Nabulondera *et al.*
Contraception and Reproductive Medicine (2025) 10:21
https://doi.org/10.1186/s40834-025-00354-7

Contraception and Reproductive Medicine

RESEARCH

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"I felt my rights were violated": Challenges with the discontinuation of provider-dependent contraceptive methods in Eastern Uganda

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Abstract

Background The right to autonomy in family planning is a cornerstone of reproductive health. Yet, many women face challenges when seeking to discontinue provider-dependent contraceptive methods, such as implants and intrauterine devices (IUDs). This study explored the experiences of women in Eastern Uganda regarding the discontinuation of implants/IUDs.

Methods Using a qualitative descriptive design, we conducted 15 in-depth interviews with women and six key informant interviews with healthcare providers. The study obtained ethical clearance and used a thematic analysis.

Results Two themes were identified: (1) reasons for refusal and (2) women's reactions to refusal to discontinue IUDs/implants. Women were denied to discontinue IUDs/implants because the due date had not been reached, insertion cards were missing, and there were healthcare constraints, especially inadequate equipment. Early removal or discontinuation before the due date was considered as a waste of resources, unjustifiable, and it was seen to increase risk of pregnancy among young girls. Healthcare workers preferred to first counsel for side effects instead of heeding women's requests to discontinue IUDs/implants. Women often felt betrayed and powerless when they were denied to discontinue using IUDs/implants. They felt that their reproductive rights were undermined which fostered mistrust towards future use of provider-dependent contraceptives. Women reported physical, social, and mental health struggles including strained marital relationships following denial to discontinue IUDs/implants. Most of the women incurred costs in discontinuing the use of IUDs/implants in private facilities.

Conclusion The findings underscore the need to uphold women's autonomy by improving access to removal services, and addressing systemic and provider-level barriers to discontinuation of IUDs/implants. Insertion cards should not be a mandatory requirement during discontinuation of contraceptives, while enhancing record-keeping systems can address the need for insertion cards. Respecting women's rights to discontinue contraceptives is essential for ensuring voluntary and sustained family planning use.

Keywords Reproductive autonomy, Contraceptive discontinuation, Provider-dependent methods, Human rights in family planning

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Background

Family planning is fundamentally rooted in a human rights framework, emphasizing individuals' autonomy to decide whether to use or discontinue contraceptive methods [1]. However, provider unwillingness to discontinue provider-dependent contraceptives or methods such as implants and intrauterine devices (IUDs) that require trained medical personal to remove them often presents significant challenges to clients' reproductive autonomy [2–4]. In the US population, healthcare providers discouraged 5.8% of women from discontinuing the use of IUDs/implants [5]. Studies in Burkina Faso and Kenya have further shown that 9% and 7% of women, respectively, were denied requests to remove implants [6]. Such refusals undermine reproductive autonomy and constitute contraceptive coercion, violating women's human rights [1, 2].

Refusal to discontinue implants and IUDs occurs across a spectrum of covert to overt tactics [7]. Providers often prioritize counseling for side effects to encourage continued use of contraceptives rather than respecting their decisions to discontinue contraceptive use [6, 8]. Women's reasons for seeking removal are dismissed as illegitimate, amidst barriers such as rigid organizational policies, convoluted referral pathways, and inconvenient appointments to delay or prevent removal of the contraceptives [2, 9]. While limited provider capacity can be a barrier to IUDs/implant removal [10], providers may also refuse to discontinue contraceptives based on their personal or systemic beliefs about appropriate birth spacing or the perceived wastefulness and risks of early discontinuation [2, 3, 7].

Global family planning initiatives have largely focused on scaling up the provision and insertion of long-term contraceptive methods due to their extended protection against unintended pregnancies [2]. This has led to increased attention to insert and promote long-term use of IUDs/implants [11]. Several studies have been conducted to determine and explore the timing and reasons for early removal of long-term contraceptives [12, 13]. However, limited attention has been directed to barriers to discontinuation of provider-dependent contraceptive methods. Therefore, this study was conducted to explore the experiences of women with discontinuation of provider-dependent contraceptive methods in Eastern Uganda.

