Operational Research on Consumers' Perceptions towards Implants as a Long Term Family Planning Method

ANGKOR RESEARCH

Contents

Acknowledgements

Angkor Research and Consulting Ltd. would like to thank the organizations and individuals that made this research possible. First of all from the United Nations Population Fund (UNFPA); Dr. Marc Derveeuw, G.L, Representative and Dr. Sokun Sok, Sexual and Reproductive Health Programme Specialist, for designing the overall study and assistance and expertise in designing instrument and sampling framework. Also the team from Merck for their assistance and funding of this project; our particular thanks to Brett Johnson and Anant Vailaya.

Thanks also to the National Ethical Committee for Health Research (NECHR) Cambodia for their support of this project and facilitation of necessary approvals to conduct this research.

Special thanks go to Prof. Tung Rathavy, Director of the National Maternal and Child Health Centre (NMCHC) for her overall guidance and support to research and Dr. Lam Phirun, Manager of the National Reproductive Health Programme (NRHP) for being a co-investigator of the research.

Mr. Ian Ramage oversaw the entire research project. Ms. Kren Bopha led the survey teams for the data collection, and Mr. Benjamin Lamberet was the Data Manager/Analyst, in charge of designing the database and overseeing data encoders. Mr. Lachlan Bruce was responsible for conducting the analysis and writing the report. Mr. John Nicewinter assisted with the sample design, questionnaire and data analysis, and edited the report.

Thanks to all of the project staff who collected the data, conducted quality control and supervision, and entered the data into the database. Lastly, but most importantly, we'd like to express our gratitude to the respondents and commune and village authorities who took the time to participate in the survey, providing us with valuable information about their lives and contraceptive preferences.

Executive Summary

Study aims

Merck contracted Angkor Research and Consulting to implement the NMCHC, MSD, and United Nations Population Fund (UNFPA) designed study on *Operational Research on Consumers' Perceptions towards Implants as a Long Term Family Planning Method* across three operational health districts in Cambodia. The study was commissioned with the broad aim of better understanding the determinants of contraceptive choice amongst Cambodian women, with specific focus on the Implant.

To meet these aims, a mixed method study was undertaken consisting of a quantitative study, in depth interviews and focus groups. Across all of these methodologies respondents were sampled from three distinct groups; current users of the implant, former users, and non-users. By gathering opinions and experiences from these three groups the perceptions and experiences can be compared and contrasted to better understand the determinants behind contraceptive method choices.

Results

What drives women to make specific choices for contraception? Including discontinuation and method switching

There were a number of factors which contributed to women's choice in choosing contraceptive methods, however the most commonly cited reason across all methods was that the method be 'easy to use' closely followed by the effectiveness of the method. Acting upon a recommendation was also a noteworthy driver, especially amongst those who had chosen the implant. Perhaps surprisingly the cost of the method was mentioned only by a small percentage of respondents as a reason for choosing one method over another.

In regards to reasons behind discontinuation, the most obvious reason that the woman wishes to have a child was excluded from the sample here because it is a well understood reason. With this removed by far the strongest negative factor for the medicinal based methods (implant and daily pill) were inconvenient side effects. A sentiment that was commonly discussed in the qualitative study was the importance of being able to work for Cambodian women, side effects which make work impossible or uncomfortable are the strongest driver to discontinue or change method.

The availability of Health financing schemes such as HEF, SOA, Voucher, etc were not a factor in women's choice for venue of contraceptive counselling or the chosen method itself. Looking specifically at the implant, no respondents from either the current or former users groups mentioned the availability of health financing amongst the reasons for choosing the implant. However, this is not to say that these schemes are unused; in relation to the implant almost half of respondents had received it for free. Contrasting this usage there was little to no knowledge of availability of financing schemes amongst the non-users of the implant, compared to the almost half who received the implant for free only a handful of non-users said the implant could be obtained for free when they were asked about their perception of price.

Assess the influence in decision-making of women's partners or other parties

Most women felt that they themselves were the main influencer over their choice of contraceptive method across all contraceptive types surveyed in this study. This was especially true for the daily pill and the implant which had a higher percentage of women who felt they were not influenced by others than the withdrawal method.

While the majority of women made their own decision related to contraception choice, this was not the case for all, some women were influenced by other people. Looking specifically at the role played by partners and husbands there was a significantly higher percentage of husbands which had influenced women to use the withdrawal method when compared with the daily pill and the implant. That is not to say that all women who are influenced primarily by their husband will end up using withdrawal method but that for women who are primarily influenced by the husband about contraceptive use there is a greater chance they will using withdrawal method than the daily pill and less chance again of them using the implant. Further, from the qualitative data gathered the influence of the husbands varies between individual couples varying from very positive to very negative influences.

Another influence to note is that of the health staff, who were strong influencers in choosing the implant. In fact more women had been primarily influenced to use the implant by their health staff than influenced by their husband, an opposite trend to the daily pill and withdrawal method.

Determinants for choosing or discontinuing the implant

In addition to looking at the reasons women choose to use the implant it is also pertinent to look at their initial source of information about the implant. The most common initial information source was the local health centre, where just under half of respondents found information on the implant, second to this was information from friends and family where almost one quarter of respondents first got implant information from. The role of family and friends is emphasised again when looking to the reasons respondents started to use the implant and the third most cited reason was a recommendation cited by more than four in ten respondents. Additionally more than eight in ten respondents said they would recommend the implant themselves, so we can certainly say that word of mouth recommendations are a strong determinant of implant choice.

While recommendations and word of mouth are a significant determinant, there were two reasons more commonly cited for starting use, in fact cited by almost twice as many respondents as recommendation; these were 'ease of use' and 'more effective'. Close to nine in ten respondents cited each of these reasons so we should consider them to be the strongest determinant to implant uptake but also be mindful of the role that recommendations play.

In terms of discontinuation of the implant there was one reason which was clearly more important than others in terms of both being recognised as a negative factor by current users and also the most common reason former user stopped using and that was the 'inconvenience of side effects'. The most commonly experienced side effect was amenorrhea or other period problems, experienced by over half of current and former users. As discovered through the qualitative section of the study it is not pure inconvenience of side

effects, but more that fact that it prevents women from working comfortably and effectively, that elevate inconvenience to the strongest determinant for discontinuation.

Women's perceptions towards family planning and contraceptives, the quality of counselling and services rendered

All women in this study were asked about their recent experiences with both the government health staff (for any treatment type) and also their recent experiences with contraceptive counselling for themselves or another. The telling point is the significant contrast between the two, government health staff were found to be impolite and the facilities to be dirty with long wait times which lead to very low satisfaction of respondents. On the other hand the satisfaction with contraceptive counselling and services was much more positive with over seven in ten respondents finding that the service was effective and only 3% found it ineffective (the remainder thought neither effective nor ineffective). This strong result, especially its contrast to general experience with government health staff, shows that the quality of contraceptive counselling is considered high by respondents.

Perceptions and misconceptions to long-term family planning methods (including the implant)

The perception of long term methods was quite favourable amongst the respondents, when asked about the type of women who use long term methods most respondents described a working class woman who wanted to postpone her childbirth so that she has time to work or do business. In all of the in depth interviews only a handful of respondents mentioned sex workers; and when they did they mentioned it alongside family women or business women. So there is no misconception that long acting methods are exclusively for sex workers or that by having an implant or other long term method women will be judged. This is backed by the findings of the quantitative study where the factor of 'stigma' only attracted nominal responses whenever asked in terms of the implants negative factors.

Possible barriers to accessing contraceptive care (including the implant), including users' perceptions of costs, user fees, existing financial support schemes, and any health care provider bias which could impact women's decisions

When the non-users perceived costs of the implant were compared to the actual costs paid by the users a discrepancy was revealed. On average the perceived costs were considerably higher than the actual costs paid, but perhaps most telling was the awareness of free implants. Only 5% of non-users responded that the implant was free, as opposed to close to half of users who actually received the implant for free. This suggests a lack of awareness of HEF and other schemes which supply the implant to poor respondents for free. This is supported by the fact when non-users were asked about factors which they thought would influence women to use the implant, none mentioned the availability of health schemes such as HEF.

However it is questionable how serious of a barrier this is given the fact that amongst actual users only a nominal amount mentioned the availability of health financing schemes as a re ason they chose the implant, as mentioned previously ease of use and effectiveness dominated this measure. Similarly amongst the non users only 5% mentioned the expense of the implant as a reason they felt women would not use. That said, increasing awareness of health financing scheme availability for the implant can potentially help

women to choose the implant over another more expensive method when both satisfy the key drivers of ease of use and effectiveness.

Accessibility and cost of removal experienced by former users and perceptions and knowledge of removal for current users.

A key finding in relation to the removal of implants was that over eight in ten respondents removed their implants early, before the date recommended by their health staff. This is backed by the fact that most respondents used their implant for one year or less. When analysing the reasons for discontinuation the most prevalent was uncomfortable side effects, as mentioned during the qualitative study this was closely tied to the desire of Cambodian women to work and do business. Connected to this reason was women who stopped using the implant due to the high cost of treatment and consultations of the side effects they were experiencing, suggesting it is cheaper to remove the implant than to treat it's side effects.

Current users were asked their perceptions around the cost and accessibility of their removals in the future. Tellingly, over six in ten of these respondents said that they didn't know how much the removal would cost, those who did know had varied answers between free and a highest of $20. This lack of knowledge around removal costs does not appear to be a strong barrier because although current users had low awareness of removal cost they still had the implant inserted in the first place, more than half of current users had the implant inserted even though they were unaware of how much it would cost to take out. Likewise access of removal does not appear to be a barrier in that all except for a nominal number of respondents said that they would return to the same place they had the implant inserted for their removal.

Background to the Project

The National Reproductive Health Program (NRHP) of MOH, with financial and technical support from MSD and UNFPA, has commissioned the Operational Research on Consumers' Perceptions towards Implants as a Long Term Family Planning Method with the broad aim of understanding the key determinants of women in choosing or discontinuing contraceptive methods. More specific goals of the research are:

- What drives women to make specific choices for contraception, including discontinuation and method switching;
- Assess the influence in decision-making of women's partners or other parties
- Determinants for choosing or discontinuing the implant;
- Women's perceptions towards family planning and contraceptives, the quality of counselling and services rendered;
- Perceptions and misconceptions to long-term family planning methods (including the implant);
- Possible barriers to accessing contraceptive care (including the implant), including users' perceptions of costs, user fees, existing financial support schemes, and any health care provider bias which could impact women's decisions.
- Accessibility and Cost of removal experienced by former users and perceptions and knowledge of removal for current users.

In June 2015, to meet the goals of the research, Angkor Research and Consulting completed a mixed method survey of three target groups; *current users*, *previous users* and *non-users.* Targeting these three groups allowed analysis to be undertaken as a whole on knowledge and perceptions of the implant, also the opinions of the three groups can be compared and contrasted to find if perceptions about the implant match realities of usage.

A mixed methods approach was used in this research to interview the three target groups described above:

- Quantitative interviews to gather data of implant experiences and perceptions
- In Depth Interviews (IDIs) to explore greater individuals detail and provide insight to quantitative findings
- Focus Group Discussions (FGDs) to further illuminate study findings

All of the above were conducted in three operational health districts; Kampot, Kroch Chmar and Mong Russei. Each target group and method above was split evenly amongst the three districts to ensure no bias in data.

Methodology – Quantitative

Sample Design

A total of 336 respondents were interviewed about their perceptions and experiences of contraceptive methods. These were split evenly amongst three target groups:

Current Implant Users - Women currently using the implant, who received family planning services from either public or private providers and have been using the implant for less than 2 years;

Former Implant Users - Ever-married women of reproductive age who have previously used the implant (within the last 2 years), and discontinued its use (for reasons other than pregnancy);

Non Users -Ever-married women of reproductive age who are post-partum by at least 6 months and have never used long-term methods of contraception (IUD, implant, etc.).

The respondents were also split geographically across three health operational districts (ODs); Kampot (Kampot), Kroch Chmar (Tboung Khmum) and Mong Russei (Battambang). These operational districts were selected due to the high concentration of implants as per the Implanon distribution data from the period of 2010 to 2014. In addition to a higher concentration of current and former users, these three regions provide representation in terms of urban / rural as well as access to different health financing schemes. These three operational districts were selected in co-operation with NRHP/NMCHC and UNFPA officers. Table 1 below details the Health Financing scheme available at the time of fieldwork in each operational district.

	Existing Health Financing and other schemes		
Name of OD and Province	**SOA**	**HEF**	**Voucher**
Kampot (Kampot Province)	No	Yes	Yes
Tbong Khmum (Tbong Khmum Province)	No	No	No
Mong Russei (Battambang Province)	No	Yes	No

Table 1: Health Financing Schemes by Province

Within each operational district (OD), 5 health centres were chosen at random to sample from all Health Centres in that OD. For each Health Centre, its containing village and some nearby villages was selected to interview respondents from. These villages were selected because it has been Angkor's' experience that the closer the village to the Health Centre the higher the prevalence of medical treatments and products is. It should be noted that this targeted method of sampling will not provide completely accurate prevalence information about the implant but will be fulfilled the goals of the research which is to better understand experience and perceptions of the implant, rather than measuring a representative prevalence.

Instrument

The instrument was designed in consultation with NRHP/NMCHC and UNFPA officers and measures the knowledge and perception of different contraceptive methods amongst women as well assessing the key determinants in choosing a contraceptive method. The instrument includes a screening form, whose purpose is to determine whether a respondent is eligible for the survey and if so which of the three sample

groups they should fit into. Following the screening section the instrument was designed in a modular way so that respondents are asked relevant questions depending on their experience, or lack of, with LAPM methods and specifically the Implant.

	Implant Users	Former Users	Non-Users
Respondent Background and Assets	✓	✓	✓
Knowledge about Contraception	✓	✓	✓
Contraceptive experiences			✓
Knowledge of the Implant			✓
Experiences with the Implant	✓	✓	
Removal of Implant		✓	
Perceptions of removal	✓		
Trust and Satisfaction with Health Care Providers	✓	✓	✓
Ranking Contraceptives and Information sources	✓	✓	✓

Table 2: Instrument modules

The instrument was pre tested on the 12th May in Kampong Cham province by one team of enumerators. Following this revisions were made to the instrument based on pre test findings. From June 8th to 12th the team completed one week of training at Angkor offices in Phnom Penh, including a second pre-test in the field. At the conclusion of training the instrument was finalised in both Khmer and English languages before fieldwork began on the 14th June.

Data Collection & Analysis

Data collection was completed by one team consisting of one supervisor, one editor, four enumerators and one driver / security from the 14th June to 2nd July. Due to the sensitive subject matter of this study (contraception) all enumerators, the supervisor and the editor selected were females. This was done to ensure the respondents felt at ease while participating in the interview and thus providing the highest quality data.

Initially three operational districts were selected in co-operation with NRHP/NMCHC and UNFPA officers. For each OD villages were selected based on proximity to the Health Centre in the OD as these villages will be more likely to contain a higher percentage of current and former implant users.

Within each village a mixture of purposive and random sampling was used. Initially field teams obtained a list of implant users from the local health centre and attempted to purposively seek and interview these women in the village. The lists provided some help in locating respondents but in some instances were unreliable or outdated so when enough current or former users could not be found; random sampling was used to locate more respondents. Random sampling was also used to locate respondents for the non-users group.

The random sampling was conducted using a modified version of the Expanded Program for Immunisation (EPI) Random Walk method. Using this method, the village population is ascertained and a sampling ratio is calculated based on the pre-determined required number of interviews. Key intersections in the village are identified and one is chosen at random. From this point, researchers turn right and walk down the

road/path selecting every Xth household based on the sampling ratio. At the end of the road they turn around and return and whenever they come to an intersection they always turn right. In this way the entire village is covered and all households have an equal chance of being included in the sample.

At each house, the enumerators firstly identified if there were any women of reproductive age to administer the survey to. If so, a short screening form was administered to determine which (if any) of the three target groups the respondent fit into. The prevalence of the non-users group was much higher than the other two groups, so non-user respondents were limited to ensure that they were spread evenly across operational districts.

Data was entered at the Angkor Research offices in Phnom Penh from 8th July to 20th July using a specially designed data entry system in CSPro. The data was entered using a double entry method, whereby the data is entered twice by two different data entry staff. Then any discrepancies between the two entries are resolved to produce a clean data set. The data was then analysed using SPSS.

Qualitative

In order to best understand the research aims a mixes method of quantitative and qualitative was used in this study. In addition to the quantitative interviews described above 45 In Depth Interviews (IDIs) were completed with respondents who had completed the quantitative also to gain a deeper understanding of the rationale behind their perceptions in the quantitative instrument. Also 6 Focus Group Discussions (FGDs) were completed; their purpose similarly to the IDIs was to gain a deeper understanding of respondents' experiences and perceptions but doing so in a group setting which allows respondents to discuss sensitive issues such as contraception more candidly and openly.

	IDI	FGD
Current Implant Users	15	2
Former Implant Users	15	2
Never used LAPM	15	2
Total	**45**	**6**

Table 3: Qualitative research by group

Sample Characteristics

The quantitative research into family planning was completed with 336 respondents with a response rate of 99.40%. Only one respondent did not complete the survey, this respondent was only able to partially complete the survey because they were busy selling at their shop. The respondent who refused did not provide a reason for refusal.

Response Type	N	%
Complete	335	99.40%
Incomplete	1	0.29%
Respondent refusal	1	0.29%
Total	**337**	**100%**

Table 4: Response rate from sample

The total sample was divided amongst the three target groups (current users, former users and non-users) and gathered across three operational districts in three separate provinces. Table 5 below, shows the composition of the sample in relation to target groups and operational districts.

	Kampot	Kroch Chmar	Mong Russei	Total
Implant Users	36	41	37	**114**
Former Users	37	34	38	**109**
Never used LAPM methods	38	38	37	**113**
Total	**111**	**113**	**112**	**336**

Table 5: Quantitative sample by sample group and operational district

Respondent Characteristics

Age

Respondents were only eligible for the study if they were of reproductive age (18-49) and ever married. Figure 1 below shows the distribution of age across the entire sample (n=336), from this we can see that there is a good representation of women from various ages within the range for this study. The vast majority of respondents were married (n=329). Only a small handful were either widowed (n=3) or divorced (n=3).

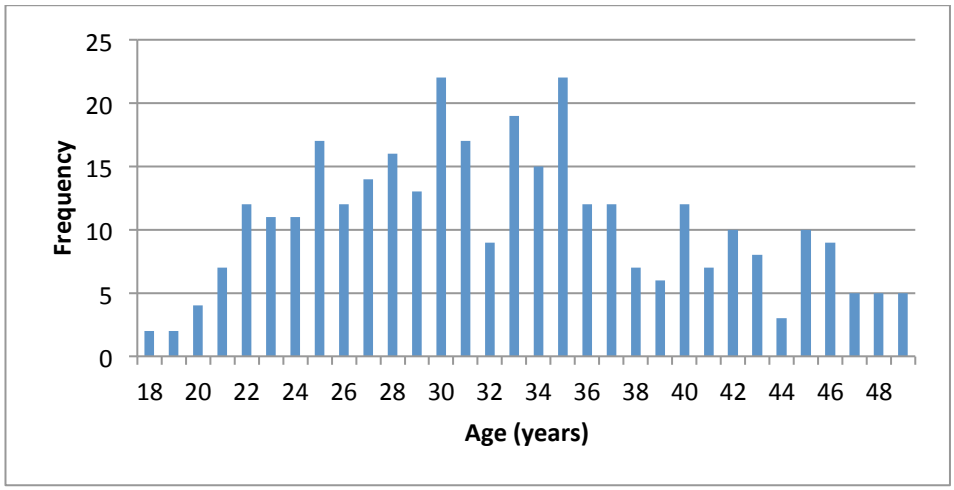

Figure 1: Distribution of respondents' age (n=336)

Number of children

All respondents had given birth to at least 1 child. The most common number of children was 2, the frequency decreases for each child after this until we see just a few outliers who have seven or more children.

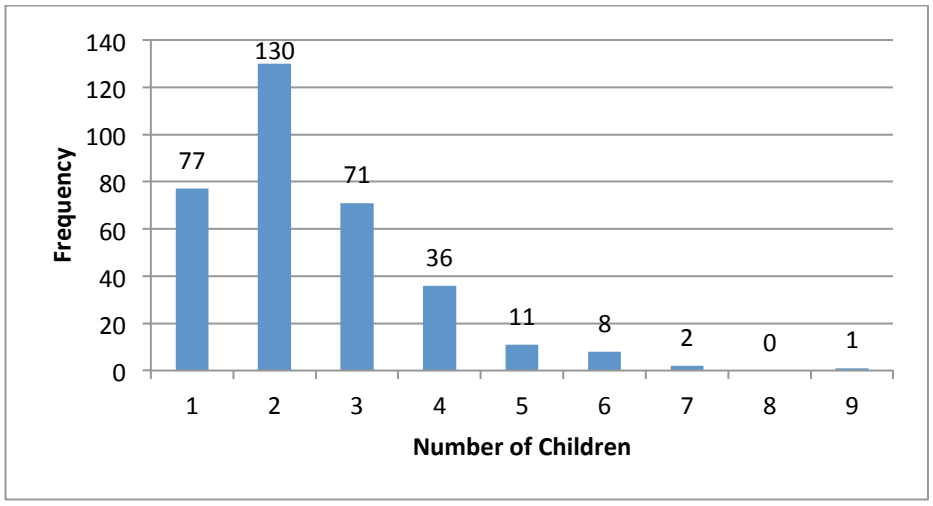

Figure 2: Number of children (n=336)

When looking at the total number of people living in the household the most common amount of household members was four, after this the frequencies decrease following a normal distribution and we witness some outliers of households with over 10 members. The average number of children under 5 years of age per household was 0.80.

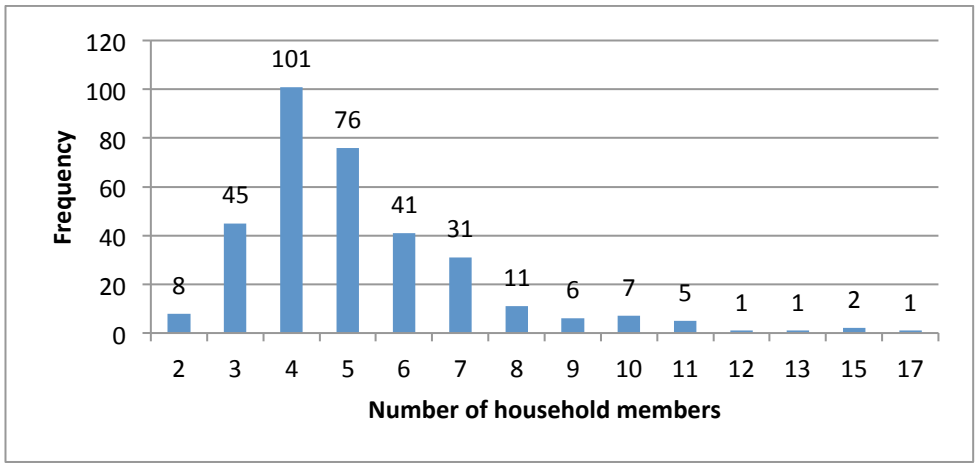

Figure 3: Number of household members (n=336)

Education

Most respondents had attended school at some point, 87.5% overall. Battambang had a slightly lower percentage (83.9%) then Kampot with 88.3% and Tboung Khmum was the highest of the three ODs with 90.3%. The respondents who had attended school at some point (n=294) were asked for the highest grade they completed. This is detailed in Figure 4 below, where we can see the most common grade completed was grade 6 (end of primary school) with a normal distribution of results falling around this. Only 1% of respondents had completed university.

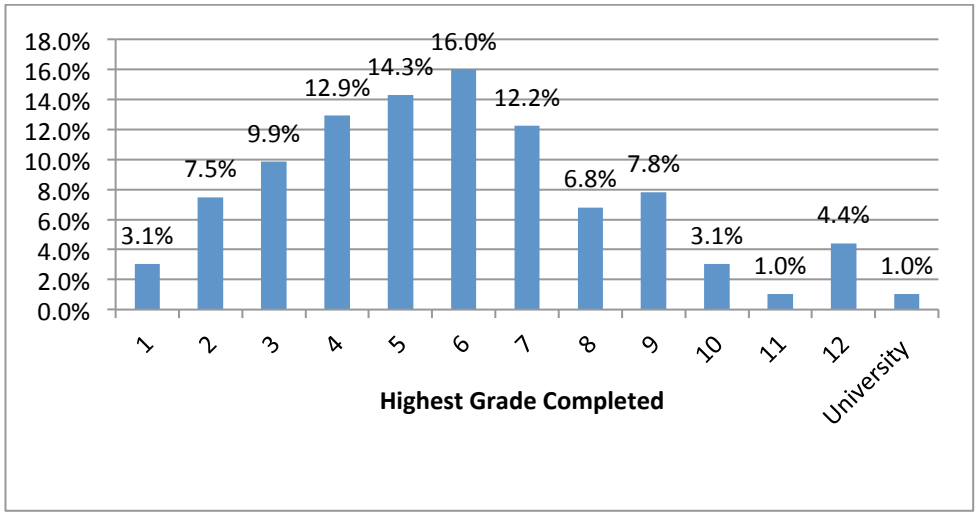

Figure 4: Highest grade completed (n=294)

Work and Income

Respondents were asked what their primary work is, the most common work overall was farming or fishing. Figure 5 below shows respondents work split by province as the area of the country will likely have an impact on the composition of respondents work. The largest difference is in Battambang (blue bars) where there is a higher percentage of respondents who work in farming or fishing and a lower percentage who work as labourers or in factories. This is representative of Battambang which is a more agriculturally based province and is far from the heartland of garment factories.

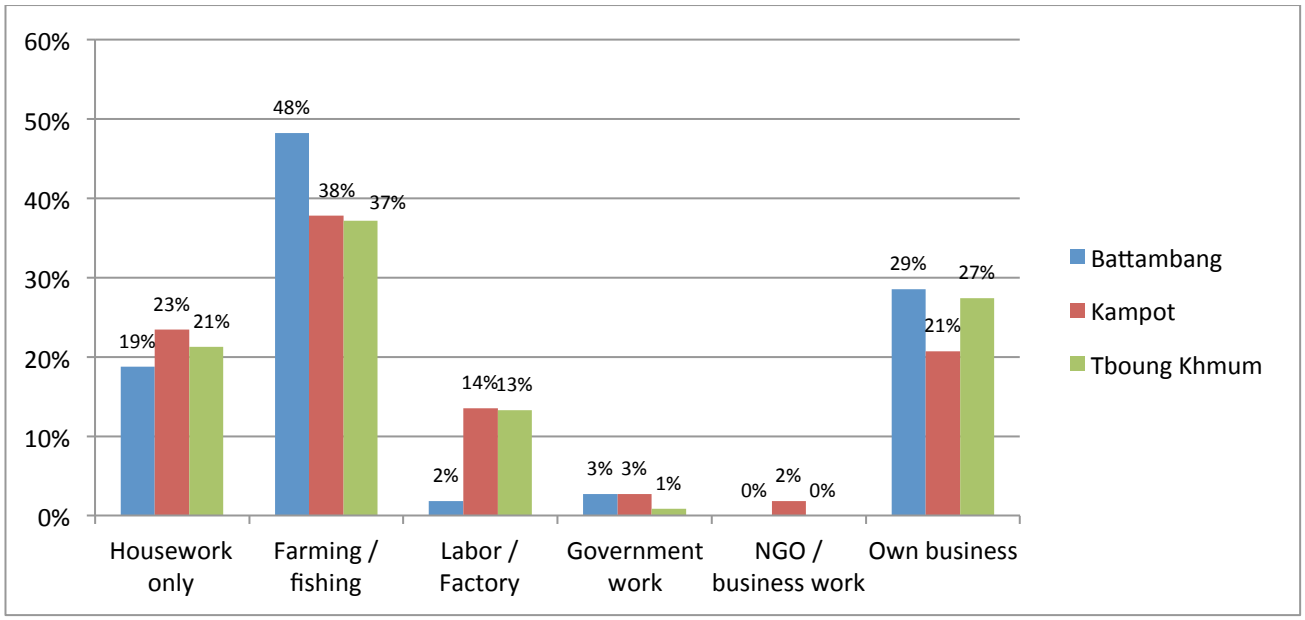

Figure 5: Respondents work (n=336)

Respondents were also asked what the main source of income for their household was. Again for the household as a whole there is a similar trend to the respondents' work, with Battambang taking a higher percentage from farming and fishing and a lower amount from labouring / factories. Interestingly we can see the gap between Battambang and the other provinces has closed considerably when related to the main income for the household suggesting that there are a larger number of husbands or other household members working most likely in labouring roles in Battambang.

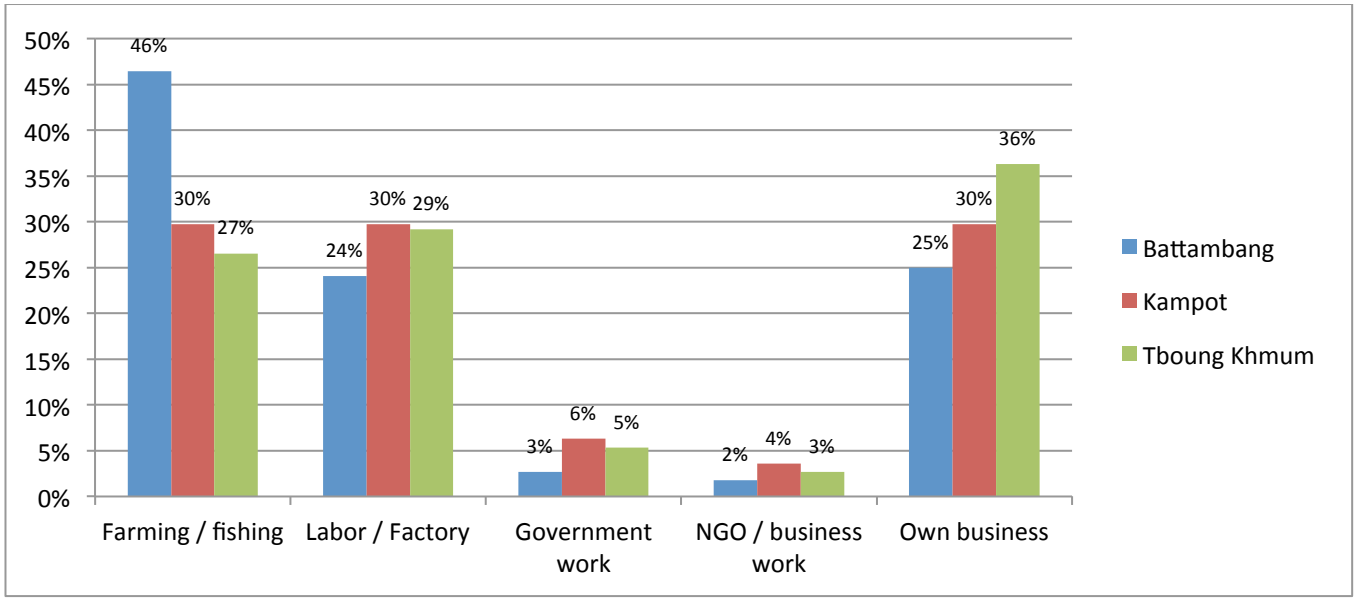

Figure 6: Main source of income (n=336)

Household Wealth Index

Angkor Research used the wealth index originally developed by members of our team in 2005, and used in numerous surveys since then, to calculate the wealth distribution of respondents in this survey. This index is fast and easy to administer in the field, making it an ideal addition to other metrics, and is very well correlated to other wealth ranking methodologies, such as IDPoor. This index comprises six components, whose weighted values are computed to obtain a final wealth score, ranging from 1 to 19. The detailed methodology for the wealth index can be consulted in Annex 1.

The wealth scores obtained for this survey follow a classic bell-curve distribution (Figure 7). The lowest score recorded is 2 (2 households), while the highest score is 16 (n=1). The mean wealth score for all respondents is 9.39, and the median is 9 (standard deviation=2.54).

We used these wealth scores to group respondents into three wealth group categories: the poorest, the poor and the better-off groups. The poorest and the better-off classes are chosen to correspond as much as possible to the lowest and the highest quintiles, respectively. In other words, each of these two categories represents around 20% of the sample population. Therefore, the wealth group categories were determined as follows:

Poorest = wealth score ≤7.25. This category represents 20.5% of the survey population.
Poor = 7.25 ≤ wealth score ≤ 11.5. This category represents 59.8% of the survey population.
Better-off = wealth score ≥ 11.5. This category represents 19.6% of the survey population.

