Arineitwe Ronald Kibonire**  
**Contact details: [12749966@mylife.unisa.ac.za](mailto:12749966@mylife.unisa.ac.za)**  
**Supervisor(s): Name: Prof Mphuthi Ditaba D**  
**Contact details: [mphutdd@unisa.ac.za](mailto:mphutdd@unisa.ac.za)**

**Title: Strategies to enhance indigenous men's support for utilisation of long-acting reversible contraceptives amongst rural women in Uganda**

**Degree Purpose: PhD**

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The *low risk application* was reviewed by College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the



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confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

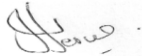
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**29 November 2026**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

*Note:*

*The reference number **12749966\_CREC\_CHS\_2021** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: pp



Prof. KB Khan  
CHS Research Ethics Committee Chairperson  
Email: khankb@unisa.ac.za  
Tel: (012) 429 8210

Signature: PP

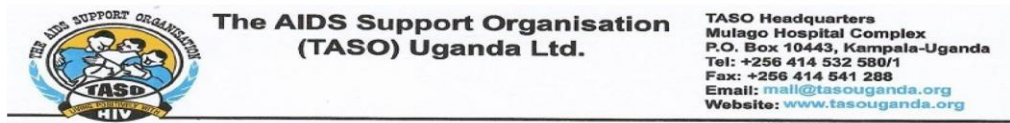


Prof K. Masemola  
Exécutive Dean: CHS  
E-mail: masemk@unisa.ac.za  
Tel: (012) 429 2298



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## Annex 2: Letter of approval from TASO, Uganda



18/03/2022

To: Ronald Arineitwe Kibonire

0782680067

**Type:** Initial Review

**Re: TASO-2021-56: Strategies to enhance indigenous mens support for utilisation of long-acting reversible contraceptives amongst rural women in Uganda, Research Protocol, 2021-12-05**

I am pleased to inform you that the The AIDS Support Organization (TASO) REC, through expedited review held on **17/03/2022** approved the above referenced study.  
Approval of the research is for the period of **18/03/2022** to **18/03/2023**.

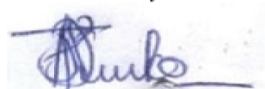
As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **18/03/2023** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by The AIDS Support Organization (TASO) REC:

No.	Document Title	Language	Version Number	Version Date
1	Informed Consent forms	English	Informed consent form	2021-12-05
2	Prior Ethical Approval	English	UNISA Ethical approval	2021-11-30
3	Request to participate in the Study	English	Request to participate in the study	2021-11-30
4	Data collection tools	English	Data collection tool	2021-12-05
5	Protocol	English	Research Protocol	2021-12-05

Yours Sincerely



Dr. Adrian Jjuuko

For: The AIDS Support Organization (TASO) REC

## Annex 3: Letter of approval from UNCST, Uganda



### Uganda National Council for Science and Technology *(Established by Act of Parliament of the Republic of Uganda)*

Our Ref: HS2152ES

7 April 2022

Ronald Arineitwe Kibonire  
International Planned Parenthood Federation  
Kabale

**Re: Research Approval: Strategies to enhance indigenous men's support for utilisation of long-acting reversible contraceptives amongst rural women in Uganda**

I am pleased to inform you that on 07/04/2022, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of 07/04/2022 to 07/04/2023.

Your research registration number with the UNCST is HS2152ES. Please, cite this number in all your future correspondences with UNCST in respect of the above research project. As the Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. Keeping all co-investigators informed of the status of the research.
2. Submitting all changes, amendments, and addenda to the research protocol or the consent form (where applicable) to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval **prior** to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with copies to the National Drug Authority and a notification to the UNCST.
4. Unanticipated problems involving risks to research participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST notification after review by the REC.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. An annual progress report and approval letter of continuation from the REC must be submitted electronically to UNCST. Failure to do so may result in termination of the research project.

Please note that this approval includes all study related tools submitted as part of the application as shown below:

No.	Document Title	Language	Version Number	Version Date
1	Request for permission to participate in the study	English	3	07 March 2022
2	Request for permission to participate in the study	Rukiga	2	25 February 2022
3	Request for permission to participate in the study	English	1	30 November 2021
4	Request for permission to participate in the study	Rukiga	2	25 February 2022
5	Informed consent form	English	2	25 February 2022
6	Informed consent form	Rukiga	2	25 February 2022
7	Interview guide for individual and focus group interviews	English	2	25 February 2022
8	COVID 19 risk mitigation	English	1	07 March 2022
9	Project Proposal	English	VERSION 3	
10	Approval Letter	English		
10	Informed consent for for focus group Interview	English	2	25 May 2022
11	Informed consent for Individual Interview	English	2	25 April 2022

Yours sincerely,



Ms Beth Mutumba

For: Executive Secretary

UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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**LOCATION/CORRESPONDENCE**

*Plot 6 Kimera Road, Ntinda  
P.O. Box 6884  
KAMPALA, UGANDA*

**COMMUNICATION**

TEL: (256) 414 705500  
FAX: (256) 414-234579  
EMAIL: [info@uncst.go.ug](mailto:info@uncst.go.ug)  
WEBSITE: <http://www.uncst.go.ug>



## Annex 4: Administrative clearance from Kiboga and Rubanda Districts



THE REPUBLIC OF UGANDA  
KIBOGA DISTRICT LOCAL GOVERNMENT  
DIRECTORATE OF HEALTH  
P.O BOX 1 KIBOGA

5<sup>th</sup> April 2022  
Mr. Arineitwe Ronald Kibonire  
Researcher and PhD student

**RE: ADMINISTRATIVE CLEARANCE TO CONDUCT RESEARCH.**

Reference is made to your letter dated 30<sup>th</sup> march 2022, requesting for an acceptance letter and permission to conduct a study in kiboga district

We wish to give permission for the conduction of a research study titled, "developing strategies to enhance men's support for utilisation of long-acting reversible contraceptives amongst rural women in Uganda."

We have reviewed and noted the protocol and the approval letters so far from from REC in South Africa.

With this letter, I grant permission for the conduction of the study in kiboga district. This letter should also serve to enable you get clearance from the Uganda National Council for Science and Technology (UNCST),

Sincerely,

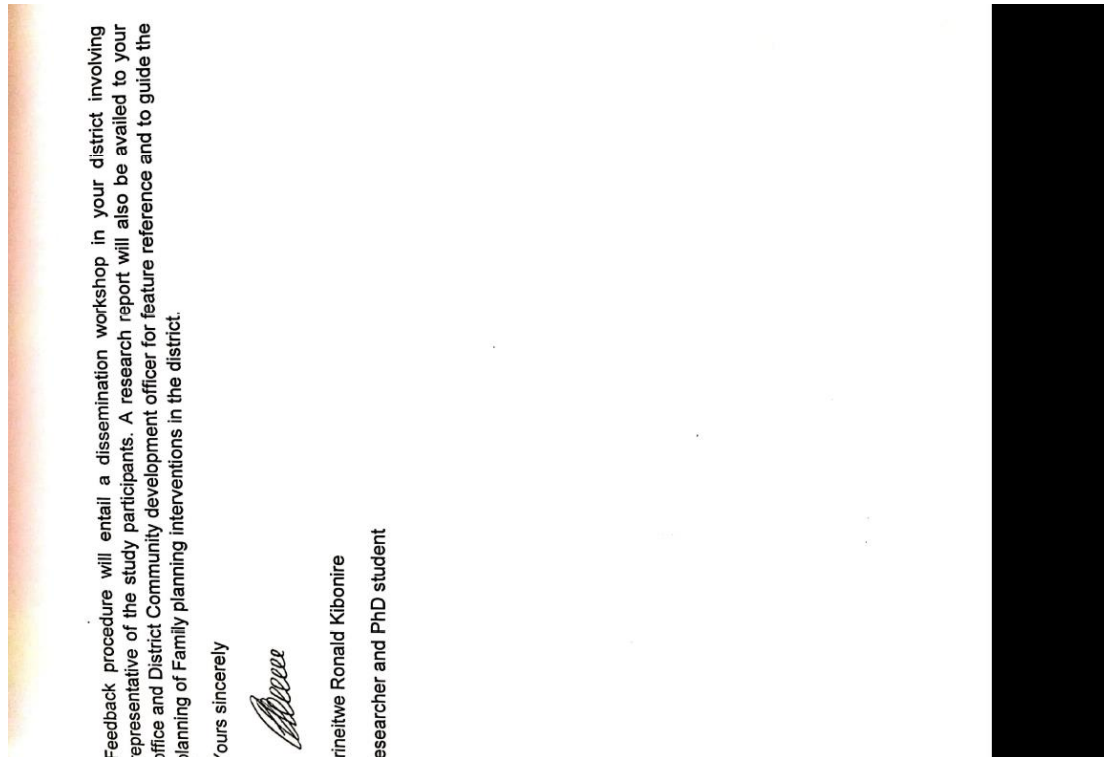
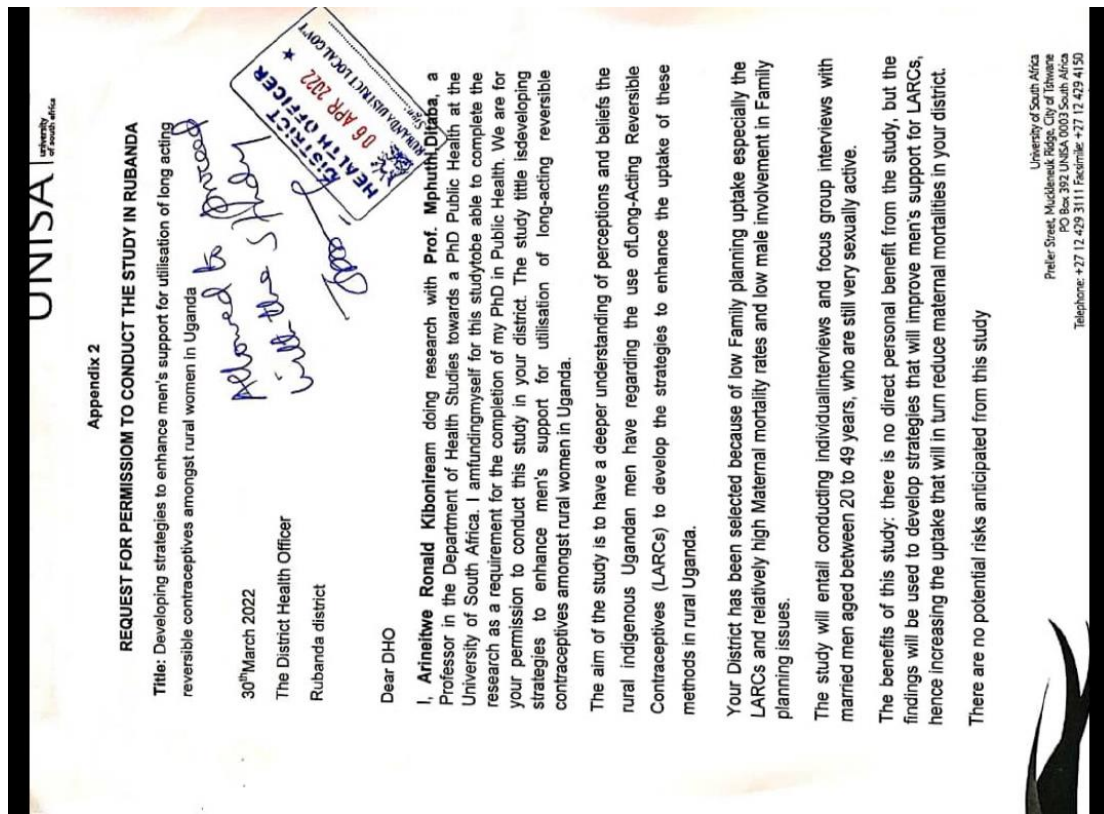
  
Dr. Tebandeke Francis

District Health Officer, Kiboga





**Annex 5(a): Permission letter**



## Annex 5(b) information sheet



Information Sheet  
for consent\_combined

## Annex 6: Covid\_19 Mitigation plan

### COVID-19 RISK MITIGATION PLAN

During the process of data collection, the researcher will ensure that the process is in line with WHO and Uganda Ministry of Health (MOH) standard operating procedures (SOPs) for prevention of COVID-19 (MOH, 2020). The researcher will make sure that both the research assistants, research supervisors as well as research participants are following the WHO and MOH SOPs. At each of the meeting venue for the individual interview and focus group interviews, all participants and the researcher team that will be accessing the meeting venue will undergo temperature screening and the researcher will avail a handwashing facility with soap for each participant to wash hands before accessing the venue.

