Babali Nursing Research
2024, Vol. 5, No. 4, 741-756
https://doi.org/10.37363/bnr.2024.54433

Original Research

Contraceptive Selection among Couples of Childbearing Age in the Perspective of Healthcare Workers

Riska Dwi Prihatiningsih[1*], I Wayan Agung Indrawan[1], & Nanik Setijowati[1]

[1]*Midwifery Master Program, Faculty of Medicine, Brawijaya University, Malang, Indonesia*

Article Info

Article history:
Received:
10 September 2024
Accepted:
23 October 2024

Keywords:
childbearing-age, contraceptive, healthcare-worker

Abstract

Introduction: Women are susceptible to unwanted pregnancies. This makes them susceptible to risk factors such as maternal mortality, abortion, and stress. This study aims to explore health workers' perspectives on contraceptive selection among couples of childbearing in East Lombok Regency.
Methods: Qualitative research design was employed with an interpretive phenomenological approach. This study was conducted in 4 Public health centers (PHCs) in East Lombok Regency, namely the Montong Betok PHC, Wanasaba PHC, Selong PHC, and Denggen PHC between May and June 2024. There were 12 participants consisting of 2 doctors, 8 midwives, and 2 nurses, recruited by purposive sampling. Data was collected using a recording device through in-depth interviews and field notes. Data were analyzed using a process based on four stages: transcribing, organizing, recognizing, and coding.
Results: Eight themes emerged through data analysis, including 1) the role of health workers in contraceptive selection, 2) provider factors, 3) contraceptive availability, 4) access to contraceptive services, 5) cost of contraceptive use, 6) provision of contraceptive information by health workers, 7) social influences, and 8) fears and myths about contraception.
Conclusion: Many factors influence contraceptive choice, but social influence is the most critical factor that determines whether couples of childbearing age choose and use contraception

*Corresponding Author:

e-mail: dprihatiningsih@gmail.com

INTRODUCTION

Contraception is a way to prevent pregnancy in couples of childbearing age by regulating the number and intervals of births. The choice of contraceptive method is essential because the contraceptive method used by a woman will have an impact on preventing unwanted pregnancies. Indonesia is one of the most populous countries in the world. In some years, Indonesia continues to experience an increase in population. In 2017, the average birth rate in Indonesia was 2.4 births, meaning that each family had 2-3 children [1]. Although it has decreased, it is still far from expectations. There is still a high Maternal Mortality Rate of 305 per 100,000 births due to emergencies in pregnancy, childbirth, and postpartum that occur in women at risk. One of the causes is "4 T": too young, too close birth spacing, too old to give birth, and too many children [2]. Women are susceptible to unwanted pregnancies.

One of the government's efforts to overcome population control problems and reduce maternal mortality rates (MMR) and women's reproductive health problems is through the family planning program [2]. According to the National Population and Family Planning Board, the number of family planning participants in 2021 shows that the prevalence of couple childbearing as family planning participants in Indonesia is 57.4%. The number of couples of childbearing age in East Lombok Regency is the highest in West Nusa Tenggara Province. The East Lombok Regency Health Office's 2022 Family Planning Report data recorded that active family planning participants in 2022 in the East Lombok Regency were 167,951 people (78.7%) out of 213,481 couples childbearing.

The achievement of active family planning participants in East Lombok Regency is still lower than that of NTB Province of 896,115 people or 86.3% of existing couples childbearing. Although the coverage of active family planning participants has reached the target, this year's achievement has decreased compared to 2021, which was 87.5%. The pattern of choosing the type of contraception active family planning participants is injection by 53.8%, pills by 12.3%, implants by 20.5%, Intrauterine Devices IUD by 8.6%, condoms by 1.8%, Tubektomi by 2.1% and Vasektomi 0.3%. Family planning participants mostly choose to use non-LARC compared to the long-acting reversible contraceptive (LARC), even though long-term contraception is more effective [3].

Based on preliminary research that has been conducted, the choice of contraception used by fertile couples is still uneven. Factors that hinder fertile couples from choosing the LARC method and preferring Non-LARC such as injecting include convenience and more practicality, feelings of fear and shame about using IUDs and implants, issues that develop in society, husbands not giving permission, distance, and financing factors.

Women's choices are influenced by partners, friends, family, health workers, and social norms. Knowledge and ability to make decisions also play a role. In addition, contraceptive methods, convenience, privacy, healthcare costs, and health worker attitudes influence choices [4]. Some women described that health workers directed them to choose LARC by providing inaccurate information

and emphasizing the weaknesses of non-LARC. A study by Brunei et al. (2021) showed the importance of recommendations from health workers and the information provided can be a motivator for women to decide to use contraception [5].

