ACCESSIBILITY AND USE OF FAMILY PLANNING INFORMATION AMONG RURAL PEOPLE IN KILOMBERO DISTRICT, TANZANIA

By

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A dissertation submitted in partial fulfilment of the requirements for the degree of Master of Arts (Information Studies) of the University of Dar es Salaam

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation entitled: ***Accessibility and Use of Family Planning Information among Rural People in Kilombero District, Tanzania***, in partial fulfilment of the requirements for the degree of Master of Arts (Information Studies) of the University of Dar es Salaam.

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Prof. ELIZABETH KIONDO

(Supervisor)

Date.....15th July 2005.....

DECLARATION

AND

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I, **Grace Emmanuel**, 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.

Signature.....

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DEDICATION

This work is dedicated to my daughter, Gloria Peter Msoffe. Her patience and understanding during my study made my academic-engagement easier.

ABSTRACT

This study investigated accessibility and use of Family Planning Information (FPI) among rural people in Kilombero District, Tanzania. The purpose was to examine the entire infrastructure required for accessing and using FPI in rural settings. The study used survey method for data collection. Data gathering instruments were questionnaires, interview schedule and observation guide. A total of 120 respondents were involved in the survey. These included women and men of reproductive age, Maternal and Child Health (MCH) clinic staff and community health workers. The study revealed that, there is high awareness of the availability of Family Planning Services (FPS), inadequate knowledge of various family planning methods and limited access and use of FPI. This situation is mainly caused by a number of factors which include: ignorance, inconsistent availability of family planning methods, few staff (providers) with limited training, inaccessibility of FPS and patriarchal gender relations. Furthermore, the study found that rural communities access FPI through radio and MCH clinic staff; and there are unequal opportunities between women and men in accessing FPI. The study concludes that the surveyed rural communities are disadvantaged in accessing and using FPI. In addition, family planning knowledge has an influence on the adoption and use of family planning methods. The recommendations made include: provision of more health facilities in rural areas, providing training to family planning providers, raising public awareness of family planning, ensuring constant availability of all the family planning methods, provision of family planning education in schools for both sexes and provision of all the necessary facilities needed for effective dissemination of FPI in the rural settings.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
CBD	Community Based Distribution
FPI	Family Planning Information
FPS	Family Planning Services
HIV	Human Immunodeficiency Virus
IUD	Intra-Uterine Device
MCH	Maternal and Child Health
NGOs	Non Governmental Organisations
STIs	Sexually Transmitted Infections
TDHS	Tanzania Demographic and Health Survey
UMATI	Family Planning Association of Tanzania
UNFPA	United Nations Fund for Populations Activities
URT	United Republic of Tanzania
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Introduction and background to the study

Rapid population growth is of major concern worldwide. Declines in fertility rates in some developed countries have led some people to declare, incorrectly, that population growth is no longer a global concern. In fact, every twelve or thirteen years, another billion people are added to the world's population, majority of them from developing countries (Brown *et al.*, 1999). The 20th century ended with more than six billion people on earth compared with 2.3 billion at mid-century. The world population has doubled in a single lifetime (Brown *et al.*, 1999). The United Nations has projected that the world population will be 8.9 billion in 2050, nearly 50% increase over the current six billion. There are still some 123 million women around the world, mostly in developing countries, who are not using family planning methods in spite of an expressed desire to space or limit the numbers of their births. It is estimated that, there are 182 million pregnancies each year in developing countries (Ross and Winfrey, 2002). Although fertility levels are falling in many parts of the world, rapid population growth remains a critical issue in most developing countries, where needs are great and resources are scarce (Upadhyay and Robey, 1999). A study of twenty developing countries in 1990, found that an average of 22% of all births are unwanted (Bongaarts, 1997). This estimate is probably low because many parents do not want to acknowledge that a child was unwanted (Westoff, 1981).

The need for family planning service in Africa is huge and in most cases not met by the current family planning services interventions. It is estimated that almost 30 million married women of reproductive age have unmet needs. Given the fact that the vast majority of the African population lives in rural areas and given that most urban areas are better supplied with family planning services, it is safe to assume that most of the unmet need for family planning in Africa is among the rural population (Haile *et al.*, 2000). Although family planning information and services have been made available to the rural population, there are still hundreds of millions of rural people who wish to plan their families but are unable to do so (Guerny and Stloukal, 2000). In sub-Saharan Africa, the health system is mostly concentrated in urban areas and is built around curative services because family planning was introduced as a clinical method. In most countries, less than half of the population, mostly those living in major urban centres, have access to a health facility (Haile *et al.*, 2000). Unlike the situation in the urban setting, health and family planning services in the rural areas are provided predominantly by government providers. In addition, the rural areas feature a considerable presence of less trained providers and a much smaller number of modern commercial providers and facilities (Routh *et al.*, 2001). "Even if the assertion of health officials in many countries that family planning is integrated into their primary health system is true, it is still unavailable for the vast majority of the population who live in rural areas" (Haile *et al.*, 2000: 1).

In Tanzania, fertility is on the decline generally through changes in reproductive behaviour, including increased use of family planning methods (World Population Trends, 2001). However, the total fertility rate has remained high over the last thirty

years at 6.3 children per woman (Tanzania Demographic and Health Survey (TDHS), 1997). Currently, the population is 34,443,603 with a growth rate of 2.9% (United Republic of Tanzania (URT), 2003). In the course of fast population growth, one would wish that economic growth take place at the same speed to be able to provide necessary resources for the population. However, the national economy did not grow significantly in the 1990s (World Bank, 2000). Rapid population growth and poor economic growth have hindered the ability of the government to pursue its goals for human resource development such as education, health and sanitation, and poverty alleviation (TDHS, 1997). It is evident; therefore, that improvement in the quality and expansion of these social services is unlikely to happen without controlling rapid population growth (Kessy, 2001). Slowing population growth buys time for a country to invest in development aimed at raising living standards of the people.

In many parts of the world, family planning services are at present an essential element of reproductive health care and have saved the lives and protected the health of millions of people, especially women and children (World Health Organisation (WHO), 1997). Family planning was first recognized as human reproductive rights in 1968, and has been endorsed and strengthened in successive international forums. The 1994 International Conference on Population and Development (ICPD) held in Cairo emphasized the importance of family planning and called for programmes to increase the availability and accessibility of family planning services in developing countries (United Nations Fund for Populations Activities (UNFPA), 2000). Therefore, use of family planning methods is one of the major measures taken to control the rapid population growth.

The government of Tanzania has all along recognised the importance of family planning. The Family Planning Association of Tanzania (UMATI) introduced family planning services to Tanzania in 1959. During the early years, the services were mostly provided in few urban areas with little support from the government. In 1973, the National Executive Committee declared its support for UMATI (Kessy, 2001). The government passed various laws and regulations aimed at promoting and encouraging family planning in the country. These include paid maternity leave for female workers whose delivery occurs three years after the previous delivery, the income tax relief for up to four children, the provision of travel allowance for up to four children once every two years, and free maternal and child health services (Kinemo, 1992). All these measures aim at encouraging the practice of child spacing and family planning at large.

The government of Tanzania began to integrate family planning into maternal and child health care services in 1988 (Magari and Olson, 1990). In 1989, The National Family Planning Program (NFPP) was launched to promote and provide family planning as a major part of its primary health care strategies. The aim of this programme was to encourage people to avoid pregnancies before the age of eighteen years or after thirty five years, birth intervals of less than three years and birth orders of five or lower (Beegle, 1994). In 1992, the government adopted a national population policy calling for wider dissemination of family planning information (FPI) (Ngallaba *et al.*, 1993; Weinstein *et al.*, 1995). With specific reference to family planning, the goals of the policy were to strengthen family planning services, to promote the health and welfare of the family, and eventually to reduce the rate of

population growth. Other specific objectives included making family planning services available to all who want them, encouraging every family to space births at least two years apart, and supporting family life education programs for youth and family planning for men and women (Kinemo, 1992). In order to implement the policy as far as family planning services are concerned, there was the launching of the integrated Maternal and Child Health (MCH) program in 1994. Also, family planning services used to be provided free of charge in the government facilities (TDHS, 1997). This was mainly done to encourage people to use family planning methods irrespective of their economic situations. Therefore, assumption is that provision of free family planning services would increase the use of family planning methods.

This study investigated access to and use of FPI as one among several important aspects of the family planning issue. "Information in itself is not enough to bring changes and for information to meet its objective of bringing about changes, it must be accessible to the users" (Chailla, 2001: 33). In addition, it must not only be accessible but a conducive environment for its use should exist. Access to FPI could assist low-income citizens (the rural people) to plan and space their pregnancies and to make informed choices, which could help in reducing unintended pregnancies and improve their living standards. These in turn could help to reduce the rate of population growth and poverty.

