

Family Planning Practices and Women's Impression of an Adapted Reproductive Life Plan in a Disadvantaged Area in Eswatini

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Research

Keywords: Family planning, Reproductive Life Plan, Unmet need for contraception, Unintended pregnancy, Eswatini, Swaziland

Posted Date: March 24th, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-18287/v1>

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Family Planning Practices and Women's Impression of an Adapted Reproductive Life Plan in a Disadvantaged Area in Eswatini

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Abstract

Background

Family planning in Eswatini is limited and unplanned pregnancies are common. The Reproductive Life Plan (RLP) is a clinical tool formerly evaluated in high-income settings aiming to increase pregnancy planning. Mentor Mothers (MM), i.e. Community Health Workers, were trained in using an adapted RLP and introduced it into family planning (FP) discussions with their clients. This study aimed to evaluate these women's impression of the RLP and to investigate their FP practices.

Method

Women were recruited during home visits, purposively selected to cover all areas where the MMs are working. Data were collected in September and October 2018 using anonymous questionnaires filled out by women aged 15-44 years that were either mothers or pregnant mothers-to-be. The questionnaire consisted of 20 questions on background, fertility desires, pregnancy planning as well as quality and perceived need for FP support. Chi-square tests or Fisher's exact test were used for group comparisons and the need for more FP support.

Results

A total of 203 women participated. Most women (74% n=148) expressed that FP discussions with their MM using the RLP had helped them 'very much'. A majority had a perceived need for these discussions; 70% wanted to have more support from their MM and 92% wanted more information about FP. Significantly more women with lower educational level (secondary or lower) and younger women (age 15-24 years) wanted more support compared to women with higher educational level and older women ($p < 0.001$ and $p = 0.028$). The unmet need for contraception was 22%.

Conclusion

The introduction of the RLP was well received among women but most of them requested more support in FP. Using the RLP may help women in this context achieve their reproductive goals.

Keywords

Family planning; Reproductive Life Plan; Unmet need for contraception, Unintended pregnancy, Eswatini, Swaziland

Plain English summary

Globally, many women die every year in connection to pregnancy and childbirth. Use of contraception can decrease the number of deaths as it prevents unplanned pregnancies. In Eswatini, a small country in Sub-Saharan Africa, unplanned pregnancies are common, use of contraception is limited and the number of women dying in connection to pregnancy remains high. Health workers called Mentor Mothers (MMs) work to improve maternal and child health in disadvantaged areas in Eswatini. The MMs have recently been trained in using a clinical tool, called the Reproductive Life Plan (RLP). Using the RLP, the MM asks the woman whether she desires another child or not. Depending on the answer, the MM gives structured advice, either to help the client prepare for a pregnancy, or to prevent a pregnancy.

Our aim was to evaluate women's impressions of the adapted RLP and to investigate women's family planning practices. Women (n=203) who had participated in RLP discussions with their MM answered an anonymous questionnaire. We found that most women appreciated discussing family planning and wanted more support from the MM in the future. One in five women who did not want to have any more children were not using contraception, and could therefore be at risk of becoming pregnant unplanned. Using the adapted RLP seems like a good way to identify women at risk of having an unplanned pregnancy and to help them get contraception. We suggest that the adapted RLP should be used and further evaluated in similar settings.

Introduction

The past two decades, increased use of contraception in developing countries has reduced the number of maternal deaths by 40% mainly by reducing the number of unplanned pregnancies (1). Yet, 214 million women in low- and middle-income countries have an unmet need for contraception (2). The greatest proportion of these women live in Sub-Saharan Africa, where the unmet need for contraception is 24% (3). If the unmet need for contraception could be satisfied globally, a further reduction of maternal deaths by 30% is expected (1). To achieve this, access to family planning is crucial.

Family planning (FP) means the ability to decide number and timing of pregnancies and is often used synonymously with contraceptive practice (4). FP is one of the most cost-effective interventions in health (2), and improves health by preventing mother to child transmission of HIV, contributing to child spacing, decreasing the infant mortality risk and by reducing the number of unsafe abortions (4).