Health workers play an essential role in providing comprehensive and accurate services to women about the types of contraceptive methods and helping women make the right decisions when choosing appropriate contraceptive methods information during counseling [6]. Most of the current research on factors influencing contraceptive choice come from women's point of view [7];[8];[9]. However, more is needed to know about health workers' perspectives on this topic.

This study is part of qualitative research that aims to explore the perspective of health workers in contraceptive selection among couples of childbearing at East Lombok Regency.

METHODS

Research Design

This study used a qualitative research design with an interpretive phenomenological approach to explore health workers' perspectives on contraceptive selection among couples of childbearing age in East Lombok Regency.

Study setting

This study was conducted in 4 Public health centers (PHCs) in East Lombok Regency, namely the Montong Betok PHC, Wanasaba PHC, Selong PHC, and Denggen PHC, conducted between May and June 2024.

Population, Sample, Sampling

The population in this study was 385 healthcare workers (doctors, nurses, and midwives) who provided contraceptive services in East Lombok Regency. Participants in this study were 12 healthcare (doctors, nurses, and midwives) who are working at Selong Public Health Care/PHC (3 people), Denggen PHC (3 people), Montong Betok PHC (3 people) and Wanasaba PHC (3 people), was taken based on the saturation point through purposive sampling. The inclusion criteria of the participants were healthcare workers (doctors, midwives, and nurses who provide family planning services), able to communicate using good Indonesian language, having experience in contraceptive services for at least 1 year, and being willing to become participants. The exclusion criteria were healthcare workers who do not have experience in contraceptive services or have experience in contraceptive services for less than 1 year.

Instruments

The study used an interview guide containing 20 open-ended questions with sub-topics on the role of healthcare workers, contraceptive service provider factors, contraceptive availability, access to services, costs, information from healthcare workers, and social aspects. The interview guidelines were developed based on the objectives of the study. The interview guidelines in this study focus on the role of health workers in contraceptive selection and healthcare

workers' perspectives on contraceptive selection in couples of reproductive age.

Procedures

In the first process, the researcher met the participants and explained to them verbally and in writing through an explanation sheet before the study. If they agreed, the participants signed the informed consent. They then agreed on the contract for the time and place where the interview would be conducted. Data collection was carried out through semi-structured, in-depth interviews. Interviews were conducted by one of the researchers directly (face-to-face) with all participants. Interviews were conducted using interview guidelines on the role of healthcare workers and the perspectives of healthcare workers in choosing contraceptives for couples of childbearing age. Interviews lasted for 45-60 minutes and were recorded using a recorder.

Data Analysis

Data were analyzed using a process based on four stages: transcribing, organizing, recognizing, and coding. Interviews were transcribed verbatim by the researcher. Data organization was carried out by recording the data collection date and marking each participant's data by giving a code, for example, P1 for the participant, P2 for participant 2, and so on. Data were recognized by listening carefully to audio-recorded interviews, reading transcripts, and making summaries. The coding process was carried out by collecting data with the same meaning.

The validity of the research data was carried out with four criteria, including:

1. Credibility: the researcher conducted extended observations, increased diligence, triangulation of sources, analysis of negative cases, using reference materials, and member checking through follow-up interviews with participants to clarify data that needed more information.
2. Transferability: the researchers outlined the results in detail, clarity, and systematization to make it easy for readers to understand.
3. Dependability: researchers conducted audits of the entire research process by involving supervisors during the research.
4. Confirmability: the objectivity of research depends on the approval of a person's opinions, views, and findings.

Ethical Approval

This study has received approval from the Health Research Ethics Commission of the Faculty of Medicine, Universitas Brawijaya, with the number 141/EC/KEPK-S2/05/2024. Informed consent was obtained from every participant, ensuring that they were aware of the objectives and methods of the study, as well as their opportunity to withdraw from the study at any time without incurring any penalties.

RESULTS

Twelve healthcare workers agreed to participate in this study, including doctors, nurses, and midwives. Table 1 illustrates the

characteristics of the participants who completed the interviews (n=12).

Table 1
Characteristics of Participants (n=12)

Variable	n
Age	
26-35	3
36-45	9
Sex	
Male	3
Female	9
Education Level	
Bachelor of Medicine	2
Bachelor of Nursing	1
Diploma of Nursing	1
Diploma of Midwifery	8
Job	
Doctor	2
Nurse	2
Midwifery	8
Contraceptive Training (Contraception Technology Update)	
Ever join training	4
Never join training	8
Length of Work	
<5 years	1
5-10 years	4
>10 years	7

There were three male participants and nine female participants. Participants were health workers who worked as doctors (2 people), nurses (2 people), and midwives (8 people). Four participants participated in the Contraception Technology Update, and eight did not. Participants who worked for less than five years were one person, who worked for 5-10 years were four people, and those who had worked for >10 years were seven.