1.2 Statement of the problem

Although the government of Tanzania acknowledges the importance of family planning to the overall development of the nation, and has made efforts to promote family planning at no monetary cost, the total fertility rate has remained high at 6.3 children per woman (TDHS, 1997). In Tanzania, 74% of the population live in rural areas (World Bank, 1999). Most of rural populations are still growing at a higher rate, and it is estimated that Tanzania's population will grow to 35.4 million in 2010 despite the effects of Acquired Immune-Deficiency Syndrome (AIDS) (World Population Trends, 2001). The population has grown from 12,313,469 persons in the first post-independence census held in 1967 to 34,569,232 persons counted in the census held in August 2002. Over the period from 1967 to 2002 the population of Tanzania has almost tripled. Though it is said that rural people in Tanzania have access to family planning services (Kessy, 2001), the fertility rate is still high (Speizer *et al.*, 2000; URT, 1997). The use of family planning methods in rural Tanzania is still very low (Chen and Guilkey, 2002). In Morogoro region, Kilombero District has highest percent population growth rate compared to its rural counterparts. The percent population growth rate for Ulanga District (2.0), Kilosa District (2.3), and Morogoro Rural District (2.2), while that of Kilombero District is 3.4. Kilombero District has a total of 322,779 people (URT, 2003). There is a problem of rapid population growth in this district despite of all the efforts that are taken to promote family planning services. This means that ensuring low monetary costs to family planning services is not enough to guarantee adoption of family planning and eventually reduce population growth. The causes of high fertility rate and in turn high population growth, presume an existence of one or more obstacles to

the use of family planning. This study assumes that access to quality FPI could increase the use of family planning methods and thereby accelerates the process of population decline. Family planning acceptance and use cannot spread without advocacy on FPI. Therefore, in order to increase the levels of acceptance and use of family planning methods, every person of reproductive age should have access to FPI.

1.3 Purpose of the study

This study sought to investigate the way FPI is accessed and used by the rural people in Kilombero District, Morogoro. Specifically, it examined the entire infrastructure required for accessing and using FPI and recommended strategies for improving accessibility and use of FPI in rural communities of Tanzania.

1.3.1 General objective

To investigate accessibility and use of FPI among rural communities in Kilombero District.

1.3.2 Specific objectives

1. To gather demographic data of surveyed rural community
2. To identify sources of FPI, delivery systems and communication channels used by rural communities to access FPI.
3. To investigate family planning awareness and knowledge of rural people.
4. To identify factors which determine accessibility and use of FPI among rural communities

5. To identify problems experienced in accessing and using FPI
6. To determine whether there is equal opportunity in accessing FPI between men and women.
7. To determine the levels of intervention by various government and non-government organizations in dissemination of FPI in the area of study.
8. To recommend ways in which rural communities can effectively access and use FPI.

1.4 Research questions

1. What is the demographic status of the surveyed rural community?
2. How do rural communities access FPI?
3. What family planning knowledge do rural people have?
4. What factors determine accessibility and use of FPI?
5. What problems are experienced in accessing and using FPI?
6. Do men and women have equal opportunities in accessing FPI?
7. Who is involved in the dissemination of FPI?
8. What strategies should be employed to ensure effective dissemination of FPI?

1.5 Significance of the study

The significance of this study to the community is as follows:

- The study findings would create awareness and contribute to a better understanding on family planning needs of rural communities in Morogoro region.
- The study could also be the basis for improving dissemination of FPI.

- It could become the basis for mobilising donor, government and other institutional support for more family planning programmes in the country.
- Findings would contribute to literature on the topic.
- The study findings are therefore expected to provide the necessary information to the information providers, to design strategies that will enable rural people to access FPI, and be able to use it.
- People living in rural areas are expected to benefit from improved accessibility of FPI.

1.6 Scope and limitations of the study

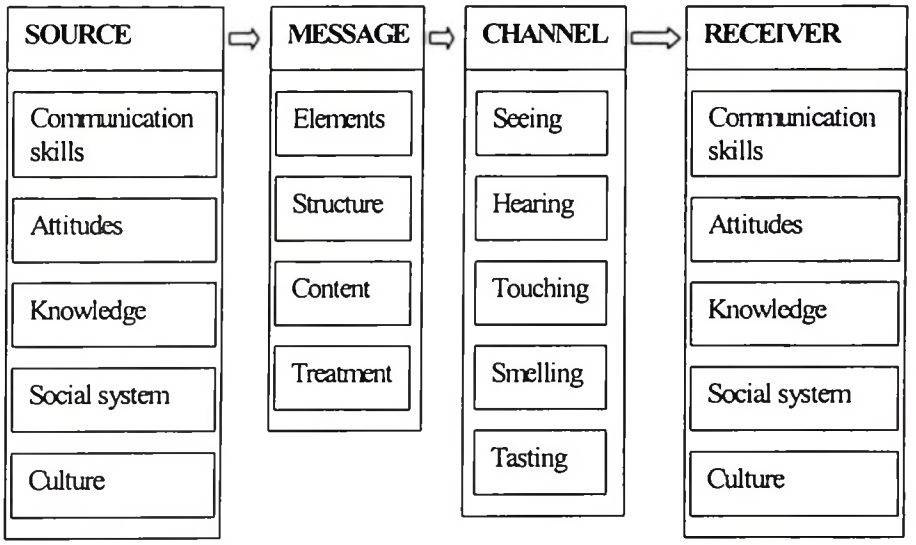
The study focused on accessibility and use of FPI among rural people in Kilombero District. The research was conducted in ten villages namely; Katindiuka, Kikwawila, Kisegese, Lipangalala, Machipi, Mbasa, Michenga, Mkasu, Namawala, and Sekamaganga. The findings may not be generalized to the areas where the material conditions are different. The study dealt with only information side of family planning, and involved women and men of reproductive age together with family planning providers. The major limitation in this study is that some respondents were reluctant to reveal information on whether they use family planning methods or not or whether all their pregnancies were planned; this may slightly affect the findings.

1.7 Theoretical Framework

There are several models of communication, for example Berlo's S-M-C-R model, Shannon-Weaver model, and Lasswell model. The study utilised the Berlo's S-M-C-R (Source-Message-Channel-Receiver) model of communication, which focuses on

social aspects, which could affect both the process of information communication and the acceptance of information by users. These social aspects include communication skills, attitudes, knowledge, social systems and culture. It also subdivides the communication channel into various components: hearing, touching, smelling, and tasting (Williams, 1989). In addition, the model emphasises the need for the knowledge of consumers in order to efficiently use appropriate and accessible media as well as to regulate the volume of information. Thus information must be in the context of the social system and culture. The **message** from the **source** is transmitted through the **channel** to the **receiver**. The content, elements, structure and treatment of the message have influence on the receiver's perception and hence acceptance or rejection of the information. Therefore, all these should be taken into account for effective communication that possibly will result in acceptance of information delivered to the user (Gray, 2005). A diagrammatic representation of Berlo's S-M-C-R (Source-Message-Channel-Receiver) model of communication is shown in figure 1 on page 11.

Figure 1: Theoretical framework



Source: Gray, (2005)

1.8 Operational definition of terms

This section defines different key terms that are used in this study. It is important to define these terms because a term may have different meanings.

1.8.1 Family planning

Family planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of family planning methods (WHO, 2002).

1.8.2 Information

"Information is defined as a meaningful message transmitted from source to users for the purpose of imparting new knowledge to the users" (Chailla, 2001: 61).

1.8.3 Family planning information

This is the information on family planning, which when given to people help them in making decisions on the number and spacing of their children and method they should adopt in doing so.

1.8.4 Population

It is the number of inhabitants/people (either the total number or the number of a particular race or class) in a given place, a territory or state.

1.8.5 Accessibility of information

It is availability of information infrastructure, which includes communication channels, delivery systems and access points needed for acquisition, processing and use of information (Chailla 2001).

1.8.6 Informed choice

It is the process by which an individual arrives at a decision about family planning. It is an informed choice when it is based upon access to, and full understanding of, all necessary information from the client's perspective. The process should result in a free and informed decision by the individual about whether or not she/he desires to obtain family planning services and, if so, what method or procedure she/he will choose and consent to receive (Association for Voluntary Surgical Contraception, 1998).