During the process of data collection, the researcher will make sure that participants in each focus group are not more than 10 in number and they will sit two metres apart in order to ensure social distancing. The researcher will also ensure that the focus group interview takes place under the shade in open with very good air saturation. The researcher will come with a box of Masks to give to the participants that may turn up for the interviews without wearing face masks and all participants will be advised to keep their masks on as long as they are still in the meeting. More to that, the researcher will have a box of sanitisers to give to each of the participants to sanitise their hands before, during and after interviews and they will be allowed to go with the remaining sanitiser in their bottles provided.

At the venue for the meeting, the researcher will display MOH posters that have key messages on COVID-19 in Luganda/Rukiga languages. These guidelines will be placed in places that are easily visible to participants. The researcher will also Provide guidelines on Do's and Don'ts to every participant who will be participating in the study.

By ensuring that all the measures mentioned above are followed, the researcher will minimise any risk of spreading COVID-19 during the process of data collection

# Annex 7: Informed consent form for focus group and individual interviews-English



## Appendix 6

### CONSENT TO PARTICIPATE IN THE STUDY

I, \_\_\_\_\_ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.



Should you have concerns about the way in which the research has been conducted, you may contact:

1. My research Supervisor at University of South Africa Prof Mphuthi Ditaba D, [mphutdd@unisa.ac.za](mailto:mphutdd@unisa.ac.za), Tel: +270124292058
2. And you can also contact the research ethics chairperson of the TASO REC Dr. Adrian Jjuuko; Tel: 0782169505; Email; [jjukoa@gmail.com](mailto:jjukoa@gmail.com)

I agree to the recording of the focus group interview/ Individual interview

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print)

Participant Signature.....Date.....

Researcher's Name & Surname.... **Arineitwe Ronald Kibonire**... (please print)

Researcher's signature.....  .....Date... **13<sup>th</sup> September 2021**.....



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Witness' signature.....Date.....

Researcher's Name ..... (please print)

Researcher's signature..... Date.....



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## Annex 8: Informed consent form for individual interviews-Luganda



Ebigattiddwako 6: Okwikkiriza kwe kwebiteso Obyomuntu ssekinoomu

### OLUPAPULA OLULAGA NTI OKKIRIZA OKWEETABA MUKUNONYEREZA KUNO

Nze, \_\_\_\_\_ (Erinya ly'omuntu agenda okubuzibwa), Nkakasa nti omuntu ansaba olukusa okweetaba mukunonyereza kuno ambulidde ekika ky'okunonyereza kuno, emitendera, byenyinza okufunamu n'engeri gyenya okutataganyizibwamu singe n'etaaba mukunonyereza kuno.

Nsomye (oba nnyinyonyodwa) era n'entegeera okunonyereza kuno nga bwekunyonyodwa mulupapula oluliko amawulire.

Mpereddwa omukisa ogumala okubuza ebibuuzo era ndi mweteefuteefu okweetaba mukunonyereza.

Ntegeera nti okweetabamu kwange kwakyeagalire era nto ndiwaddembe okubivaamu obudde bwona nga ate sivunaniddwa wadde. (bwekibanga kyetaagisa)

Nkimanyi nti ebiva mukunonyereza kuno bigenda kuteekebwatekebwa mungeri ye alipota, obutabo ne/oba ebikozesebwa mumisomo, naye okweetabamu kwange kujja kukumbwa nga kwakyaama okujako nga wakwe embeera endala eyetaagisa okunokolayo.

Singa obeera n'okwemulugunya kwona kunge okunonyereza kuno gyekukoleddwa, osobola okutukkirira:



1. Mukama wange okuvamu tendekero /yunivasite ya south Africa, Kakensa Mphuthi Ditaba D, kumukutu omugata bantu; [mphutdd@unisa.ac.za](mailto:mphutdd@unisa.ac.za), essimu: +270124292058
2. Era osobola okutukkirira ssentebe w'ekitongole ekigaba olukusa okunonyereza mukitongole kya TASO Musawo Adrian Jjuko; kussimu: 0782169505; Omukutu omugatta bantu; [jjuko@gmail.com](mailto:jjuko@gmail.com)



Nzikiriza okukwatiibwa amaloboozi mukukyumimiyamu/okukubaganya ebirowoozo kw'ekibinja/o kwassekinomu

Nkufunye olupapula olusiddwako omukono olulaga nti nzikiriza okweetaba mukunonyereza

Erinya ly'oyo agenda okweetabamu & Erinya ely'ekika.....  
(Wandiika munyukuta Enene)

Ssaako omukono.....Ennaku z'omwezi.....

Erinya ly'omujulizi aha abwogo otamanyi kuwandika.....

Ssaako omukono.....Ennaku z'omwezi.....

Amanya g'omunonyereza & Erinya ely'ekika.... (Wandiika munyukuta enene)

O mukono gw'omunonyereza.....Ennaku z'omwezi.....



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## Annex 9: Informed consent form for focus group and individual interviews- Rukiga

Ekiregita ahabindi 6: Eyomuntu Omwe

### OKWIKIIRIZA OKWEJUMBIRA OMUMUSHOMO

Nyowe, \_\_\_\_\_ (eziina ryowajumbira omumushomo), nimpamya kunabuzibwa kekiriza kwejumbira omukucondoza nagabirwa ahabikwatireine, nebyokukuratira, ebirungi ebiri omumushomo nebirikubasa kundabanisamu nayejumbira omumushomo.

Nashooma (nashobororerwa) kandi nayetegyereza omushomo okubiri omurumpapura.

Natunga obwire burikumara kubuza ebi buzo kandi nyetegwire kwejumbira omumushomo.

Nayetegyereza kwejumbira omumushomo tagyemirwe kandi kundikubasa kurugamu obwire obundayeedere taherezibwe ekibonerezo (kukyakwentegyesibwa)

Nimanya ngu ebirarugye omumushomo ogu nibiza kutembwa omu ripota yokucondoza, ebibitabo byokucondoza hamwe nebihandiko byekiiko konka ebikwatireine nokukwejumbira kwangye omumushomo nibiza kuba ebyekihama oyihireho ebimanyisibwe.

Kuwakuba oyine ebikwasire ahamushomo okugwatwazibwe nobaasa kuhikirira aba:

1. Orikukurira okucondoza owa University of South Africa Prof Mphuthi Ditaba D, [mphutdd@unisa.ac.za](mailto:mphutdd@unisa.ac.za), Tel: +270124292058
2. Nobaasa kuhikirira mukuru webyemitwarize yokucondoza owa TASO REC Dr. Adrian Jjuuko; Tel: 0782169505; Email: [juukoa@gmail.com](mailto:juukoa@gmail.com)

Ninyikiriza kukwatwa amaraka omukubuzibwa omugurupu/nokubuzibwa komuntu

Natunga ekimpapura kyokwikiriza kwangye kubuzibwa

Eziina ryo wajumbira omumushomo hamwe neziina ryobuzarwa..... (yosamu)

Omukono gwowajumbira omumushomo.....Ebiro.....

**Omujurizi ku owayetaba mukukyondoza taramanya**

**kuhandika..... Ebiro.....**

Eziina ryomucondozi hamwe neziina ryobuzarwa ..... (washabwa kwosamu)



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Omukono gwowacondoza.....Ebiro.....



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**Ekiregita ahabindi 6: Okwokwetaba mu Kiganiro kya gurupu**

**OKWIKIRIZA OKWEJUMBIRA OMUMUSHOMO**

Nyowe, \_\_\_\_\_ (eziina ryowajumbira omumushomo), nimpamya kunabuzibwa keikiriza kwejumbira omukucondoza nagabirwa ahabikwatireine, nebyokukuratira, ebirungi ebiri omumushomo nebirikubasa kundabanisamu nayejumbira omumushomo.

Nashooma (nashobororerwa) kandi nayetegyerereza omushomo okubiri omurumpapura.

Natunga obwire burikumara kubuza ebi buzo kandi nyetegwire kwejumbira omumushomo.

Nayetegyerereza kwejumbira omumushomo tagyemirwe kandi kundikubasa kurugamu obwire obundayeedere taherezibwe ekibonerezo(kukyakwentegyesibwa)

Nimanya ngu ebirarugye omumushomo ogu nibiza kutembwa omu ripota yokucondoza,ebibitabo byokucondoza hamwe nebihandiko byekiiko konka ebikwatireine nokukwejumbira kwangye omumushomo nibiza kuba ebyekihama oyihireho ebimanyisibwe.

Kuwakuba oyine ebikwasire ahamushomo okugwatwazibwa nobaasa kuhikirira aba:

1. Orikukurira okucondoza owa University of South Africa Prof Mphuthi Ditaba D, [mphutdd@unisa.ac.za](mailto:mphutdd@unisa.ac.za), Tel: +270124292058
2. Nobaasa kuhikirira mukuru webyemitwarize yokucondoza owa TASSO REC Dr. Adrian Jjuuko; Tel: 0782169505; Email: [juukoa@gmail.com](mailto:juukoa@gmail.com)



Ninyikiriza kukwatwa amaraka omukubuzibwa omugurupu/nokubuzibwa komuntu

Natunga ekimpapura kyokwikiriza kwangye kubuzibwa

Eziina ryo wajumbira omumushomo hamwe neziina ryobuzarwa..... (yosamu)

Omukono gwowajumbira omumushomo.....Ebiro.....

**Omujurizi ku owayetaba mukukyondoza taramanya**

**kuhandika..... Ebiro.....**



Eiziina ryomucondozi hamwe neiziina ryobuzarwa ..... (washabwa kwosamu)

Omukono gwowacondoza.....Ebiro.....



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## Annex 10: Interview guide for individual interviews and focus Group-English

Version 1 Date 25<sup>th</sup> February 2022

### ANNEXURE I: INTERVIEW GUIDE FOR THE INDIVIDUAL INTERVIEWS FOR MEN

UNIVERSITY OF SOUTH AFRICA DEPARTMENT OF HEALTH STUDIES

P.O. Box 392 Unisa, Pretoria, South Africa

#### Introduction

Dear Participant,

I would like to thank all of you for accepting to participate in sharing your views and experiences with me [us]. During our interaction today, I request you to feel free and comfortable as you share your views and thoughts about Long-Acting reversible contraceptives (LARCs). This discussion will for at least one hour or until a time where you will have nothing more views and thoughts to share about LARCs, feel free to bring out your views you wish, and I assure you that you comment, and views will not be shared with anyone else.

#### Biographical Information

Before we start the interview, I would like to ask you a few questions to help us understand you better.

- Age,  Occupation,  Language,  Telephone contact,  Village, Parish, Sub-County, District,  Tribe,  Marital status,  How long have you stayed in the district?  
 Number of live children?