The results obtained based on the research objectives obtained eight main themes: 1) the role of health workers in contraceptive selection, 2) service provider factors, 3) contraceptive availability, 4) access to contraceptive services, 5) the cost of contraceptive use, 6) contraceptive information by health workers, 7) social influences, 8) fears and myths about long-acting reversible contraceptive (LARC).

These themes are explained as follows:

1. **The role of health workers in contraceptive selection**

The theme of health workers' role in contraceptive selection consisted of three sub-themes: health workers' role in providing counseling, health education, and contraceptive services. The first sub-theme is the role of health workers in providing counseling. The following are the statements of participants in relation to this.

> *"Ee if here it is for me through counseling, right we use the ABPK sheet to help the community to get the right contraception according to the needs*

and conditions of the mother's body, the mother's health" (P11).

Based on the participant's statement above shows that health workers provide counseling using decision-making tools. Doctors and midwives explain that their role is to provide counseling by explaining everything about birth control, types of contraception, advantages, disadvantages, and side effects of contraception.

In addition, health workers help patients determine their contraceptive choices, namely helping to make decisions, provide advice, and direct them to the right contraception as needed. Participant statements supporting this are as follows:

"Usually, we suggest, for example, that if she wants to delay her pregnancy, we will suggest it the most, but it depends on whether the couple of childbearing age is newly married or not. If she is newly married, we advise her to have interrupted intercourse or not to use condoms. But if she already has children, we usually recommend using an IUD. The IUD can be removed at any time, and it's not hormonal, so it doesn't affect other hormones like that if she wants to have children" (P3)

Based on the participant's statement above shows that health workers help patients determine their contraceptive options by first providing information about contraception. Although couples decide on childbearing age, health workers still offer advice and direct contraception according to their needs and prioritize long-acting reversible contraception.

The second sub-theme was providing health education. Participant statements supporting this are as follows:

"We have a family posyandu right here....then we can educate them there about the use of this LARC which is more important"(P8).

Based on the statements of the participants above show that health workers have provided health education by providing education, counseling, and socialization about family planning and how to use LARC so that people can choose the proper and effective contraception such as LARC. The provision of health education is carried out in various places such as posyandu.

The third sub-theme formed from this theme is providing contraceptive services. The participant expressed this in the statement:

"So more or less the role of the village midwife here is vital, we as village midwives and PHC midwives are the main spearhead here regarding eee... family planning insertion" (P10)

The statements of the participants above show that health workers play a role in providing contraceptive services. Contraceptive services by health workers such as village and health center midwives play an essential role in inserting family planning.

2. Service Provider Factors

The theme of service provider factors consisted of three sub-themes: contraceptive training, recommendations for contraceptive options by health workers, and provider attitudes. In the first sub-theme, a few participants have participated in contraceptive training. The following are the statements of participants in relation to this:

"Because the training taught me how to do counseling. First, the most basic is counseling. Counseling the patient and then what the correct installation action is like. Yes, it is very helpful, especially for us

as midwives. We know how to insert long-acting reversible contraception and choose the right contraception properly" (P 7)

Based on the participant's statement above, the benefits of contraceptive training that have been followed are that knowledge becomes more extensive related to counseling and more appropriate techniques when installing and removing contraceptives, especially long-term contraceptives such as implants and IUDs. So that when providing contraceptive services, they become more confident and help couples of childbearing age to choose the right contraception.

The second sub-theme was the recommendation of contraceptive options by health workers. It is based on the types of contraception available. This is expressed in the following statement:

"But here, the average will provide a long-acting reversible contraception option" (P1)

Based on the participant's statement above, health workers recommend long-acting reversible contraception such as implants and IUDs because they are the best.

The third sub-theme is the attitude of service providers. What health workers consider in the medical eligibility criteria for couples of childbearing age when they want to use contraception is the risk factors they have, age, and the number of children. This can be seen from the statements expressed by the participants.

"Implants and IUDs...especially those who have many children, like G3 who have G4, Hehehehe. Some give birth every year. Not many, but there are. Usually, those who are sterile are, on average, those who have grande-multi and those with a bad childbirth history, for example, PEB, and their age is not possible to get pregnant again" (P12)

The participants' statements above show that health workers consider risk factors such as a history of high blood pressure and certain other diseases. Couples of childbearing age can use any contraception they want. Health workers stated that those who are suitable for using contraception are postpartum mothers who can use injections, implants, and IUDs. In addition, couples who have had many children and have a history of poor childbirth can use IUDs and sterile contraceptives.

