ASSESSMENT OF LONG TERM CONTRACEPTIVE UTILIZATION AMONG WOMEN OF REPRODUCTIVE AGE: A CASE OF KIBAHA TOWN COUNCIL

ASSESSMENT OF LONG TERM CONTRACEPTIVE UTILIZATION AMONG WOMEN OF REPRODUCTIVE AGE: A CASE OF KIBAHA TOWN COUNCIL

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A Dissertation Submitted to School of Public Administration and Management (SOPAM) in partial fulfillment of Requirements for the Award of Masters of Science Degree in Health Monitoring and Evaluation (MSc HM&E) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled "***Assessment of Long Term Contraceptive Utilization among women of reproductive age: A case of Kibaha Town Council"*** 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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I, **PhidmanYusuph,** 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

This dissertation is dedicated to all my family members for their moral, encouragement, and financial support during the whole period of this study at Mzumbe University. May God bless them all!

ABBREVIATIONS AND ACRONYMS

BCC	Behavior Change
CHMT	Council Health Management Team
CDC	Centers for Disease Control and Prevention
CHW	Community Health Workers
CPR	Contraceptive Prevalence rate
CYP	couple-year of protection
DC	District Council
DFID	Department for International Development
DHIS	District Health Information Software
DHS	Demographic Health Survey
DMO	District Medical Officer
DRCHCO	District Reproductive and Child Health. Coordinator
FP	Family Planning
HFR	Health Facility Registry
IUCD/IUD	Intra Uterine contraceptive Device
KRA	Key Results Area
LARC	Long Acting Reversible Contraceptive
LGA	Local Government Authority
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NBS	National Bureau of Statistics
OR	Odds Ratio
PITC	Provider-Initiated Testing and Counseling
PO-LARG	President's Office – Regional Administration and Local Government
PSI	Population Services International
RCH	Reproductive and Child Health
RCHMT	Regional Health Management Team
RMO	Regional Medical Officer
TA	Technical Assistance
TC	Town Council

TDHS	Tanzania Demographic Health Survey
TFR	Total Fertility Rate
TOT	Training of Trainers
TWG	Technical Working Group
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
USAID	United State Agency for International Development
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS AND THEIR CONCEPTS

Family Planning:

This is process that makes people to decide on their reproductive goal especially number of children and the time they plan to space for children and sometimes limiting. Basically this can be done by the use of contraceptive methods (WHO, 2019)

Unmet need for Family Planning

This is defined as the percentage of women of reproductive age, either married or in a relation, who are not using any type of contraceptive method but they want to limit or to space for children (program, 2012)

Contraceptive Prevalence Rate (CPR)

Is defined as the percentage of women in reproductive age who are currently using any one modern contraceptive at particular point of time or whose partner is using any contraceptive method at particular point of time, woman can be married or in union (Measure Evaluation,)

Long acting reversible contraceptives are contraceptive methods which the user can take longer period of time to protect against pregnant, there are two types of LARC which are implant and the intra uterine contraceptive device (IUCD). Implants are small flexible rods that release a progestin like the natural hormone progesterone in a woman's body. It is placed just under the skin of the upper arm. After being inserted, they provide pregnancy protection for up to 3 to 5 years depending on the brand. In Tanzania, two brands are used (Anasel, 2017)

Short-term family planning methods includes family planning which containing hormones and non-hormonal. The short acting hormonal methods are the most common contraceptive methods and they are reversible- that is a woman can become pregnant again soon after stopping using the those methods (Anasel, 2017).Non-hormonal contraceptive methods are the male condom, female condom and natural methods (Anasel, 2017).

Permanent methods-The permanent family planning methods are those methods used by woman and man who don't want more children. It involves a surgical

procedure for both women and men, in women the procedure called mini-laparotomy while for men it's called vasectomy (Anasel, 2017)

IUCD – Is a small plastic rod which also contain copper, normally inserted in the uterus which used as a contraceptive to protect a woman from having pregnancy, it also have thread which facilitates the IUCD removal. (Harding, 2017)

Implant – Is a contraceptive device which can have a single rod or two rods containing hormones released slowly to provide protection against pregnancy, single rod normally protect a woman for three years while double rods protect woman for five years, basically the rod(s) are inserted under the skin of the arm (Family Planning, 2019)

ABSTRACT

Family planning is important in the community as it gives an opportunity for the individual to make decision on the number of children they wish to have, but also it prevent unintended pregnancy which lead to abortion especially unsafe abortion. For those women who are using family planning they have a chance to restore their health wellbeing. Economically it's also benefiting the couple as they can make plans of their life depending with the number of children they have or they wish to have.

The study approach was sequential mixed study which involved both quantitative and qualitative. The sample size quantitatively was determined by using Yamane formula and the sample size obtained was 396. On the other part of qualitative, the data were collected until saturation from key informants.

Quantitative data were analysed by assistance of Stata and that the descriptive statistics finding were presented in percentage, charts and tables. Logistic regression used in analysis so as to give out inferential statistics findings, The qualitative data were analysed with the assistance of Atlas ti ,according to the views from the key informant's especially health care providers and DRCHCO, they said education level and living in urban makes women to be aware on LARC services as also they proved that myths and misconceptions on the LARC, religious, availability of the services and husband decision on FP use have been obstacles for the women to use Long Acting Reversible Contraceptive methods.

The study recommends efforts from different stakeholders and the Government to put much emphasis on ensuring that the health education on family planning especially LARC is reaching the community and male involvement it's also a key

Knowledge and awareness is the source of women and the community in large to change their behavior towards the use of long acting Contraceptive methods and avoid them from unwanted pregnancy which could lead to unsafe abortion and death.

Key word: Long Term Contraceptive; Utilization; reproductive age; Kibaha

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CHAPTER ONE

INTRODUCTION

1.1 Background

About 214 million women of reproductive age in developing countries who are in need of avoiding pregnancy are not using modern contraceptive methods, with various reasons such as availability of the methods of choice, accessibility problem especially for poor and young people, fear of the side effects and adverse events, cultural or religious issues, poor quality of services, providers and clients bias, gender based issues etc. Unmet need of family planning methods become high as the population growth. In Africa about 24.2% of women of reproductive age have unmet need for modern family planning methods, In Asia and Latin America and Caribbean- regions with relatively low prevalence with the unmet need 10.2% and 10.7% respectively (WHO, 2017).

Unintended pregnancy globally shows the need for family planning programs. Eighty-five million pregnancies, representing 40 percent of all pregnancies, were unintended in 2012 ,50 percent of all pregnancy lead into abortion, 13 percent miscarriage, and 38 percent ended in unplanned birth (Sedgh, Singh, & Hussain, 2014).

The total fertility rate in Sub-Saharan Africa was 6.8 in the late 1970s and current a little below, modern contraceptive use is also low as only 25% of married women in the region were using a modern contraceptive method in 2015, compared with 58% of global use. Contraceptive use is increasing, however, largely because of rising uptake of the injectable. In 2015, injectable accounted for 45% among of all modern method use in Sub-Saharan Africa, followed by pills which accounted about 22%.Basically injectable can be provided by lower-level paramedical staff, but there is low adherence, high discontinuation and low switching to alternative methods after discontinuation.

The use of family planning methods in Sub-Saharan Africa is the low comparing with the developing world. Modern methods by married women is higher in Latin America (63%), followed by Asia (48% excluding China) and sub-Saharan Africa

18%, According to current data from several countries with Demographic and Health Surveys (DHS), an average 30% of women in sub-Saharan Africa have an unmet need for modern family planning methods. Nineteen of the 31 countries have a reported unmet need for family planning up to 49%. On average, sub-Saharan Africa not seen much decrease in the unmet need for family planning in the last decade, resulted more women (25 million) with an unmet need for family planning than women currently using modern methods (18 million) (Prata, 2009).

The population of Tanzania is around 50 million, with the total fertility rate (TFR) of 5.2 children per woman with rural women having more 2.2 children than urban women in 2015.Total fertility rate in Tanzania contributed by relatively low age at first marriage and low age at first birth among women, Another contributor to high fertility is low contraceptive prevalence rate (CPR)).Current Modern contraceptive use by married women has increased over the last decade from 20% in 2004-05 to 27% in 2010 and 32% in 2015-16. Unmet need for family planning among currently married women has remained between 22% and 24% since 1999 Injectable are the most popular contraceptive, used by 13% of currently married women (NBS, 2016).

The contraceptive prevalence rate (CPR) among currently married women in Tanzania is 38%. Most women who are using contraception are using a modern method (32% of currently married women). Among sexually active unmarried women age 15-29, 54% are using contraception; 46% are using a modern method. In Tanzania Modern contraceptive methods utilization increases with level of education. 36% of married women who completed primary education and 33% of those with more than a secondary education use a modern method compared with 24% of married women with no education. In this context due to the low education level in rural areas it means that most of the women both married and those not married the use of modern contraceptive methods is low. Furthermore Modern contraceptive methods use in Tanzania tends to increase with the level of income from 20% among married women in the lowest income to 40% among those with middle income, and 35% among women in the highest income level (NBS, 2016).

1.2 Statement of the Problem

With the data of 2018, shows that a total of 1678392 Implants and IUCD had been utilized by the country where by 1357415 were Implants and 320977 were IUCD,

while at Kibaha TC the total amount of LARC methods utilized in 2018 was 7604, Implants inserted were 6134 while IUCD were 1470 with population of Women of Reproductive age at the district being 87116 which is almost 8.7% of the population of the women of reproductive age (DHIS2).

In order to motivate women to use family planning especially LARC, the Government has imposed no fees for the users and among the strategy in one plan phase II is to ensure the regular supply of the family planning commodities, also several partners are working closely with the Government so as to ensure LARC services and other contraceptives are being available at the facilities.

But having a wide range of contraceptives methods within a basket of choices in Tanzania does not guarantee the use rate as the rate observed to be 32% among the women of reproductive age (15-49 years), with the adolescents the rate is only 13.3%, as the results there is an increase in unwanted pregnancy as well as abortions, 27% of the women of reproductive age (15-49) have begun childbearing, 21% had already given birth, with additional 6% having first pregnant (NBS, 2016).

With high discontinuation of short acting contraceptive methods such as Pills (34%), injectable and Withdrawal (32% each), and male condoms (28%) (NBS, 2016), there is a need to motivate women of reproductive age to use long acting reversible contraceptive methods. Tanzania Contraceptive Prevalence Rate (CPR) is 27% while the Government through the Ministry of Health committed to achieve 45% by 2020 (MoHCDGEC, 2016) with support from other partners and stakeholders. The utilization at Kibaha TC for LARC is only 7604 women comparing with the population which is 87116 is still low.

1.3 Broad Goal of the Study

The study was set to assess the utilization of long term contraceptive among women of reproductive age at Kibaha Town Council.