#### Questions

1. What are Long-Acting reversible contraceptive methods?
2. Give examples of Long-Acting reversible contraceptive methods?
3. What are your views about family planning use by your partners?
4. *What do you think about the use of LARCs as a method of choice for contraception by women?*
5. What are your perceptions about Long-Acting reversible contraceptive methods?
6. What are your beliefs about Long-Acting reversible contraceptive methods?
7. What are other views that you have about Long-Acting reversible contraceptive methods use by your partner?
  - a. *Are LARCs helpful as methods of contraception? Explain your reasons.*

b. *Would you encourage the use of LARCs by your partner?*

*If yes, why?*

*If no, why?*

8. What can be done to encourage men to support the use of Long-Acting reversible contraceptive methods by their partners?



## Annex 11: Interview Guide for Luganda FGD

**EKYONGERWAKO H(b): ENGERI YO OKWOGERAGANYAMU NABAMI**  
Okwebibinja.

**UNIVERSITY YE SOUTHAFRICA DEPARTMENT OF HEALTH STUDIES**  
P.O. Box 392 Unisa, Pretoria, South Africa

### Enyanjula

Omwetabi waffe omulunji,

Nkwebaza olwokukiriza okwenyigira mu ku gabanyako ebirowozo byo ne byoyisemu nange(naffe).Nga njogerako nawe olwalero,nkusaba oberewa ddembe era mugumu nga ogabanako nange endowozazo ku nkola za kizala gumba ezebbanga egwanvu.Okwogeraganya kwaffe tekujja kusuka sawa emu,oba wona wowulirira nga tokyalina byakugabana ku nkola za kizala gumba ezebbanga egwanvu,bera wa ddembe okugaba byona byoyagala era nkukakasa nti byetunaba twogeddeko byona sigenda bigabanako namuntu,mutala yena.

### **Ebikukwatako**

Nga tetunatandika kwogeraganya kwaffe ,nagala kubuzako kubibuzo bitono neyongere okukutegera obulunji.

Emyaka  Okola mulimu kki?  Oyogera lulimiki?  Enambayo eye siimu  Ekyalo Parish,  Omuluka,  Egombolola,  Disitirikiti,  Egwanga ryo  ebyobufumbo  Omazze bbanga ki mu Disitirikiti eno ?  Oyina abana bameka abalamu?

### **Questions**

1. Enkola zakizala gumba ezebbanga eggwanvu kitegeza kki?
2. Menyerayo enkola zakizala ggumba ezebbanga eggwanvu zomanyi?
3. Mpa ku ndwozo za ku nkozesa ye kizala ggumba ku mwagalwawo?
4. Kiki kyolowoza ku nkozesa zekizala ggumba ezebbanga egwanvu nga enkola eyekyagalire eri abakyalu?



5. Otegera otya enkola zino ezakizala ggumba ezebbanga eggwanvu era oyliriza zogerako biki?

6. Bintu ki byewali owulidde era nga obikirizamu nti bituffu ku nkola zino eza kizala ggumba ezebbanga eggwanvu?

Ndwoza kki endala gyolina kunkola zakizala ggumba ezebbanga egwanvu?

a. Olowoza Enkola za kizala gumba ezebbananga eggwanvu zamugaso?

*Explain your reasons. Wa ensonga zo lwaki.*

b. Osobola okuzamu omwagalwawo/mukyala wo amanyi okukozesa enkola zakizala ggumba ezebbanga egwanvu?

Bwoba okuzala lwaki?

Bwoba omwagalwawo lwaki?



## Annex 12: Interview Guide for Luganda Individual Interviews

**EKYONGERWAKO I(b):ENGERI YO OKWOGERAGANYAMU NABAMI  
SSEKINOOMU  
UNIVERSITY YE SOUTH AFRICA DEPARTMENT OF HEALTH STUDIES  
P.O. Box 392 Unisa, Pretoria, South Africa**

### Enyanjula

Omwetabi waffe omulunji,

Nkwebaza olwokukiriza okwenyigira mu ku gabanyako ebirowozo byo ne byoyisemu nange(naffe).Nga njogerako nawe olwalero,nkusaba oberewa ddembe era mugumu nga ogabanako nange endowozazo ku nkola za kizala gumba ezebbanga egwanvu.Okwogeraganya kwaffe tekujja kusuka sawa emu,oba wona wowulirira nga tokyalina byakugabana ku nkola za kizala gumba ezebbanga egwanvu,bera wa ddembe okugaba byona byoyagala era nkukakasa nti byetunaba twogeddeko byona sigenda bigabanako namuntu mulala yena.

### **Ebikukwatako**

Nga tetunatandika kwogeraganya kwaffe ,njagala kubuzako kubibuzo bitono neyongere okukutegera obulunji.

Emyaka  Okola mulimu kki?  Oyogera lulimiki?  Enambayo eye siimu  Ekyalo Parish,  Omuluka,  Egombolola,  Disiturikiti,  Egwanga ryo  ebyobufumbo  Omazze bbanga ki mu Disiturikiti eno ?  Oyina abana bameka abalamu?

### **Questions**

1. Enkola zakizala gumba ezebbanga eggwanvu kitegeza kki?
2. Menyerayo enkola zakizala ggumba ezebbanga eggwanvu zomanyi?
3. Mpa ku ndwoza zo ku nkozesa ye kizala ggumba ku mwagalwawo?
4. Kiki kyolowoza ku nkozesa zekizala ggumba ezebbanga egwanvu nga enkola eyekyayagalire eri abakyala?
5. Otegera otya enkola zino ezakizala ggumba ezebbanga eggwanvu era oyinza zogerako biki?



6. Bintu ki byewali owulidde era nga obikirizamu nti bituffu ku nkola zino eza kizala ggumba ezebbanga eggwanvu?
7. Ndwoza kki endala gyolina kunkola zakizala ggumba ezebbanga egwanvu?
- Olowoza Enkola za kizala gumba ezebbananga eggwanvu zamugaso? Explain your reasons. Wa ensonga zo lwaki.*
  - Osobola okuzamu omwagalwawo/mukyala wo amanyi okukozesa enkola zakizala ggumba ezebbanga egwanvu? Bwoba okkiriza, lwaki? Bwoba oggana, Lwaki?*
8. Ki ekiyinza okolebwa okukubiriza abasajja oku wagira nokuzamu bakyala babwe amanyi okukozesa enkola zino ezakizala ggumba ezebbanga eggwanvu?



## Annex 13: Interview Guide for Rukiga FGD

ANNEXURE H(a): EGYENDERWAHO YOKUBUZA GURUPU ZA ABASHAIJA

UNIVERSITY OF SOUTH AFRICA DEPARTMENT OF HEALTH STUDIES

P.O. Box 392 UNISA, Pretoria, South Africa

OKWANJURA

OKWANJURA

Omukundwa omurungi owayenjumbira omukiganiiro. Ninyenda kukusiima ahabwokwenjumbira omukuherezayo ebitekateko byawe hamwe nobukugubwawe nanye (nitwe). Twaba nituganira erizooba, nikushaba kuhuriragye kandi okatebekana orikuherezayo ebiteiso byawe netekateka ekwasire ahabuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro. Ekiganiiro eki nikizakumara eshaaha emwe nari kuhisya ahu oramirire kuherezayo ebitekateko byawe ebikwasire ahabuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro, bagye ohereze ebitekateko byawe okworikwenda, kandi nikuhamiza ndu ebyoraherezayo hamwe nebitekateko byawe tibirikuza kubaganwa hondo weena.

Ebirikukwa aha owayenjumbira omukiganiiro Tutakatandikire ekiganiiro, ninyenda kukubuuza ebibuuzo bikye kutuyamba kumanyanagye.

Emyaka,  Omurimo,  Orurimi,  Enamba Yesiimu,  Ekyaro,  Omuruka,  Egomborora,  Disiturikiti,  Oruganda,  Ebyobushwere,  Obwire Obwomazire  Omudisiturikiti  Abaana Oyine Bagahe?

### Ebibuuzo

1. Obuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro niki?
2. Herezayo ebyokureberaho byo obuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro?
3. Nibiteisyoki ebyoyine ahakuzesa ebarira yaruzaaro n'omukundwa waawe?
4. Nibiteisyoki ebyoyine ahamirango yobuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro?

5. Okeikiriza omukundwa wawe kukozeza omubazi gwokuzimbira kugira enda komuringo gwokubarira ruzaaro?
- c) Yeego ahabwenki?
  - d) Igaaha, ahabwenki?
6. Okeikiriza omukundwa wawe kukozeza omubazi gwokuzimbira kugira enda komuringo gwokubarira ruzaaro?
- e) Yeego ahabwenki?
  - f) Igaaha, ahabwenki?



## Annex 14: Interview Guide for Rukiga Individual Interviews

ANNEXURE I(a): EGYENDERWAHO YEBIBUZO BYA BURIMUNTU EBYA  
ABASHEIJA  
UNIVERSITY OF SOUTH AFRICA DEPARTMENT OF HEALTH STUDIES  
P.O. Box 392 UNISA, Pretoria, South Africa  
OKWANJURA

Omukundwa omurungi owayenjumbira omukiganiro,  
Ninyenda kukusima ahabwokwenjumbira omukuherezayo ebitekateko byawe hamwe  
nobukugubwawe nanye (nitwe). Twaba nituganira erizooba, nikushaba kuhuriragye  
kandi okatabekana orukuherezayo ebiteiso byawe netekateka ekwasire ahabuhereza  
bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro. Ekiganiro eki nikizakumara  
eshaaha emwe nari kuhisya ahu oramirire kuherezayo ebitekateko byawe ebikwasire  
ahabuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro, bagye  
ohereze ebitekateko byawe okworikwenda, kandi nikuhamiza ngu ebyoraherezayo  
hamwe nebitateko byawe tibirikuza kubaganwa nondijo weena

**Ebirikukwa aha owayenjumbira omukiganiro Tutakatandikire ekiganiro,  
ninyenda kukubuuza ebibuuzo bikye kutuyamba kumanyanagye.**

Emyaka,  Omurimo,  Orurimi,  Enamba Yesimo,  Ekyaro,  Omuruka,  Egomborora,  
 Disiturikiti,  Oruganda,  Ebyobushwere,  Obwire  Obwomazire  Omudisiturikiti   
Abaana Oyine Bagahe?



### Ebibuuzo

1. Obuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro niki?
2. Herezayo ebyokureberaho byo obuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro?
3. Nibiteisyoki ebyoyine ahakukozesa ebarira yaruzaro n'omukundwa waawe?
4. Notekatekaki ahamiringo yobuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro nka okukozesa emibazi kuzibira kugira enda?
5. Noreeba ota emiringo yobuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro nka okukozesa emibazi kuzira kugira enda?

6. Okeikiriza omukundwa wawe kukozeza omubazi gwokuzimbira kutwara enda komuringo gwobarira ruzaaro?
- Yeego ahabwenki?
  - Igaaha, ahabwenki?
7. Noreeba ota ebikwatinine enkozesa yemiringo yobuhereza eyokubaririra ruzaro eyobwire buringwa kandi oburikubasa kushuba bukihwaho?
- Notekatekaki ahakuzesa omubazi komuringo gwobuhereza bwo obwire buringwa oburikuhinduka bwebaririra yaruzaro?
  - Emiringo yo obwire buringwa oburikuhinduka bwebaririra yaruzaro neyamba nka omubazi gwokuzimbira kutwara enda? Shoborora ebibyorikutekateka?
- Okahabura abakazi kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaro?
- Yeego, ahabwenki? valid until.....
- Igaaha, ahabwenki?
8. Nihabasika kukoraki kuhangira abasheija bashangika okukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaro?