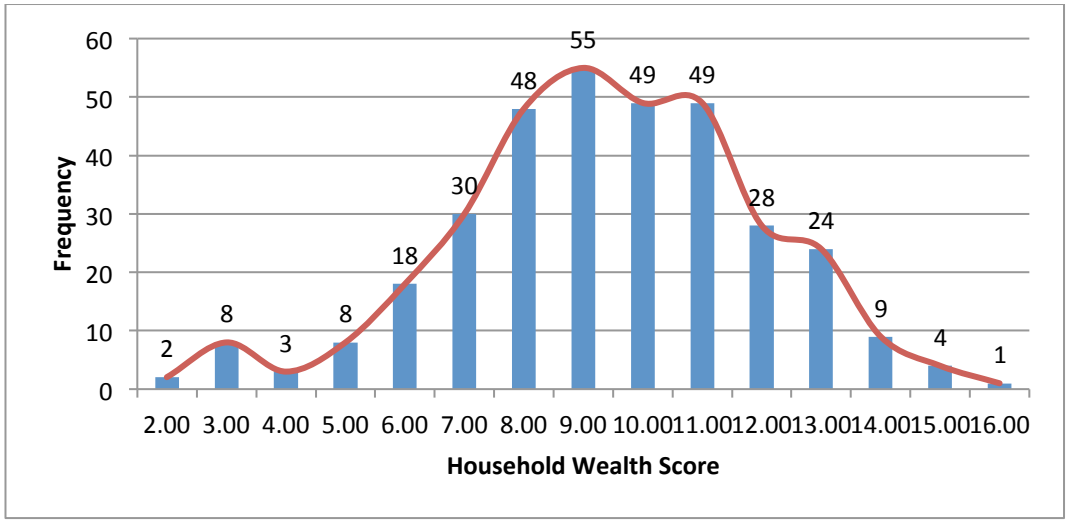

Figure 7: Household wealth score (n=336)

Household Debt

Overall 63.1% of respondents said that their household had some amount of debt, The differences between provinces is detailed below in Figure 8. Kampot has the lowest prevalence of household debt (under half) while Battambang is the highest where 81.3% of respondents said their household had some amount of debt.

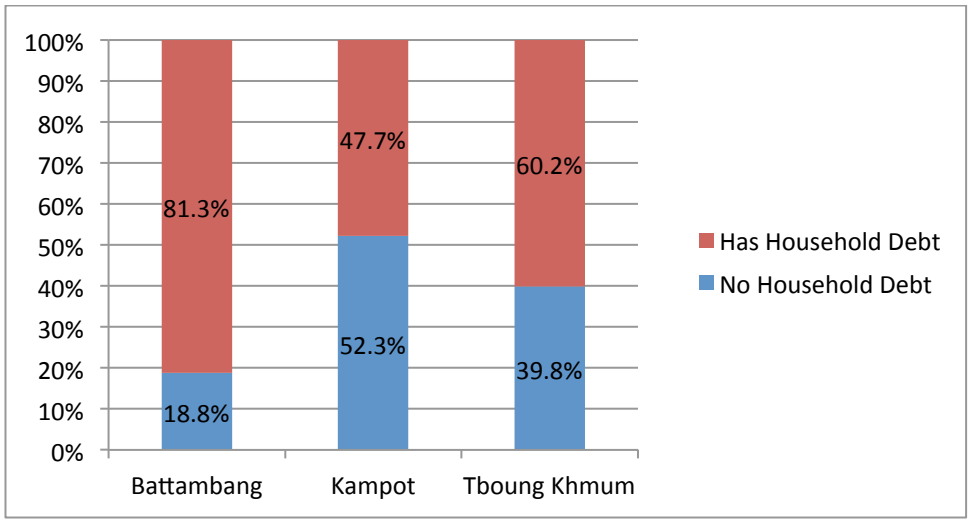

Figure 8: Household debt by province (n=336)

In terms of the amount borrowed the average debt overall was USD 2200[1], and the average monthly repayment was USD 476. Regionally Tboung Khmum had the highest amount of debt (USD 2691) and the highest monthly repayments averaging USD 778. In terms of user groups the former users had the most debt averaging USD 2836 total. It should be noted that these average figures appear to be higher than established averages for Cambodia, this is due to the fact that there was 12 respondents who had a

[1] All amounts in USD were asked to the respondents in Riel in the instrument. During analysis converted to USD using exchange rate of $1USD = 4000 Riel.

household debt of over $10,000 USD which inflated the average. The median amount of debt was USD 1000 USD and the median repayment was USD 75.

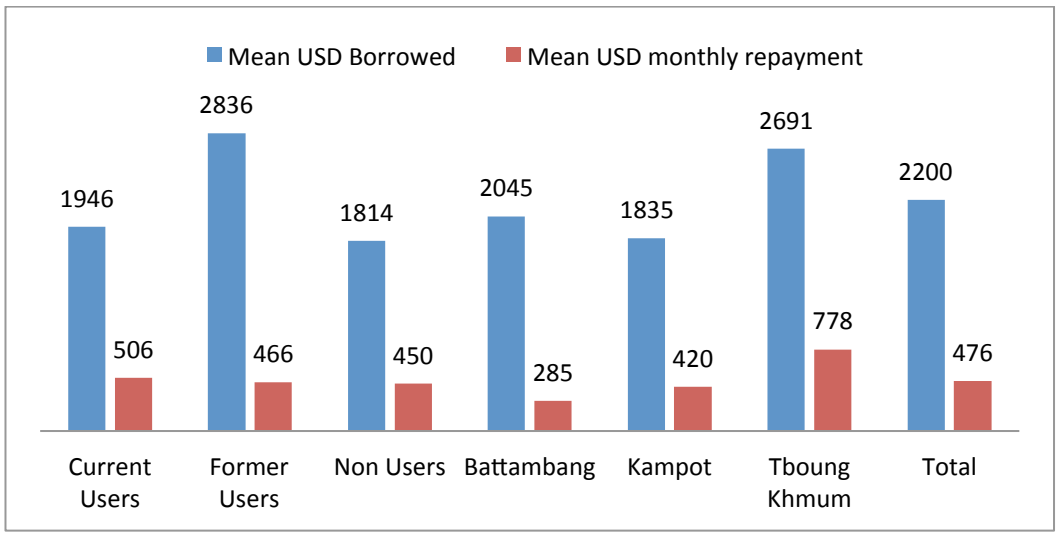

Figure 9: Average amount of household debt (n=212)

Lastly, respondents were asked how many lenders they had taken their debt from. The majority of respondents (151) only owed debt to one lender. 34 respondents had borrowed from three sources; following this a small number had borrowed from more lenders, up to nine lenders for one respondent.

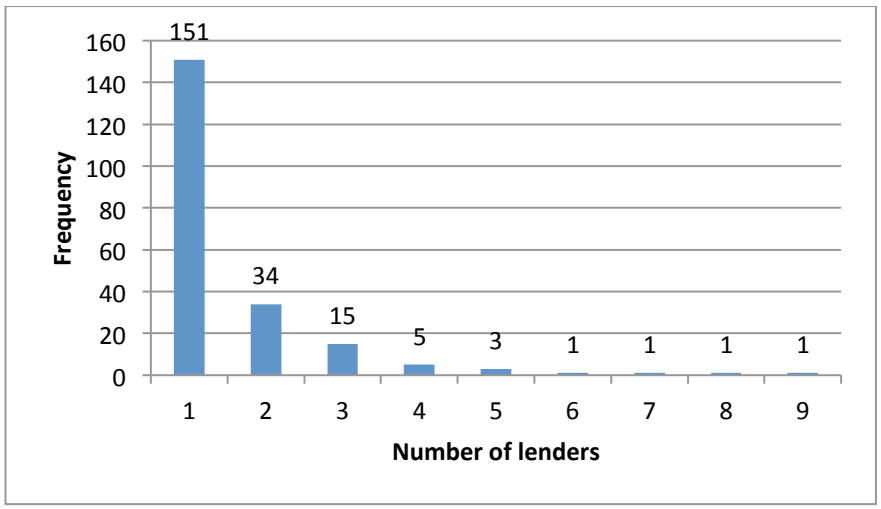

Figure 10: Number of lenders (n=212)

Knowledge of Contraception

In this section respondents were asked initially about their awareness of contraception in general and which methods they had heard of before. Additionally respondents were asked about their past experiences with contraception; methods used, age when they first started using contraception and the location where they initially obtained contraception from. This section was asked to all three target groups of respondents.

Awareness of Contraception

All respondents interviewed were aware of the concept of contraception, i.e. things that the man or woman can do to prevent the woman falling pregnant. Following this they were asked for which methods they had ever heard about. The most heard about method was the implant with 96.7% of respondents aware of it, however this figure cannot be said to be a true measure of awareness prevalence because two thirds of the respondents were either current of former users of the implant, thus inflating awareness.

Apart from the Implant, the daily pill was widely recognised by over 9 in 10 respondents. The long acting methods, Injection and IUD also had high levels of awareness (78.9% and 71.1% respectively). Just under half of respondents were aware of condoms. The least heard of method was the traditional method[2] with only 1.2% of respondents.

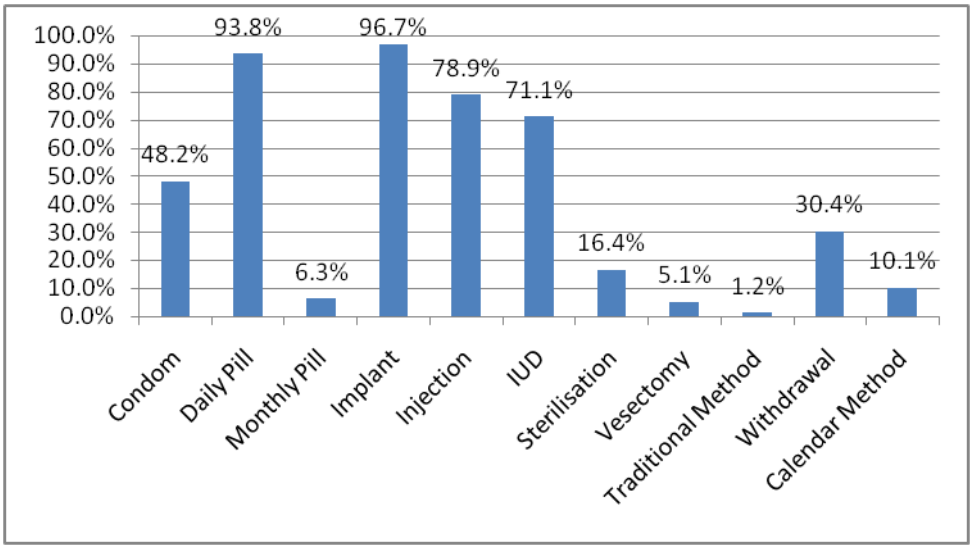

Figure 11: Methods ever heard about (n=336)

In addition to awareness of methods, data was also collected on which methods respondents had ever used. This has been graphed in Figure 12 below in the red bars alongside the previous awareness levels from Figure 11 so that the differences between awareness and use of the various methods can be contrasted. Once again the figures for the implant should be interpreted cautiously as they are the basis for the sample of this study so will not be accurate for awareness or use. The largest gap found between

[2] Traditional method through this report refers to traditional medicines, usually obtained through gru khmer doctor, used to prevent falling pregnant.

awareness and use is for the IUD where over 70% had heard of the method but only 7.3% had actually used it themselves. The daily pill was the most commonly used method with 63.4% of respondents having used it at some time in their lives.

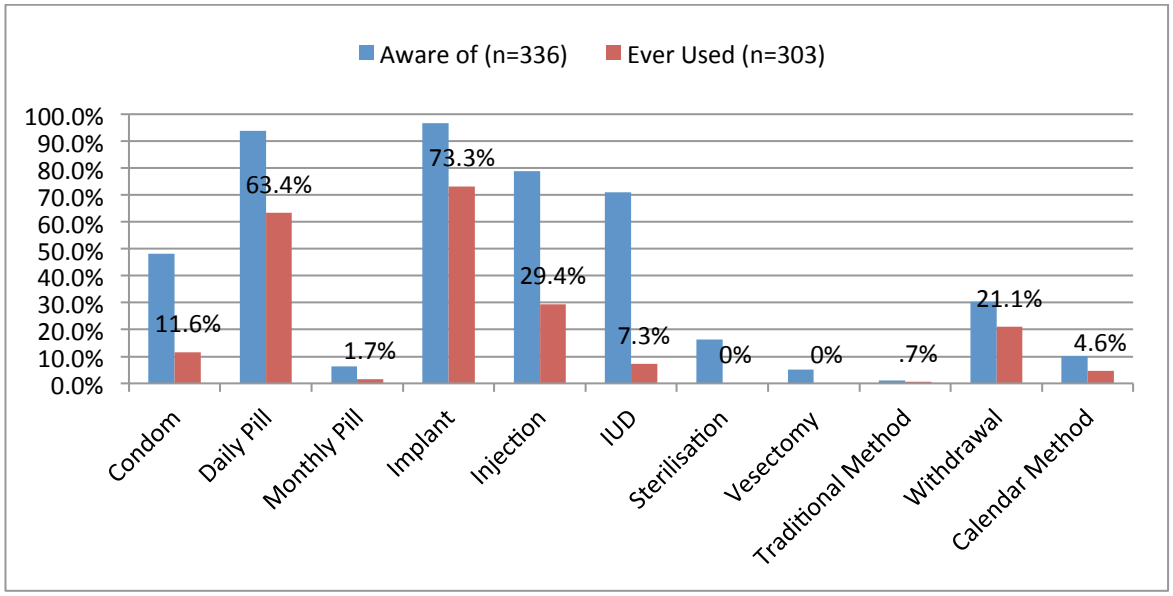

Figure 12: Methods use vs awareness

Initial Contraceptive experiences

The age when respondents first began using contraceptives varied greatly, the range was from 17 to 45 years and the average age was 26 years old. For more detail the age and frequencies have been graphed below, we would consider those who started under 20 years of age and above 40 to be the outliers with the largest grouping of frequency being in the 20's, with 26 being the most common age to start using contraceptives.

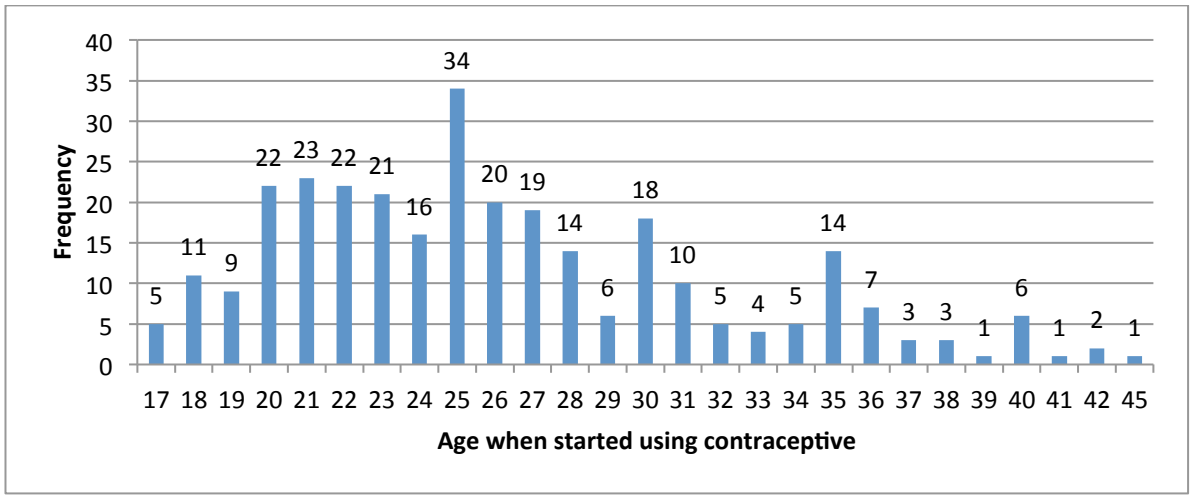

Figure 13: Age when started using contraceptive (n=303)

In addition to the age when first used contraceptive, respondents were asked also where they first sought contraceptive advice. By far the most common place was at the health centre (65.3%). Next was at a

private clinic with 13.2% followed by pharmacy with 8.6% of respondents. Interestingly 5.6% of respondents initially sought advice from a friend or neighbour in their village, twice the amount which sought advice from their husband.

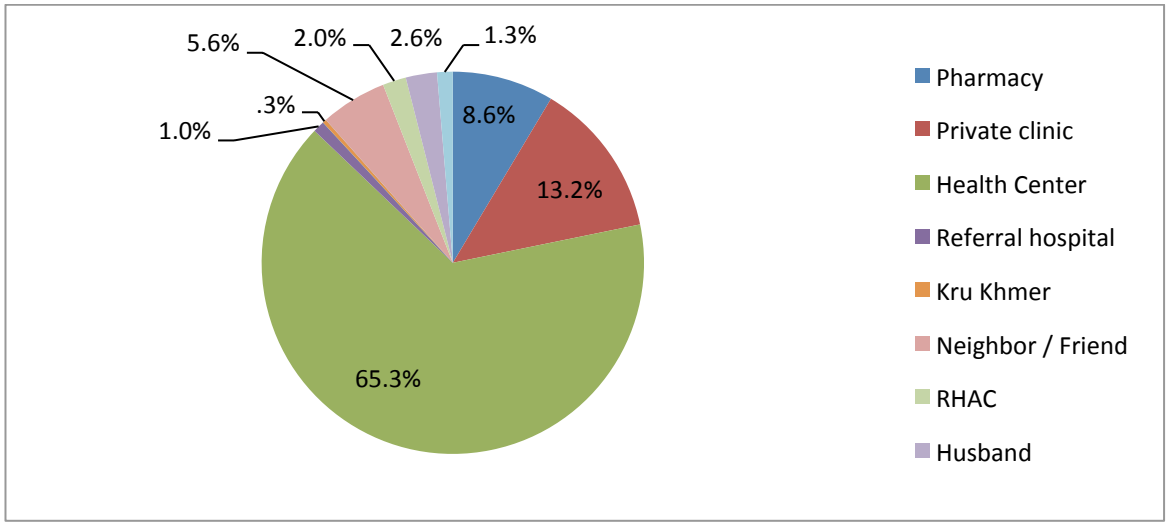

Figure 14: Place where first sought contraceptive advice (n=303)

This can further be analysed by comparing current, former and non-users to determine any significant differences. The first difference is in the percentage of respondents who initially sought advice at the Health Centre, for current and former implant users these were relatively similar (71.1% vs 68.8%) however for non-users this percentage is much lower (52.5%) and this difference is in fact statistically significant[3]. This shows that a woman who received contraceptive counselling at the health centre is more likely to use the implant than a woman who did not receive contraceptive counselling.

Another interesting feature of this analysis is that all respondents who said they initially went to their husbands for advice were non-users, however it is a very small number of respondents so we cannot make any solid conclusions from this but it is interesting to note and will be explored later in this report when analysing the role of husbands in contraceptive choices.

[3] Chi Square test was significant at $p < 0.05$ ($x2 = 5.2027$, $p = 0.022552$)

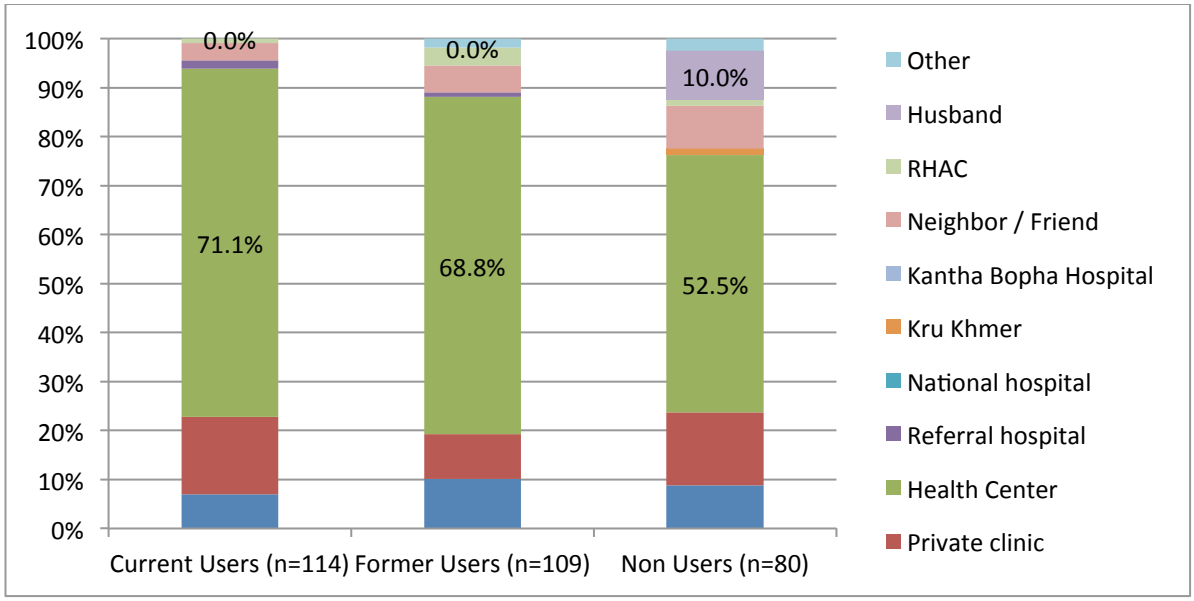

Figure 15: Place where first sought contraceptive advice by group

Respondents were asked the reasons that they chose that initial place for advice, the most common reason was that the place was close to their house with over half (52.5%) of respondents selecting this amongst their reasons. Also strong contributors were recommendations from friends or family and knowing the health staff. The availability of health financing was not a strong determinant with only a nominal amount of respondents selecting this amongst their reasons.

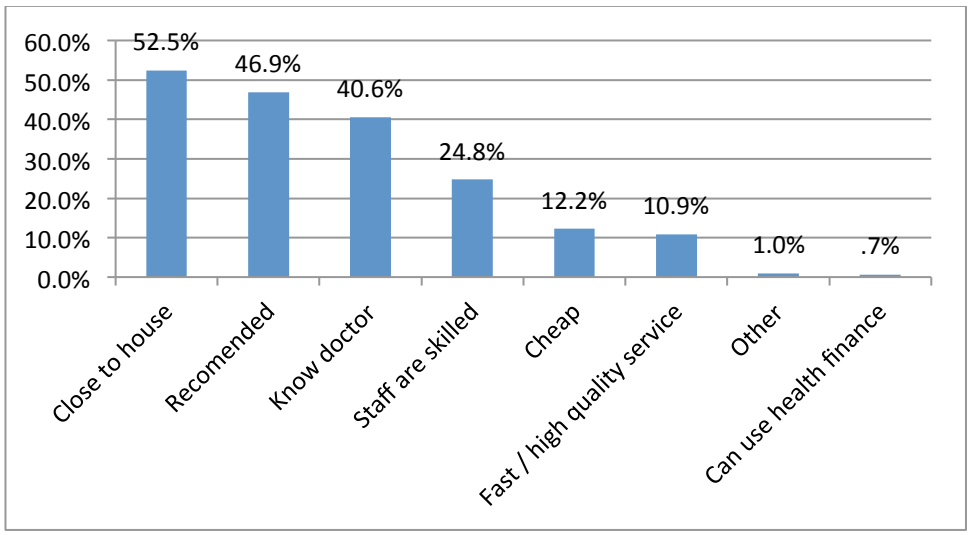

Figure 16: Reasons for choosing initial place (n=303)

Contraceptive Experiences of non- users of Implant

This section details the current contraceptive experiences of non implant users only. Firstly respondents were asked if they are currently using any contraception, and if so, which method(s). Further details about current method were explore including place obtained, reason for choice of method, cost of method and support schemes used.

Rate of Contraceptive use and Methods

The first piece of information to gather from non-implant users is if they are currently using any contraceptives at all; just under half (46.9%) were currently using contraceptive of some kind. Due to sampling this should not be considered a representative statistic of prevalence of use because any respondent who has ever used a LAPM including the implant has already been excluded.

Of those who are currently using contraception their primary method is detailed below in Figure 17. By far the most popular method is the daily pill, followed by withdrawal. Only a small percentage is using the calendar method and condoms.

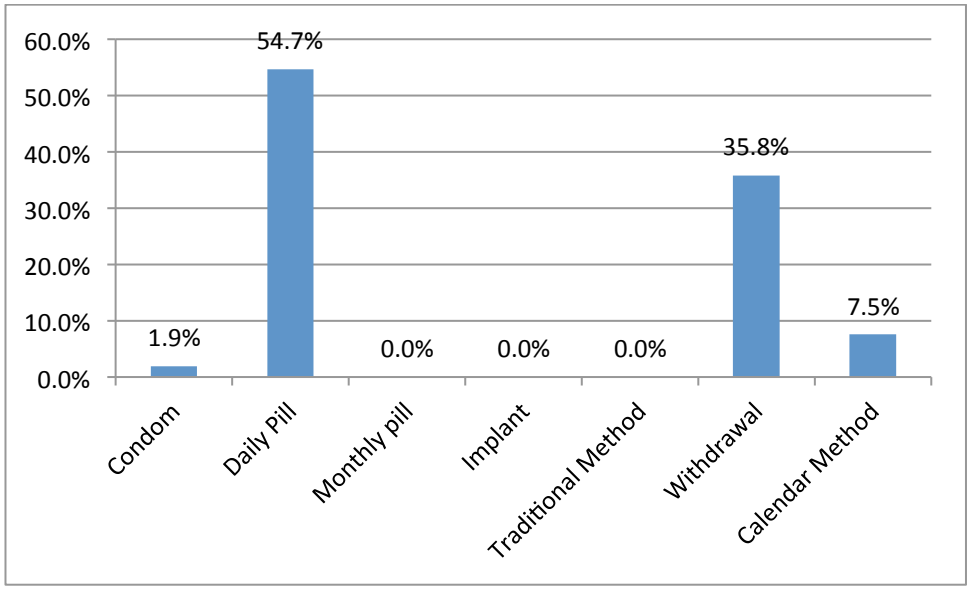

Figure 17: Current primary method of non-users (n=53)

Reasons for use and initial information sources

Of these methods above there is only sufficient base size to analyse further is the daily pill and withdrawal. So for these two methods the place where respondents first received information about them is below. The main information channels for the daily pill were the public health provider (44.8%), television/radio (24.1%) and family or neighbour (24.1%). Conversely for withdrawal the most common information source was family and neighbours (42.1%) followed by the public health provider (21.1%).

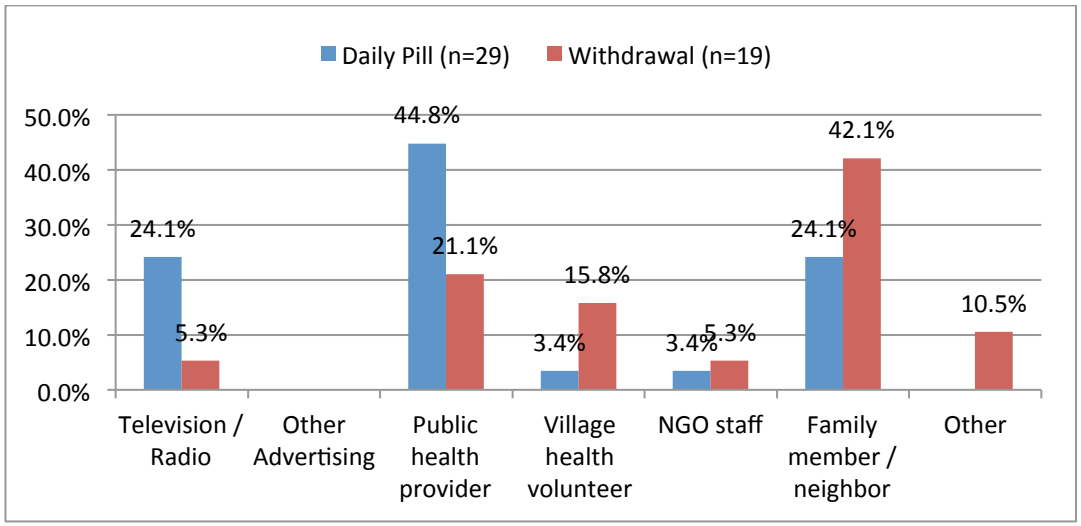

Figure 18: Initial information for daily pill and withdrawal

Looking next at respondents reasons for choosing either the daily pill or withdrawal we can see that a common factor for both is the importance of ease of use, the most frequent reason cited by users of both methods. Recommendation remains a strong reason for both methods, with withdrawal slightly higher at 31.6% of respondents.

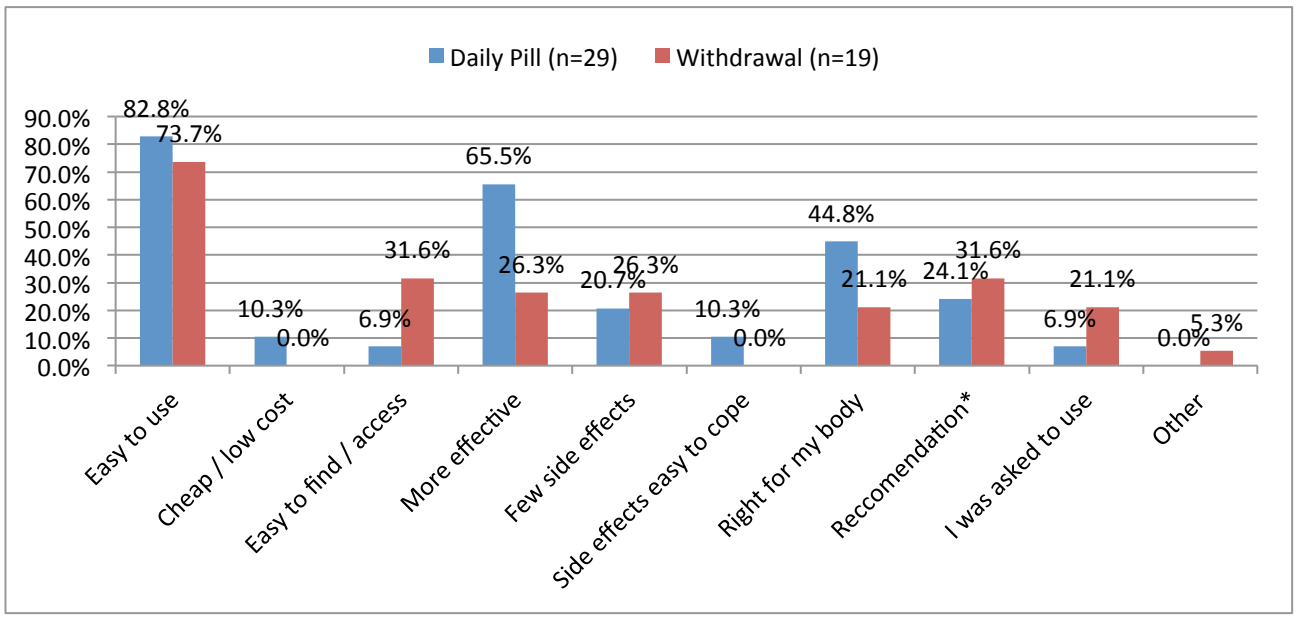

Figure 19: Reasons for choosing daily pill and withdrawal

**Recommendation from a friend, neighbour or family member*

Place where obtained

Looking at where these contraceptive methods were obtained we can only analyse the daily pill as the only other method with significant base size; withdrawal, does not need to be physically obtained from anywhere. So looking at the daily pill only below in Figure 20 we can see that the majority (86.2%) of

respondents obtained the daily pill from a health centre. Next most popular was private clinics with 10.3% of respondents and a small number obtained the daily pill from a pharmacy.

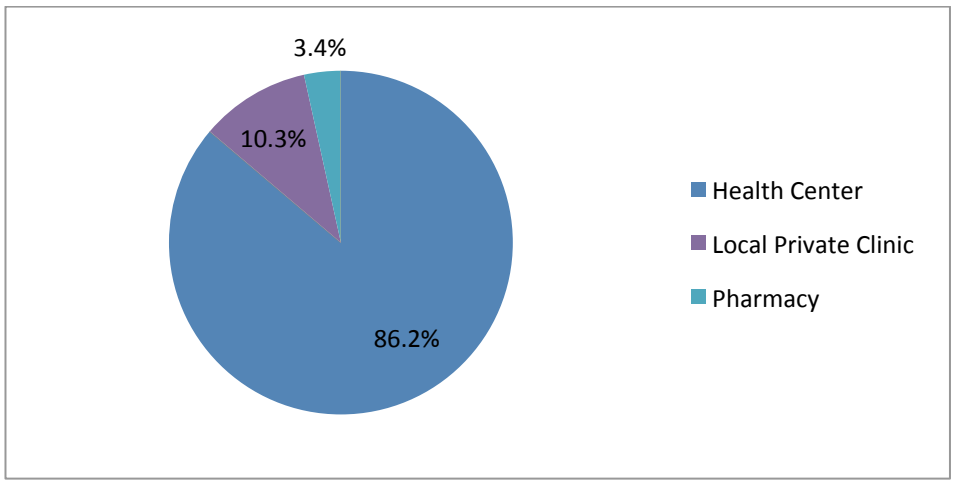

Figure 20: Where daily pill was obtained (n=29)

The reasons for choosing the Health Centre are displayed below in Figure 21 below. The strongest reason for using the health centre to obtain contraceptives was that it was recommended to the respondent (57.9%), also strong contributors to choice were the respondent knows the health staff (44.7%) and that the facility is close to their house (42.1%). No respondents mentioned the availability of health financing as a factor in their choice.