1.8.7 Family planning services

Family planning services are various services offered to enable men and women have the ability to anticipate and attain their desired number of children and the spacing and timing of their births. These include education and counselling on matters related to family planning, and providing methods of birth control such as pills, Intra-Uterine Device (IUD), Depo-Provera, jelly or foam, condoms, tubal-ligation, withdrawal, calendar rhythm, the mucus method, vasectomy for men and female sterilization.

1.8.8 Accessibility of family planning services

Accessibility of family planning services refers to the potential user's ability to physically reach service providers. This can be measured directly, by distance or by travel time needed to reach the nearest facilities if one uses the most popular means of transportation available in the community (Thang and Anh, 2002).

1.8.9 Family planning methods

Family planning methods include traditional methods of family planning (withdrawal method, mucous method and calendar rhythm) and modern methods of contraception (intra-uterine device, injectables, female and male sterilization, male and female condoms, foam, jelly, diaphragm or implants, and pills).

1.8.10 Family planning providers

The family planning providers are the ones who deal with provision of family planning services. In this study, the family planning providers include MCH clinic staff and community health workers.

1.8.11 Reproductive age

Reproductive age is normally defined as the range of 15 to 49 years.

1.9 Summary

This chapter introduced the study by reviewing the population growth and family planning services situation in the world and Africa in general and specifically in Tanzania. The problem was stated on the grounds that, despite of all the government efforts to promote family planning at no monetary cost, the total fertility rate in Tanzania has remained high at 6.3 children per woman. The situation is more prevalent in rural areas than in urban areas. Therefore, this situation made the researcher to be interested in investigating if these rural people have access to FPI, and if so, do they use the information. Furthermore, the chapter highlighted the purpose of the study, research objectives; significance of the study, the theoretical framework used and defined the key terms used in this study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses issues that have been covered in previous studies in relation to access and use of FPI. It aims at showing what has already been done, pinpointing the gaps in knowledge and hence the need to fill them through the present study. The literature is reviewed based on theories, research objectives and research questions identified in Chapter One.

2.2 Family planning services

2.2.1 Accessibility and use of family planning services

Previous studies (Tsui and Ochoa, (1992); Entwistle *et al.*, (1997) have shown that the availability and accessibility of family planning services is an important determinant of family planning methods use. The major goal of most family planning programs in developing countries is to increase access to family planning services. Much of the work on access to family planning has focused on access to services and health facilities (Thang and Anh, 2002). The assumption is that provision and availability of family planning services will help adoption of family planning and generate new users of family planning services (Jain, 1989). Thang and Anh, (2002: 3) argue that;

> for services to be considered accessible, potential users must have access to at least one fixed service point (which may be a commune health clinic, a mobile team, a drugstore, a hospital, an inter-commune clinic or a private doctor) not more than one kilometer away or to a community health worker or a family planning worker who visits at least once every two weeks.

Several studies (Betrand *et al.*, 1995; Cochrane and Guilkey, 1995; Ali, 2001; Katende *et al.*, 2003; Ross *et al.*, 2002; Steele *et al.*, 1999; Frankenberg *et al.*, 2003; Koenig *et al.*, 1997) have found that access is an important determinant of use of family planning methods. A study by Mroz *et al.* (1999) examined access and use of contraceptives in rural Tanzania. They found that access to services has effect on the use of family planning methods. Another study by Levin *et al.* (1999) found that couples were less likely to use family planning methods if the travel time to fixed clinics was greater than thirty minutes. Therefore, accessibility to family planning services relative to the spatial distribution of the population in need is a prerequisite for family planning use (Hall and Bowerman, 1996).

Accessibility to family planning services has influence on the choice of family planning method to use, thus broadening the types of service delivery can provide more choices (Population Action International, 1997). In addition, with more service delivery outlets, people who want a particular method for example, a specific brand of condom or pill formulation can more easily find it. Many people base their choice of family planning on how accessible a method is, particularly if visiting a clinic requires long travel (Georgetown University, 2000). A nearby source can even make the difference between using family planning methods and not using it at all. In Morocco, for example, a survey of women who in 1992 had not intended to use contraception found that by 1995 those who lived close to a hospital, clinic, doctor, or pharmacy were more likely to be using family planning than those who lived further away. While such other factors as social and economic differences or changes

in reproductive intentions could explain the difference, the researchers concluded that proximity to a source of supply was the most likely reason (Magnani *et al.*, 1999).

Furthermore, unless services are available, there can be consideration for other factors such as social and economic differences, information, education, proximity and other factors that influence the access of individuals or group to needed services (Hall and Bowerman, 1996). Therefore, along with availability of family planning services, access to information on individual family planning methods is essential for their effective use (Thang and Anh, 2002). Also, offering many choices on available family planning methods encourages use of family planning services, making it easier for people to choose a method they like and to switch methods as they wish or as needs arise (Greenwell, 1996).

2.2.2 Importance of family planning services

It is essential that women and men have access to family planning services. Family planning services play critical role in reducing unintended pregnancy. These pregnancies occur more frequently among women who are of low income, teens and minorities and often result in infants dying or being born very sick. Unplanned births often translate into children who grow up without fathers and in poverty. They are at greater risk for injury, child abuse, drug use, poor school performance, violence, psychological problems, and early and risky sexual behaviours (UNFPA, 1997). The availability of family planning services enables women and men to limit family size. It safeguards individual health and rights, preserves our planet's resources, and

improves the quality of life for individual women, their partners, and their children. Helping couples now to avoid unintended births can make a huge difference in future population size. With family planning being accessible, it will help millions of people today and assure a better future (Alan Guttmacher Institute, 1999). Therefore, family planning services benefit the health and well-being of women, children, families and communities; and is a key component of sexual and reproductive health services (Virginia Department of Health, 2002). Using family planning methods by women and men help families space births, prevents unwanted pregnancy, and in the case of consistent condom use, prevents transmission of sexually transmitted infections including Human Immunodeficiency Virus (HIV) (WHO, 2001).

Family planning services play important role in economic and social development. Slowing population growth buys time for a country to invest in development aimed at raising living standards of the people (Thang and Anh, 2002). As more people choose to use family planning, fertility falls and population growth slows. Slower population growth helps protect the environment. It conserves resources, preserves clean air and water, improves health, eases pressures on cities, and helps avoid conflict. Slower population growth aids development. It buys time and provides a demographic bonus that can be invested in education, job creation, health care, and other efforts to raise living standards. The sooner fertility falls to low levels, the better most countries will be able to achieve sustainable development. Even small declines in fertility today will make a substantial difference in helping to meet people's needs today and improves prospects for future (Upadhyay and Robey, 1999).

2.3 The role of information in accessibility and use of family planning services

Information carries message and when the message is received by the recipient, it will increase their level of knowledge. Therefore, information adds something new to our awareness, removes the vagueness of our ideas and thus brings changes in our lives and environment (Dubey *et al.*, 1994). Information, in one way or another has consistently been a significant element in the development of human society. It has shaped over a long time, the way in which we think and act. It has become an ingredient of human lifecycle such that there is no life in the society without information. Information has become an essential commodity for the man to perform his day-to-day duties. Therefore, information is prerequisite to all development activities. The goal is to ensure that the right information reaches the right clientele at the right time (Dubey *et al.*, 1994).

Information communicated in the mass media and from person to person affect how much people know about family planning and how interested they are in it (Cleland and Mauldin, 1991; Retherford and Palmore, 1983). Several studies (Jato *et al.*, 1999; Bongaarts and Bruce, 1995; Sherpa and Rai, 1997 and Bruce, 1990) have examined the role that information plays on the use of family planning and found that information is important. For example, Jato *et al.* (1999) was looking on the impact of multimedia promotion of family planning and concluded that the use of multiple sources of information promotes adoption of family planning. Bongaarts and Bruce (1995) expressed that good-quality FPI, has helped people have smaller families they prefer, fertility has fallen, and population growth has slowed. Moreover, "FPI encouraged people to visit family planning service sites, to discuss

family planning with their spouse, to space their children and to have only the number of children they could afford to care for adequately" (Jato *et al.*, 1999: 61). In addition, the messages provided information on available family planning methods, emphasizing that modern methods are effective and safe and have health and economic benefits for the entire family (Sherpa and Rai, 1997). The continued exposure to different media sources of the same message on family planning was also found to help changing people's attitudes and knowledge, as a result, create a climate in which family planning is perceived as a social norm (Jato *et al.*, 1999).