## Annex 15: Translated Transcription for English, Rukiga and Luganda

### ENGLISH TRANSLATATION OF FOCUS GROUP INTERVIEWS

Rubanda District

Nyamweru Sub-country

FGD for Rubanda district-Nyamweru Sub-country(R).

Date: 1 Date: 14<sup>th</sup> April 2022

No.	Age	Occupation	Language	Tribe	Time spent in district	No. of children
R1	42	Farmer	Rukiga	Mukiga	42	5
R2	47	Farmer	Rukiga	Mukiga	47	5
R3	27	Farmer	Rukiga	Mukiga	27	2
R4	34	Farmer	Rukiga	Mukiga	34	3
R5	38	Businessman	Rukiga	Mukiga	38	2
R6	35	Motorcyclist	Rukiga	Mukiga	35	3
R7	43	Farmer	Rukiga	Mukiga	43	5
R8	48	Motorcyclist	Rukiga	Mukiga	48	9
R9	48	Business	Rukiga	Mukiga	48	12
R10	45	Farmer	Rukiga	Mukiga	45	7

#### I: What do you understand by the word family planning?

R7 Giving a child adequate space of either 2 or 5 years so that they are well brought up and prevention of unintended pregnancies.

R1 family planning means using the injections to stop the women from producing.

R6 Family planning is about producing a number of children that he can feed well and take care of them.

R 4 family planning tying the birth so that the woman cannot produce again.

**I: Any other person who wants to tell us more about family planning?**

**Participants:** No

**I: Can you tell me examples of family planning?**

R4- There are injectables for 3- or 5-years R 3-Capsules R2- Know injection for 3 months R1- Capsules for 5 or 3 years, R7 For me the examples of family planning that I know include the coil that they put in the womb, capsules, and implants.

**I: What are your views about family planning and the long-acting reversible contraceptive methods (LARCs)? Would you allow your wife to use the methods? Why?**

R 5 Some women have weak immunity and therefore fear complications like operations while giving birth. Therefore, for this reason, the long-acting family planning are not a good choice and I do not support my woman to use.

R 7 When our women use an Implant or a capsule (IUD), they make them bleed non-stop. As a man, you can imagine what we feel spending a long time without touching your wife. I cannot allow my wife to use family planning method.

R8 Longer-acting family planning is good as it helps the family preparation especially finances for the children.

R 4 Because the woman knows that she cannot be impregnated by another man when she goes out while using a long-term family planning method, this encourages her to continue cheating. For that reason, I cannot support women using those long-acting family planning methods.

R1 I would support capsules for 5 years, however, women using such often fall sick. Family planning that works for a long term causes excessive bleeding or for extended periods and can easily kill them if they continue to use the methods. The LARCs make our women impotent and unresponsive when aroused in preparation for doing the adult game of the bed. "Women who use long-acting family planning do not produce again when they stop the method because all the eggs in a woman are already destroyed. This is bad when they still have few children and make family planning bad. This makes us men not allow our women to use those bad methods.

**I: Any other comment on the long-acting reversible family planning methods?**

R3-Long-acting family planning causes weakness in women due to some FP methods and they become less efficient in doing their usual home chores. They also hear that women become very fat and lose interest in meeting their men in bed.

R2 I also here that family planning brings a lot of bleeding, and excessive weight gain making a woman unable to go and dig. Family planning also causes producing weak babies and cancers in the uterus When a woman is using family planning, it also affects their husband's libido which reduces. This makes the methods not good ones.

R5-Family planning that work for long causes excessive weight leads to less productivity in doing chores missed periods and if they finally come, there is excessive bleeding and general body weakness. Women who use long-acting family planning (LARCs) get excessive weight which leads to less productivity in doing chores and this makes men suffer with no one to do the work of the woman at home.

R3-Using long-acting family planning methods cause complications in the succeeding pregnancies, producing weak babies who eventually die and can cause cancer of the womb.

R9-Some take long to get pregnant when the period of a method is done so if I want more children, I cannot accept my woman to use those methods.

R 4 Some get pregnant while they are still using long-acting methods and therefore no reason to keep using those methods as they do not work. We have heard about women who used family planning of inserting in the arm and they since failed to use the arm properly. These methods are not good at all.

R8 Long-acting family planning is not good as they cause children to be born with a disability. Therefore, as a man, I encourage my wife to use natural family planning to avoid problems of such children who are difficult to care for.

**I: Anyone else who want to share his views on long-acting family planning in relation to your religion?**

R10-Long-acting family planning causes reduced libido in women, and it can affect men also when they do not meet their women in bed. Some of the women who use a



capsule that is put in the womb end up going and causing swellings in the stomach and also causes cancer” (FGD-R10).

R6 For me family planning would be good, but I need to increase on my clan of Bahimba. We are few in this sub-county and if we use family planning whether long or short, we shall remain few and other big clans will fight and overpower us.

R5. Like now I have only two girls, how do I allow my wife to use a long-acting family planning method? Suppose she does not produce again? It means I will have no boys or if I want one, I have to go outside to produce there. That is why I do not support those methods.

**I: Any other views in regard to your religions?**

R4, as a Catholic I believe that the use of any family planning even the long-acting one is murder and sin and hence won't want to commit a big sin by allowing my wife to use a long-acting family planning method.

R3 Some women like mine are leaders in the church and even though they would want to use both family planning they fear losing their positions in the church. We have to use those methods that are acceptable to the church and God.

R10- As an Anglican, I follow the teaching of the Bible that tell us to produce and fill the world. For that reason, do not allow the use of long-term Family Planning. I also want to produce and preserve the clan so that I am counted as having contributed to the size of the clan. So, I cannot allow my wife to use a family planning method.

**I: Is there a way your culture affects your views on long-acting reversible family planning use.**

R4- According to my culture we value a boy child therefore like me a man with only girls will keep producing until when he gets boys

R10-For my case, the Bakiga culture guides us and recognize one as a man to be having many children both boys and girls. Therefore, I don't want my wife to use any family planning method let it be for a short time or the one that last long time.

R7 according to our culture and clan, they advise we men to produce many children and to have boys that will look after our wealth as heir. So, we are supposed to have

many children. Also, when you have many girls and they get married, they pay dowries in form of cows and goats and you get a lot of wealth which is good for the home. Also, according to the Bakiga culture, a man should have as many children as possible and therefore if you use a long-acting family planning method, that will not be possible to get many children

R2, I need produce more children to preserve and strengthen the clan. If I allow my wife to use any family planning method, this will not be achieved. For that reason, I cannot allow her to use a long-acting family planning method. If a family has many children and they go to cultivate, they dig a very big area for food production, and you will find such a family had enough food and money from selling excess food.

R5 as a man, I am the head of the family, and I am supposed to be the one to allow my wife to use or not use a contraceptive method.

R9 when I have many children especially girls and I am lucky they get married, I get cows and that is wealth in the family. So, if I allow my wife to use family planning, you cannot get enough girls and that means few cows.

**I: What can we do to make you support your wives to use long-acting reversible family planning methods?**

R7 We need other methods like the natural ones to replace medical methods.

R4, You make ways of reducing on bad things that family planning bring about and then we can support it.

ENGLISH TRANSLATION OF INDIVIDUAL INTERVIEWS

MUKO SUB COUNTY

**Individual Interview in Rubanda Muko Subcounty(I-RM)**

**Participant 43(P:43) is 32 years old with Six children.**

**Date: 12<sup>th</sup> April 2022**

**I: What do you understand by family planning?**

Family planning means producing one or two children but not more than three.

**Examples of LARCs**

Injectables for 3 and 5 years, Capsules, withdrawal

**I: What are your views about family planning and the long-acting reversible contraceptive methods (LARCs)? Would you allow your wife to use the methods? Why?**

Family planning is good, but they are many challenges associated with it such as side effects like missed periods, excessive weight gain and fatigue make it bad to use.

**I: What do you say about the long-term reversible family planning methods?**

Long-acting family planning like the injection of 3 years and five years makes a woman very dry and lose appetite for a man which make it not a good method to use by a woman.

**I: Would you support your wife to use the long-acting family planning methods?**

P: No, I am not in support because of the bad side effect that comes with the use of those family planning methods. I have seen some women who use family planning fail to conceive after ceasing to use the long-acting family planning methods. Other they become very big and you find a woman cannot move even for one Kilometres she gets tired very quickly.

**I: Anything more?**

I also hear that women bleed too much if they use those methods and others get their body parts damaged and also, they cause cancer. Like capsules administered on the arm, some women complain of paralysis on several occasions. Some are not compatible and if the method is for a long time, it may be too late to reverse the process. Also, some children may die and if there is a need to produce another one before the time elapses it may be hard to reverse the process if the woman has been using family planning. Also, a woman may commit adultery because she is sure she won't get pregnant. Also, you should first check an individual to see if they are compatible before using the family planning method on them. For women who usually undergo operations while giving birth, it is good to use the long-acting reversible family planning method to avoid unintended pregnancies

**I: Is there anything more you would like to share about Long-acting family planning in relation to your religion view of the use of FP**

P I am a protestant, and my religion does not talk a lot about family planning, but God said that we should produce and fill the world. That means if you produce few children after using family planning, it is not in line with what God wants. Therefore, those who use the family planning methods are doing things that God does not like. Also, our women fear using the long-acting family planning methods because they a man will go and produce children from other women. So, they also do not support family planning.

**I: Is there anything in relation to your cultural and use of long-acting reversible Family Planning?**

P: As long as resources are available to take care of the children, one is advised to produce as many as they can according to my culture. The more children you have, the more you are considered a strong man. Our parents say that we need to get someone to inherit the property and other riches and that can only come you produce many children. As farmers here in Rubanda, if you have many children, they provide you with the labour force you need to produce food for selling and for eating. So, if you are using family planning, you miss out on those good things. In my view, family planning should be used by older women beyond 35 years who have already finished producing the children they want. If I have many girls, I can get enough cows when they get married that my boys need when they are also going to marry. So, the many

girls I produce, the richer I can become when I happen to get the cows although these days not a sure deal.

**I: What is to be done to enhance the use of LARCs by women.**

P: More sensitization to the people about the positives of long-acting family planning. Get the family planning methods that do not bring issues to our women. The long-term methods should be used only by older people who already have enough children. Long-term family planning should be used by older women beyond 35 years who have already finished producing.

**I: Is there any more information you would like to share?**

P: No, I have shared all that I have.

**I: Thank you very much for your time. I will be coming back in the near future to share the outcome of this study.**

## RUKIGA TRANSLATION OF FOCUS GROUP INTERVIEWS

Rubanda District

Nyamweru Sub-country

FGD for Rubanda district-Nyamweru Sub-country(R).

Ebiro: 14<sup>th</sup> Okwakana 2022

No.	Emyaka	Omurimo	Orurimi	Oruganda	Obwire obwo omazire omudisiturikiti	Abaana aboyine
R1	42	Omuhingi	Rukiga	Mukiga	42	5
R2	47	Omuhingi	Rukiga	Mukiga	47	5
R3	27	Omuhingi	Rukiga	Mukiga	27	2
R4	34	Omuhingi	Rukiga	Mukiga	34	3
R5	38	Omushubuuzi	Rukiga	Mukiga	38	2
R6	35	Omuvugi waboda yapikipiki	Rukiga	Mukiga	35	3
R7	43	Omuhingi	Rukiga	Mukiga	43	5
R8	48	Omuvugi waboda yapikipiki	Rukiga	Mukiga	48	9
R9	48	Omushubuuzi	Rukiga	Mukiga	48	12
R10	45	Omuhingi	Rukiga	Mukiga	45	7

### I: Noyetegyereza ota embarira yaruzaaro

R7 okuhereza omwana oburikumara nka emyaka 2 nari 5 kugira ngu akuregye hamwe n'okwerinda kutware enda zitategyendereirwe.