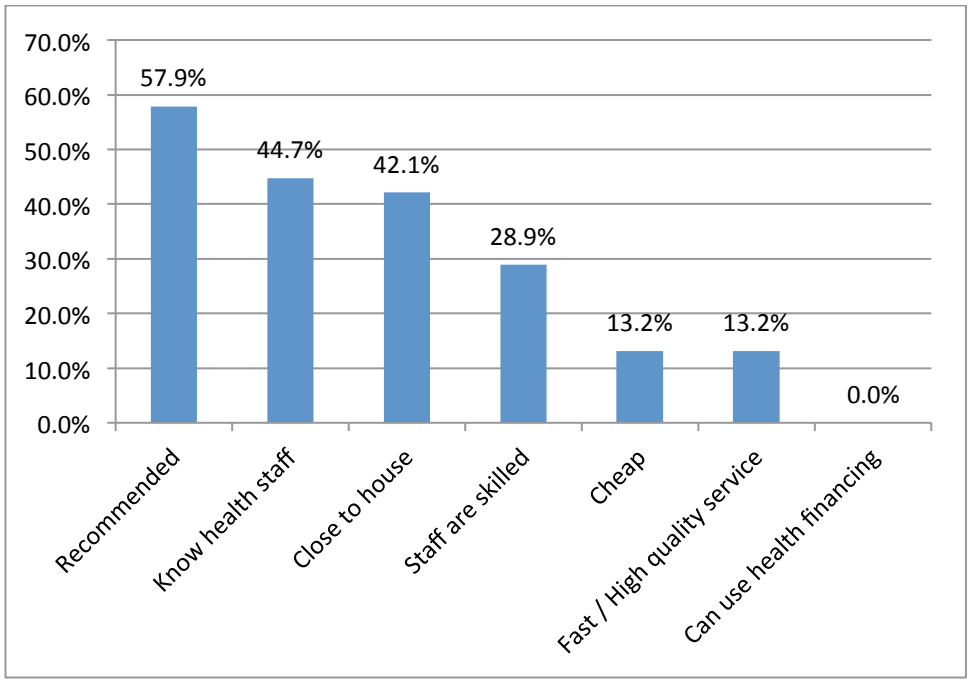

Figure 21: Reasons for choosing health centre (n=38)

Payment and Support Schemes

Being that the calendar method and withdrawal are methods which do not require any costs we can only analyse the cost of the daily pill as it is the only method with adequate sample. The minimum cost respondents reported paying for the pill was 500 riels, the maximum 40,000 riels per 3 month supply. The average cost of obtaining the daily pill was 4,483 riels.

Only 36% (n=16) of non-users had to pay transport costs to obtain their contraception, excluding respondents using withdrawal and calendar method as they didn't need to travel anywhere. For these 16 respondents their average cost of transport was 2688 Riels. Of the 16, only 2 respondents said their costs were reimbursed by a health financing scheme; one respondent through HEF and one through community health insurance.

Influencers of Choice

Respondents were asked initially if anyone or anything influenced their choice on contraceptive method, those were influenced were asked which source was their main influence. All respondents using withdrawal said they had been influenced by someone else, while 72.4% of daily pill users said that they had been influenced by another in their choice.

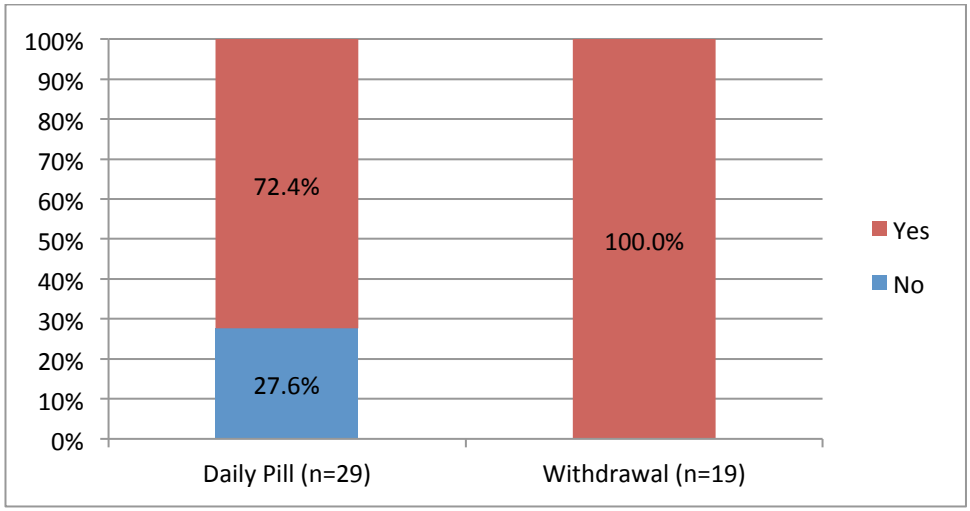

Figure 22: Did anyone influence your choice of contraception

When asked who was the main influencer in the contraceptive choice of respondents, an option for "no one / myself) to capture respondents who had some influence but ultimately felt the final choice was theirs. 81% of daily pill users felt this way compared to only 42.1% of withdrawal users. In terms of the influence of the husband, 42.1% of withdrawal users said that their husband was the main influencer compared with only 14.3% of daily pill users. Despite the small number of respondents asked this question the difference was found to be statistically significant[4], so we can say confidently that women who use the daily pill method are more likely to make the choice themselves without influence from their husband than those who practice withdrawal.

[4] Chi Square test was significant at $p < 0.05$ ($x^2 = 3.8721$, $p = 0.049096$)

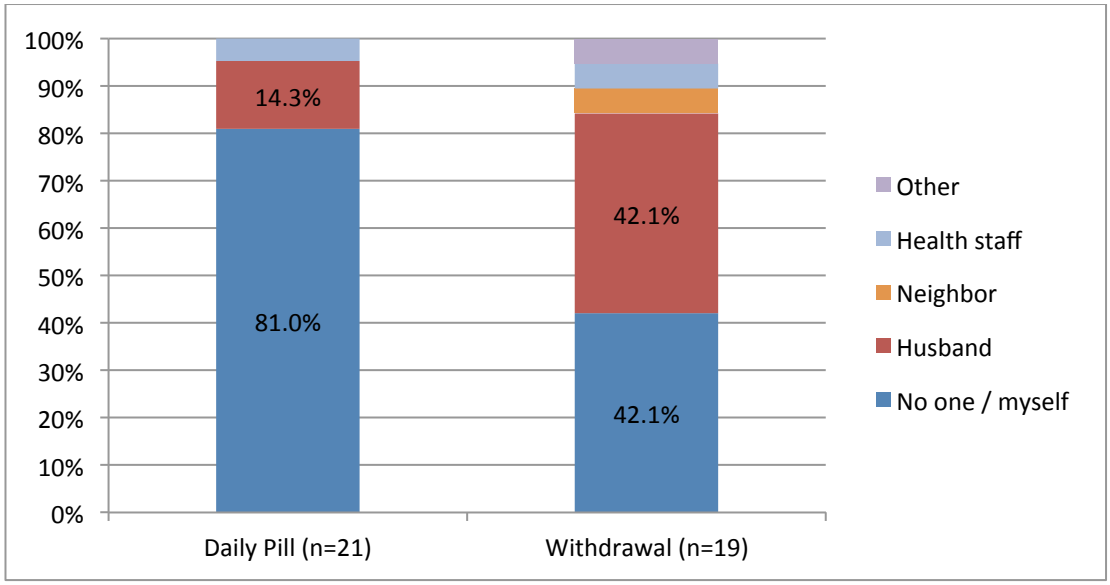

Figure 23: Main influencers of contraceptive choice

Positive and negative aspects of current method

When analysing the positive aspects it is again only possible to conduct analysis on the daily pill and withdrawal methods as these were the only methods with adequate sample. Both methods rated very highly for 'easy to use' withdrawal 73.7% and the daily pill 69%. Most other factors also recorded similar percentages, with the exception of the 'more effective' which was selected by over 30% more daily pill users than withdrawal users.

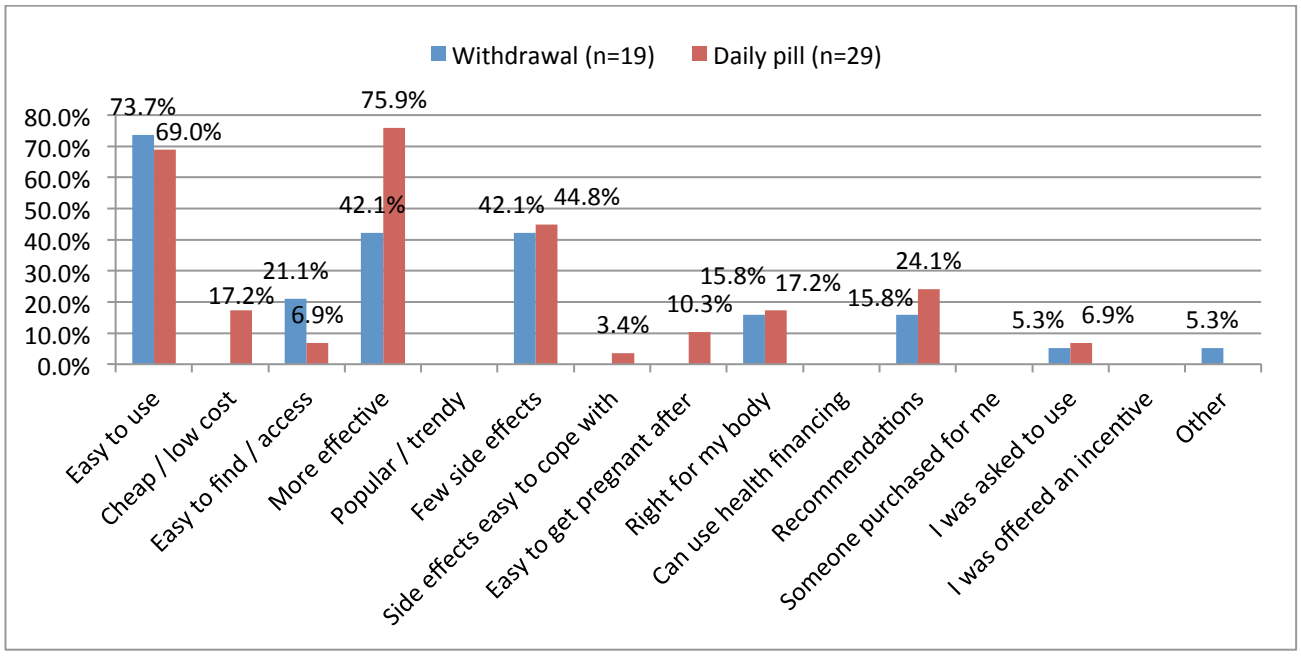

Figure 24: Positive aspects of current method

Following this respondents were asked to narrow down their selection of positive aspects to the main or most important one. When comparing the daily pill and withdrawal we can note that similar positive

aspects were identified by both groups of respondents, the main difference being that for daily pill the highest rated positive aspect was its effectiveness (44.8%), compared with the main positive aspect of withdrawal being considered its ease of use (47.4%).

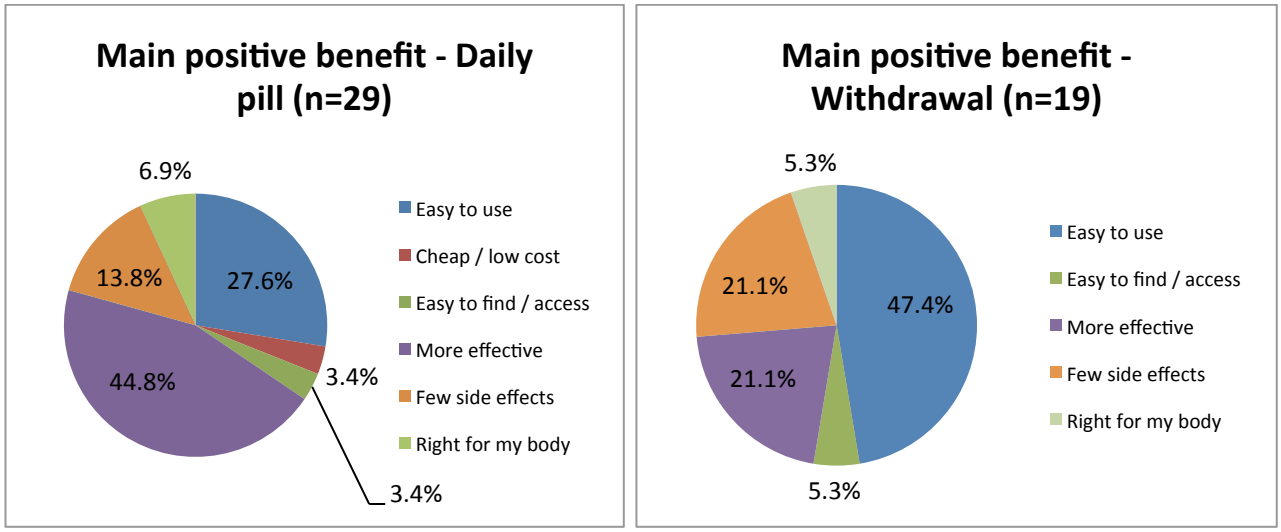

Figure 25: Main positive aspect of daily pill and withdrawal

Moving on to the negative aspects, Figure 26 below shows the negative aspects selected by respondents, interestingly over half (57.9%) of withdrawal users thought their method had no negative aspects, whereas the only 10.3% of daily pill users thought the method was without negatives. For daily pill users, 69% mentioned the inconvenient side effects as a negative aspect of their method.

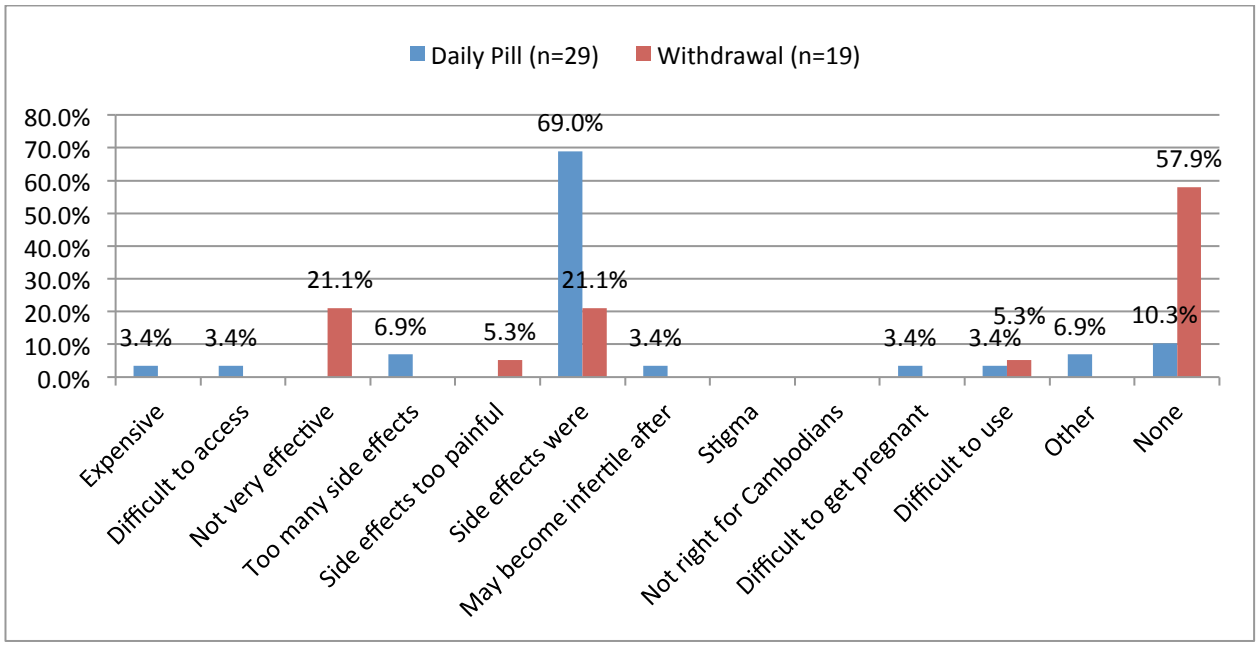

Figure 26: negative aspects of daily pill and withdrawal

With such a small number of negative aspects selected per respondent, the picture when looking at the main negative aspect is very similar to that of all negative aspects. For the daily pill the main negative aspect for 69% of respondents was uncomfortable side effects followed by no negative aspects (10.3%). Conversely over half (57.9%) of withdrawal users thought there was no negative aspects to their chosen method.

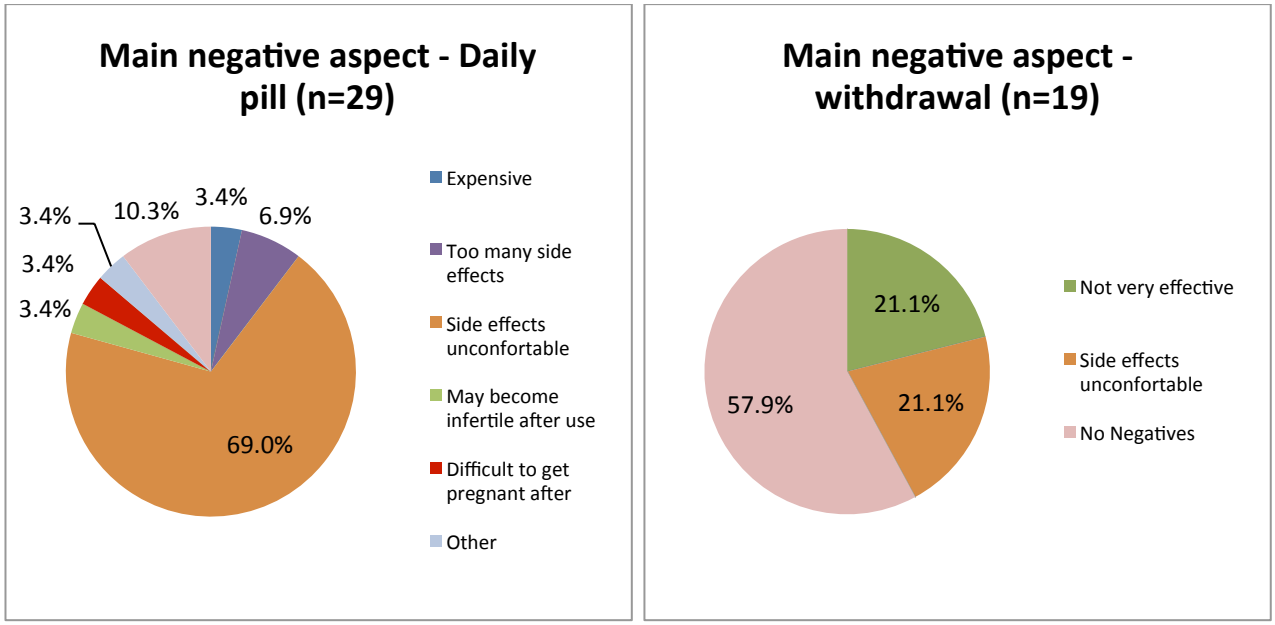

Figure 27: Main negative aspect of daily pill and withdrawal

Recommendation of method to friend / family member

Respondents were asked if they would recommend their current method to a friend or family member. Most respondents were happy with their method and happy to recommend, 93.1% of daily pill users would recommend while slightly less (78.9%) of withdrawal users would recommend the method to friends / family.

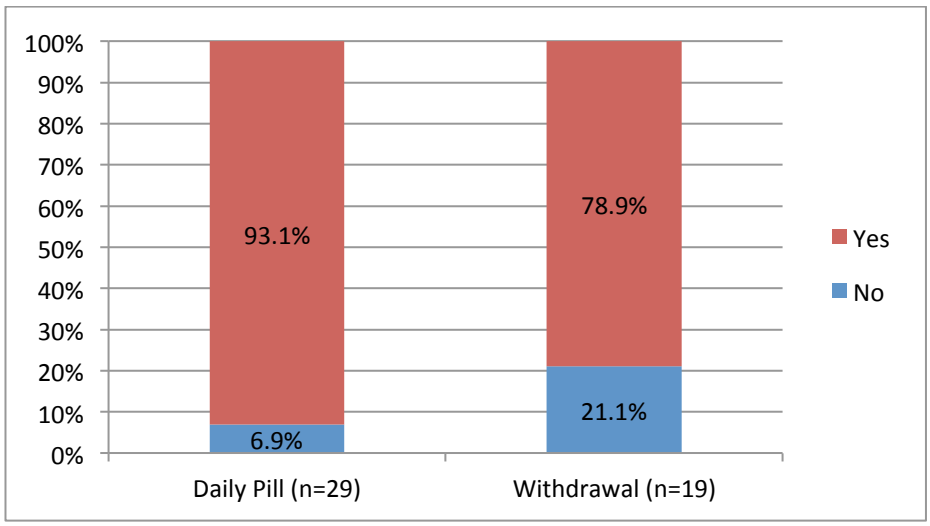

Figure 28: Would you recommend daily pill and withdrawal

The reasons why and why not respondents would recommend were also explored. In relation to the why not there are only a handful of respondents who would not recommend; these reasons included inconvenient side effects and difficult to use for the daily pill and for withdrawal not very effective and some respondents who misunderstood the hypothetical nature of the question and said they were too shy to make a recommendation.

As the majority of respondents said they would recommend their current method, there is sufficient data to represent graphically below in Figure 30. Almost all respondents who said they would recommend the daily pill responded that they would do so because of its ease of use (92.6%). The next most popular reason for the daily pill was that it is more effective with 59.3% of respondents citing this as a reason for recommendation. These were the two strongest reasons for recommendation of the withdrawal method also, although not as higher percentage cited these reasons as daily pill users with 60% selecting ease of use and 33.3% selecting effectiveness.

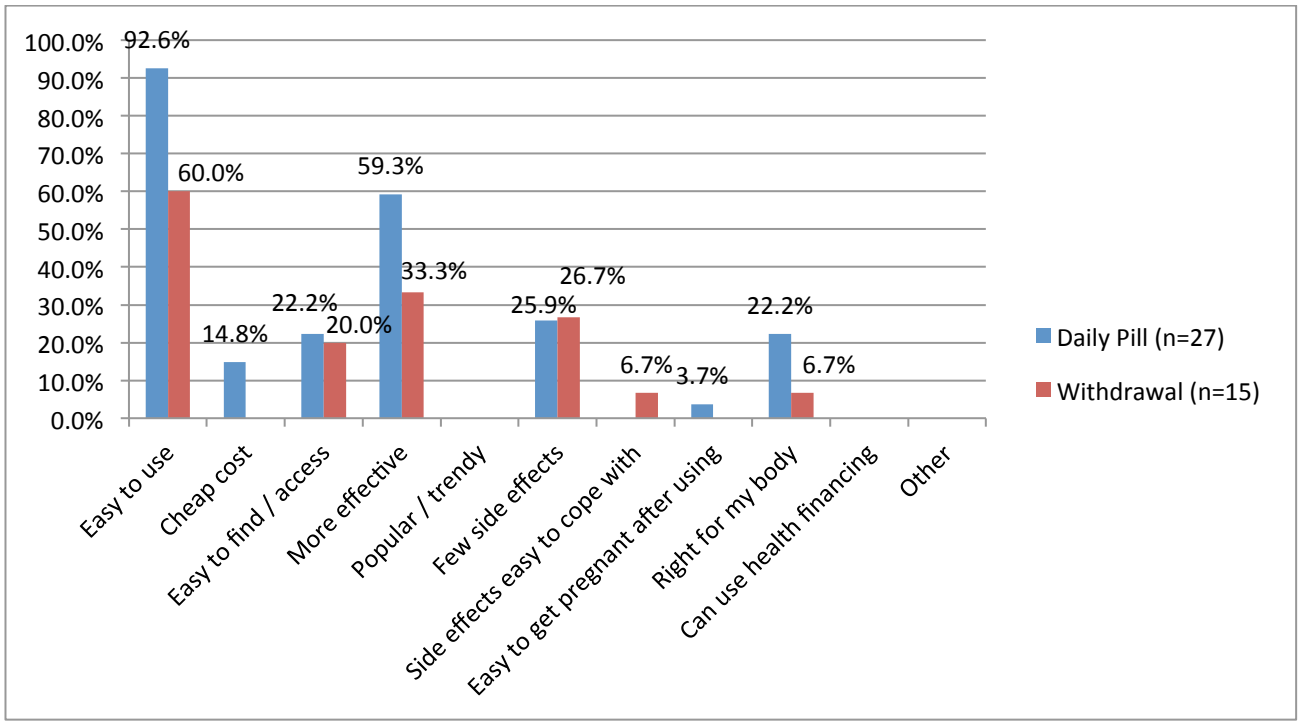

Figure 29: Reasons for recommending current method

Knowledge of the Implant

This section was also asked only to non-users to determine their levels of knowledge about the implant. In this section of the report the knowledge and perceptions of non-users have been compared to the actual experiences of former and current users so that any misalignments between perception and experience can be identified. Respondents were asked if they knew where to obtain the implant in Cambodia, the cost of the implant, perceived side effects as well as their overall perceptions about the implant as a contraceptive method.

Awareness of Implant and providers

All except for two of the respondents had heard of the implant before meaning that amongst the non-users group 98.2% of respondents were aware of the implant. Of these respondents who had heard of the implant 91.9% said they knew where to obtain the implant from.

These respondents were then asked which place(s) in Cambodia the implant can be obtained; their perceptions are displayed below in Figure 30. Over 9 in 10 respondents (91.2%) said that the implant can be obtained at the local health centre, also mentioned was the referral hospital (26.5%) and the local private clinic (22.5%).

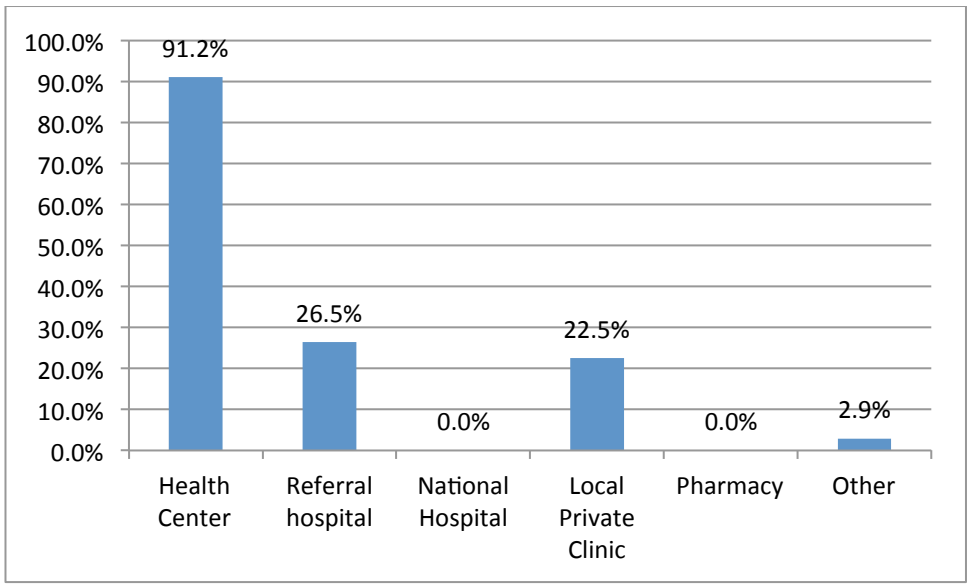

Figure 30: Perceptions of where the implant can be obtained (n=102)

Amongst the non-users the awareness of the implant is very high; likewise respondents had strong knowledge of where the implant can be accessed from, with over 9 in 10 saying the health centre. So awareness of the method or where to access it from cannot be said to be barriers to use of the implant amongst the non-users group.

Cost of Implant

Next respondents were asked if they knew how much the implant cost, compared to the amount of awareness of the implant itself and where to obtain the level of knowledge around cost was much lower, in

fact only 18.9% of respondents were aware of the cost of the implant. When asked how much they thought the implant cost, this small number of respondents gave varied answers ranging from 3000 riels ($0.75) up to 240,000 riels ($60.00). Only one out of these 21 respondents answered $0 (free) for cost and the average across all was 71571 riels or $17.89. This is compared below in Table 6 to the actual costs of the implant experienced by current and former users.

	Perception (n=21)	Actual (n=223)
Min	$0.75	$0.13
Max	$60.00	$50.00
Mean	$17.89	$6.28
% Free	5%	49%
Mean (free excluded)	$18.79	$12.29

Table 6: Perceived cost vs actual cost

Despite the variance in cost estimation amongst non-users, most (61.9%) thought that the cost was affordable. However only a small number thought their estimated cost was cheap (9.5%) compared with 28.6% of respondents who thought it was expensive.

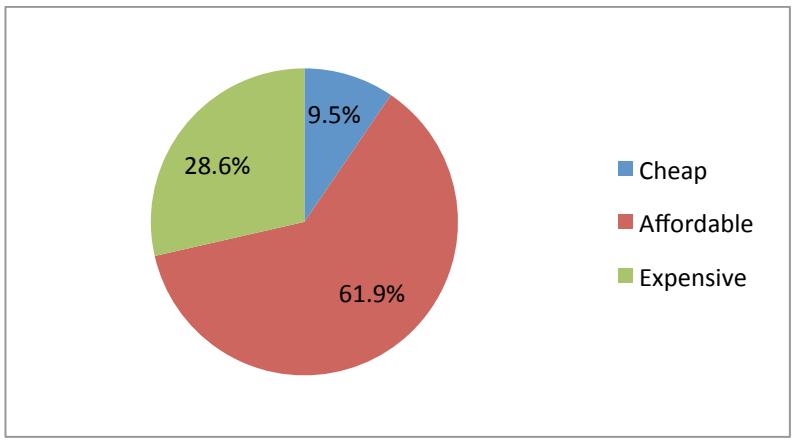

Figure 31: Perceptions of estimated cost (n=21)

Knowledge of the cost was much lower compared with knowledge of the method and where to access it. Over eight in ten respondents did not know the cost of the implant and those that did thought mostly perceived it to be more expensive than it actually is. This lack of awareness around costs could be a barrier to uptake of the implant, in particular that only 5% of respondents knew the implant could be obtained for free. Educating non-users about the costs and health financing options available can help to circumvent this barrier.

Interest in the implant

Non-users were asked if they would be interested in getting the implant in the future and 25.2% of respondents said that they would be. These respondents were then asked how easy they thought it would be for them to obtain the implant, 85.7% of respondents said it would be easy for them to obtain, the remainder were evenly split between difficult and impossible for them to obtain.

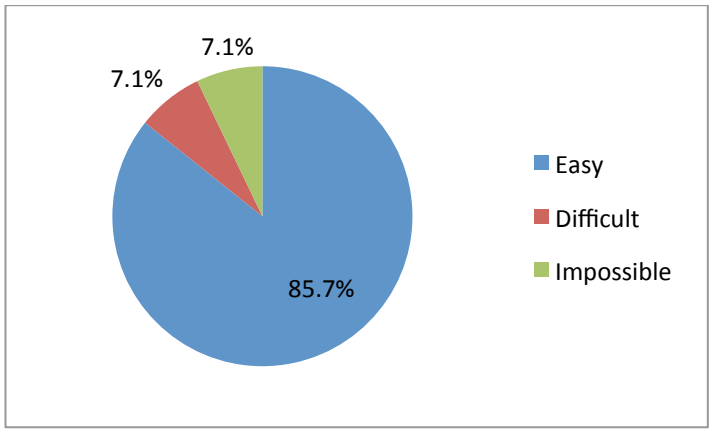

Figure 32: How easy would it be to obtain the implant (n=28)

Perceived side effects

Non-users were asked what side effects they thought the implant could have. Measuring the perceptions compared to the reality of side effects we can identify if there is any incorrect perceptions which could be a barrier to implant adoption. The most commonly perceived side effect amongst non-users was weight gain with 26.4% of respondents selecting this side effect. Also commonly perceived were hot / dry body and general pain in the body. 9% selected 'other', and specified things such as dizziness, not being able to work or sleep and one respondent answered photopsia (perceived flashes of light).