Clients should be given adequate information in order to make informed and voluntary choices regarding use of family planning methods. Information given to clients to help them make this choice should at least include: understanding of the relative effectiveness of the method; correct use of the method; how it works; common side-effects; health risks and benefits of the method; signs and symptoms that would necessitate a return to the clinic; information on return to fertility after discontinuing certain methods used; and information on Sexually Transmitted Infections (STIs) protection (WHO, 2002). Evidence from a study conducted in Mexico suggests that, providing potential family planning users with information have significant effect on their choice on family planning (Jain *et al.*, 1999). With more information and encouragement, more men would be able to play positive roles in reproductive health. For example, a husband can help his wife have safe pregnancies and give birth to healthy babies if he becomes better informed about maternal and child health (Sherpa and Rai, 1997). Bruce (1990) stressed the importance of providing information about the range of family planning methods

available, their scientifically documented contraindications, and advantages and disadvantages associated with each method.

When a prospective user of family planning makes decisions, the best decisions about family planning are those that people make for themselves, based on accurate information and a range of family planning options. People who make informed choices are better able to use family planning safely and effectively. Providers have a responsibility to help people make informed family planning choices (Upadhyay, 2001). Good communication between clients and family planning providers during counseling is a key to informed choice. When counseling is a partnership, in which clients and providers communicate openly, share information, express emotion, and ask and answer questions freely, clients are more satisfied, understand and recall information better, use family planning more effectively, and live healthier lives (Dimatteo, 1994; Donabedian, 1988; Hall *et al.*, 1988).

UNFPA (1997) reported that provision of FPI to individuals and community will do the following,

- Increase awareness that family planning saves the lives of women and children and brings many benefits to the community
- Enhance the ability of couples and individuals to exercise their basic right to decide freely and responsibly the number and spacing of their children.
- Encourage action to improve the quality and accessibility of family planning services

- Change attitudes or beliefs about the safety of family planning methods and about the advantages of proper birth spacing.
- Change behaviour and prevent major reproductive health problems such as STIs, unwanted pregnancy, and high-risk pregnancy.

However, other studies (Huezo and Malhotra, 1993; Orobaton, 1995) suggest that more FPI may not necessarily be better. Family planning providers have limited time in which to counsel each client, and clients may have difficulty identifying and retaining the key facts from an extensive, unfocused flow of information (Centre for Communication programmes, 1989). Clients also may find too much information and too much choice to be stressful (Mills and Krantz, 1979). Thus, the focus should be on improving the quality of information and the interaction between provider and client rather than the quantity of information conveyed (Kim *et al.*, 1997). A study undertaken in Kenya, suggests two ways to improve the quality of the information offered to family planning clients. First, providers might put FPI into a more personal context, relating the facts to each client's reproductive goals, values, priorities, and lifestyle. This alters the provider's job, shifting the emphasis from technical expertise to an advisory role. Second, after the clients are fully informed about all options of family planning methods, based upon information gathered about the client at the session, the provider might narrow the detailed discussion to two or three methods that best suit an individual client's expressed needs and preferences. This would give providers the time to discuss each of these methods fully, offering more complete information and making it easier for clients to understand the options (Kim *et al.*,

1997). Therefore, a well informed client or prospective client has a better chance of making an informed choice.

2.4 Sources of family planning information

In earlier days, information on family planning was spread by the word of mouth, often surreptitiously. This was the case not only because illiteracy existed, but because family planning was not a permissible subject for the printed page (Stycos, 1971). There is evidence, on the few occasions when literature on family planning was widely read. For example, "the long-term decrease in British fertility that began in 1876 was accelerated by huge increase in public information about family planning" (Stycos, 1971: 25). In a family planning programme in East Pakistan, FPI was disseminated by a singing team, recruited from local artists who performed in towns, villages and bazaars. The group composed songs in the local medium, emphasising the economic and family health aspects of family planning. A similar musical effort was initiated in Kenya, which tells the benefits of family planning and had greater success (Harvey, 1966). Mass media particularly radio, makes information available at low cost, in remote areas and can reach large numbers of people (Zijp, 1994).

However, nowadays there are many information sources which are useful in dissemination of FPI. Several studies (Olaleye and Bankole, 1994; Ryerson, 1994; Valente, 1994; Piotrow, 1992) have documented increased use of family planning and other behavioural changes following specific communications interventions using one or more media channels. Another study by Jato *et al.* (1999) on the impact

of multimedia family planning promotion on the contraceptive behaviour of women in Tanzania concluded that multiple media sources of information reinforce one another and extend the reach of family planning messages. They argue that "complimentary messages may help to create an environment where family planning is perceived as a social norm. Therefore, varied media should continue to be used to promote family planning" because the more types of media that people are exposed to, the more likely they would use family planning methods. For example Kiragu *et al.* (1996) were promoting family planning through mass media in Nigeria and reported on increase in family planning use from 25% to 32% within six months.

2.5 Factors affecting access and use of family planning services

The UNFPA has estimated that, over 350 million couples worldwide (more than one-third of all couples) do not have access to a full range of modern FPI and services (United Nations, 1995). The reasons why family planning needs are often not met may include: poor access to quality services, a limited choice of methods, lack of information, concerns about safety or side-effects and partner disapproval (WHO, 2001). For instance, women and men often worry about side effects of family planning use. Others lack accurate information about reproductive health or access to appropriate services (Bongaarts and Bruce, 1995).

Maintaining regular supplies of all family planning methods was found to be important in promoting and sustaining the use of modern family planning methods (Katende *et al.*, 2003). Grady *et al.* (1993) found evidence of the positive effects of ready access to FPI and services to be associated with family planning use

effectiveness in United States. A study by Entwistle *et al.* (1997) suggested that convenience of local family planning providing facility encourages use of family planning methods. Several studies (Beegle, (1994); Mroz *et al.*, (1999); Feyisetan and Ainsworth, (1994); Oliver, (1994); Topcuoglu, (2000); Cohen (2000)) found that increasing quality and accessibility of family planning services have positive effect on family planning use. Moreover, Pullum (1991) concluded that geographic proximity of the facility which provides family planning services is an important determinant of family planning use. In addition, improved availability of services (as evaluated by distance to sources and availability of a wide range of services) is generally associated with high level of access and use of family planning services (Ainsworth, 1994).

2.6 Involvement of men in access and use of family planning services

The historic focus on family planning services for women has led to neglect of men's need for FPI and services, often to the disadvantage of both men and women (Ringheim, 2002). In 1994, the International Conference on Population and Development (ICPD) called on organizations that historically had provided family planning and other reproductive health services to women to constructively involve men in their programs for the benefit of both men and women (Ringheim, 2002). Involving men in reproductive health has been found to have a positive impact on women's and children's health in a number of ways, including improving family planning use-effectiveness and continuation (Family Health International, 1998). There are studies (Wang *et al.* 1998; Tefere and Larson, 1993; Tapsoba *et al.* 1993) that have shown that involving men can increase family planning adoption, client

satisfaction, family planning use-effectiveness, and continuation. This means that women whose husbands were included in family counselling easily adopted use of family planning and continuation was high. Similarly a study by Raju and Leonard (2000) stressed that there could be only very small improvement in women's access and use of FPI without men's support and active involvement.

A review of studies of reproductive health interventions undertaken by Becker in 1996 concluded that "in most instances a couple approach can be more successful than serving individuals" (Becker. 1996:3). Improving communication between partners on sexual and fertility-related matters appears to improve family planning use (Salway, 1994) but "is not necessarily a prerequisite for men's involvement in family planning use" (Karra *et al.*, 1997: 3). "Even in areas in which the prevailing culture emphasizes men's authority over women, many couples report discussing matters related to family size and family planning use" (Renne, 1993: 4). Green *et al.* (2002) reviewed research in 13 countries to determine whether recruiting men as Community-Based Distribution (CBD) workers increases the use of male condoms. They found that male CBD workers were acceptable to communities, distribute more condoms than women do, and serve more male clients. They concluded that male CBD workers may encourage men to share responsibility for family planning more equally with women and may increase the acceptability and use of family planning methods. Furthermore, the 1993-1994 male motivation campaign in Zimbabwe demonstrated that men can be reached with family planning messages (Kim *et al.*, 1996). The keys are to select appealing and appropriate communication channels, such as radio dramas and sports events, and to develop messages that use virile

images, such as winning games. The campaign showed that involving men in family planning encourages couples to communicate and ultimately to decide to use family planning (Kim *et al.*, 1996). Therefore, involving men in matters regarding family planning is very important especially in African settings (patriarchal societies) where men have strong influence on women's reproductive health.