Some participants showed different attitudes in dealing with patients who had a history of disease (hypertension, diabetes mellitus, and kidneys) and wanted to use hormonal contraceptives. The following statements were made by the participants:

"Once, it happened that this mother was using an implant, but her blood pressure was high because Ee, if you have high blood pressure you can't use hormonal birth control, the higher she is ah, you have already insertion it, for example, you don't want it, I just use it like an implant, Mrs midwife or just use an injection, but it has been explained in all kinds of ways explained that the higher it will cause strokes and all kinds of things if she has high blood pressure, it's better if she uses an IUD, Eh but she doesn't want it, I don't dare to take risks, I don't want to insertion it, she goes home. We wait, or we consult a doctor first, we give her medicine and then come back 3 days later if her blood pressure drops, then we put it in" (P8)

Based on the participant's statement above, it is known that health workers show an attitude of disagreement or refusal to provide contraception when the patient has a medical history, which is a contraindication to the use of the desired contraception. The use of hormonal contraceptives can worsen the health conditions of patients who have a

history of diseases such as hypertension, diabetes mellitus, and kidney disease. Most of them will advise women of childbearing age to choose IUD contraception.

3. Contraceptive availability

The Contraceptive availability theme consists of one sub-theme: most contraceptive availability is adequate. Participants who worked as midwives stated that the availability of contraception was quite complete in their workplaces. The availability of contraception at health centers and polindes is based on entries in the New Siga application. This determines the number of contraceptives they get every three months. This was revealed in a statement:

> *"It's adequate. It's just because here, the point is that there is a New Siga called yes. We use Alkon [contrateption], which is directly entered by name and address. Yes. Here, it is a bit limited because many have not entered New Siga, so the remaining stock of Alkon is seen in New Siga, too; if there is still a lot of remaining stock of Alkon, it will affect the Alkon drop like that" (P1)*

However, in contraception that is in high demand, such as implants, the availability is often lacking. Participants said that the stock of implants was ten pieces. Running out of contraceptive stock affects the ability of couples of childbearing age to choose their preferred method of contraception. This results in women being forced to use methods they do not select and reject suggested contraceptive alternatives. This is supported by the statements of the participants.

> *"Less, especially implants. Implants because there are a lot of people here who use implants,..... After being counseled, many women want to use LARC. When the availability is empty, so those who are forced to use what is available first" (P10)*

4. Access to Contraceptive Services

The theme of access to contraceptive services consists of two sub-themes: affordability by residence and limited availability and long distance to services. The first sub-theme of affordability with housing determines access to contraceptive services. This was expressed by the participant in the statement.

> *The village people are like that, which one is close to which one is close to him, the one in what is called his place chooses so. Now, it happens that this family planning is not like people choosing treatment, right, which is resting or what not, which is healthy. For family planning, it must be the closest. That's why that person also came to me. Access is the closest place compared to polindes or PHC" (P2)*

Based on the participant's statement above shows that couples of childbearing age tend to go to the contraceptive service provider closest to where they live when accessing contraceptive services. Although polindes and PHC have complete contraceptive availability, if access is far, couples of childbearing age prefer to go to the nearest contraceptive service place.

The second sub-theme is limited availability and distance from contraceptive service sites. The participant's statement in support of this is as follows:

> *"For example, what I said, if it's the one in Gunung Sepang, sometimes the mother has already given birth, the postpartum period has been completed, so the midwife goes there and we confirm that it's better to use an IUD, this is using an implant so she wants it. Sometimes, she wants to, but because of her access here, inserting it at her house when we visit is impossible. They will be waited for by the midwife at the PHC, but they are lazy because it is far away. Yes, it has an effect too. In the end, they took a different route.*

Maybe they go to the polindes midwife, so they don't use it right, they use injections contraception maybe it's easier. Like that" (P4)

Based on the participant's statement above, it is known that if the desired contraception is not available at the nearest service place, for example, injection contraception, then couples of childbearing age look for other places farther away. In addition, although women have expressed their desire to use IUD contraceptives, because of the conditions of their residence from PHC, they finally prefer to go to the nearest place and use injections. This can ultimately affect the choice of contraception to be used.

5. Contraceptive Costs

The cost of contraceptive use theme consisted of two sub-themes: cost sources and affordability of contraceptive services. The first sub-theme was cost sources. Most participants, especially those who worked in government health facilities such as PHC, said that the service was free if couples of childbearing age had health insurance such as BPJS. Meanwhile, for those whose source of funds came from personal costs because they did not have BPJS and did not want to participate in free contraceptive services, there was a fee to be paid. The family fee amount has been adjusted according to local regulations. This only applies to government health facilities. This was expressed in the statement.

"There are many free contraceptive services because there is indeed a program from family planning itself, such as free insertion implants. But if you are told to pay, that's the name of our society. So I think it can affect the insertion, but because there is such a thing as BPJS, there are also free ones like that, so the insertion of implants and IUDs can be covered by that" (P3).