Methods and materials

Study design and setting

This study employed a qualitative descriptive design to explore the experiences of women discontinuing provider-dependent contraceptive methods [14]. The study was conducted in diverse settings, including various units within Mbale Regional Referral Hospital and community locations in Mbale City. Mbale City is situated in eastern Uganda, approximately 250 km east of Kampala.

Study population and sampling criteria

The study population comprised women who were currently using IUDs/implants, as well as women who had used these methods in the preceding five years. Participants were recruited from community settings, family planning clinics, and hospital units such as antenatal care, gynecology, and postnatal wards. Additionally, nurses and midwives involved in providing family planning or reproductive health services were included in the study.

The sample size was determined by data saturation [15]. Data was collected until no new themes and issues arose. Data saturation was reached after 15 interviews with women and six with healthcare providers. A purposive sampling technique was used to identify women who had ever been denied or faced difficulty in the form of discouragement to discontinue IUDs/implants [15]. Participants were selected from diverse backgrounds and experiences to ensure maximum variation.

Data collection tool

Data collection was conducted between 15th September and 30th October 2024. In-depth interviews (IDIs) were conducted with women, while key informant interviews (KII) were conducted with nurses and midwives. An interview guide was used in the study. In the IDIs, questions in the interview guide explored women's experiences with discontinuation of IUDs/implants, challenges and enablers in discontinuation of IUDs/implants, and their overall response to being denied to discontinue IUDs/implants. The KIIs explored general reasons why healthcare providers may refuse to discontinue IUDs/implants, what healthcare providers consider in accepting to discontinue IUDs/implants, strategies to limit discontinuation of IUDs/implants, and healthcare providers' response to women who may insist on discontinuation of IUDs/implants after counseling of side effects of the contraceptives. The IDIs and KIIs were audio-recorded after obtaining consent from the study participants [16].

Study rigor and trustworthiness

Study credibility was maintained through triangulation by use of interviews of both healthcare providers and women [16]. Transferability was maintained through a thorough description of the study setting, data collection procedures, and the use of purposive sampling techniques to select participants with different experiences and perspectives. Confirmability was achieved through

proper documentation of data collection and analysis procedures and systematic coding [16].

Data analysis

Interviews with women were transcribed and translated from the local languages (Luganda and Lugishu) to English, while interviews with healthcare providers were transcribed verbatim. The first and the last author analysed the transcripts using thematic analysis [17]. The transcripts were read several times followed by identification of codes, subthemes, and themes [17]. Identification and interpretation of codes and subthemes were done by consensus [17].

Ethical considerations

Ethical clearance was obtained from the Research and Ethics Committee of Busitema University Faculty of Health Sciences (reference number: BUFHS-2024–193). Administrative clearance was also granted by the Mbale Regional Referral Hospital. Written informed consent was sought from the study participants before enrolment in the study. Participants were assured of confidentiality, and all information was anonymized and securely stored.

Results

Study participants

The majority of study participants had either previously used or were currently using contraceptive implants (Table 1). Regarding discontinuation, 80% of the women had made multiple requests to have their contraceptive implants or IUDs removed. Six key informant interviews (KIIs) were conducted with healthcare providers, including nurses and midwives. Of these, five were female and one was male. All healthcare providers held diploma-level qualifications, with work experience ranging from one to 16 years.

Table 1 Description of the characteristics of the women in the study

Variable	Frequency	Percentage
Age		
24–30	7	46.7%
31–45	8	53.3%
Marital status		
Married	14	93.3%
Separated	1	6.7%
Contraceptive use		
Current users	4	26.7%
Former users	11	73.3%
Contraceptive method		
Implant	12	80%
IUDs	3	20%
Frequency of requests		
Once	3	20%
Twice	5	33.3%
Thrice	6	40%
Seven times	1	6.7%
Actual/intended place of IUDs/implant removal		
Public health facility	04	26.7
Private for-profit facility	07	46.7
Private not-for-profit facility	02	13.3
Not specified	02	13.3

Experiences of discontinuation of IUDs/implants

Two main themes were identified from the study: Underlying reasons for and response to refusal to discontinue IUDs/implants (Table 2).