Planning for a pregnancy is beneficial as it enables actions to improve preconception health (5). These actions include adherence to prescribed medication, intake of micronutrients such as folic acid, cessation of harmful lifestyle habits and weight loss for overweight women. Women that are healthy before pregnancy are more likely to have successful pregnancies and healthy children (5). Conditions associated with adverse pregnancy outcomes are for example folic acid deficiency which increase the risk for neural tube defect of the child, HIV which could be transmitted from the mother to the child, as well as diabetes and hypertension that are associated with increased risks of mortality and morbidity for both the mother and the child (6).

In order to improve family planning and preconception health, the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and

Gynecologists in the United States recommend Reproductive Life Plan (RLP) assessment (6–8). The RLP is a clinical tool consisting of a set of questions, which is used by health care providers together with patients. It has a patient-centered approach and uses the patient’s reproductive preferences as a starting point for discussing preconception health and pregnancy planning. Using the RLP gives individuals or couples a structured opportunity to reflect on their reproductive intentions and to create an individual, personalized plan to achieve those reproductive goals (9). There are several versions of the RLP available, but they all include the same five core elements: desire to have children, number of children desired, spacing of children, timing of children and a plan (9). Non-normative questions that represent each of these components have been developed (9,10). Previous studies have shown that the RLP is an effective tool for counselling women and increasing their knowledge about preconception health (11–13) but no association with contraceptive use has been found (14,15). So far, the RLP has only been used and evaluated in high income settings.

This study aimed to evaluate women’s impression of an adapted RLP in a low-income setting in Eswatini and to investigate these women’s family planning practices.

Methods

Setting and study population

The Kingdom of Eswatini (previously named The Kingdom of Swaziland) is a small country in Sub-Saharan Africa, bordering South Africa and Mozambique. Eswatini has the highest HIV prevalence in the world at 32.5% among women (16). Early sexual debut is common and 25% of all institutional deliveries are by adolescent girls (17). The maternal mortality ratio in Eswatini was 389 per 100’000 live births in 2015. Family planning is limited, abortion laws are restrictive and around 70% of pregnancies are unplanned (18,19). In 2015,

the unmet need for contraception was 15.2% among currently married women in Eswatini (20). With this discouraging demographic evidence as a background, Eswatini was chosen as the setting for this study.

Siphilile Maternal and Child Health is a non-governmental organization active in peri-urban areas outside Eswatini's largest city, Manzini. Many inhabitants in these areas are internal migrants that have moved from rural areas to earn their living by working in textile and plastic factories. Previous studies have shown that this population is disadvantaged regarding both health and social standards (21). Many do not have access to clean water and the majority rent their house, which often consists of a single room. The prevalence of HIV among women (41%) is higher than in the general population and the proportion of single mothers is high (18,22). Siphilile works to improve maternal and child health through a community-based Mentor Mother program. This program is built on the Philani Mentor Mother Model, first developed in the townships of Cape Town, South Africa. The Philani model is effective on several health outcomes, including prolonged breastfeeding and increased condom usage (21,23). Mentor Mothers (MMs), who share characteristics with Community Health Workers, are peer supporters recruited from the neighborhoods. They are educated in a four weeks course about basic health issues such as malnutrition, danger signs during pregnancy and HIV. The MMs make home visits to pregnant women and mothers of young children, with the main goal to support and empower women to make informed decisions about their own and their children's health (22,24).

A project about family planning and pregnancy intentions was initiated at Siphilile after finding that 70% of pregnancies in this population were unplanned (18). In order to decrease the number of unplanned pregnancies and to improve preconception health, a RLP tool with additional guidelines tailored for this context was developed together with the MMs. The MMs were trained in using this adapted RLP and introduced it into family planning

discussions with their clients starting in January 2018.

Study design

Data for this cross-sectional study were collected through anonymous questionnaires designed by the research team. It contained 20 questions divided into two sections: one with background questions and one with questions about family planning and impressions from the RLP discussions. Background questions covered nationality, age, number of living children, educational level, housing conditions, marital status and number of sex partners in the last month. Questions on family planning were inspired by the RLP questions developed by the CDC (10) and included desire for children, use of contraception and if the woman had discussed contraception and number of children with her partner. Finally, to evaluate the use of the RLP in family planning conversations, women were asked about quality of FP support and perceived need for FP support from MMs. Questions were ‘Have discussions with your Mentor Mother about family and pregnancy planning helped you?’ and ‘What do you think about discussing family planning and pregnancy with your Mentor Mother?’. Women could choose to answer ‘very much’, ‘a little’, ‘not at all’, ‘no difference’ or ‘don’t know’. Most other questions were also multiple choice and women were instructed to choose one or more alternatives. A few questions requested a written answer or a comment.