The second subtheme is that the affordability of contraceptive services in health services affects the choice of contraception for couples of childbearing age. Every month or every three months, free contraceptive services are held for all people who want to use contraceptives. This applies to those who have BPJS and those who do not have BPJS by bringing a photocopy of their family card. Most health workers report that most couples of childbearing age take advantage of this free service, especially those who do not have health insurance and want to use long-acting reversible contraceptives (LARCs) such as IUDs and Implants.

"This is very helpful. Especially for LARC, payment outside the service is quite expensive, so these mothers wait for the service. Usually, many WhatsApp me, 'When is the service?" wait every month. Usually, the service is at the end of the month because it clashes with posyandu and classes" (P8).

6. Provision of contraceptive information by health workers

This theme consists of 3 sub-themes: barriers to information provision, implementation of information provision, and the effect of the information provided. The first sub-theme is a barrier to providing information. Participants reported that patients' knowledge needed to be improved when giving information. This was revealed in the participant's statement.

".... because people's education is different, so the ability to grasp the information differs for each person. So,

some have long understood the information provided using Indonesian. Therefore, I use the Sasak language to understand it better. The point is, use simple language like that" (P5)

The participant's statement above shows that the barrier health workers face when providing information is caused by the different educational backgrounds of fertile couples, which can affect their ability to understand the information provided. Therefore, information needs to be conveyed using more straightforward language.

The second sub-theme is the implementation of information provision. The following are participant statements that support it.

"So we are explained about all contraceptives, both injectable contraceptives, implants, IUDs. We explain the side effects of each contraceptive. Then the benefits and advantages so that acceptors want to choose the right contraceptive after we provide counseling" (P1)

Based on the participant's statement above shows that the contraceptives provided by health workers include various types of contraceptives, their benefits, disadvantages, and side effects.

Sub-theme 3 influences the choice of contraceptives. This is expressed in the following participant statements, including:

"It is very influential if we can provide clear information regarding the choice of this contraceptive, especially regarding the effects, side effects because some are short-term and some are long-term, right? "Later, fertile couples will choose those with fewer side effects, for example, if they suffer from hypertension, if they use long-acting reversible contraceptive (LARC), there will be no problems with their joints, and so on" (P2)

Based on the participant's statement above shows that providing clear information about contraception can give understanding to fertile couples so that they can determine the choice of contraception that suits their needs.

7. Social Influence

The theme of social influence consists of two sub-themes: the influence of husbands on decision-making and the influence of family and environment on contraceptive choice. The first sub-theme was the husband's influence on decision-making. Interference with sexual pleasure leads to disapproval of the choice of contraceptives used by women. One participant who worked as a nurse told how couples of childbearing age associated the use of injectable contraceptives with interference with sexual pleasure. This was expressed in the participant's statement.

"As far as I know, when I have provided KIE to patients, the most uh, what's the name, it's dominant for what's the name, for example, if someone comes with their husband who decides to use contraceptives, it's the husband. Yes, because the husband might be worried about his wife for some reason. For example, if we say if he uses injectable contraception, his wife will have a little less libido, so her husband is worried that his wife doesn't have the same libido as her husband, like that" (P2).

Health workers said that women, in choosing contraception, first ask permission from their husbands. So that there are no problems in the future. Health workers said that the people in their working area respect their husbands because the family's responsibility lies with the husband. This was expressed by participants in the statement:

"He'ee later sometimes he asks first with the husband to ask the husband's permission sometimes like that so it cancels ... more what his responsibility is, his responsibility is to the husband...."(P4)

The second sub-theme was the influence of family and environment in contraceptive selection. This was expressed in the participants' statements.

"It's just that sometimes the in-laws are afraid, right? They have ordered injections from home because all of us here use injections, so the hardest thing to do is turn to something else. If she and her husband come here, God willing, they will still be given' (P7).

Based on the participants' statements above show that the experience of in-laws often influences the choice of contraceptives to be used by couples of childbearing age who live with in-laws. Mostly, women who live with in-laws are afraid if they do not follow the wishes of their in-laws. In addition, women sometimes choose to use contraceptives used by their families.

8. Fears and Myths

The theme of fears and myths about LARCs consisted of two sub-themes: fears of the LARC insertion process and misconceptions about LARCs. The first sub-theme was fear of the LARC insertion process. Fear of the contraceptive insertion procedure scared many women and was the reason for not choosing the IUD and implant for contraceptive use. This was expressed in the statement.

"For the IUD insertion, they are afraid, and then the device is inserted into their genitals. If the implant is also ripped out of the hand" (P3).