Theme 1: Underlying reasons for refusal to discontinue IUDs/implants

Subtheme 1: Removal before the due date

Healthcare providers often refused to remove IUDs or implants because the intended due date had not reached. Removal before due date was seen as a waste of resources, time, and supplies. Early discontinuation was perceived as an inefficient use of government-provided contraceptives, contributing to stockouts and potentially denying access to other women who could have benefited from long-term use.

> *"You have wasted this, the one if somebody would have benefited from, and when you keep wasting these things like this, we shall run short of stock.... That's why we're encouraging some of our mothers to keep their methods to avoid wastage." (KII 6, 60-year-old provider).*
>
> *"They refused to remove it because they told me that the years had not yet reached. It is a waste of government drugs." (IDI 15, denied after two requests).*

Providers also highlighted the significant financial implications of early removal, particularly for long-term methods like IUDs, which were deemed costly to procure.

> *"Most of those methods are really very expensive.... So, if somebody opted for like IUDs...then after one year somebody comes to remove it is wastage." (KII 5, a 54-year-old provider).*

Women were frequently encouraged—or compelled—to use the method until its "due date," with healthcare workers expressing frustration and negative attitudes toward women seeking early removal without what they deemed valid reasons.

Table 2 Thematic representation of experiences of discontinuing IUDs/implants

Themes	Subthemes	Codes
Underlying reasons for refusal to discontinue IUDs/implants	Removal before the due date	• Seen as wastage • Unwillingness of providers • Perceived risks of early discontinuation
	Health system constraints	• Work overload • Difficult removals (deep implants/ missing strings) • Stockouts • Inadequate equipment
	Asking for missing insertion cards	• Missing insertion cards
	Focus on counseling and management of side effects	• Counseling and treatment of side effects • Encouraging continued use of IUDs/implants
Women's Responses to denial of removal	Emotional and physical responses	Feelings of betrayal, frustration, insecurity, trapped, anger, hopelessness, anxiety, fear, and disappointment
		Headaches, gastric ulcers, high blood pressure, and heart problems
	Social and Economic Responses	• Gender-based violence & extramarital affairs • Costs discontinuing in private facilities • Lost opportunity cost
	Mistrust of provider-dependent contraceptives	• Myths and misconceptions • Negative attitudes • Violation of rights • Intentions not to use modern contraceptives

"They insisted that they would not remove it and I endure up to when the three years are over" (IDI 1, 24-year-old, denied on first request).
"There are those clients…who can irritate you, like…. After one month or two, over a year, you come with no reason, you want to remove….. you can also lose temper, you also get irritated" (KII 6,60-year-old provider).

Younger women, in particular, faced greater resistance due to assumptions that they were at a higher risk of becoming pregnant soon after discontinuation.

"We look at the age of the client. Like somebody comes at the age of 45, she's about to reach menopause we remove, but for our young girls they have a long way to go" (KII 6,60-year-old provider).
"The health workers told me not to remove because I would again get pregnant when the child is still young. I tried another health worker….but she told me that I am still a young girl…you are going to remove it and get pregnant immediately."(IDI 1, 24 year old denied on first request).

Subtheme 2: Healthcare system constraints.
Several systemic issues hindered access to IUDs/implant removal services. High patient volumes, staff shortages, and workload demands, especially on clinic days with competing priorities (e.g., cervical cancer screening), often led to postponed removal requests.

"Other issues include work overload, particularly when there are many patients at the time…we may postpone them for removal to the following week." (KII 2, 25-year-old provider).

Limited skills among healthcare providers further constrained services, with women referred to other facilities due to the unavailability of trained personnel. Challenges with removing contraceptives, such as deeply embedded implants or missing IUD strings, compounded these delays.

"There are a few people who are trained on insertion and removal… maybe a technical person is not there, they will always find it hard to remove it, so they keep referring," (KII 3, 40-year-old provider).

The inadequate equipment and supplies partly hindered discontinuation of IUDs/implants. IUDs/implant removal required the use of sterilised equipment which was often inadequate given the high patient load. Although inadequate equipment and supplies would affect both the insertion and removal of IUDs/implants, its effect was more pronounced among women seeking removal than insertion of the contraceptive methods. For example, while the supply of lignocaine, an anaesthetic drug, was limited, it was available for women seeking insertion of implants and not for those who wanted it removed.