1.3.1 Specific Objectives

i. To examine community awareness on Long Term Contraceptive services
ii. To explore the accessibility of Long Term Contraceptive services.

iii. To examine how the Social-Cultural issues affect the utilization of Long Term Contraceptive services at Kibaha TC?
iv. To determine how demographic factors, affect long term contraceptive utilization

1.3.2 Evaluation Questions

i. How does community awareness contributed to improve long term contraceptives services?
ii. What is the contribution of accessibility on utilization of Long Term Contraceptive services?
iii. How does the social-cultural issue affect utilization of long term contraceptive at Kibaha TC?
iv. How do demographic factors affect long term contraceptive utilization?

1.4 Significance of the Study

The provision of long acting family planning services is the intervention which aimed to provide the women of reproductive age the opportunity to space between children and to limit, so as to manage their health status and to ensure the wellbeing of the mother is being in good health. Most of the women who had unintended pregnancies they end up in terminating them whereby among them they use unsafe ways of terminating pregnancies leading them to maternal complications, disability and even death.

However, the project intention of reaching its desired results is not yet achieved, as this study will provides more information which will help to cover an existing gap within MOHCDGEC and supporting different stake holders to have established information so as to understand about conducting and implementing the similar kind of the project.

Academically, the study will be conducted to fulfill the requirements of the evaluation research for the completion of the master's degree of science in health monitoring and research.

CHAPTER TWO

DESCRIPTION OF THE PROGRAM TO BE EVALUATED

2.1 Introduction

In order to reduce maternal mortality rate, the Government of Tanzania prioritized to increase contraceptive prevalence rate (CPR) among the women of reproductive age (15-49) years. Although there is an increase in contraceptive prevalence rate in different periods from 6.6% in 1992 to 13.3% in 1999 (MoHCDGEC, 2016), but still there is a lot the Government is doing to ensure the quality and sustainability of modern contraceptive services are being available.

This evaluation had been done from the document stipulating the National Road Map Strategic Plan to improve reproductive, maternal, newborn, child and adolescent health in Tanzania (2016 – 2020) (One Plan II).

With efforts done by the Government to improve the CPR in collaboration with stakeholders, but still CPR differed by residency, by zone, by region, by education and by wealth, Women from rural areas, non-educated, poor and living in Western or Lake Zones, in particular have comparatively lower CPR (NBS, 2010)With the difference in socioeconomic and Geographical location which impact on CPR and the documented limited availability of long term contraceptive, there is need to increase efforts on demand generation in order to improve access to a full range of FP services (MoHCDGEC, 2016).

Eighty percent of 6734 health facilities with RCH services were offering family planning services in 2011, whereby in 2012 this proportion had been increased to 85%, and to 93.9% in 2014 out of the 5820 health facilities were providing RCH services (MoHCDGEC, 2016). The situation has affected the women to have a range of choice as it reflected in community as the results from the survey shows that only 0.6% of women use IUCD and 2% use implants (NBS, 2010)

Table 0: Indicators and targets for Performance Management of Health Facilities

SN	Indicators	Baseline Value	Targets by 2020
1	Modern methods CPR	27 %	45 %
2	Number of clients receiving modern FP methods	2.6 million	4,2 million
3	Proportion of modern FP methods clients reached through outreach service	15.2 %	30 %
4	Couple Year Protection for all modern methods (CYP)	4.3 million	6.4 million
5	Increase male involvement on HIV testing during PITC interventions	8 %	30 %

Source: (MoHCDGEC, 2016)

My evaluation study focused on the first indicator, which was about assessing the utilization of long acting reversible contraceptive. Under the first indicator above I will also assess the community awareness on LARC (how they know or they get information on the FP). Another area which will be assessed is accessibility of LARC services, how myths and misconceptions affect the LARC utilization and Demographic- Social cultural issues how it affects LARC utilization.

2.2 Program stakeholders

Stakeholder's analysis is an important aspect as it helps to identify individuals, group or organizations with an interest in long acting reversible contraceptive and FP in general program. MoHCDGEC is the owner and designer of the program and main role is the coordination of overall implementation of family planning services and the Department of Reproductive Child Health (RCH) is one assigned to coordinate all the activities of this program.

Presidents' Office-Regional Administration Local Government (PO-RALG) oversees the implementation of FP Plan. Also, ensure accountability to R/CHMTs in day-to-day implementation of the program. Other stakeholders are R/CHMTs, Development Partners, Implementing Partners; and facility in charges, RCH healthcare workers and program beneficiaries. The roles and functions for each stakeholder are summarized in the table 2.

Table 2.2: Stakeholders Analysis Matrix

S/N	List of Stakeholders	Role of the stakeholders in the program and evaluation	Interest in utilization of evaluation findings	Means of communication	Level of Importance H, M, L
1	**MoHCD GEC-RCH Section**	- Project owners - Coordinating all activities on FP - Provide guidelines, strategic plans - Training of National and LGA Trainers (TOT)	- Knowing the gap in the implementation of FP services - Use of the evaluation findings to improve the program	- Formal Reports - Emails - RMOs and DMOs meetings	High
2	**RHMT**	- To support and supervise CHMTs in performing its duties in implementation of FP services - To report about FP services to the higher levels.	- To identify the gaps for FP services in their region - To use findings to improve the supportive supervision	- Formal Reports - Briefing with RMO and RHMTs - Meetings	High
3	**CHMT**	- To supervise all Health facilities - To report on quarterly basis to RHMTs and other authorities - Budgeting for supportive supervision	- To use the finding to improve the status of FP services in their councils	- Formal Reports - Meetings	High
4	**Facility In charges**	- Supervise the RCH health care providers on daily activities	- To use the findings in improving the quality of	- Meetings	High

		- Report progress of FP services to CHMTs on monthly basis.	services at their facilities		
5	**RCH Health Care Providers**	- Implementation of FP services on daily bases	- To use the findings in improving the quality of services at their facilities	- Meetings	High
6	**Implementing Partners (i.e.PSI, Marie Stopes, Engender Health, Pathfinder, UMATI etc.)**	- Support the Ministry in terms of financial and TA on implementation of program - Supporting the Ministry by offering FP services in private health facilities as well in outreach	- Findings will help to know the status of implementation and to see if there is value for money	- Formal Reports - PowerPoint Presentations - Technical Working Groups (TWG) Meetings	Medium
7	**Development Partners (Donors-DFID, CDC, KFW, USAID, Bill and Melinda Gates etc.)**	- Financial support to the Ministry and implementing partners	- Findings will help to know the status of implementation and to see if there is value for money	- Formal Reports - PowerPoint Presentations - Technical Working Groups (TWG) Meetings	High
8	**Clients/Beneficiaries**	- Receiving the services	- Improved service leading to client satisfaction	- Community Meetings	Low

Source: Researcher (2019)

2.2.1 Expected Program Objectives

2.2.2 Broad objective

By 2020, the Government of Tanzania in collaboration with its partners and the private sector will increase the availability and accessibility of modern contraceptive methods at all levels of its health system.

2.2.3 Specific Objectives

1. Increasing family planning demand and support
2. Overcoming family planning barriers through innovative approach

2.3 Major strategies

Basically the program has four main strategies but for the purpose of this study, the main focus will be on one strategy below, which is:

Implementation of a country-wide FP campaign and engagement of the mass media at national and sub-national level in the family planning special event days.

Awareness among the community members is an important aspect as whatever the Ministry will do good but without the community being aware there will be no sense, so this is another strategy that the Ministry use to reach the women of reproductive age and the rest of the community to ensure the community understand the importance of FP and they use the services.

Awareness is the source of knowledge which could play a major role in clarifying some difficulties arising social cultural issues from using contraceptive especially Long Acting Reversible Contraceptive as the community will have enough knowledge which will help them to ignore myths and misconceptions they had on the use of LARC.

2.4 Program activities and resources

The program has seven key results areas with its activities; however, for the purpose of this study only two Key results areas were taken which were KRA 5 and KRA 6 with its activities.

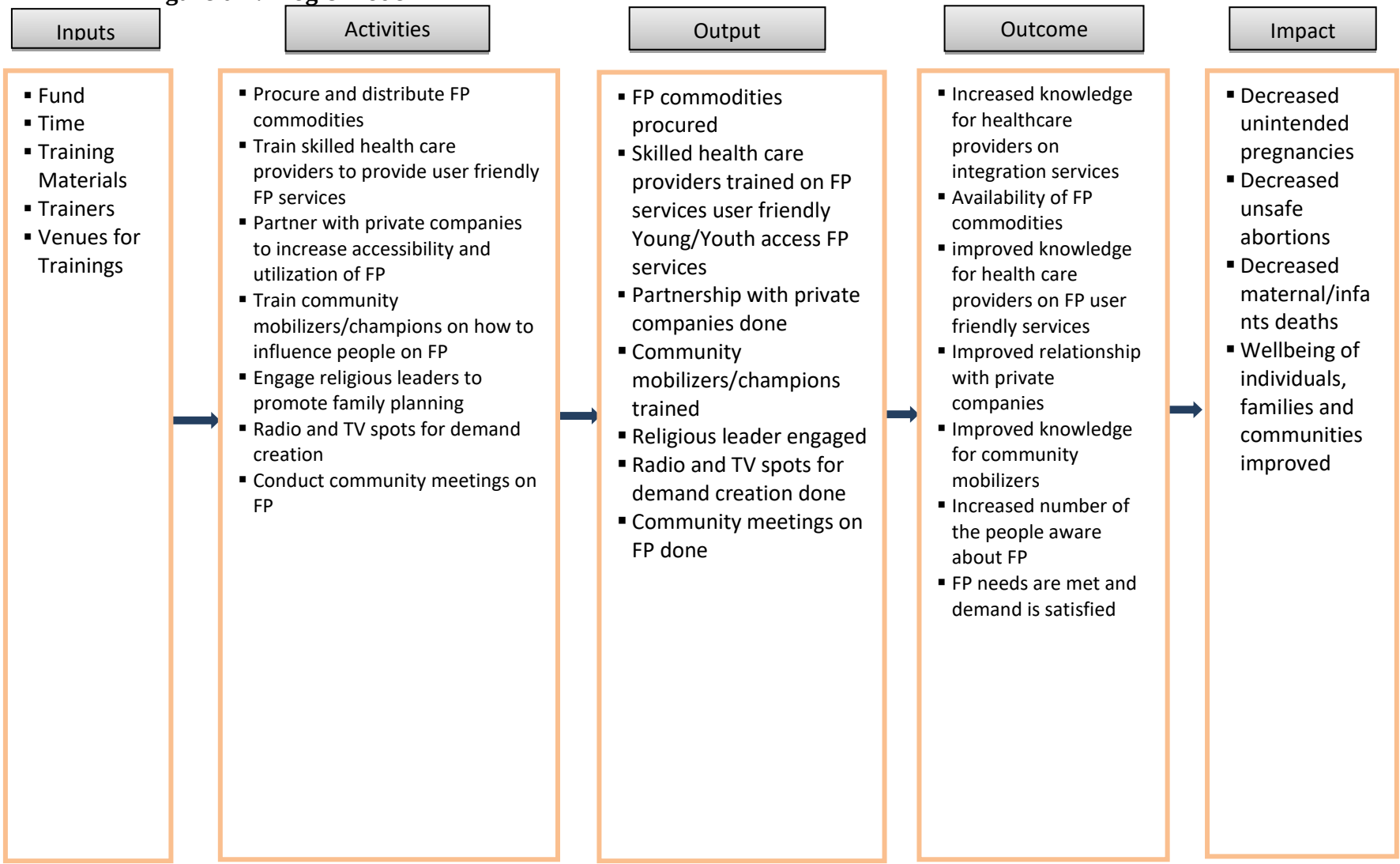
KRA 5: Contraceptive coverage at community level improved by 2020

- Activity 5.1: Train CHW to increase scope of FP service provision at community level.
- Activity 5.2: Train community mobilizers/champions on how to influence people on FP
- Activity 5.3: Engage religious leaders to promote family planning

KRA 6: Demand for FP improved by 2020

- Activity 6.1: Hold annual FP Day across the country
- Activity 6.2: Radio and TV spots for demand creation

Figure 0-1: Logic Model



Source: Researcher 2019

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

This chapter deals with literature review focused on the context which had been studied. The literature review helped in various ways to identify gaps within the study area or project. Literature review focused on the utilization of the long acting contraceptive methods in both urban and rural areas, in such a way that the evaluation study will be looking what other researchers did the same study to get a wide knowledge about the study.