The second sub-theme was misconceptions about LARC. A health worker who is a midwife in urban areas said that women of childbearing age prefer implants to IUDs. If using an IUD, then the menstruation is more prolonged, and the bleeding is more. This was expressed in the participant's statement.

"Most here prefer implants. Rather than maybe the IUD, she said she was usually afraid, then much talk from others that like bleeding. Eh longer menstruation is still lacking understanding from the community" (P9)

In addition, health workers reported that there are many stories and rumors in the community that using the IUD is not safe. This was expressed by nurses and midwives in urban areas.

DISCUSSION

The study findings revealed that various factors influence contraceptive choices among fertile couples, including the role of health workers in choosing contraception, service provider factors, availability of contraception, access to contraceptive services, cost of contraceptive use, information about contraception by health workers, social influences, fears and myths about long-acting reversible contraception (LARC). This is in contrast to several previous studies, which examined the influence on the provision of contraceptive services [10][11][12]. The current findings expand our knowledge of factors influencing contraceptive selection among couples of childbearing age.

Health workers in this study believed that providing information about contraception was part of their role. Many reported currently providing some

contraceptive counseling to women. However, some health workers had not received formal training related to family planning or contraception, and knowledge of different contraceptive methods varied. These findings contribute to the limited literature in East Lombok on health workers' views and experiences of contraceptive counseling. Increasing outreach by health workers in providing family planning and counseling services would not only help build knowledge about contraceptive methods but would also increase women's willingness to use them [13] [14].

This study found that service provider factors influence contraceptive choice in couples of childbearing age. This is related to the training that has been attended, recommendations for contraceptive choices by health workers, and the attitude of service providers. To provide suitable contraceptive options for women, responsible health workers need to have good training and education to be able to provide consultations [15]. In a study conducted by Fataar et al. (2022), it was found that sexual and reproductive health training increased the confidence of service providers to provide contraceptive services [12]. Most health workers in this study reported choosing IUD contraception to recommend to fertile couples. Not many fertile couples use long-term contraception, especially IUDs. This is because the final choice is the client's right [16]. Whereas the previous study on the influence of service providers on contraceptive provision focused on certain specialties and specific contraceptive methods [10].

Several health workers acknowledged that availability, access to contraceptive services, and cost support contraceptive choices for couples of childbearing age. Some places where contraceptive demand is high, such as implants, often have limited availability. According to Shiferaw et al. (2018), their study showed the influence of access to services and the availability of contraceptive methods on contraceptive use [16]. When women face barriers to accessibility to long-term contraceptive provision, they change their behavior by switching from long-term to short-term contraception [17]. Cost is a significant barrier to accessing contraceptive services, and not all contraceptive methods are available for free, so choices are limited [18]. Providing free health services in some public facilities and ownership of health insurance in some countries facilitate access. However, free services often result in long waiting times [18]; [19].

Participants in this study noted that social influences, fears, and myths in the community about LARC influenced the choice of contraceptives in couples of childbearing age. Previous studies have shown that the husband's opinion greatly influences the decision to use contraceptives [20]. In addition, contraceptive service providers identified a lack of support from husbands as a significant barrier to contraceptive use [21]. Meanwhile, previous studies have shown that positive experiences from friends or relatives also have a significant influence on method selection, meaning that women are 1.9 times more likely to use the same method [22]. In-laws are one of the social factors that

influence the family planning decision-making process [20],[23].

Fear of the contraceptive insertion procedure makes many women afraid and is a reason not to choose IUDs and implants as contraceptives [24],[25]. These myths come from family, friends, and partners and are believed without scientific evidence [26],[27]. These findings suggest an opportunity to promote a collaborative model with cross-sectors to help increase community support for the use and selection of effective contraception. To improve understanding and knowledge about contraceptive methods and reduce misunderstandings about contraceptive methods, it is necessary to increase the level of education in women [28],[29].

The results of this study produced new findings, namely how health workers' perspectives on choosing contraceptives for couples of childbearing age. Potential factors that can be modified by policymakers and implementers of family planning programs such as health workers must pay attention to various elements in choosing contraceptives, namely by involving husbands in decision making and in addition, improving the skills of health workers in providing counseling, health education, and contraceptive services to couples of childbearing age.

LIMITATION

This study has limitations: the health workers involved were taken from various professions, such as doctors, midwives, and nurses. Different types of health workers have different levels of knowledge, training, and comfort regarding contraceptives.

CONCLUSION

Many factors influence contraceptive choice, but social influence is a significant factor that determines whether couples of childbearing age choose and use contraception. Healthcare workers must increase contraceptive counseling, and it is hoped that service institutions can improve the competence of health workers through continuous education and training to update their knowledge and skills so that equitable use of contraceptive types can be evenly distributed, especially in increasing the selection of long-term contraceptive types such as implants and IUDs. Especially, the use of IUDs is still small.