"Currently, we don't have lignocaine in the hospital. Since June it's been out of stock. But for insertions, we don't tell them to buy the lignocaine. But these ones

for removal, at least if they are like two, they combine money they go and buy it." (KII 4, a 57-year-old provider).

Subtheme 3: Asking for missing insertion cards

Women were denied removal of IUDs/implants because of the missing insertion cards. This was mostly experienced among women seeking the removal of contraceptive implants. Providers refused to remove IUDs/implants for women who had misplaced, lost, or forgot to bring the insertion cards to the clinic. Healthcare workers insisted on the insertion cards citing the need to verify the date of insertion, to know whether the due date had been reached, the type of contraceptive implants inserted, and for accountability purposes.

"I came without a card. That card got lost.... They can't work on me without a card... The card got lost. I can't find it anywhere. So, I will try somewhere else" (IDI 6, a 32-year-old, denied on her first request).

"Some of them refuse because the patient may not avail the card or the documentation of when it was inserted or when it is expiring" (KII 2, 60-year-old provider).

Subtheme 4: Focus on counselling and management of side effects

Six out of 15 of the women reported having been counseled upon citing the need to discontinue the contraceptives. Counseling of side effects was mostly for women whose due date had not been reached or those who wanted to remove after a short period of use. Healthcare workers felt that side effects were not justifiable reasons for discontinuing IUDs/implants as they thought side effects were normal and would reduce with time. While counseling focussed more on the management of the side effects, it also had an element of counseling against the removal of the contraceptive methods. Most of the women who were counseled for the first time did not remove the contraceptive as they felt pressured and they were expected to continue using the method. Healthcare workers noted that they were trained to first counsel for side effects in cases when women wanted to discontinue the contraceptive methods before the due date.

"I wanted them to remove but instead they counselled me and gave me some treatment but there was no marked improvement" (IDI 15, 28-year-old, denied after 2 requests).

"The first thing we do, according to the training, is to counsel them about the side effects. So, we go by the standard, we first counsel, treat, and monitor them according to the severity of the side effect." (KII 6, 60-year-old provider).

Women were counseled multiple times with significant pressure to continue using contraceptives after every visit.

"When I went to the hospital, I was told that the time of removal had not yet reached. They counselled me... I decided to go back the second time. I wanted this time they remove.....They again counseled me."(IDI 15, a 28-year-old, denied after a second request).

All the women who did not remove the contraceptive after being counselled for multiple times eventually opted to go to a private health facility to discontinue the methods. While health workers prioritised counseling and managing contraceptive side effects, they stated that they were willing to remove the contraceptive method if clients insisted on removal despite being counseled.

"You first try to counsel her on advantages of having that method, but if she insists that she no longer wants it, you remove, she has a right" (KII 3, 40-year-old provider).

Theme 2: Women's responses after denial of IUDs/implant removal

Women were affected following the denial of their requests to discontinue IUDs/implants. They had emotional and physical health problems, and social and economic problems, while some developed mistrust towards the use of modern contraceptives.

Subtheme 1: Emotional and physical health problems

Women described a range of emotional responses to being denied removal of IUDs/implants. Denial of IUDs/implant removal left women feeling scammed, betrayed, frustrated, insecure, trapped, angry, scared, hopeless, anxious, fearful and disappointed. Some reported mental health struggles, including anxiety and depression. Feelings of betrayal and other emotional reactions were partly because women were informed that they were able to discontinue at any time for any reason during pre-insertion counseling.

"I felt so bad because I went there two times but they refused to remove the implant and yet the health workers told me during insertion that in case you encounter any problem, you come back; we remove but it was like they scammed me" (IDI 12, a 36-year-old, denied after three requests).

Women felt powerless to discontinue using IUDs/implants.

"Of course, I felt so bad and angry, because I wanted it to be removed. I think it's my personal decision.

Except that I can't do it on my own. It's supposed to be medical providers to remove it" (IDI 6, a 32-year-old, denied after the first request).

Besides emotional problems, women recounted having physical health problems upon being denied to discontinue using IUDs/implants. While some of the women were experiencing the side effects of the contraceptives, denial to discontinue the contraceptives heightened their physical health problems. They recounted having headaches, heart problems, gastric ulcers, and reproductive health problems upon being denied to discontinue the contraceptive methods. Delaying the removal of IUDs/implants left the women feeling vulnerable and insecure.

