Research Protocol
Multi-Country Use Dynamic Study[1]
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The qualitative research for the proposed PAA paper is under way in three countries: Cambodia, Nigeria and Malawi. Data collection has just been completed in Cambodia and Nigeria and will start shortly in Malawi. The research is based on the following protocol.

Background & Rationale

More than 324 million couples in the developing world voluntarily use a modern contraceptive method. But another 180 million have an unmet need for family planning—they want to space their children or have reached their desired family size but do not use contraception. Strikingly, in developing countries, 41% of all pregnancies are unintended, and 35% of maternal deaths result from unintended pregnancies. Voluntary use of family planning can reduce these health risks and help women and men achieve childbearing intentions.

It is, therefore, important to ensure that women and men have access to a range effective of short-acting, long-acting and permanent contraceptives. Long-acting contraception and permanent methods are the least available, least used and possibly least understood methods in many developing countries. Long-acting methods (intrauterine devices and implants) and permanent methods (female and male sterilization) are safe and provide continuous protection. They can meet a range of clients' intentions (i.e., can help them delay, space, or limit births) and promote greater continuation of family planning.

Persistent rumors about long acting and permanent methods, poor provider training and logistical issues may undermine their acceptability and accessibility. Programs need to deepen the understanding of policymakers and program implementers about people's attitudes toward LA/PMs—positive and negative—and develop strategies to make correct, positive information available and offer high quality service delivery.

Little research has been done to fully explore the complex service-related, social, cultural and individual decision-making dynamics that interact to affect an individual's or couple's intention and use of LA/PMs:

- **Providers:** Provider influence is a key factors in LA/PM decision-making. Providers may have biases about what types of methods are appropriate for certain types of clients, or they may not understand that long-acting methods are appropriate for spacing and limiting. They may not take the time to ascertain a client's fertility intentions and suggest appropriate methods. In addition, when clients perceive that they have been negatively treated by their provider, they are much less likely to be open to suggestions for appropriate FP methods or adhere to use protocols. But when well counseled--an integral element of the fundamentals of care--clients trust and use the information they receive.[2,3] Providers therefore affect decisions made well outside clinic walls and can have a dramatic impact on family planning uptake, continuation, and positive attitudes about one's choice. For example, a six-country study on vasectomy revealed that while respondents across all countries reported hearing similar negative comments about the procedure, their concerns were dispelled when they received information from service providers.[4]

- **Social Norms:** Reproductive behavior and fertility intentions are socially constructed.[5] Community norms play a pivotal role in shaping attitudes toward contraceptive use. In parts of Asia, for example, a strong normative preference for sons affects fertility desires and contraceptive behavior. Women with more sons are less likely to want another child and are more likely to use contraception.[6] [7] Pressure from in-laws to have children soon after marriage is another key pressure for many women and couples.[8] Expectations about the "right" time to have a child forces many couples into child-bearing before they feel ready. The judgment and criticism of family, neighbors and community members may affect decisions about when to have a child as well as the appropriate number one should have. In some countries, women who do not space their births or have large families are stigmatized for being "uncivilized" or are labeled with other derogatory terms.[9] [10]

- **Spousal Communication and Trust:**. A woman's perception of her husband's approval of family planning can directly affect whether she uses contraception.[11] [12] At the same time, these influences and decisions are dynamic within couples. [13] As women age and have more children, spousal discussions about and agreement over the use of contraception, particularly LA/PMs, increases.[14] [15, 16] [17] Yet, family planning programs may not be effectively encouraging those discussions and providing supportive tools to enable them. More study is needed into what constitutes communication within marriage by examining the nature and quality of discussions, whether issues are resolved, and whether partners are satisfied with the results and committed to outcomes.[18]

  Spousal distrust and misunderstanding may also influence uptake of LA/PMs. Potential users of permanent methods express apprehension about the effect of vasectomy, for example, on the faithfulness of their partners. [19] Women may worry that without fear of pregnancy a vasectomy provides their husbands with the freedom to have extramarital partners, while men fear that rumored loss of virility from the procedure would lead their wives to be unfaithful.[20] Both underscore the view that fears about infidelity carry weight within relationships and in decisions to use LA/PMs. Decision-making within a marriage clearly involves a complex process of negotiation and discussion which impacts child spacing, contraceptive use, and agreement as to when to cease childbearing all together.[21] [22] According to Tanzanian women, for example, it is not just the vasectomy procedure that frightens men, but the entire concept of "planning one's family" that scares men who think the process requires periods of abstinence or unfulfilling sexual intercourse.[23] [24] Side effects such as excessive bleeding or spotting can interfere with traditional or religious practices and become a source of marital friction as sexual intercourse is suspended.[25] [26]

- **Intention**: Understanding fertility intentions and unmet need for family planning are key planning tools for family planning programs; however, such intentions cannot be understood through a simplistic and straightforward belief that a person either intends or does not intend to get pregnant and acts accordingly. Intention operates across a continuum that includes varying degrees of ambivalence about avoiding pregnancy, which is associated with imperfect use of contraceptives. [27] [28] [29] [30] In addition, many women may simply cope with the consequences of an unintended pregnancy.[31] While they may not intend to get pregnant, they also may feel powerless to prevent pregnancy. Many women may not relate their desire to space or stop childbearing with the need to take deliberate action through the use of contraception.[32]

Objectives of this study

To address the gaps in knowledge and contribute to RESPOND's mandate, the study has five broad objectives: .