FUNDING

This research came from personal funds.

ACKNOWLEDGEMENT

We would like to thank the doctors, nurses, and midwives at Selong PHC, Denggen PHC, Wanasaba PHC, and Montong Betok PHC, who have agreed to be respondents in this study.

REFERENCES

[1] Kementrian Kesehatan RI, “Survei Demografi dan Kesehatan Indonesia Tahun 2017,” 2018.

[2] Direktorat Jenderal Kesehatan Masyarakat, “Modul Pelatihan Pelayanan Kontrasepsi bagi Dokter dan Bidan di Fasilitas Pelayanan Kesehatan,” Kemenkes RI, pp. 37–64, 2021.

[3] Dinas Kesehatan NTB, “Profil Kesehatan Provinsi NTB 2021,” Dinas Kesehat. NTB, pp. 1–101, 2022.

[4] P. D'Souza, J. V. Bailey, J. Stephenson, and S. Oliver, "Factors influencing contraception choice and use globally: a synthesis of systematic reviews," Eur. J. Contracept. Reprod. Heal. Care, vol. 27, no. 5, pp. 364–372, 2022, doi: 10.1080/13625187.2022.2096215.

[5] A. Brunie, R. L. Callahan, A. Mackenzie, S. P. S. Kibira, and M. Wayack-Pambè, "Developing acceptable contraceptive methods: Mixed-method findings on preferred method characteristics from Burkina Faso and Uganda," Gates Open Res., vol. 3, p. 1205, 2019, doi: 10.12688/gatesopenres.12953.1.

[6] R. Yirgu, S. N. Wood, C. Karp, A. Tsui, and C. Moreau, "'you better use the safer one... leave this one': The role of health providers in women's pursuit of their preferred family planning methods," BMC Womens. Health, vol. 20, no. 1, pp. 1–9, 2020, doi: 10.1186/s12905-020-01034-1.

[7] S. Aryati, S. Sukamdi, and D. Widyastuti, "Faktor-Faktor Yang Mempengaruhi Pemilihan Metode Kontrasepsi (Kasus di Kecamatan Seberang Ulu I Kota Palembang)," Maj. Geogr. Indones., vol. 33, no. 1, p. 79, 2019, doi: 10.22146/mgi.35474.

[8] J. O. Maitanmi, M. F. Tanimowo, B. T. Maitanmi, O. E. Okondu, S. K. Olubiyi, et al., "Factors Influencing Choice of Contraceptives among Women of Reproductive Age Attending Lagos State University Teaching Hospital, Nigeria," J. Res. Dev. Nurs. Midwifery, vol. 18, no. 2, pp. 8–10, 2021, doi: 10.52547/jgbfnm.18.2.8.

[9] S. K. Mody, C. Cansino, R. Rible, J. P. Farala, J. Steinauer, and T. Harken, "Contraceptive use among women with medical conditions: Factors that influence method choice," Semin. Perinatol., vol. 44, no. 5, p. 151310, 2020, doi: 10.1016/j.semperi.2020.151310.

[10] A. K. Mann, A. Khoury, P. McCartt, M. G. Smith, N. Hale, et al., "Multilevel Influences on Providers' Delivery of Contraceptive Services: A Qualitative Thematic Analysis," Women's Heal. Reports, vol. 3, no. 1, pp. 491–499, 2022, doi: 10.1089/whr.2021.0128.

[11] N. Lince-Deroche, C. Hendrickson, A. Moolla, S. Kgowedi, and M. Mulongo, "Provider perspectives on contraceptive service delivery: Findings from a qualitative study in Johannesburg, South Africa," BMC Health Serv. Res., vol. 20, no. 1, pp. 1–11, 2020, doi: 10.1186/s12913-020-4900-9.

[12] K. Fataar, V. Zweigenthal, and J. Harries, "Providers' approaches to contraceptive provision in Cape Town," Front. Glob. Women's Heal., vol. 3, 2022, doi: 10.3389/fgwh.2022.917881.

[13] C. Dehlendorf, C. Krajewski, and S. Borrero, "Contraceptive counseling: Best practices to ensure quality communication and enable effective contraceptive use," Clin. Obstet. Gynecol., vol. 57, no. 4, pp. 659–673, 2014, doi: 10.1097/GRF.0000000000000059.

[14] A. Kumar, A. K. Jain, F. Ram, R. Acharya, A. Shukla, et al., "Health workers' outreach and intention to use contraceptives among married women in India," BMC Public Health, vol. 20, no. 1, pp. 1–9,

2020, doi: 10.1186/s12889-020-09061-1.

[15] K. Sedlecky, M. Rašević, and J. Bitzer, "Education and training of health care workers for contraceptive service delivery in 21 countries across Europe," Sex. Reprod. Healthc., vol. 24, no. May 2019, 2020, doi: 10.1016/j.srhc.2020.100498.