3.2 Theoretical Literature Review

In theoretical literature, it focused on the concepts and theories, which are relating to the area of the study.

3.2.1 Health promotion from the perspective of social cognitive theory

As the technology and science advanced the health sector which is important had been promoted as the public health professionals focused on preventive measures of the diseases and other health problems facing the community. Instead of making people to scare with the side effects or any bad outcomes of preventive measures such as provision of contraceptives methods, the cognitive theory basically rewarding the community and health workers into health, to equip them with skills, and knowledge but for the community to promote behavior change among them so as they can utilize the health services including the family planning services. Social cognitive theory addresses the socio structural determinants of health as well as the personal determinants health promotion and disease prevention from the perspective of social cognitive theory. The approach should basically focus on promotion, which would need to change the social system of practice that caused the effects in health rather than changing the behavior of an individual (Bandura, 2004)

3.3 Empirical Literature Review

Globally, 61% of all women in who are married or in relationship which is around 635 million used at least one of the family planning method in 2003 with the data in developing countries shows the preference based on oral contraceptives pills (16%), female or male sterilization (15%) and condoms (13%), as for long acting reversible contraceptive methods were not much preferred which were only(9%) used the methods (Mavranezouli, 2008).Based on the literature review different issues discussed which affects the Long Acting Reversible Contraceptive utilization.

3.3.1 Community awareness

Long acting family planning methods regarded as the most effective contraceptive methods among all compared with the short term family planning methods. With the data showing that long term family planning methods has lower failure rate which is less than 1% than other methods such as pills 8% and condoms 15%. The use of IUCDS is low in United Kingdom as well as in United states of American though they have high unintended pregnancy, which forced government in United Kingdom to increase awareness and use of long term family planning methods especially intra uterine devices LARC (Myat, Arrowsmith, Majeed, Lee, & Saxena, 2014)

The study conducted in Nigeria among rural women of Nsukka local Government, revealed that many of the people living in rural areas are not knowledgeable about the advantages of the family planning, as they feel that the family planning programs are not brought on board for their use which cause them not to participate, data of the study showed that younger women (55.2%) were more knowledgeable about family planning while the older women were (44.2%). The issue of religious also played a role in adoption of family planning methods in the area (Ndubisi, 2014).

The Study conducted in Bangladesh, the Use of long term and permanent contraceptive methods among women of reproductive age increasing contributed with higher level of education, awareness, social and economic issues. An important aspect of education which is communication activities motivates the women to adopt long term and permanent contraceptive methods (Nasir Uddin, 2013)

Another study conducted in south Africa on the knowledge, attitude and practice of IUD users, only 25% of the participants had heard about IUD, however less than 2% had been used it (Gutin, Mlobelib, Mossc, Bugad, & Morroni, 2011). In the study conducted in Kenya shows that the probability of using long term methods in urban is higher than in rural as the community in urban got the advantage of the family planning media messages (Curtis, 2003).

Women understand the importance of using family planning contraception but agreed that it more risk. Pills and condoms were more knowledgeable and acceptable. Women were not well informed about long acting family planning contraceptives, they also had incorrect beliefs about and side effects had rather a low opinion of advice given by health care providers. Correct information was not much successful in clearing negative views on LARC (Glasier, Scorer, & Bigrigg, 2008).

With many of the benefits of using Long acting family planning methods, but the utilization is still less. These methods may not be used like other short term family planning methods with some reasons such as: women's misperceptions and misinformation about the methods (Gemzell-Danielsson, Blumenthal, & Voedisch, 2011).

3.3.2 Distance from the Health facilities

According to the study conducted in Karatu by (Nderingo, 2013) distance from the health facility where modern contraceptive methods are found with professional to provide advice, is one of the barriers for the women of reproductive age to access contraceptive. The study conducted in Kenya detailed that short distance to the health facilities reduce travel time and cost to the client as the results the accessibility will be high as she gone far by saying that FP is not a serious illness so if the services are provided far from the clients residents it possible that they can't leave other economic activities and travel for FP services (Agesa, 2016).

Another study conducted in Kenya also revealed that those women of reproductive age living in less than 5km from health facilities were 26% more likely to use modern contraceptive method in comparison with those living more than 5km from

the health facilities (Ettarh & Kyobutungi, 2012). The study done in Ghana shows that those women living within 5km from the health facilities were 3.63 times more likely using modern contraceptives compared to those living 5km away from the health facilities (Eliason, Awoonor-Williams, Eliason, Novignon, Nonvignon, & Aikins, 2014).

3.3.3 Availability of Long Acting Reversible Contraceptive Commodities

In order for the women of reproductive age to access and even use the contraceptives there should be a consistent supply chain of contraceptives throughout. Maintaining supply chain management will also enable the clients to get the services and continues with other economic activities rather than coming back to the health facilities of which in other way round it is a cost for them, However in many African countries settings the problem of maintain supply chain for contraceptives had been observed, as the study from Mathere in Nairobi county shows that women wasting much of their time waiting for their preferred modern contraceptives which were not available (Keesara, Juma, & Harper, 2015), the study conducted in Tanzania show that supply chain management of modern family planning is still facing a major challenge of which need considerable improvement in order to improve the accessibility of the modern family planning commodities by the community (Kahabuka, 2014).

According to the study conducted by (Tessema, Gomersall, & Mahmood, 2016) it shows that privacy and confidentiality for client from other clients and parents were factor for quality of care in family planning and it affects the accessibility of it. The issue of privacy and confidentiality had been stipulated well by WHO as they need to be exercised by the providers especially by not subjecting the client with any interference during service provision and also the providers should keep secret of their clients, by doing so these clients will be willing to attend the family planning services which would lead to improve on accessibility of the contraceptives services (WHO, 2014).

According to WHO, the unmet need for family planning commodities is still high as it contributed by shortage of family planning services, as in Africa it account 24.2%

of women of reproductive age have unmet need for modern contraceptive (WHO, 2018).

3.3.4 Myths and Misconceptions

According to the study conducted in Jinka and Butajira town of Ethiopia documented that husband disapproval, considering children as assets, fear of sterility, lack of knowledge, and religion disapproval and fear of several side effects such as heavy period, slipping out during heavy work in the case of IUCD (Mekonnen, Enquselassie, Tesfaye, & Semahegn, 2014). The study done in Egypt showed that nearly 40% of married women do not believe in practicing contraception especially Long acting reversible contraceptive, as more than half believe that family size should be left up to God (Holly Ratharuth, 2006).

Major obstacles to modern family planning contraceptive use among young women are myths and misconceptions. Social network approval has influence on the use of family planning, beyond the individual's beliefs. In this way, family planning programme should engage the community through mass and peer campaign strategies to promote family planning use, example, Population Services Kenya developed a mass media campaign to address key myths and misconceptions among youth (Ochako, et al., 2015).

The study conducted in South Africa shows that, some women where having myths and misconceptions on IUD such as the device might move to other place of the body, IUD might perforate the uterus and the issue of unspecified side effects (Gutin, Mlobelib, Mossc, Bugad, & Morroni, 2011). The study conducted in El Salvador reveal that the major reason for negativity on IUD among women was fear originated from the rumors and myths, cancer, baby will be born with IUD in its body, and IUD can lost in the body (Karen R. Katz, 2002). Another study conducted in Rawalpindi Pakistan showed that women of the reproductive age are reluctant to use IUCD's because of the myths and misconceptions (Shaikh, 2013).

3.3.5 Social, Demographic and Cultural Issues

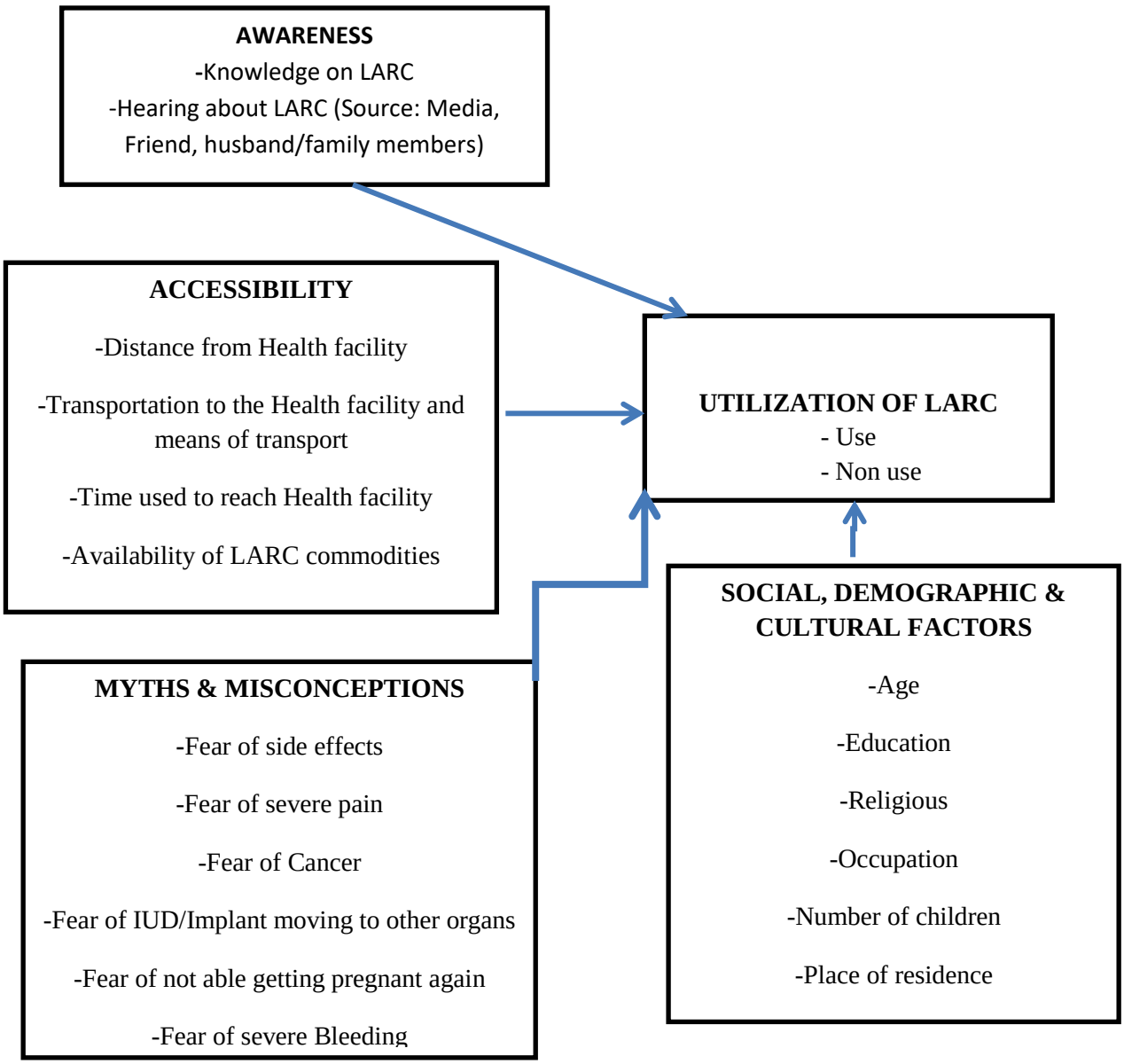
According (Mosha, Ruben, & Kakoko, 2013)in developing countries the use of family planning contraceptive methods is low in which male dominated culture and decision within the family. Basically the study explored family planning (FP) decisions, perceptions and gender dynamics among couples in Mwanza region of Tanzania. Creation community awareness in Family Planning programs and couples' involvement aimed at promoting family planning use.