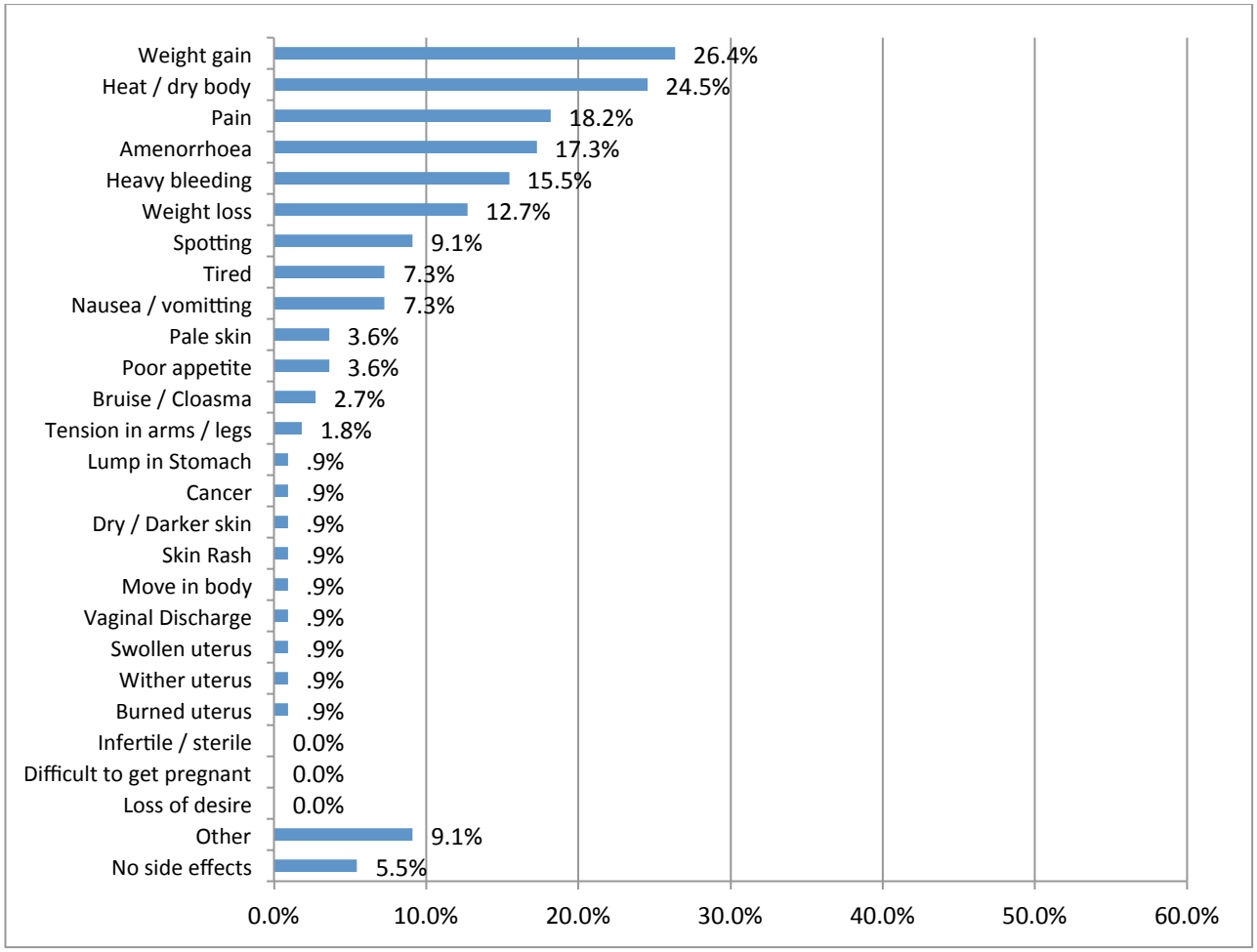

Figure 33: Perceived side effects of the implant (n=110)

To examine how these perceived side effects of non-users compare, Figure 33 has been re-produced below but with the actual side effects experienced of current and former users inserted in red. On a general level we can observe that the percentage of non-users who were aware of side effects is often less than the percentage of users who have actually experienced that given side effect. We therefore cannot say that the side effects are being over-estimated by non-users and thus not a barrier to adoption of the implant. In fact it is more likely to be the opposite, the actual side effects are more common and numerous than estimated by non-users. The case with the biggest discrepancy is amenorrhoea (missing or irregular period) where only 17.3% of non-users perceived this to be a side effect whereas 56.5% of users had experienced this side effect.

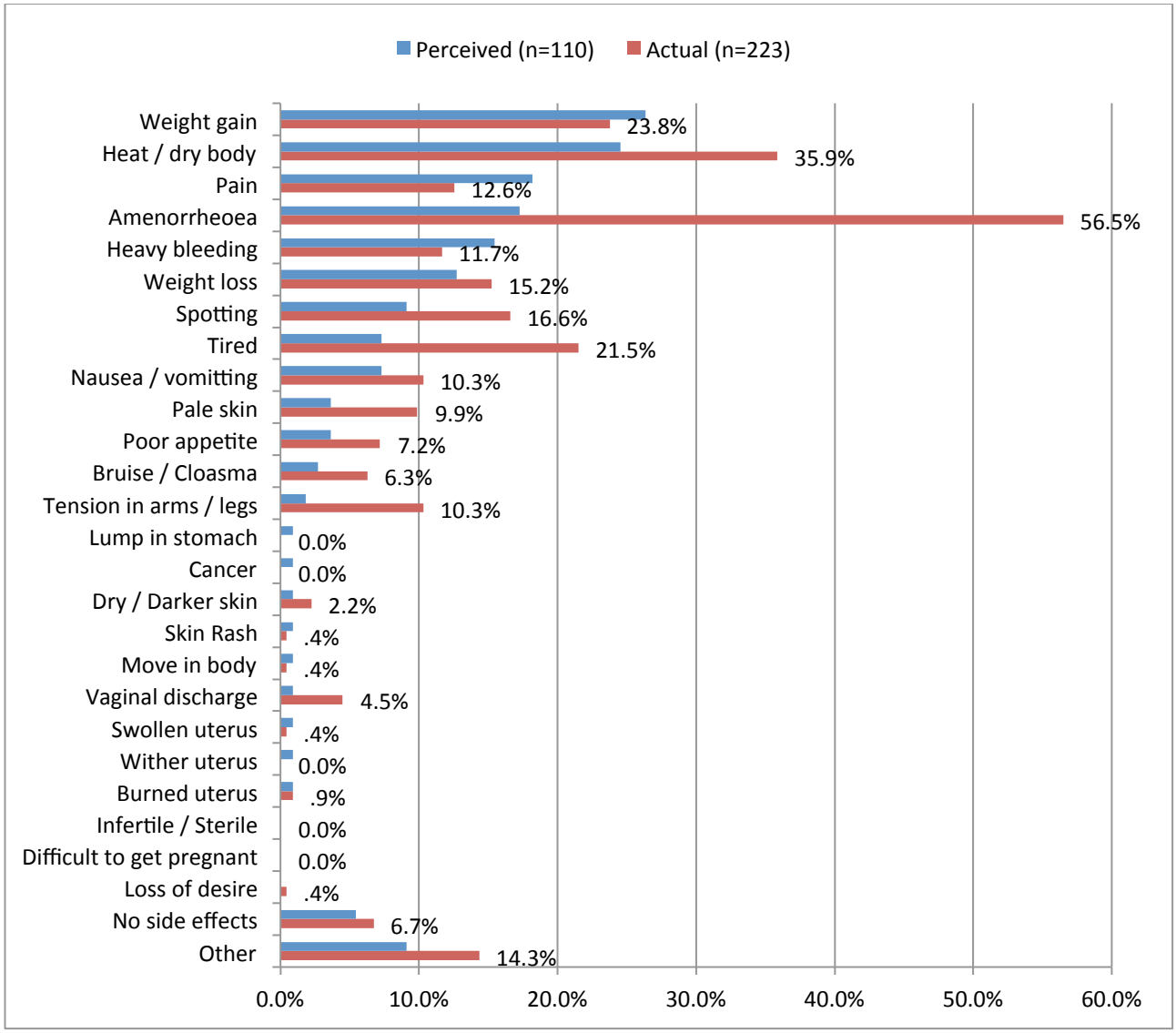

Figure 34: Perceived side effects of the implant vs actual side effects

Overall perceptions

In Figure 35 we can observe the overall opinion on the implant of non-users (blue) compared with former and current users (red). Both groups had almost identical percentages that had a negative opinion of the implant. The main difference of this metric is that a higher percentage of users thought the implant was 'mostly positive' compared to non-users; 44.8% compared to 26.1% respectively. From this we can conclude that overall perceptions of the implant are in line with the actual opinions of those who have used the implant.

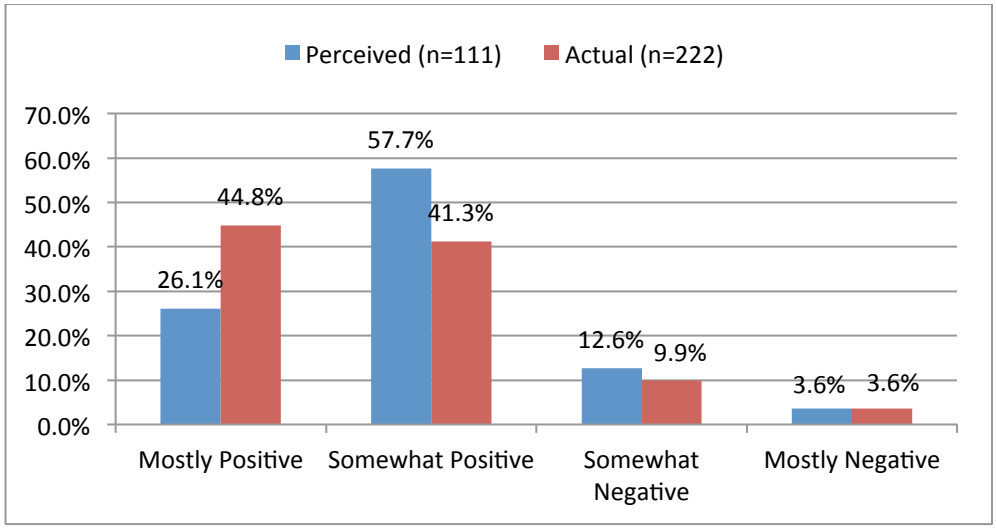

Figure 35: Perceived overall opinions of the implant vs actual opinions

Another perception that can be tested against the actual experience of implant users is the reason they started to use the implant. Non-users were asked the main reason they thought some women would use the implant, likewise users were asked why they themselves started using the implant. The results are displayed below in Figure 36. Similarly to the overall satisfaction measure above the perceptions of non-users align very closely with the actual experience of users. In both perception and experience two reasons stood out; easy to use and more effective.

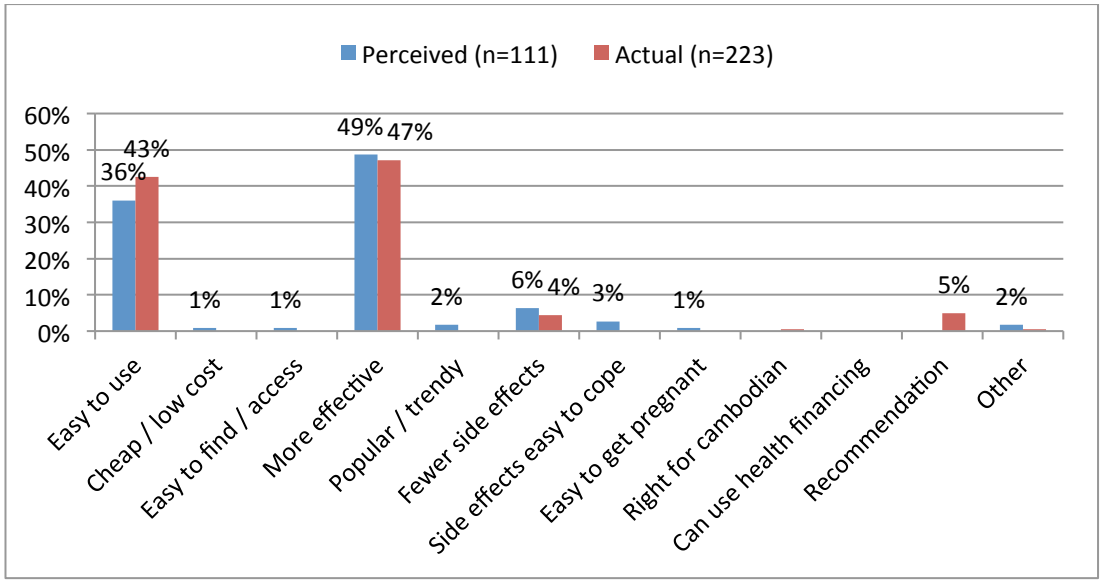

Figure 36: Perceived reasons for using the implant vs actual reasons

To contrast the perceived main reason respondents used the implant the non-users were asked why they think women (or themselves) would not use the implant. Just over half (51.4%) of the respondents thought that the inconvenience of side effects would be the main reason.

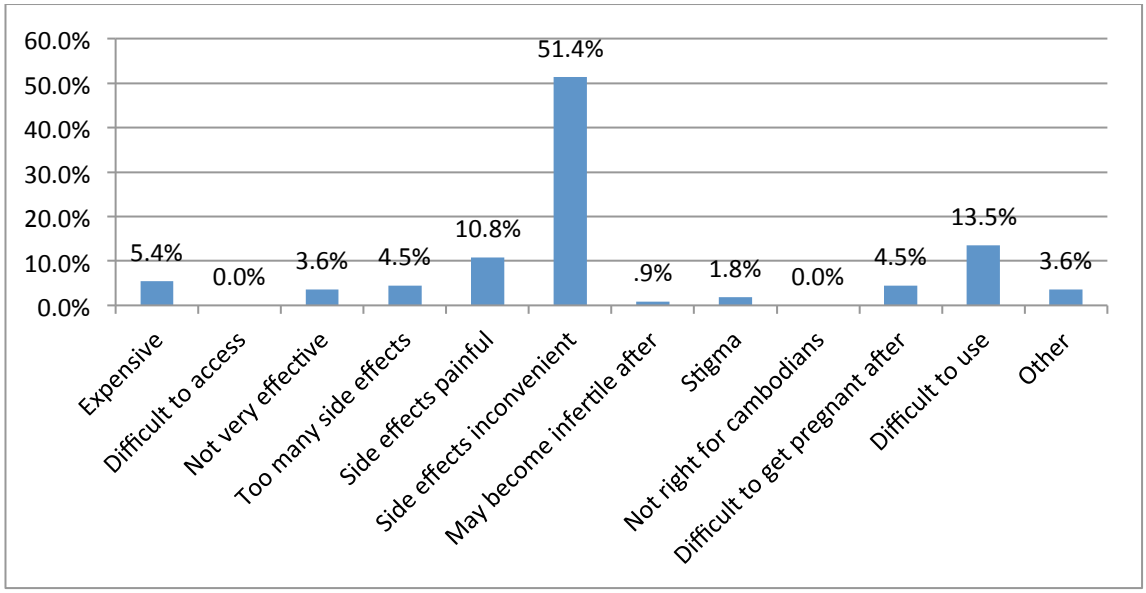

Figure 37: Reasons non-users would not use implant (n=111)

The final perception question asked to non-users was "what is the most important thing that would encourage more women / you to use the implant". This question was also asked to current and former users so we can compare and contrast their responses with non-users as below in Figure 38. Similarly to previous measures the non-users perceptions match very closely to the experiences of the users. Here the most common response was to improve access (49.5% of non users and 47.5% of users).

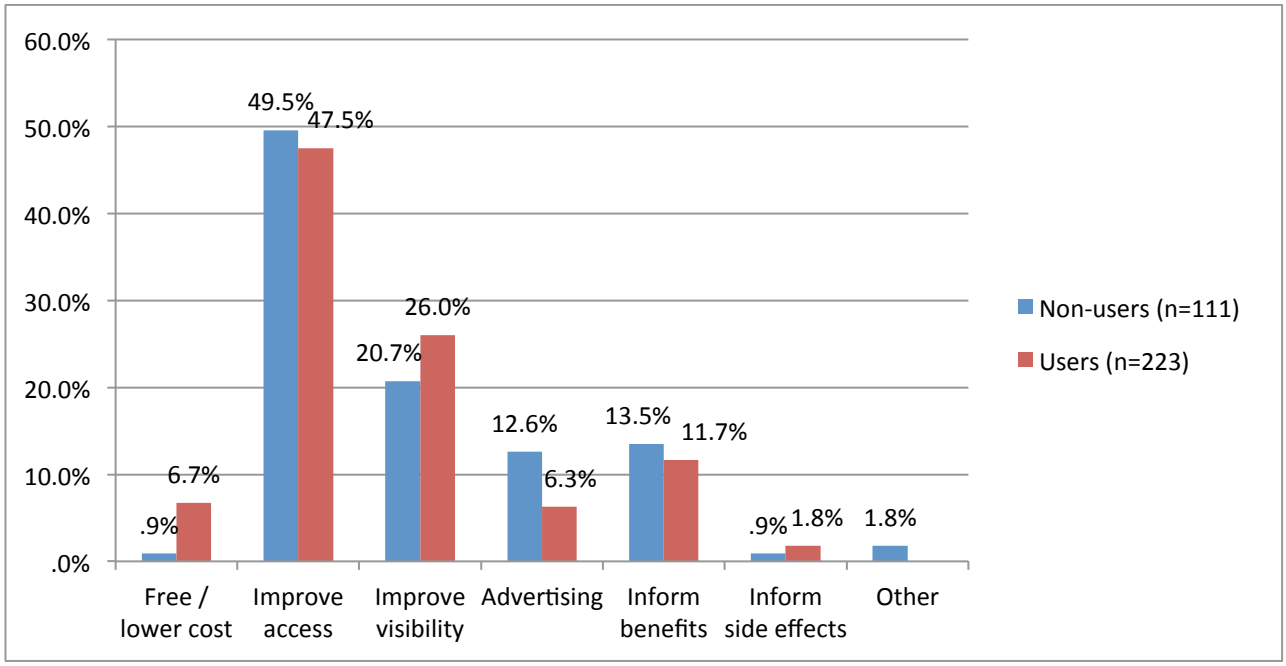

Figure 38: Most important thing to encourage women to use Implant

Experiences with the Implant

Those who had experience with the Implant, either currently or in the past, were asked to detail their experience with it. Questions were asked covering the whole cycle of the implant including initial information sources, insertion, side effects, and overall satisfaction of the implant as a long acting contraceptive method.

Initial Decision to Use

In relation to current and former users experience they were first asked where they initially obtained information about the implant. The largest initial information source was a public health provider (42.2%) followed by a family member or neighbour (22.4%).

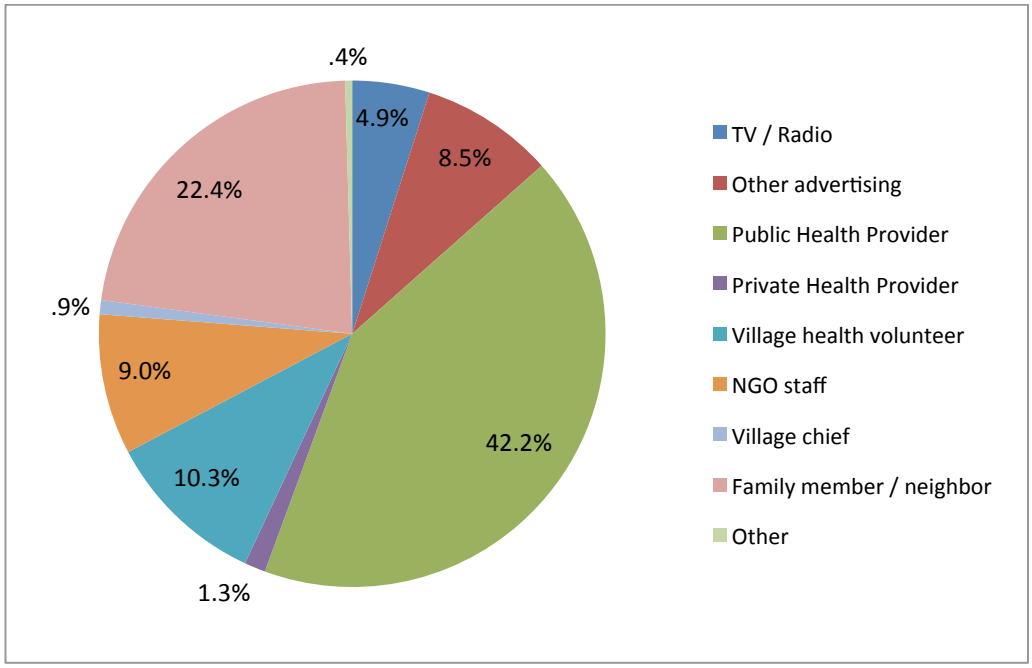

Figure 39: First obtained information on the Implant (n=223)

After initially receiving information on the implant the next point to analyse are the reasons for deciding to use the Implant. The reasons for choosing the implant can be compared with the reasons non-users chose the daily pill or withdrawal methods, Figure 40 below shows the reasons for using daily pill and withdrawal from Figure 19 earlier, now with the Implant data added in the green columns. Similarly to the other methods, ease of use (85.7%) and effectiveness (87%) were the strongest drivers of method adoption. A recommendation from friend or family member was a stronger driver for the implant than other methods with 44.4% of implant users saying it was a factor in their decision to use. There was no impact of incentives on the choice to use the implant as no respondents selected this as a reason why they started using the implant.

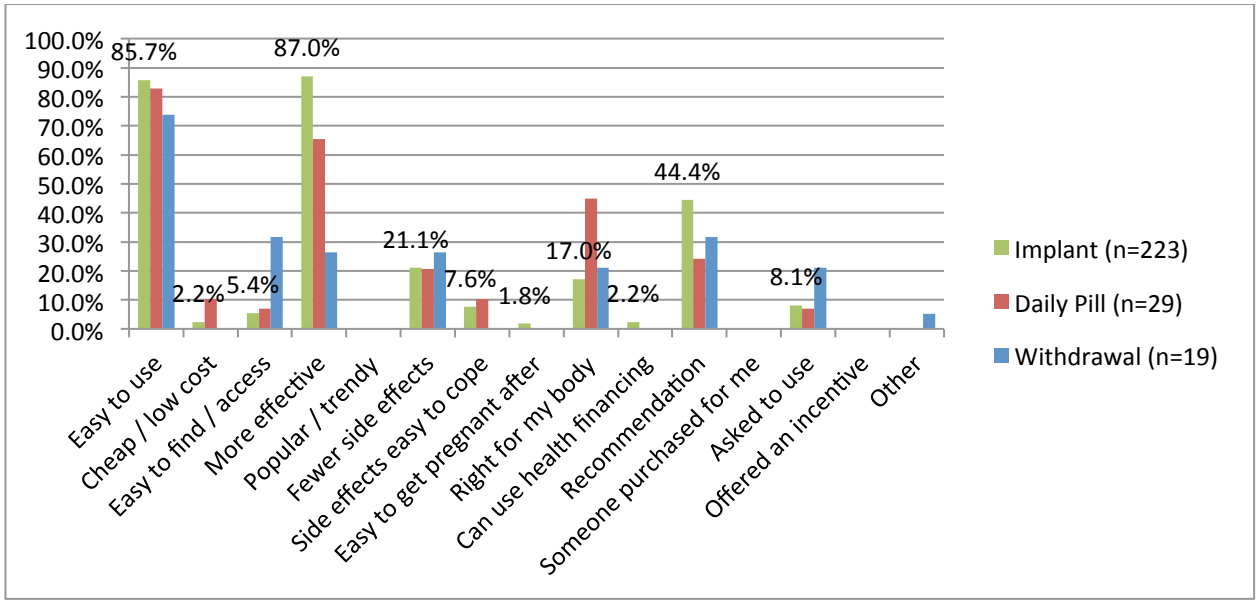

Figure 40: Reasons for using Implant

Current and former Implant users were asked if the implant was available at their local health centre; a very high majority said that they were, a small amount said they didn't know. Interestingly the only respondents to say the Implant was not available at their local health centre were in Tboung Khmum province which also had the highest percentage of respondents who didn't know.

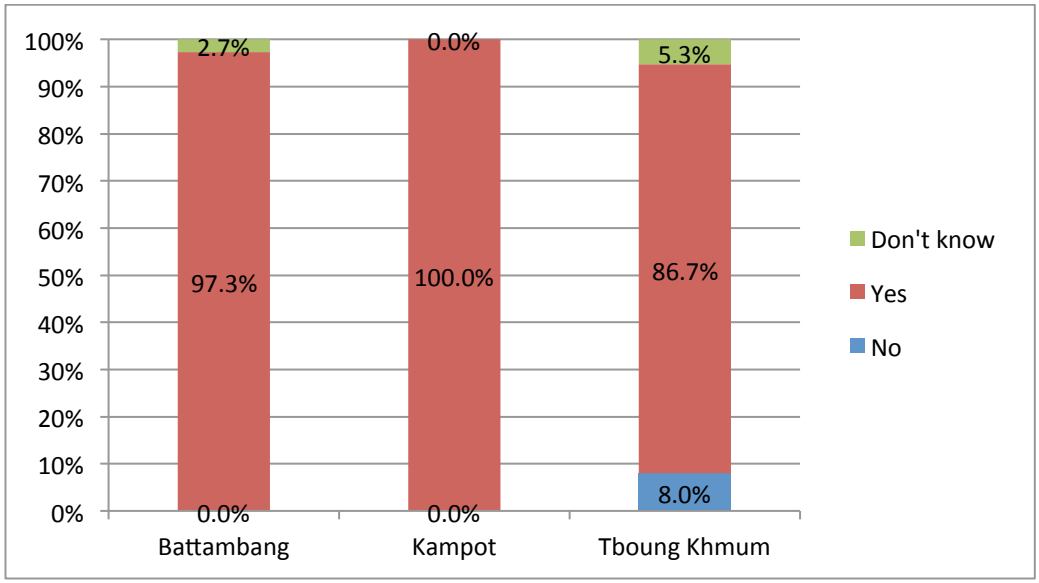

Figure 41: Availability of Implant at health centre (n=223)

Place of insertion

The most common place to have the Implant inserted was the local health centre with over 80% of respondents in each of the three operational districts having their implant inserted there. A small number (<10%) had their implants inserted in a local private provider and a nominal number of respondents had their implant inserted in a different health centre or the referral hospital. The respondents who answered other all specified that they had their insertion done at a RHAC clinic.

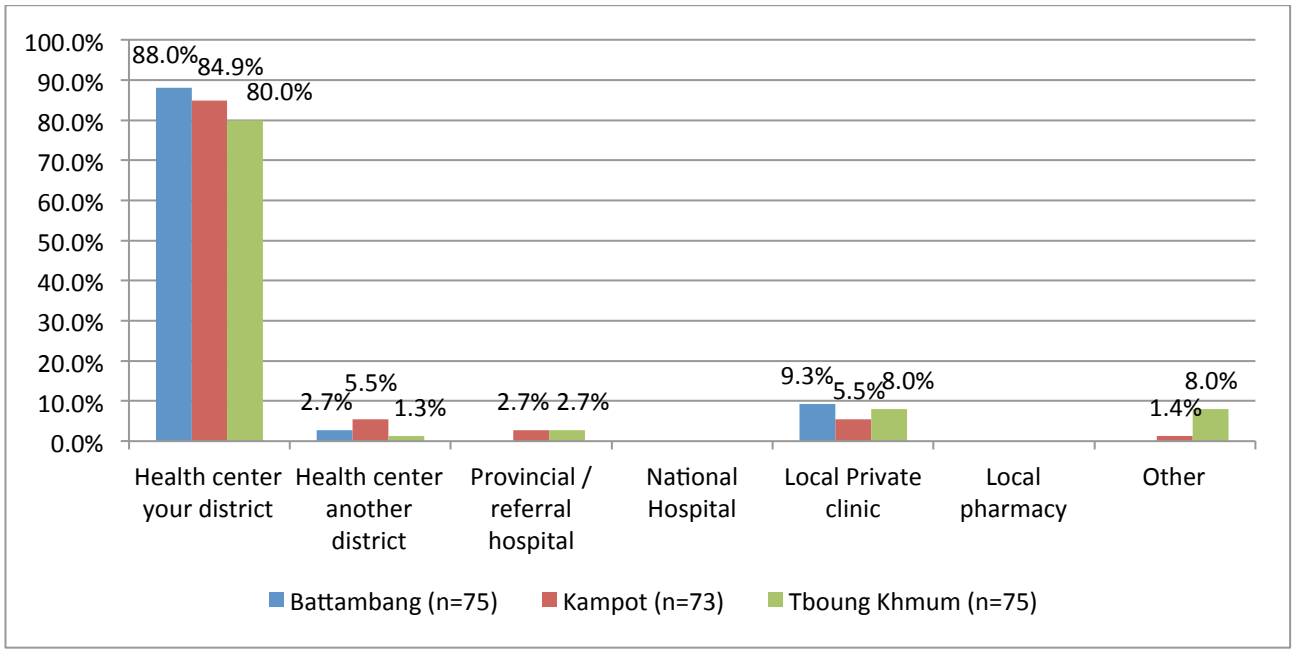

Figure 42: Place of Implant insertion

Cost of insertion

The summary of implant costs were discussed earlier in Table 6 in comparison with the perceived costs of non-users. In this section the costs of the implant will be analysed in relation place of insertion. The table below shows the average price payed by respondents, it is important to analyse also the % of respondents who received the implant for free so as to not distort the average. Unsurprisingly no respondents received a free implant from the private provider whereas over half received free implants from the Health Centre's. Similarly the average price excluding free implants was close to double at private clinics ($20.44) compared with $10.47 average from local health centres.

Place	n	Average price (free excluded)	Percent free	Average price (free included)
Health centre another district	7	$ 15.00	57%	$ 6.43
Health centre your district	188	$ 10.47	54%	$ 4.84
Local Private clinic	17	$ 20.44	0%	$ 20.44
Provincial / referral hospital	4	$ 15.83	25%	$ 11.88
Other	7	$ 12.50	43%	$ 7.14

Table 7: Average cost by place of insertion (n=223)

Respondents' opinion on their costs was also asked; whether they felt the cost was cheap, affordable or expensive. Only a very small percentage of respondents thought that the implant cost was cheap, and all of these had obtained it from their local Health Centre (8.5% blue in chart below). The higher cost of the implant at private clinics above has been reflected in the 41.2% of respondents here who thought it was expensive, this highest of any places of insertion.

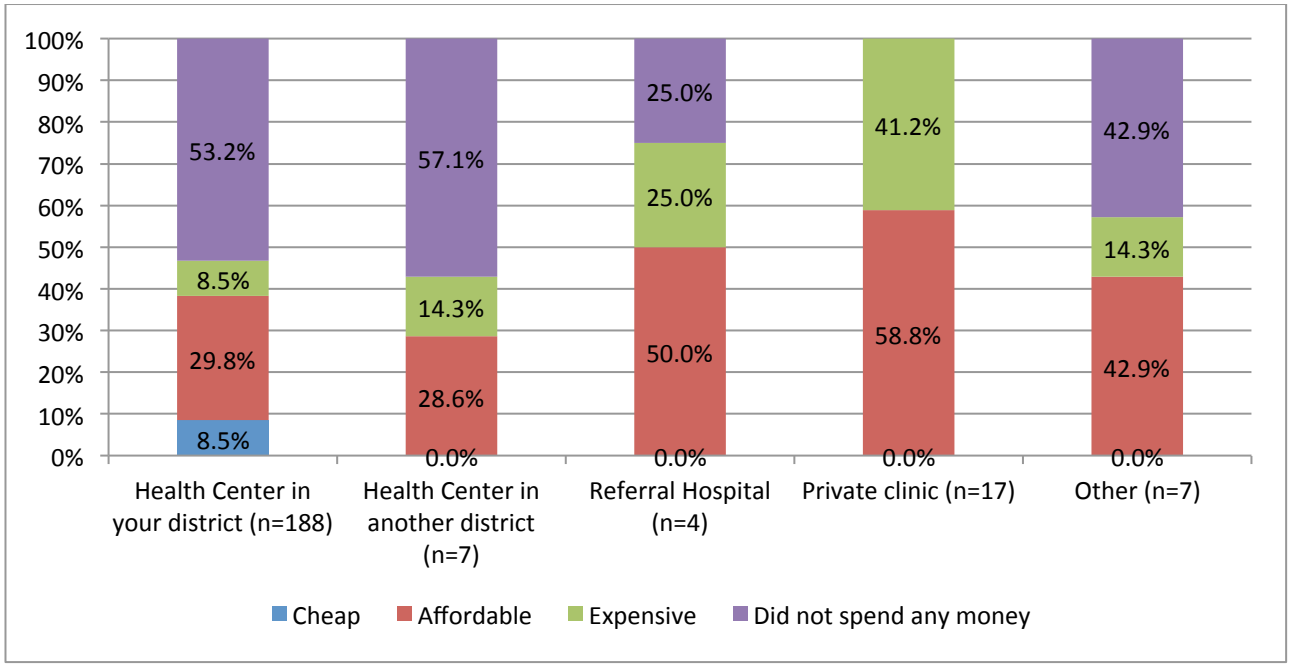

Figure 43: How affordable was Implant cost

The final way to analyse the actual cost data of users is to calculate a mean cost for each opinion on price – cheap, affordable and expensive. Figure 44 below shows these mean costs, respondents who thought the price they paid was cheap averaged a cost of $4.34, affordable on average was $11.79 and finally the average price of those who considered it to be expensive was $18.12.

