FACTORS ASSOCIATED WITH UTILIZATION OF IMMEDIATE POSTPARTUM FAMILY PLANNING SERVICES AMONG POST DELIVERY MOTHERS

A CASE OF CHAGUO LA MAISHA PROGRAM IN ILALA DAR ES SALAAM

By

Rose Marco Ntambuto

A Dissertation submitted to the School of Public Administration and Management in partial Fulfillment of the Requirement for the award of the Master of Science in Health Monitoring and Evaluation of Mzumbe University2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled ***"Evaluation of Factors associated with Utilization of Immediate Postpartum Family Planning (IPPFP) Services among Post Delivery Mothers: A Case of Maisha Program-Ilala Dar Es Salaam"*** in partial fulfillment of the requirements for award of the degree of Master of Science in Health Monitoring and Evaluation (MSc HM&E) of Mzumbe University.

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Major Supervisor

_____

Internal Examiner

_____

External Examiner

Accepted for the Board of the School of Public Administration and Management

_____

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DECLARATION

I, Rose Marco Ntambuto, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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DEDICATION

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LIST OF ACRONYMS

ANC	Antenatal Clinic
CHMT	Counsel Health Management Team
CHW	Community Health Worker
CLM	Chaguo la Maisha
CPR	Contraceptive Prevalence Rate
DMO	District Medical officer
FP	Family Planning
HCP	Health Care Provider
HF	Health Facility
IPPFP	Immediate Postpartum Family Planning
MMR	Maternal Mortality Rate
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSWF	Ministry of Health Social Welfare
MU	Mzumbe University
PAFT	Post Abortion Family Planning
PPFP	Postpartum Family Planning
PPIUCD	Post-partum Intra Uterine Device.
RHFP	Reproductive Health Family Planning
RMO	Regional Medical Officer

SCT	Social Cognitive Theory
TRA	Theory of Reasoned Action
TPB	Theory of Planned Behavior
WHO	World Health Organization
WRA	Women in Reproductive Age

DEFINITION OF KEY TERMS AND THEIR

CONCEPTS

Family Planning

Is defined as the intended, responsible decision made by an individual or couples as to the desired family size and timing of births; or is the sensible action taken by an individual or couples to control the number and spacing of their children in agreement with their individual choices,[CITATION Jam13 \l 1033].

Unmet need for Family Planning

This is defined as an event that occurs to the woman who are not using family planning "FP" methods and are in reproductive age (15-49 years), sexually active but desires not to give birth to children or postpone or delay to give birth, This situation points to the gap between intention of the women who are not ready to become pregnant while they have behavior of not using any contraceptive methods [CITATION WHO19 \l 1033].

Immediate Postpartum Family Planning (IPPFP)

This means the use of suitable contraceptive method 48 hours after birth or before discharge from health facility, [CITATION Mar17 \l 1033]. This assures protection of pregnancy before the return to fertility and restart of the sexual activity [CITATION Placeholder2 \l 1033]. At this time the unmet need women will have time to be informed by health care provider on the role of using contraceptive methods before discharge and they will be motivated to use them since at this time most of women are highly not in need to become pregnant within short period of time [CITATION Rep17 \l 1033].

Postpartum Family Planning (PPFP)

These words describe the provision of family planning method to the woman post-delivery for the purpose of preventing unplanned pregnancy that occurs within twelve months following the delivery of the last child [CITATION WHO \l 1033] ,([CITATION Ant10 \l 1033]. Also, PPFP is defined as the process of offering or initiation of modern contraceptive services as part of care provided during child birth to twelve

months after delivery or six months following miscarriage of pregnancy [CITATION ope18 \l 1033].

Contraceptive Prevalence Rate (CPR)

Is defined as the percentage of women in bearing age who are currently using at least one method of contraception irrespective of which type of contraceptive method and with her sexual partner in married or in-union women aged 15-49 years, (WHO, 2018). MEASURE Evaluations defines CPR as the ratio of women aged 15-49 years with their spouse or in sexual union who are using any kind of contraceptive method which may be modern or traditional. It is calculated by finding the ratio between women aged 15-49 using contraceptive method divide by number of women aged 15-49 in a population time 100. The purpose of this ratio is to know the coverage of contraceptive use [CITATION Fam18 \t \l 1033].

Postpartum Period

post-delivery (first six weeks after birth). This period is dangerous to the health and survival of a mother and her newborn, as it needs special attention. If any mismanagement occurs or there is any absence of care in this period, may cause death or disability to both woman and her newborn. Missing chance of health counseling on

family planning and proper care of her new borne may end up in catastrophic[CITATION WHO \l 1033].

Return to fertility.

Is a situation where by a woman can become pregnant or get back again to her fertile state following delivery or miscarriage (pregnant is terminated either intentionally or not intentionally before the age of when the fetus can survive). This condition fluctuates conditional on when the woman can conceive after live birth which depends on breastfeeding status of the woman if she is exclusively on breast feeding it may take six months to become pregnant and it may take short time as early as one month after birth [CITATION Ant10 \l 1033].

ABSTRACT

Introduction: Family Planning (FP) program is a key strategy for reducing maternal, infant and child morbidity. Effective Provision of PPFP prevents unplanned pregnancy during 12 months after delivery. **Objective**: The aim of this evaluation was to evaluate factors associated with utilization of IPPFP in Ilala Municipality.

Methods: Descriptive Cross-sectional study design deployed both quantitative and qualitative methods for data collection and analysis. Selection of six Health Facilities used probability sampling strategies, with cluster sampling, non-probability sampling technique was used to select 395 who were selected conveniently and were given coded structured, translated to Kiswahili and pre-tested questionnaire to collect data. Quantitative observation checklist was used to quantify resources availability. Data were entered into the Microsoft excel sheet and imported into the STATA version 13 for data cleaning before analysis. Chi square test analysis was used to create the relationship between IPPFP services and the utilization of it. For Qualitative data, Purposive sampling methods were used to select health workers who had key information, and used in depth interview guide. Content analysis was used to analyze the data, transcription of the interview, formation of meaning units, condensation of the unit followed by codes formation then themes were created to produce report.

Findings: The study findings show 79(20) % of clients were discharged with IPPFP. Aassociation was found between IPPFP use and counseling session (p-value 0.023), session clearly understood (p-value 0.030). Another finding which has no association was stock out of medical supplies and equipment for IPPFP, (p-value 0.360) and adequate room (p-value 0.332).

Conclusion: There is low utilization of IPPFP use in Ilala Municipality. Reason for not using the service were; pain following delivery, not discussed with their husband, fear from side effect of methods and husband not approved to use IPPFP. **Recommendation:** Therefore, individual counseling, community and male involvement should be promoted to increase IPPFP utilization.

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CHAPTER ONE

INTRODUCTION

This chapter provides general information of immediate Postpartum Family Planning (IPPFP) utilization, background information of the study, description of the program to be evaluated, statement of the problem, with evaluation question, objectives and significance of the study.

1.1 Background Information

Family Planning Program is one of the key areas in which the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) has been putting its efforts. Such efforts are meant to prevent Maternal and prenatal deaths in all health facilities which provide RCH services [CITATION Placeholder4 \ l 1033] .

FP is a key strategy for reducing maternal, infant and child morbidity and mortality through the prevention of unintentional pregnancies and the promotion of health to the mother and child [CITATION Mli14 \l 1033].

Globally, Maternal mortality is public health problem which needs special attention, it becomes an alarming issue since in every woman who dies with pregnancy related problem represents 20 or 30 pregnant mothers who end up with acute or chronic morbidity which in some cases ends up with permanent disability and affects them physically, mentally and psychologically [CITATION WHO14 \l 1033].

Maternal deaths, maternal morbidity and maternal disability among women is second contributing to the burden of disease and third in terms of disabilities adjusted life in women aged 15-45 with 2.7% of death among the women worldwide [CITATION Mar12 \l 1033].

Burden of maternal mortality and morbidity is higher in developing countries where the economic status is poor [CITATION WHO13 \l 1033]. In Sub-Saharan Africa maternal mortality are 196 per 1000 live births [CITATION Sta18 \l 1033]. 6.6 million of children who are under five years die (44% as newborns) with 289,000

maternal deaths [CITATION WHO14 \l 1033]. The major causes of Severe maternal morbidity and mortality in developed countries is hemorrhage and hypertensive disorders [CITATION Sta18 \l 1033], while in developing countries the highest cause is hemorrhage, infection, hypertensive disorders, unsafe abortion, and obstructed labour. Most of these complications are preventable through training to health care provider's" HCP's" and provision of effective emergency obstetric care [CITATION WHO191 \l 1033].

Offering family planning services to post-delivery women within the first 12 months (PPFP) is of greater importance as it prevents unwanted pregnancy and useful in child spacing. Pregnancy that occurs within one year sometimes called "a birth-to-pregnancy interval of less than 12 months" causes uppermost risk to the mother and child which predisposes them to maternal and fetal complication. Those adverse health outcomes can be unsafe induced abortion, intrauterine fetal death, premature delivery, low birth weight baby and small for date baby. Closely spaced pregnancy is also associated with stunting growth, undernourishment and finally infant mortality [CITATION Mar14 \l 1033].

Following this situation attention have been made to reduce maternal mortality and morbidity where the millennium goal 4(reduce child mortality) and 5(Improve maternal health) aimed to reduce maternal death by 75% from 1990 to 2025. The primary focus in reducing maternal death is through improving family planning and obstetric care [CITATION Joe18 \l 1033]. PPFP use reduces perinatal and maternal death. Effective use of PPFP was expected to prevent maternal and child mortality for 30% in women and 10% of child mortality[CITATION Ant10 \l 1033]. In 1990 the child and maternal death decreased for approximately at rate of 50% following the increase of contraceptive prevalence rate from 55% to 63% [CITATION WHO14 \l 1033].

Tanzania targets to improve reproductive maternal, new born and child health through different international and national programs. The report from Tanzania's Demographic Health Survey (TDHS) of 2015/2016 shows an increase in maternal mortality rate (MMR) from 432 to 556[CITATION Nur19 \l 1033]**.** At National level Pathfinder International through Chaguo la Maisha (CLM) project came up with the strategy of increasing the utilization of PPFP, which was meant to reduce maternal and neonatal death by increasing the use of IPPFP.

The strategy for decreasing maternal death which was used to increase knowledge and awareness on the importance of family planning use were to strengthen, education of the women, increased contraceptive utilization, increase of prenatal care, increasing HF's deliveries with use of skilled HCP's , availability of medicine, medical equipment proper treatment for complications with the advancing the specialized care for high risk pregnancies and deliveries and neonatal units which contributed a lot in reducing maternal and neonatal death [CITATION Don19 \l 1033].

In Tanzania Prevalence contraceptive rate (PCR) is still low, (32%) in comparison to the estimated target of 45% [CITATION Placeholder4 \l 1033]. Unmet needs for FP were 25%, [CITATION Placeholder3 \l 1033], however Sixty-four percent (64%) of all deliveries are assisted by skilled providers in health facilities. Though, the number of women who are being discharged with Immediate PPFP in Tanzania is low of 4%, ([CITATION Rep17 \l 1033].

Despite the government efforts to prevent Maternal and prenatal deaths through family planning program, there is still low utilization of family planning methods. Going to Ilala municipality, there is low coverage of contraceptive use since the CPR of Ilala is still low compering to the clients who are being served in RCH clinic and in Labor ward. In 2015 Ilala Municipality had FP coverage of 12.2% in 2016, 14.9% and 11.7% in 2017. Looking to the data above in comparison with health facility delivery where almost all pregnant women delivered in health facilities with skilled health care providers and percentage of deliveries in three years were 97.2% in 2015, 98.6% in 2016 and 98.5% in 2017 [CITATION DHI181 \l 1033].

Based on the findings found above , there is a need for more studies to sightsee the causes of these discrepancies on low utilization of IPPFP while the pregnant women have several visit to HF and come into contacts with HCP's during pregnant at least four visits to those pregnant women who have no complications [CITATION Placeholder4 \l 1033]. Following routine visit of pregnant woman, it is a good time where HCP's interacts with pregnant women and provides health talk to them to create awareness and prepare those clients to have informed choice on IPPFP use. When the pregnant is at full term, Pregnant women come into contact with health care providers at time of admission, in antenatal ward, during delivery, in post-natal ward and finally during the time of discharge where ample health talk and counseling is being provided. Likewise, in Ilala Municipality most women come to health facility for different reason, when they are pregnant and when they are breast feeding their babies who visit HF for immunization and growth weight monitoring in monthly bases for five years. The importance of several HF visit increases the knowledge on using IPPFP as every day in the RCH clinic starts with Health education before the start of the service and IPPFP is among of the topic discussed. Likewise, the HCP's knows the importance of IPPFP use, on how it preys greater role in reducing maternal death, infant and under-five morbidity and mortality [CITATION Mac17 \l 1033].

WHO recommends PPFP use as a component of health care which, when implemented effectively will meet women's desire since offering of IPPFP at this time is safe to the post-delivery mothers who have not resumed sex and are highly motivated not to become pregnant in near future [CITATION Bla161 \l 1033]Also, it helps to reduce unmet need women who sometimes fails to come back for PPFP. 70% of them are not using contraceptive methods[CITATION WHO18 \l 1033]

PPFP is offered in three different points of time; the first level is called immediate Postpartum Family Planning (IPPFP) where contraceptive methods are used soon after birth to forty-eight hours after delivery (0-48 hours post-delivery). Early postpartum is the second level which starts from fourth-eight hours to sixth weeks after birth; and the third level is from sixth week to one year which is called extended postpartum.[CITATION Ann152 \l 1033] .

If couples space their pregnancies for 2 years can prevent maternal deaths for more than 32% and 10% of child mortality. In order to avoid maternal, perinatal, (Gebremedhin, 2018) and infant complications, the suggested interval between pregnancies is 24 months [CITATION Rep17 \l 1033]. Like wise in children, child mortality rate depends on the interval of time that the woman stays before conception. Child mortality rate decreases to 13% if couples wait 2 years to conceive and more decrease is noted to 25% if the couples stays for 3 years without conceiving [CITATION WHO \l 1033]. Therefore, this study intends to know the factors associated with utilization of IPPFP in Ilala Municipality.

1.2. Program Description

Tanzania targets to improve reproductive maternal, new born and child health through different international and national programs. The report from Tanzania's Demographic Health Survey (TDHS) of 2015/2016 shows an increase in maternal mortality rate (MMR) from 432 to 556 [CITATION Nur19 \l 1033]**.** At National level Pathfinder International through Chaguo la Maisha (CLM) project came up with the strategy of increasing the utilization of PPFP, which was meant to reduce maternal and neonatal death by increasing the use of IPPFP.

Pathfinder International is an organization which over the decades has been working on implementing high-impact, quality sexual and reproductive health (SRH) service delivery projects to strengthen Contraception and post abortion care Service delivery in Urban Tanzania project. In Tanzania, Pathfinder International through Chaguo la Maisha (CLM) commenced its operation in Temeke Municipality (2016) and later in the second year of its implementation was expanded to be in Ilala Municipality (2017)**.**

Primary focus in this project was on clinical part whereby the project intended to improve service delivery by empowering HCPs and Space creation in the targeted Health facilities (HF) with inadequate space for Post abortion care. Also, the other area of focus under service delivery is accessibility of the services and that the excising system procurement of medical supplies and equipment is done to HFs

according to their requirements. The second focus is on Demand creation where by community is sensitized to increase the services seeking behavior and individual engagement in practice for demanding quality services through CHWs. Third focus is system strengthening by making networking among different stakeholders (CHWs, District and community Health Board, Citizen Report Card- CRC) to create the sustainability of the project process for community feedback with interaction with the health system.

CLM projects focus on addressing provision of modern contraceptive methods use to unmet need for contraception, limited uptake of long – acting methods and high maternal mortality due to unsafe abortion which demonstrate gaps in service delivery in sexual and reproductive health services. In order to improve this situation CLM advocating for increased and strengthened utilization of PPFP by increasing demand creation to the community. This is done by equipping knowledge and information to the clients using community health worker (CHW), system strengthening where realistic and quality data will be obtained for planning and policy making. Finally, this is also done by ensuring sustainability of the program, equipping with proper knowledge and skills to HCPs, and ensure availability of resources, and space creation**.** Effective implementation of this strategy will automatically guarantee the utilization of modern contraception prevalence rate from 27% to 45% in 2020 as it is targeted in National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020) one plan II [CITATION Placeholder4 \l 1033].This strategy has been under implementation for the past two years. The researcher conceived a need to undertake process evaluation to determine whether the program is being implemented as it was planned to do and identify any problems in program implementation for timely correction.