The questionnaire was translated into the local language siSwati by a person with advanced language skills in siSwati and English. Free text answers were translated to English by the same person. A pilot study was performed in order to evaluate the feasibility of the questionnaire. Two MMs and six women were included in the pilot study. Five of them could fill out the questions without any guidance and one woman needed help to read the questions due to limited reading skills. All participants gave feedback and amendments were made where needed. Written instructions were also added to the final draft of the questionnaire.

Participants and data collection

All women recruited to this study were clients enrolled by Siphilile. Only clients who had engaged in the RLP discussion with their MM were included. Twenty-nine out of 53 MMs participated in the RLP intervention, purposively selected to cover all geographical areas where Siphilile is working. Nine of these were no longer employed by Siphilile and two were on sick leave. The remaining 18 MMs were included and clients from each of them participated in this study. Approximately 1500 clients had engaged in the RLP discussions with their MM in the past year. Data were collected during September-October 2018.

Women (clients) were recruited through convenience sampling during home visits, purposively selected to cover all geographical areas where Siphilile is active. To avoid possible bias from the MM, she was not informed about the study or the questionnaire until the researcher (EE) met her in the field. The MM had already chosen which clients she was going to visit that day and therefore minimizing the risk of sampling bias. After meeting with the MM, she got information about the study and how it was going to be performed. The MM was instructed to do her daily work as usual and the researcher informed the women about the questionnaire in English.

To make sure that the woman felt comfortable and to assure anonymity, the researcher and MM waited where they were not able to see the woman's answers. When the woman had answered the questionnaire, the researcher put the questionnaire in a closed folder to assure anonymity. If the woman did not know English very well, the MM translated the verbal information into the local language siSwati. Women who were illiterate or had poor reading skills were assisted by the MM who read the questionnaire out loud from another part of the room to ensure that she could not see the women's answers. Each questionnaire took about 30 minutes to fill in. Women who responded to less than 50% of

the RLP questions were excluded.

Statistical analyses

Data analysis was performed in IBM SPSS Statistics version 25. Chi-square tests or Fisher's exact test (when sample size was less than 5) were used to measure group differences. P-values of <0.05 were considered significant. The unmet need for contraception was calculated as the percentage of married women or women in a union who did not want to become pregnant but were currently not using any modern contraception.

Ethical considerations

The study was approved by the ethical committee in Eswatini (SRH010/2018), by the regional ethical review board in Uppsala (2017/514-1) and by the board of Siphilile. All questionnaires were answered anonymously to ensure confidentiality and are impossible to track to any specific person. All participants received oral and written information about the study; that the questionnaire would be answered anonymously and that participation was voluntary. Women were given the possibility to ask questions and those who wanted to participate gave their verbal consent. A written consent was not used in order to protect clients' integrity.

Results

Description of study population

A total of 207 women were recruited to the study. Three women declined due to time constraints and one woman was not at home when data were collected. Thus, 203 women participated but four were excluded in the analyses because of low response rate.

Most women (76%, n=152) were between 20-34 years old and one woman was currently

pregnant. Number of living children ranged from 0-8 children, with a median of 2 children. Almost all women (98% n=194) had attended school at any level, and a majority had attended secondary level. Most women were single, and a majority of women were tenants (Table 1).

Evaluation of the RLP

Most women (74% n=148) reported that having family planning discussions using the RLP tool had helped them ‘very much’ and most women (88% n=175) thought that it was ‘very good’ to have these discussions with the MM (Table 2). Comments were written by 21 women. Common comments were that family planning discussions with MMs ‘helped to reduce unplanned pregnancies’ and ‘increased knowledge about family planning’.