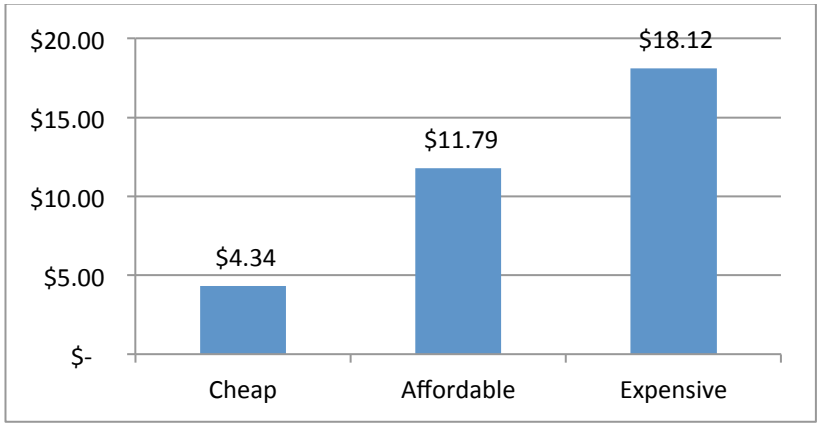

Figure 44: Average cost by affordability opinion

Transport and Reimbursement

Across all current and former users 61.9% of respondents paid something for transport to obtain the implant. The average of this cost for this transport was 5,565 riels or around $1.40.

All current and former users were asked if they had been reimbursed any of their transport or treatment costs and a total of 26.9% (n=60) had been reimbursed in some way. It should be noted here that all but

one5 of these 60 respondents said they had paid nothing for treatment and there was an additional 50 respondents who said they had paid nothing for service, most likely covered by HEF / SOA without actually paying and being reimbursed.

Figure 45 below shows for these n=60 respondents which scheme was responsible for re-imbursement. The Reproductive Health Association of Cambodia (RHAC) was the most common scheme used with 40% of respondents receiving their costs back from here. Next was HEF/SOA responsible for 30% of re-imbursements of current and former users. It should be noted that 15% of respondents didn't know or can't remember who it was which covered their costs. For these who received a re-imbursement the average amount they received back from their scheme was 8,331 Riels ($2.08).

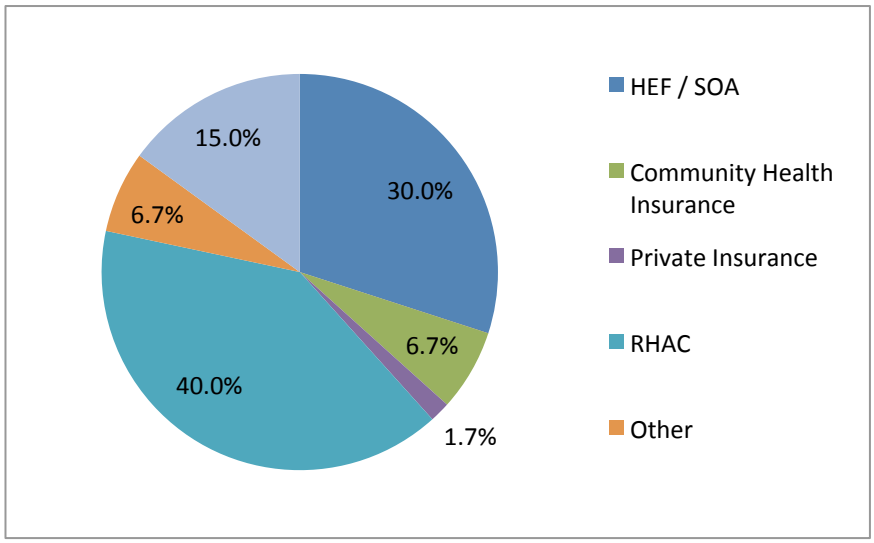

Figure 45: Which support scheme covered the costs

Influences on choice of Implant

87.9% of respondents said that they were influenced by someone else to some extent in their choice to use the implant. So the remaining 12.1% here felt that they were not influenced by anyone else in their decision to use the implant.

The 87.9% of respondents who said they had some influence were asked what the main or primary influence was. The main influence for these respondents is detailed in Figure 46. Over half (66.8%) of these respondents said that they themselves were actually the largest influence. Considering this alongside the 12.1% who were not influenced at all it can be concluded that for the majority of women they make the decision to use the implant themselves with minor or no influence from others.

The next biggest influence at 13.3% was the health staff. The third largest influence was the respondents' husband, who was the main influence in 7.1% of Implant users decision to take up the Implant.

[5] This respondent paid 60,000 riels for treatment, 10,000 for transport and was re-imbursed 20,000 riels by private health insurance.

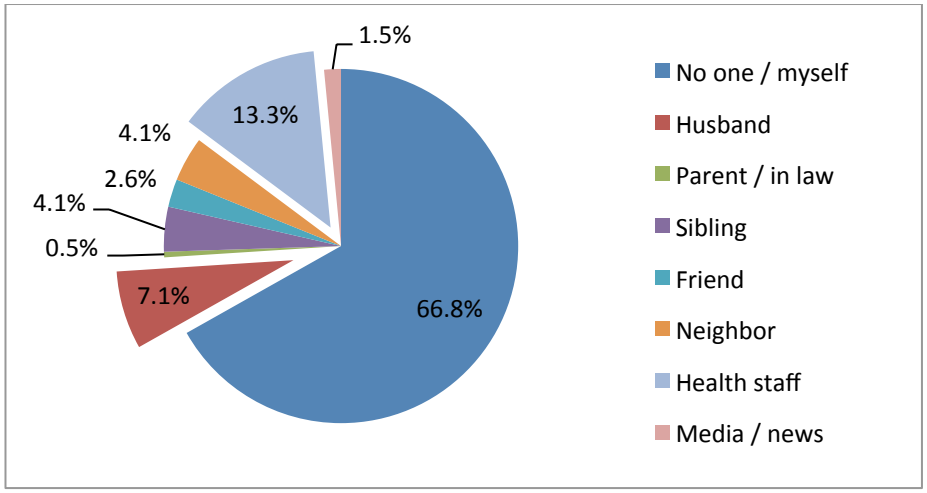

Figure 46: Who influenced you the most to start using the Implant

In order to better understand the influence of the husband the percentage of husbands who were the main influence of implant choosers is compared the husbands influence on other contraceptive methods with adequate sample, the daily pill and withdrawal. Figure 47 shows that amongst respondents who were influenced by someone else about their contraceptive choice, 42.1% of women who used withdrawal were most influence by their husband to use this method and 14.3% of respondents who used the daily pill said that their husband was their main influencer. So we can conclude that for women whose husband will be the main influence over their contraceptive choice they have a smaller chance to end up using the Implant when compared with other methods.

The opposite is true for respondents who are most influenced by the health staff where 13.3% of Implant users were most influenced by the health staff, a higher percentage than the husband whereas for daily pill and withdrawal the percentage of women influence by the health staff was much less than the percentage influenced by their husband.

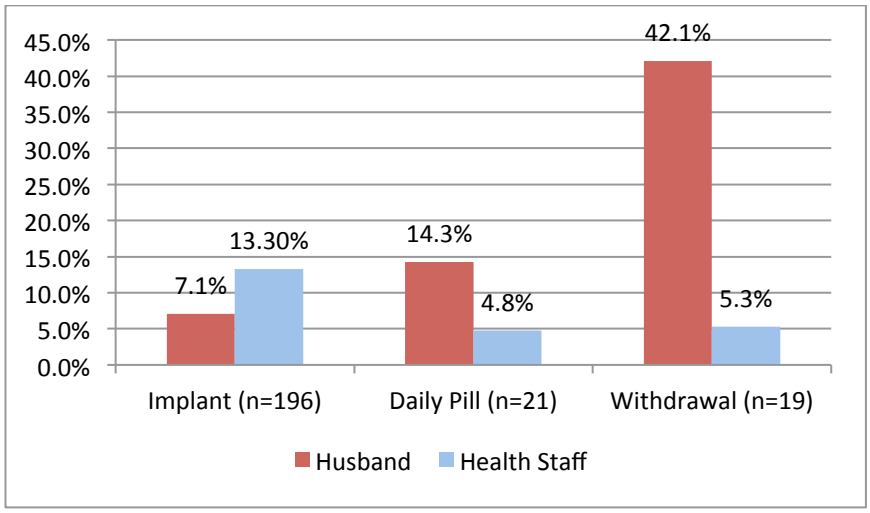

Figure 47: Influence of husband and health staff on contraceptive type

The influence of the Husband and Health staff has been compared by operation district below in Figure 49. The Health staff has a similar impact amongst the three ODs, however in terms of the Husband, the influence of this actor was lower in Kampot OD than the other two.

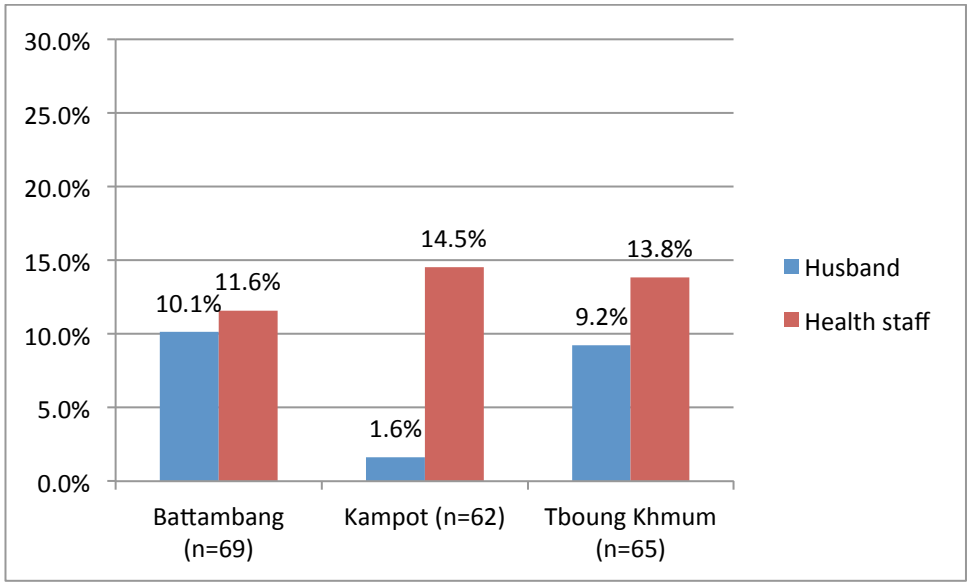

Figure 48: Influence of husband and health staff on implant by OD

Overall perception and Rating of Implant

In regards to the positive aspects of the implant we observe a similar pattern to the reasons that respondents decided to try the Implant initially[6] with ease of use and effectiveness being the most frequently mentioned positive aspects mentioned by 90.6% and 89.2% of respondents respectively. Also common positive factors were few side effects (40.4%) and "right" for my body (17.9%).

[6] **Figure 40**

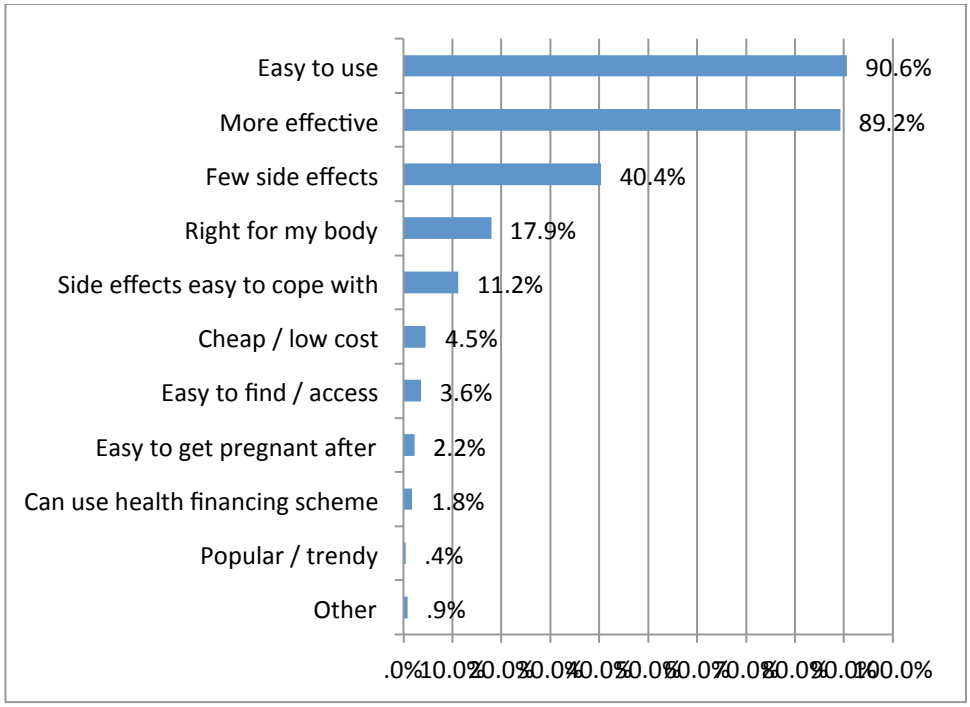

Figure 49: Main positive aspects of the implant

When asked for just the most important aspect of the Implant the majority chose again 'more effective' and 'easy to use' with 48.0% and 40.8% for each. Although just over 40% of respondents identified 'few side effects' as a positive aspect and only 7.6% of respondents felt this was the most positive aspect.

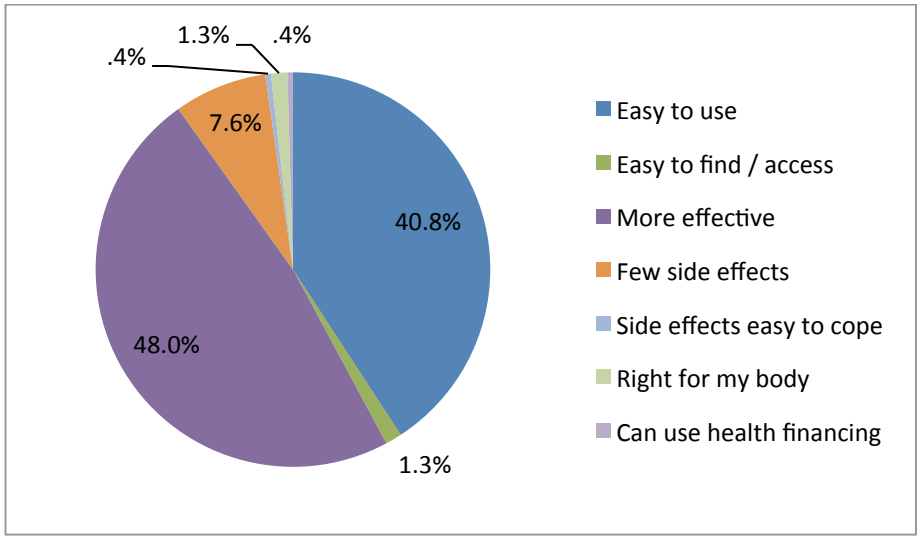

Figure 50: Most positive aspect of the implant

Respondents were also asked about the negative aspects of the implant. By far the most commonly mentioned negative of the implant was inconvenient side effects, mentioned by 85.2% of respondents. 'Painful side effects' was the next most frequently mentioned negative aspect, mentioned by 14.3% of respondents. Interestingly, 5.8% of respondents noted that 'stigma' was a negative aspect of the implant.

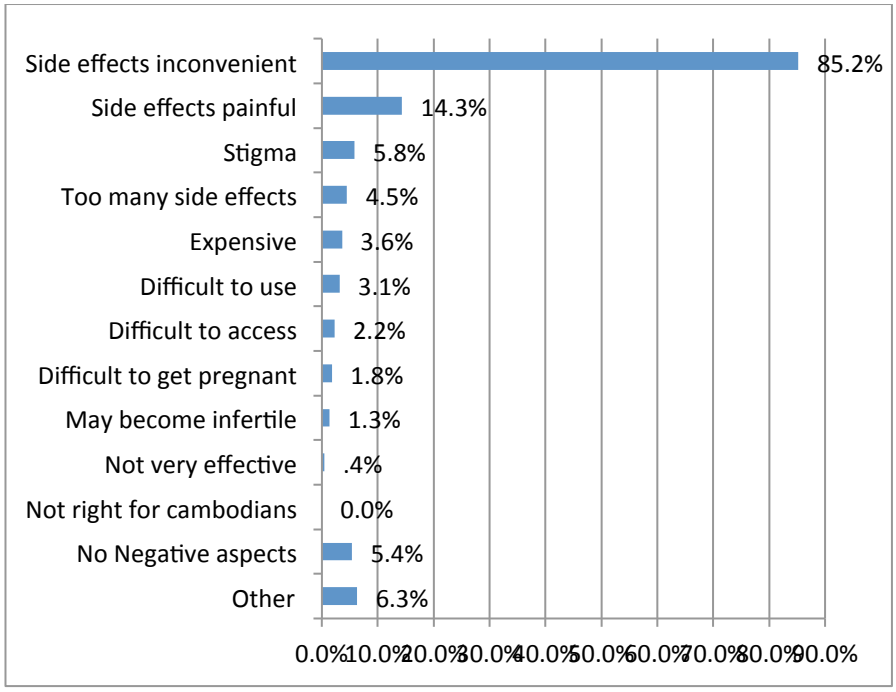

Figure 51: Main negative aspects of the implant (n=223)

Unsurprisingly when asked which aspect was the most negative, a very high percentage (79.4%) of respondents thought that inconvenient side effects were the most negative.

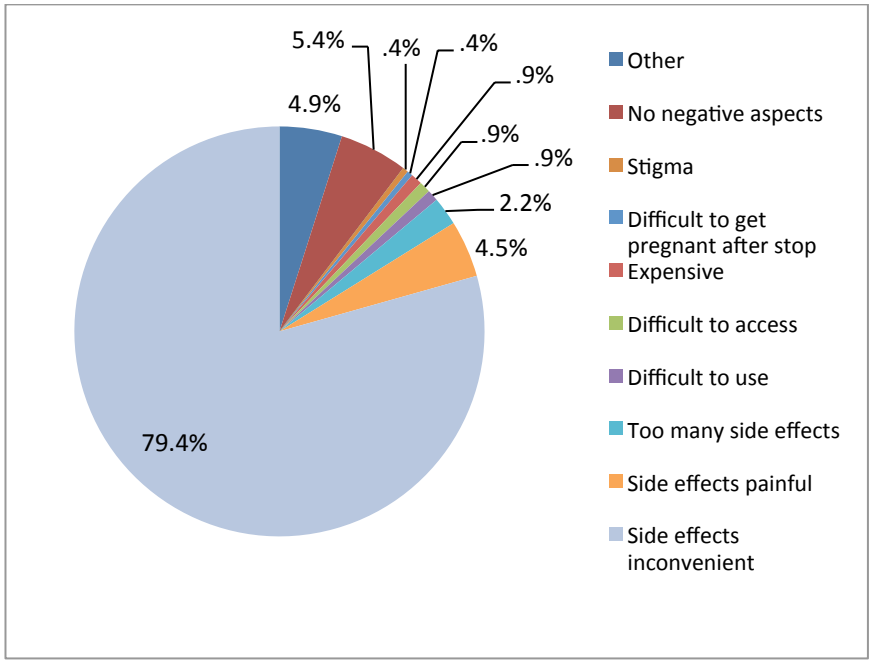

Figure 52: Most negative aspect of the implant

Recommendation of the Implant

86.5% of current and former users said that they would recommend the Implant to a friend or family member as a long term contraception method.

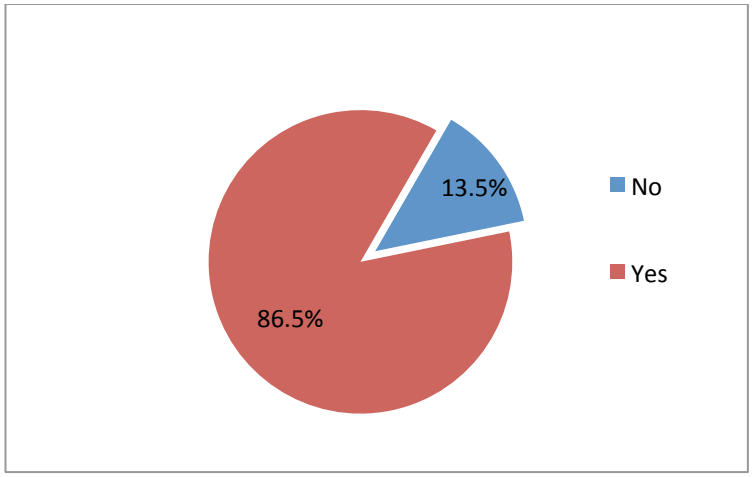

Figure 53: Would you recommend the implant?

The 13.5% of respondents (n=30) were asked for the reasons that they would not recommend the implant, and the results are displayed below in Figure 54. As expected from the previous analysis of negative aspects the most frequently mentioned reason to not recommend was side effects inconvenient, mentioned by 63.3% of respondents. 20% of respondents said 'other' these respondents did not grasp properly the hypothetical nature of the question and gave answers like "friends and family know already" or "too shy to make a recommendation about contraception".

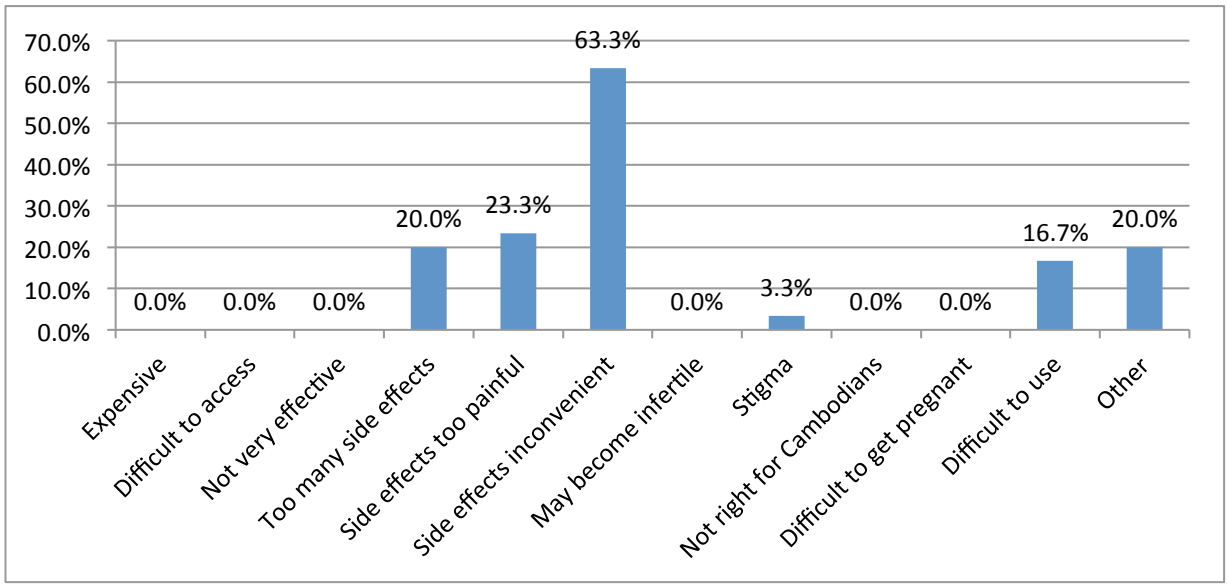

Figure 54: Reasons for not recommending

Likewise the reasons for recommending the implant were similar to the positive aspects identified by respondents earlier in this section. Easy to use and more effective were the most commonly mentioned reasons for recommendation.

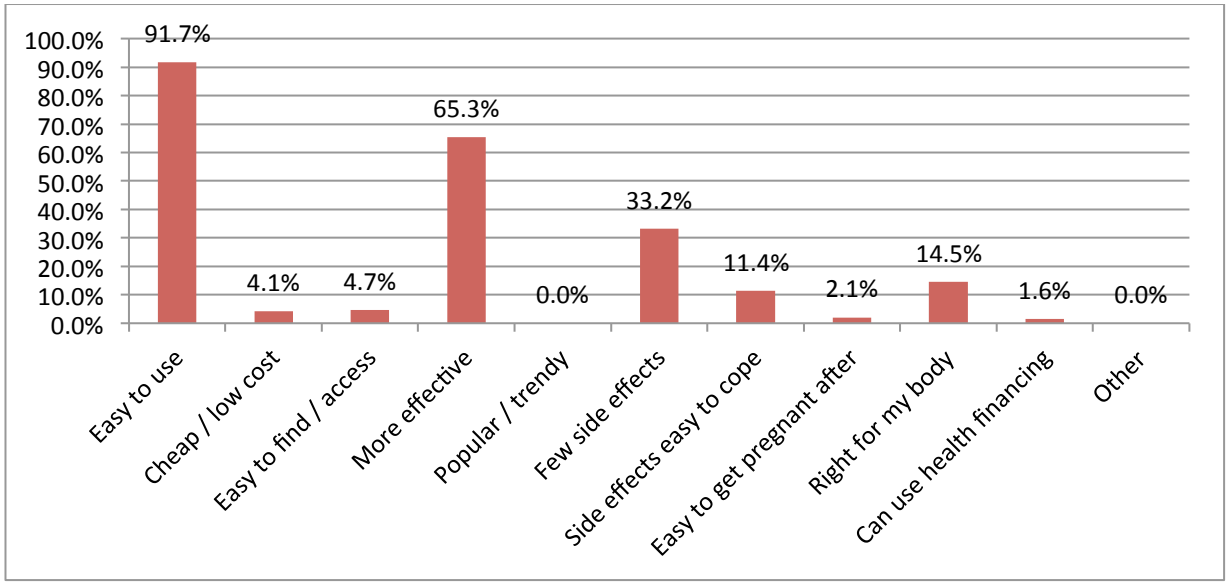

Figure 55: Reasons for recommending

Finally in this section respondents were asked what they thought was the main thing that could be done to encourage more women to use the Implant. Almost half of respondents (47.5%) thought that improving access was the best way to encourage more women to use. Next most common answer was improving visibility with 26% of respondents selecting this option. Only a small percentage of respondents (6.7%) thought that providing the Implant for free or lower cost would increase uptake amongst women.

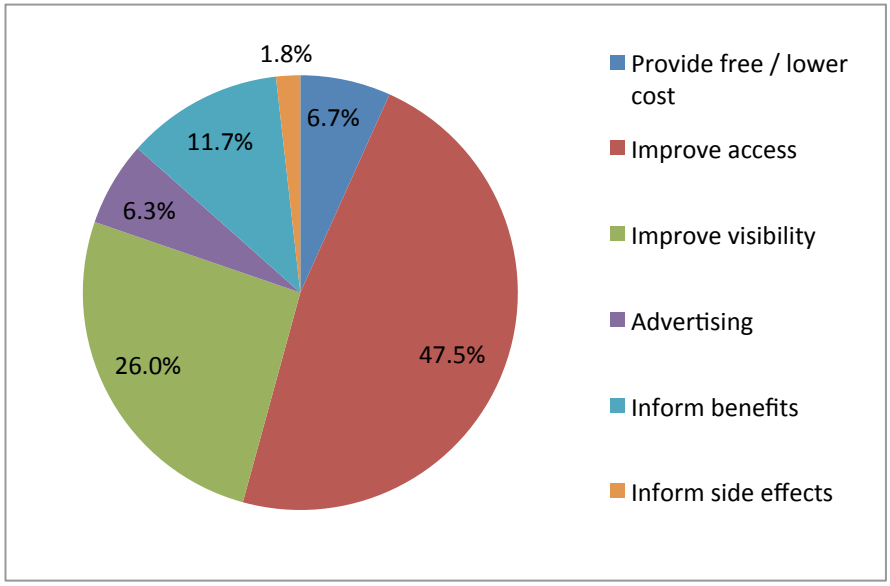

Figure 56: Most important thing to encourage more women to use the Implant

Removal of the Implant - Experiences

This section was asked only to former users, as they are the only group to have experienced the removal procedure. Primarily the section explores respondents' reasons for either not continuing with another implant after expiration or reasons why respondents removed the implant early, if this was the case.

Period of Implant use

The former users had used the implant for an average of 1.32 years. Figure 57 below shows the frequency of number of years former users had used the implant for, where 0 is less than 1 year. The majority of respondents had only used the implant for less than 2 years so it is not surprising that 87.2% of respondents had their implant removed early (before the time initially recommended by their health staff).

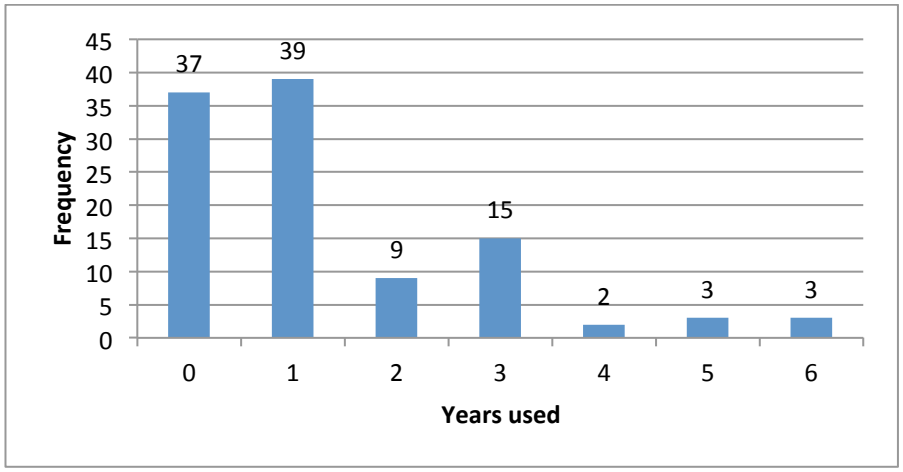

Figure 57: Number of years implant used for (n=108)

Influences in stopping use

When asked if anyone influenced them to stop using the implant, 83.5% of respondents said that someone had. Similarly to the analysis of those who influenced women to start using the implant, the majority of respondents here said that they themselves were the largest influence to stop with 77.2%. Another similar trend was the husband and health staff both having an influence on respondents and the husband (6.5%) was slightly less influential than the health staff (8.7%).

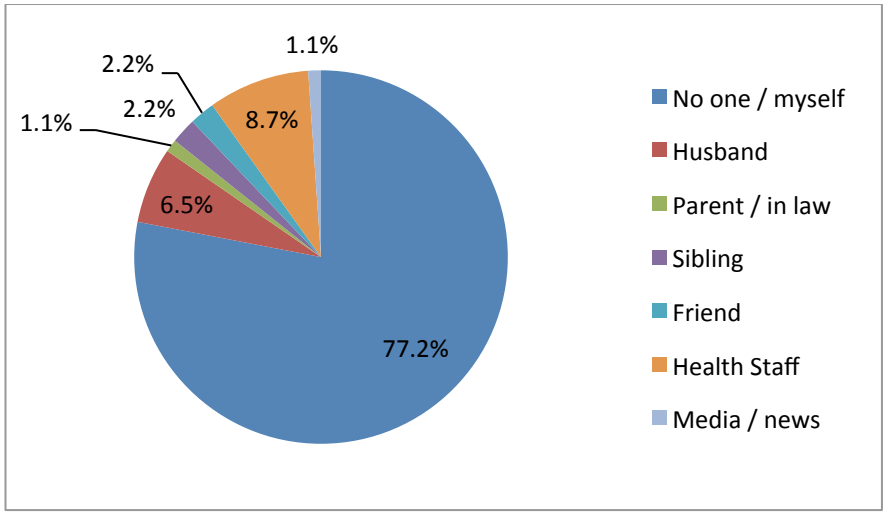

Figure 58: Most influenced to stop using Implant (n=91)

Reasons for removal

87.2% of former users said that they had their implant removed early (before the date their health staff recommended), the reasons for early removal are displayed below in Figure 59. 'Inconvenient side effects' was the most commonly selected reason for early removal with 82.1% of respondents who had removed their implant early selecting this reason. The 'other' reasons were a mixture of stopped or irregular period and a couple of respondents whose husbands had moved away to Thailand or Phnom Penh for work. The reason 'can't afford' initially seems counterintuitive as the implant is a fixed cost for contraceptive, however from anecdotal evidence in the qualitative section of this study this reason is actually tied in with inconvenient side effects because of the costs associated with consultations and treatments for the side effects.