[16] A. Maytan-Joneydi, E. W. MacLachlan, B. I. Agali, K. Louis-Charles, S. Chaibou, et al., "Providers' views on hormonal family planning methods: a qualitative study from Dosso, Niger," Gates Open Res., vol. 6, p. 75, 2022, doi: 10.12688/gatesopenres.13674.1.

[17] R. Sato, J. Rohr, S. Huber-Krum, Y. Esmer, B. Ayca, et al., "Effect of distance to health facilities and access to contraceptive services among urban Turkish women," Eur. J. Contracept. Reprod. Heal. Care, vol. 26, no. 5, pp. 374–382, 2021, doi: 10.1080/13625187.2021.1906412.

[18] R. Reed, O. Osby, M. Nelums, C. Welchlin, R. Konate, and K. Holt, "Contraceptive care experiences and preferences among Black women in Mississippi: A qualitative study," Contraception, vol. 114, pp. 18–25, 2022, doi: 10.1016/j.contraception.2022.05.009.

[19] S. Ameh, B. O. Akeem, C. Ochimana, A. O. Olusawanu, S. F. Mohamed, et al., "A qualitative inquiry of access to and quality of primary healthcare in seven communities in East and West Africa (SevenCEWA): perspectives of stakeholders, healthcare providers and users," BMC Fam. Pract., vol. 22, no. 1, pp. 1–12, 2021, doi: 10.1186/s12875-021-01394-z.

[20] M. Sarfraz, S. Hamid, A. Kulane, and R. Jayasuriya, "'The wife should do as her husband advises': Understanding factors influencing contraceptive use decision making among married Pakistani couples—Qualitative study," PLoS One, vol. 18, no. 2 February, pp. 1–19, 2023, doi: 10.1371/journal.pone.0277173.

[21] C. Aristide, B. W. Bullington, M. Kuguru, R. Sundararajan, N. T. Nguyen, et al., "Health providers' perspectives on contraceptive use in rural Northwest Tanzania: A qualitative study," Contracept. X, vol. 4, p. 100086, 2022, doi: 10.1016/j.conx.2022.100086.

[22] J. N. Mumah, J. B. Casterline, K. Machiyama, M. Wamukoya, C. W. Kabiru, and J. Cleland, "Method-Specific Attributes that Influence Choice of Future Contraception Among Married Women in Nairobi's Informal Settlements," Stud. Fam. Plann., vol. 49, no. 3, pp. 279–292, 2018, doi: 10.1111/sifp.12070.

[23] M. R. Pradhan and S. Mondal, "Examining the influence of Mother-in-law on family planning use in South Asia: insights from Bangladesh, India, Nepal, and Pakistan," BMC Womens. Health, vol. 23, no. 1, pp. 1–20, 2023, doi: 10.1186/s12905-023-02587-7.

[24] P. S. Rasyid, "Pengaruh Pemberian Informasi Prosedur Pemasangan Implant Terhadap Tingkat Kecemasan Calon Akseptor Implant di Kota Gorontalo," J. Nas. Ilmu Kesehat., vol. 1, no. 3, pp. 15–27, 2019.

[25] J. I. Muna and G. R. Mahiti, "Perceptions of Intrauterine Devices among Women in Tanzania," East African Heal. Res. J., vol.

6, no. 1, pp. 32–38, 2022, doi: 10.24248/eahrj.v6i1.687.

[26] A. Namasivayam, P. J. Schluter, S. Namutamba, and S. Lovell, "Understanding the contextual and cultural influences on women's modern contraceptive use in East Uganda: A qualitative study," PLOS Glob. Public Heal., vol. 2, no. 8, pp. 1–16, 2022, doi: 10.1371/journal.pgph.0000545.

[27] R. Ochako, M. Mbondo, S. Aloo, S. Kaimenyi, R. Thompson, et al., "Barriers to modern contraceptive methods uptake among young women in Kenya: A qualitative study Global Health," BMC Public Health, vol. 15, no. 1, pp. 1–9, 2015, doi: 10.1186/s12889-015-1483-1.

[28] B. L. Solanke, O. O. Banjo, B. O. Oyinloye, and S. S. Asa, "Maternal grand multiparity and intention to use modern contraceptives in Nigeria," BMC Public Health, vol. 18, no. 1, pp. 1–15, 2018, doi: 10.1186/s12889-018-6130-1.

[29] D. Wijayanti, "The Effect of Health Education on Knowledge of The Prevention of Diabetes Mellitus," Babali Nurs. Res., vol. 3, no. 1, pp. 23–29, 2022, doi: 10.37363/bnr.2022.3176.