2.7 Summary

This chapter reviewed the literature on what has been done as far as access and use of family planning services is concerned and what gaps need to be addressed and filled for better access and use of family planning services by rural communities. The chapter reviewed literature on access and use of family planning services, importance of family planning services, and the role of information on access and use of family planning services. In addition, issues related to sources of family planning information, factors affecting access and use of family planning services and involvement of men in access and use of family planning services literature have also been reviewed. As mentioned in the previous sections, several studies (Jato *et al.*, 1999; Bongaarts and Bruce, 1995; Sherpa and Rai, 1997 and Bruce, 1990) have examined the role of information in use of family planning and found that information is an important aspect in promoting use of family planning. However, little research has been done as far as accessibility and use of FPI among rural communities in Tanzania is concerned. This study fills this gap by investigating the accessibility and use of FPI in rural Tanzania, particularly Kilombero District. The research methodology used in this study is presented in Chapter Three.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section describes the location of the area of study, the research methods, the study population, sampling methods, and the methodology that were employed in conducting the study. It explains the data collection methods and the appropriateness of the methodology used with regard to the nature of the research problem and related research objectives.

3.2 The study area

The study was conducted in Kilombero District, Morogoro region. Selection of Kilombero District was based on its higher population growth rate (3.4%). Morogoro region is one of the twenty one regions in Tanzania mainland. The region lies between latitude 5^0 58″ and 10^0 0″ to the south of the Equator and longitude 35^0 25″ and 35^0 30″ to the east. It is bordered by eight other regions namely Arusha, Manyara and Tanga regions to the north, Ruvuma and Lindi to the south, Dodoma and Iringa to the west, and the Coast region to the east. Morogoro region occupies a total area of 72,939 square kilometres, which is approximately 8.2% of the total area of Tanzania mainland. It has six districts, Morogoro Urban, Morogoro Rural, Kilosa, Kilombero, Mvomero and Ulanga. Kilombero District occupies an area of 14,246 square kilometres, which is 20% of the area of Morogoro region. The District has five divisions. The divisions are divided into nineteen wards. These in turn are sub-divided into forty-six villages. The main ethnic groups in Morogoro region are the Waluguru, Wasagara, Wakaguru, Wandamba and Wapogoro. The Waluguru are the

majority in Morogoro Rural District, Wasagara/Wakaguru in Kilosa, Wandamba in Kilombero and Wapogoro in Ulanga District (URT, 1997). Morogoro region had a population of 1,759,809 in 2002 with a population growth rate of 2.6. Kilombero District had a population of 322,779, with a population growth rate of 3.4% (URT, 2003).

3.3 Study population

Population is defined as the theoretically specified aggregation of study elements from which the sample is actually selected (Babbie, 1995). The population of this study included men and women of reproductive age from different villages of Kilombero District, MCH clinic staff and community health workers. Although women are the ones who get pregnant, men were also included in this study because they are the ones who cause pregnancy. Not only that, but also in patriarchal societies, men are the heads of most households; hence have great influence on their partners' adoption and use of family planning methods. All the selected women and men were of reproductive age because the study dealt with reproductive issue (family planning). MCH clinic staff provide family planning services to those who attend MCH clinics, while community health workers provide education and counselling on matters related to health aspects including family planning. Staff from non-governmental organisations dealing with provision of family planning services in the District were also the target, but unfortunately, there were no such organisations.

3.4 Research methods

The study used descriptive survey method because it was deemed relevant to the nature and purpose of the research. The survey technique has the ability of determining the characteristics, opinions, attitudes, behaviour and beliefs of the larger population (Sanders and Pinhey, 1974). Nature of this study was to get information on people's opinions, attitudes, behaviours and beliefs in relation to access and use of family planning information (FPI). Equally important is the fact that survey technique tends to save time and money without sacrificing efficiency, accuracy and information adequacy (Busha and Harter, 1980).

3.5 Sampling methods

This study used a multi-stage sampling method. It was a three-stage sampling design and simple random sampling methods. Kilombero District has nineteen wards and forty-six villages, from which five wards were randomly selected. From a list of all villages in the selected wards, two villages were randomly selected from each of the selected wards (ten villages in total). From a list of all the households in the selected villages, ten households were selected from each of the ten selected villages (100 households). The selection of households was done by randomly picking two households in every ten households. One respondent from each of the selected households was purposely selected to include only those engaged in reproduction. In order to have gender balance, in each village five men and five women were interviewed. Two community health workers from each of the selected wards were randomly selected (ten community health workers). One MCH clinic was randomly selected from each of the selected wards. From the selected MCH clinics, two MCH

clinic staff dealing with provision of family planning services were randomly picked (ten MCH clinic staff). Initially, it was proposed to interview ten staff from non-governmental organisations dealing with provision of family planning services in the District, but it was not feasible since there were no NGOs providing family planning services in the area.

3.6 Sample size

The sample size for the study was 120 respondents that include; 100 women and men, 10 community health workers, and 10 MCH clinic staff.

3.7 Data collection methods

The study used a combination of data collection methods, this is known as triangulation. Triangulation in research refers to the combination of two or more theories, data sources, data collection methods, investigators, or data analysis techniques to provide confirmation, validity and completeness (Mitchell, 1986). The use of triangulation in data collection, improves validity and reliability of the data collected as recommended by Babbie (1995). The method was also used by Kiondo (1998) in her study of access to gender and development information by rural women in the Tanga region. The data collected include primary and secondary data.

3.7.1 Primary data

Primary data were collected using questionnaires, face-to-face interviews, and direct observation. The methods were chosen because they are most appropriate to the respondents and type of information collected as explained in section 3.8

3.7.2 Secondary data

Secondary data were collected from published and unpublished documentary sources available in the library and on the Internet. These include journal articles, books, research reports, conference proceedings and reports from different organizations.

3.8 Instruments

3.8.1 Questionnaire

Pre-tested questionnaires were administered to selected respondents for them to answer the set of questions provided. The advantage of a questionnaire is that it involves many respondents to answer the questions at a time, and in so doing, provides the required data in a short time. It is also cheaper in terms of money. The questionnaire was structured, standardized and included both open- and close-ended questions. The study used a combination of both structured and unstructured questions because of its advantage of increasing reliability of the responses (Line, 1982).

3.8.2 Face-to-face interview schedule

Face-to-face interviews were conducted with the community health workers. This method requires the interviewer to meet face-to-face with the respondents. Advantages of interviews are that they are flexible and can give more information by providing the researcher an opportunity to probe and ask follow up questions. However, they have disadvantage of being expensive especially in dealing with large samples (Kothari, 1990). An interview schedule (Appendix IV on page 146) was used to guide the interview.

3.8.3 Observation guide

The observation of FPI dissemination activities and delivery systems available at the MCH clinics that provide family planning services in the community was done. Observation provides an opportunity to document activities, behaviour, and physical aspects without having to depend upon people's willingness and ability to respond. To guide the observation process, the researcher used an observation guide (Appendix V on page 147).

3.9 Administration of research instruments

A total of 100 of questionnaires (Appendix II on page 119) were administered to women and men respondents in the selected households through face-to-face interview. The questionnaire was translated into Swahili language (Appendix III on page 133) since most of the respondents do not understand English language. The interviewer met face-to-face with the respondents either spontaneously or via scheduled appointment and asked them the set questions. Ten questionnaires (Appendix I on page 111) were self administered to MCH clinic staff in the MCH clinics surveyed. Interview schedule (Appendix IV on page 146) was used in interviewing ten community health workers. The observation guide (Appendix V on page 147) was used to observe family planning activities in the surveyed MCH clinics.

3.10 Pilot study

The pilot study was conducted in order to pre-test the research instruments and see if they can answer the formulated research questions accordingly. According to Line

(1982) a pilot study in any research is important because it show up the shortcomings and unnoticed errors.

3.11 Data analysis and presentation

Data analysis was performed in order to summarise and organise the collected data so that they could be easily interpreted with respect to research questions. The manual and content analysis were used. Data collected from close-ended questions were analysed manually as follows; first, tallying the responses each time they appear from each of the questions; second, counting the tallies of each response in a particular question; third, comparing the total counts of each response in a question for all the questions. The response which had a higher total count was taken to be the response of that particular question. Content analysis is a research method which consists of establishing a number of different content categories and counting up the number of times items relevant to each of them occurs in a particular set of data (Powell, 1992). Content analysis was used to analyse responses from open-ended questions, interviews, and observation. In general categories of responses were identified and a number of times they appear were counted. Analysed data were presented using the descriptive statistics such as averages, percentages, frequencies, tables, and figures.

3.12 Data quality control

Data quality control was achieved through the guidance of pre-tested research instruments, objectivity and the triangulation of research methods, sources and data analysis.