1.2.1. Program Objectives

CLM program has the following three major strategic objectives:

1. Young women (15-24) as they are facing discrimination risk of getting unplanned pregnancy with limited post abortion care accessibility

2. Provision of postpartum Family Planning services to postpartum and lactating women who are critical entry point for services delivery at approximately 90% of deliveries in Dar es Salaam region that occur in HFs as compared with National average of 45%, (CLM, 2015).
3. Post abortion women is another priority area as post abortion group has unmet need for contraception

But for this particular evaluation, the researcher selected the second strategy, which focuses on Provision of postpartum family planning among post-delivery and lactating mothers in the postpartum period (one year post-delivery). In Ilala Municipality most of the women deliver in HFs. For example, for delivery surveys which were conducted in HFs, in 2016, the expected deliveries were 42,851 with actual health facility deliveries of 42,242 (98.6%). In 2017, the expected deliveries were 47,324 while the actual health facility deliveries of 46,611(98.5%),[CITATION DHI181 \l 1033]. This project increases support to dispensaries in order to enhance the PPFP coverage. At the dispensary level is an area where most of the clients visit health facilities and attend all uncomplicated clients. Counselling is done to increase awareness on the use of modern contraceptive specifically IPPFP.

Under the Strategy two above, improvement in Contraceptive Prevalence Rate (CPR) will be achieved through this program by increasing the usage of IPPFP. This will be reached by implementation of the following interventions in Women in Reproductive Age (WRA):

- Equipping knowledge and information to the post-delivery mothers on the effective IPPFP utilization.
- To enable community, use high quality services on contraceptive services by creating awareness and increasing demand of PPFP use through CHW
- To increase CPR by using CHW in addressing the community needs and right on the use of eligible method of contraceptive method

- Training of HCP to increase competence and develop on job training guidelines to capacitate HCP.
- Also, to strengthen supportive supervision mentorship and coaching.
- To conduct collaborative planning with stakeholders to reduce noted challenges during the implementation of the program and address them.
- Procurement of Medical supplies and medical equipment by using existing system aiming at reducing stock out according to facility requirement

Through the above intervention, this evaluation was based on the use of PPFP among post-delivery mothers in post-partum period by ensuring availability of skilled HCP's, availability of PPFP medicine and equipment's and effective counselling.

Ilala Municipality has governmental and parastatal health facilities of different levels (Hospitals, Health Centers and Dispensaries) which conduct delivery services. Among those facilities, 27 of them are supported by Pathfinder International program through CLM.

By 31st December 2016, Ilala Municipality had enrolled 1,526 clients of IPPFP in its health facilities, which accounted for 4% of all clients who had health facility delivery and assisted by skilled midwives, were discharged with IPPFP. Following this discrepancy Pathfinder international project come up with this project which aimed at correcting this gap. In 2017 the number of clients who had IPPFP was 4,514(10%) [CITATION DHI181 \l 1033]. Clients had health facility deliveries, which have shown a gradual, increase of IPPFP following its commencement. The achievement of these initiatives was reached due to good strategies initiated by the project which was emphasizing on the team work among government's officials, clinical staff, and community which started from community level to the Municipal level and finally to Ministry level.

1.2.2 Program Stakeholders

Stakeholder is defined as a person with direct or indirect interest (stake) in a program or its evaluation. Stakeholder can be people who conduct, participate in, fund or manage a program or who may otherwise affect or be affected by decisions about the program or the evaluation [CITATION Car981 \l 1033]. WHO from WWF, in Cross-Cutting Tool, defines "Stakeholders" as an inclusion of all agencies, organizations, groups or individuals who have a direct or indirect interest in a health, health services and the activities of the health cluster, and whose attitudes and actions could have an influence on health and the outcomes of humanitarian health activities [CITATION WHO05 \l 1033]. Additionally, Bryson defined the word "stakeholder" to be any person, group or organization that can place a claim on the organization attention, resources, or output, or is affected by that output [CITATION Joh04 \l 1033]. Pathfinder International in the project conducted in Ilala has the stakeholders as presented in Table 1.1who are involved in implementation of CLM program.

Table 1.1: Program Stakeholders

Stakeholders	Role in the program	Interest on evaluation	Role in the evaluation	Means of communication
Council Health Management Team (CHMT)	Supportive supervision, mentoring and couching. Improving data by doing data analysis, data quality and data auditing. Monitoring the implementation of the plan. Making informed decision by using findings. Assessment	Improve counseling on provision of IPPFP during ANC visits and when pregnant women visit health facility for delivery which will increase the community awareness on the use of IPPFP	Secondary users of evaluation findings Conducting supportive supervision to health facilities Develop and maintain strong partnership	• Meeting • Face to face • Letters • Telephone/ mobile phone • Electronic mail

	of the effectiveness of the program. Organize workshops Distributing IEC materials Establish working relationship with stakeholders			
Implementing partners (Pathfinder International)	Provision of Technical support, fund the intervention, Training and materials Making guidelines in collaboration with the MOHSWF	Improve quality of service delivery Increasing utilization of IPPFP Improve quality of life of all clients who meet eligibility criteria of using	Capacity building of Health care providers and community on the importance of the use of IPPFP Advocacy and communication, on provision of IPPFP in the facility Importance of data collection, and use of	• Letters • Telephone/ mobile phone • Electronic mail • Fax

		IPPFP	information for decision making	
Region Health Management Team (RHMT)	Supportive supervision, Monitoring the implementation of the plan Making informed decision by using findings Assessment of the effectiveness of the program	Improve quality of service delivery	Recommendations from the evaluation to improve the performance	• Meeting • Face to face • Letters • Telephone/ mobile phone • Electronic mail
Health Care Providers	Provision of IPPFP services. Providing Health Education and Counselling on importance of PPFP use	Increase counseling to pregnant women during ANC visit and during delivery to all clients who are	Routine monitoring of data, primary source of information and user of the information found	• Meeting • Letters • Telephone/ mobile phone • Electronic mail

	Data collection, collation validation and data use Provision of counseling on importance of IPPFP at ANC during labor and after delivery before and before discharge	enrolled in ANC and admitted to health facility for delivery which will finally increase the client using IPPFP		
Clients	IPPFP services recipients	Improved quality of life to all post-delivery mothers and reduced number of unplanned pregnancies.	Respondents during evaluation Benefit of the implemented program	Face to Face
Ministry of Health,	Establish working	Improve quality of	Recommendations from the	• Letters • Telephone/

Community Development, Gender, Elderly and Children (MOHCDGEC)	relationship with stakeholders Responsible for overarching polices and planning, identification of national trainers for TOTs and adaptation of the technique to other urban setting in Tanzania Proportional of Health Care Provider trained	service delivery Increasing utilization of IPPFP Improve quality of life of all clients who meet eligibility criteria of using IPPFP	evaluation to improve the performance	mobile phone • Electronic mail • Fax
Communities and Family members	Recipients of the services	Improve quality of life to post-delivery mothers and post abortion mothers,	Benefit of the evaluation	• Letter through community leaders • Physical visit by CHW's

		provide social support with proper decision to all client who are in reproductive age		

Source: Researcher, 2019

Through this evaluation, the following are the expected results;

- There will be an increase in knowledge and skills concerning counseling skills, and provision of IPPFP to post-delivery mothers
- Availability of all ratified contraceptive methods with no stock out
- Increased IPPFP use due to increased awareness on the importance of IPPFP
- HCW will be able to provide quality health care services since they will be knowledgeable on the IPPFP and consistently using the job aid counseling algorithm
- Clients will receive sufficient and comprehensible counseling on IPPFP use
- Referral system from different levels of health facilities and community will be improved
- improve Government supervision system to ensure quality services delivery

1.2.4 Major Strategies of CML

These include tooutline the strategic priority needs and to increase the family planning usage by increasing the prevalence rate of modern contraceptive from 27%-45% in 2020 [CITATION Placeholder5 \l 1033].

1.2.5 Program Activities and Resources.

1.2.5.1 Activities

In order to accomplish the above result, the program has been implementing the following activities:

- To conduct competence-based training (refresher training) to those HCWs and develop on job training guidelines to capacitate health care providers on how to increase the use of IPPFP
- To conduct participatory assessment to 27 targeted health facilities in Ilala Municipality
- Conduct supportive supervision, mentorship and coaching to those sites on provision of high-quality care, data management and use
- To conduct proper counseling on the use of IPPFP
- To provide services based on National guideline
- To conduct collaborative planning with stakeholders to reduce noted challenges during the implementation of the program and address them

1.2.5.2 Resources

In the implementation of this program the following activities were required to get the expected results: The resources required include Funds, Human resource for health, improved Infrastructure, Furniture, Stationeries, Medicine and Medical supplies, Transport, Information system and suitable guideline on provision of health services.

1.2.6. Stages of Program Development

Different stages or approaches for programs implementation has been used in implementation of program depending on the nature of the program which is being implemented. In CLM program Phased implementation method were used. This approach was used to change the existing system that is old system to a new system. This goes through different stages of program implementation, where time factor was considered in preliminary stage and that every stage of program implementation has its time limit. Project management consulting, project management training & PMO development experts in their study elaborated four stages of implementation as Initiation Phase, Project-Level Installation Phase, Enterprise-Level Installation Phase, Maintenance Phase [CITATION CDC12 \l 1033]. Rotheberg also explained theadvantage of a phased approach implementation on timeline restriction which guides the program to be completed on time. During those phases, different information is collected. Qualifying requirements are supplied and everyone involved plan and schedule the needs depending on the project phase requirements [CITATION Chu171 \l 1033].

The Pathfinder International project in Tanzania has adopted a phased implementation approach and that the project has three phases. Phase one is known as the early implementation and learning phase; phase two is the expansion phase while the third phase is the sustainability phase. Participatory facility assessment was done to qualify the needs of the program and status of the service provision was well known. This enabled the CLM to come up with this Phased implementation approach. Now, the programmer is in the second phase where the program has expanded from Temeke Municipality to Ilala Municipality. All targeted 27 health facilities have been covered, which implies that the program was sufficient to undergo the process evaluation to see whether the program is doing what it is supposed to do or determine whether the project is implemented as it was planned.

1.2.7. Program Logic Model for CLM.

Figure 1.1: Program Logic Model for CLM.

Source: Researcher, 2019

1.3 Statement of the problem

Postpartum family planning PPFP aims at preventing unwanted and closely spaced pregnancies by offering contraceptive methods to post-delivery mothers 12 months after delivery. Post-delivery women who are in postpartum period do not want to become pregnant within two years but 70% of them are not using contraceptive methods[CITATION WHO18 \l 1033]. IPPFP being the provision of contraceptive methods soon after birth to forty-eight hours after delivery (0-48 hours post-delivery) [CITATION Ann152 \l 1033]. It intends to provide contraceptive methods to the unmet need for FP who are being delivering their babies in HF but not using contraceptive methods. Closely spaced pregnancies which occur within one year have high risk to both mother and child by predisposing them to fetal and maternal complications. Those adverse health outcomes can be unsafe induced abortion, intrauterine fetal death, premature delivery, low birth weight baby and small for date baby. Closely spaced pregnancy is also associated with stunting growth, undernourishment and finally infant mortality [CITATION Mar14 \l 1033].

Effective use of PPFP was expected to prevent maternal and child mortality for 30% in women and 10% of child mortality [CITATION Ant10 \l 1033]. Effective use of PPFP was expected to prevent maternal and child mortality for 30% in women and 10% of child mortality [CITATION WHO131 \l 1033].

Different efforts have been done by the government to alleviate this situation by increasing HF deliveries from 47% in 2005 to 63%. HF deliveries to be conducted by skilled HCP's have also increased from 46% in 2005 to 64% in 2015[CITATION UNi18 \l 1033]. CPR has been increased from 55% to 63% and its implication was due to increased use of PPFP which finally reduced perinatal and maternal death at rate of 50%[CITATION WHO14 \l 1033].

In Ilala Municipality, the DHIS -2 shows that most of the pregnant women visit ANC services and finally deliver in health facilities. Data show that, in 2015 the expected deliveries were 36,018 and deliveries conducted in health facilities were 35,024 (97.2%). In 2016, the expected deliveries were 42,851 and the actual health facility deliveries of 42,242 (98.6%), while in 2017 the expected deliveries were 47,324 with

actual health facility deliveries of 46,611(98.5%) [CITATION DHI181 \l 1033]. While the ANC (Antenatal clinic) attendance in 2015 was 130.9% and only 12.2% was the prevalence rate of FP coverage. In 20I6 prevalence of FP was 14.9%, with 99.1% who attended ANC, while in 2017 the FP prevalence was 11.7% with ANC attendance of 117%. In comparing the ANC attendance, Health facility deliveries, and clients who were discharged with IPPFP there is an obvious gap on provision of immediate PPFF. In 2016 health facility deliveries were 42,242, among them 1,526 (4%) clients were discharged with IPPFP while in 2017 among 46,611 health facility deliveries conducted only 4,514 (10%) were discharged with IPPFP [CITATION DHI181 \l 1033].

High number of women delivering in health facility creates an opportunity to HCP and Post-delivery mothers to have knowledge and information on the use of IPPFP. Despite the time where both HCP and Clients stay all together, there is low utilization of IPPFP. To overcome the above situation, it needs special attention to which further investigation is needed to determine the causes of low utilization of IPPFP, as its focus is to offer IPPFP services to all unmet need women who fails to come back if they are discharged without contraceptive methods being in place. This study intended to evaluate the factors associated with low utilization of IPPFP in Ilala Municipality.

1.4. Evaluation questions, objectives and significance of the evaluation.

This section presents the overall goal, specific objectives, research question and significance of my study. Since my scientific research design is cross section, it has been used in determining the causes of low utilization of IPPFP. The study examined the health-related factors in terms of how counselling process is associated with IPPFP utilization, how knowledge and information is associated with IPPFP utilization and how availability of resources, is associated with IPPFP utilization. The description of events was made in form of hypothesis and tested concerning the relationship among variables which is derived from theories or set of idea that make estimation [CITATION Jam18 \l 1033].

The study intended to determine the causes of low utilization of IPPFP. Furthermore, this study had the research question which guided the methods and the tool used in data collection and finally in understanding the problem under investigation [CITATION All18 \l 1033]. The section also describes the research objective in order to know what has been achieved by the study. A clear objective, brief and statement which provide direction to investigate variables, focused on the ways they assessed the variables and identified their relationship or differences between those variables [CITATION JAY13 \l 1033]. **1.4.1 Main Evaluation Question**

What are the factors associated with utilization of IPPFP among post-delivery mothers in Ilala Municipality?

1.4.1 Evaluation question

This study was guided by the following evaluation research questions

i. To what extent is the counselling process associated with the IPPFP utilization among post-delivery mothers in Ilala Municipality?

ii. To what extent are the knowledge and information on IPPFP related to utilization of IPPFP among post-delivery mothers in Ilala Municipality?

iii. To what extent are IPPFP resources availability associated with IPPFP utilization in Ilala Municipality?

1.4.2 Overall Objective

To evaluate the factors associated with utilization of IPPFP among post-delivery mothers in Ilala municipality.

1.4.3 Specific Objectives

i. To evaluate the extent to which counselling process is associated with the IPPFP utilization among post-delivery mother's

ii. To evaluate the extent to which knowledge and information on IPPFP is related to utilization of IPPFP among post-delivery mothers in Ilala Municipality.

iii. To determine how IPPFP/PAFP availability of resources is associated with FP utilization among post-delivery mothers in Ilala Municipality.