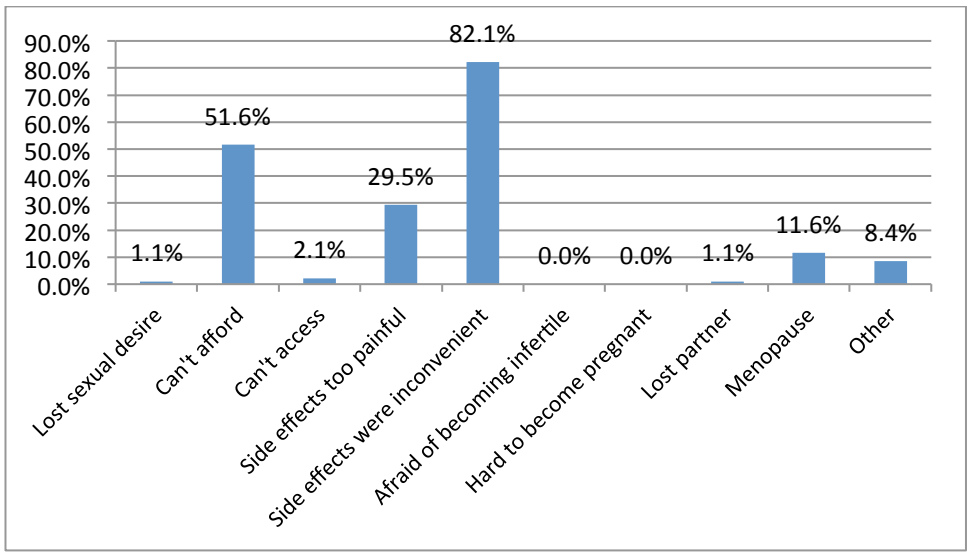

Figure 59: Reasons for early removal (n=95)

The remaining respondents (n=13) who stopped using the implant at the time their health staff recommended were asked why they chose not to continue with another implant. Similarly to those who removed the implant early inconvenient and painful side effects were the main reasons.

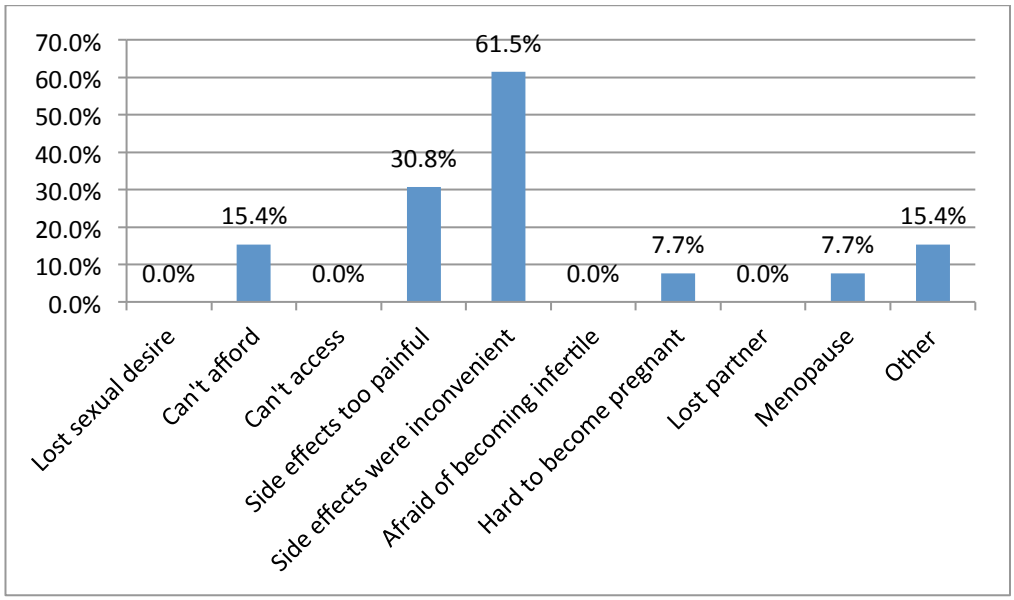

Figure 60: Reasons for not continuing with the implant (n=13)

Perceptions about removal

An important factor in adoption of the implant is the availability and affordability of the removal procedure. For this reason the current users of the implant were asked about their knowledge of the removal process and costs. Also, current users were asked if they intended to get another implant after their current one expires.

Knowledge of Implant life

All respondents reported that their health staff had advised how long the implant could remain in for at time of insertion. There was however some slight differences in the amount of time advised by the health staff as shown in Figure 61. The majority (86 out of 113) respondents said that their health staff told them the implant would last for 3 years, 6 respondents said 4 years and 21 said 5 years.

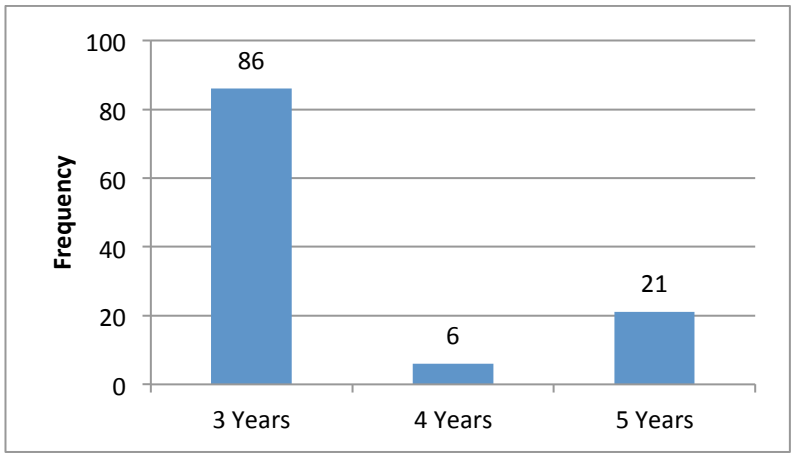

Figure 61: Implant life as advised by health staff

Perceptions of removal

When asked how much they thought it would cost to have the implant removed 61.9% of respondents said that they did not know how much it would cost. Of those who did know their responses ranged from free up to $20, with an average of $5.44.

When asked if they would return to the same place for removal as they had the implant inserted all respondents except for 2 individuals said they would return. The reasons for the two respondents who thought they would not return were for one respondent the health staff were not knowledgeable and the other respondent had moved to a different area.

Only a very small amount of respondents (3.5%) said that they didn't know any reasons why the Implant could be removed earlier than scheduled. The remainder gave similar reasons to the actual reasons that former users had stopped (see Figure 59) with the exception of wanting to have children as these respondents were screened out of the former users sample.

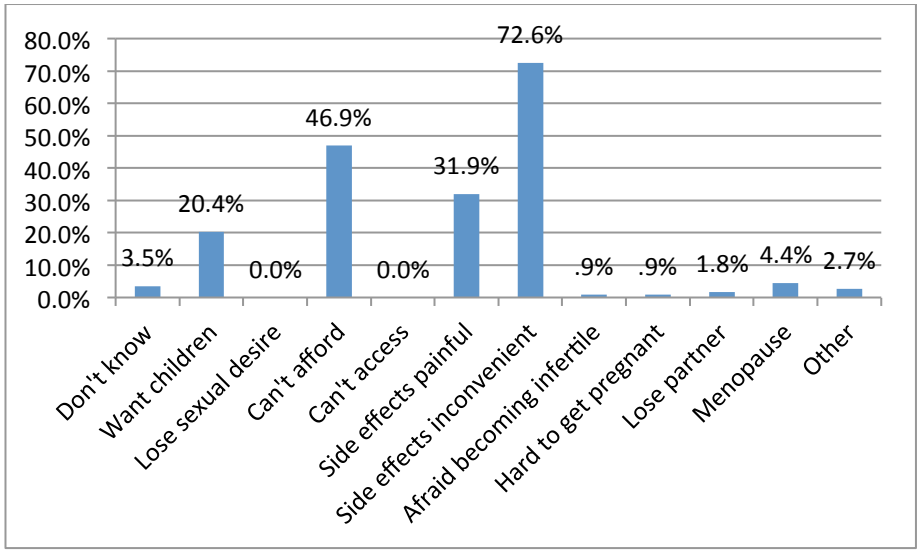

Figure 62: Perceived reasons for early removal

Continuation of Implant use

In terms of future intention to use another implant most respondents were positive and 68.1% of current users said that they would continue with another implant. Only 12.4% said that they intended to switch to a different method of contraceptive and 13.3% were unsure if they would continue.

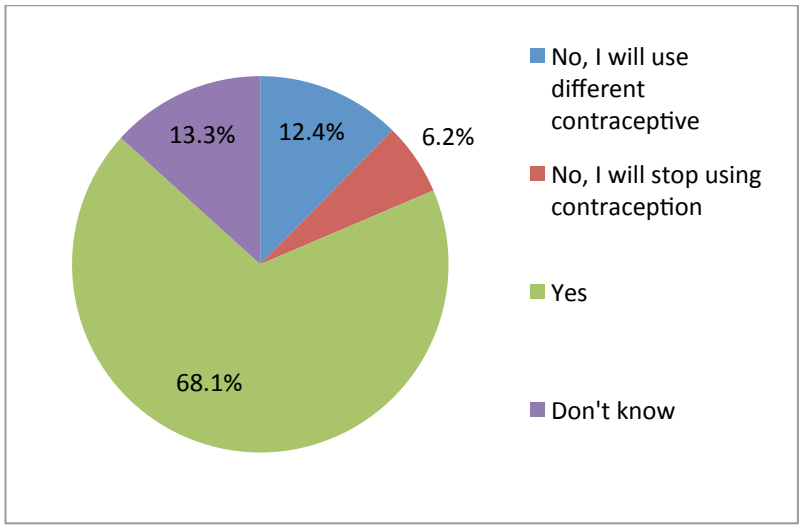

Figure 63: Future intentions of implant use

Trust and Satisfaction with Health Care Providers

All respondents were asked about their satisfaction with their experience with Government Health Services. This section is related to all experiences with health services; not only experiences relating to contraception. Metrics measured in this section include facility cleanliness, waiting times, friendliness of health staff and cost of service.

Across all respondents 39% had visited a government health staff in the last 3 months. This prevalence varied between the three operational districts surveyed, this variation is shown below in Figure 64 where we can observe similar rates of visitation between Battambang and Kampot with 44.6% and 48.6% respectively having visited a government health facility in the last 3 months. However the prevalence of visitation in Tboung Khmum is much lower at only 23.9%, a chi square test against Battambang has shown that this is significantly different7.

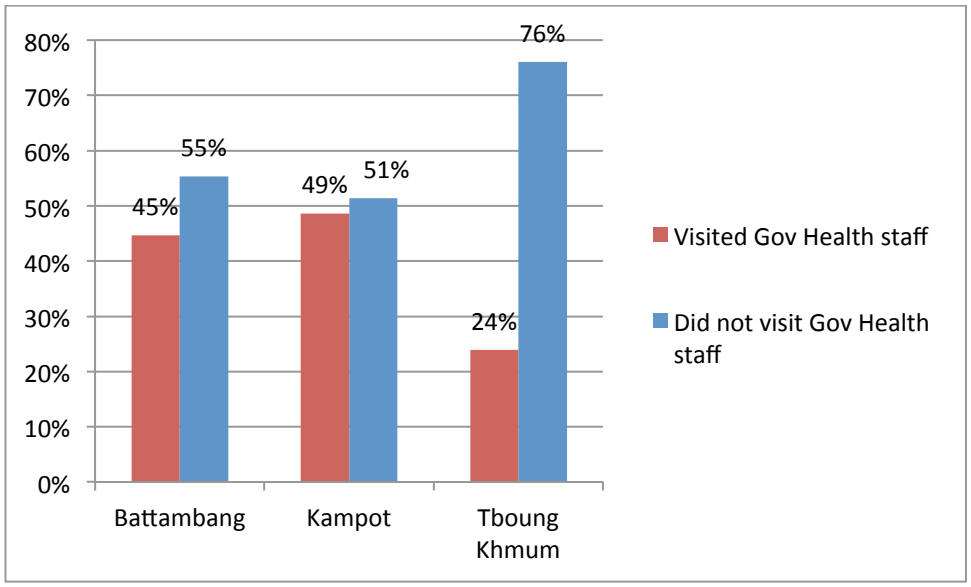

Figure 64: Visited Government health staff in the last 3 months

The reason for the last visit was also obtained from respondents and displayed in Figure 65. The most common reason for last visit was to receive contraceptive counselling with 63.1%. Next at 13.9% each was treatment for others and preventative checkups for others, most likely reflecting the women's role in caring for family members.

[7] Chi Square test was significant at $p < 0.01$ ($x^2 = 10.7578$, $p = 0.001038$)

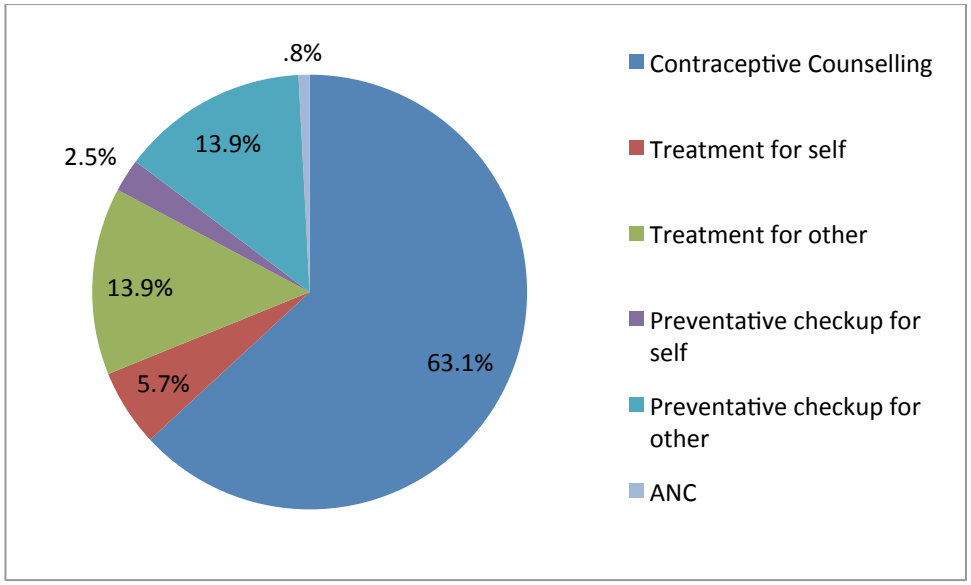

Figure 65: Type of health staff visit

Satisfaction with public Facility and health staff

Looking firstly at the waiting time for respondents, the most common rating was that they had to wait a long time. On this measure Tboung Khmum had a higher percentage of respondents (44%) rate the wait as medium and no respondents who selected that they had to wait for a very long time. Apart from that Battambang and Kampot operations districts were very similar with only a few percentage different for each rating.

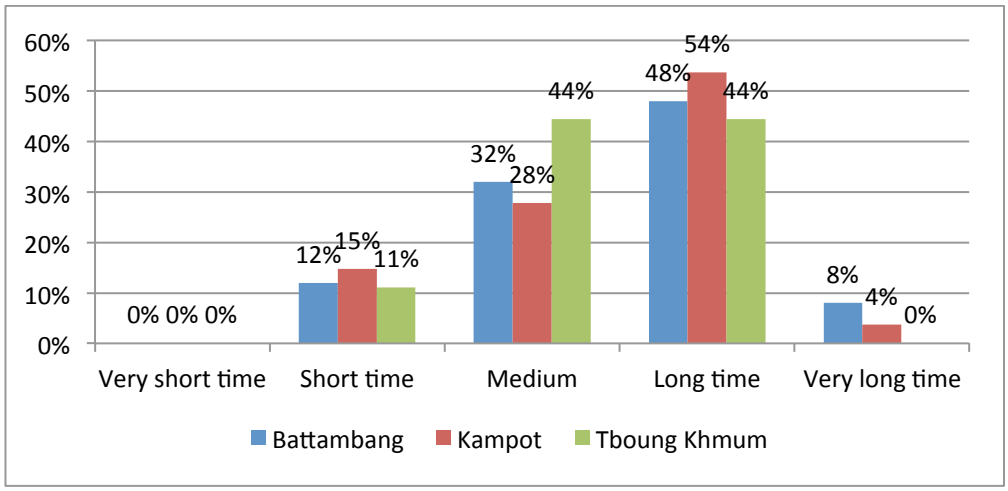

Figure 66: Waiting time at government facilities by OD[8]

The next factor of government health centres that was rated was the politeness of the health staff. As we can see from Figure 67 below polite or very polite health staff were outliers. Aside from that there are no

[8] Measurements used here are subjective, i.e. respondents rated how they felt the waiting time was as opposed to quantifying what a "long time" constitutes. This applies for politeness of health staff, facility cleanliness and overall satisfaction.

significant differences across provinces with the majority of respondents split between medium and not polite in all three ODs.

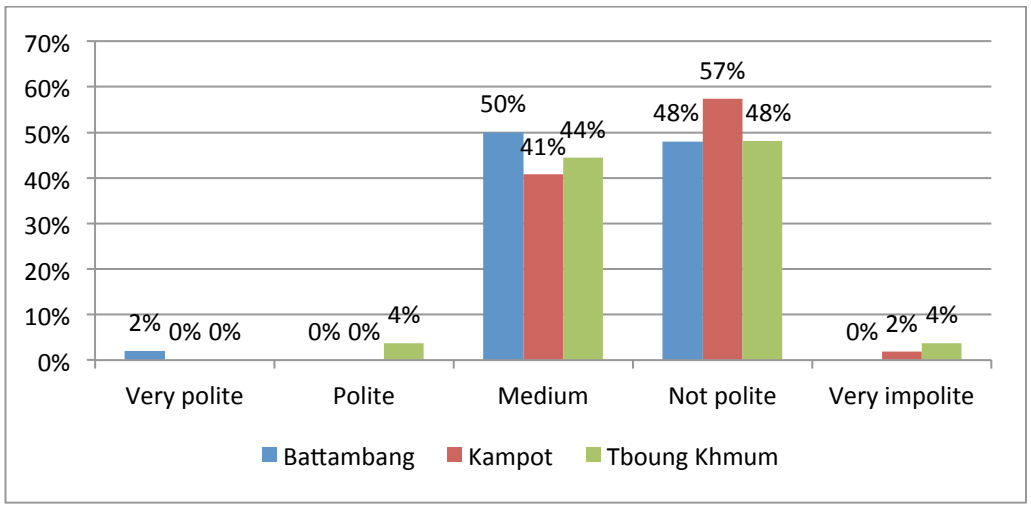

Figure 67: Politeness of government health staff by OD

It was a similar picture when looking at the cleanliness of the facility where no respondents rated their facility as very clean or even clean. 11% of respondents in Tboung Khmum found their facility to be very unclean compared with on 2% for Battambang and 4% in Kampot.

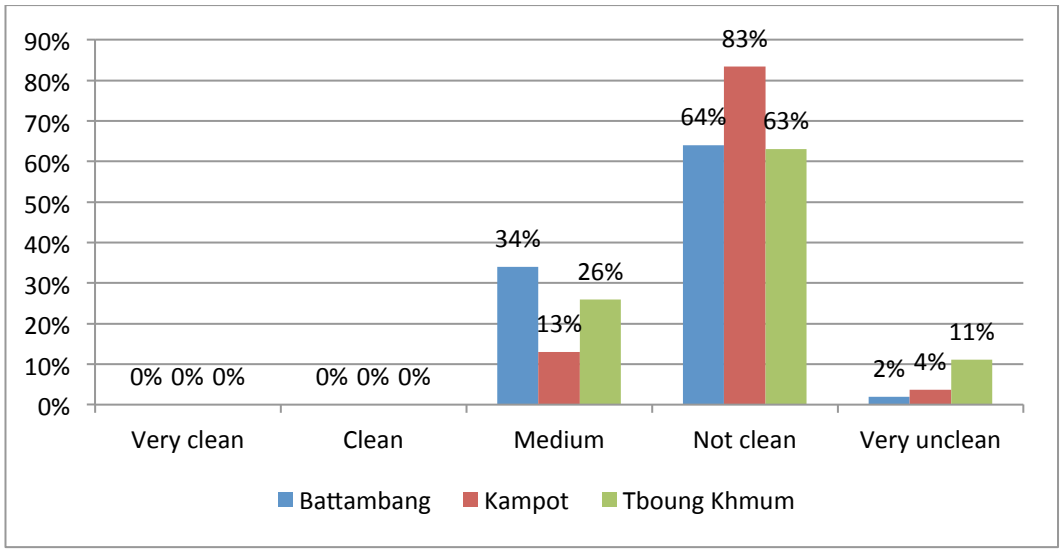

Figure 68: Cleanliness of government health centres

Finally in terms of overall satisfaction with the services of the government health staff the responses again were not very positive, only a nominal amount were very satisfied or satisfied. The majority of respondents were unsatisfied and in Tboung Khmum one third of respondents were very unsatisfied.

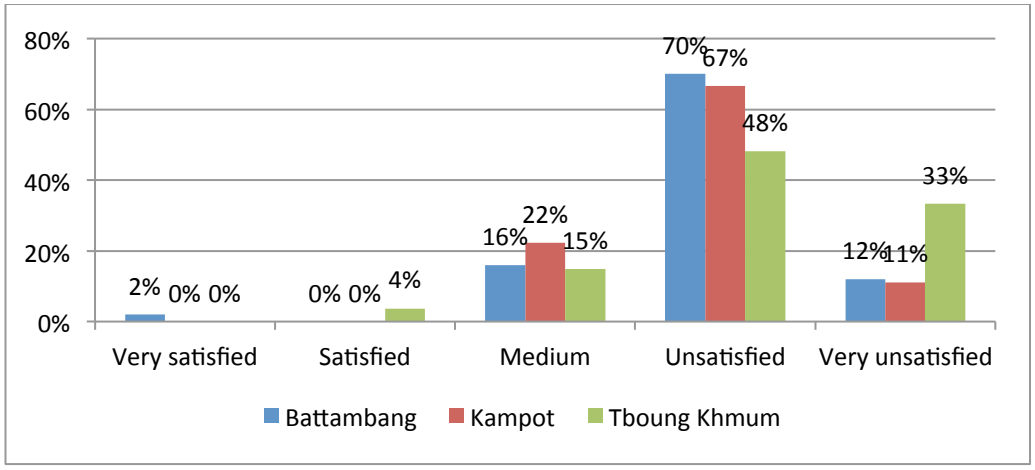

Figure 69: Overall satisfaction with government health staff services

Satisfaction with Contraceptive Counselling and Services

In the last 3 months 25% of women had been for contraceptive counselling for themselves and 1.5% had accompanied someone else for counselling, giving a base size of n=89 respondents to gauge satisfaction of this service with.

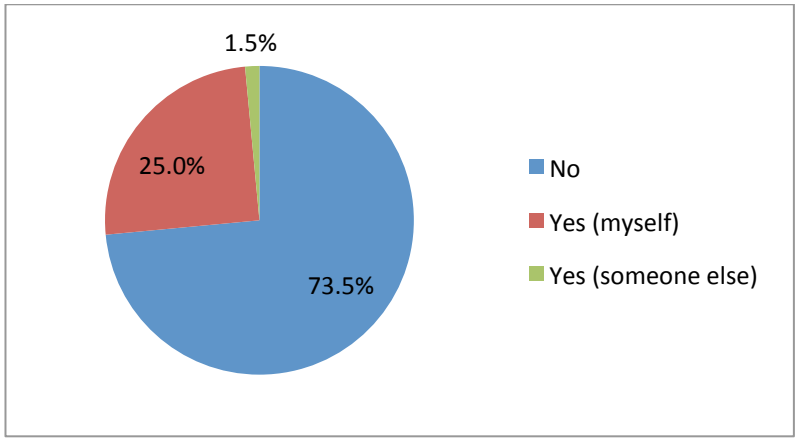

Figure 70: Used contraceptive counselling in the last 3 months

The quality of the contraceptive counselling and services was perceived to be much better than the quality of the governments' health staff service in general. More than seven in ten respondents found the service to be very or somewhat effective and only 3.4% found the counselling to be ineffective.

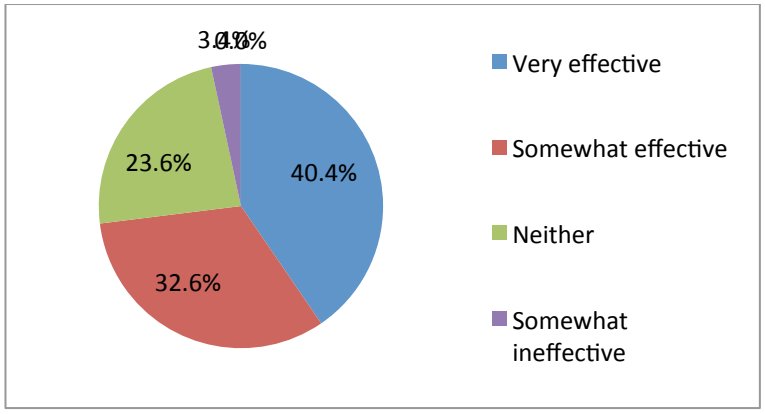

Figure 71: satisfaction with contraceptive counselling

Ranking Contraceptive Methods and Information Sources

In this final section of the quantitative questionnaire, respondents were asked to complete 2 ranking questions using show cards as stimulus. They were asked to rank contraceptive methods from best to worse and also different sources of information to find out information about contraception.

The contraceptive method with the highest average score from rankings was the Implant with an average of 7.94[9]. Similarly to other comparative questions in this survey there will be some sampling bias here as implant users are over represented in the sample. However, it is still promising that so many implant users were positive about this method. The next highest was the daily pill (6.73) followed by the injection at 5.79 which is a strong result for an uncommonly used method amongst the sample. Vasectomy and traditional method were the lowest ranked on average with 3.28 and 3.03 respectively.

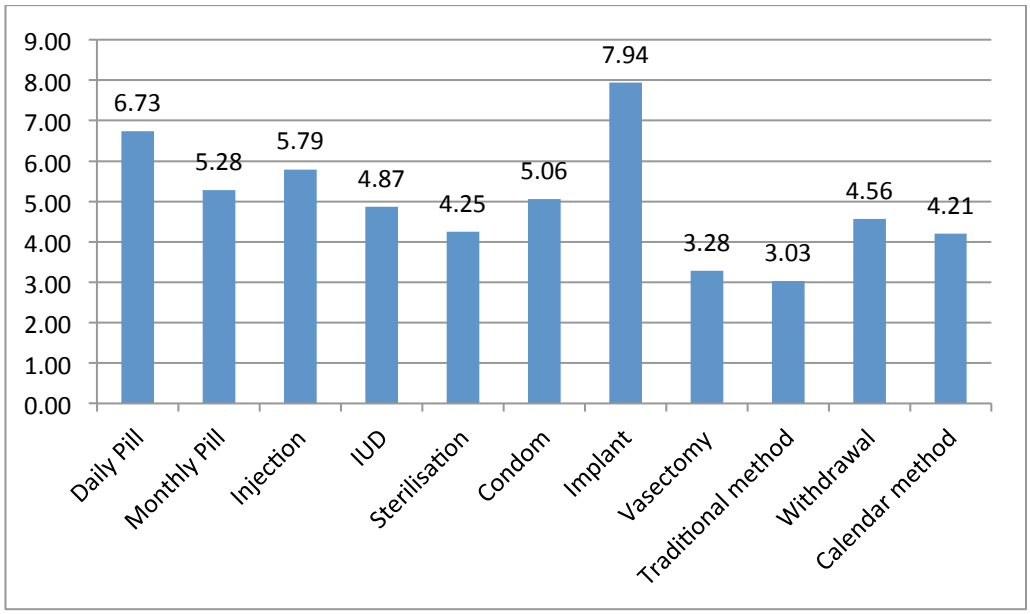

Figure 72: Mean scores for contraceptive rankings

[9] Average inversed to show the best as highest as "1" was the highest score and "11" the lowest.

Analysing the means of respondents' rankings gives a good insight into the overall popularity of each method, however it doesn't tell us about the variation in each method. For example IUD in Figure 72 above has a mean score of 4.87 and is placed around the middle of the methods, but what we can't determine from this is if IUD was ranked around the middle by the majority of respondents, or was it very polarising and received lots of high and lots of low votes causing a average score in the middle? By plotting the scores on a bubble chart such as Figure 73 below we can visually see the distribution of scores for each method by the relative size of the bubble for each score. Continuing to look at the IUD example we can see that all its circles are of a similar size meaning a similar number of respondents ranked it "1" as "2", etc. Compare this to condom which had a similar mean score of 5.06 however we can note that its bubbles are larger towards the centre meaning that it was not as polarising across the sample as the IUD was.

Also of note is the very large size of the implant bubble for number 1 "the best", it's very high mean score was driven by its large number of number 1 rankings, the most of any score for any method. It should be noted here that this figure is likely increased as a result of the project sampling where a disproportionate amount of respondents are Implant users. On the other hand, vasectomy and traditional method have their largest circles at the bottom indicating that a large amount of respondents thought they were "the worst" method.

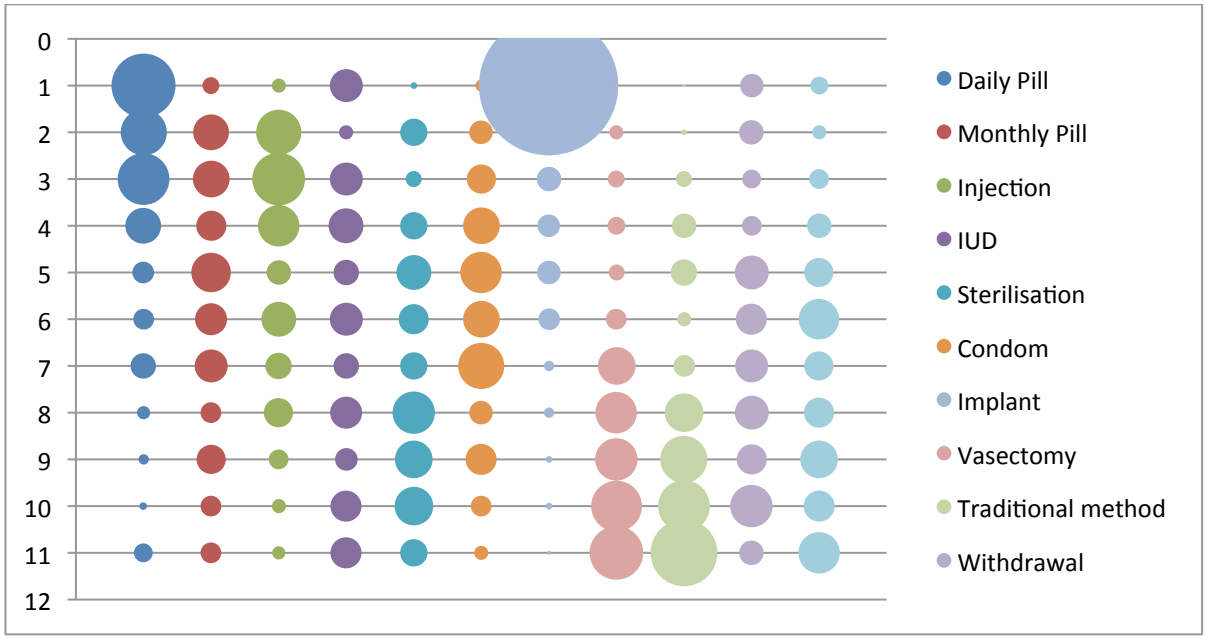

Figure 73: Bubble chart of contraceptive rankings[10]

A similar ranking style question was conducted on the sources to access information about contraceptive methods. In terms of mean rankings the Health Centre staff was the highest ranked with an inverse average of 6.14. Strong rankings for the village health support group and the village meeting show that respondents do like to receive this type of information from trusted personal sources in their village. However TV, with the third highest mean, was the strongest of the media related sources. Radio (4.44) was much higher

[10] Size of bubbles indicates the proportion of respondents who assigned that rank (1 to 9) to each contraceptive method, larger bubble indicates higher number of respondents.

ranked than social media and the internet suggesting that the 'traditional' media sources are still more trusted than online.