3.13 Ethical issues

The study was dealing with sensitive personal issues, family planning matters. Therefore, respondents were reluctant to reveal the information particularly male respondents. However, they agreed after the researcher was able to convince them that the information given would be secret and used for research only, and that they were not going to mention their names.

3.14 Summary

This chapter presented the methodology used in data collection. The survey method was used, and involved the use of questionnaire, interview schedule and observation guide as data collection instruments. A multi-stage sampling method was used which comprised of three-stage sampling design and simple random sampling methods. In the first stage, five wards were randomly selected, the second stage was random selection of two villages from each ward, and the third stage was random selection of ten households from each village. Data collected were analysed using manual analysis for structured questions; and content analysis for open ended questions and data from interviews and observations. The study findings are presented in Chapter Four.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

The study was conducted in order to investigate accessibility and use of family planning information (FPI) among rural people in Kilombero District, Tanzania. The purpose of the study was to investigate the way FPI is accessed and used by people rural people in Kilombero district. The assumption of the researcher was that establishing the status of accessibility and use of FPI in these areas may provide baseline information for policy makers and practitioners for future planning and improvement of family planning services in the rural areas.

The research was conducted in ten villages namely, Katindiuka, Kikwawila, Kisegese, Lipangalala, Machipi, Mbasa, Michenga, Mkasu, Namawala, and Sekamaganga. A total of one hundred and twenty respondents instead of one hundred and thirty that were initially proposed for the study were surveyed. Therefore the success rate was 92.3%. This is due to the fact that, the other (7.7%) targeted respondents were staff from NGOs, which provide family planning services. Unfortunately, there were no NGOs dealing with provision of family planning services in the surveyed area. Furthermore, a total of five MCH clinics in the area were also surveyed. Out of the 120 respondents, 100 were women and men of reproductive age from the selected households (fifty women and fifty men); 20 were family planning providers in the surveyed areas; these included ten MCH clinic staff and ten community health workers. The fifty women and fifty men were purposely selected to avoid gender biasness.

Two sets of questionnaires (Appendix I and II), for MCH staff and women and men from selected households; Interview Schedule (Appendix IV on page 146) and Observation Guide (Appendix V on page 147) were used in data collection. The data were analysed in two groups, the family planning providers and clients. This chapter is presenting the findings of the study based on the sequence of the research questions presented in section 1.4.

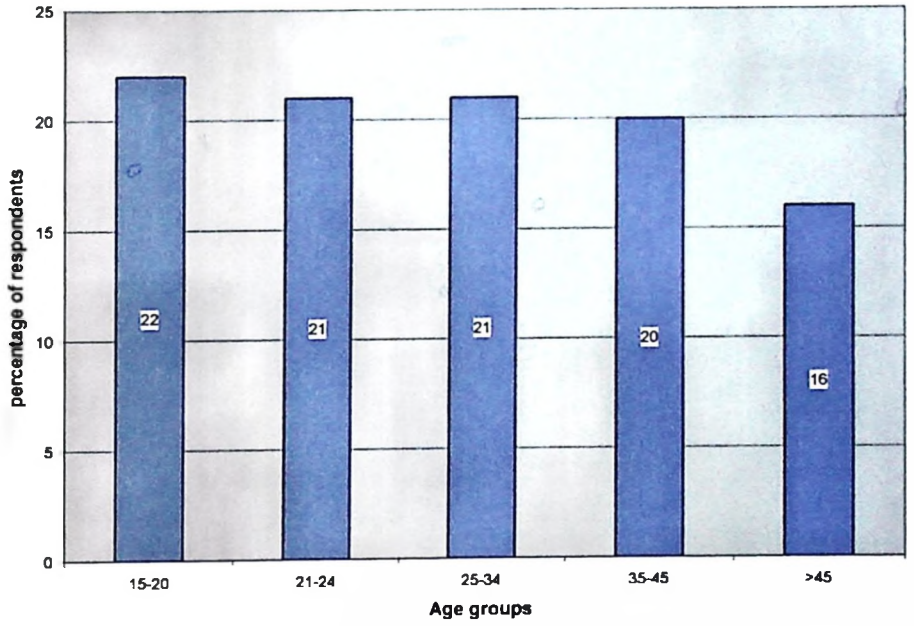
4.2 Demographic information of the respondents

Some of the questions were designed to provide the demographic information on the study population. The demographic information was essential in order to know the characteristics and nature of the study population. All one hundred respondents gave their demographic information. Respondents were requested to indicate their gender, age, education level, sources of income, income levels per annum, number of children and the spacing between births of their children. Demographic information collected from the family planning providers includes gender and education. The findings from the study indicate that all the family panning providers in the surveyed area were women.

4.2.1 Age

The study findings (figure 2 on page 38) indicate that 22% of respondents were within the 15 - 20 age group. Others were within 21-24 (21%); 25 – 34 (21%); 35 – 45 (20%) and more than 45 (16%) age groups.

Figure 2: Age of respondents

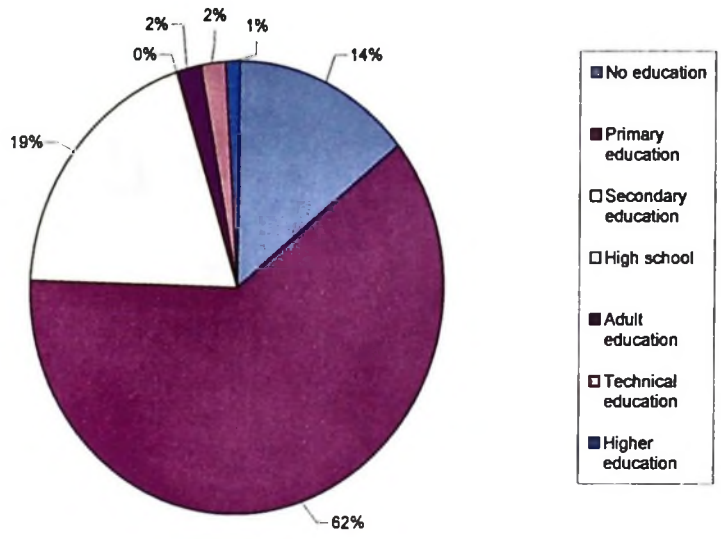


Source: Field Data, 2004

4.2.2 Education

The findings (figure 3 on page 39) indicate that majority of respondents had primary school education (62%). Few had secondary school education (19%) and some were illiterate (14%), very few had adult education (2%), vocational training (2%) and higher education (1%).

Figure 3: Education of respondents



Source: Field Data, 2004

As far as education is concerned, the family panning providers had Certificates of Public Health (30%), Certificates of Nursing (20%) and Primary Education (50%) as shown in Table 1 below.

Table 1: Education of family planning providers

N=20

Categories	**N**	**%**
Primary education	10	50
Nursing certificate	4	20
Public health certificate	6	30
Total	**20**	**100**

Source: Field Data, 2004

4.2.3 Income sources and levels per annum

The study findings (Table 2 below) indicate that the main source of income of the respondents was agriculture. About 98% of respondents depended on agriculture, on which 78% depend on agriculture only; 14% depend on agriculture and business; 3% depend on agriculture and formal employment; and 3% depend on agriculture and grants from relatives. However, 2% depended on formal employment and business. Furthermore, majority of respondents (43%) earned between 100,001 and 200,000 Tanzania shillings (Tshs) per annum. Others earned between 200,001 and 300,000Tshs (31%), 300,001 and 400,000Tshs (15%), more than 400,000Tshs (7%), and less than 100,000Tshs (4%) per annum.

Table 2: Income of respondents

N=100

Sources of income	**%**	**Income levels per annum (Tshs)**	**%**
Formal employment & business	2	<100,000	4
Formal employment & agriculture	3	100,001 -200,000	43
Business & agriculture	14	200,001 -300,000	31
Agriculture only	78	300,001 -400,000	15
Grants from relatives & agriculture	3	>400,000	7
Total	**100**	**Total**	**100**

Note: frequency is equal to percentage because N is 100

Source: Field Data, 2004

4.2.4 Total number of children

Majority of respondents (54%) had 4-6 children, and others had 7-9 children (30%), 1-3 children (10%) and more than 10 children (6%).