1.5 Significance of the Study

The findings from this evaluation are expected to help the community (clients), HCP, CHWs on responsibility of each stakeholder to work on the detected deviation in program plan. The CLM management will know which are or, are not being delivered as planned and work on gaps to improve the quality of service on PPFP services as whole. Following this evaluation, the organization will be able to identify the difficulties that face HCPs during their daily performance on PPFP services. Lastly but not least, the organizations may identify some possible improvement and work on them for improvement of performance in Ilala Municipality and Tanzania as a whole. In addition, the policy implication for these findings may assist the policy maker to make decisions on modification or initiation of the programs, which will increase the acceptability of IPPFP. Furthermore, this study supplements the existing literature and can be used as reference point for similar studies elsewhere. Finally, this evaluation will help the evaluator to accomplish a Master of Science in Health Monitoring and Evaluation, since it is mandatory to fulfill this requirement.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter, literature review helps to conceptualize the literature around the study context, identifying the gaps that contribute to low utilization of PPFP among post-delivery mothers who deliver in Health Facilities. The review of literature aimed as analyzing critically the existing research on the topic, which are organized by other researchers' ideas or argument which aim to contribute solution to the problem in the study [CITATION Leo15 \l 1033]. This section is organized in the sense that different theories and policy studied under IPPFP have been reviewed. Empirical literature was reviewed to determine what has been done before and what is needed to be done and look for knowledge gap. This chapter also presents the conceptual framework of the study.

2.2 Theoretical Literature Review

The chapter identifies and describes different theories behind FP utilization with potential ways for overcoming the problem. Since theoretical literature review describes on how the author reviews what has been written about the policy, guidelines and then aggregate those view into a review. In Tanzania different factors causes low utilization has been identified which resembles with causes found in the countries surrounding Tanzania. Most of those factors resemble all-over Sub-Saharan Countries and in the word in general.

This study is informed by the theory-based intervention for contraception use. It is specifically guided by Social Cognitive Theory (SCT) which is also called Social Learning Theory and the Theory of planned behavior (PTB). SCT was propounded by Albert Bandura in 1925 and stated that, people are moving agent, they learn from one another through observation, imitation, and modeling [CITATION Ban17 \l 1033]. He explained the theory as a bridge between behavior and cognitive learning theory as it involves attention, memory and motivation. Cynthia Vinney stated the theory as

a learning theory that provides basis for understanding how people are shaped by their environment by detailing the process of observational learning and modeling to influence the self-efficacy on making behavior [CITATION Cyn192 \l 1033]. Bandura explained the theory as human behavior in relationship of continuous mutual communication between cognitive, behavioral, and environmental effects. Four sequences of processes occur in observational learning which starts with Attention, whereby people must select the information to communicate about the model.

Secondly, retention of the information communicated storing them and recalls them and acts on them later. Third process is reproduction, where by the observed memories are reconstructed and learned behavior replicate the modeled behavior at some time. Fourth process is Motivation which focuses in determining the extent to which the observed behavior is performed and produce the desired outcome, leading to desire to perform modeled behavior. Nevertheless, observational learning is done by people to observe and reproduce models they meet in their environment, which influence them to acquire information quickly [CITATION Ban17 \l 1033].

Therefore, in this study CLM program by using theoretical implication for SCT intends to build the health relationship among HCP and post-delivery/ post abortion mothers basing on using skills creation developed through different training to increase self-efficacy toward the behavior, self-confidence and develop behavior among HCP to provide the desired service. On the other hand, by using the SCT clients who come for services will benefit during counseling sessions and improve communication which will allow them to acquire knowledge in relation to observation on what others within the environment, social interaction, experience and outside CHW's influences. Communication during counselling process on IPPFP utilization among post-delivery and post abortion mothers aims to increase the awareness to influence clients to acquire information quickly and meet the desired goal of increasing IPPFP utilisation. On other hand HCP will be motivated as they will attend the training and become competent to use skills and knowledge adopted during training. Provision of resources will motivate HCP to provide the service, resources availability, knowledge and skills on IPPFP use and its effects, to both

post-delivery and Post abortion mother, will influence the accessibility of IPPFP utilization. Clients will be encouraged on the use of chosen eligible method, which will improve the contraceptive use in Ilala municipality.

Theory of planned behavior (TPB) was also used to inform this study to determine the PPFP use among post-delivery mothers. This theory was propounded by Icek Ajzen, and it links beliefs and behavior which helps in improving the predicted power in perceived behavior control[CITATION Ice99 \l 1033]. Psychologist defines the theory as the link between what an individual beliefs and behavior, it is stated that, attitude, behavior, subjective norms, and perceived behavioral control, simultaneously shape an individual's behavioral intentions and behaviors, (Definition.net., 2019). Martin also stated that in TPB behavioral outcome depends on the intention and behavior control, where he distinguished three types of beliefs to be attitude, subjective norms, and behavioral control. Attitude is associated with positive or negative perceptions on behavior. The subjective norms focus on how the internal and external control shapes of an individual's intention while Behavioral control reflects on the advantage and disadvantage of performing the behavior [CITATION Asa15 \l 1033].

In this study, TPB were used to inform this study since those three types of beliefs affects post-delivery women in one way or another to use PPFP service. On the personal altitude most of the women intend to have methods before discharge but it is influenced by views in which clients perceive from different source of information, and experience from those who uses the methods ending with or without complications. This situation builds intention of individual and cognitive beliefs on the method hence fails to have proper decision, Also In this study subjective norms influence on decision making to the women who decide before delivery to use methods but when they come during delivery refuses to have methods for the reason of refusal from husband or other family member, though HCP have an influence to make change when they provide proper effective persuasive counseling session which increase positive attitude towards the use of the methods . Furthermore, on

behavioral control can be influenced on both external and internal control in shaping intentions and behavior outcome [CITATION Asa15 \l 1033]

The assumption of this theory is on perceived behavioral control affects individual intention, which results in individual's behavior and affect them in their performance. The intentions and the resulting behaviors of the individuals are affected by their, or what they think and believe to be their ability to perform**.** Internal control shows how an individual perceives or sees in her/his own control. While on external control, external factors influence in shaping an individual character [CITATION Ros13 \l 1033].

In 2017 the coverage of modern contraceptive family planning was 32%, with estimated target of 47%. Following an increase of maternal,newborn and underfive deaths which were associated with the women who had postpartum pregnances, the only solution was to strengthern PPFP [CITATION Mli14 \l 1033]. WHO come up with the strategy of intergrating Family planning which was emphasizing on the use of PPFP. "PPFP should not be considered as a vertical program,but should be an intergrated part in the existing maternal and child effort"[CITATION Bla16 \l 1033]. WHO come up with the strategy of intergrating Family planning which was emphasizing on the use of PPFP. "PPFP should not be considered as a vertical program,but should be an intergrated part in the existing maternal and child effort" [CITATION Placeholder3 \l 1033]. Despite those effort done by government the maternal death was increasing from 432 to 556 in 100,000in live births where the commonest three leading cause of death were hemorrhage, infections and abortions which can be prevented through effective use of IPPFP (Ngailo, 2017)**.** In 2011, the Government in collaboration with private partners had been working on those challenges where among the 6,734 health facilities with RCH services 5,366(80%) were offering family planning services. In 2014, services were improved by 93.9 % of 5,820 facilities which were providing RCH services. In spite of this initiative of improving the services, the acceptance of long acting reversible contraceptive (LARC) which include Imp anon and IUCD is still low, where IUCD accounts for 0.6% and implants has 2% [CITATION Placeholder4 \l 1033]. The cause of low

utilization can be explained by the Tran theoretical theory (sometimes known as Stage of change model), which was propounded, by Prochaska and DiClemente in the late 1970s, the model focuses on the individual decision making to change. The operating assumption of the model is that, people do not change in behavior rapidly. Change occurs continuously through a recurrent process, it also shows on how the person passes through different stages to adopt certain behavior and make any changes [CITATION The18 \l 1033]. This model of change implies that more efforts and time are needed to create awareness and knowledge in the community, also on the time when IPPFP is given, as this strategy is new to the users.

This strategy has been incorporated in some programs of family planning targeting on capturing most women who come for health services for delivery, this was also justified by the increase in number of deliveries at health facilities [CITATION WHO \l 1033]. This is supported by the theory of diffusion of innovation that has been propounded by Everett Rogers in 2013 where he defined the theory as the process by which an innovation is communicated over time among the system. The theory explains how the information is being communicated; the reason of communicating and at what rate the new ideas and technology spread. Decision on adopting or not to adopt the innovation depends on characteristics of an innovation which may influence its adoption, the individual decision making to adopt the new ideas, characteristics to adopt the innovation, its significance to individual and society in accepting change and finally the way communication is used in facilitating the process of adoption [CITATION Rog03 \l 1033].

The strategy of integrating IPPFP focuses on reducing unwanted pregnancies leading to induced abortions hence maternal deaths. As it is observed in different studies conducted worldwide, different methods are given after meeting the medical criteria eligibility. Most women do not desire to be pregnant immediately after delivery but are unclear about contraceptive usage in postpartum period. This results in unplanned and undesired pregnancies, which in turn increase induced abortion rates and consequently maternal morbidity and mortality [CITATION San16 \l 1033].

Following the factors that affect community and healthcare providers on acceptability of IPPFP, for client creating behavior or a negative altitude on using the method of family planning, the theory of Reasoned Action and Theory of Planned Behavior focuses on constructing an individual motivational factors, attitude of an individual, subjective norms and perceived control which finally contributes to behavioral intention[CITATION Dan \l 1033] This explains to why women and their relatives refuse to have the services that are beneficial to them, and yet they create a negative altitude to the services. As we have seen most of women had no final say as the result, they face problems from their partners and families. Likewise, the Social Ecological Model elaborates how the characteristics of an individual influence an individual change of behavior with descriptive interactive characteristics, which are determined by context that surrounds an individual.

The first level of this theory affects individual decision as when he/she wants to accept some changes. At individual level, factors that increase the likelihood of becoming a victim of program is prevented by personal altitude, beliefs, and behavior that prevent the individual decision. The second level is the level of close relationship where by an individual decision, the peer group, partner, and family member influence. Following the advice, an individual receives from the close group may affect his or her decision whether is good or bad advice as a result the person decides not to use the proper method which might be of benefits to him or her.

The third level explores the setting found at the community level where by neighborhood, school, churches and work place members may influence the characteristic of individuals in decision making like church members that may stand against the use of FP for the reason of being believed to have committed sin, hence alters the individual decision. Fourth level looks at broad society factor where different factors including social and cultural norms influence change in behavior of an individual [CITATION CDC12 \l 1033]. This is observed in PPIUCD program where there is a wrong belief and myth at the level of society that contributes to low utilization of PPIUCD. Most women have no final decision on their health as it is observed at ANC where health education on PPIUCD is done and most of the

women agree but finally after delivery do change their ideas with the reason of fear from external or partners and families as well.

The main reasons for refusal by clients who verbally accepted but refused at the time of insertion were family refusal and pain from delivery [CITATION Nee17 \l 1033]. This is typical the subjective norms in which those clients are subjected to forms of social pressure surrounding them and affect them negatively to participate on their choices. The negative influence against IPPFP usage from partners and family members may all prevent them to access the family planning services [CITATION man16 \l 1033].

Furthermore, according to the Theory of Reasoned Action/Theory of Planned Behavior, behavior is a strong determinant to forecast of performing a particular behavior or activity. This is observed in both clients and HCPs whose attitude contributes in under performance. Subjective norm and perceived behavior control are the basic determinants to individual's specific behavior performing (behavioral intention). On the other way around, negative attitude towards the PPIUCD insertion is affected by myths and beliefs that surround the intervention. In behavioral control, HCPs chose not to practice following training, when this habit of not making practice for long time persists, they forget because practice makes perfect. HCPs have the ability to control them and decide to change their behavior, this act will increase the awareness of the community on IPPFP perception and clear all doubts, myths and false believe on the approach.

2.3 Empirical Literature Review

Under this section causes of low utilization are identified and described from other researchers who have similar study. This aims at finding the mechanism, which will reduce the problem. Post-delivery mothers have the perceived benefit with the use of IPPFP but yet most of the women are unwilling to use the service. The only way that can help to overcome the problem is to increase counseling and male involvement counselling the use of IPPFP.

Different studies have identified different reasons as factors affecting response towards utilization of PPFP among post-delivery mothers in different areas of the

world. The commonest reasons found in different studies among others can be grouped into four groups: First being the method related barrier, second fertility related barrier third barrier is the knowledge on the method used and fourth barrier is lack of awareness. Other barriers apart from those four groups are Religion beliefs, ignorance on when fetility begins after delivery, fear of side effect, and postpartum abstenence, these were the other reasons for not using the service [CITATION Kay18 \l 1033] .

Motivation factors for IPPFP use noted in different studies as it is found in the study conducted in Uganda on Determinants of family planning services uptake and use of contraceptives among postpartum women in rural Uganda were level of education where most of the women who are educated from secondary education tends to use PPFP, male involvement also shows good outcome where those women who communicated with partners were motivated to use contraceptive methods. Those clients who were using FP methods before the index pregnant and those who had information prior to delivery on the use of IPPFP had perceived need of FP use. This factor should be considered in ANC counseling [CITATION Kat15 \l 1033].

The study done in India on "Awareness and acceptance of contraception in post-partum women in a tertiary care hospital of Delhi." found that in 493 post-delivery mothers, 56.9 % accepted the use of PPFP before being discharged home. This signifies that provision of effective high quality prenatal and postnatal contraceptive counseling increases awareness and knowledge which finally increase the use of contraceptive and reduce unplanned pregnancies, decrease maternal and fetal morbidity and mortality and prevent unsafe abortions. Therefore, encouragement should be made to HCP to provide counseling on IPPFP during antenatal and immediately after delivery [CITATION Mee15 \l 1033].

The study was done in four countries; Afghanistan, Honduras, Indonesia and Nigeria on Immediate Postpartum Family Planning: A key component of childbirth care. In this study the strategy of providing contraceptive counseling service as part of child birth care before discharge were used. This practice had high impact and revered that if the woman post-delivery is provided with high quality comprehensive counseling

and given contraceptives depending on their choice as part of child birth care. Approximately 20% to 50% of women will be discharged from the facility with FP methods in place and on doing that the number of unmet needs of FP will be reduced since most of the women will adopt the use of contraceptive methods before discharge [CITATION USA17 \l 1033].

The study done in South-East Rajasthan, on the awareness of the community and factors affecting acceptance of PPIUCD discovered that most of the women who come at Hospital lack awareness as it is shown in the study. The respondents in this study were 18,550 where out of 18550 women, only 480 (2.6%) had information on the method and 2.94% accepted [CITATION Ash171 \l 1033].This results suggest how awereness creation pray greater role in contraception acceptability. Therefore, more empasis should be made in promotion of use of IPPFP in the community to increase knowledge and information on the use of contraceptive methods at this time.

A study done in Liberia on "Barriers to acceptance of post-partum family planning among women in Montserrado country, Liberia" revealed that, there is low preverance of PPFP use in Liberia which accounts for 11.9%. In this study they found that for those women who were aware had four times rate to use PPFP in comparing with those who lacked awereness. In this study found that there is postive association among knowledge on PPFP use, therefore awereness creation in every visit when women comes for health services will be of important in increasing knowledge on PPFP[CITATION Kay18 \l 1033].

The study done by Gabremedhin *et al.* (2018)on "Family planning use and its associated factors among women in the extended post-partum period in Addis Ababa, Ethiopia" found that the prevalence of PPFP was 80.3%. The main factors which motivated them were marriage, menses resumption, child spacing and history of previous contraceptives. The achievement noted in this study was due to appropriate information given to pregnant woman on the possibility to be exposed to pregnancy before the beginning of menses. Special attention was made to those clients who had no previous history of contraceptive use and exposed to other barrier of not using FP method [CITATION Alm18 \l 1033].

In the study by Rutaremwa and Kabagenyion "Postpartum family planning utilization in Burundi and Rwanda: A comparative analysis of population based cross-sectional data" different predictors in both countries were found. Burundi had low prevalence of PPFP (20%) and predicted causes were level of education where those mothers with secondary education and higher were using PPFP; religion (protestant) was the other factor contributed to the low utilization of PPFP. However, low economic status, age of the women, number of living children and exposure to media were among predictive factors in both Rwanda and Burundi. Though the prevalence rate in Rwanda revealed to be better in comparison to Burundi, Rwanda had prevalence rate of PPFP at 51% which was contributed by delivering in the areas where deliveries were assisted by skilled midwives [CITATION Kab15 \l 1033] . Under this situation efforts should be made to increase awareness and knowledge on reaching those women living in remote areas, low education, low economic status and those who have no access to media. Also, accessibility and improving infrastructures could increase the utilization of PPFP use in Burundi.