- Deepen global understanding of decision-making and action-taking related to LA/PMs by
  - ✓ Clients who have chosen to use a LAPM (especially in low use settings)

  - ✓ Individuals with unmet need for family planning, for whom LA/PMs might be appropriate
  - ✓ Service providers whose attitudes toward and training to provide LA/PMs influence clients' choices
  - ✓ Influentials at community and national levels who affect policy and programs and their implementation
- Deepen understanding of differences between LA vs. PM decisions, and for LAs, the decision between IUD and implants
- Paired with the Futures Institutes DHS analysis for RESPOND, contribute contextual information to global policy dialogue on how to best meet unmet need
- Support policy dialogue at the country level (in countries chosen for the study)
- Support RESPOND's integrated interventions by highlighting concepts that support or inhibit demand for LA/PMs

The study will be qualitative to paint a picture of what people understand about the attributes – positive and negative—of LA/PMs, compared to all contraceptive methods, and how that understanding influences either method choice among users and potential users; the services provided to clients; or the policy environment. The study will also look at the cultural or normative underpinnings of people's attitudes, for example, gender dynamics or communication within couples.

Methodology

The study will be carried out using a phased set of qualitative approaches to elicit a nuanced understanding of LA/PMs in a variety of contexts. In each of the countries where the study takes place , data will be collected from four sites, balanced between rural and urban as indicated by the desk review. The study will follow the "classic" process of first holding a few key–informant interviews and FGDs at the study sites to set the context and get the correct vocabulary for exploring concepts in more depth. The focus groups will discuss the kinds of questions outlined above, as appropriate to each site, and ask the participants to create lists of terms for family planning concepts—reasons for using or not using methods, the names of methods, their positive and negative attributes, etc. Key informant interviews and focus groups will be recorded, if the participants agree and the tapes transcribed. One observer will also take notes on the atmosphere and non-verbal attributes of the interviews. After these groups, the textual data are analyzed and refined lists of key terms developed. While the study hopes to achieve a degree of comparability across sites and countries, these lists also need to use vocabulary familiar to the respondents.

After analyzing the transcripts researchers will develop lists of family planning methods known to the participants and the attributes of those methods or why a person might choose to use them. Participants in the next set of session will be asked to group these sets in any way that makes sense (using a technique called pile sorts[33]). Pile sorts are assessed to determine how closely participants associate the various terms. Thus the analysis—multidimensional scaling (MDS)[34]—can assess if individual LA/PMs are mainly associated with negative attributes or positive ones and whether they are associated with other contraceptive methods or thought of in a separate light. The MDS analysis results in a series of images that offer a visual interpretation of people's thinking. The data from this set of interviews include the piles of terms, which are entered into a computer program (Anthropac, for example) for analysis and observations from the researchers on why each participant made the piles they did. This textual information is key to interpretation. Researchers will take and transcribe detailed notes.

The selection of sites and numbers of participants will be based on convenience, in the sense that sites will be chosen from among those with which RESPOND partners and in-country sub-partners already have working relationships. This will allow the work to go more quickly since the basis of trust will already be established. The sites will be based in health facilities that

provide LA/PMs to maximize the chances of identifying respondents with knowledge of these methods. While the groups of people to be interviewed do not all have to be LA/PM users, if they have not at least heard of the methods, they will not be able to do the pile sorts linking methods and their attributes. The researchers will need to work closely with clinic staff to identify respondents in the various categories.

Confidentiality and Protection of Human Subjects

The research will be carried out using qualitative techniques, primarily key informant interviews and focus groups. The researchers will be careful to protect the confidentiality of the informants who agree to share their valuable time and thoughts with the research team. All interviewers will be asked to sign a pledge of confidentiality.

In addition, all respondents will be read, by the interviewers, an informed consent message (see attachment 2). They will be asked if they consent to the interview. If they consent, then the interviewer will sign that they have consented. If they do not consent, the interview will end. Five steps will be undertaken:

1. Each key informant will be asked to sign the informed-consent form (Attachment 2). Each of these forms will receive a unique identifying code, which will then be used on each page of the completed interview discussion guides. The completed discussion guides will be stored separately from their informed-consent cover sheets for the length of time required by EngenderHealth and USAID.
2. All researchers will create a password protected folder to store the completed interview discussion guides as they are transcribed. They will be filed only by the identifying code, not the name of the interviewee.
3. At the end of the project, all researchers will copy these files onto a CD or memory stick and remove the originals from their computers. The CDs will be sent to Nancy Yinger for appropriate storage. Researchers will not retain paper copies of these transcribed interviews after the assessment is completed.
4. Analysis of the interviews will be presented so that statements cannot be attributed to specific interviewees. They will not be identified in the reports by name or job title, if they hold a unique position.

References

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[1] The research is supported by USAID through the RESPOND Project, a five-year, USAID-funded, cooperative agreement (2009-2013) is working to increase the use of high-quality family planning services. [1] It addresses the unmet need for the healthy timing, spacing, and limiting of childbearing by improving access to long-acting contraception and permanent methods. This study will support RESPOND's work by collecting richly textured qualitative data on people's knowledge of and attitudes toward LA/PM's, particularly among early adopters and those with unmet need, as well as policymakers and service providers.

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