In the study conducted in Nigeria on different social demographic factors against the knowledge on long acting reversible contraceptive shows that women with secondary school education were 2.64 times more likely to use LARC than those who don't have education, while those women with higher education were 3.30 times more likely to use LARC than those who don't have education, on marital status, the results show that married women were 4.61 times more likely to use LARC than those unmarried women, another aspect was age as women with the age between 25 and 34 years were 1.67 times more likely to use LARC than those with the age ranges from 15–24 years, while those women with the age of 35 years and above were 1.73 times more likely to use LARC methods than those with the age group ranges from 15–24 years, also the number of children was vital in the study as it shows that women with 1–4 children at the time of contraceptive use were 4.28 times more likely to use LARC than those women with no child, moreover those women with more than 4 children were 6.08 times more likely to use LARC than women with no child. Also, women who heard about contraceptive at health facility were 1.38 times more likely to use LARC than those that heard it somewhere else (Olagunju, 2019).

With the view from (JG. Schenker and V Rabenou, 1993), shows that Catholics and other Fundamental Protestants perceive sexual activity as solely meant for procreation and the use of family planning is against God's purpose of sex. The same applied to Muslim as they believe only God is the one who can determine the number of children.

(Haider & Sharma, 2013). Review assessed barriers on the contraceptive use among women in sub Saharan Africa, with the study conducted between January 2010 and July 2012 found that cultural and societal pressure on women, socioeconomic factor, financial issue and lack of access to services are among the barriers causing low use of family planning contraceptive methods among the women in sub Saharan Africa.

Figure 2-1: Conceptual Framework



Source: Researcher 2019

CHAPTER FOUR

EVALUATION METHODS

4.1 Introduction

This section covered the details of the study area, study design, target population, sample frame, sample size determination, sampling technique, and tools for data collection as well as ethical consideration issue.

4.2 Study area

The study was conducted at Kibaha TC in Pwani Region on the assessment of long acting reversible contraceptive utilization among women of reproductive age. The study included users and non-users of FP both short term and long term, healthcare providers, decision makers from each level of healthcare delivery starting from facility and then Council.

Pwani region is among 26 regions in Tanzania mainland with a population of 1,098,668 people according2012 population and housing census (NBS, 2013). The region is bordered to the north by the Tanga Region, to the east by Dares Salaam region and the Indian Ocean, to the south by Lindi region, and to the west by Morogoro region. The region has 9 administrative councils namely; Kibaha TC, Kibaha DC, Mkuranga DC, Chalinze DC, Bagamoyo DC, Kisarawe DC, Kibiti DC, Mafia DC and Rifiji DC. According to Health Facility Registry (HFR), the region has a total of 360 health facilities (MoHCDGEC-HFR, 2018), which includes primary healthcare facilities (dispensaries, health centers, and hospitals at council level), stand alone and super specialized clinics and a regional referral hospital.

Kibaha TC is among 9 Councils in the region and is the headquarters of the region. According to 2012 population and housing census population the council had a population of 128,488 (NBS, 2013). The council is bordered to the North and West by Kibaha DC, to the east by Dar es Salaam region, and to the South by Kisarawe DC.

According to (MoHCDGEC, 2018) assessment on star rating, Kibaha TC has a total of 34 health facilities of which among those 6 are health canters while 28 are dispensaries. Current at Kibaha TC the total amount of LARC methods utilized in 2018 was 7604, Implants inserted were 6134 while IUCD were 1470 with population of Women of Reproductive age at the district being 87116 (DHIS2).

4.3 Evaluation Period

This evaluation study started from November 2018 to June 2019 for proposal development and data collection followed by data analysis.

4.4 Study Design

A descriptive cross sectional study design employed in this evaluation. Cross-sectional study includes the description and analysis of a single group, person, process or system or any other entity at one particular point in time and in great detail. The objective is to determine how the objective of study works and to identify the factors or dynamics that leads to success or failure (Yin, 2013).

The study employed sequential mixed, where by quantitatively it was looking the relationships between independent and dependent variables while qualitatively the goal was to generate the understanding on why the utilization of long acting family planning affected by other factors beyond the ones known.

4.5 Evaluation approach

This study is a process evaluation hence the implementation of the program is still in the progress, as it focused on assessing long acting reversible contraceptive utilization especially those factors affecting the utilization.

4.6 Study Variables

In order to fulfill the objectives of this study, variables were set in order to cover all the study objectives. Dependent variable of this study is utilization of which underneath it involves users and non- users, while the independent variable of this study are: Awareness which involves knowledge on LARC, hearing about LARC

with its source of information, Accessibility is another study variable which include distance from health facility, transportation cost to the health facilities, means of transport and availability of the LARC, Myths and misconceptions includes fear of side effects, fear of pain, fear of cancer etc. while social demographic and cultural variable included age, education level, religious, occupation, number of children and place of resident.

4.7 Evaluation Framework

4.7.1 Target Population and unit analysis

All women who are living at Kibaha TC district formed a target population. The study also targeted health care providers in health facility level but also involved DRCHCO in the district level. The main reason to include health care providers and DRCHCO in this study was to get their inputs which were triangulated with information from the women as the health care providers and DRCHCO are the ones having major roles to play in all issues of modern family planning within the district.

4.7.2 Sample Frame

All women of the reproductive age living at Kibaha TC district from 15-49 years, the reason of choosing this group of women was simply because the group is having potential clients of utilizing modern contraceptive including short term and long term within the district.

4.7.3 Sample Size Determination for Quantitative

The appropriate sample size for a population was determined by using Yamane formula in which some important aspects was considered, below is the formula as the population known, the formula was suitable as other parameters considered.

$$n = \frac{N}{1 + N(e)^2}$$

n= 45844/1+45844$(0.05)^2$

n=396

n- Required sample size

N- Population under study

e- Margin of error =5%

So, the sample size for this study was 396 women aged between 15-49 years old, convenient sampling procedure employed quantitatively to recruit women who then responded to the study questionnaires. Therefore, women found in health facilities by research team are the ones selected for the study.

4.7.4 Sample Size Determination for Qualitative

The sample of the study was purposively determined until the saturation reached (Vasileiou, Barnett, Thorpe, & Young, 2018). Data collected from the healthcare providers and DRCHCO until all necessary information obtained.

4.8 Sampling Techniques

4.8.1 Sampling Technique for the Health facilities

Different sampling techniques used in selection of the Health facilities involved in the study as simple random sampling employed excluding the health Centre which was selected purposively. Four health facilities selected for data collection which were Mkoani Health Centre, Kongowe Dispensary, Galagaza dispensary and Mwendapole Dispensary.

4.8.2 Sampling Technique for the Qualitative Method

For qualitative study non-probability purposive sampling technique used after identified the key informants who provided the information for the study.

4.9 Inclusion and Exclusion Criteria

4.9.1 Inclusion Criteria

- Women with the age from 15-49 years who had been living at Kibaha TC for more than 6 months' period.

- Health care providers who were working at RCH clinic and DRCHCO who is working in Kibaha TC.

4.9.2 Exclusion Criteria

- Women who used emergency contraception & permanent method were excluded from the study.
- Health care providers who are not working at RCH were excluded from the study

4.10 Development of Data Collection Tools

4.10.1 Methods of Data Collection

Data for the study were collected by using structured questionnaires quantitatively and in-depth interview for qualitative part.

4.10.2 Questionnaires

For quantitative data collection, questionnaires administered to the participants but as the level of literacy at Kibaha TC is low, the research team helped the respondents to fill the questionnaires through face to face interview, doing so it increased the response rate (Fowler, 2009). Data collected from the Health facilities through the questionnaires and basically convenient sampling technique used as those women found at RCH clinic are the ones involved for the study.

4.10.3 In Depth Interview

In-depth interview employed for collecting qualitative data from key informants such as DRCHCO and RCH health care providers. Four Health care Providers and one DRCHCO were included in data collection, data were collected through audio tape and took an average of 60 minutes per interview. Generally, eight interviews conducted.

4.11 Pre-testing the Research Instrument

In order to ensure the reliability and validity of the instrument before collecting data, questionnaires were tested in similar situation of which the research conducted. Pretest conducted at Mtakuja Dispensary because the place had similar situation with the study area especially those women shares common characteristics.

4.12 Data Processing and Analysis

4.12.1 Data Analysis for the Quantitative Method

At the end of the interview, all filled forms of questionnaires were checked for completeness, followed by entering, cleaning and then analyzed through the assistance of Stata version 13 of which descriptive and inferential analysis conducted

Descriptive findings such as frequencies and percentages presented in the form of the tables and charts, for inferential analysis, Logistic regressions used to explain the relationship between one dependent binary variable and one or more independent variables.

Moreover, with the current situation of long acting reversible contraceptive use is a categorical variable, with two classifications: use and non-use, logistic regression models used to analyze the possible associations with the independent variables.