In Liberia the IPPFP prevalence was 11.9%. The study conducted in Liberia by Kaydor et al. on "Barriers to acceptance of post-partum family planning among women in Montserrado County, Liberia "found that among 378 women who were under the study, 52.9% were aged less than 25 years, 24.1% were married, with education to high level at least secondary education were 66.4% and 92.1% were Christians. The contributing factors for not using the services were lack of access to services, myth and misconception on the use of PPFP, though 76.7% were aware on PPFP, Therefore, high quality counseling on importance of IPPFP is needed including the community and religion leaders, [CITATION Kay18 \l 1033].

In order to increase IPPFP usage, integration of RCH services and provision of high-quality counseling had greater role as it was observed in the study conducted in India by Kathpalia and Mustafa. In their study on awareness and factors contributed to low utilization of PPIUCD, they noted that in spite of low awareness and lack of knowledge of the clients on IPPFP, timing of insertion, was not clear among clients

and some HCPs. Some of HCPs (Medical and Paramedical) were not aware on the time when IPPIUCD were to be inserted [CITATION Placeholder1 \l 1033].). This implies that the awereness regarding to PPIUCD is very low which needs more and strong strategy on mass campaign and publicity through different media.

Ashutosh and Gupta in their study noted that, the source of information in 480 clients who were under the study, 82.5% got informaion from Health care providers, while 17.5 % of the source of information were through media; this implies that increasing knowledge to HCPs will have good impact on increasing the use of IPPFP, [CITATION Ash171 \l 1033]. Cafeteria Approach' should also be encouraged where the couples will have information about the available option aiming to reach the informed decision. HCPs should have regular training and refresher courses being updated on the changes that occur; this will increase confidence, and transform HCPs who were previously unable to offer all available methods [CITATION Dev18 \l 1033].

Similarly, in Tanzania, the study conducted at Muhimbili National Hospital on Acceptability and Safety of Postpartum Intrauterine Contraceptive Device among Patients at Muhimbili National Hospital, Tanzania. A total of 3158 clients were involved in the study, where by 74%were not aware on the method of PPIUCD as it has been found in other studies done in different areas [CITATION Ruk12 \l 1033] .

This finding is dissimilar with those of Agarwal whose study results showed that high acceptance was in those clients with first and second pregnancies. This can be justified as for those clients whose pregnancies are from fourth pregnant that prefer permanent method as they have completed their family size. Some findings were observed in the study done at Muhimbili National hospital where those women who have fourth pregnancies and above preferred PPIUCD were 41.2%, in contrast with 25.2% of those clients who had first and second pregnancies [CITATION Ruk12 \l 1033].

Use of long acting IPPFP contraceptive method is of importance comparing with those methods of short acting. Ashutosh Sharma and Vinita Gupta in their study found that those clients aged 21-30 years had 82.96% of acceptability on PPIUCD [CITATION Ash171 \l 1033]. This finding is similar to findings found in the study done

by Agrawal and Sharma [CITATION Nee17 \l 1033]. The other factors noted in their study include level of education where for those clients who completed secondary education had high acceptance rate comparing with those who were illiterate. In the study done in Burundi among the contributing factors for acceptance of PPFP; 20% was education, and in Rwanda education contributed to 51%[CITATION Kab15 \l 1033] . Other factors that were found in this study to be the contributing factors to the highest acceptance were clients coming from urban area which contributed to 61.72%, and clients with middle socio-economic status had 55.6%. Other factors that were found to affect the acceptance of PPIUCD were fear of side effects complication, desire of other family planning methods and being satisfied with previous family planning methods [CITATION Ash171 \l 1033].

Other factors that were found in this study to be the contributing factors to the highest acceptance were clients coming from urban area which contributed to 61.72%, and clients with middle socio-economic status had 55.6%. Other factors that were found to affect the acceptance of PPIUCD were fear of side effects complication, desire of other family planning methods and being satisfied with previous family planning methods [CITATION Ash171 \l 1033]. Likewise, pressure or disagreement from their partners or families was also the main factors for the refusal to contraceptive use among those clients who were being counseled and accepted during ANC visits. The main reasons for refusal of clients who verbally accepted but refused at the time of insertion were partners /family refusal which accounted for 60.07% [CITATION Ash171 \l 1033] . In the other study conducted in a Tertiary Care Hospital on Awareness, Acceptance and Reasons of Refusal of PPIUCD, different factors were found to be contributing to refusal of husband and pressure that comes from the family which contributed to 28.9% [CITATION Ash171 \l 1033].

Similar to the study above, in the study conducted in Government Medical College, Thrissur, Kerala, India on PPIUCD: Awareness and reasons for non-acceptance found that the reasons for rejecting was that, they wanted permanent sterilization without consensus with their husbands, and fear of complications [CITATION San16 \l 1033]. This is different from the study findings done in Tanzania on Determinants of contraceptive use among married women in Tanzania: Policy implication done by

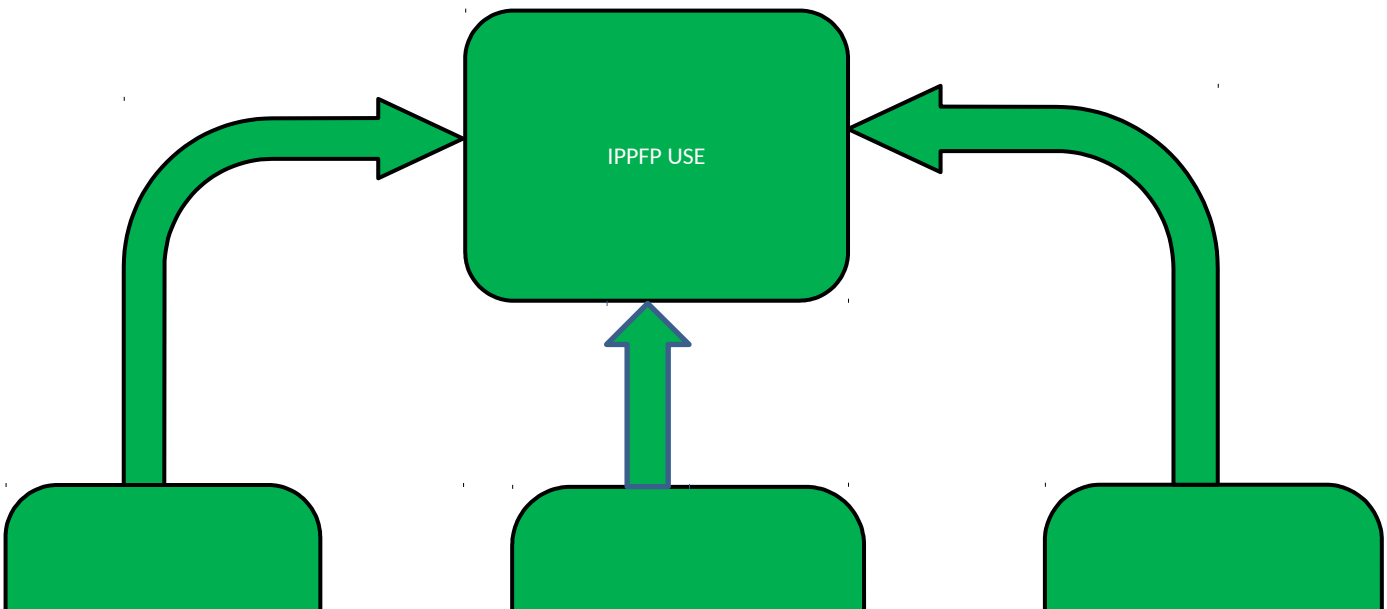
Mlinga (2014), found that husband and women approval, discussion of FP use, family member pressure, religion issues and education level were the determinant of FP utilization in married women in Tanzania [CITATION Mli14 \l 1033]. In Tanzania, Anasel and Upendo in their study of "Determinants of contraceptive use among married women in Tanzania: Policy implication" noted that the knowledge of contraception in Tanzania is widespread where 96% of women and 97% of men know at least one modern method, but only 26% of married woman are using contraceptives, which indicates that in Tanzania marriage is not a motivation factor of using contraceptives like in Ethiopia [CITATION Mli14 \l 1033]. Despite the Tanzanian community's awareness, at least on the one method of contraceptive the prevalence of FP is low accounting 32% and health facility deliveries has increased to 64% [CITATION Rep17 \l 1033]. though the IPPFP use is low. In Tanzania, the study conducted in Northern Tanzania on baseline survey on Postpartum Contraception in Northern Tanzania on Patterns of Use, Relationship to Antenatal Intentions, and Impact of Antenatal Counseling. In this study they determined that there is high unmet need on contraception and concluded that the Antenatal counseling had an effect on postpartum contraceptive intentions, contraceptive service integration models should be tested to determine how and when antenatal counseling can be most effective. Based on the reasons mentioned above it signifies that the low coverage of IPPFP in Tanzania is highly associated with lack of awareness [CITATION Keo15 \l 1033].

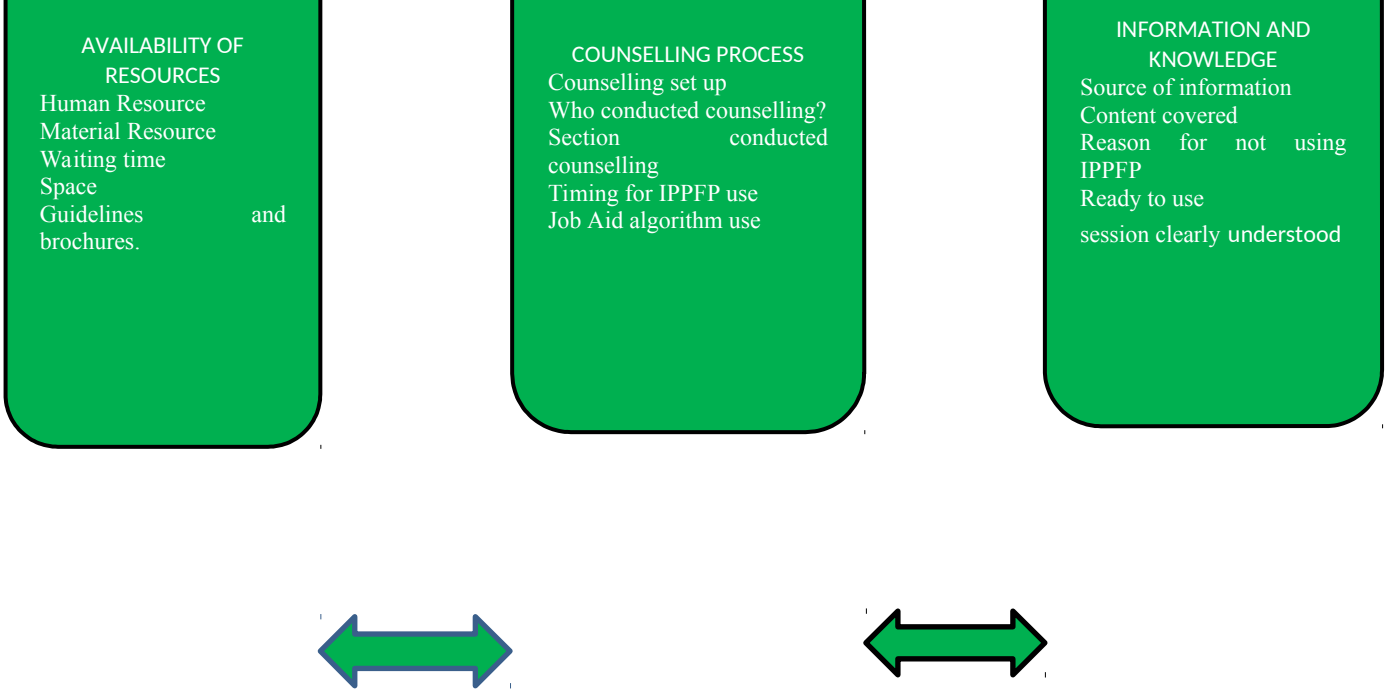
In Ilala Municipality the health facility delivery is 98% with IPPFP use of less than 10% [CITATION DHI181 \l 1033]. In this situation there is a need for a government to come up with strategies, which can motivate married woman, HCPs, community and other stakeholders to be sensitized and use the service. Integrating FP in other program provided during ANC services to pregnant women might increase the use of PPFP as it has been suggested by other researchers who had an ideal of increasing effort on PPFP counseling on routine Antenatal HIV testing, that could increase the coverage to 97% of pregnant women with information who are highly in need to have their choice on which method will be used before discharge after delivery [CITATION Keo15 \l 1033].

2.4 Conceptual Framework

Conceptual Framework is defined as a structure or a simplest way through which a researcher presents his/her constructive views on the phenomenon to be investigated. It highlights the reasons why a research topic is a worth studying [CITATION Dic181 \l 1033]. The conceptual framework of this study design is indicated in the figure 2.1 The conceptual framework of this study design is indicated in the figure 2.1 which has two parts: the dependent Variable "Utilization of the IPPFP" considered being the main focus of our IPPFP evaluation. On utilization the study is focusing to know the user and non -user of the contraceptive method. The second part is the independent variable "the factors affecting utilization of the IPPFP. These factors are grouped into three groups: Knowledge and information to create awareness on PAFP to Post-delivery mothers. Counselling process on IPPFP with availability of resources for IPPFP utilization. These three factors work together to increase the utilization of IPPFP. Starting with availability of human resource provides counselling and offers service when there is availability of medical commodities, space and guidelines which are used when providing services .Effective counselling also increases information and knowledge to clients who sometimes get knowledge even from other source like from media, pear group or different campaign but they have to go back to health facility where they will be counselled to receive method of their choice.

Figure 2. 1 Conceptual Framework.





Source: Researcher, 2019

CHAPTER THREE

EVALUATION METHODOLOGY

3.1. Introduction

This chapter covers different parameters of this evaluation. Different explanations are made to explain the study area, evaluation period, evaluation approach, evaluation design, indicator variable, population and design, target population, evaluation design, tools and techniques for data collection, method for data collection and unit of the evaluation. The chapter also presents sample size, sampling procedure, data collection and quality control, data entry and cleaning, data variable and analysis and ethical consideration.

3.2. Study Area

This study was conducted in Ilala, which is among the five Municipalities in Dar es Salaam City. It is estimated to have an area of 210 Km^2 with projected population of 1,479,121(NBS, 2018). It has an annual population increase rate of 4.6% as projected from Population projection 2012. This area was purposely chosen basing on the increased number of ANC attendance with low coverage of IPPFP coverage which was 130.9% in 2015. One third (1/3) of deliveries which is 38% in 2016 and 37 % in 2017 of all deliveries in Dar es Salaam city are from Ilala Municipal. Also, the IPPFP methods provided in Ilala Municipality were 4% in 2016 while in 2017 was less than 10% [CITATION DHI181 \l 1033]. Therefore, a significant number of ANC attendance, HF deliveries, low coverage of IPPFP and location at the city centre necessitated this study to be conducted in Ilala.

3.3 Evaluation period

The evaluation took three months (April – June 2019), which was followed by data analysis and report writing.

3.4 Evaluation approach

The study deployed process evaluation since the program is in implementation phase. The aim was to evaluate factors associated with utilization of IPPFP in Ilala Municipality.

3.5 Evaluation design

This study employed both quantitative and qualitative methods as it aimed to capitalize on strength and reduce weakness that can occur by using a single design. Quantitative were used in addressing both three objectives (counselling process, knowledge and information availability of resources (human resource, medical equipment's, medical supplies space availability). Qualitative design was used to address third objective, on availability of medical supplies and equipment which need key informants on the system used to procure medicine. Mixed procedures were used in data collection and data analysis. The study employed a Cross sectional study design for the evaluation. This design allowed the researcher to collect data at single point in time. Results from the sample with similar characteristics of the population

studied were obtained. This made it easy to show the association between Independent and dependent variables on how it can affect each other. This design helped the researcher in determining easily the factors associated with IPPFP utilization. Data was collected at single point of time. The results were measured at the same time from post-delivery mothers who were found in the ward at the time of data collection. In addition, all women who had the child less than one year at ANC were recruited to participate in this study. This design guided the examination of health - related factors in accessibility of IPPFP methods and other variables in terms of counselling process and resource availability.