Almost all women (92% n=182) wanted to have more information about FP in the future. All teenagers (n=19) and 70% (n=144) of all women expressed that they wanted to have more support on FP from their MM. Significantly more women with lower educational level (secondary level or lower) wanted more support in FP from their MM compared to women with higher educational level ($p < 0.001$). Younger women (age 15-24) requested more support compared to older women ($p = 0.028$). There were no significant differences between women who had three or more children compared to women with fewer children, between women in a relationship compared to women who were not in a relationship, or between women who were homeowners compared to those who were not ($p > 0.05$ for all of them) (Table 2).

Family planning practices

Most women (70% n=140) reported that they did not want to have any more children in the future and only two wanted to have a child within the next year. Almost 80% of women (n=157) were currently using modern contraception, injection was the most common

method and was used by 55% of women (Table 3). The unmet need for contraception among married women or women in a union was 22%, and 14% for sexually active single women. The corresponding rate for all women was 17%.

Eighty women (40%) reported they had never thought about how many children they would like to have in total before discussing this subject with their MM and more than one out of four (28% n=55) had never discussed how many children they wanted to have with a partner. Thirty-one women (16%) had never discussed family planning methods with a partner. It was more common that women who had discussed family planning methods with a partner were currently using a family planning method (85% compared with 65%, $p=0.01$).

Discussion

To the best of our knowledge, this is the first study evaluating the RLP among women in a low- or middle-income country and with community health workers in these contexts.

Women in this study had a positive impression of family planning counselling using the RLP. Most women expressed they had been ‘very much’ helped by these discussions and had ‘very good’ impressions of family planning discussions with their MM. Interestingly, a majority of women had also taken action to avoid or plan for a pregnancy during the last year. Some even commented that they had ‘gained more knowledge’ and that the RLP conversations ‘helped to reduce unplanned pregnancies’. Although we did not have a control group, our results strongly suggest that Mentor Mothers using the RLP are key persons in family planning discussions in this context.

Most pregnancies in this population are unplanned (18) and we found that the perceived need for discussing family planning with MMs was high in the studied population: all teenagers stated that they would like to have more support in the future. However, teenagers in this sample are teenage mothers, and many of them have former experience of at least one

unplanned pregnancy, as 86% of pregnancies among this group are unplanned (18). This is a great health concern as adolescent pregnancies are associated with adverse health outcomes for both the mother and the child. Childbearing as a teenager is also associated with adverse social consequences especially regarding educational matters since teenage mothers are more likely to drop out of school (26). Therefore, young women and teenagers in particular would benefit from additional support from MMs.

Few women reported wanting more children in the future and therefore the RLP counselling in this setting was focused on contraception to avoid unplanned pregnancies. A common reason for discontinuing contraceptives in this population is because of side effects (23). Therefore, increased focus on information and counselling in this area is needed to increase knowledge. Focus group discussions with the MMs have acknowledged that many women stop using contraceptives after a few months as there is no regular follow-up on family planning (27). In a previous study from Eswatini, contraceptive counselling including long-term and permanent methods reduced the unmet need and pregnancy intentions as well as counselling on future fertility were significantly associated with current contraceptive use (28). These results support our findings that using the RLP is a feasible and effective way of providing family planning counselling in this population.

In sub-Saharan Africa, men often are the decision-makers on contraception and covert contraception use among women is common as a way of regaining reproductive autonomy (27,29,30). This may explain why the unmet need for contraception was higher among married women (22%) than among all women (17%) as men may be more influential on their married counterpart. A majority of women in our study had discussed family planning with their partner and this was associated with current use of contraceptives. This has previously been shown in several Sub-Saharan countries including Ethiopia (31,32). In Ethiopia, there was also a high discordance between future fertility intentions within

couples, and male partners not wanting more children was associated with increased contraceptive use (32). In our study, more than one fourth of all women had never discussed with their partner how many children they would like to have as a couple. Encouraging couples to discuss FP and reproductive intentions, could therefore be a crucial step towards decreasing the unmet need for contraception in this setting. Men's attitude towards family planning was not investigated in this study since Siphilile only have women and children as clients. One suggestion to improve men's knowledge and attitude towards family planning could be to have peer supporters for men, as this was associated with an increased uptake of modern contraception in Malawi (33).