4.12.2 Data Analysis for the Qualitative Method

Qualitative data analysis presented in the form of narrative where by all the information from in-depth interviews captured, the transcribed data analyzed after being coded and reduced, Atlas ti7 used to assist in analyzing the transcribed data in which emerging themes and patterns were deductively captured, however all predetermined themes and patterns were coded inductively. Descriptive report created through all codes, Quotations, memos and families then transferred through word document. Data quality was done as reading and re-reading was done, Data quality can be achieved only and only if careful and repeated reading done (Anasel, 2017).

4.13 Ethical Consideration, Confidentiality and Privacy

The ethical consideration obtained from Mzumbe University, Pwani Regional Medical office, Kibaha TC District Medical Office as well as all the offices of facilities health in charge. During data collection, the respondents were given information about the study and were assured that all the information will be confidential. Verbal consent was obtained from individual participant who agreed to participate in the study.

Confidentiality and Privacy maintained by interviewed respondents in separate rooms and places a bit away from the mass.

CHAPTER FIVE

PRESENTATION OF THE FINDINGS

5.1 Introduction

This chapter present the results of the study based on the study objectives, as the broad objective of the study was to assess the utilization of long acting reversible contraceptives among women of reproductive age, as the study used different instrument for data collection during the study such as questionnaires and in depth interview guide from 401 women of reproductive age between 15-49 years old, health care providers and DRCHCO. The findings provided was based upon the study variables which were accessibility, myths and misconceptions and social, demographic and cultural factors which are independent variables while dependent variable was utilization which included users and non- users.

5.2 Social, Demographic & Cultural Characteristics of the Respondents

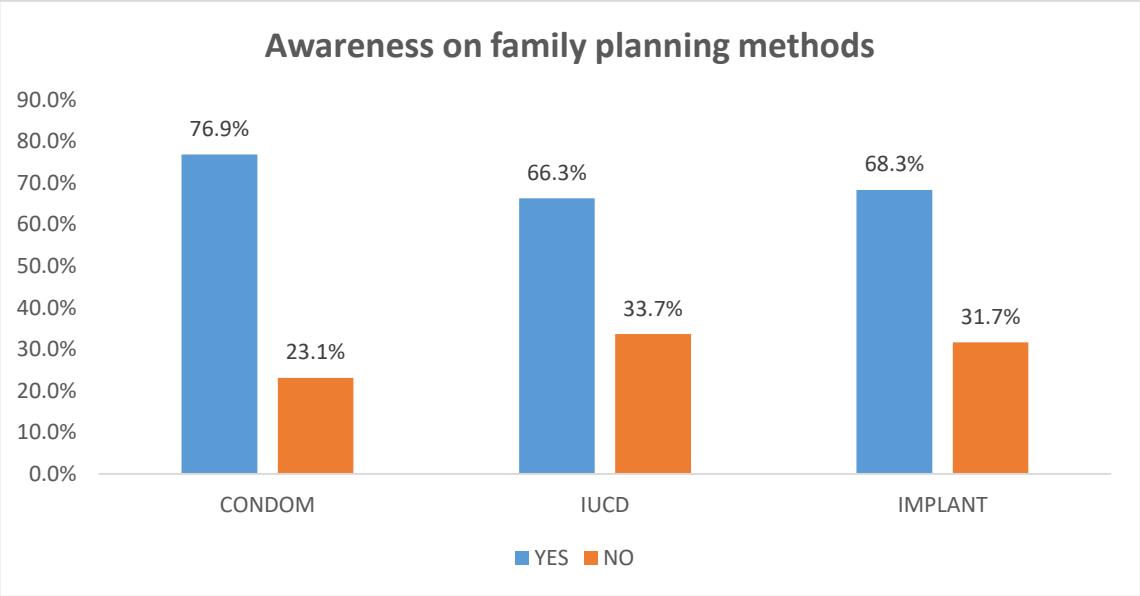
Among the respondents were 42% (169) with the ageless or equal to 25 years old while those respondents with the age above 25 were 57%(232), concerning marital status of the respondents 76% of the respondents women were married while 23% of respondents are single, on the issue of religious data shows that 42% of the respondents are Christian and 57% of the respondents are Muslim, while the education level of the respondents were 47% for those who end up at primary school level, 32% end up at secondary school level and 19% managed college and higher educational level. Majority of the respondents were not employed as it accounts about two third of the respondents which is 74% while 25% of the respondents were employed.

Table 5.1 Social, Demographic & Cultural Characteristics of the Respondents

Characteristics	Categories	Frequencies	Percentage
Age	>=25 years old	169	42.14%
	<25 years old	232	57.86%
Marital status	Married	305	76.06%
	Single	96	23.94%
Religious	Christian	171	42.64%
	Muslim	230	57.36%
Education level	Primary education	192	47.88%
	Secondary education	131	32.67%
	College and higher education	78	19.45%
Occupational	Employed	103	25.69%
	Unemployed	298	74.31%

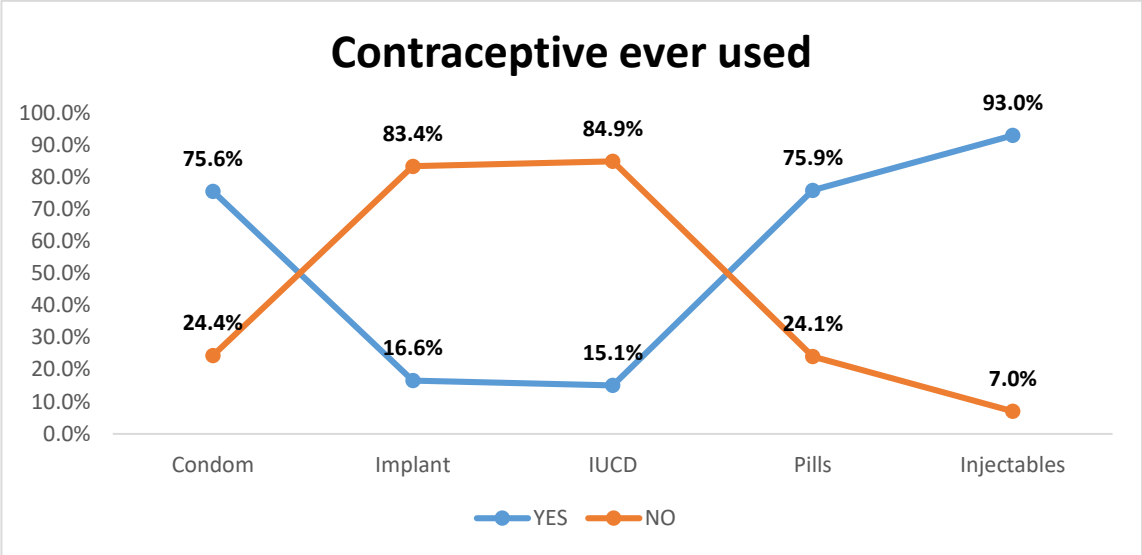
As the analysis started with descriptive results as the graph shown on awareness variable regarding different contraceptives among the respondents, all respondents at least they are aware with all the methods listed but the percentage differs from one method to the other as the condom shows that 76% of the respondents are aware on it while 66.3% are aware on IUCD and 68.3% of the respondents are aware about implant, furthermore with descriptive analysis the results shows that injectable and pills are the contraceptives methods which are leading on awareness among respondents as both accounts about 100%.However being aware of the method does not guarantee the use as the results shows 16.58% are only using Implant while 11.56% of the respondents are using IUCD.

Figure 5.1: Awareness on Family Planning Methods



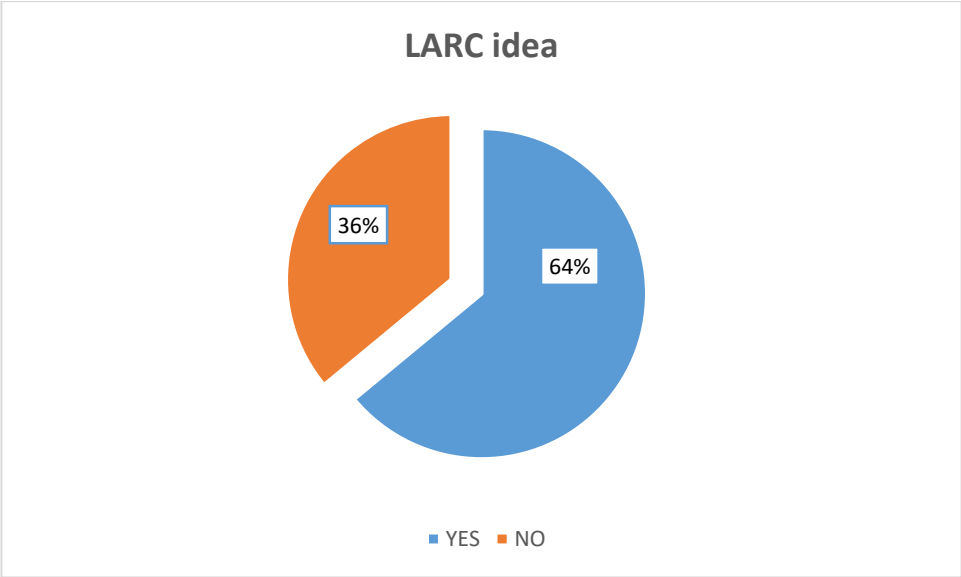
The results from the graph on contraceptive ever used by the respondents shows that implant and IUCD which are LARC methods have the lowest percentages of the respondents who ever used them , as the data reveal only 16.6% for implant and 15.1% for IUCD of all respondents have ever used them, however short term contraceptive methods such as injectable, pills and condoms are leading as the contraceptives ever used by majority of the respondents with the percentage 93% injectable, 75.9% pills and 75.6% for condoms.

Figure 5.2: Contraceptive Ever Used



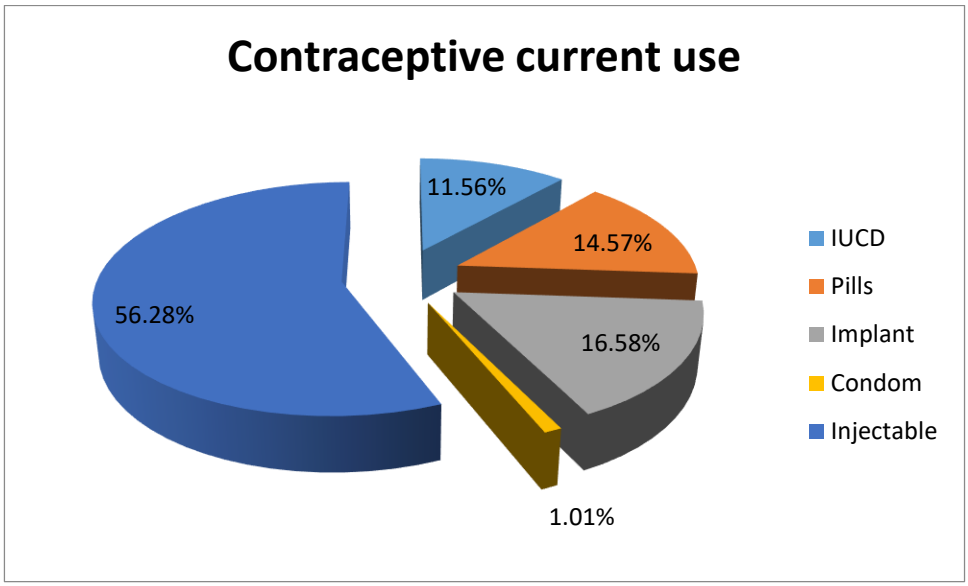
When respondents were asked if they have idea on long acting reversible contraceptives, 64% reported to have an idea of the methods while 36% of the respondents do not have idea on LARC. Those who have idea on LARC they got such idea through information from the RCH clinic or from the mass media.