"I saw my health was at risk. Yet at first, when the health workers were inserting, they said that if it is treating you badly you come back and we remove and change to another method but they just deceived me." (IDI 12, a 36-year-old, denied after three requests).

"I started having heart palpitations and the heart used to pain me a lot. I had a lot of thoughts, sometimes I would fail to eat food and ulcers almost killed me" (IDI 11, a 40-year-old, denied after seven requests).

Subtheme 2: Social and economic problems

Women wanted to remove the contraceptive methods because of social problems in the family. Most of the women experienced side effects such as bleeding which had affected their marriage. Some women experienced gender-based violence, sexual harassment, and extramarital affairs related to contraceptive use. Women, who were denied services to discontinue the contraceptive methods despite their social problems, felt disappointed and fearful. Women were worried that the social problems would continue if the contraceptive methods were not discontinued.

"I felt so bad and anxious because I wanted them to remove it because my husband was not now having sex with me because of bleeding and he was now harsh to me. …that is why I had to go to remove from a private clinic to save my marriage." (IDI 13, a 32-year-old, denied after two requests).

Women had to make multiple visits to the health facilities which resulted in additional transport costs, opportunity costs, and the lost time to engage in income-generating activities. While women accessed services in the public health facilities free of charge during insertion of IUDs/implants, those who were denied had to incur costs of removal in the private health facilities.

"I have even wasted my time and transport instead of doing productive things…I have opted to go and be removed from the private clinic yet I have to pay money there (IDI 6, a 32-year-old, denied on first request).

Subtheme 3: Mistrust of provider-dependent contraceptives

Women who were denied removal of IUDs/implants developed mistrust of modern contraceptives, particularly provider-dependent contraceptives. Women thought that modern contraceptives were brought to destabilise marriages and reduce the population size. Women noted that their rights were being violated when healthcare providers did not listen and acknowledge their need to discontinue contraceptive methods. Consequently, some women expressed intentions not to use modern contraceptives because of the challenges with discontinuation of the provider-dependent contraceptives.

"No! No! No! Never in my life again will I use implants again with the hard time I have gone through" (IDI 9, 30-year-old, denied on two requests).

"Yes, I felt my rights were violated because health workers didn't listen and felt what I was really going through and they act as per my request. I just advise my fellow women not to go for artificial family planning at least let them use natural family planning to avoid such problems" (IDI 14, a 30-year-old, denied after two requests).

Although some recommended the use of modern contraceptives, they acknowledged the difficulty in accessing services to discontinue their use.

"I think they can use them [IUDs/implant]; it has no problem except that now when it's time for removing it, that's where the problem always comes from. It becomes hard to access removal." (IDI 6, 32-year-old, denied on first-time request).

While some women planned not to use modern contraceptives in the future, some opted to use contraceptive methods which they were able to discontinue by themselves.

"I felt so bad and mentally disturbed when they denied me… I felt relieved because at least it was out of my body. And for now, I can use an injection which myself can stop at any time." (IDI 8, a 38-year-old, denied after three requests).

Discussion

This study explored women's experiences of discontinuing provider-dependent contraceptive methods in Eastern Uganda. Our findings reveal tendencies of

contraceptive coercion, where women's requests for discontinuation were denied for various reasons and employing strategies that undermined their autonomy. Consequently, women had negative emotional, physical, social, and economic impact and they were reluctant to use modern contraceptive methods in the future.

A key finding was that healthcare providers often denied requests to remove IUDs or implants before their due date or after what was perceived as a "short" period of use. This aligns with previous studies, which show that early removal is frequently deemed a waste of resources and an unjustifiable decision, particularly for young women [2]. These denials are often grounded in the perception that early removal increases the risk of unintended pregnancies [12, 13]. Additionally, the emphasis on promoting long-term contraceptive methods, bolstered by donor funding, likely reinforces provider biases that prioritize sustained use over women's autonomy [5]. Such practices amount to reproductive and contraceptive coercion, with significant unintended consequences for modern contraceptive use in the future.