3.6 Focus of evaluation and dimension

The focus of this study was to evaluate the factors associated with low utilization of IPPFP among post -delivery mothers. Health related factors in terms of availability of resources for IPPFP, knowledge and information with counselling process on how they contribute to IPPFP utilization have been studied.

The dimensions of this evaluation were all post-delivery mothers and lactating mother found in labour ward and at RCH clinic during the time of data collection in selected health facility, National TOT's mentors, facility management staff, District Reproductive Child Health Coordinator" DRCHCO". Therefore, this study intended to evaluate factors associated with utilization of IPPFP among post-delivery women in Ilala Municipality

3.7 Indicators/variables

The dependent variable has been the utilization of IPPFP services. The independent variables include the following characteristics: Counselling process on IPPFP utilization, source of knowledge and information on immediate PPFP use and availability of resources for IPPFP utilization were used as independent variable.

3.8 Population and sampling

Sampling method is the procedure or technique of drawing a definite number of individual or observation from a certain universe.

3.8.1 Target population

3.8.1.1 Quantitative.

The target population of this evaluation study was estimated to be 49,823, which included all women in bearing age of 15 to 49 years who were post-delivery mothers in postpartum period who were delivering in Health Facilities in Ilala Municipality, [CITATION DHI181 \l 1033].

3.8.1.2 Qualitative

This design targeted to use key informants who are experienced in the program and with Ilala Municipal. The respondents included; DRCHCO, National TOT, Medical officer in charge and Matron of HF's in the selected health facilities.

3.8.2 Source population/Sampling Frame

3.8.2.1 Quantitative

The pre and post-delivery mothers who had been found in selected heath facilities were automatically included in the study. The subjects have been drawn randomly from all selected health facilities.

3.8.2.2 Qualitative

Health care providers working with program and who have key information's were drawn purposively.

3.8.3 Study units and sampling units

Study unit was divided into two groups: The first group entails individual women; second group were the health care providers working with the program at CHMT and in selected health facilities where the study was conducted. This is the smallest units where data were collected.

3.8.4 Sampling Procedure and Sample Size

In this study, under Quantitative, sample size was determined by using Marginal of error calculator and that the tool informed the researcher if the populations surveyed were enough to sense the confidence regarding the accuracy of collected data. Three factors were critically used namely population size, confidence level and margin of error. In this study:

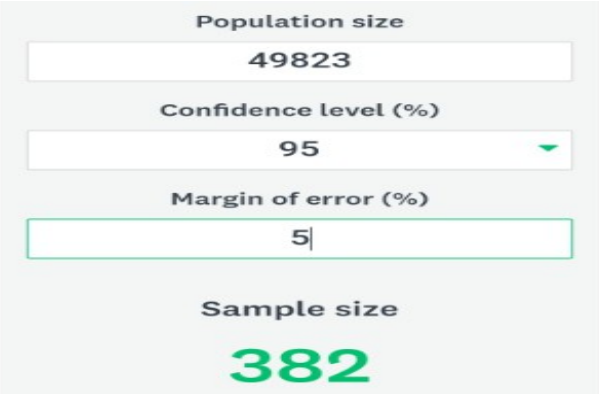
(i.) The population size of expected women to be pregnant in 2018 in Ilala Municipality is estimated to be 49,823[CITATION DHI181 \l 1033].

(ii.) The desired level of confidence is 95% and

(iii.) The acceptable margin of error is 5%

By putting the above data in the Marginal of error calculator

The sample size was calculated as follows:



Therefore, the sample size of this study was 382 and value of sample size (n) to be 382. That is, any value of n, which is greater than 382, is within the error limit at 95 percent confidence level.

In qualitative, under this part information was collected from respondents in consideration of variation of information that were collected when it reached to the point of leveled off that is when there was no new perception and clarification were coming from the respondents, and when researcher had sufficient data to answer

research question. Non-probability purposively, method was used to select respondents where respondents in this study were Health Facility In-charge or Matron of health facility, National TOT of PPFP and District Reproductive and Child health Coordinator (DRCHCO) who were chosen purposively as they were experienced in the topic. In-Depth Interviews were used since the respondents had the key information on how resource availability for IPPFP is procured.

3.8.5 Sampling Techniques

In selection of HF, probability sampling strategies were used. A list of 24 health facilities which conduct delivery in Ilala municipality formed the sampling frame. Clustering sampling method was preferred to select the facilities to be involved where six facilities were chosen, 3 hospitals that perform Cesarean section and three health centers that had many deliveries were selected. Non-probability sampling technique was used in selection of 395 respondents, where by all post-delivery mothers within one year in selected facilities were selected purposively and conveniently, who were found in the ward and at RCH clinic at the time of data collection, to represent the target population. At the same time purposive sampling methods were used to select Health workers basing on their positions to provide the potential and resourceful information for the study.

3.8.6 Inclusion criteria

Heath care providers who are working at RCH, and Maternity ward specifically in antenatal section, labour and in postnatal section, national TOT's, Mentors, shift supervisor and DRCHCO. Also, all post-delivery mothers within one year that are being found during data collection in selected Health facility in Ilala Municipality.

3.8.7 Exclusion criteria

These include heath care providers who are not working at RCH, and Maternity ward specifically in antenatal section, labour and in postnatal section, national TOT's, Mentors, shift supervisor and DRCHCO. Also, clients who are post-delivery, post abortion mothers and lactating mothers more than one year that are being found during data collection in selected Health facility in Ilala Municipality.

3.9 Data collection methods

3.9.1 Data Collection

In this study three data collection tools were used to collect different information from respondents. Structured questionnaire, structured observation checklist and semi structured individual interview were employed as a research instrument to collect different information from delivery mothers in labour ward, Post-delivery mothers in RCH who were within postpartum period and HCPs who provided the service in different levels from Health facility, National TOT on IPPFP, and DRCHCO, gathered information were used for statistical analysis

3.9.1.1 Structured Questionnaire

This tool was used to collect Quantitative data from 395 respondents, where, a structured questionnaire was developed. Series of questions were established to gather information from respondents which covered demographic characteristics, counselling process, Source of knowledge and information, with availability of IPPFP resources were covered to address three objectives of this study. Developed Questionnaire were tested in selected HF, respondents were selected randomly from the study population, identification of gaps in questionnaire that was confusing participants to have different understanding to the question was collected to have the some meaning to all respondents. Coding of questionnaire was done before distributed to the respondents in the study facility.

In selected HF pre-tested coded questionnaire was distributed to the post-delivery women within one year who were found in the selected HF at the time of Data collection. For those clients who were in pain and those who do not know how to write, evaluator assisted them to fill the information. Questionnaires were verified if they are properly filled before collected from the respondent.

3.9.1.2 Structured Interview

Face to face semi structured individual interview tool were used to collect Qualitative data in this study. The interview guide questions were developed ahead of time which was designed to collect information through open ended question on

the factors associated with IPPFP utilization. Probing was done to guide interviewer to follow the topic. Key informants who were selected provided critical description experience on how availability of resources through CLM program is implemented. The interview was recorded after the verbal consent from the researcher. The obtained information was ready to be analyzed through content analysis.

3.9.1.3 Observation

Quantitative observation checklist tool was used to collect different data from ANC, Labor ward and in postnatal ward where observation of resources availability of IPPFP in working area was verified. Other activities that were observed were on how counselling sessions were conducted, content was covered, and who conducted counselling, availability of guidelines, brochures, and job aid algorithm. Quantification of different resources like availability of medical supplies, space, equipment, and different FP methods with workload to HCPs was determined. Furthermore, the resources that can be quantified by using numbers were recorded and relationship among variables and events analyzed to come up with the solution

3.9.2 Data Collectors

Two nurses from each selected facility (one from RCH clinic and One from Labor ward) were included in data collection since nurses are the ones used in conducting counselling sessions and finally imparts information, knowledge to clients were at last offers contraceptive methods. Orientation on the tool to be used and on evaluation objectives and ethical consideration was done before and during data collection.

3.9.3 Field Work Data Collection

All data collectors were oriented on how to collect data and each data collector collected the data from HF. Convenient number of participants was obtained. All questionnaires were checked for completeness before data entry.

3.9.4 Development of Data Collection Tools

This study had three Data collection tools which included; structured questionnaire, structured observation checklist and in-depth interview which were prepared in English. Since the majority of the respondents were not used to English, structured

questionnaire was translated in Kiswahili language. The pilot study was conducted in Tabata 'A' Health center before it was used to the field.

3.10.1 Data management

Data management means the process of organizing data from its entry to the point of dissemination with valued results. In this study, data were managed from point of data collection, quality control, data entry, cleaning technique, data variable and data analysis planning aim to create a reliable data of high quality.

3.10.1.1 Data collection and quality control

Data collection was done by researcher herself with one assistant who were oriented on how to collect data on June 2019 during working hours from 7:45 AM to 3:00 PM. Qualitative data was collected from key informants working with program.

3.10.1.2 Data entry and cleaning techniques

After collection of data from ground, collected data was coded from text into numerals and entered into MS excel by double entrants and later was cleaned to eliminate errors aiming in maintaining accuracy, consistence, and responses. Each possible answer was given number to ease the determination of correctness of data during the whole process of data entry and cleaning. After that, analysis of the clean data was done by Statistical Package for Social Science (SPSS) according to research objectives.

3.10.1.3 Data variables and analysis

Data variables for analysis included background characteristics of variables to post-delivery mothers like age, parity, marital status, Religion, education level, employment and distance from home to HF. Variables for frequency and percentages on factors associated with IPPFP utilization depending on the objectives were; in counselling process, variables were counselling set up, section conducted counselling. Who conducted counselling, timing for IPPFP use and job aid algorithm use. On information and knowledge variables were source of information, content covered reason for not using, ready to use and session clearly understood. The last objective was resource availability; variables were human resource, content covered, waiting time and space availability

Qualitative

In Qualitative design, data analysis and interpretation are the procedure of conveying meaning to the collected information and determining the conclusions, significance, and implications of the findings. The stages involved in data analysis functional depended on the type of data collected. In order to get an appropriate finding, collected qualitative data was analyzed using content analysis. Before the start of data collection reliability of the data was maintained where a structured questionnaire was used, as well as assessment of reliability was done using the test re-test method. The questionnaire was administered twice to three respondents from the desired population. The obtained data was correlated with the data obtained earlier using the same questionnaire which ensured that the right data was collected and vague questions avoided.

Validation of the questionnaire was done at Tabata 'A' Health Centre where pilot testing of those questionnaires was conducted, and sample was selected from the facility (matron was interviewed) she was selected since she was among of the targeted population and served with the questionnaires to respond on interview and finally data was recorded.

Content analysis was used to analyze the Qualitative data whereby collected data (interviews) was analyzed by researcher, in order to identify the main themes that emerge from the responses given by the respondents. In analysis the following steps were followed;

Interview was conducted where the researcher recoded the interview after the consent of the respondent. For Qualitative data, content analysis was used to analyze the data, where the researcher transcribed, read and re-read the interview to gain the general understanding of respondent's idea. The text was divided into small parts which had the meaning to form the meaning units; condensation of units was done with maintaining the core meaning. Codes were framed and grouped into categories and finally themes were created. under the different themes Integrating themes and responses into the text of my report was done, after identifying the responses that fall within different themes, the next step was to integrate into the text of the report

3.10.3 Ethical Issues

Ethical clearance was obtained from Mzumbe University after submission of proposal and approval by researcher team. The letter from MU with Ref No MU/DPGS/INT/38/Vol.IV was submitted to Regional administrative officer of Dar es Salaam Region with Ref No—(no Ref no found), District administrative secretary Ilala with Ref No AB.60/87/01/, Municipal Director Ilala with Ref No IMC/AF.3/31, District Medical officer-Ilala with Ref No. IMC/DR.6/IV/97 and Amana Reginal Referral Hospital with Ref. No MOHCDGEC/ARRH/R.1/X/45. Informed consent to respondents was obtained verbally. Clear explanations were given for voluntary participation, the respondents were also assured on confidentiality and the information they provided were assured to be for only the purpose of this research and not otherwise.

3.10.4 Quality Assurance

The quality assurance of the data in this study was assured by proper designing; pretest of the collection data tool, data collected precisely, proper instructions to data collectors. All collected data were examined for completeness and consistence. The investigators entered the data after careful cleaning and editing, to ensure quality assurance of the collected data.

3.10.5 Evaluation Dissemination Plan

The evaluation findings obtained from this study will be disseminated as a written report to MU, Ilala Municipal Council (DMO Office, Pathfinder Dar es salaam, and all six Health facilities where the study was conducted. Dissemination meeting among those stakeholders involved in the study will be done and the explored gaps be worked on with respective organization for improvement of the performance of the organization.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1 Introduction

This chapter presents the findings based on the evaluation objectives. The general objective of this evaluation was to evaluate factors associated with utilization of IPPFP among post-delivery mothers in Ilala Municipality. The specific objectives were first, to evaluate the extent to which counselling process is associated with the IPPFP utilization among post-delivery mother's, second, to evaluate the extent to which knowledge and information on IPPFP is related to utilization of IPPFP and to determine how IPPFP availability of resources is associated with IPPFP utilization among post-delivery mothers in Ilala Municipality. Evaluation findings are presented as follows:

4.2 Background information of respondents

Three hundred and nighty five (395) respondents were recruited in this study where by all of them were female (100%). In this evaluation the study found that most of the respondents were between age group of 25-34 years 178(45.1%) followed by 15-24 years 153 (38.7%) and followed by 35-44 years 57(14.4%) and the least group was 45 years and above who was 7 (1.8%). This is supported by the parity of the respondents where most of them who had first to third deliveries 309(78.2%), and those with four deliveries and above accounted for 85(21.8%). On the issue of marital status, most of the respondents were married 323(81.8%) and unmarried accounted for 72(18.2%). The evaluator found that most of respondents in this study had low level of education where the group of not educated, primary and secondary education had 358(90.6%)

while the rest that 37(9.4%) had higher level of education of diploma to PHD. Most of the respondents in this study were not employed counting for 312(78%) and only 83(21%) were employed. On the religion issue, most of the respondents were Moslem who were 220(55.7) and Christians were 175(44.3%). Distance from home to health facility, the evaluator found that almost half of respondents 200(50.6%) live in less than five kilometers from health facility while the 195(49.4%) were living in the distance of more than five kilometers. The results are presented in table 4.1.