Methodological considerations

Results from this study must be read with consideration to some limitations. Only clients of Siphilile; pregnant women or women with children less than 6 years old, were included. Additionally, these women were inhabitants of less privileged areas in Eswatini. Thereby result on family planning practices from this study are not applicable to women of Eswatini in general.

All data were collected during home visits when the MMs were present. Some women were not able to read questions themselves and required help from the MM to read the questions out loud. Although the MMs were not able to see the answers, their presence may have affected the answers and created a social desirability bias.

The questionnaire was designed for this specific study as validated questions on pregnancy planning from this context were not available, which is a limitation of the study. As mentioned in the methods section, some of the questions were designed by the CDC for healthcare purposes and not for research. However, to increase the validity of the questions a pilot study was performed. Further, this study investigated family planning practices and impressions only

from women who had participated in the RLP-discussions. There was no control group to compare with, meaning it is unknown if the result would differ among women who participated in family planning discussions without the RLP approach.

Conclusion

The introduction of an adapted RLP into family planning counselling in this context has been well received among women and most expressed that they have been helped by it. There was a perceived need among women for having these discussions and a majority requested more help from their MM. Using the RLP in order to encourage women to reflect on their reproductive goals could be a first step to reduce the unmet need for family planning and to reduce unplanned pregnancies in this context. Further research to investigate possible health benefits from the implementation of the RLP in the future is needed.

Abbreviations

CDC – Centers for Disease Control and Prevention

FP – Family Planning

HIV – Human immunodeficiency virus

MM – Mentor Mother

RLP – Reproductive Life Plan

Declaration

Ethics approval and consent to participate

The study was approved by the ethical committee in Eswatini (SRH010/2018) and by the regional ethical review board in Uppsala (2017/514-1). All participating women gave their verbal consent.

Consent for publication

Not applicable.

Availability of data and materials

The dataset is available from the corresponding author on reasonable request.

Competing interests

The authors declare no competing interests.

Funding

This study was performed with financial support through a Minor Field Study scholarship from the Swedish International Development Cooperation Agency, SIDA.

Authors' contributions

EE, MM and JNH conceptualized the study. EE collected data, performed analysis and wrote the manuscript under supervision of JNH and MM. All authors have read and approved the final manuscript.

Acknowledgements

The authors would like to thank the Siphilile staff, including the Mentor Mothers and all of Siphilile's clients who participated in this study.

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Table 1: Background characteristics of the study population (n=199).

Background information	N (%)	Missing N (%)
Nationality (n=199)		0 (0)
Swazi citizen	195 (98)	
South African citizen	0 (0)	
Mozambique citizen	4 (2)	
Age (n=197)		2 (1)
15-19	19 (10)	
20-24	55 (28)	
25-29	58 (29)	
30-34	39 (20)	
35-39	17 (9)	
40-44	9 (5)	
Number of children (n=194)		5 (3)
0	1 (1)	
1	57 (29)	
2	47 (24)	
3	44 (22)	
4	21 (11)	
5	12 (6)	
6	3 (2)	
7	6 (3)	
8	3 (2)	
Education (n=196)		3 (2)
Never attended school	2 (1)	
Primary	46 (23)	
Secondary	95 (48)	
High School	40 (20)	
College	13 (67)	
Living situation (n=199)		0 (0)
Tenant	116 (58)	
Homeowner	31 (16)	

Parental housing	42 (21)
Other	8 (4)
Don't know	2 (1)
Marital status (n=196)	3 (2)
Married	60 (30)
Single	108 (54)
Cohabiting	24 (12)
Separated/divorced	4 (2)
Sexually active the latest month (n=193)	6 (3)
Yes	132 (66)
No	39 (20)
Don't know	4 (2)
Do not want to answer	18 (9)

Table 2: Family planning practices and impressions from the RLP discussions among women (n=199) of different demographic and socioeconomic groups in Eswatini. Chi square or Fisher's exact test used.