Healthcare providers often prioritized counseling and managing side effects over honoring women's requests for removal. This practice, documented in studies from Burkina Faso, Tanzania, Kenya, and Senegal, reflects a widespread belief that side effects are minimal and will diminish over time [2, 6, 8, 18]. While the healthcare providers thought the side effects were minor, women rated that they were major and it resulted in gender-based violence, sexual harassment, and extra-marital affairs. Therefore, focusing on counseling for side effects may have reflected a failure to listen to the woman's healthcare needs and disregard of their healthcare needs and autonomy. While some providers stated they would ultimately honor women's insistence on removal, women who lacked agency or faced provider resistance were pressured into continuing use against their wishes.

Some of the women were denied to discontinue of IUDs/implants because of the missing or misplaced insertion cards. These cards were required to track insertion and expiration dates, compensating for inefficient record-keeping systems in healthcare facilities. The requirement for insertion cards was seen to limit access to removal services, particularly for women who had lost their cards or could not obtain them. This highlights the need for improved clinic-based record-keeping systems to reduce reliance on physical cards and ensure women's access to removal services.

Consistent with previous studies [4, 19], denial of women's requests to discontinue IUDs or implants resulted in a range of negative emotional, physical, social, and economic outcomes. Many women felt trapped, deceived, and powerless, leading to mental and physical health issues. Consistent with previous findings, our study also noted double standards in the availability of services for insertion versus removal of contraceptive methods [4, 11]. For example, anesthetic drugs were often available for insertion but not for removal. Difficulty in discontinuing contraceptives despite pre-insertion assurances of freedom to do so exacerbated feelings of mistrust. Women also experienced social repercussions, including harassment, gender-based violence, and marital conflicts, as well as economic burdens from additional healthcare costs and the need to purchase anesthetic drugs or seek care in private facilities. In some settings, the cost of removing IUDs/implants was a major barrier which suggests forced continued use in women who may not afford services in private facilities [18, 20].

Denials of removal requests also contributed to negative attitudes toward modern contraceptive methods. Women who were denied discontinuation developed myths and misconceptions about modern contraceptives, fueling distrust and resistance to future use. This aligns with broader concerns about negative perceptions towards the use of modern contraceptives [21]. Our findings suggest that such experiences may further discourage the uptake of long-term methods, which are already less popular in Uganda compared to Depo-Provera, pills, and condoms [4, 22]. The low uptake of IUDs/implants could be related to the reliance on healthcare providers and women's fears of difficulty in discontinuing the methods. Addressing women's experience with discontinuation is critical for promoting the sustained and voluntary use of IUDs and implants.

Conclusion

Women in this study faced significant barriers to discontinuing provider-dependent contraceptive methods. These barriers included provider perceptions of early removal as resource waste, reliance on insertion cards, perceived risks of early removal, and a preference for managing side effects over honoring women's requests. Such denials led to emotional and physical health challenges, social conflicts, and economic burdens. The findings have important policy implications, emphasizing the need to uphold women's human rights to autonomy, informed choice, and decision-making in contraceptive use. Insertion cards should not be a mandatory requirement during discontinuation of contraceptives, while strengthening record-keeping systems, ensuring the availability of removal services, and fostering respect for women's choices are essential to improving the experiences of women using provider-dependent contraceptive methods.

Authors' contributions
A.N., M.P., R.C.N., and J.E. participated in conceptualizing, designing, and analyzing the data. S.R.A. and M.T. analyzed the data. J.E. supervised the implementation of the study and wrote the first draft of the manuscript. A.N., M.P., R.C.N., S.R.A. and M.T. reviewed the first draft of the manuscript.

Funding
We received no funding for the study.

Data availability
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
We obtained ethical clearance from the Research and Ethics Committee of Busitema University Faculty of Health Sciences (reference number: BUFHS-2024–193). Administrative clearance was also granted by the Mbale Regional Referral Hospital. Study participants provided a written informed consent before enrolment in the study. Participants were assured of confidentiality, and all information was anonymized and securely stored.

Consent for publication
The authors consent to the publication.

Competing interests
The authors declare no competing interests.

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Received: 1 February 2025 Accepted: 4 March 2025
Published online: 18 March 2025

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