4.2.5 Child spacing

The findings (Table 3 below) indicate that, the birth interval for the 1st and 2nd birth were; 2-4 years (49%), less than two years (46%), 5-6 years (4%) and more than six years (1%). The birth intervals for the 2nd and 3rd births were; 2-4 years (55%), less than two years (43%), and 5-6 years (2%). The birth intervals for the 3rd and 4th births were; more than two years (46%), less than two years (40%), and 5-6 years (4%). The birth intervals for 4th and 5th births were; 2-4 years (49%), less than two years (36%) and 5-6 years (2%). The birth intervals for 5th and 6th births were; 2-4 years (50%), less than two years (17%) and 5-6 years (2%). The birth intervals show the same trend throughout all the births. Majority had birth interval of 2-4 years, followed by less than two years.

Table 3: Child spacing

N=100

Birth intervals (years)	**1st & 2nd birth (%)**	**2nd & 3rd birth (%)**	**3rd & 4th birth (%)**	**4th & 5th birth (%)**	**5th & 6th birth (%)**
<2	46	43	40	36	17
2-4	49	55	46	49	50
5-6	4	2	4	2	2
>6	1	0	0	0	0
Total	**100**	**100**	**90***	**85***	**69***

Note: * The total is not 100 because other respondents had fewer children

Frequency is equal to percentage because N is 100

Source: Field Data, 2004

4.3. Provision and accessibility of family planning services

Before assessing the accessibility and use of FPI, it was necessary to determine the provision and accessibility of family planning services in the surveyed area. This is because for the dissemination of FPI to be meaningful, family planning services must be available and accessible.

Respondents were asked if they were aware of the availability of family planning services. 69% of the respondents indicated that they were aware of the availability of family planning services, while 31% were not aware. Those respondents who were aware of availability of family planning services (69%) were asked if they access family planning services. The findings indicate that 47% were accessing family planning services and 22% were not accessing family planning services. Those who indicated that they had access to family planning services (47%) were asked to indicate where they access the family planning services by choosing from three sources listed by researcher. The study findings revealed that majority of respondents were accessing family planning services from MCH clinics (35%). Others were accessing family planning services from local hospital (5%) and from community healthy workers (7%).

On the other hand, family planning providers were asked to state whether they provide family planning services; all of them (20 respondents) agreed that they provide family planning services. Majority of the family planning providers (80%) stated that they have been successful in the provision of family planning services, while some (20%) were uncertain. They also agreed that they target both men and

women but only women attended the family planning educations sessions (55%) and others indicated that they target mothers who attend MCH clinics (45%).

From the observation point of view, the provision of family planning services was done in MCH clinics. However, the provision was most of the time done in hurry, may be because the providers had a lot of clients waiting and other duties to perform.

4.3.1 Reasons for inaccessibility of family planning services

Respondents who indicated that they do not access family planning services (22%) were asked to state possible reasons for not accessing the family planning services. The findings indicate that the major reason for not accessing family planning services was insufficient knowledge about family planning (11%). Other reasons are the long distance (more than 10 kilometres) to reach the health facility that provides family planning services (6%) and family planning providers do not reach the rural areas/rural people (5%).

4.3.2 Strategies for improving accessibility to family planning services

Respondents (providers and clients) were also asked to provide their opinions on improving accessibility to family planning services in their community. Tables 4a and 4b on page 44, show the opinions provided for improving accessibility to family planning services by clients and providers respectively.

Table 4a: Strategies for improving accessibility to family planning services (as recommended by clients)

N = 100

Strategies	%
To build more health facilities in rural areas so that family planning services are brought near the clients e.g. every village to have one health facility.	45
To improve the working conditions of the providers by providing all the facilities needed to reach rural communities such as reliable transport	30
To make sure all the family planning services are available all the time	25
Total	**100**

Note: frequency is equal to percentage because N is 100

Source: Field Data, 2004

Table 4b: Strategies for improving accessibility to family planning services (as recommended by providers)

N = 20

Strategies	N	%
To build more health facilities in rural areas so that family planning services are brought near the clients e.g. every village to have one health facility.	4	40
To employ more family planning providers and give them good salaries to motivate them	2	10
To improve the working conditions of the providers by providing all the facilities needed to reach rural communities such as reliable transport.	6	30
To make sure all the family planning services are available all the time.	8	20
Total	**20**	**100**

Source: Field Data, 2004

4.4 Family planning information sources, delivery systems and communication channels

4.4.1 Sources

Respondents who were aware of family planning services (69%) were asked to indicate the FPI sources through which they accessed FPI from eleven FPI source listed by the researcher. The findings of the study indicate that majority of those who were aware of family planning services accessed FPI through radio (23%). Other FPI source were MCH clinic staff (20%), community health workers (10%); friend/neighbour (5%), leaflets (4%); posters (3%); pharmacy (2%) and newspapers (2%).

4.4.1.1 Preferred family planning information sources

Respondents were also asked to choose FPI source which they prefer from eleven FPI source listed by the researcher and rank them in a scale of one to four as 1 = most preferred, 2 = preferred, 3 = least preferred, 4 = not preferred. The findings (Table 5 on page 46) show that, the most preferred FPI source was radio (76%). Others were MCH clinic staff (62%), leaflets (49%), newspapers (40%), community health workers (39%), and songs (37%). Preferred FPI source were drama (42%), posters (41%), films (40%) and television (39%). The least preferred FPI source was friend/neighbour (54%).

Table 5: Preference of family planning information sources

N=100

FPI source	Most preferred		Preferred		Least preferred		Not preferred	
	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
Radio	76	1	15	9	9	10	0	8
Posters	18	10	41	2	29	2	12	5
Friend/ neighbour	10	11	16	8	54	1	20	1
Leaflets	49	3	17	7	14	9	20	1
Newspapers	40	4	27	5	23	4	10	5
Television	22	7	39	4	21	5	18	3
Community Health Workers	39	5	24	8	24	3	13	4
MCH clinic staff	62	2	16	8	18	7	4	6
Films	16	9	40	3	24	3	20	1
Drama	19	8	42	1	17	8	2	7
Songs	37	6	24	6	20	6	19	2

Note: frequency is equal to percentage because N is 100

Source: Field Data, 2004

4.4.2 Appropriateness of family planning information delivery methods

Respondents were also asked to choose the FPI source which were appropriate in dissemination and delivery of FPI to their community and rank them in a scale of one to four as 1 = very appropriate, 2 = appropriate 3 = least appropriate 4 = not appropriate. The findings (Table 6 on page 47) indicate that, the very appropriate FPI source for disseminating and delivering FPI in the surveyed community were radio (92%), MCH clinic staff (76%), community health workers (49%), newspapers (47%) and leaflets (42%). Appropriate FPI source were posters (45%), songs (44%),

television (43%), films (42%), drama (38%) and the least appropriate FPI source was friend/neighbour (47%).

Table 6: Appropriateness of family planning information delivery methods N=100

FPI delivery methods	Very appropriate		Appropriate		Least appropriate		Not appropriate	
	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
Radio	92	1	3	11	5	8	0	9
Posters	12	10	45	1	26	3	17	3
Friend/ neighbour	11	11	17	9	47	1	25	1
Leaflets	42	5	31	6	20	6	7	8
Newspapers	47	4	22	8	22	4	9	6
Television	17	9	43	3	21	5	19	2
Community health workers	49	3	27	7	20	6	4	
MCH clinic staff	76	2	10	10	7	7	8	7
Films	24	7	42	4	27	2	7	8
Drama	26	6	38	5	26	3	10	5
Songs	21	8	44	2	20	6	15	4

Note: frequency is equal to percentage because N is 100

Source: Field Data, 2004

However, the family planning providers interviewed indicated that they use only posters in dissemination of FPI, and they do not have outreach programmes for those people who do not attend MCH clinics. On top of that all of them said the only plan they have is to train traditional birth attendants so that they can help in dissemination of FPI. They disseminate FPI through educational sessions in their clinics. The study findings from the interview with family planning providers on effectiveness of

information sources in the surveyed area indicated that posters, radio and leaflets were the most effective information sources for disseminating FPI. Community health workers, MCH clinic staff, drama and newspapers were effective information sources. The fairly effective information sources were television, films, and songs. Friend/neighbour was the least effective information source.

As per observation, the main FPI delivery method used was posters and education sessions in MCH clinics. However, the posters were very few and some of them were very small to be read from far or to attract a distant viewer.