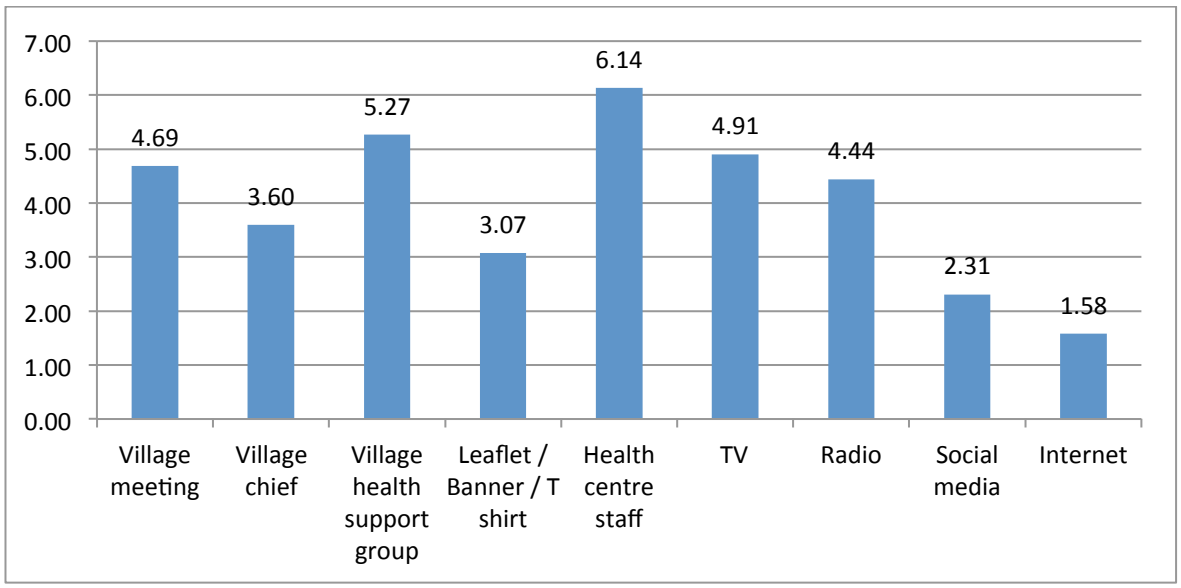

Figure 74: Mean score for information source ranking

When looking at the distribution of these scores in Figure 75 below the largest bubble is for the internet being ranked number 9 (the worst), showing that respondents were very negative about the internet as an information source, possibly to do with the lack of access to the internet of many respondents. The health centre staff took a large proportion of the number 1 votes which lead to their high average score.

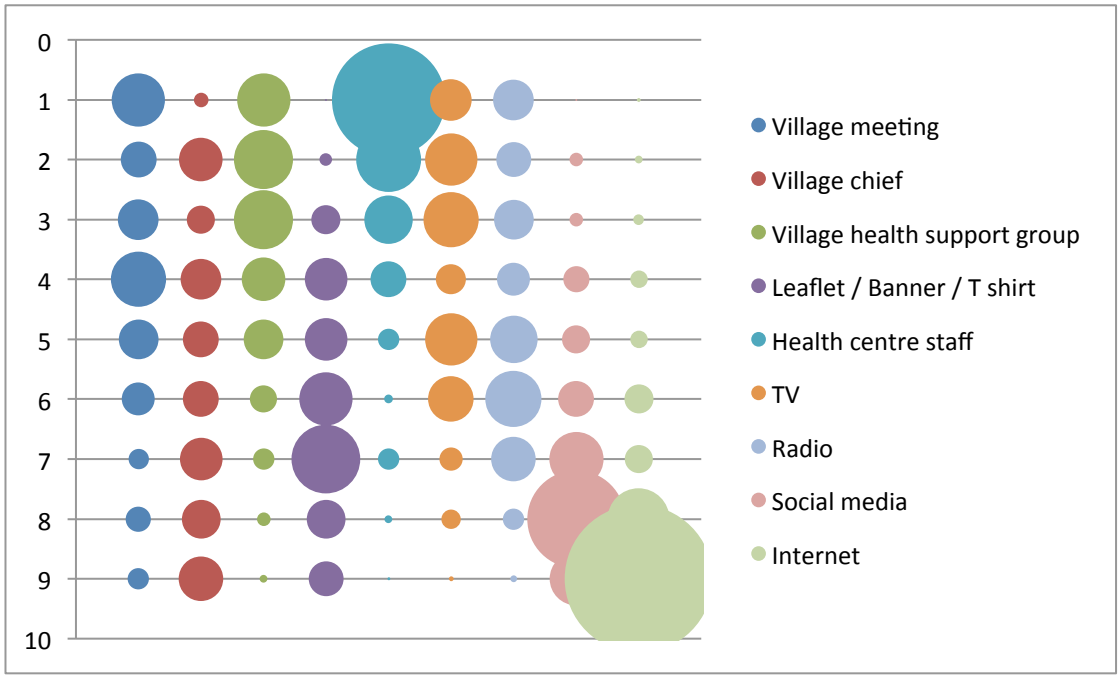

Figure 75: Bubble chart of contraceptive information sources

Qualitative Findings – In Depth Interviews

General perceptions of contraceptives

Initially respondents were asked about their awareness of contraception in general. All respondents asked were aware of contraception, however interestingly a very common initial comment here was around contraception freeing time for women to conduct business, rather than have children:

> *Yes, I have heard about family planning, it is for those who want to avoid having children. I have more time for business if I can limit the number of children - Current User, 29, Bor Veal (Khleng Meas HC)*

> *I have heard about contraception to avoid having child and have enough time for business – Non-User, 42, Tbong Khmum (Health center Peam Chileang), Tbong Khmum*

> *I have heard it is method that makes us unable to fall pregnant which makes it easier to do business – Current User, 35, Oreang Oua (Chork Health center), Tbong Khmum*

Likewise the idea of contraceptives creating time for women to do business came through strongly when asked what type of women use long term contraceptives.

> *The kind of women that I see use the implant have jobs in factories, teachers, middle class people. The reason is they can delay childbirth for business and work long term. - Non-User, 22, HC Oreang Oua*

> *Women who are 21 years and up want to use contraception to prevent having children or they won't have much time to do business and this can make their family get poorer and poorer - Previous User, 23, Ruck Kak Kiri (Preak Chick health center)*

> *Middle women 26-27 and up and women don't want a new baby because they want limited children to make time for business - Current User, 29, Bor Veal (Khleng Meas HC)*

In addition to those who wanted to continue doing business, several respondent identified sex workers as another type of woman who use long term contraception but sex workers are always mentioned in the same breath as other demographics, suggesting there is not much stigma associated with the implant.

> *Women who have a family, women who work in the sexual business and single women - Previous User, 44, Bor Veal (Khleng Meas HC)*

> *Women who have a husband, women who are sex workers; all women can use it - Current User, 35, Oreang Oua (Chork Health center)*

Reasons for and against implant use

Respondents were asked about the reason that they or other women would use the implant. The majority expressed that the main reasons were the high effectiveness of the implant and also the ease of use; specifically it was often cited that it was easier than the daily pill which is easy to forget to take.

> *Easy to use, highly effective, have a lot time to work, rich and poor can use - Current User, 35, Oreang Oua (Chork Health center)*

> *Because the implant can work for a long time, it is easy than medicine because we can forget easily but with the implant we can't forget and it has less side-effects than pill - Previous User, 36, Tbong Khmum (Chub health center)*

> *Because it is easy to use, it can be used for a long time. It is easy to forget to take the pill and then have children - Non-User, 31, Bor Veal (Khleng Meas HC)*

When asked the opposite, why would they or other women not use the implant, most responded by discussing side effects. However the side effects cited differed between each respondent.

> *They don't want to use because they are afraid of the effects on their body; become pale, lose weight, increase weight, no periods - Non-User, 29, Bor Veal (Khleng Meas HC)*

> *Afraid of getting sick when using implants, implants can make people feel dizzy, vomiting or tired - Current User, 40, Ruck Kak Kiri (Preak Chick health center)*

Convenience of Access

Almost all respondents said that they could access the implant at their local health centre. Additionally there were some anecdotal mentions of the Reproductive Health Association of Cambodia (RHAC) NGO, District Hospitals and Private Providers. The majority of respondents said that the implant was easy for them to access; some of their reasons are detailed below:

> *Because staff in the Health center have expert skills and enough equipment. - Non-User, 42, Khroch Chmar (Svay Khlang health center)*

> *Because the Health center is near my house, cost is medium and health staff have skills and are honest - Current User, 25, Tbong Khmum (Health center Chi Ro)*

A minority of respondents however said that the implant was difficult for them to access, mostly to do with distance to health centres or their local health centre not providing implants. One respondent discussed the difficulties of NGOs not remaining in one place.

> *Because after the NGO provided the implant they went away and now we don't have anyone who can provide this service, I don't know who can I ask about the impact to my health. - Current User, 30, Oreang Oua (Chork Health center)*

Perceptions of Local Health Centers

All but a handful of respondents thought that their local health care centre was a good place to have the implant procedure done:

> *Health Staff have good skills, I know some of the staff and it is easy to find - Current User, 30, Bean Teay Meas (Rom Peun Health center)*

> *Because family planning is not expensive, we can afford it. At the Health centre there is staff who have good training and skills - Previous User, 39, Bean Teay Meas (Kong Sdach Health center)*

> *Because the place has good hygiene, the staff have good skills. It is close to my house and there are friendly staff to insert the implants - Previous User, 41, Ruck Kak Kiri (Preak Chick health center)*

Despite mostly positive feelings about the health centre there were a couple of respondents who weren't as positive about their local centre:

> *They are only good for poor people like me that usually apply for implant but when my sister visited (she has money) she said that health staff were not friendly. I think that they are friendly and I want all poor people to use the implant like me too. - Current User, 20, Tbong Khmum (Chi Ro Ti Pir health center)*

> *Health provider don't have good skills - Previous User, 40, Orang Oua (Chork Health center)*

42 out of the 46 in depth respondents had previously received contraceptive counselling or care from a health centre. The general consensus among these respondents was that the advice received at the health centre was good; staff were knowledgeable about contraceptive measures and often checked for other symptoms.

> *I received advice from a health worker. The health workers are friendly, kind and have high level of experience. - Previous User, 24, HC Oreang Oua*

> *Health center provided good advice and also talked about disadvantages and side effects in short term. The health staff examined my nipple to check for cist inside. - Current User, 25, Tbong Khmum (Health center Chi Ro)*

Fewer respondents had experience with a private provider for their contraceptive advice / treatment; around 4 out of 10 respondents. The reasons cited for visiting private providers were mostly related to convenience.

> *Because the health provider is close to my house, When I am busy I buy pills from private provider store but the most I buy from HC because it is costs less money - Previous User, 40, Khroch Chmar (Khroch Chmar HC)*

Because I am busy so that's why I bought the pill from a private provider because it is closer to my house - Non-User, 33, Khroch Chmar (Kampong Treas HC)

One respondent had concerns over the confidentiality of using Health Centres:

The reason that I chose that place was because my husband wanted to buy in secret so we don't go to health center. - Non-User, 22, HC Oreang Oua

Influencers on contraceptive decisions

Respondents were asked who they discuss contraception and reproductive health with the most. There was no consensus here but the most common answers were husbands, health care workers, neighbours and friends.

Health worker in Health center, she is a midwife and health worker. She provided me advice about disadvantages and advantages of contraception. She allowed me to choose any one and I took the daily pill. - Non-User, 33, Khroch Chmar (Kampong Treas HC)

I was influenced by my husband because he has more understanding related to family planning due to reading more books. We discussed family planning and he told me that there is no need to take pill and please use implant as you can use for a long time. - Previous User, 18, Banteay Meas (Sdeach Kong Khang Tbong HC)

With my neighbor because she has experience using implants and when we use it can make us have no periods dizziness, headache. Moreover, it made me lose weight - Previous User, 27, Kampot (Troeuy Koh health center)

When asked about which person helped them to make a final decision about contraceptive methods, two thirds (30 out of 46) of the respondents answered that they made the decision alone:

Nobody can help me to make decision related to contraception method, only me - Non-User, 22, HC Oreang Oua

Some respondents commented that they decided together with their husbands. A few said their mother was an influencer and one respondent mentioned traditional healer (Kru khmer):

My mother because she doesn't want me have more children, she wants me to take time for business - Current User, 27, Khroch Chma (Kampong Treas Health center)

Kru Khmer said that when using the traditional method people can eat rice and sleep. Others have used this method before modern contraceptives. - Non-User, 48, Kampot (Kampong Kandal health center)

Former users who stopped using Implant

Former users were asked about why they decided to stop using. The majority said it was due to various side effects, one respondent had become divorced and another's husband was working in Thailand most of the time. The most commonly mentioned side effects were dizziness, sore arm, heavy bleeding, nauseousness, irregular period and weight loss.

> *Because I had a constant period, headache, fever, dizziness, tired until unconscious, sore hand and leg. It seemed to have a strong effect on my health so that's why I took implant out. - Previous User, 24, HC Oreang Oua*

> *Because it made me very sore in my hand and leg. Lots of headaches and I couldn't do work. - Previous User, 33, Toek Chhour (Chum Kreal health center)*

One respondent mentioned an unusual perceived side effect relating to weight of future children:

> *Because I stopped getting my period. And by the way my father in law asked me to stop using because he thinks it will make his grandchildren thin (lose weight faster) - Previous User, 18, Banteay Meas (Sdeach Kong Khang Tbong HC)*

Current users' future intentions

Of the 15 current users who took part in in-depth interviews, 9 said that they wanted to continue to use the implant when their current one expired. The reasons were similar to the positive aspects of the implant; easy to use, effective and allow time for business.

> *Because when we use we don't have to worry about pregnancy and don't have to remember to take a pill or tablet, the implant it is easy - Current User, 35, Oreang Oua (Chork Health center)*

> *It's highly effective, it is easy to use and leaves more time to do business - Current User, 40, Ruck Kak Kiri (Preak Chick health center)*

The six respondents who indicated that they would not continue cited varying side effects as to why they would not continue with another implant.

> *Because now I am thin so I'm afraid that implant is not suitable for me and so I chose the pill for family planning - Current User, 21, Toek Chhour (Chum Kreal health center)*

> *I want to use other methods because implants make me hurt inside the body, dizzy, headaches, shaking body and fever - Current User, 34, Moeurng Russei (Ta Leas Health center)*

> *Because when I use it I don't get my period and it is easy to get tired so I can do less work. I want to choose a different method because it won't have as many side effects as the implant - Current User, 20, Tbong Khmum (Chi Ro Ti Pir health center)*

In Depth Ranking Questions

Given there was more time available when conducting the in depth interviews, respondents were asked several ranking questions similar to the quantitative study. They were asked to rank which contraceptives from "best" to "worst" overall, easiest to most difficult to access and most to least side effects. In each of these measures respondents were asked to rank the contraception from 1 to 11, with 1 being the most positive ranking and 11 the most negative.

To analyze which contraceptive respondents thought was best, we can begin with an average of the rank each respondent assigned to each contraceptive. This is shown below in figure **Figure 76**, with the inverse means shown so that the "best" contraceptive receives the highest average rather than the lowest, as lower scores mean better contraception. So the implant was regarded as the best contraceptive with an inverse mean of 7.96 out of 11. This result should be considered in light of the sample for this project where there are a higher proportion of implant users than users of other methods. Also popular was the daily pill (6.85), monthly pill (5.76) and injection (5.96). The least popular or "worst" contraceptive was considered to be vasectomy (3.04).

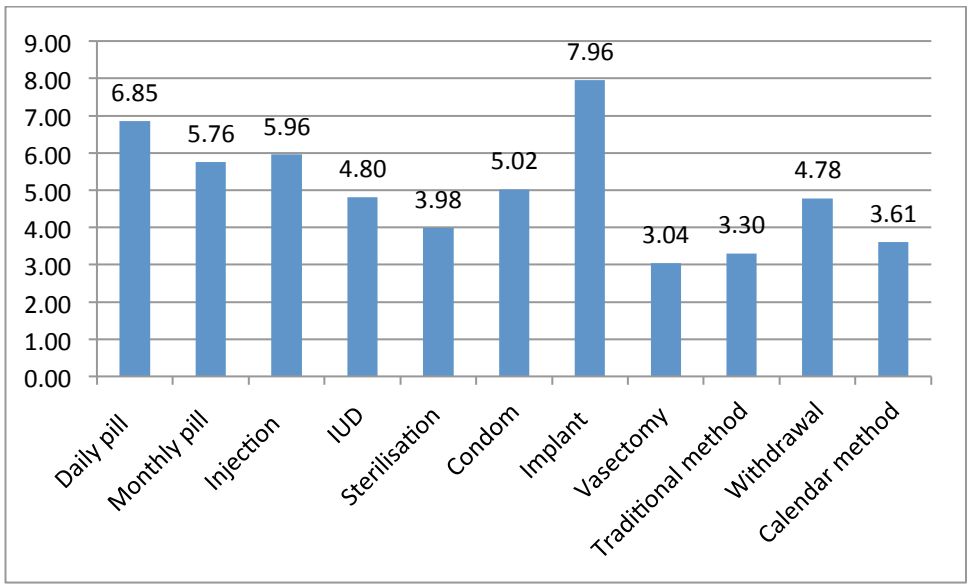

Figure 76: Inverse means of best to worst ranking

The average scores provide a good overall measure of popularity, however the ranking questions allow us to analyze in greater detail. For example injection scored an inverse mean of 5.96, from this figure we cannot tell if all respondents had similar opinion on injection and ranked it consistently in the middle or was injection a polarizing method, having a mixture of very high and very low scores? Both would yield a similar average, so we can further analyze the data using the bubble chart below. In this chart each colored set of bubbles represents the scores given by respondents for one method. For example, again looking at injection in green we can see that it's most common score was 4 as this is its largest bubble and it received a very small proportion of its scores for 1 or 11 (very best or very worst contraceptive).

The distribution for implant rankings is very heavily skewed towards scores of 1 (the best) as we can see by the very large purple bubble at the top. We can also see that the IUD and Calendar method are the most polarizing contraceptives as both have relatively large bubbles on both the top and bottom of the scale.

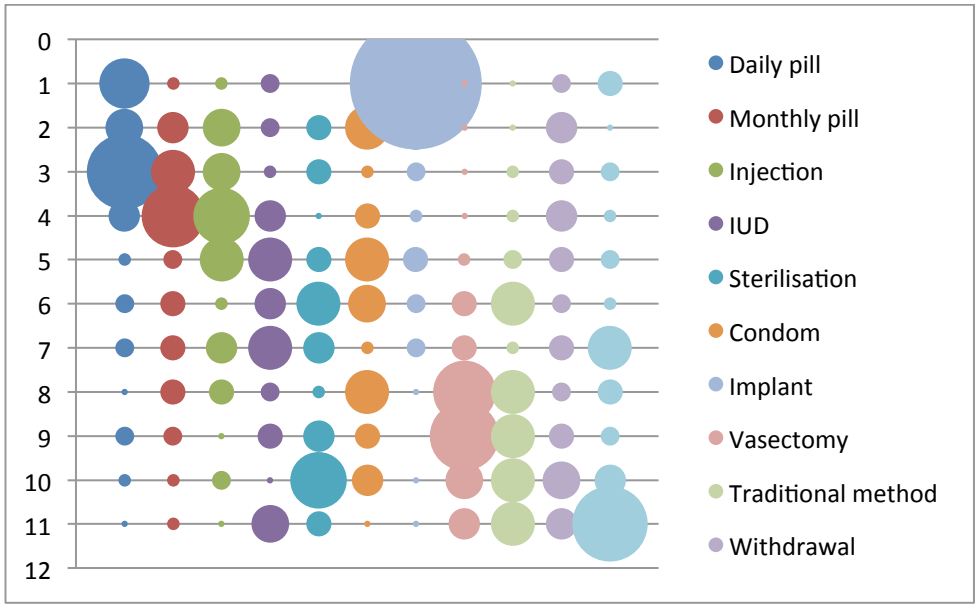

Figure 77: Bubble chart distribution of rankings for best to worst

Additionally in the IDIs, respondents were asked to give a reason for what they ranked as best, worst and the ranking applied to the implant. Some of the reasons behind the 21 respondents who ranked the implant the best are below:

> *Because it is easy to use and there is no need to spend more money. We can't forget to take it like the pill. It works for a long time and it can allow me to do my job without disturbing me too much. - Previous User, 32, Bean Teay Meas (Kong Sdach Health center)*

> *It is easy to use and highly effective. I don't have to worry about pregnancy - Non-User, 27, Tbong Khmum (Chi Ro Ti Pir health center)*

Another method with many top rankings was the daily pill, the reasons why are explained below:

> *Because every village has it for sale. Before I took the pill I didn't have any side effects but after I had my first child the pill made me have a fever and not well inside my body, so then I used the implant but I still think that the pill is better than the implant because we can buy it everywhere - Previous User, 40, Khroch Chmar (Khroch Chmar HC)*

> *Because if works inside the body and it doesn't cause pain, increases weight and makes regular periods - Non-User, 33, Khroch Chmar (Kampong Treas HC)*

The calendar method was the method with the most worst rankings (11). Some of the reasons are confusion, unreliability and lack of information about this method:

The reason that I ranked it 11 is because it is worst contraception, I don't understand how to use calendar method when I have an irregular period - Non-User, 22, HC Oreang Oua

Because I'm afraid I'll get confused and afraid that I will forget - Non-User, 27, Tbong Khmum (Chi Ro Ti Pir health center)

Next, respondents were asked to rank which contraceptive method was the easiest for people to access in their area to which was the most difficult to access. When looking again at the inversed means the daily pill is clearly the highest with a inverse mean of 8.78 out of 11. The next easiest to access methods were the monthly pill and the injection (6.63 and 6.65 respectively). On the lower side sterilisation and vasectomy had the lowest inverse mean meaning they were widely considered the most difficult to access in respondents' local area.

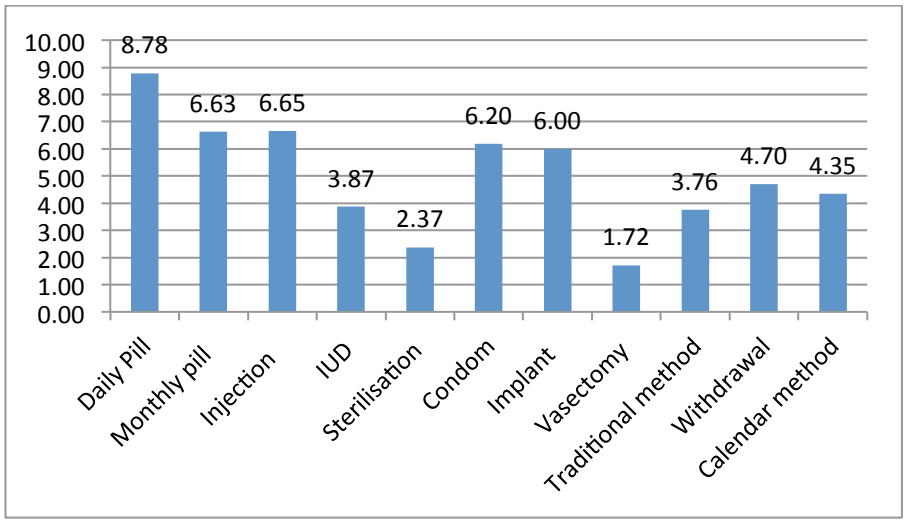

Figure 78: Inverse means of best to worst access

As expected the daily pill, with its very high average had the majority of number one rankings. Similarly the low scoring sterilization and vasectomy methods have large concentrations of their rankings at the bottom, being ranked 9th, 10th or 11th best in terms of access by the majority of respondents. In regards to the ease of access for the implant, its distribution is spread relatively evenly across the top half of rankings, however it still has some way to go to be considered as easy to access as the daily or monthly pills.

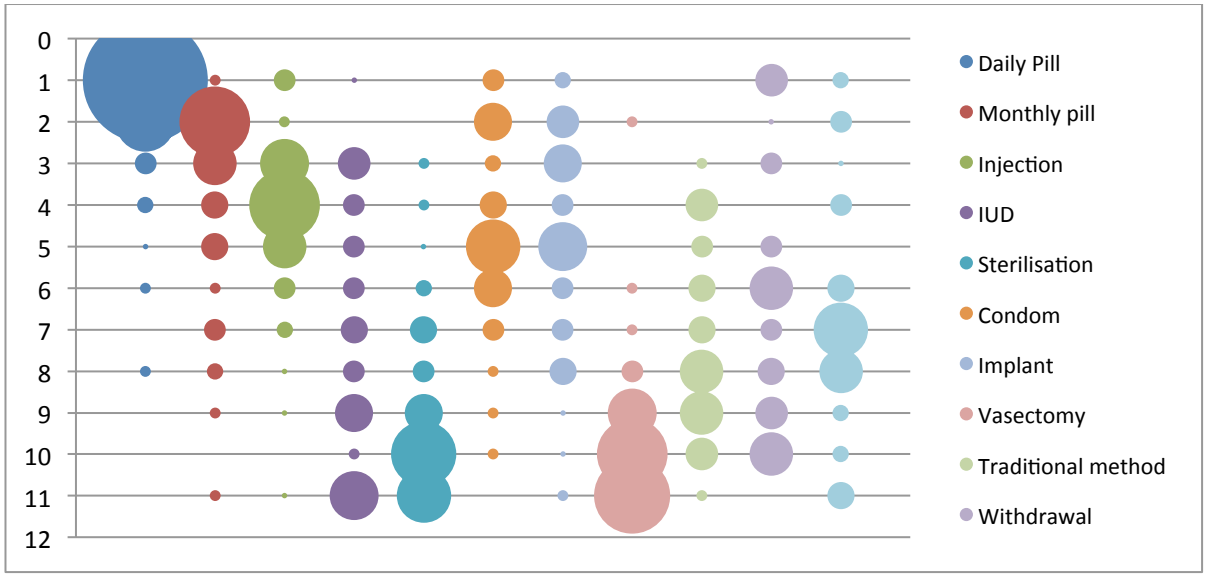

Figure 79: Bubble chart distribution of rankings for ease of access

Qualitative findings - Focus Group Discussions (FGDs)

Six focus groups were completed as part of the survey, two groups with each of three target groups; current users, former users and non-users. This section of the report will detail the general trends discovered in the groups, any differing opinions between target groups and interesting quotes and anecdotes from respondents.

General perceptions of contraception

Across all groups the awareness and understanding of contraception in general was good. All respondents were able to explain the general principle of contraception and name some methods. One interesting difference here was that in one of the non-user groups respondents often mentioned that they had heard about contraception through other community members, other groups did not make this remark as they had learned about contraception through experience or speaking with medical staff. This lack of formal education on contraceptives could be a barrier to use of long term methods such as the implant.

> *"I have heard others say there is injection, pill, IUD and condom." - Non-user, 34, Phnom Touch group, Kampot*

> *"Injection, condom and natural method. But I never use, I have heard others say.". – Non-user, 34, Phnom Touch group, Kampot*

Similarly to the in depth interviews many respondents in the focus groups made reference to contraception and family planning allowing time for business.

> *"For me, I would like to delay having more children until my current child is older, then I will have one more child, then when they are grown they can take care of their sibling so that I can have time*

to do business. We will use family planning to give us enough time to do business". – Former user, 23, Chrang Bak group, Battambang

For another respondent family planning was a necessity due to the high cost of children.

"Yes, I use family planning to avoid having too many children, if we don't use family planning we will have too many children. Now I have four children it is hard to find money for them to study. Sometimes I cannot afford to earn money to feed them. More eating, more spending, everything". – Current user, Chum Kreal group, Kampot

Side effects of the implant

The two groups of current users were the most positive about side effects, with many respondents in these groups noting no side effects. Those who had noticed side effects had only experienced minor side effects like weight gain, amenorrhea, pain in the arm, headaches, dizziness and itchy skin. Most of these side effects had been felt immediately after insertion for a short period and most respondents noted that health staff had warned them about these things.

"Implants are good to use because health staff told me that implants will make you have headache and dizziness. Moreover, health staff said that if implant is effective, it will have the same symptoms as pregnancy headache, dizzy and then later on no problem". – Current user, Chum Kreal group, Kampot.

"Health staff said that some women will have fewer periods or can't have periods"- 35, Current user, Khsach Dandal Group, Tboung Khmum

The former users gave a different perspective on side effects than the current users, noting more serious side effects. This reflects the quantitative findings from former users where the most common reason for removal was 'side effects too inconvenient'. Most former users had some accounts of experiencing many side effects similar to the verbatim below, however it was commonly noted that the health staff warned them of side effects and often made efforts to provide additional medication to limit the side effects.

"For me, the first time I used it I got side effects like headache, fever. My period used to come every month, one time per month. It is not the same when I insert it, I had less bleeding for 3 years, three times per month I had black bleeding, and had smell, shaking chest, headache. So then health staff gave me medicine for one to two months, they said it would be painful at first but then it would stop the side effects. I ran out of medicine so when I stopped taking medicine for 1 week it has came back again the same kind of bleeding. My husband said please go to remove it and then when I removed it no problems, it made me feel good and then my weight decreased by 3 Kg. When I insert it the first time my weight was 52Kg after I insert implant it made me increase to 57Kg, now I am only 53Kg but I removed it one year ago". – Former user, 32, Chrang Bak group, Battambang

The two groups of non-users perspective of side effects was formed mostly from experiences they had heard from friends, neighbours and relatives. One perceived side effect was that the implant could be inserted incorrectly resulting in pregnancy still being possible;

R3: "I don't have any idea but I heard that when we use implants we can still get pregnant. Why do we have this case where we want to use implants to prevent pregnancy but it still has more pregnancy?"

R4: "Maybe the health staff inserted it opposite?"

R3: "I don't know too, why would they insert opposite way - they are health staff. Why insert implants wrong way so that it is not good? And sometimes, when the implants are inserted incorrectly and we have heavy work it cause pain so we have to get the implant removed".

– Non-users, Chey Tri Pir group, Battambang

The idea of the implant causing pain in the arm, thus preventing women from doing heavy work was most commonly cited amongst the non users:

"I heard from my sister, who had used implants too but she told me that when she inserted it made her fatter and often her arm and legs hurt. It hurt only when she had to do heavy work so she cannot do heavy work with the implant." 34, Phnom Touch group, Kampot

Perception of LAPM users

During the focus groups respondents were asked "what kind of women use long acting contraception" to uncover any kinds of stigma which may be associated with long term contraception use. Across the focus groups no negative perception were uncovered in this respect, mostly respondents viewed implant users as ever married women who needed time to do business and postpone rather than prevent having children.

"For me, I understood the same too, women who have family situation where they have a business, so they can delay having children for 4 to 5 years. So that we have time to do business". - Former user,32, Chrang bak group, Battambang

In the Chrang Bak group in Battambang respondents said that women who go to work in Thailand commonly use the implant because the pill is difficult to obtain and more expensive in Thailand.

"Because some women want to have business far away for their hometown and they have to take the pill, it is hard for them to buy pill in Thailand because it is expensive. Some women will buy 10 to 20 tablets then when they run out of the pill they will came back to buy in Cambodia. But most women insert implants when they have to work at Thailand." –former user,23, Chrang bak group, Battambang

Barriers to use

One of the non-user groups had the perception that problems with the early removal process were a reason that some women chose not to use the Implant.

R3: "Some women have experienced that when they went to health centre to remove the implant the health centre staff blamed them and said 'why did you come here to have it removed? Why did you insert it?"

R2: "If they cannot afford the side effects they have right to remove it, so why do the health staff blame her like this? So these experiences can mean that some women don't dare to insert implants in Health Centre."

- *Non-users, Chey Tir Pir Group, Battambang*

The other non-users group cited difficulty to access, as they were very far from the health centre as a reason why women don't use and also the perception that the implant will render them unable to work in the fields.

> *"Because we stay at the rice field so we have to do heavy work, if we have implants we can't do the work. But some women said that they inserted the implants and didn't have any problem". – 34, non user, Phnom Touch group, Kampot*

Some other respondents spoke about some women's perception that the implant could cause users to have darker or unattractive faces when using.

> *"Because some women said that when they use implants they can make our face or skin became black and not beautiful. And their periods are irregular. But for me I think that if we have more children we are afraid that we will no longer be able to feed and support the studies of our children" . – Current user, 40, Chum Kreal group, Kampot*

> *"Some women won't have periods when they use implant, some are afraid it can hurt them inside and also can make our face not pretty." – Current user, 30, Chum Kreal group, Kampot*

Ease of access

Most respondents were aware of where to get the implant inserted and thought that the process was easy.

> *"When we have it inserted, we insert at health centre, removing we must to remove at the same health staff no problem. And health staff said that when we have problem please came to see a health staff." – Non user, 33, Phnom Touch group, Kampot*

> *"When I inserted the first time I went to village chief house to get poor letter. I think that it was easy, he wrote letter for me and I went back to health centre. I invited my niece go with me too, when we arrived there the health staff inserted for me and my niece. When I insert it the first time I didn't hurt and I heard from others that didn't hurt also. After we inserted the health staff gave us 2 dollars more." – Former user, 32, Chrang bak group, Battambang*

The Chey Tir Pir group, as noted before, had the perception that insertion of the implant was easy however having it removed would be more difficult.

"When we arrived there it was easy to insert. We go there and then the health staff checks our health and inserts soon after. But if we want to remove, they make it difficult because they want to do another job." – Non user, 39, Chey Tir Pir group, Battambang

Perceptions and experiences of insertion

Looking now to the actual procedure of insertion, the experience of users was generally that the procedure was simple and not too painful. Respondents in one group noted that in terms of long acting methods the implant was preferred to the IUD because of the invasiveness of the IUD insertion compared with the implant.