Table 4.1 Background information of respondents (n=395)

QUESTION	RESPOSPONSES	FREQUENCY	PERCENTAGES
Age of the Client	15-24	153	38.7
	25-34	178	45.1
	35-44	57	14.4
	45 and above	7	1.8
Parity of client	First pregnant to third pregnancy	309	78.2
	Fourth and above pregnancy	86	21.8
Marital status	Married	323	81.8
	Unmarried	72	18.2
Level of Education	Not educated, primary and secondary education	358	90.6
	Diploma to PHD	37	9.4
Religion	Christian.	174	44.3
	Moslem.	221	55.7
Occupation of client	Employed	83	21.0
	Unemployed	312	79.0
Distance from home to health facility	Less than five kilometers	200	50.6
	More than five kilometers	195	49.4

Source: Field Data (2019)

4.3 Association between Counselling process and IPPFP utilization

The study hypothesized the association between counselling process, and utilization of IPPFP/PAFP. The relationship between dependent variables and the IPPFP utilization was examined using chi-square test. The independent variables related to dependent variables (p-value ≤0.05). This indicates strong association between variables and if a large p-value was > 0.05, this would indicate a weak or no association between variables. For a goodness-of-fit test, if the p-value is 0.05 or less, then you must reject your prediction, [CITATION Mic17 \l 1033]. Results from chi-square test are presented on table 4.2

The study finding shows that there is association between IPPFP utilization and counselling session p-value shows 0.023. Also result indicates association between session (subject leaned) clearly understood and use of IPPFP p-value shows 0.030. The study further had shown association between setup of counselling sessions and use of IPPFP p-value shows 0.029 however results show no association between utilization of IPPFP and heard about family planning Method before p-value shows 0.170. Study finding further shows no association between utilization of IPPFP and counselling session p-value shows 0.140. No association was also shown between utilization of IPPFP and used contraceptive before p-value found was 0.579, this implies that utilization of IPPFP before is not associate with the current use. In increasing more patient to be counseled in those section which has few clients who were counseled, the National TOT and In patient department (IPD) in charge of Mnazimmoja Hospital suggested that more effort should be done at RCH where respondents should come for delivery when they have already chosen their method to be used after delivery, and it should be marked on their RCH cards, and she said

> *"...yaaah, we have noted that and talk to RCH staff that when they provide health talk should talk about on how successfully counseling can be provided, and we have already told them to mark on RCH card FP choice of the client and when the client has given birth will receive IUCD or implant, but now days they are not writing on cards. At the beginning of this program CLM gave those 2 stamps one written IUCD and other implant whereby they were stamping on the cards according to client's*

choice. Therefore, if they could be doing it would have been easier in labour ward after delivery to inform the client and if they are ready, we give them brief counseling and provide the method of their choice. Due to this gap has made provision of IPPFP within 10 minutes to be not much applicable. Counseling should start from RCH. But we are still insisting them to do it……. respondent…2"

The study assessed if the content on contraceptive counseling that were covered during training (contraception curriculum) were effectively used during counseling session and asked on what component were learnt during counseling sessions, the majority 226(57.2%) knew the types of available methods in the health facility, side effect of each methods and its reversibility 169(42.9%), timing for IPPFP/PAFP 161(40.8%), indication and contraindication of each method 102(26%), infection prevention and control 79(20.0%) and medical eligibility criteria 29(7.3%). The counseling was not effectively conducted as it was noted by evaluator in observation checklist where she found that, guidelines and counseling job aid algorithm were not used in most HF, only one HF used job aid algorithm though guideline were not found at the service delivery area in all facilities.

Table 4.2: Association between counselling process and IPPFP utilization (n=395).

Variables	Sub variables	Used IPPFP	Did not use IPPFP	Total	Pv
Have you ever heard about family planning Method before?	Yes	191	195	386	0.170
	No	3	6	9	
Did you receive counselling sessions?	Yes	176	168	344	
	No	17	34	51	0.023
	Total	193	202	395	
Was the session clearly understood?	Yes	186	183	369	0.030
	No	8	18	26	
	Total	194	201	395	
What was the setup of counselling?	Individual counselling	60	44	104	0.029
	Group counselling	133	158	291	

	Total	193	202	395	
Have you ever used contraceptive before?	Yes	142	150	292	0.579
	No	53	50	103	
	Total	195	200	395	
	No	29	32	61	
	Total	193	202	395	

Source: Field Data (2019)

4.4 Extent to which knowledge and information on IPPFP is related to utilization of IPPFP among post-delivery mothers.

The study assessed the respondent have ever heard about family planning method before, the majority of respondents 387(98.0%) had information while 8(2.0%) had no information. This was also supported by DRCHCO from Ilala municipality who stated that;

> *"...First of all, CLM started its implementation in 2016, it started at Temeke, then scaled up to Ilala municipal. When they came in Ilala municipal they looked at the need of Ilala on FP. They found out there are a lot of discrepancies on skills and knowledge on LAC to HCPs, though we were conducting activities of short and long acting contraceptive methods team which including surgeons and assistant surgeons, where we were visiting different facilities to provide services. This was due to shortage of skilled health care providers in facilities, therefore, when CLM came, we told them we had shortage of skilled HCP, looking on training issues we focused on government HFs, we analyzed together with CLM in collaboration of HFs' I/Cs to select participants to attend the training, and they supported us to train many staff, for that I can declare that there is no HF which cannot provide LARC in government facilities. The trained staff are providing information to clients on FP..". label this respondent 1,*

On the issue of source of information, the study found that the major source was from health facility by health care provider who counted for 387(98.0%), followed by peer group 220(55.7%). Media had 200(50.6%), followed by ICT materials 191(48.4%), Mass campaign had 174(44.1%), followed by CHW's counted for 79(20.0%) and the least source of information were from partner /Family member 58(14.6%). The study assessed if the respondents had ever used family planning methods before and found that 204(51.6%) had not used the methods while 191(48.4%) had the history of using the methods. But most of respondents had knowledge on family planning methods despite the fact that they were not using them before. The evaluator found that 374(95%) had knowledge on contraceptive

methods. Most of respondents 374(94.7%) knew contraceptive pills, followed by injection for 370(93.7%), Implants and IUCD had the same number of respondents of 325(82.3%) followed by natural methods accounted for 226(57.2%), Condoms had 152(38.5%), and the least known were bilateral tubal ligation/vasectomy which accounted for 36(9.1%). Most of the respondents who received the family planning counseling were from health care provider where 93.7% were counseled by health care provider and only 4.8% were counseled by community health workers.

This was supported by the number of clients who received counseling sessions which was conducted by health care provider in health facility which accounted for 325(82.3%), and 26(6.6%) got counseling from community health care, the rest 14 (3.6%) respondents had counseling from both health care providers and community health workers. Most of the respondents had group counseling setup where almost 226(57.2%) of all respondents were counseled in groups followed by 111(28.1%) who had both individual and group counseling and those who had individual counseling were 29(7.3%).

The section that were providing counseling in high rate were at RCH where 324(82.03%) were counseled followed by postnatal ward which had 231(58.5%), then in labour ward during delivery only 96(24.3%) and the least section were during admission which had 82(20.8%).In increasing more patient to be counselled in those section which has few clients who were counseled, the National TOT and In patient department (IPD) in charge of Mnazimmoja Hospital suggested that more effort should be done at RCH where respondents should come for delivery when they have already chosen their method to be used after delivery, and it should be marked on their RCH cards , and she said

> *"...yaaah we have noted that and talk to RCH staff that when they provide health talk should talk about on how successfully counseling can be provided, and we have already told them to mark on RCH card FP choice of the client and when the client has given birth will receive IUCD or implant, but now days they are not writing on cards. At the beginning of this program CLM gave those 2 stamps one written IUCD and other implant whereby they were stamping on the cards according to client's choice. Therefore, if they could be doing it would have been easier in labour ward after delivery to inform the client and if they are ready, we*

give them brief counselling and provide the method of their choice. Due to this gap it has made provision of IPPFP within 10 minutes to be not much applicable. Counselling should start from RCH. But we are still insisting them to do it... respondent...2.".

The study assessed whether the content on contraceptive counselling that were covered during training (contraception curriculum) were effectively used during counselling sessions and asked on what components were learnt during counseling sessions, the majority 226(57.2%) knew the types of available methods in the health facility, side effect of each methods and its reversibility 169(42.9%), timing for IPPFP 161(40.8%), indication and contraindication of each method 102(26%), infection prevention and control 79(20.0%) and medical eligibility criteria 29(7.3%).

The counselling was not effectively conducted as it was noted by observer in observation checklist where she found that, guidelines and counselling job aid algorithm were not used in most HF, only one HF used job aid algorithm though guideline were not found at the service delivery area. Likewise, the evaluator also asked if the learned subjects were clearly understood, the majority understood the subject for 358(90.6%), while 13(3.3%) did not understand. Apart from that the evaluator asked them if they have ever used family planning methods before, the majority of respondents used family planning before and were 283(71.6%), while 92(23.3%) have not used. But when the evaluator asked on those who are ready to use family planning methods before discharged home, 191(48.4%) were ready while 200(50.6%) were not ready.

On the timing of when the respondent prefers to be offered the service, almost half of respondents 198(50.1%) preferred to have the service in the other day after discharge and who were ready before discharge were 102(25.8%), the rest had no answer. For those respondents who were ready to use Family planning before discharge had different reasons that were hindering them to use which were child spacing were 268(67.9%), economic condition 61(15.4%) and 41(10.4%) had the reason of desired to have been completed the family size. For those respondents who agreed to have the service and could not get the service before discharge had different reasons which made them not to use, those reasons were pain and

complications that they experienced during labour 184(46.6%), shortage of health care providers 35(8.9%) and lack of equipment 2(0.5%).

Furthermore, the study assessed the reasons that made respondents not to use family planning, the commonest reasons found were; pain after delivery, and fear from side effect of the contraceptive methods accounted for 239(60.4%), followed by those respondents who had not yet discussed with their spouse 155(39.2%),followed by refusal of spousal/family member were 53(13.4%), delaying to have menstruation hence no need of using IPPFP accounted for 24(6.1%),other reasons were religious beliefs 21(5.3%), stock out of the methods 17(4.3%) and family size not completed 3(0.8%). Evaluator also asked those respondents who were counseled by community health workers on what service were provided by CHW's, 207(52.4%) the responses were; family planning mobilization, followed by FP counseling 79(20%), FP follow-up visit were55(13.9%) and FP referral 50(12.6%).

Table 4.3:Knowledge and information in relationship with IPPFP utilization.

QUESTION	RESPOSPONSES	Frequency	Percentages
Have you ever heard about family planning Method before?	Yes	387	98.0
	No	8	2.0
Where did you get information about IPPFP / PAFP tick in appropriate number?	Media	200	50.6
	HF by HCP	387	98.0
	Community by CHW's	79	20.0
	Peer group	220	55.7
	Mass Campaign	174	44.1
	ICT materials	191	48.4
	Partner/ Family member	29	7.3
Have you ever used family planning methods before?	Yes	191	48.4
	No	204	51.6
Do you know any family planning contraceptive methods?	Yes	374	94.7
	No	16	4.1
If "Yes" in question above, mention them	Pills	374	94.7
	Injection	370	93.7
	IUCD	325	82.31
	Implants	325	82.3
	Condom	152	38.5
	Natural	226	57.23
	BTL/Vasectomy	36	9.1
If you received information from healthcare provider or community	Yes	370	93.7
	No	19	4.8

health workers on IPPFP / PAFP			
If received counseling sessions, who conducted counselling session.	HCP	325	82.3
	CHW	26	6.6
	HCP&CHW	14	3.6
What was the setup of counselling?	Individual counselling	29	7.3
	Group counselling	226	57.2
	Both individual and group counselling	111	28.1
In which section in HF you had counselling?	RCH	324	82.03
	During Admission	82	20.8
	During Delivery	96	24.3
	Discharge	231	58.5
What did you learn in counselling session you attended? Tick them?	Types of FP methods available in the HF	226	57.2
	Side effect of each method, and its reversibility.	169	42.9
	Indication and contraindication of each method	102	26
	Medical Eligibility Criteria	29	7.3
	Timing for IPPFP/PAFP.	161	40.8
	Prevention of HIV and IPC	79	20.0
Was the session clearly understood?	Yes	358	90.6
	No	13	3.3
Have you ever used contraceptive before?	Yes	283	71.6
	No	92	23.3
Are you ready to use Family planning method before discharge?	Yes	191	48.4
	No	200	50.6
Reason for using Family planning (mention five reason).	Child spacing	268	67.9
	Economic condition	61	15.4
	Health		
	Desired Family size completed	41	10.4
What time do you prefer to receive the service?	Before discharge	102	25.8
	Other day after discharge	198	50.1
	Any time	95	24.1
Reason of not getting the service before discharge?	Shortage of health care provider	35	8.9
	Because of pain	184	46.6
	Lack of equipment	2	0.5
Reason of not using Family Planning (tick answers).	Refusal of spouse/Family members	53	13.4
	Religion beliefs	21	5.3
	Stock out	17	4.3

	My family size not completed	3	0.8
	Pain and fear from side effect	239	60.4
	always delay to have my menstruation no need of using IPPFP	24	6.1
	Had no discussion with husband	155	39.2
Service was provided by CHW	FP mobilization	207	52.4
	FP counseling	79	20
	FP follow up visit	55	13.9
	FP Referral	50	12.6

Source: Field Data (2019)

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter presents a discussion of the findings presented in chapter four. The discussion mainly focuses on specific objectives, to examine a counselling process, knowledge and information on IPPFP utilization among post-delivery mothers and to determine the availability of resources for IPPFP methods among post-delivery mothers. Therefore, evaluation of findings is presented as follows:

5.2 Background information of respondents

Based on chapter four, the present study hypothesized the association between the use of IPPFP and demographic information of respondents among women. The relationship between the dependent variables and the use and non-use was examined using chi-square test. The relationship between independent variables and dependent variables with p-value (≤0.05) indicated association between variables. This means a large p-value (> 0.05) indicated weak or no association between variables, (minitab.com, 2019). The study findings have shown association between use of IPPFP and parity of clients. This implies that having many children has an association with the use of IPPFP.

In 2017 the coverage of modern contraceptive family planning in Tanzania was 32%, with estimated target of 47%. Following an increase of maternal, newborn and underfive deaths which were associated with the women who had postpartum pregnances,the only solution was to strengthern PPFP [CITATION Mli14 \l 1033]. Although the Tanzanian community is aware at least on the one method of contraceptive, the prevalence of FP is low accounting for 32% and health facility deliveries has increased to 64% [CITATION Rep17 \l 1033]. Therefore IPPFP utilization is highly associated with birth control in Tanzania. However, the study indicates a weak association between utilization of IPPFP and Level of Education religion Occupation and Distance from home to health facility. These findings are contrary to the findings by Jalang'o et al. (2017) on the determinants of contraceptive use among postpartum women in a county hospital in rural Kenya, which indicated significant association ($p \leq 0.05$) between uptake of postpartum family planning and

marital status, education level, occupation and getting contraceptives at a health facility [CITATION Ros171 \l 1033].

The findings are however, contrary to the study by Bwazi et al. (2014) on Utilization of Postpartum Family Planning Services between Six and Twelve Months of Delivery at Ntchisi District Hospital, Malawi. The study found that there was a significant association ($P < 0.05$) between utilization of post-partum family planning services and clarity of family planning information given, level of education, religion and occupation [CITATION Chr14 \l 1033]

Following the findings of this study, it is stated that level of education was not associated with FP utilization. The findings are similar to the study done in Burundi and Rwanda by Kabagenyi and Mutaremwa (2011) on postpartum family planning utilization with a comparative analysis of population based cross-sectional data. The findings indicated that in Burundi 53.9% of the respondents had no education on PPFP use of 20% while in Rwanda only 19.4% were not educated on the PPFP use of 51%. Marital status was also not associated with FP [CITATION Kab15 \l 1033].
The findings are different from the study done in Ethiopia by Gebremedhin et al. (2014) whose study on family planning use and its associated factors among women in the extended postpartum period in Addis Ababa-Ethiopian where prevalence of PPFP use was at 80.3%.The factors associated with this were marriage time when menses begin and history of FP use before [CITATION Alm18 \l 1033]. The findings are different from the study done in Ethiopia by Gebremedhin et al. (2014) whose study on family planning use and its associated factors among women in the extended postpartum period in Addis Ababa-Ethiopian where prevalence of PPFP use was at 80.3%.The factors associated with this were marriage time when menses begin and history of FP use before

5.3 Association between Counselling process and IPPFP utilization

In order to increase IPPFP usage, integration of RCH services and provision of high-quality counseling has crucial role. It was observed in this study that, since there is strong relationship between the use of IPPFP and counseling session p-value shows 0.023. This study is similar to the study conducted in India by Kathpalia and Mustafa

(2015). In their study on awareness and factors contributed to low utilization of PPIUCD, they noted that despite the low awareness and lack of knowledge of the clients on IPPFP, counseling sessions conducted among women influenced women to undergo PPIUCD. Some of HCP's (Medical and Paramedical) were not aware on the time when PPIUCD were to be inserted, but counseling sessions influenced uptake of PPIUCD. Women who are in use of IPPFP have a higher chance of controlling birth compared to women who are not utilizing family planning [CITATION Placeholder1 \l 1033]. Similarly, the study done in India on "Awareness and acceptance of contraception in post-partum women in a tertiary care hospital of Delhi." found that in 493 post-delivery mothers, 56.9 % accepted the use of IPPFP before being discharged home. This signifies that provision of effective high quality prenatal and postnatal contraceptive counseling increases awareness and knowledge which finally increases the use of contraceptive. Therefore, encouragement should be done to HCP to provide counseling on IPPFP during antenatal and immediately after delivery [CITATION Mee15 \l 1033].