R1 okubarira ruzaaro nikimanyisa kukozeza ebikato kuzimbira omukazi kuzaara.

R6 okubarira ruzaaro nokuzara enamba yabaana abomusheija arikubasa kurisya kandi akabareberera.

R 4 okubarira ruzaaro nokusiba ruzaro kugira ngu omukazi atarishuba kuzaara.

**I: Hariho orikwenda kwogyera kutugambira ahabikwatireine nokubarira ruzaaro?**

**Any other person who wants to tell us more about family planning?**

**Abayejumbira omukiganiro: Ingaaha**

**I: Nimubasa kugamba ebyokureberaho by'embarira yaruzaaro?**

R4- hariho ebikato byemyaka 3 nari 5 R 3- Obujuma R2- nibamanya ekikato kyemyezi 3 R1-Obujuma byemyaka 5 nari 3, R7 Nyowe ebyokureberaho by'ebarira yaruzaaro ebindikumanya nakaheta komurinyinenda, obujuma hamwe nakaheta komumukono..

**I: Nibitekatekoki ebimwine ebikwatsire ahakubarira ruzaaro hamwe nemiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaro? Noyikiriza omukazi wawe kukozeza emiringo egyo? Ahabwenki?**

R5: Abakazi abamwe beine emibiri tarikwerindagye endwara kandi nibatina okushemezibwa barikuzaara. Ahabwegyoshonga, emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaro tibarikukunda kubutorana kandi nanye tindikugihangira omukazi owagye kugikozeza..

R7: Abakazi beitu kubakukozeza akaheta komumukono nari akumunyinenda, nibutuma bajwa batarikureka. Niwe nkomusheija noobasa kweshwaniriza okworikwehurira wamara obwire burigwa otakwasire ahamukazi wawe. Nyowe tikubasa kwikiriza omukazi wangye kukozeza omuringo rwebarira yaruzaaro.

R8: Omuringo gwobwire buringwa oburikuhinduka bwebaririra yaruzaro nimurungi hakuba niguyamba eka kutebekanisa sente zabaana

R4: Ahakuba omukazi namanya ngu tarikutwekwa enda ondijo musheija yaza aheru yaba nakozeza omuringo gwobwire buringwa oburikuhinduka bwebaririra yaruzaro, ekyo nikimuhangira kuhereza abandi basheija. Ahabwe egyoshonga tikahangira abakazi kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaro.

R1: Nyowe nkaahyire obujuma bwemyaka 5, konka, abakazi abarikubukozesa nibakira kundwara munonga. Embarira yaruzaaro erikukora obwire burigwa nereeta okujwa munonga narikuza omumicwe kumara obwire buringwa kandi nebasa kubeita bagumizamu kugikozesa. Emiringo yobwire buringwa oburikuhinduka bwebarira yaruzaro nibutuma abakazi batateerana nabasheija kandi tibarikuhuriragye waba nobatebekanisa kukora muzano gwomukitanda. 'Abakazi abarikukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro tibarikushuba kuzaara bareka omuringo rwebarira yaruzaaro hakuba amahuri gomukazi nigabagasisikeire. Ekinikibi baba bakyine abaana bakye kandi nikituma eka yapuranninga kubi. Eki nikituma itwe nkabasheija tutayikiriza abakazi beitu kukozesa egyomiring mibi.

**I: Heine ekindi ekyorikuherezayo ahamiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro.**

R3: Emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro nentuma abakazi bahwa amani kandi tibarukoragye emirimo yaburijo yomuka. Nibahurira ngu abakazi nibaba bahago munonga kandi tabarikukunda kuteerana nabasheija omukinda.

R2: Nyowe nimpurira ngu emiringo yebarira yaruzaaro nereeta okujwa munonga kandi nokuhaguha okuregeine nkituma omukazi atabasa kugyenda hamwe nokuhinga. Embarira yaruzaaro neretera okuzaara abaana abateine maani hamwe nakasa ya nyinenda. Omukazi yaba nakozeza imbarira yaruzaaro, nikitumanya amani gokuteerana kwomusheija kwakyendera. Ekyo nikituma emiringo yebarira yaruzaaro yaba mibi.

R5: Okubarira ruzaaro okurikora obwire buringwa nikureeta okuhaguha okuregeine kituma okukora emirimo kwakyendera hamwe nokutaza omumicwe kandi korikuza omumicwe ojwamunonga kituma omubiri gwahwamani. Abakazi abarikukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro nibahagomoka munonga kituma baremwa kukora emirimo yaburizooba kandi abasheija babonabona bateine abokukora emirimo yekikazi omuka.

R3: Okukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro nikureta okukugumirwa omukuzaara enda ezirikurataho, okuzaara abaana abateine mani bagumizamu bafa kandi netuma wandwara kaasa yanyinenda.



R9: Abamwe nibatwara obwire buringwa kandi obwire bwomuringo bwahwayo nabaninyenda abandi baana tikayikiriza omukazi wagyе kukozeѕа egyomiringo.

R4: Abamwe nibangira enda barikukozeѕа emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro kandi tihariho shonga erikutuma baguma barikukozeѕа emiringo egyo hakuba terikukora. Nituhurira abakazi abakozeѕе emiringo yokubarira ruzaaro eyakaheta komumukono kandi baremwa kukozeѕа omukono kurungi. Egyo miringo tebonire nakakye.

R8: Emiringo yobwire buringwa yebarira yaruzaaro tebonire hakuba netuma abaana bazarwa beine oburema. Nahabwekyo nyowe komusheija nimpagira omukazi wagyе kukozeѕа emiringo yebarira yaruzaaro eyobuhangwa kwetatara obuzibu oburikuba ahabaana abagumire kureberera.

**I: Hariho ondiyo orikwenda kubagana ebitekatekyerezobye ebikwasire ahamiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro nenyikirizaye?**

R10: Emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro netuma obwezi bwomukazi bwakyendera kandi nobyomusheija nebishishi yabatatereine nomukazi omukitanda. Abakazi abamwe abarikukozeѕа ekijuma ekyokuta omurinyinenda nibahendera barikuza kandi bagira ebironda omunda kandi nereta bandwara kaasa (FGD-R10).

R6: Nyowe okubarira ruzaaro kukabeire kurungi, konka ninyenda kwogyera aharuganda rwagyе rwa Bahimba. Turibakye omugomborora egyi kandi twakozeѕа embarira yaruzaaro oba eyobwire buringwa naribukye, nituzakuguma turibakye kandi ezindi ganda nizija kurwa zitusingure.

R5: Obwahati nyine abahara babiri kusha, nibasata kwikiriza omukazi wagyе kukozeѕа emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro? Hatishi kuyokuremwa kugaruka kuzaara? Ekyo nikimanyisa ngu tidikwija kugira aboojo narishi kunokwendayo omwe, nikimanyisa ngu nizkumuzaara aheru? Nahabwekyo ekyo nikyotarikuhangira egyo miringo.

**I: Hariho ebindi biteisyo ebikwatireine nenyikiriza zanyu?**

R4: Nyowe komunyaturiki ninyikiriza ngu okukozesa omuringo nangumwe gwembarira yaruzaaro nakurwakuba ogwobwire buringwa nobawayita kandi nekibi kandi tikwenda kukora ekibi kihango keikiriza omukazi wangye kukozesa omuringo gwobwire muringwa bwebarira yaruzaaro.

R3: Abakazi abamwe kowagye nabembezi omukereziya kandi bakabeire bibenda kukozesa emiringo yebarira yaruzaaro konka nibatiina kuruga omubwebembezi bwekereziya. Twine emiringo yebarira yaruzaaro erikwirizibwa omukereziya hamwe na Ruhanga.

R10: Nyowe komukurisitayo, nikuratira okushomesibwa kwa baiburi erikutugira ngu tuzare twijuze ensi. Nahabwe enshonga egyo, tindikwikiriza okukozesa emiringo eyobwire buringwa yebarira yaruzaaro. Ninyendo nokuzaara kandi karinda oruganda bakabara kowayogyeyire ahahungu bworuganda rwangye. Nabwekyo tikeikiriza omukazi wangye kukozesa omuringo gwebarira yaruzaaro.

**I: Hariho omuhanda ugu emitwarize yekinyakare erikuzimbira ebitekateko byawe ahari emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro**

R4: Kurugirira ahamicwe yekinyakare nituta omugasho ahamwana wobwojo bwenu nyowe komusheija oine abahara bonka ninyija kugumiza ndikuzaara kuhisya ahundazarire aboojo.

R10: Ahabwagye, Abakiga emitwarize netuhabura ngu kandi tuhereze ekitinisa omusheija orikuba ayine abaana baboojo nabahara. Nabwekyo, tindikwenda omukazi wangye ngu akozese omuringo gwebarira yaruzaaro nahugwakuba ogwobwire bugufu nari ogwobwire buringwa.

R7: Emitwarize ekinyakare hamwe noruganda rweitu, nibituhabura itwe abasheija kuzaara abaana bingi abareije kureberera obugeiga bweite nka omusika. Bwenu tushemereire kugira abaana bingi. Kwogyeraho kokuzara abahara bingi kandi bakashwerwa nibareeta ejugano zente hamwe nebuzi kandi otungye obugeiga ekyo nikirungi ahanka. Kwogyera ahandyekyo emitwarize yabakiga, omusheija ashemereire kugira abaana bingi kokukirikubasika kandi nahabwekyo kokuzesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro tikirikubasika kuzara abaana bingi.

R2: Ninyenda kuzaara abaana bingi kurinda kandi kagumya oruganda. Kundikwikiriza omukazi wangye kukozeza imbarira yaruzaaro ekyo tindikwija kukihikiriza. Nahabwe egyoshonga, tikeikiriza omukazi wangye kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro. Eka yaba eyine abaana bingi kandi baza kuhinga nibahinga ekirakihango kyokweeza ebyokurya kandi egyoka negira ebyokurya birikumara hamwe nesente zirikuruga omukuguza ebyokurya byeshagye.

R5: Nyowe komusheija ninye mukuru weeka, kandi shemereire kuba omwe wokwikiriza kukozeza nari kuzimbira kutakozeza akajuma komuringo.

R9: Abaana bingi kukirmunonga abahara kandi kangira omugisha bakashwerwa, nituga ente kandi obwenobugeiga omuka. Nahabwekyo, nikiriza omukazi wangye kukozeza imbarira yaruzaaro tukutunga abahara barikumara kandi ekyo nikimanyisa okungira entekye.

**I: Nitubasakukoraki kuhangira abakazi beitu kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro?**

R7: Nitwetenga endijo miringo nka eyobuzarwa kwihaho emiringo eyemibazi..

R4: Nobasa kutekeho emihanda yokukyendeza ebitari birungi ahabarira yaruzaaro reero tubone kungihangira?

## RUKIGA TRANSLATION OF INDIVIDUAL INTERVIEWS

### MUKO SUB COUNTY

#### Individual Interview in Rubanda Muko Subcounty (I-RM)

**Participant 43 (P:43) is 32 years old with six children.**

**I: Noyetegyereza ota imbarira yaruzaaro**

Embarira yaruzaaro nikimanyisa okuzaara omwana omwe naribabiri konka batirikurenga bashatu.

**Ebyokureberaho emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro**

Ebikato ebya ebirikumara emyaka 3 and 5, Obujuma, okwihamu

**I: Nibitekatekoki ebimwine ahabarira yaruzaaro kandi emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro? Okiririza omukazi wawe kukozeza emiringo egyo? Ahabwenki?**

Embarira yaruzaaro ninungi, konka obuzibu nibwingi obukwatireineyo nka okutaza omumicwe, okuhagaha munonga kandi netumawagira oburuhe netuma yakozesibwa kubi.