	Total N (%)	Age groups			P	Education			P	Marital status			P	Parity		P	Living situation		P
		15-19 N (%)	20-34 N (%)	35-44 N (%)		Primary or lower N (%)	Secondary N (%)	Higher than secondary N (%)		Married N (%)	Cohabitating N (%)	Single, divorced or separated N (%)		2 or less N (%)	3 or more N (%)		Homeowner	Not homeowner (tenant, parental housing or other)	
Want to have more children	198 (96)				<0.001				0.328				0.797		<0.001			0.184	
No	140 (70)	10 (59)	102 (70)	26 (100)		38 (81)	65 (71)	34 (68)		45 (76)	18 (75)	75 (71)		54 (56)	81 (91)		26 (84)	112 (71)	
Yes	51 (26)	7 (41)	44 (30)	0 (0)		9 (19)	26 (29)	16 (32)		14 (24)	6 (25)	30 (29)		43 (44)	8 (9)		5 (16)	46 (29)	
Desired time to pregnancy	107 (54)				0.244				0.951				0.903		0.094			0.040	
< 1 year	3 (3)	0 (0)	2 (2)	0 (0)		1 (4)	1 (2)	0 (0)		1 (4)	0 (0)	2 (3)		1 (1)	2 (6)		2 (14)	1 (1)	
> 1 year	70 (65)	13 (81)	55 (66)	2 (33)		17 (65)	35 (65)	18 (72)		16 (59)	7 (64)	45 (67)		51 (71)	16 (52)		7 (50)	63 (68)	
Don't know	34 (32)	3 (19)	26 (31)	4 (67)		8 (31)	18 (33)	7 (28)		10 (37)	4 (36)	20 (30)		20 (28)	13 (42)		5 (36)	29 (31)	
Currently using contraception	196 (98)				0.003				1.000				0.802		0.852			1.000	
No	36 (18)	6 (32)	20 (13)	10 (38)		9 (19)	17 (18)	10 (19)		12 (20)	3 (12)	20 (18)		18 (18)	17 (19)		6 (19)	30 (18)	
Yes	160 (81)	13 (68)	129 (87)	16 (62)		39 (81)	75 (82)	43 (81)		48 (80)	21 (88)	89 (82)		84 (82)	72 (81)		25 (81)	134 (82)	
Used condom during first intercourse with most recent partner	198 (99)				0.178				0.048				0.492		0.301			1.000	
No	79 (40)	4 (21)	64 (42)	9 (35)		26 (54)	34 (36)	17 (32)		24 (40)	12 (50)	41 (37)		37 (36)	39 (44)		12 (39)	66 (40)	
Yes	119 (60)	15 (79)	87 (58)	17 (65)		22 (46)	60 (64)	36 (68)		36 (60)	12 (50)	70 (63)		67 (64)	50 (56)		19 (61)	100 (60)	
Have discussed wanted number of children	194 (97)				0.001				0.053				<0.001		1.000			0.074	