This study found that 102(25.8%), post-delivery mothers were discharged with IPPFP, this signifies that counselling Strategy of providing counselling in several times from RCH to labour ward till time of discharge is of greater importance. This finding is similarly with the findings found in the study done by USAID in four countries in Afghanistan, Honduras, Indonesia and Nigeria on IPPFP: A key component of childbirth care. In this study the strategy of providing contraceptive counseling service as part of child birth care before discharge were used Approximately 20% to 50% of women will be discharged from the facility with FP methods in place. High quality comprehensive counseling will help unmet need for contraceptive to adopt the use of contraceptive methods before discharge, [CITATION USA17 \l 1033].

In Tanzania, a baseline survey was conducted in Northern Tanzania on Postpartum Contraception for Patterns of Use, Relationship to Antenatal Intentions, and Impact of Antenatal Counseling. The study hypothesized that there is high unmet need on contraception and concluded that the Antenatal counseling had an effect on

postpartum contraceptive intentions. Contraceptive service integration models should be tested to determine how and when antenatal counseling can be most effective [CITATION Keo15 \l 1033]. Based on the reasons mentioned above, it signifies that the low coverage of IPPFP in Tanzania is highly associated with lack of awareness which is influenced by poor counseling sessions. This was also found in Ilala.

In Ilala Municipality the health facility delivery is 98% with IPPFP use of less than 10% [CITATION DHI181 \l 1033] . Therefore, as it is presented in chapter four, the analysis has shown a strong relationship between counselling session and IPPFP utilization. The study has further shown strong relationship between setup of counseling sessions and use of IPPFP. In this situation there is greater need for a government to come up with strategies, which can motivate married and unmarried woman, HCPs, community and other stakeholders to be sensitized and use the service. Post-delivery and post abortion mothers have the perceived benefit with the use of IPPFP but yet most of the women are unwilling to use the service. The only way that can help to overcome the problem is to increase counseling and community involvement specifically male involvement so that they are fully involved in the family planning process as they have high influence in decision making to their partners who sometimes fail to use PPFP for the reason of having not discussed with their husband. In doing that it can increase the attendance of male to ANC and increase awareness to male and increase the use of IPPFP.

5.4 Knowledge and information on IPPFP utilization

The study also hypothesized the association between utilization of IPPFP and knowledge and information on IPPFP. The relation of dependent variables to use and non-use was examined using chi-square test; the independent variables related to dependent variables with p-value (≤0.05).This indicates strong association between variables and if a large p-value was (> 0.05), this would indicate a weak or no association between variables [CITATION Mic17 \l 1033].

The study found that the majority of respondents 387(98.0%) had information on FP use, even though those who were discharged with IPPFP were 102(25.8%), This signifies that despite the fact that respondents had information and knowledge, more effort should be done in giving education and involving male since most of the

reason for not using IPPFP was due were pain after delivery, and fear from side effect of the contraceptive methods 239(60.4%), not yet discussed with their spouse 155(39.2%), refusal of spousal/family members were 53(13.4%), delaying to have menstruation 24(6.1%),other reasons were religion beliefs 21(5.3%).These findings are similar with the study conducted in Ghana by Apanga1& Adam (2015) on factors influencing the uptake of family planning services in the Talensi District, Ghana. The study revealed that 89% (249/280) of respondents were aware of family planning services; 18% (50/280) of respondents had used family planning services in the past. Parity and educational level of respondents were positively associated with usage of family planning services (P<0.05). Major motivating factors to the usage of family planning service were to space children, 94% (47/50) and to prevent pregnancy and sexual transmitted infections 84% (42/50). Major reasons for not accessing family planning services were opposition from husbands, 90% (207/230) and misconceptions about family planning 83% (191/230) [CITATION Pas152 \l 1033]. This is observed in PPIUCD program where there is a wrong belief and myth at the level of society that contributes to low utilization of PPIUCD. Most women have no final decision on their health as it is observed at ANC where health education on PPIUCD is done and most of the women agree but finally after delivery do change their ideas with the reason of fear from external or partners and families as well.

The main reasons for refusal by clients who verbally accepted but refused at the time of insertion were family refusal and pain from delivery [CITATION Nee17 \l 1033] .

Kathpalia and Mustafa in their study conducted in India on awareness and factors contributed to low utilization of PPIUCD, they noted that despite of low awareness and lack of knowledge of the clients on IPPFP, timing of insertion, was not clear among clients and some HCPs. Some of HCPs (Medical and Paramedical) were not aware on the time when IPPIUCD were to be inserted [CITATION SKk15 \l 1033]. This findings is similar to this study where in 395 respondents only 161(40.8%), was aware on the timing for IPPFP. This implies that the awereness regarding to PPIUCD is very low which needs more and strong strategy on mass campaign and publicity through different media.

The study is also similar to the study done in South-East Rajasthan by Ashutosh & Gupta (2017), on the awareness of the community and factors affecting acceptance of PPIUCD discovered that most of the womenn who come at hospital lack awareness as it is shown in this study. The respondents in the study by Ashutosh & Gupta (2017) were 18,550 whereby, out of 18,550 were women, only 480 (2.6%) had information on the method and 2.94% accepted [CITATION Ash171 \l 1033]. These results suggest how awereness creation playgreater role in contraception acceptability. Therefore, more empasis must be placed on the promotion of use of IPPFP in the community of Ilala to increase knowledge and information on the use of contraceptive methods in Ilala municipality.

Different reasons have been identified in different studies as a causal factors affecting utilization of IPPFP among post-delivery mothers in different areas of the world. The commonest reasons found in different studies among others can be put into four groups: First, being the method related barrier, second, fertility related barrier, third barrier, is the knowledge on the method used and fourth barrier, is lack of awareness. Other barriers apart from those four groups are Religion beliefs, ignorance on when fetilitybegins after delivery,fear of side effect,and postpartum abstenence, these were the other reasons for not using the service.

In the current study most of those mentioned reasons affect the utilization of IPPFP among post-delivery mothers in different areas of the world are not evident in Ilala municipality. The results show a weak association between utilization of IPPFP and information about family planning method before. The study findings further show weak association between utilization of IPPFP used contraceptive before. This implies that utilization of IPPFP before is not associated with the current use. The study has further shown a weak relationship between out of stock and use of IPPFP uutilization and time when waiting service, utilization of IPPFP and FP service available, utilization of IPPFP and adequate room.

This signifies that provision of effective high quality prenatal and postnatal contraceptive counseling increases awareness and knowledge. This finally increases

the use of contraceptive; reduces unplanned pregnancies, decrease maternal and fetal morbidity and mortality and prevents unsafe abortions compared to other factors. Encouragement need to be done to HCP to provide counseling on IPPFP during antenatal and immediately after delivery. The implementation process of IPPFP in post-delivery mothers and lactating women in Ilala Municipality required a number of issues. One among is provision of knowledge and information on IPPFP

5.5. Availability of resources and its association with IPPFP/ PAFP utilization

Resources are important in the implementation process of IPPFP. Availability of resources such as IUD toolkit, implants toolkit, injectable toolkit, oral contraceptive, condoms, enough health workers and available room are important in the utilization of IPPFP. Resources are directly related to the cost hence it affects utilization of IPPFP among women. Despite the fact that availability of resource is an important factor for IPPFP utilization, the current study has shown weak association between utilization of IPPFP andout of stock, utilization of IPPFP, availability of health care providers, utilization of IPPFP, available space in the hospital, utilization of IPPFP and adequate room. These findings are contrary to the findings by Sultan (2018) in the study on the effects of education, poverty, and resources on family planning in developing countries. Sultan (2018) found that, women in developing countries are struggling for the use of modern contraceptive methods but are lagging behind due to the scarcity of resources. The study recommended the need to make contraceptive methods more accessible and available in resource-scarce countries [CITATION Son18 \l 1033].

Abdulwahab & Ali's (2014) study at Muhimbili National hospital investigated the acceptability and safety of postpartum intrauterine contraceptive device among patients at Muhimbili National Hospital, Tanzania. A total of 3158 clients were involved in the study, and 74%were not aware on the method of PPIUCD [CITATION Ruk12 \l 1033]. This implies that resources are available but there are other factors hindering utilization of IPPFP in Ilala municipality. These factors are putinto four

groups: First,one is a method related barrier, second, fertility related barrier; third, barrier is the knowledge on the method used and; fourth barrier is lack of awareness. Other barriers include religion beliefs, ignorance on when fetility begins after delivery,fear of side effect,and postpartum abstenence; these are the other reasons for not using the service[CITATION Kay18 \l 1033].

The current study is also contrary to the study by Kaydor *et al.* (2018) on barriers to acceptance of postpartum family planning among women in Montserrado County, Liberia. The study found that serious barriers to the utilization of PPFP in Liberia include lack of access and awareness of PPFP, plus myths and misconception [CITATION Kay18 \l 1033]. In the current study resources did not influence IPPFP utilization. Despite the fact that Post-delivery and post abortion mothers have the perceived benefit with the use of IPPFP, yet most of the women are unwilling to use the service. The only way that can help to overcome the problem is to increase counseling and community involvement concerning the use of IPPFP. Different reasons have been identified in different studies as factors affecting response towards utilization of PPFP other than resources availability.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONs

6.1 Introduction

This chapter presents summary, research conclusion, suggestions and recommendation which different people, countries, actors and research consumers should work upon.

6.2 Summary

This study examined the process of IPPFP implementation in post-delivery mothers and lactating women in Ilala Municipality. The study specifically examined the counselling process, knowledge and skills on IPPFP utilizationamong of post-delivery and post abortion mother; and determined the availability of resources for IPPFP methods among post abortion and post-delivery mothers. Evaluation findings are presented as follows.

The study used a cross sectional evaluation design in which data was collected as a snap shot and applied to evaluate Chaguo la Maisha program. The sample size was 395partcipants. Purposive sampling and convenient sampling were used to select women while the qualitative sample consisted of participants who provided detailed and comprehensive information till the researcher met the saturation point. Purposive sampling was used to select these key informants who were health care providers. Primary data was collected through interviews, questionnaire and direct observation, and secondary data were collected through documentary reviews. Qualitative method was used to analyze the in-depth interviews. Questionnaires were analyzed using STATA computer software. Descriptive statistics such as frequencies and percentages were determined and the information was presented in form of tables and figures. Chi-square test was used to hypothesize the association between utilization of IPPFP and counselling session's knowledge and information on IPPFP/ PAFP. The relationship between dependent variables and the use and non-use was examined using chi-square test. The independent variables relate to dependent

variables with p-value (≤0.05). This indicates strong association between variables and if a large p-value (> 0.05) this would indicate a weak or no association between variables.

The study found that there is a strong relationship between use of IPPFP and the counseling session (p-value0.023). Also results indicate strong association between session clearly understood and use of IPPFP (p-value 0.030). The study further has shown strong relationship between setup of counseling sessions and the use of IPPFP (p-value 0.029) however, results show weak association between utilization of IPPFP andheard about family planning Method before p-value shows 0.170. Study findings further show weak association between utilization of IPPFP and counseling session p-value shows 0.140. Weak association was also shown between utilization of IPPFP and used contraceptive before (p-value 0.579). This implies that utilization of IPPFP before is not associate with the current use.

The study findings have shown a weak association between utilization of IPPFP andout of stockwith a p-value 0.360. Study findings have further shown a weak association between utilization of IPPFP and availability of health care providers (p-value 0.953). Weak association was also shown between utilization of IPPFP and used contraceptive space for FP (p-value 0.465), which implies that, the utilization of IPPFP does not depend on the available space in the hospital.

6.3 Conclusion

Information and knowledge are very important aspects for the increase of the utilization of IPPFP program. Information creates understanding among women hence utilization of IPPFP. Adherence to counseling is a key for women utilization of IPPFP. Counseling is important in improving women utilization on IPPFP because when women understand what they are counseled about and what the health personnel has told them they will follow and this will make them attending the clinics regularly to ensure utilization of IPPFP. Male involvement is also key area where should be strengthened in order to increase the IPPFP use, since male plays greater role in decision making for their wives to decide on the use of contraceptive

methods. Adherence to counseling helps women in counting pills; it also helps women in attending clinic as scheduled. This indicates that, systematic monitoring and adherence is a key to the success utilization of IPPFP.

6.4 Recommendations

i. The study recommends that adherence to counseling should be capacitated regularly in line with the changes on how to counsel women. The government should hire more health workers to reduce the gap of insufficiency health care providers in order to provide proper and adequate counseling.

ii. In order to be successful in IPPFP, it is recommended that this IPPFP/PAFP should be increased so as to provide counseling in a wide area of the community.

6.5 Policy Implication

i. The policy implication of this study to Chaguo la Maisha and MoHCDEC informs implementing partners to achieve IPPFP utilization and encourage stronger partnership with, CHW's, HCP's in sensitization of male to be involved in Family planning and other stakeholders.

ii. The findings of this evaluation can remind the government to have rationalized and resourced plan for increasing quality services, improved working environment to providers and IPPFP and ensure large waiting space by for patients has large space.

iii. The policy implication in this study pertaining to gaps in counseling process, MOHCDGEC can review the counseling curriculum and guideline to improve knowledge and technical competence of HCP's.

iv. Fear from side effects that caused by use of FP methods is among the reason for non-user, Therefore, Stakeholders should come up with the strategy of addressing this gap through timely information provision to spousal and effective counseling.

6.6 Limitation of the evaluation

The evaluation process was constrained by finance because the evaluator did not have adequate financial resources.

6.7 Area for further evaluation

Further evaluation can be done on how men involvement contributes to improved utilization of IPPFP.

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APPENDICES

APPENDIX I

INFORMED CONSENT FORM

Dear sir/Madam

I would like to introduce myself to you that, I am Rose M. Ntambuto a student at Mzumbe University. I first thank you for accepting my request to be among the clients who will give needed information in this evaluation study. I am conducting an evaluation research for academic purpose on **"Factors associated with utilization of Immediate Postpartum Family Planning (IPPFP) among post-delivery mothers in Ilala Municipality"** The obtained information will be treated confidential and used for this study only. There are no right or wrong answers, just tick or fill in the blank provided based on how you understand the question according to the instruction given to each question. I would like to remind you not to consult on how to answer questions, since I am interested to know your experience knowledge and your understanding in general on Family Planning as client/HCP who receives/provides services from/at this facility and come up with the findings that will help in increasing the IPPFP utilization. Before we start do you have any question to ask me?

I once again thank you for participating in this study.

KIAMBATISHO CHA II

FOMU YA RUSUSA YA KUHOJIWA

Ndugu,

Awali ya yote ningependa kujitambulisha kwako kuwa mimi ni Rose .M. Ntambuto, mwanafunzi kutoka chuo kikuu cha Mzumbe. Kwanza kabisa nashukuru sana kwa kukubali ombi langu la kuwa mmoja wa wahojiwa watakaonipa taarifa katika tathmini hii ya kitafiti.

Ninafanya tathimini kwa madhumuni ya kitaaluma pekee juu ya "***sababu zinazopelekea matumizi ya huduma ya uzazi wa mpango mara tu baada ya uzazi kwa akina mama waliojifungua"*** katika manispaa ya Ilala.Taarifa zitakazopatikana zitabaki kuwa siri na zitatumika kwa matumzi ya utafiti tu. Katika mahojiano haya hakuna jibu sahihi wala lisilo sahihi. Kinachohitajika ni wewe kuweka alama ya vema (V) au kujaza sehemu zilizoachwa wazi kwa kuzingatia namna unavyoelewa swali kwa mujibu wa maelekezo yanayotolewa kwa kila swali.

Ningependa kukukumbusha kutofanya mashauriano juu ya namna ya kujibu maswali kwani ninachokihitaji ni kujua uzoefu, ujuzi na uelewa wako kwa ujumla juu ya uzazi wa mpango kama mteja/mtoa huduma/mhitaji wa huduma katika kitengo hiki hivyo kupata taarifa zitakazosaidia kuongeza matumizi ya huduma za uzazi wa mpango mara baada ya kujifungua.