Figure 5.3: LARC Idea



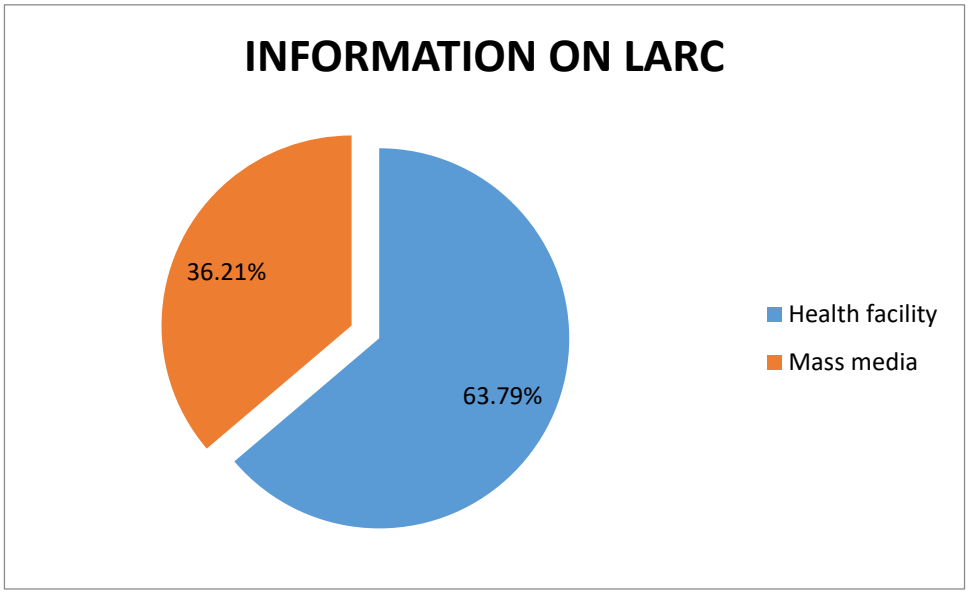
Out of the respondents asked on the current contraceptive method they use, 26.13% utilized LARC methods while the remaining 73.87% of the respondents utilized short term acting reversible contraceptive, as the data from the pie chart analyzed different methods current used as injectable leading by 56.28%, implant 16.58%, Pills 14.57%, IUCD 11.56% and Condom 1.01%. Some clients chose more than two methods especially condom as dual protection so during analysis we considered the method which is more highly effective than the other.

Figure 5.4: Contraceptive Current Used



Regarding the source of information on Long Acting Reversible Contraceptive it was observed that majority of the respondents 63.79% got the information on LARC from the health facility while 36.79% of the respondents they got information on LARC from the mass media.

Figure 5.5: Information on LARC



From the Regression model, there are variables which are significant and fits the model especially those variables with $p<0.05$ which are occupational, awareness, IUCD activities, and Implant shift, while other variables with $p>0.05$ were not significant.

The output shows that the odds of utilization of LARC services increased significance by 3.813574 times for those women who are aware on LARC services compared with those who are not aware about LARC services.

Another variable that show significance in the model is IUCD shift (those who does not have perception on the inserted IUCD can move to other parts of the body) which it's Odds of using LARC services especially IUCD is more likely to be 6.730353 times than those who have perception that inserted IUCD can shift into other parts of the body.

In IUCD activities which is another variable showing that those respondents who does not perceive that inserted IUCD can interfere with other activities having the Odds of 4.472427 times are more likely to utilize LARC services compared with those who perceive that inserted IUCD can interfere with other activities, However this is not statistical significant with the p-value is 0.059 which is greater than 0.05.

Another variable that show significance in the model is implant shift showing that those respondents who does not perceive that inserted Implant can shift to other parts of the body having the Odds of 0.295619 times are more likely to utilize LARC services compared with those respondents with perception that inserted Implant can move to other parts of the body.

Qualitative Results

Awareness

In-depth interview discussions conducted with the 4 health care providers and DRCHCO revealed challenges faced by clients in utilization of Long Acting Reversible Contraceptive methods. One of the challenge is awareness on LARC methods as some women they are not aware on LARC methods which might be due to nature of their set up , literacy level and other factors revealed through the in depth interview with the health care providers , there was a quote from a provider regarding that:

> *Many women in Pwani region have a low level of education, as we know most of the educated women are the ones who use long term methods as they can read about LARC from different source such as newspapers, internet, magazines etc. but also they normally share good things among themselves through what sup, but for those who are not educated this cannot happen (Provider- 3)*

The issue of place of residence was another important issue affecting Long Acting Reversible Contraceptive utilization as Kibaha TC having the women living in urban and the other group living in rural areas where by the level of literacy and understanding about LARC is different, one of the provider explaining how the situation affecting the LARC use.

> *Another health care provider said: "Living in urban make someone being aware about the LARC compared to those who lives in rural, they are more aware on injectable and pills even at the clinic when they come those from the rural they don't want to be seen so they normally want to get injectable and go back so it's difficult for them as*

they even don't want to get family planning education which could help them to understand all the method. (Provider- 2)

Myths and Misconceptions

Another challenge which seems to be a major problem among the women at Kibaha is the issue of myths and misconceptions concerning Long Acting Reversible Contraceptive, with the literacy level is low in the district still they have some issues they perceive and believe about the use of LARC that will happen when you decide on using them , basically these myths and misconceptions are being spread much within the community and makes feeling bad for those who decided to use LARC which sometimes prompt them to remove the methods due to the myths and misconceptions, this issue supported by health care providers as they had different views:

There were several myths and misconceptions among the women on Long Acting reversible Contraceptive, which might influence selecting the method to use. For example, some of the women who are coming to the clinic said: "if you have few eggs and then you decide to use Long term family planning the time when you need a child you won't get as all the eggs crushed by the long term family planning methods" (provider-1)

The study also revealed that some of the women they fear that LARC methods might cause serious disease such as cancer which could lead to death, not only death but also they have perception that using IUCD or Implant might cause infertility. The Health care provider quoted about the issue.

Many women coming at the clinic complaining that their relatives and neighbor died with cancer caused by the use of IUCD and implant so for them to use the same contraceptive it will be difficult." "Also some of the women they fear that after having a child using IUCD or implant might cause infertility later on if they want more children" (Provider 2)

Although at the clinic health care providers are conducting health education on all contraceptive methods including clearing myths and misconceptions among the women, but still the problem persists as some women they don't believe from what had been said by health care providers, rather they believe what had been said in their community. They believe using LARC will impair with other issues such as

sexual activity and also might cause disability, this had been said by one health care provider:

> *Some of the women they have more than one partner so they think by using IUCD it will interfere during sexual intercourse. Others say that their husband are complaining that IUCD disturbing them during sex. For LARC method at least some use Implant but still low as many of them they say Implant is having severe side effects such as bleeding and you can insert Implant today but after three weeks she come for removal and saying am bleeding every day, but when you examine her you will find she don't have signs of bleeding every day, for example one girl came for Implant removal but I tried to ask her many questions why you want to remove before she told me she is bleeding but later she said her mother don't like her to have implant, so sometimes within the community they get motivation of not using LARC methods. (Provider 4)*

Others think that all their economic activities might be affected by inserting the Long Acting Reversible Contraceptive, DRCHCO pointed on the issue:

> *Some of the women they have a fear on LARC methods that might affect physical activities after use as they normally give an example of implant that after inserted she will not be able to use that hand inserted." Others also they believe using Implant can cause the women not be able to bleed again which for them it is bad as it can cause cancer in future. (DRCHCO)*

Perception that Implant or IUCD might move to other parts of the body and because some serious problem, had been a major challenge in the community as some women they don't want the methods due to such reason, the issue had been also highlighted by DRCHCO:

> *Most of women perceived that IUCD move to the head and abdominal and leading to cancer, severe bleeding, affecting working and cause smelling. They also perceived that implants might cause paralysis of the arm inserted with bleeding. (DRCHCO)*

> *Some women decided to remove implants and IUCD because they have been told by friends or relatives in their community that they will end up getting cancer of the uterus and cervix. (DRCHCO)*

LARC Utilization

As compared with other methods the use of LARC is still low, but this had been due to some issues the women having concerning the methods as the nature of coast people with religious issue its quite difficult for them to utilize LARC despite the advantages of LARC over the Short Term Acting Reversible Contraceptive which are preferred by the majority of the women, health care providers provided their opinion on the issue of Utilization.

" Some women in our community they prefer injectable because no one can understand that she got it while using LARC for them it's a problem as for IUCD they don't want to be exposed and seen their private part of the body" (Provider-1)

The same issue of why the women in area prefer short term methods had been pointed out by another Provider but she also insisting that these women they think that LARC has several side effects compared to short term methods

> *Some of the women they believe that using injection, no one would understand if they use contraceptive not even a partner. Also for them they do not disturbed by having a foreign material in their body like having IUCD or Implant which they think lots of side effects are due to those LARC method (provider-4)*

The issue of religious was another area where by some of the women they have believes that LARC is the use of foreign body that stays within their bodies of which it's against their religious rules. One provider explained on the issue:

> *Some of our clients they say that implant and IUCD are not supposed to be used as religious prohibit any foreign material within the human body of which after death you are not supposed to have any foreign material, by having it is a sin, so with that caption they don't use at all the LARC method (Provider2)*

Number of the children is another factor that forces some women not utilizing LARC as those women with many children they are more likely to use LARC methods compared with those having few children or not having. This had been quoted by the providers during the interview.

At the clinic some women they have one child or two, they reject using Long Acting Reversible Contraceptive as they say they can't use family planning for 10 years while they need to get more children as they are not aware that IUCD can be removed at any time when you need to conceive" In addition Those who have more than 4 children they normally requesting Long Acting Reversible Contraceptive compared with those having few children or they don't have" (Coordinator)

Decision of using contraceptive methods especially LARC, also in some women dictated by others rather by themselves, of which they can be directed to use the method which they don't like but they can't oppose what had been decided for them, in most cases the decision are being made by mothers, mother in law and sometimes husband or partner, this is supported by health care provider.