with any partner															
No	55 (28)	12 (63)	38 (26)	4 (17)	19 (42)	24 (26)	11 (21)	5 (9)	6 (26)	42 (38)	28 (27)	24 (28)	4 (14)	50 (31)	
Yes	139 (70)	7 (37)	111 (74)	20 (83)	26 (58)	70 (74)	41 (79)	51 (91)	17 (74)	70 (62)	75 (73)	62 (72)	25 (86)	113 (69)	
Have discussed FP methods with a partner	197 (99)				0.046			0.162			0.001		0.229	0.006	
No	31 (16)	7 (37)	21 (14)	3 (12)	11 (24)	15 (16)	5 (9)	2 (3)	2 (9)	25 (22)	19 (18)	10 (11)	0 (0)	30 (18)	
Yes	166 (83)	12 (63)	130 (86)	22 (88)	35 (76)	80 (84)	48 (91)	57 (97)	21 (91)	87 (78)	86 (82)	77 (89)	30 (100)	136 (82)	
Thought about wanted number of children before discussion with MM	193 (97)				0.129			0.240			0.110		0.075	0.106	
No	80 (40)	12 (63)	58 (39)	9 (38)	22 (48)	40 (44)	17 (32)	17 (29)	10 (45)	50 (45)	49 (48)	29 (34)	8 (27)	71 (44)	
Yes	113 (57)	7 (37)	90 (61)	15 (62)	24 (52)	51 (56)	36 (68)	41 (71)	12 (55)	60 (55)	54 (52)	56 (66)	22 (73)	91 (56)	
Have been helped by discussions with MM	180 (90)				0.794			0.934			0.736		0.402	0.029	
Very much	148 (74)	15 (83)	109 (81)	23 (92)	40 (85)	66 (80)	39 (81)	48 (83)	18 (82)	81 (82)	71 (78)	73 (86)	29 (94)	118 (80)	
A little	6 (3)	0 (0)	5 (4)	1 (4)	1 (2)	3 (4)	2 (4)	2 (3)	1 (5)	3 (3)	3 (3)	3 (4)	1 (3)	5 (3)	
Not at all	1 (1)	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)	0 (0)	1 (2)	0 (0)	0 (0)	0 (0)	1 (1)	1 (3)	0 (0)	
No difference	3 (2)	0 (0)	3 (2)	0 (0)	0 (0)	1 (1)	2 (4)	2 (3)	0 (0)	1 (1)	2 (2)	1 (1)	0 (0)	3 (2)	
Don't know	22 (11)	3 (17)	17 (13)	1 (4)	6 (13)	11 (13)	5 (10)	5 (9)	3 (14)	14 (14)	15 (16)	7 (8)	0 (0)	21 (14)	
Have taken action to avoid/plan for pregnancy in the last year	186 (93)				0.011			0.015			0.270		0.009	0.085	
No	56 (28)	10 (53)	43 (31)	3 (12)	14 (31)	18 (21)	23 (44)	13 (22)	8 (35)	35 (34)	38 (39)	17 (20)	5 (16)	51 (33)	
Yes	130 (65)	9 (47)	96 (69)	23 (88)	31 (69)	68 (79)	29 (56)	45 (78)	15 (65)	68 (66)	60 (61)	67 (80)	26 (84)	103 (67)	
Impression	189				0.653			0.834			0.552		0.769	0.547	

of FP discussion with MM	(95)														
Very good	175 (88)	17 (89)	130 (92)	26 (100)	43 (91)	82 (93)	47 (92)	55 (93)	23 (100)	94 (90)	93 (94)	77 (91)	31 (100)	143 (92)	
A little good	2 (1)	0 (0)	2 (1)	0 (0)	0 (0)	1 (1)	1 (2)	0 (0)	0 (0)	2 (2)	1 (1)	1 (1)	0 (0)	2 (1)	
Bad	1 (1)	0 (0)	1 (1)	0 (0)	1 (2)	0 (0)	0 (0)	1 (2)	0 (0)	0 (0)	0 (0)	1 (1)	0 (0)	1 (1)	
Don't know	11 (6)	2 (11)	9 (6)	0 (0)	3 (6)	5 (6)	3 (6)	3 (5)	0 (0)	8 (8)	5 (5)	6 (7)	0 (0)	10 (6)	
Want more support from MM	184 (92)				0.012			<0.001			0.006		0.085	0.254	
No	44 (22)	0 (0)	39 (28)	5 (21)	3 (7)	19 (22)	22 (42)	21 (37)	1 (5)	22 (21)	29 (30)	15 (18)	10 (32)	34 (22)	
Yes	140 (70)	19 (100)	101 (72)	19 (79)	39 (93)	68 (78)	30 (58)	36 (63)	21 (95)	81 (79)	69 (70)	67 (82)	21 (68)	118 (78)	
Do not want to answer	5 (3)														
Want more information about FP in the future	190 (95)				0.553			0.813			0.769		1.000	0.232	
No	8 (4)	0 (0)	8 (6)	0 (0)	1 (2)	5 (6)	2 (4)	3 (5)	0 (0)	5 (5)	4 (4)	4 (5)	0 (0)	8 (5)	
Yes	182 (91)	18 (100)	136 (94)	26 (100)	45 (98)	84 (94)	50 (96)	56 (95)	23 (100)	101 (95)	95 (96)	83 (95)	31 (100)	150 (95)	

Table 3 – Distribution of modern contraception methods used by the study population of women, aged 15-44 years, in Eswatini.

Contraceptive method currently used	N (%)
Total	160
Unspecified	31 (19)
Injectable	71 (44)
Pills	18 (11)
Implant	19 (12)
Condom	18 (11)
IUD	2 (1)
Sterilization	1 (1)