**I: Nogambaki ahamiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro?**

Emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro nka ekikatu kyemyaka 3 hamwe nemyaka etaano nikituma omukazi yayoma munonga kandi yayanga omusheija nomuringo ngutarimurungi kukozeza omukazi.

**I: Okahangira omukazi wawe kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro**

P: Ingaaha, tindikuhangira habwe ebitaribirungi ebirikurugamu wakozeza egyo miringo yabarira yaruzaaro. Ndebire abakazi abamwe abarikukozeza imbarira yaruzaaro barikuremwa tongira endijo enda hanyima yokureka kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro. Abandi nibaba bahango

munonga kandi onshanga omukazi atarikubasa kutambura kiromita emwe arikuruha jumba.

**I: Heine ekimurikwenda kwongyeraho?**

Nanye nimpurira ngu abakazi nibajwa munonga bakozesa emiringo yebarira yaruzaaro kandi abandi ebikyeka byemibiri yaabo esisikara kandi nendwaza nakaasa. Nkakaheta komumukono abakazi abamwe nibetobeitwa ngu nikashanyaraza obwire bwingi. Abamwe tibakukwatagana nako kandi kakozesibwa obwire buringwa nikarengwa kugarukwa enyima. Okwogyera ahandyekyo abaana abamwe nibabasa kufa kandi wokwetega tuzaara omwana ondiyo obwire butakahwireyo nikiguma kugaruza enyima omukazi yaba arikukozesa imbarira yaruzaaro. Kwogyeraho omukazi nabasa kushabana hakuba nahamyagye ngu takubasa kutwara enda. Kwogyera ahandyekyo nokubanza wareeba yaba omuntu arikukwatagana nomuringo gwebarira yaruzaaro atakandikire kugokozesa. Abakazi abarikukiira kushemezibwa barikuzara nikirungi kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro kwetantara kutwa enda zitagyendereirwe.

**I: Heine ekyorikwenda kugamba ahamiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro ekwatireine nendini ahabarira yaruzaaro**

P: Nyowe ndomukurisitayo kandi endini yangye tirikugamba ahabyebarira yaruzaaro, konka Ruhanga akagira ngu tuzare twijuze ensi. Ekyonikimanyisa ngu wazara abaana bakye hanyima yokukozesa imbarira yaruzaaro tikiri eki Ruhanga arikwenda. Bwenu abarikukozesa emiringo yambarira yaruzaaro nibakora ebintu ebi Ruhanga atirikukunda. Kwogyeraho, abakazi beitu nibatiina kukozeza emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro hakuba abasheija nibangyenda kuzaara abaana abandi ahabandi bakazi. Nahabwekyo nabo tibarikuhangira imbarira yaruzaaro.

**I: Heine ekyorikwenda ekikwatireine nemitwarize yakare kandi nokukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro?**

P: Ebikwato byaba biriho byokureberera abaana omuntu nahaburwa kuzaara abaana bingi okwarikubasa kurungirira omumitwarize yekinyakare. Abaana baaba bingi noba ori omusheija wamani. Abazaire beitu nibangira nibenda owokusikira ebintu hamwe nobugeiga kandi omuntu nabasa kuzaara abaana bingi. Itwe nkabahingi kunu muri

Rubanda waba oyine abaana bingi, nibakuhereza amani gokuhinga okasharura ebyokurya bingi byokuguzza nokundya. Nahabwekyo waba nokozesa imbarira yaruzaaro, noferwa ebirungi bingi. Nyowe omutekateka yangye, imbarira yaruzaaro eshemereire kukoze sibwa abakazi bakuru abarengizye emyaka 35 abamazire kuzaara abaana abubarikwenda. Waba oyine abahara bingi, nibasa kutunga ente ezirkumara bazakushwerwa ezaboojo bangye barikwenda barikwenda kushera. Nahabwekyo abahara bingi aboyine nikworikuba omugeiga kyabaho katunga ente nobu ebiro byahati tokakihamy.

**I: Nihabasika kukoraki kuhangira abakazi okukozesa emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro**

P: okuteera omuranga ahabantu ahaburungi bwe emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro. Tunga emiringo yembarira yaruzaaro etarikureeta akabi ahabakazi. emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro neyokukozesibwa abakazi bakuri abangizire abaana abarikumara. Emiringo yobwire buringwa oburikuhinduka bwebaririra yaruzaaro neyokukozesibwa abakazi bakuru abeine emyaka 35 abamazire kuzaara.

**I: Heine ekyorikwenda kwogyeraho kubagana nitwe?**

P: Ingaaha, nabagana byoona ebinabanyine.

**I: webare munonga kuhayo obwire bwawe. Ninyija kugaruka obwire bwahehi kubagana ebirarugye omumushomo ugu.**

## ENGLISH TRANSLATATION OF FOCUS GROUP INTERVIEWS FOR KIBOGA DISTRICT

### Bukomelo Sub-County

Date: 15<sup>th</sup> June 2023

Interview time: 1 hour 10 min

#### BIODATA OF THE PARTICIPANTS

No.	Age	Occupation	Language	Tribe	Time spent in district	No. of children
K1	22	Motorcyclist	Luganda	Muganda	15	3
K2	32	Farmer	Luganda	Muganda	32	4
K3	23	Farmer	Luganda	Muganda	23	0
K4	44	Farmer	Luganda	Muganda	44	10
K5	39	Farmer	Luganda	Muganda	39	5
K6	46	Farmer	Luganda	Muganda	46	6
K7	48	Farmer	Luganda	Muganda	48	13
K8	38	Farmer	Luganda	Muganda	11	6
K9	30	Mechanic	Luganda	Muganda	18	2
K10	20	Farmer	Luganda	Munyoro	20	2

#### **I: What do you understand by family planning?**

K5: Family planning is spacing between children.

K8: I understand family planning the as giving little spacing between the children

K4: Family planning is what helps in bringing up children well and proper management of finances of the family.

K3: Family planning is about giving children adequate space of either 2 or 5 years so that they are well brought up and prevention of unintended pregnancies.

K9: Me I understand family planning as the prevention of giving little spacing between the children

#### **I: What are some examples of family planning methods.**

K4 for me the examples of family planning that I know include the coil that they put in the womb, capsules, and implants

K5 know there is natural whe6e you use safe days and withdraw. The woman can also use tablets as family planning methods.

K3-Me I know the withdraw method so that you do not finish in the woman

K8- The family planning I know are tablets

K2, I know God is family planning because he is one who gives children

**I: What are your views about family planning and the long-acting reversible contraceptive methods (LARCs)? Would you allow your wife to use the methods? Why?**

K2- Family planning is good as it helps in preparation especially finances for the children. Therefore, if it does not give my wife side effects, I can allow her to use the methods.

K1- The long-term family planning come with issues like low libido in women and to me, they are not good.

K4-The long-acting family planning methods are good but there are associated issues like over bleeding in women which deny their husband the fruit.

K 8 Family planning that are long-lasting is incompatibility with the body which may lead to cancers of the uterus. Therefore, I do not support their use.

K3 Long-term contraceptives are good because women reduce the frequent visits they would make to the hospital if they were using short-term methods

K5: [The methods]...leads to adultery by a woman because she knows they will not get pregnant and therefore she can easily go out for other men. For that reason, cannot support the method use by my wife.

K6: In my view, family planning that works for long time would be fine, but we have had many women getting problems with their body and therefore not a good method.

K9: Due to the low incomes of our families in Buganda, I have no problem with using family planning that lasts longer.

K10: To me I am of the view that a woman should produce the children the man wants and not use family planning since it will damage her body organs.

**I: What are your beliefs about the use of LARCs**

K8: Something should be done so that a woman remains in her normal state even after using a certain family planning method.

K4: There is increased expenditure while treating the side effects that arise from the use of LARCs

K2: "The LARCs make our women impotent and unresponsive when aroused in preparation for doing the adult game of the bed with her husband.



K7: True I agree with K2 that the woman is like the log in bed when the man wants to have access to the goods. Therefore, long-term family planning is not good at all and should not be accepted by the man in the home.

K5: Women's work output is reduced when the woman is using long-acting family planning methods. Thank means the family will not have enough food if a woman uses such long-term family methods because she becomes weak

K4: Since women using long-acting family planning bleed a lot, they get complications during the next pregnancy and are operated

PK9: Family planning especially those that work long is destroying the eggs of women rendering them unable to produce again. So those methods are not good at all.

K3-Reduced libido results in adultery on the side of men because the woman is using long-acting family planning and the man can go out to look for services somewhere else.

**I: *Would you encourage the use of LARCs by your wife? Elaborate***

K4: Women may leave marriages because they don't have many children there and they are still attractive to other men.

K5: A woman easily leaves the marriage if they don't have many children with the man.

K5: When they are calling women to come for family planning to the Health Centres, they tell them that the services are free but when they get problems and they want the methods removed, they are asked a lot of money or referred to places which require payment.

K9: Some women take longer to get pregnant when the period of using the long-term family method is done which is not good when a man wants another child.

K7: You see the problem they are telling us Baganda to use family planning (LARCs) when the Banyankole and Banyarwanda are busy producing as many children as they can. They will end up taking our land as many non-Baganda are already owning a very big chunk of land in our district.

K2: Why do they want us to use a long-term type of family planning (LARCs) when other tribes in our sub-county are producing like rabbits? Don't you think there is a motive for stealing our land as it is already happening? We cannot support such methods of family planning.

K6: As a man, I cannot allow my wife to use a long-acting family planning method except when we have finished producing.

K4: Long-term family planning can lead to difficulties in labour which lead to operation while giving birth. This is not good method for women as it damages them.

K5: Because the women using long-acting family planning have long libido, men end up going for younger girls outside their marriages and may get STIs and HIV. Therefore, to avoid that, the woman should not use long-term family planning services.

K1: In central Uganda, there are high campaigns for family planning, which could be a strategy to weaken the men in central Uganda.

P7: As a Catholic, I believe that family planning is murder and therefore not in support of it except for those methods where good is the one in control.

P5: suggests that one should produce any number of children they are comfortable with as long as they can take care of them and there no need for using a long-term family planning method.

P4: According to the bible, Family planning is not good as we need to produce and fill the world.

P8: Due to my low income of the I have no problem with family planning. It will help me to have the number of children in a regulated way.

P3: If one produces many children, they may end up on the streets, so I support the use of family planning.

#### **I: QN How does culture influence the use of LARCs?**

K4: Family planning including the long-acting one not good because even the ancestors used to produce many children and therefore, we should follow what they did.

K7: As a man, I should have both boys and girls and if the boys are few, I have to continue producing until when I have a good number of boys. According to our culture, if the man does not have boys to inherit his things, then he is not considered a man.

K5: we have natural methods of Family planning which were used in old days and were good and should be used instead of the one in the hospital.

K9: Family planning is not good because even in the past, the power of a man was seen in the number of children he has.

K3: He thinks FP is good due to reduce on expenditures in the homes if good methods are available and not the ones that cause bad effects on the body.

K8: Culture commands that people produce but as a person I support family planning including the long-term ones.

#### **I: What can be done to encourage women to use LARCs**

K 9: If the government can develop the local family planning ones instead of promoting the one for bazungu, that would be nice.

K1: they should make sure the long-term family planning ones have no bad effects on the bodies of our women especially bleeding and low libido. There we shall think of what to do to allow the women to use the methods.

K7: When my woman is using a long-term family method, when she wants to remove, they should not refuse to remove or ask her money as it is the case these days.

K4: They should introduce family planning methods that do not cause women to bleed nonstop and not causing low sex activity in women. There we shall support the women to use them.