> *Many of our Clients also complaining several times that the decision of using or not using family planning especially Long term is being decided by their husband, mother in law and for those who are single their mother take such decision. (provider1)*

Availability of LARC services

Availability of the service is an important factor on the use of Long Acting Reversible Contraceptive as sometimes when the women decided on a method and they don't get its easier for them to change the mind and go for the method which is available at the health facility, this issue of availability of LARC services was said by the DCHCO and health care providers

> *In some health facilities within the district we don't offer the LARC services with the main reason that we don't have providers who can offer the services and those who were available they have already retire from their duties, but also insertions kits is a problem in some facilities which cause the services not to be found- (DRCHCO))*

Concerning availability of LARC services, some of the facilities which offers all contraceptives methods are being overwhelmed by a number of patients as most of the women attend in those facilities so as they can get the services

> *We are getting a lots of clients because we offer all the methods including LARC, but am working alone in providing the services, so*

some clients they don't want to stay longer at the clinic and instead of getting LARC they decide another method and most of them they prefer injectable as LARC having a lots of steps to follow and takes time so having few providers it's a challenge (DRCHCO)

CHAPTER SIX

DISCUSSION OF THE FINDINGS

6.1 Introduction

Long Acting Reversible Contraceptive are the most effective method which can help the women to continue with their economic activities after being inserted as they don't need to come to the clinic like other methods, but also the methods can be removed as soon as the woman want to get pregnant.

This chapter presents discussion of the findings from the study. The discussion mainly focuses on the major findings from the study variables relating to other researchers what they found in the same issue

From the analysis results shown as per study objectives, the results included both descriptive and inferential statistics for the quantitative part but also the results were in narrative form from the qualitative part.

Specific objective one: To examine community awareness on Long Acting Reversible Contraceptive services:

From this objective the results from the study in descriptive shown that 66.3% of the respondents are aware with IUCD while 68% are aware with Implant, however data shows that majority of the women are more aware on Injectable and pills as the methods account about 100%

Being aware on Long Acting Reversible Contraceptive is an important aspect which could lead to its use, as the study conducted in Nigeria revealed that respondents were aware on implant about 70.3% while on IUCD is about 55.5% (Bolarinwa & Olagunju, 2019).Moreover, another study conducted in Ethiopia shows that 63.5% women currently on family planning have heard about LARC, whereby 46% of the respondents who heard about LARC have knowledge on IUCD while 62.7% of the respondents who heard about LARC have knowledge on implants (Nejimu Biza, 2016).

Looking on the source of information the results revealed that 63.79% of the respondents they had information about Long acting Contraceptive methods from the health facility while they came for other services or for family planning and 36.21% they got information on LARC through mass media, including television, radio, newspaper etc.

In the study conducted in Nigeria on Contraceptive use among women of reproductive age shows that respondents were aware on LARC through newspaper/magazines about 28.5%, on Television 49.7% on radio 67.2% while from the health facility is about 53.6% (Bolarinwa & Olagunju, 2019)

Regarding LARC idea as another variable the results shown that 64% of the respondents having idea on Long Acting Reversible Contraceptive while 36% they don't have idea on Long Acting Reversible Contraceptive methods. In the study conducted in Egypt on Awareness, attitude and preference of long-acting reversible contraceptives by Tanta University contraceptive clinic attendants , when the respondents asked about the source of knowledge and awareness about LARC methods, the results revealed that 145 (49.87%) got the knowledge from paramedical personnel, 108 patients (27.63%) got the awareness from non-medical personnel, while 54 (13.81%) got awareness from different social media while the least number of respondents 34 (8.69%) got awareness and knowledge from medical personnel (Dawood, 2017)

Through binary logistic regression, the results shown that those women who are aware are more likely to utilize Long Acting Reversible Contraceptive 3.813574 times than those respondents who are not aware on LARC services. This is similar with the study conducted in Gondar city on Factors associated with utilization of long-acting and permanent contraceptive methods among women who have decided not to have more children revealed that utilization of LARC and permanent methods were having high odds among women who had information about LARC and permanent methods compared with women who had no such information (AOR: 8.85; 95% CI: 2.04- 38.41) (Chernet Baye Zenebe, 2017)

Specific Objective two: To assess the accessibility of Long Acting Reversible Contraceptive services

Concerning this objective, the qualitative results from the study revealed that in some health facilities the Long Acting Reversible Contraceptive services are not provided due to the lack skilled of health care providers and sometimes lack of the equipment's especially insertion kits.

In the study conducted on Prevalence, Perceptions and Factors Contributing to Long Acting Reversible Contraception Use among Family Planning Clients, Jimma Town, Oromiya Region, and South-West Ethiopia. 398 (95.7%) clients were using contraception which they choose themselves while 18 (4.3%) of them were not provided with the contraceptive they prefer , as the main reasons were unavailability of the methods and sometimes the health care providers were not around (Workneh, 2017)

Specific Objective three: To determine on how Myths and Misconceptions affect utilization of Long Acting Reversible Contraceptive services.

Regarding this objective, both quantitative and qualitative results had shown that myths and misconceptions on Long Acting Reversible Contraceptive is a major challenge encountered by the women in the district. The results revealed that those respondents who don't have perception that inserted IUCD can shift to other parts of the body are more likely to use LARC methods 6.730353 times than those who have the perception on the inserted IUCD can shift to other parts of the body. This was statistically significant. This is similar with the study done on Acceptance of long acting contraceptive methods and associated factors among women in Mekelle city, Northern Ethiopia. Their reasons for not accepting LARC were fear of side effect 128 (44.8%) and fear of infertility after use 117 (40.9%), and husband's disapproval in 38 (11.1%) (Hailay Gebremichael, 2014)

Another variable as per results shown is IUCDactivities, which the results shown that those respondents who don't have perception on inserted IUCD can interfere with other activities with odds 4.472427 time s are likely to utilize LARC method compared with those who have perception on that. However this is not statistically

significant with p-value greater than 0.05 which is 0.059,this is in line with the study conducted in Ethiopia which also revealed that wrong perception on LARC methods had shown statically significant association with LARC utilization (Nejimu Biza, 2016), This study is also supported by another study conducted in Ethiopia which also revealed about 36.3% of the respondents said IUCD prevent them from doing different activities (Gebremichael, Haile, Dessie, Birhane, & Alemayehu, 2014)

Another variable was Implantshift as the results shown that those respondents who don't have perception that inserted implant can shift to other parts of the body are more likely to use Long Acting Reversible Contraceptive by 0.295619 times than those who have perception on the inserted Implant can shift to other parts of the body. From the study done by International Planned Parenthood Federation on Myths and facts about implants shown that some women who believe that implants can cause complications in the arm and can move from the inserted place to other parts of the body (Federation, 2019). The same objective on qualitative results shows that religion, number of children, myths and misconceptions on the LARC can cause cancer, bleeding and smelling emerged as the factors causing many women not using LARC methods.

Specific Objective four: To examine how the Social-Cultural issues affect the utilization of Long Acting Reversible Contraceptive services

From the qualitative results shown that decision of using contraceptive for some women is not made for herself rather made by other people who have influence in the family such as mother, mother in law and husband or partner.

In the study on Effect of Male Partner's Support on Spousal Modern Contraception in a Low Resource Setting in Ethiopia the results revealed that the male partners were not aware if their partners are using contraceptive 22(7.2%) as the men were against about contraception (11; 50%) or they want more children (11; 50%) (Olayinka Balogun, 2016)

Another study on Knowledge and attitudes towards use of long acting reversible contraceptives among women of reproductive age in Lubaga division, Kampala district, Uganda, the results revealed was approximately (48.1%), 272 of 565

respondents agreed that the decision on using the family planning methods is being done by their partners (Ronald Anguzu, 2014)

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

7.1 Introduction

This section presents the summary of the evaluation study, the conclusion, suggestions and recommendation which can be utilized by different stakeholders in research or other activities and also the recommendation from this study might be the resourceful for improvement in this study area.

7.2 Summary of the Study

This study was assessing Long Acting Reversible Contraceptive Utilization among women of reproductive age, a case of Kibaha Town Council with four specific objectives which were examining community awareness, assessing accessibility of LARC, myths and misconceptions which affecting the LARC utilization and examining how the social –cultural issues affect the utilization of LARC.

The study employed descriptive cross sectional design as the study aimed to evaluate the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, and Child & Adolescent Health in Tanzania (2016 - 2020) –Family Planning Program.

The study is a process evaluation since the program is still in progressing, study approach was sequential mixed study which involved both quantitative and qualitative, as the target population were all women living at Kibaha TC while the sample frame were those women from the age between 15-49 years, the sample size quantitatively was determined by using Yamane formula and the sample size obtained were 396 though during data collection we collected data from 401 respondents, on the other part of qualitative the data were collected until saturation from key informants such as health care providers who work at RCH department and the DRCHCO. Different sampling technique used, while selecting health facilities for the study simple random sampling used as well as purposive sampling technique for the Health Centre. Convenient sampling technique used to recruit women

involved in the study, while the Health care providers and DRCHCO purposive sampling was employed.

Questionnaires were used to collect quantitative data from the respondents and few of them were given to fill the data by themselves but majority the research team were helping them to fill the questionnaires soon after providing the answers. In depth interviews used to collect data from the key informants such as Health care providers and DRCHCO. Quantitative data were analysed by assistance of Stata where by descriptive statistics finding were presented in percentage, charts and tables. Logistic regression and Chi square were also used in analysis so as to give out inferential statistics finding especially about the association between independent variable and dependent variable which is utilization (use or non-use). The qualitative data were analysed with the assistance of Atlas ti of which after analysis the output were imported in this report.

7.3 Conclusion

Awareness, Knowledge and myths and misconceptions observed to be an important aspects which affects LARC utilization, thus we need to ensure that women and community they understand about Long Acting Reversible Contraceptive which would also enhance people to clear their minds about myths and misconceptions which is one of the major barrier in LARC use, other issues like availability of all contraceptive methods is also important , as we need to improve so as to increase the LARC uptake in the community as the Ministry of Health and other stakeholders set a target to reach by 2020 to increase CPR to 45%.

7.4 Recommendations

Based on the findings of this study ,we need to ensure that the health education on family planning especially Long Acting Reversible Contraceptive should be reaching in every village of the country as this strategy will help the community to gain knowledge of contraceptive and will ultimately increase the utilization of LARC methods, as the education provided at the health facilities is not enough as many women they heard about LARC when they visit the clinic of which it become

difficult to accept the method while if they could have the knowledge before it could be easy for them to make decision of using them. The campaign should ensure that proper education are given on LARC as many women they use short term method such as injectable so they need to understand the benefits of using LARC especially on their health but also economically.

7.5 Limitation of the evaluation

It was difficult for the Researcher to cover the whole district or even the region to understand the situation of other districts within the region, which may be, could give different picture due to resources constraint especially time.

7.6 Area for further evaluation

This study had been done in small area but need more research to be done especially on Myths and Misconceptions the way they affect the LARC utilization, other area which also need to be researched is about the cultural aspect especially the use of IUCD as women in Coast area they don't want to be seen their private parts so this topic I suggest to be done in different Geographical location to understand different culture on the use of LARC especially IUCD.