Kabla hujaanza kujibu je una swali lolote ungependa kuniuliza?

Kwa mara nyingine nakushukuru kwa ushiriki wako katika tathmini ya tafiti hii.

APPENDIX III

DATA COLLECTION TOOLS

QUESTIONNAIREFOR CLIENTS

TITLE: AN EVALUATION OF IMMEDIATE POSTPARTUM FAMILY PLANNING (IPPFP) UTILIZATION AMONG POST-DELIVERY MOTHERS - A CASE OF ILALA MUNICIPALITY

Instruction: Put a tick in the appropriate answer /fill in the blank

PART A: BACKGROUND INFORMATION

NO	QUESTION	RESPOSPONSE /CODE	ANSWER
1.	Age of the Client	1. 15-24	
		2. 25-34	
		3. 35-44	
		4. 45 and above	
2.	Parity of client	1. First pregnant to third pregnancy	
		2. Fourth and above pregnancy	
3.	Marital status	1. Married	
		2. Unmarried	
4.	Level of Education	1. Not educated, primary and secondary education	

		2. Diploma to PHD	
5.	Religion	1. Christian.	
		2. Moslem.	
6.	Occupation of client	1. Employed	
		2. Unemployed	
7.	Distance from home to health facility	1. Less than five kilometers	
		2. More than five kilometers	

	PART B: KNOWLEDGE AND INFORMATION ON IPPFP/ PAFP		
NO	**QUESTION**	**RESPOSPONSE /CODE**	**ANSWER**
8.	Have you ever heard about family planning Method before	1. Yes	
		2. No	
9.	If your response in Question 8 above is "Yes", where did you get information about IPPFP / PAFP tick in appropriate number. If no go to Qn. No 10	1. Media	
		2. HF by HCP	
		3. Community by CHWs	
		4. Peer group	
		5. Mass campaign	
		6. ICT Materials	
		7. Partner/Family member	
10.	Have you ever used family planning methods before?	1. Yes	
		2. No	
11.	Do you know any family planning contraceptive methods?	1. Yes	
		2. No	
12.	If "Yes" in Question 11, mention them	1. Pills	
		2. Injection	
		3. IUCD	
		4. Implants	
		5. Condom	
		6. Natural	
		7. BTL/Vasectomy	
13.	If the answer in Question 9 above is number 2 or 3. Did you have counselling session	1. Yes	
		2. No	
14.	If in Question 12 above is Yes, who conducted counselling session.	1. HCP	
		2. CHW	
14.	If in Question 13 above is number 1, what was the setup of counselling. And if the answer is "No" go to Question number 20.	1. Individual counselling	
		2. Group counselling	
		3. Both individual and group counselling	
15.	In which section in HF you had counselling (tick applicable)	1. RCH	
		2. During Admission	
		3. During Delivery	
		4. During Discharge	
16.	What did you learn in counselling session you attended? Tick them	1. Types of FP methods available in the HF	
		2. Side effect of each method, and its reversibility.	
		3. Indication and contraindication of each method	
		4. Medical Eligibility Criteria	
		5. Timing for IPPFP/PAFP.	
		6. Prevention of HIV and IPC	
17.	Was the session clearly understood	1.Yes	
		2.No	
18	Have you ever used	1.Yes	

30.	Are Health care provider enough in comparing to clients who are waiting for the service?	1.Yes	
		2.No	
31.	Is the space for FP service available	1.Yes	
		2.No	
32.	If “Yes” in Question 27 above, is the room adequate?	1.Yes	
		2.No	
33.	How many client/clients are saved in one room at some time	1.One client	
		2.More than one client	
34.	Is there any confidentiality?	1.Yes	
		2.No	
35.	Is there enough furniture to accommodate all FP clients?	1.Yes	
		2.No	
36.	Mention any four suggestions / opinions that can increase IPPFP/ PAFP utilization	1.	
		2.	
		3.	
		4.	

APPENDIX IV

DODOSO LA WATEJA

KICHWA: TATHIMINI YA UTOAJI WA HUDUMA YA UZAZI WA MPANGO MARA BAADA YA KUJIFUNGUA /KUHARIBIKA KWA MIMBA(IPPFP/PAFP)-KATIKA HALMASHAURI YA MANISPAA YA ILALA.

Maelekezo: Weka vema katika eneo husika /Jaza katika eneo lililoachwa wazi.

SEHEMU A: TAARIFA ZA MTEJA

NO	SWALI	2 JIBU	TIKI JIBU
1.	Umri wa Mteja	1. 15-24	
		2. 25-34	
		3. 35-44	
		4. 45 na Zaidi	
2.	Umezaa mara ngapi	1.Uzao wa 1-3	
		2.Uzao wa nne na Zaidi	
3.	Hali ya ndoa	1.Ameolewa	
		2.Hajaolewa	
4.	Kiwango cha elimu	1.Hajasoma, darasa la saba hadi kidato cha nne	
		2.Diploma naelimuyajuu	
5.	Dhehebu	1.Mkristo	
		2.Muislam	
6.	Hali ya ajira	1.Ameajiriwa	
		2.Hajaajiriwa	
7.	Umbali kutoka nyumbani hadi kituo cha kutolea huduma	1.Chini ya kilometa 5	
		2.Zaidi ya kilometa 5	
SEHEMU B: UFAHAMU NA TAARIFA JUU YA UTUMIAJI WA UZAZI WA MPANGO MARA BAADA YA KUJIFUNGUA /KUHARIBU MIMBA.			
8	Ulishawahi kusikia habari za uzazi wa	1.Ndiyo	
		2.Hapana	

	mpango		
9.	Kama “Ndiyo”katika swali namba 8 hapo juu, Habari hizo za utumiaji wa uzazi wa mpango mara baada ya kujifungua/kuharibika kwa mimba,ulizipata wapi. (weka vema sehemu ulizopata taarifa) Kama jibuni “Hapana” nenda swali namba 10.	1.Vyombo vyahabari	
		2.Vituo vya kutolea huduma na watoa huduma wa afya (HCP).	
		3.Kwenye jamii na watoa huduma za afya wa jamii(CHW’s)	
		4.Makundi rika	
		5.Kampeni za uhamasishaji	
		6.Vipeperusi na mabango mbalimbali	
		7.Mwenza /mwanafamilia.	
10.	Ulishawahi kutumia uzazi wa mpango	1.Ndiyo	
		2.Hapana	
11.	Unafahamu njia yoyote ya uzazi wa mpango?	1.Ndiyo	
		2.Hapana	
12.	Kama “Ndiyo”katika swali namba 11 weka vema kwenye njia zote za uzazi wa mpango unazofahamu	1.Vidonge	
		2.Sindano	
		3.Kipandikizi	
		4.Kitanzi	
		5.Kondomu	
		6.Njia zaasali	
		7.Kufunga kizazi	
		8	
13.	Kama jibu katika swali namba 9 hapo juu ulipata taarifa kwa mtoa huduma wa kituo cha huduma za afya. Ulipewa elimu ya unasihi juu ya uzazi wa mpango.	1.Ndiyo	
		2.Hapana	

14.	Kama “Ndiyo katika swali la 12 hapo juu nani alitoa elimu ya ushauri nasaha	1.Mtoa huduma wa Afya wa kituo cha kutolea huduma.	
		2.Mtoa huduma ya Afya katika jamii	
15.	Kama katika swali 13 hapo juu jibuni 1, mpangilio ulikuwaje wakati wa utoaji wa ushauri nasaha.	1.Ushauri wa mtu mmoja	
		2.Ushauri wa kundi	
		3.ushauri wa kundi na mtu mmojammoja.	
16.	Katika kitengo kipi ulipata ushauri nasaha	1.Kitengo cha mama,baba na mtoto	
		2.Wakati wa kulazwa ulipo kuwaunakuja,kujifungua.kuharibika mimba	
		3.Wakati wakujifungua/kuharibikamimba	
		4.Wakatiwakuruhusiwakurudinyumbani.	
17.	Ulijifunzaninikatikasomo la ushaurinasaha(wekavemakwaya leuliyojifunza)	1.Njia mbalimbalizilizopozauzaziwampango	
		2.Madharayatokanayonakilanjia.	
		3.Vigezo vyakutumia/kutotumiakwakilanjia	
		4.Sababuzakitaalamzautumiajiwakilanjia.	
		5.Muda wautoajiwauzaziwampangobaadaya kujifungua	
		6.Uzuiajiwamaambukiziyaukimwinautunzajiwa taka (utakasajiwa taka hatarishinazisizoharishi).	
18.	Somolilielewekavizuri	1.Ndiyo	
		2.Hapana	
19	Je UpotayarikutumiauzaziwaMpangobaadayakujifungua? kablahujaruhusiwa	1.Ndiyo	
		2.Hapana	
20	Kama jibuni “Ndiyo” swali la	1.Watoto	

	17, wekavemakwenyesababuzilizofanyauamuekutumiauzaziwampango	wapishaneumrikatiyamtotonamtotomwingine.mudaunaoshauriwakitaalamu(baadayamiakamiwili)	
		2.Hali yauchumisiyonzuri	
		3.Afya yangusiyonzuri	
		4. IdadiyaWatotonilionaoinatosha	
21.	Kama ulikuwatayarikupewahudumaUlipewawakatigani	1.Kabla yakuruhusiwakurudinyumbanibaadayakujifungua	
		2.Siku nyinginebaadayakuruhusiwa	
22	Kama jibukatikaswali la 20 niNamba 2, Sababuganiilisababishausipateuzaziwampangosikuhiyo	1.Wahudumu walikuwawachache	
		2.Nilikuwa namaumivumakali	
		3.Vifaa vilikosekana	
23.	Sababuzipizilifanyausitumienjiazauzaziwampango	1.Mwenzi/nduguzanguwalikataa	
		2.Dini hairuhusu	
		3.Dawa hazikupatikanahospitali	
		4.Watoto hawajatosha	
		5.Naogopa kutumiakutokananamaumivubaadayakujifungua	
		6.Nachelewa kupatasikuzangu,hivyosinasababuyakutumiamarabaadayakujifungua	
24	Kama Swalinamba 13 ulipatahudumakwamtoahudumawaafyakutokakwamhudumuwaafyakatikangaziyajamii, ulipatahudumagani.(wekavema)	1.Uhamasishaji waUtumiajiwauzaziwampango	
		2.Ushauri nasahawautumiajiwauzaziwampango	
		3.Ufuatiliaji wawatejawauzaziwampango	
		4.Rufaa kw ajiliyauzaziwampango	
25	Unafikirinisababuzipizinazosababishawazazibaadayakujifungua / kuharibikakwamimbahawatumii	1.	
		2.	
		3.	

	uzaziwampango.		
Tajasababutatu. **SEHEMU C: UPATIKANAJI WA VIFAA NA HUDUMA YA UZAZI WA MPANGO**			
26.	Uliwahikosahudumayauzaziwa mpangokwanjiauliyotakakutumia?	1.Ndiyo	
		2.Hapana	
27.	Kama "Ndiyo" katikaswalinamba 22 tajanjiazipihukupata.	1.	
		2.	
		3.	
28.	Baadayakukosahizonjiaulichukuauamzigani?	1.Kununua duka la dawa	
		2.Kwenda kituokinginenilipoambiwaniendekupatahuduma(rufaa)	
		3.Sikuwanafedhaniliamuakurudinyumbani.	
29.	Watoahudumawanatosha	1.Ndiyo	
		2.Hapana	
30.	Je unatumia muda gani kupata huduma?	1.Ndani yamasaamawili	
		2.Zaidi ya masaa mawili	
31	Eneo la kutolea huduma ya uzazi wa mpango linatosha	1.Ndiyo	
		2.Hapana	
32.	Chumba kinatosha	1.Ndiyo	
		2.Hapana	
33.	Ni wateja wangapi wanahudumiwa katika chumba kimoja kwa wakati mmoja?	1.Mmoja	
		2.Zaidi ya mmoja	
34.	Je kuna usiri unapohudumiwa?	1.Ndiyo	
		2.Hapana	
35.	Je viti vilivyopo vinawatosha wateja wote mnaosubiri kupata uzazi wa mpango?	1.Ndiyo	
		2.Hapana	
36.	Taja mapendekezo ambayo yanaweza kuongeza utumiaji wa uzazi wa mpango baada ya kujifungua.	1……	
		2……	
		3……	

APPENDIX V

OBSAVATION CHECK LIST

Objectives: To determine accessibility of IPPFP methods in where the service is provided (RCH, Labour ward/ Delivery room, postnatal ward). Also to observe how counselling process is done.

Health Facility name…….

S/N	Item	Present and adequate	Inadequate	Absent	Remark
01	**Availability of medical resources**				
	Contraceptive pills				
	Implants/Jadelle				
	IUCD				
	Condoms				
	Injectable				
02	**Availability of medical supplies and equipment**				
	Gloves				
	IUCD Sets				
	BTL Sets				
	Drums				
	Shelves				
	Coup board				
	Screen				
03	**Availability of trained and skilled staff on PPFP.**				
	Trained personnel in PPFP/PAFP				
	Nurse				
	Clinician				
04	**Counseling Session Point.**	**Yes**	**No**	**Comments/opinion**	
	Is counselling session done at RCH				
	Is counselling session done at				

	during admission			
	Is counselling session done at discharge time.			
	What information is learned in counselling session Tick them	**1.** Types of FP methods available in the HF		
		2. Side effect of each method, Indication, Contraindication and its reversibility.		
		3. Prevention of HIV and IPC		
		4. PPFP availability in the facility, its indication and Medical Eligibility Criteria with timing for IPPFP/PAFP		
		5. FP methods displayed during counselling		
06	**Space**	**Yes**	**No**	**Comments**
	Is the space for PAFP/PPFP available			
	Is the room adequate for FP service			
	Is the room having confidentiality			
	Light(examination)			
	Good ventilation			
	Availability of guideline and procedure manual at the service delivery			
	Availability of posters, leaflets, provider toolkit for PPFP/PAFP			

APPENDIX V

IN-DEPTH INTERVIEW GUIDE FOR STAKEHOLDERS

Informed Consent Form

Dear sir/Madam

I would like to introduce myself to you that, I am Rose M. Ntambuto a student at Mzumbe University. I would like to thank you for giving me your time to talk with me. Iam conducting an evaluation research for academic purpose on **"An Evaluation of Immediate Postpartum Family Planning (IPPFP) utilization among post-delivery and post abortion mothers in Ilala Municipality"** evaluating Chaguo la Maisha Program (CLM). You as stakeholder in CML program I would like to ask you some Questions about your experience as a DRCHCO of Ilala Municipality/ HF I/C or Pharmacist of HF. I am interested in hearing about your experiences, thoughts and recommendations in your own words. If you find a question that youare not comfortable on responding to it feel free to tell me and we can skip them. Before we start do you have any question to ask me?

I once again thank you for participating in this study

Objective Number Two: To evaluate the extent to which knowledge and information on IPPFP is related to utilization of IPPFP among post-delivery mothers in Ilala Municipality.

1. I have not been in Ilala Municipality for some time, can you tell me about CLM program on how it provides knowledge and skills on PPFP/PAFP training to HCP?
2. Are there any criteria used to select participants for PPFP/PAFP training?
3. Do you have regular stakeholders meetings? , Who attends the meeting and what is the importance of that meeting?
4. From the District/Region are there any supervision mentoring and coaching done to HF, and how often?
5. In case, HCP meets any problem when providing PAFT/PPFP service, how do they solve their problem?
6. How data do helps in decision making?
7. How do you address the challenges in data management?

Objective Number Three: To determine how IPPFP/PAFP availability of resources is associated with FP utilization among post-delivery mothers in Ilala Municipality.

1. Can you tell me the availability of resources i.e. human resource, material resource and space for PPFP/PAFT? In your HF
2. What challenges do you encounter when providing PPFP/PAFP?
3. Can you tell me the whole process of medicine, medical supplies and equipment's procurement through CLM program?
4. What are your opinion /suggestions in improving the accessibility of the PPFP/PAFP resources?
5. In what ways do you think availability of resources contribute to low PPFP/PAFP utilization?