**I: Is there any other information you would like to share?**

K 5-No due to the complications associated with all family planning methods especially those that work for long time, those methods should be stopped.

K3-For me I support the use of family planning because of the small income and property at home. If I don't use family planning, I will have many children close to each other and it will be very difficult to take care of them.

K 9 I cannot support all methods of family planning because of my cultural beliefs in many children, the low libido associated with the methods, cheating which leads to STDs in the family.

K1-I am not in support of family planning especially the long-term ones because they lead to unfaithfulness in the family because women are sure they will not get pregnant. They go out to enjoy other men.

**Thank you for your time. I will be returning to share with you the outcomes from this group discussion in the near future.**

## ENGLISH TRANSLATATION OF INDIVIDUAL INTERVIEWS FOR KIBOGA DISTRICT

Dwanilo Sub-county.

Individual interview: Participant No11(PKD 11) with 7 children and is 43 years old.

Date: 15<sup>th</sup> June 2022

### **I: What do you understand by Family Planning**

Family planning is about helping a child to grow well when there is adequate spacing before the next one is born.

### **I: Can you give me examples of Family Planning methods that you know**

Cutting tubes for women, Capsules, Condoms, IUDs, Injections, pills

### **I: What do you think about the use of LARCs**

**P:** The long-acting family planning methods are good but because of side effects like sexual argue, too much bleeding and destroying the eggs in a woman, it makes them not good at all. You can imagine a woman bleeding every day because of family planning, do not you think she can easily get problems and die? But also, as a husband, it means I will not fulfil my obligations as a man to build the home on bed matters. Family planning also I hear makes the woman very dry yet as a man, I enjoy the waters and therefore for that reason, I cannot allow my wife to use the long-term family planning methods.

### **I: Would you allow your wife to use LARCs.**

**P:** No, I cannot support my wife to use long term family planning even if they say they are good.

### **I: Why?**

**P:** You can imagine a woman bleeding every day because of family planning, do not you think she can easily get problems and die? But also, as a husband, it means I will not fulfil my obligations as a man to build the home on bed matters. Family planning also I hear makes the woman very dry yet as a man, I enjoy the waters and therefore for that reason, I cannot allow my wife to use the long-term family planning methods.

### **I: Any other reason why you cannot support her to use LARCs?**

**P:** Also, as a Muganda, I am only counted as a man if I have many children both boys and girls who can help me in day-to-day work in the home like farming. If I allow my woman to use family planning, she will produce few children and therefore I will not be fit to be called a Man. Also, currently I have only three girls and no boy and if I allow

my wife to use family planning, I will not have a boy. We have to continue to produce until when we have got enough boys and girls. Also, as a Muganda man I need boys some of whom will be an heir to me in old age and when I have died.

**I: Do you have any more reason for not accepting your wife to use a LARC?**

**P:** I am a good Muslim, and my religion does not allow us to use family planning other than a natural one. So, in order to stick to the teachings on my religion, the use of any modern method of family planning including those that work for a long time is not acceptable and I cannot support them.

**I: Is there anything that can be done so that you support the use of the long-acting family planning method?**

**P:** As per my religion and culture, I think I will only continue to support and practice natural family planning methods.

**I: Any more information you can share with more regarding long-acting family planning methods?**

**P:** Family planning that is modern is destroying the homes of people and women. People should go slow on them.

**I: Thank you very much for your time and for sharing with me about your ideas. In the near future, I will come back to give you the feedback of the outcome of this study.**

## LUGANDA TRASLATION FOCUS GROUP INTERVIEWS FOR KIBOGA

Bukomelo Sub-County

Date: 15<sup>th</sup> June 2023

Okubuza kwe Kibinja

Interview time: 1hour 10 min

### BIODATA OF THE PARTICIPANTS

No.	Emyaka	Omulimo	Olurimi	Tribe	Enywaka ebyomaze mukitundu	Olina abana bameka
K1	22	Avaga Boda	Luganda	Muganda	15	3
K2	32	Mulimi	Luganda	Muganda	32	4
K3	23	Mulimi	Luganda	Muganda	23	0
K4	44	Mulimi	Luganda	Muganda	44	10
K5	39	Mulimi	Luganda	Muganda	39	5
K6	46	Mulimi	Luganda	Muganda	46	6
K7	48	Mulimi	Luganda	Muganda	48	13
K8	38	Mulimi	Luganda	Muganda	11	6
K9	30	Makanika	Luganda	Muganda	18	2
K10	20	Mulimi	Luganda	Munyoro	20	2

#### I: Kizala gumba okitegera otya?

K5: *Kwekulekawa akabanga ngozala abana.*

K8: *Nkitegera nga okulekawo akabanga katono wakati wabana bozala.*

K4, Kizala gumba kyekiyamba okukuza obulunji abana no kubalabirira obulunji mubyenfuna.

K3: Kizala gumba ebera ku kuwa abana bozala ebbanga elimala nga emyaka 2 oba 5 osobole okubakuzza obulunjinokuziyiza okufuna embuto zoteyagalidde.

K9: Nkunze kitegeza okuwa abana bozala akabanga katono.

#### I: Mpayo ebika bya kizala ggumba byomanyi.

K4 Nze ebika bya kizala ggumba byemanyi mwemuli; akaweta ko mu nabana ne kapiso yomukono.

K5 Waliwo eyobutonde wetubalira enaku wotasobola funira lubuto. Omukyala asobola nokozesa amakerenda nga enkola endala eyakizala ggumba.

K3: Nze manyi obutamalira mu mukyala nga mwegatta.

K8: Nze enkola ya kizala ggumba gyemanyi ya makerenda.

K2: Nze manyi katonda kubanga yagaba abana.

**I: Dndowoza za ki zolina ku nkola za kizala ggumba ezebbanga eggwanvu? Osobola okukiriza mukyala wo okuzikozesa? Lwaki?**

K2, Kizala ggumba nungi kubanga eyambako okutekera tekera abana naddala mubyensimbi. Nolwekyo singa teretawo ncukacuka eri omubiri gwo mukyala wange nsobola omukiriza okozesa enkola zino.

K1 Enkola zino ezakizala ggumba zijja nensonga nga okukendeza obwagazi mu bakyala kunze, sinunji nakamu.

K4 Enkola zakizala ggumba nunji naye zesigamibwako ebintu nga okuvamu omusayi omunji mubakyala neziremesa abami babwe okwegatta nabo.

K 8 Ezikozesebwa ebbanga eggwanvu ziretawo kokolo wa nabana nolwekyo si ziwagira nakamu.

K3 Enkola za kizala ggumba empanvu nunji kuba zikendeza ku mirundi omukyala gyayina okugenda mu ddwaliro singa aba akozesa enkola ezebbanga elimpi.

K5 Zikuliriza omuze gwobenzi nobukaba mubakyala kubanga babera bekakasa nti tebasobola kufuna lubuto nolwekyo ayanguyirwa okubera nabasaja abalala.

K 6 Mundowiza yange enkola zakizala ggumba ezebbanga eggwanvu zandibade nunji naye tulabye abakyala banji nga bafuna okusomozebwa oba encukacuka mu mibiri gyabwe nolwekyo sinunji.

K9 Okusinzira ku nfuna entono mu maka gaffe wano mu Buganda, sirina buzibu bwona nankola za kizala ggumba ezebbanga eggwanvu.

K10 Nze ndowoza nti omukyala atekeddwa okuzala abana bona omusajja bayagala era teyandikozeseza kizala ggumba olwokuba nti eja kwonona ebi tundu ebyenjwulo mu mubiri gwe.

**I: Nzikiriza kki zolina ku nkola empanvu eza kizala ggumba?**

K8-Wabewo ekikolebwa omukyala asobola okusigala mumbera ze ezabulijo newankubadde nga ayina enkola zakizala ggumba zakozesesa.

K 4-Sente nyinji sifulumizibwa nga bajanjaba encukacuka ezibawo mu mubiri gwomukyala okuva mukukozesa enkola za kizala ggumba empanvu.

K 2 Enkola zakizala ggumba ziremesa abakyala baffe okwetegekera obulunji ebyomukisenge.

K 7 Kitufu nzikiriziganya ne k2 nti omukyala abera nga kiti mubuliri nga tayina bwagazinolwekyo enkola zakizala ggumba empanveu sinunji.

K5- Amanyi gomukyala mukola emirimu gakendera nga ali kunkola za kizala ggumba ezebbanga eggwanvu.Kino kitegeza nti ewaka tewaja kubelawo mere emala ngomukyala akozesa enkola zino.

K4 Olwokuba nti abakyala abali ku nkola za kizala ggumba empanvu bafulumya omusayi munji, bafuna ebizibu ngabazemu okufuna embuto eziddako nebalongosebwa.

PK9- Enkola zakizala ggumba naddala ezebbanga eggwanvu zi sanyawo amajji gomukyala naba nga tasobola kudamu kuzala nolwensoga eyo sinunji.

K3-Okukendeza obwagazi kiretereza obwenzi nobukaba kuludda lwabami kubanga omukyala abera kunkola za kizala ggumba ezebbanga eggwanvu era omwami yetanira bakyala abalala ebweru.

**I: Osobola okukiriza mukyala wo okukozesa enkola empanvu ezakizala ggumba?Weyongere okunyonyola**

K4- Abakyala basobola okulekawo amaka gabwe kubanga bayinamu abana batono ,babera bakyasikiriza abasaja abalala okubagala.

K5 Kyangu nyo omukyala okulekawo obufumbo bwe bwaba nga talinamu bana banji mubufumbo obwo.

K 5 Bwebaba bayita abakyala okujja kuddwaliro okufuna enkola zakizala ggumba babagamba nti byabwerere wabula bwe bafuna obuzibu bwona nebagala okuzijamu, basabibwa sente nyini oba basindikibwa mu bifo ebisaba sente.

K9- Abakyala abamu balwawo okuddamu okufuna embuto nga ekisera kyenkola za kizala ggumba ezebbanga eggwanvu ziweddeko, nekiba nga sikirunji kubanag omusajja aba ayaggala omwana.

K7-Olaba obuzibu obuliwo ffe abaganda batugamba okukozesa kizala ggumba kyoka nga a Banyankole na Banyarwanda bbo bali mukuzala abana boona bebasobola. Bajakumaliriza batutte ettaka lyaffe kuba era banji abatali Baganda wetwogerera balina ettaka eddene mu district yaffe.

K2-Lwaki bagala ffe tukoze enkola zakizala ggumba ate nga amawanga amalala mu gombolola lyaffe gazala nga bumyu? Olowoza tewaliwo kigendererwa kyakubba taka lyaffe nga bweguli kati?Tetusobola kuwagira nkola za kizala ggumba nga zino.



K6-Nga omwami sisobola kukiriza mukyala wange kukozeza nkola za kizala ggumba ezebbanga eggwanvu mpozi nga tumaliriza ddala okuzala.

K4-Enkola za kizala ggumba empanvu ziretera abakyala okufuna obuzibu nga bazala nebalongosebwa.

K5- Olwokuba abakyala bakozesa kizala ggumba tebalina bwagazi mubuliri,abami kibaletera okufuna abawala abato ebweru ate nabajayo endwadde zobukaba nga HIV. Okwewala kino, omukyala teyandikozeseza enkola zakizala gumba.

K1 Mu masekati ga Uganda, Uganda waliwo enkungana zokubiriza ku kizala gumba kayinza okuba akakodyo ko kunafuya abami mu kitundu kino ekya Uganda.

P7- Nga omu katuliki, nzikiriza nti kizala gumba kutta muntu nolwekyo sijiwagira mpozi kunkola ezimu nga Katonda yasalawo.