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APPENDICES

APPENDIX 1 QUESTIONNAIRE

PART. I. Social, Demographic and Cultural Characteristics

1. How old are you?
    a) 15-24
    b) 25-34
    c) 35-44
    d) I don’t know
2. What is your marital status
    a) Married
    b) Single
    c) Widowed
    d) Separated
    e) Divorced
3. What is your religion?
    a) Muslim
    b) Christian
    c) Other
4. What is your level of education?
    a) Primary school level
    b) Secondary school level
    c) College and higher education
5. What is your occupation?
    a) Employed
    b) Unemployed
6. What is the distance from your home place to the health facility?
    a) Under 5 Km
    b) More than 5 km

7. What is the transport you're using to travel to the Health facility to get Family planning services?
    a) Bus
    b) Motor cycle
    c) Bajaj
    d) Bicycle
    e) By foot
8. What is the cost of that transport? …….
9. What is the time used to reach to the health facility? ……..
10. Have you ever had a child?
    a) Yes
    b) No

    If your answer is NO skip questionnumber 11
11. How many children you have? .....
12. How many children are you planning to have in your life? ……

PARTII: AWARENESS ON MODERN AND LONG ACTING REVERSIBLE CONTRACEPTIVE

1. Have you ever heard about Modern contraceptive method?
    a) Yes
    b) No

    if NO skip question 2
2. Do you know any contraceptive method?
    a) Yes
    b) No
3. What type of modern contraceptive did you heard? More than one answer is possible.
    a) Condom
    b) IUCD
    c) Injectable
    d) Pills
    e) Implants

4. What was your main source of information about modern contraceptive?
    a) Friends/Neighbors
    b) Work place
    c) Husband
    d) Health care providers
    e) Mass media
    f) Other, specify
5. Do you have any idea about long acting reversible contraceptive Methods?
    a) Yes
    b) No

    If NO skip question 5
6. If Yes, please mention Long acting reversible contraceptive that you heard/know

    ……
    ……

7. Have you ever had information on long acting reversible contraceptive within the last 12 months?
    a) Yes
    b) No
8. If YES mention the source of information.
    a) At the health facility
    b) Mass media
    c) Husband
    d) Friends/Neighbors
9. Which contraceptive method have you ever used? more than one answer is possible
    a) Condom
    b) Implant
    c) IUCD
    d) Pills
    e) Injectable

10. Which method you're using now?
    a) IUCD
    b) Pills
    c) Implant
    d) Condom
    e) Injectable
11. Where do you get the contraceptive current you're using?
    a) RCH clinic
    b) Pharmacy
    c) At NGO's
    d) Other, specify
12. How long since you started using contraceptive method?
    a) Less than 6 months
    b) 7-12 months
    c) 13-24 months
    d) More than 24 months
13. Are you discussing with your partner about contraceptive?
    a) Yes
    b) No
14. Are you satisfied with the contraceptive methods available at your place?
    a) Yes
    b) No
15. If you're not satisfied as per question number 14, what could be a reason(s)?
    a) Available methods are not much effective
    b) Available methods are not the one I prefer most
    c) More side effects than advantages
    d) Other, specify
16. In case you had given an opportunity to advice, what are the contraceptive methods you would like to be available apart from what is available

17. Is the method your currently using is the one you prefer?
    a) Yes
    b) No
18. If not as per question 17 above, what could be a reason?
    a) Husband decision
    b) Health care provider decision
    c) High cost
    d) Availability problem
19. Did you ever switch from one contraceptive method to another?
    a) Yes
    b) No
20. If the answer in question 19 above is yes, what is the reason?
    a) Unavailable of the preferred method
    b) More side effects of the methods you were using
    c) Health care provider advice
    d) Husband/partner reason
    e) I want to stay longer being protected against pregnancy
21. Have you ever been told by provider that your preferred method is not available which forced you to switch to another contraceptive method?
    a) Yes
    b) No
22. If the answer for question 21 above is yes, what is the contraceptive method you switched to as alternative to your preferred method?
    a) Pills
    b) Condom
    c) Implant
    d) Injectable
    e) IUCD

23. Have you ever been told by provider that your method of choice is not available and she referred to get the services?
    a) Yes
    b) No
24. If yes the answer for question 23 above where had you referred?
    a) Higher level of health facility
    b) At NGO's
    c) Pharmacy
    d) Other, specify
25. Who chooses for you contraceptive method your using?
    a) Self
    b) Health care provider
    c) Partner
    d) In law/family members
    e) Other, specify
26. What was the reason(s) for contraceptive use?
    a) Limiting
    b) Spacing
    c) To protect against STI's/HIV
    d) Economical reason
    e) Other , Specify
27. What was the reason(s) prompted you to prefer the current method your using?
    a) It has less side effects
    b) I need long acting contraception
    c) Convenient to use
    d) I don't have alternative
    e) Other, specify

PART III. UTILIZATION OF MODERN AND LONG ACTING CONTRACEPTIVE METHODS

1. Which type of modern contraceptive method have you ever used? More than one answer is possible.
    a) Condom
    b) Implant
    c) IUCD
    d) Pills
    e) Injectable
2. Which method are you using now?
    a) IUCD
    b) Pills
    c) Implant
    d) Injectable
    e) Condom
3. Where did you get the method of contraceptive that you are using?
    a) RCH clinic
    b) Pharmacy
    c) NGO's
    d) Other specify
4. How long have you been using contraceptive? .....
5. Do you discuss about contraceptive with your husband/partner?
    a) Yes
    b) No
6. Are you satisfied with the modern contraceptive methods available in the source of your family planning service?
    a) Yes
    b) No

    If YES skip question 6

7. What could be the reason be of not satisfied?
    a) Less effective
    b) The method not first choice for me
    c) It has more side effects than the benefits
    d) Other specify
8. If you had given the chance to advice about availability of contraceptive methods, apart from what is available at your place what other methods you would like to be available?.....
    .....
    .....
    .....
9. Are you using your first method of choice?
    a) Yes
    b) No

    If YES skip question 10
10. What could be a reason?
    a) Husband disapproval
    b) Healthcare provider disapproval
    c) High cost
    d) Problem of availability of my choice
11. What is your contraceptive of choice?
    a) IUCD
    b) Pills
    c) Injectable
    d) Condom
    e) Implant
    f) Other specify

12. Have you ever switched from one method to another?
    a) Yes
    b) No

    If NO skip question 12

13. What was the reason(s) for switching from one method to another?
    a) Accessibility problem for the first method
    b) Due to severe side effects
    c) Health care provider advice
    d) Health reason(s)
    e) Husband/partner reason
    f) I want to stay more longer protected for pregnancy
    g) Other specify

14. Have you ever been told by the provider that your first method of choice is not available and forced to switch to another method?
    a) Yes
    b) No

    If NO skip question 15

15. Which method you had been forced to switch?
    a) Pills
    b) Condom
    c) Implant
    d) IUCD
    e) Injectable
    f) Other specify

16. Have you ever toldby healthcare provider that your method of choice is not available and you referred to other place to get it?
    a) Yes
    b) No

17. If YES at question 16, where did healthcare provider refer you to get your method of choice?
    a) At higher public facility
    b) At the NGO
    c) Pharmacy
    d) Other specify
18. How much time do you spend to reach the place where you get contraceptive?
    ……
19. Who chooses the contraceptive method for you?
    a) Self
    b) Healthcare provider
    c) Husband/Partner
    d) Mother in law
    e) Other specify
20. What is your reason(s) for using contraceptive?
    a) Limiting
    b) Spacing
    c) Protecting against STI's/HIV
    d) Economical reason
    e) Other specify
21. Why you prefer the method which you're using now?
    a) It has less side effects
    b) I want long acting contraceptive
    c) Convenient
    d) No other option
    e) Other specify

PART IV: MYTHS AND MISCONCEPTIONS ON LONG ACTING REVERSIBLE CONTRACEPTIVE

1. Did you ever had that implant cause irregular bleeding?
    a) Yes
    b) No
2. Did you have ever had that inserted IUCD will move into the body?
    a) Yes
    b) No
3. Does IUCD inserted restrict other activities?
    a) Yes
    b) No
4. Inserting and removing IUCD does cause severe pain?
    a) Yes
    b) No
5. Inserting and removing implant does cause pain?
    a) Yes
    b) No
6. Did you have ever had that inserted implant will move into the body?
    a) Yes
    b) No
7. Did you have ever had that does inserted IUCD interfere with sexual intercourse?
    a) Yes
    b) No
8. Did you have ever had that IUCD cause infertility?
    a) Yes
    b) No

APPENDIX 2 INDEPTH INTERVIEW (IDI)

INDEPTH INTERVIEW (IDI) FOR HEALTHCARE PROVIDERS AND DRCHCO

Copies of informed consent and confidentiality forms will be provided to the respondents of IDI. Written agreement will be taken; also there will be introduction of each other with explanation of the objective of the study to the respondent

Discussion questions:

1. How long have you been providing family planning information or services to clients?
2. What methods do you tell them about?
    - What methods do women use most often? Please explain.
    - What methods do women use less often? Please explain.
    - What methods are available in your health center?
    - What are the challenges in providing family planning services at this community?
    - What to be done to address these challenges and improve family planning services?
3. Based on your experience, how are decisions about family planning made in thiscommunity?
    - Who is involved in the process?
4. What do you tell a client who wants to wait two years or more before becoming pregnant again? Please explain.
    - Does the age of the client influence which methods you recommend? How?
5. When did you first hear about the long acting reversible contraceptive? (IUCD&Implant)
    - What were you told about it?
    - What was your first impression of the method?
    - Has your first impression changed?

6. Do you advise clients to use the IUD?
    - Why or why not?
    - If yes, what do you tell them about the method?
7. Do you advise clients to use implant?
    - Why or why not?
    - If yes, what do you tell them about the method?
8. What questions would you expect that a client would ask a family planning counselor before requesting an IUD?
    - How would you respond these questions?
9. What questions would you expect that a client would ask a family planning counselorbefore requesting implant?
    - How would you respond these questions?
10. What is the total cost incurred by a client?
    - What is the transportation cost around this area?
    - What is their usual mode of transportation?
    - How many visits are needed before the client is able to obtain the method?
11. How well equipped as these facilities having for providing each of these methods?
    - Does it have the necessary kits?
    - Does it have emergency preparedness equipment?
    - Is a family planning counselor available for your clients prior to the procedure?
12. Have you got necessary training in providing the family planning services especially IUCD and Implant?
    - Do you have experience with certain methods?
    - Do you have less experience with certain methods?
    - How comfortable are you inyour role as family planning serviceproviders?
13. What requirements must clients meet to obtain an IUD?
14. What requirements must clients meet to obtain an implant?

15. How interested do you think clients in this community are in these long acting reversible contraceptive methods?

16. What is the best way to inform people in this community about the IUD and Implant?

17. Please describe all of the advertising and marketing for these methods that you have seen or heard about in this area.

- Do you think it has been effective? Why or why not?

18. What barriers prevent use of the two methods we have discussed (IUD and Implant)? Please explain.
19. Let us summarize some of the key points from our discussion. Is there anything else?
20. Do you have any questions?

Thank you for taking the time to talk to us.