"We had to discuss with health staff about family planning, they showed us that there are many methods of family planning such as implants, IUD, condom, vasectomy, calendar, sterilely and others. We have many choices to use for family planning. After that, the health staff asked that which one method that we want to use, then I said that I choose implants because if I choose the IUD it will make me shy with health staff" – Current user, Chum Kreal group, Kampot

Moreover, I have to use implants because if I use IUD it will make me shy with the health staff and if we are not brave, health staff will tear apart of legs to insert IUD. We can insert implants no problem, we can close our eyes and let the health staff do it every time. - Current user, 34, Chum Kreal group, Kampot

Influence of women's partners

Similarly to the quantitative study respondents sought advice from a number of different sources such as Health centre staff, friends, neighbours relatives and their husbands. As one of the objectives of this study is to understand better the influence which women's partners have on contraceptive choice we shall look more closely at the role of the husbands as experienced by women in the focus groups. There was no clear trends with the influence and attitudes of husbands varying on a case by case basis as the comments below demonstrate.

I went to use implants I told my husband that they don't allow to work heavy for 2 or 3 days. I made myself relax for 3 days didn't wash clothes myself and my husband didn't dare to let me work. – Former user, 38, Phnom Toul Vihea group, Tboung Khmum

Respondent: *At first I discussed with my husband then I discussed with Health staff. I asked health staff about which method is better.*
Interviewer: *Which one do you like to discuss with the best, husband or health staff?*
Respondent: *Health staff, haha.*

– Non user, 25, Chey Tir Pir group, Battambang

My husband said that no problem, if we want to delay we can delay and he will follow me. He asked to me to find a new method of family planning. –Non-user, 34, Phnom touch group, Kampot

I heard of one case of a woman, she went to insert the implant and then when she came back home her husband saw her arm had a cloth covering. Her husband is very handsome. When he saw like that he hit her until her face was black and body hurt. Then the next day, she went to health center to remove the implants because the husband didn't want to use. It is bad case. Just only one night her husband fought her until swollen face. Then, she came to talk with me and I felt pity for her. She said that if she didn't remove the implant her husband will beat her until she dies. So, he is bad husband – Current user, 30, Chum Kreal village, Kampot

Conclusion

Knowledge of contraception

The concept of contraception was well understood by all study respondents and the most recognised methods were the daily pill, the implant, IUD and the injection. When looking at the initial place that respondents sought advice on contraception the local health centre was by far the most common place, however not exclusively, respondents in smaller numbers had first sought advice from private clinics, pharmacies, friends and family and their partners. When analysing this place against respondents' current contraceptive method there were significant differences between respondents now practicing withdrawal as opposed to medical contraceptives; the daily pill and the implant. Significantly fewer withdrawal users had first obtained advice from the health centre compared to implant and pill users. Additionally there were a higher percentage of women who had obtained advice from their husbands amongst withdrawal users.

Contraceptive experiences

Amongst the non-user group just under half were currently using contraception. The most common methods were the daily pill and withdrawal; in fact, these were the only two methods with adequate sample size to analyse as a sub sample. However these two methods give a good comparison to the implant; one non-medical method and one medical short acting method as opposed to comparing the implant to say the injection where variance would most likely be negligible.

For both of these methods ease of use was the most commonly cited reason for use, which was also strongly represented for the implant amongst its users showing that ease of use is an important determinant in contraceptive choice. Similarities such as this between methods can reveal behaviour about contraception choice in general, however by contrasting the differences between methods we can also learn about the decision making process of women. The most pertinent example of this was in examining the influencers on contraceptive choice between the daily pill and withdrawal; here a significantly higher percentage of withdrawal users said they had been influenced by their husband than those using the pill.

Knowledge of the Implant

Barriers to implant usage can be identified by comparing the perceptions and knowledge of non implant users against the experiences of the implant user groups. For the most part the perceptions of non-users were very accurate when compared to the actual experiences, the most notable exception was in terms of costs, where non-users over estimated considerably the cost of the implant insertion and underestimated implants that were provided at no cost. So the perception of costs was higher than the actual experience, however the opposite was true when analysing the perceptions around side effects. All side effects were more commonly experienced by users than were mentioned as perceived side effects by non-users. The key gaps between perception of non-users and reality of users was that perceived costs were overestimated and perceived side effects were under estimated.

Experiences of the Implant

Amongst current and former users of the implant the strongest determinants for adoption were ease of use, effectiveness and recommendations from friends or family. Primarily women made the decision to use the implant themselves. A small amount of women were influenced primarily by their husbands or the health staff. The availability / use of health insurance schemes was found not to be a driver of implant adoption as no respondents selected it as a reason that they used the began Implant use.

The large majority had their implant inserted at public health facilities and a small amount had it inserted at private health facilities, unsurprisingly costs were lower and thought of as being more affordable at the public health centres. At the health centres over half of the respondents received the implant for free, through a health financing scheme like HEF or similar, however the use of health financing was not a factor in women's choice of the implant. The most commonly nominated negative factor was that the side effects were uncomfortable, which also has a strong impact on discontinuation of the implant.

Removal of the implant experience and perception

A high percentage of former users had removed the implant earlier than expected and the primary determinant for discontinuation was inconvenient side effects; this was true also for respondents who had removed the implant on schedule. Current users were asked about their perceptions around removal, which were accurate in terms of implant life and reasons for possible early removal. However, when asked about the cost of removal over six in ten were unsure of the cost and those that did know provided varied answers. So education around the costs of removal could reduce barriers to implant use. Encouragingly close to seven in ten users said that they would continue to use the implant after their current one expires.

Trust and satisfaction with healthcare providers

Satisfaction with government overall health services was not rated very positively. In fact, on a five point scale (2 positive ratings, 1 neutral and 2 negative) there was only a nominal amount of positive rankings on any of the four metrics taken; waiting time, politeness, cleanliness and overall satisfaction. There were no significant differences here across the three operational districts, each being rated equally poor by respondents who had visited recently. Encouragingly, respondents who had recently received contraceptive counselling were much more positive when rating it; only a small number were dissatisfied, an opposite trend to facility and health staff in general.

Appendix 1: Wealth Ranking Methodology

The index used to estimate household wealth is computed from basic information on socio-economic characteristics of households.

We categorised respondents into three groups to assess possible inequities in health. Cut-off values are percentile values of a wealth score computed on the sample.

We defined wealth categories (poorest, poor and better off) using the following data: housing type and rooms, assets, animals, and toilets. Interviewers also observed and ranked each household in three categories, from poorest to richest. We then used the algorithm below to attribute points for each answer and compute a wealth score for each respondent using the formula below.

Housing type index (from 0 to 4):

4 if they have a brick or concrete house;
3 if they have a wooden house and tiled roof;
2 if they have a wooden house and a tin roof;
1 if they have a wooden house with palm leaf roof;
0 if they have a house of palm leaves/thatched roof.

Room index (from 1-3):

3 if they have more than 2 rooms for sleeping;
2 if they have 2 rooms for sleeping;
1 if they have 1 room for sleeping.

Asset index (from 0 to 4):

4 if they have a car;
3 if they have a boat and/or ox-cart and/or motorbike;
2 if they have a TV, bicycle and/or refrigerator;
1 if they have a radio/phone;
0 if they have none of the above.

Toilet index (from 0-3):

3 if two or more toilets;
2 if one toilet;
1 if share with another family;
0 if no toilets.

Animal ownership index:

The value of animal ownership was calculated by using the following formula:

Animal = round((poultry/2+pig+goat)/2+(cow+buffalo+horse)/2)

Subjective wealth category (as rated by surveyor):

2 if least poor group;
1 if middle group;
0 if poorest group.

The wealth score is computed by adding the computed values of house type, animals, assets, toilets and subjective wealth category:

Wealth Score = housing index(0-4) *+ room index*(1-3) *+ asset index*(0-4) *+ subjective wealth index*(0-2) *+ animal index*(0-3) *+ toilet index*(0-3)

Scores range from 1 to a maximum of 19 points. We then establish two cut-off points, such that the "Poorest" category corresponds as closely as possible to the lowest quintile (20%), and the "Better-off" category corresponds to the highest quintile (20%).

Appendix 2: Final Quantitative Instrument

Filter **Now I want to ask you some information about your experiences with contraception.**		
1	How old are you?	Age: **(end interview if not 15-49)**
2	Are you currently, or have you ever been married?	Never married **(end interview)** 0 Currently married 1 Ever married 2
3	Are you currently pregnant or trying to become pregnant?	No 0 Yes **(end interview)** 1
4	Are you currently using ANY contraception?	No **(Skip to Q8)** 0 Yes 1
5	Which method(s) of contraception are you currently using? ***IF NOT CODE 4 (Implant) Skip to Q9***	Condom 1 Daily Pill 2 Monthly Pill 3 Implant 4 Injection ***LAPM*** 5 IUD ***LAPM*** 6 Sterilisation ***LAPM*** 7 Vasectomy ***LAPM*** 8 Traditional method 9 Withdrawal 10 Calendar method 11 Other 88
6	How long have you been using the implant for? ***If more than 2 years end interview***	Years:
7	Have you ever received family planning services? ***If No, end interview*** ***If Yes, Skip to Q15 and code "Group 1"***	No **(end interview)** 0 Yes 1
8	Have you ever used contraception?	No **(Skip to Q13)** 0

		Yes	1
9	Have you ever used the implant?	No **(Skip to Q12)** Yes	0 1
10	How long ago did you stop using the implant? ***If more than 2 years, end interview***	Years:	
11	What was the main reason you stopped using the implant? ***If code 1 or code 7 end interview*** ***All other codes go to Q15 and select "Group 2"***	Wanted children	1
		Lost sexual desire	2
		Can't afford	3
		Can't access	4
		Side effects	5
		Infertile	6
		Hard to get pregnant	7
		Lost partner	8
		Menopause	9
		Other (specify)…….	88
12	Which contraception methods have you ever used now or in the past? ***Multiple answers*** ***If codes 5,6,7 or 8 (LAPM) end interview***	Condom	1
		Daily Pill	2
		Monthly Pill	3
		Implant	4
		Injection ***LAPM***	5
		IUD ***LAPM***	6
		Sterilisation ***LAPM***	7
		Vasectomy ***LAPM***	8
		Traditional method	9
		Withdrawal	10
		Calendar method	11
		Other	88

13	Have you ever given birth?	No **(end interview)**	0
		Yes	1
14	When did you last give birth? ***If code 1, continue to Q15 and select "Group 3"***	More than 6 months ago	1
		Within the last 6 months **(end interview)**	2
15	DO NOT ASK Respondents Group	Group 1	1
		Group 2	2
		Group 3	3
Section 1: Respondent background and assets – **ASK GROUP 1,2,3** **Now I want to ask you some information about your background and your household.**			
16	What is your marital status?	Married	1
		Living together (not married)	2
		Widowed	3
		Divorced	4
17	Have you even given birth?	No **(Skip to Q20)**	0
		Yes	1
18	How many children have you given birth to?	Number:	
19	When was the last time you gave birth? ***If less than 1 year, code "0".***	Years	
20	How many people usually live in your household?	Number:	
21	How many children under five years old usually live in your household?	Number:	
22	Have you ever gone to school?	No **(Skip to Q24)**	0
		Yes	1
23	What was the highest grade you completed? ***If university, code '13'.***	Grade	
24	What is your work?	Housework only	0

		Farming/Fishing	1
		Labor/Factory work	2
		Government work	3
		NGO/Business work	4
		Own business (shop/seller)	5
		Other	88
25	What is the main source of income in your household?	Farming/Fishing	1
		Labor/Factory work	2
		Government work	3
		NGO/Business work	4
		Own business (shop/seller)	5
		Other	88
26	What assets does your family own? ***Prompt by reading the list.*** ***Multiple answers possible.*** ***Circle all answers given. Check your own observations as well.***	None listed	0
		Radio	1
		Television	2
		Bicycle	3
		Refrigerator	4
		Motorcycle	5
		Ox cart	6
		Boat	7
		Car/Koyun	8
		Tuk-Tuk	9
		Phone	10
27	What farm animals does your family own? ***Prompt by reading the list*** ***Multiple answers possible*** ***Check that they do not mind the animals for someone else.***	None listed	0
		Chickens/ducks	1
		Pigs	2
		Goats	3
		Cows	4
		Horses	5
		Buffaloes	6
28	Does your house have a toilet?	No **(Skip to Q30)**	0
		Yes	1
29	How many toilets does your house have?	Share with other family	1
		One toilet	2
		Two or more	3
30	How many rooms in your house are used for sleeping?	Number:	
31	Does your family have any debt?	No (Skip to **Q35**)	0
		Yes	1

32	How much have your family borrowed in total?	Riels
33	How many lenders did your family borrow this money from?	No. lenders
34	How much does your family repay every month in total? All loans taken into accounts	Riels

Section 2: Knowledge about Contraception –
ASK GROUP 1,2,3
Now I would like to ask some questions about your understanding of contraception.

35	Have you ever heard about contraception (things that a man or woman can do to stop the woman from becoming pregnant)?	No **(skip to Q37)** Yes	0 1
36	Which methods of contraception have you heard about? ***Multiple answers possible.***	Condom Daily Pill Monthly Pill Implant Injection IUD Sterilisation Vasectomy Traditional method Withdrawal Calendar method Other Don't know / Can't remember	1 2 3 4 5 6 7 8 9 10 11 88 99
37	Have you ever used **ANY** contraception, including traditional methods?	No **(skip to Q42)** Yes	0 1
38	Which methods of contraception have you **ever** used? ***Multiple answers possible***	Condom Daily Pill Monthly Pill Implant ***LAPM*** Injection ***LAPM*** IUD ***LAPM*** Sterilisation ***LAPM*** Vasectomy ***LAPM***	1 2 3 4 5 6 7 8

		Traditional method	9
		Withdrawal	10
		Calendar method	11
		Other (specify)…….	88
39	How old were you when you first started using contraception?	Age (years):	
40	Where did you first seek medical advice on contraception?	Pharmacy	1
		Private clinic / Cabinet	2
		Health center	3
		Referral hospital	4
		National hospital	5
		Kru Khmer	6
		Kantha Bopha Hospital	7
		Other (specify)…….	88
41	Why did you choose this place for contraception? ***Multiple answers***	Close to house	1
		Staff are skilled	2
		Cheap	3
		Know doctor	4
		Fast/high quality service	5
		Recommended	6
		Can use health financing scheme (HEF, etc)	7
		Other (specify)……	88
Section 3: Contraceptive Experiences **ASK GROUP 3 ONLY** ***For women who never used any LAPM contraception***:			
42	Are you **currently** using any contraception, including traditional methods?	No **(skip to Q70)**	0
		Yes	1
43	Currently, which method of contraception is your **primary method**?	Condom	1
		Daily Pill	2

	Single answer only should be the same as an option selected at Q5	Monthly Pill	3
		Implant **(skip to Q70)**	4
		Injection **(skip to Q70)**	5
		IUD **(skip to Q70)**	6
		Sterilisation **(skip to Q70)**	7
		Vasectomy **(skip to Q70)**	8
		Traditional method	9
		Withdrawal	10
		Calendar method	11
		Other (specify)…….	88
		Don't remember/can't recall	99
44	Where did you first get information about this contraceptive method?	Television/radio	1
		Other advertising	2
		Public health provider	3
		Private health provider	4
		Village Health Volunteer	5
		NGO staff	6
		Village chief	7
		Family member/neighbor	8
		Other (specify)…….	88
45	Why did you first decide to use this method? ***Multiple answers possible***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular / Trendy	5
		Few side effects	6
		Side effects easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9

		Can use health financing scheme (HEF, etc)	10
		Recommendation	11
		Someone purchased for me	12
		I was asked to use	13
		I was offered an incentive	14
		Other (specify)…….	88
46	Is this contraception available at your local health center, or at another location in your commune?	No	0
		Yes	1
		Don't know	99
47	Where did you get this contraception?	Health center	1
		Provincial/referral hospital	2
		National hospital (Phnom Penh)	3
		Local private clinic	4
		Pharmacy	5
		Other (specify)	88
48	Why did you choose this place for contraception? Multiple answers	Close to house	1
		Staff are skilled	2
		Cheap	3
		Know doctor	4
		Fast/high quality service	5
		Recommended	6
		Can use health financing scheme (HEF, etc)	7
		Other (specify)	88
49	How much did you pay for this method (the last time you purchased it)?	Cost (riels):	
50	Did you pay anything for transport to seek treatment at this place?	No **(Skip to Q52)**	0
		Yes	1

51	What was the total cost for transport to seek treatment at this place and return?	Riel:	
52	Were any of these costs (treatment and transport) covered/reimbursed by a financial support scheme?	No **(skip to Q55)** Yes	0 1
53	Which support scheme covered these costs?	HEF / SOA Voucher scheme Community Health Insurance Private insurance Other (specify)	1 2 3 4 88
54	How much of the costs were covered?	Riels:	
55	Overall, how would you evaluate your experience with this method? ***Record respondent's answer.***	Mostly positive Somewhat positive Somewhat negative Mostly negative	1 2 3 4
56	What is the main reason you use this method over another method?	Easy to use Cheap / low cost /free Easy to find/access More effective Popular / Trendy Fewer side effects Side effects are easy to cope with Easy to get pregnant after using "Right" for my body Can use health financing scheme (HEF, etc) Recommendation	1 2 3 4 5 6 7 8 9 10 11

		Someone purchased for me	12
		I was asked to use	13
		I was offered an incentive	14
		Other……..	88
57	Did anyone or anything influence you to try/start using this method?	No **(skip to Q60)**	0
		Yes	1
58	Who or what **MOST** influenced you to try/start using this meth od?	No one/myself	1
		Husband	2
		Parent/In-law	3
		Sibling	4
		Friend	5
		Neighbor	6
		Doctor/Health staff	7
		Media/news	8
		Other ……..	88
59	Who or what else influenced you to try / start using this method? ***Multiple select***	No one/myself	1
		Husband	2
		Parent/In-law	3
		Sibling	4
		Friend	5
		Neighbor	6
		Doctor/Health staff	7
		Media/news	8
		Other ……..	88
60	What do you think are the main positive aspects of this method? ***Multiple answers possible***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3

		More effective	4
		Popular / Trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify)	88
61	For you, what is the MOST important positive aspect of this method? ***Choose only one answer from the answers respondent selected in Q60***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular / Trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify)	88
62	What do you think are the main negative aspects of this method? ***Multiple answers possible***	Expensive	1
		Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9

		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other (Specify)	88
63	For you, what is the MOST important negative aspect of this method? ***Choose only one answer from the answers respondent selected in Q62***	Expensive	1
		Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other (Specify)	88
64	Would you recommend that a friend or family member use this contraceptive method?	No	0
		Yes **(skip to Q66)**	1
65	Why would you **not** recommend this method? ***Multiple answers possible. After complete skip to Q67.***	Expensive	1
		Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other (specify)…….	88
66	Why would you recommend this method?	Easy to use	1
		Cheap/low cost	2

	Multiple answers possible.	Easy to find/access	3
		More effective	4
		Popular / Trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify)	88
67	Previously, did you go to a different provider to seek contraception? ***Interviewer please confirm respondent went somewhere different before the place mentioned at Q47***	No **(skip to Q70)**	0
		Yes	1
68	Where did you previously seek contraception?	Health center	1
		Provincial/referral hospital	2
		National hospital (Phnom Penh)	3
		Local private clinic	4
		Pharmacy	5
		Other (specify)	88
69	Why did you stop getting or decide not to get your contraception at this location?	Far from house	1
		Staff are not skilled	2
		Expensive	3
		I moved to different village	4
		Slow/bad service	5
		Heard bad rumors	6
		Can't use financing scheme (HEF, etc)	7
		Other (specify)	88

Section 4: Knowledge of the Implant – Women can have a rod with medicine inserted under the skin in their arm that prevents pregnancy for a long time.

ASK GROUP 3 ONLY

Only for women who never used any LAPM contraception

70	Have you ever heard of the implant?		No **(skip to Q123)** Yes	0 1
71	Do you know where to get the implant?		No **(skip to Q73)** Yes	0 1
72	Where can you obtain the implant in Cambodia? ***Multiple answers possible.*** ***Do not prompt.*** ***Record all answers given.***		Health center Provincial/referral hospital National hospital (Phnom Penh) Local private clinic Pharmacy Other (specify) I don't know	1 2 3 4 5 88 99
73	Do you know about the cost of the implant?		No **(skip to Q76)** Yes	0 1
74	What is the cost of implant?		Riels:	
75	What do you think about the cost of the implant? ***Prompt by reading the list***		Cheap Affordable Expensive	1 2 3
76	Would you be interested in getting the implant?		No **(skip to Q78)** Yes	0 1
77	If you want the implant, is it easy, difficult or impossible for you to access? ***Prompt by reading the list***		Easy Difficult Impossible	1 2 3
78	What side effects do you think the implant can have? ***Multiple answers are possible – circle all***	**None**	No side effects	0
		Uterus/ vagina	Burned uterus Wither uterus Swollen uterus Vaginal discharge	1 2 3 4

	answers given	**Blood**	Amenorrhoea	5
			Spotting	6
			Heavy bleeding	7
		Sex/ Pregnancy	Loss of desire	8
			Difficult get pregnant	9
			Infertile/sterile	10
		Eating/ Weight	Weight loss	11
			Weight gain	12
			Poor appetite	13
			Nausea/vomiting	14
		General body	Tired	15
			Tension in arms/legs	16
			Heat/dry body	17
			Pain	18
			Move in body	19
		Skin	Pale skin	20
			Skin rash	21
			Dry/Darker skin	22
			Bruise/cloasma	23
		Severe	Cancer	24
			Lump in stomach	25
		Other	Other (specify)……..	88
		Don't know	Don't know	99
79	Overall, what do you think of the implant? ***Record respondent's answer.***		Mostly positive	1
			Somewhat positive	2
			Somewhat negative	3
			Mostly negative	4
80	In your opinion, what is the main reason that some women **would use** the implant?		Easy to use	1
			Cheap / low cost	2
			Easy to find/access	3
			More effective	4
			Popular/trendy	5
			Fewer side effects	6
			Side effects are easy to cope with	7

		Easy to get pregnant after stopped using	8
		"Right" for Cambodian bodies	9
		Can use health financing scheme (HEF, etc)	10
		Other (specify)……	88
81	In your opinion, what is the main reason that women/you **don't use** the implant?	Expensive	1
		Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other……	88
82	What is the **most** important thing that would encourage more women/you to use the implant for contraception?	Provide free/lower cost	1
		Improve access	2
		Improve visibility	3
		Advertising	4
		Inform benefits	5
		Inform side effects	6
		Other (specify)…….	88
Section 5: Experiences with the Implant. **ASK GROUP 1 and 2 ONLY** ***Only for women who CURRENTLY or PREVIOUSLY used the implant***			
83	Have you ever had the operation to insert the implant?	No **(skip to Q123)**	0
		Yes	1

84	Where did you **first** get information about the implant?	Television/radio	1
		Other advertising	2
		Public health provider	3
		Private health provider	4
		Village Health Volunteer	5
		NGO staff	6
		Village chief	7
		Family member/neighbor	8
		Other (specify)…….	88
85	Why did you first decide to use the implant? ***Multiple answers possible***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular / Trendy	5
		Fewer side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Recommendation	11
		Someone purchased for me	12
		I was asked to use	13
		I was offered an incentive	14
		Other (specify)…….	88
86	Is the implant available at your local public health center?	No	0
		Yes	1

		Don't know	99
87	Where did you get the implant?	Health center in your district Health center in another district Provincial/referral hospital National hospital (Phnom Penh) Local private clinic Local pharmacy Other (specify)	1 2 3 4 5 6 88
88	Why did you choose this place to get the implant?	Close to house Staff are skilled Cheap Know doctor Fast/high quality service Recommended Other (specify)	1 2 3 4 5 6 88
89	How much did you pay for the implant (the last time you purchased it)?	Cost (riels):	
90	What did you think about the cost of the implant the last time you purchased it? ***Prompt by reading the list.***	Cheap Affordable Expensive	0 1 2
91	Did you pay anything for transport to seek treatment at this place?	No **(skip to Q93)** Yes	0 1
92	What was the total cost for transport to seek treatment at this place and return?	Riel:	
93	Were any of these costs covered/reimbursed (treatment and transport) by a financial support scheme?	No **(skip to Q96)** Yes	0 1

94	Which support scheme covered these costs?		HEF / SOA Voucher scheme Community health insurance Private insurance Other (specify)	1 2 3 4 88
95	How much of the costs were covered?		Riels:	
96	Did you experience any side effects with the implant?		No **(skip to Q98)** Yes	0 1
97	What side effects did you experience while using the implant? *Multiple answers are possible – circle all answers*	**Uterus/ vagina**	Burned uterus Wither uterus Swollen uterus Vaginal discharge	01 02 03 04
		Blood	Amenorrhoea Spotting Heavy bleeding	05 06 07
		Sex/ Pregnancy	Loss of desire Difficult get pregnant Infertile/sterile	08 09 10
		Eating/weight	Weight loss Weight gain Poor appetite Nausea/vomiting	11 12 13 14
		General body	Tired Tension in arms/legs Heat/dry body Pain Move in body	15 16 17 18 19
		Skin	Pale skin Skin rash Dry/Darker skin Bruise/cloasma	20 21 22 23
		Severe	Cancer Lump in stomach	24 25
		Other (specify)	……..	88
		Don't know	Don't know/can't recall	99
98	Overall, how would you evaluate your experience with the implant?		Mostly positive	1

		Somewhat positive	2
		Somewhat negative	3
		Mostly negative	4
99	What was the main reason you tried the implant over another method?	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular / Trendy	5
		Fewer side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Recommendation	11
		Someone purchased for me	12
		I was asked to use	13
		I was offered an incentive	14
		Other (specify)……..	88
100	Did anyone influence you to try/start using the implant?	No **(skip to Q102)**	0
		Yes	1
101	Which one person influenced you to try/start using the implant?	No one/myself	1
		Husband	2
		Parent/In-law	3
		Sibling	4
		Friend	5

		Neighbor	6
		Doctor/Health staff	7
		Media/news	8
		Other (specify) ……	88
102	What do you think are the main positive aspects of the implant? ***Multiple answers possible***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular/trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify)…….	88
103	For you, what is the **MOST** important positive aspect of the implant? ***Choose only one answer from answers selected in Q102***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular/trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify)	88
104	What do you think are the main negative aspects of the	Expensive	1

	implant? ***Multiple answers possible***	Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other	88
105	For you, what is the MOST important negative aspect of the implant? ***Choose only one answer from answers selected in Q104***	Expensive	1
		Difficult to access	2
		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other	88
106	Would you recommend that a friend or family member use the implant for long term contraception?	No	0
		Yes **(skip to Q108)**	1
107	Why would you **not** recommend the implant? ***Multiple answers possible. After complete skip to Q109***	Expensive	1
		Difficult to access	2

		Not very effective	3
		Too many side effects	4
		Side effects too painful	5
		Side effects were inconvenient/uncomfortable	6
		May become infertile after use	7
		Stigma	8
		Not "right" for Cambodians	9
		Difficult to get pregnant after stop using	10
		Difficult to use	11
		Other (specify)…….	88
108	Why would you recommend the implant? ***Multiple answers possible.***	Easy to use	1
		Cheap/low cost	2
		Easy to find/access	3
		More effective	4
		Popular/trendy	5
		Few side effects	6
		Side effects are easy to cope with	7
		Easy to get pregnant after using	8
		"Right" for my body	9
		Can use health financing scheme (HEF)	10
		Other (specify) …….	88
109	What is the **most** important thing that would encourage more women to use the implant for contraception? ***Choose only one answer.***	Provide free/lower cost	1
		Improve access	2
		Improve visibility	3
		Advertising	4
		Inform benefits	5
		Inform side effects	6

		Other……..	88
Section 5B – Removal of implant **ASK GROUP 2 ONLY** **Now I'd like to ask you some questions about your experience when you had the implant removed.**			
110	How long did you use the implant? ***If less than 1 year, code 0.***	Years:	
111	Did anyone influence you to **stop** using the implant?	No **(skip to Q113)** Yes	0 1
112	Which one person influenced you the most to **stop** using the implant?	No one/myself Husband Parent/In-law Sibling Friend Neighbor Doctor/Health staff Media/news Other (specify)…….	1 2 3 4 5 6 7 8 88
113	Did you stop using/have the implant removed early (before the date your doctor recommended)?	No (**skip to Q115**) Yes	0 1
114	Why did you have the implant removed early? ***Multiple answer*** ***Skip to Q117 After asking***	Wanted children Lost sexual desire Can't afford Can't access Side effects were too painful Side effects were inconvenient/uncomfortable Afraid of becoming infertile Hard to get pregnant	1 2 3 4 5 6 7 8

		Lost partner	9
		Menopause	10
		Other (specify)……..	88
115	Why did you decide to not continue using the implant after the last one expired/was removed? ***Multiple answer***	Wanted children	1
		Lost sexual desire	2
		Can't afford	3
		Can't access	4
		Side effects were too painful	5
		Side effects were inconvenient/ uncomfortable	6
		Afraid of becoming infertile	7
		Hard to get pregnant	8
		Lost partner	9
		Menopause	10
		Other (specify)……..	88
Section 5C – Perception about removal **GROUP 1 ONLY** **Now I would like to ask you some questions about when you need to have the implant removed in the future**			
116	When you had your implant inserted, did the doctor tell you how long until it needs to be removed?	No **(Skip to Q118)**	0
		Yes	1
117	How many years did the doctor say the implant is able to remain in for?	Years:	
118	Do you know how much it will cost to remove the implant?	Riel:	
		Don't know	99
119	Will you return to the same place where you had the implant inserted when it's time for it to be removed?	No	0
		Yes **(Skip to Q121)**	1
120	Why will you not return to the same place you had the implant inserted?	Too expensive	1
		Doctor / staff were rude	2
		Doctor / staff were not knowledgeable	3
		Place was unclean	4

		I have moved	5
		Other (Specify)	88
121	Do you know any reasons that the implant can be removed earlier than scheduled? ***Multiple answers***	No	0
		Want children	1
		Lose sexual desire	2
		Can't afford	3
		Can't access	4
		Side effects were too painful	5
		Side effects were inconvenient/uncomfortable	6
		Afraid of becoming infertile	7
		Hard to get pregnant	8
		Lose partner	9
		Menopause	10
		Other (specify)…….	88
122	Do you think you will get another implant after your current one is removed?	No, I will use a different contraception	0
		No, I will stop using all contraception	1
		Yes	2
		Don't know	99
Section 6: Trust and Satisfaction with Health Care Providers **ASK GROUP 1,2,3** Now, I'd like to ask you some questions about satisfaction with government health services.			
123	In the last three months, did you go to see a government doctor?	No **(Skip to Q131)**	0
		Yes	1
124	How long did you wait to see the doctor? ***For the last visit.*** ***Prompt by reading the answers.***	Very short time	1
		Short time	2
		Medium	3
		Long time	4
		Very long time	5
125	Was the place clean, acceptable or dirty?	Very clean	1

	For the last visit. ***Prompt by reading the answers.***	Clean Medium Not clean Very unclean	2 3 4 5
126	How did the doctor speak to you? ***For the last visit.*** ***Prompt by reading the answers.***	Very polite Polite Medium Not polite Very impolite	1 2 3 4 5
127	Were you satisfied with the doctor's service? ***For the last visit.*** ***Prompt by reading the answers.***	Very satisfied Satisfied Medium Unsatisfied Very unsatisfied	1 2 3 4 5
128	Did you have to pay the doctor?	No **(Skip to Q130)** Yes	0 1
129	How was the cost of the health service? ***For the last visit.*** ***Prompt by reading the answers.***	Very expensive Expensive Medium Cheap Very cheap	1 2 3 4 5
130	What type of service did you receive? ***For the last visit.*** ***Prompt by reading the answers.***	Contraceptive counseling/services Treatment for self Treatment for other member Preventive check-up for self Preventive check-up for other member Birth/delivery ANC Other	1 2 3 4 5 6 7 88
131	In the last three months, did you receive contraceptive	No **(Skip to Q133)**	0

	counseling from a medical provider, or accompany anyone else to receive counseling?	Yes (myself) 1 Yes (someone else) 2
132	How effective/helpful was the counselling? ***For the last visit.*** ***Prompt by reading the answers.***	Very effective 1 Somewhat effective 2 Neither effective nor ineffective 3 Somewhat ineffective 4 Very ineffective 5
Section 7: Ranking Sources of Information Related to Contraception I will show you some cards with different types of contraception and sources of information. **ASK GROUP 1,2,3** ***Give respondent the cards for contraception/source of information types. Then ask them to rate from 1 -11 and then get the cards with answer back. Number in order from 1 to 11 by asking and answering the following questions.***		
133	Which contraception would you rank as "the best"? The next? ***Rank all answers from 1-11, with 1 being "the best" and 11 being "the worst".***	Daily Pill Monthly Pill Injection IUD Sterilisation Condom Implant Vasectomy Traditional method Withdrawal Calendar method
134	Which sources of information do you use to get information on contraception? The next source? ***Rank all answers from 1-9, with 1 being most used and 9 being least used.***	Village meeting Village chief Village Health Support Group Leaflet / banner / T-shirt Health center staff TV Radio Social media

		Internet
135	**Interviewer notes or opinions** Please note anything unusual or interesting about the interview.	

Thank you for spending time on this interview.