P5- Atesa nti omuntu azale omuwendo gwabana bawuliriramu emirembe ekikulu asobola okubalabirira nolwekyo kizala gumba teyetagisa.

P4- Baibuli egamba ,kizala gumba sinunji,kubanga tusana tuzale twale.

P8- Kulwenfuna yange entonosirina buzibu nankola za kizala gumba. Kija kunyambako okuzala omuwendo gwabana bensobola.

P3- Omuntu bwazala abana banji bamaliriza bali ku ngudo,nolwekyo mpagira enkola ya kizala gumba.

### **I:.Ebyobuwangwa bikwataganirawa nenkozesa empavu eza kizala ggumba?**

K4 Kizala gumba ngotadeko nezebbanga egwanvu sinunji kubanga nebajaja ffe bazalanga abana banji nolwekyo tulina obagoberera.

K7 Ngomusajja, ntekeddwa okuzala abawala nabalenzi era abalenzi bwebaba abatono nina osigala nganzala paka nga baweze,okusinzira ku gwanga lyaffe, omusajja bwaba tayina balenzi banji okusikira ebyobugga, talabibwa nga musajja.

K5, Tulina enkola zakizala gumba ezobutonde ezakozesebwanga edda ate nga zali nunji era zezandikozeseddwa mukifo kyezo eziwebwa mu ddwaliro.

K9- Kizala ggumba sinunji kubanga edda, obuyinza bwomusajja bwalabirwanga ku muwendo gwabana gwalina.

K3- Alwoza kizala gumba nunji kubanga enfulumya yewaka ekendera singa enkola za kizala gumba enunji zibawo okusinga ezireta encukacuka mu mubiri.

K8-Obuwangwa bulagira abantu okuzala naye nze nga omuntu mpagira kizala gumba ngotwaliddemu nezebbanga egwanvu.

### **I: Kiki ekiyinza okukolebwa okuzamu abakyala amanyi okukozeza enkola zakizala ggumba ezebbanga eggwanvu?**

K9, Singa Gavumenti ekulakulanya enkozesa ezafe ezawano okusinga eza bazungu,kiba kirunji.

K 1, Bakakase nti enkola empavu eza kizala ggumba teziyisa bakyala bubi naddala okuvamu omusayi nobutabera nabwagazi munsonga zekisenge. Awo tujja kukiriza abakyala okuzikozesa.

K7-Mukyala wange bwaba akozesa enkola empanvu ezakizala gumba, bwaba ayagala kujijamu abasawo baleme kugana kumukolako oba kumusaba sente nga bweguli ensanji zino.

K4 Baletewo enkola ezitaletera bakyala kuvamu musayi ogutakoma nobutanyumirwa byamukisenge.

**I: Bubakaki obulala bwoyagala okugabana?**

K 5- Enkola zino ezebanga egwanvu ziyimirizibwe kubanga ziyina ebizibu byezireta ngazikozesebwa.

K3- Nze mpagira enkola zakizala gumba kubanga ndi mufuna mpola. Bwesikozesa kizala gumba, njakuzala abana abokumukumu era kijja kumberera kizibu okubalabirira.

K 9 Sisobola kuwagira nkola zona eza kizala gumba kubanga obuwangwa bwange tukiririza mukuzala bana abanji, zikendeza obwagazi bwokwegatta, nobwenzi ekireta endwade zobukaba.

K1- Siwagira nkola zakizala gumba naddala ezebanga epanvu,kubanga ziretawo obutesiga ngana ewaka kubanga abakyala baba bamanyi tebasobola kufuna mbuto.

**I:Oba tiwakyaliyo kyona kyakutugamba, tweyanze tweyanze nyo ahabwobudde bwo obwotuwadde. Tujjakuba kukomawo omubisera byomumaso tukubulire ebivudde mu kunyonyeleza kunno.**

## LUGANDA TRASLATION FOR INDIVIDUAL INTERVIEWS FOR KIBOGA

### Dwanilo Sub-county

**Individual interview: Participant No11(PKD 11) with 7 children and is 43 years old**

**Okubuza kwa Ssekinoomu.**

**Date: 17<sup>th</sup> June 2022**

**I: Kizala gumba okitegera otya?**

Kwekuyamba omwana okukula obulunji nga otekawo ebbanga ngatoddamu kuzala.

**I: Mpayo enkola zakizala ggumba zomanyi?**

Okusala ensekezabakyala, kapiso, obupira, akaweta, amakerenda.

**I: Olowoza ki ku nkola za kizala ggumba ezebanga egwanvu?**

**P:** Enkola zino empanvu nunji naye zireta encukacuka nga; mubwagazi, okuvamu omusayi omunji, nokusiriza amaji, teziba nunji. Lowozamu ngomukyala avamu omusayi buli lunaku, olowoza tayinza funa buzibu naffa? Naye era nze ngomusajja kitegeza sisobola tukiriza buvunanyizibwa bwange obwomukisenge. Mpulira nti era kizala gumba ekaza abakyala ate nze ngo musajja nyumirwa omukyala ayina amazzi, nolwensonga eyosisobola kukiriza mukyala wange kukozeza nkola za kizala gumba.

**I: Osobola okukiriza mukyala wo okukozeza enkola empanvu eza kizala gumba?**

**P:** Nedda, sisobola kuwagira mukyala wange kukozeza nkola mpanvu ezakizala gumba newebangamba nti nunji.

**I: Lwaki?**

**P:** Lowozamu nga omukyala avamu omusayi buli lunaku, olowoza tayinza funa buzibu naffa? Naye era nze ngomusajja kitegeza sisobola tukiriza buvunanyizibwa bwange obwomukisenge. Mpulira nti era kizala gumba ekaza abakyala ate nze ngo musajja nyumirwa omukyala ayina amazzi, nolwensonga eyosisobola kukiriza mukyala wange kukozeza nkola za kizala gumba.

**I: Oyinayo ensonga endala?**

**P:** Nga omuganda ,mbalibwa ngomusajja bwemba nga nina abana banji, abawala nabalenzi abasobola okunyamba mumirimu jabulijo. Bwenzikiriza mukyala wange okukozeza kizala gumba, aja kuzala abana batono ddala nolwekyo sija kubalibwa nga musajja. Ate era obudde buno nina abana abobuwala basatu bokka, sirina mwana mulenzi, bwenzikiriza mukyala wange okukozeza kizala gumba sija funa mwana wabulenzi. Tulina okuzala paka nga tufunye abana abamala. Era nga omuganda netaga abalenzi abanabera abasika bange nga nfudde.

**I: Oyinayo ensonga endala eziyinza okugana okukirizza mukyalawo okukozesa enkola empanvu ezakizala gumba?**

**P:** Ndimusiramu omulunji, ate eddini ryange terinzikiriza kukozeza kizala gumba okujako eyobutonde. Nolwekyo, okugondera ensomesa yeddini ryange, enkola zakizala gumba ezize kati tezikirizibwa era sisobola ziwagira.

**I: Olowoza ki ekiyinza okukolebwa okusobola okuwagira enkozesa ya kizala gumba kulwenkola empanvu?**

**P:** Okusinzira ku ddini yange nobuwangwa, ndowoza njakweyongera okukozeza nokuwagira enkola zakizala gumba ezobutonde.

**I: Bubaka ki obulala bwoyinza okugabana ku nkola empanvu eza kizala gumba?**

**P:** Enkola za kizala gumba empya zisanyawo amaka ga bantu, abantu basana bazigendeko mpola.

**I: Webale nyo olwobudde bwo nokugabanako wamu nange endowoza zzo. Mu maso jebuja, njakudda nkubulire ebinaba bivudde mu kunonyereza kuno.**

## Annex 16: Profile of Experts and Key stakeholders consulted.

No	Age range	Qualification	Place of work	Designation
1.	30-40	MBCHB, MPH	Uganda MOH	Family Planning Focal person
2.	40-50	BNS, MSN, MPH	MOH	Registrar Uganda Nurses and Midwives Council
3.	30-40	BSc IT, MPH	Uganda Family planning Activity	National Family Planning Policy Advisor
4.	30-49	MBCHB, MPH	IntraHealth International-Eastern Uganda	Family planning Advisor
5.	40-50	BA, MPH	Development Media International-Uganda	SBCC Specialist
6.	50-60	BSc Midwifery, MPH	Reproductive Health Uganda	Family Planning Expert
7.	40-50	BA Social Works, MPH	Elizabeth Glaser Pediatrics AIDS foundation-South-Western Uganda	HIV Prevention Advisor/Family Planning Specialist
8.	40-10	BSc PH, MPH	Rubanda district	Senior Health Educator/SBCC Expert
9.	40-50	BSN, MBCHB, MPH	Rubanda District	District Health Officer
10.	40-50	MBCHB, MPH	Kiboga District	District Health Officer
11.	40-50	BA Social Works, MPH	Reproductive Health Uganda-Kampala	SBCC Manager
12.	30-40	BA Social Works, MPH	Family Health International (FHI360)	SBCC Advisor

13.	40-50	BSc PH, MPH	Reproductive Health Uganda- Tororo	SRH/Family planning Coordinator
14.	40-50	Diploma in Midwifery	Rubanda District	Senior Nursing Officer
15.	40-50	BSc Nursing, MPH	Kiboga District	Assistant District Health Officer Kiboga
16.	30-40	BA Development Studies, PGD	Kanungu District	Gender Expert
17.	20-30	Primary Seven	Rubanda district	Family planning Potential User
18.	20-30	Primary five	Rubanda district	Family planning Potential Users
19.	20-30	Primary Seven	Kiboga district	Family planning Potential Users
20.	30-40	Senior Four	Kiboga district	Religious leader Islam
21.	40-50	Senior Four	Kiboga	Religious leader Catholic
22.	30-40	Senior Four	Rubanda District	Religious leader Catholics
23.	30-40	Senior Six	Rubanda District	Religious leader Catholic
24.	40-50	Senior 3	Rubanda	Village Health Team
25.	40-50	Senior 4	Kiboga	Village Health Team
26.	30-40	Senior 2	Rubanda	Village Health Team
27.	40-50	Senior 4	Kiboga	Village Health Team

28.	30-40	Primary 7	Rubanda district	Representative of male participant
29.	20-30	Senior 4	Rubanda district	Representative of male participant
30.	20-30	Senior 3	Kiboga district	Representative of male participant
31.	30-40	Senior 4	Kiboga district	Representative of male participant
32.	40-50	Primary 7	Rubanda	Community Leader
33.	50-60	Senior 2	Rubanda	Community Leader
34.	40-50	Senior 4	Kiboga district	Community Leader
35.	40-50	Primary 6	Kiboga district	Community Leader

## Annex 17: Language editing certificate



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Date: 6<sup>th</sup> April, 2023

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, **Muchativugwa Liberty Hove**, confirm and certify that I read and edited the entire doctoral thesis, **STRATEGIES TO ENHANCE INDIGENOUS MEN'S SUPPORT FOR THE UTILISATION OF LONG-ACTING REVERSIBLE CONTRACEPTIVES AMONGST RURAL WOMEN IN UGANDA**, submitted by **Arineitwe Ronald Kibonire**, Student Number: **12749966**, in accordance with the requirements for the degree **DOCTOR OF PHILOSOPHY in PUBLIC HEALTH**, in the subject **HEALTH STUDIES** at the **UNIVERSITY of SOUTH AFRICA**.

**Arineitwe Ronald Kibonire** was promoted by **Professor David D. Mphuthi** of the University of South Africa.

I hold a PhD in English Language and Literature in English and am qualified to edit such a segment of a thesis for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s.

Yours sincerely

**Professor M.L. Hove (PhD, MA, PGDE, PGCE, BA Honours – English)**