4.4.3 Satisfaction with family planning information delivery methods

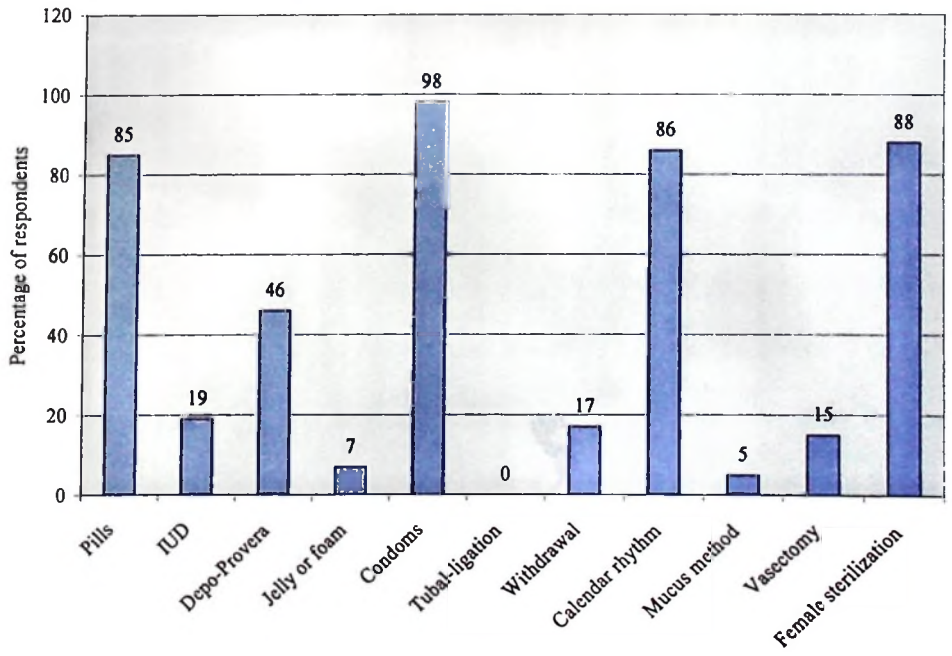
Respondents were also asked if they were satisfied with the way FPI is disseminated. Majority of respondents (78%) indicated that they were not satisfied with the way FPI is disseminated, but few (22%) were satisfied. Those who were not satisfied were requested to give reasons for their dissatisfaction. Major reasons given were; FPI is not open to all groups of people, but only those who attend MCH clinics (30%), many people in the rural areas have not been reached (24%), FPI is only given to women, men are ignorant hence do not allow their wives to use family planning methods (16%) and the use of posters which are difficult to be read by those who are illiterate (8%). On the other hand, all the family planning providers indicated that they do not encounter problems in disseminating FPI.

4.5 Knowledge and use of family planning information

4.5.1 Awareness of family planning methods

Respondents were asked to indicate all the family planning methods they were aware by choosing among twelve methods listed by the researcher. The findings (figure 4 below) reveal that majority of respondents were aware of condoms (98%); calendar rhythm (92%), pills (88%), and female sterilization (85%). Others are Depo-Provera injection (46%), intra-uterine Device (19%), withdrawal method (17%), vasectomy (15%), jelly or foam (6%), and mucus method (5%). However, all the respondents were not aware of tubal-ligation method.

Figure 4: Awareness of family planning methods



Source: Field Data, 2004

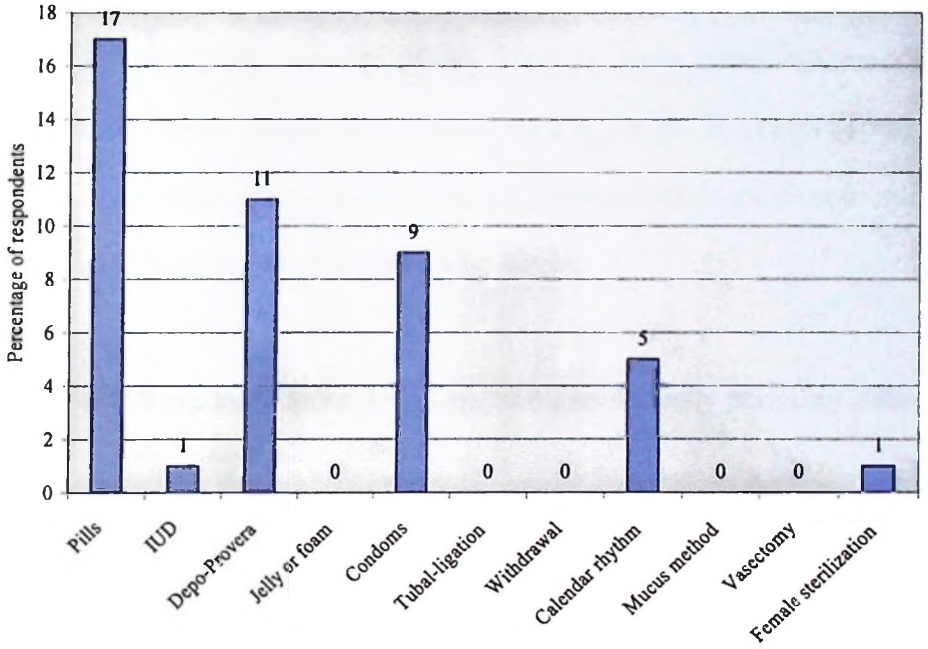
4.5.2 Knowledge of family planning methods

The respondents were asked if they have adequate knowledge on the various family planning methods. The study findings indicate that, 47% of respondents had adequate knowledge on various family planning methods, while 53% did not have adequate knowledge on various family planning methods. Those who indicated that they do not have adequate family planning knowledge were asked to provide the possible reasons. The study findings show that the reasons for inadequate family planning knowledge in the surveyed area are: many people did not attend MCH clinics where the education was provided (21%), lack of interest on family planning matters (17%), and family planning providers only directed on how to use the family planning methods; they did not educate and give details on various family planning methods (15%).

4.5.3 Use of family planning methods

Furthermore, respondents were asked to state whether they use family planning methods. 44% of the respondents indicated that they use family planning methods, while 56% indicated that they do not use family planning methods. Those who indicated that they use family planning methods were requested to state the family planning methods they were using. The findings (figure 5 on page 51) indicate that 17% were using pills. Other family planning methods used were Depo-Provera injection (11%), condoms (9%), calendar rhythm (5%), IUD (1%) and female sterilization (1%). On the other hand none indicated to use jelly or foam, tubal-ligation, withdrawal, mucus method and vasectomy.

Figure 5: Use of family planning methods



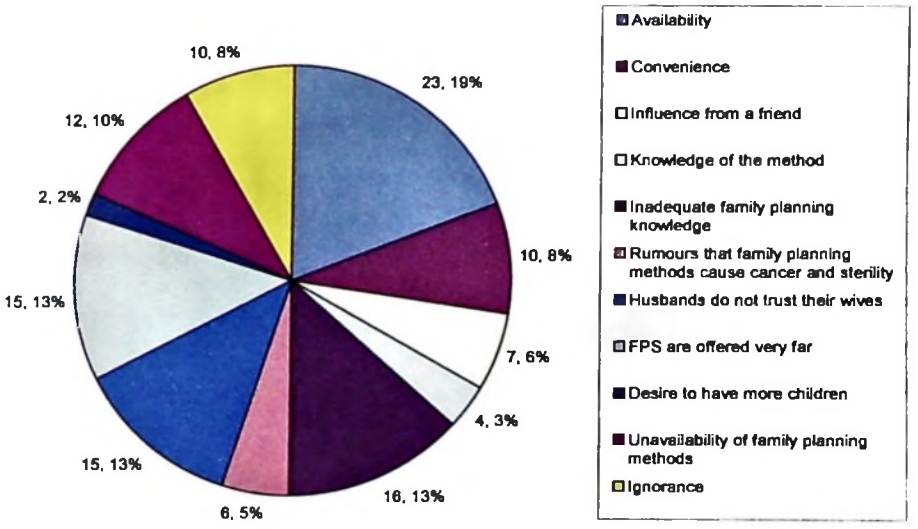
Source: Field Data, 2004

4.6 Factors responsible for access and use of family planning information

Respondents who were using family planning methods (44%) were asked to state the reasons which influenced their choice of family planning methods they were using, by choosing from the four methods listed by researcher and were allowed to state any other reasons which were not in the list. From the study findings (figure 6 on page 52), reasons given were availability of the family planning methods (19%), convenience of the family planning methods (8%), influence from a friend (6%) and knowledge of the family planning methods (3%). Those who were not using family planning methods (56%) were also requested to state the possible reasons for not using family planning methods. The study findings (figure 6 on page 52) revealed that the reasons for not using family planning methods in the surveyed area are:

inadequate family planning knowledge (13%), belief that family planning methods causes cancer and sterility (5%), husbands not trusting their wives (13%), family planning services are very far (13%), want to have more children (2%) and unavailability of the family planning methods in the MCH clinics (10%). All the reasons given for accessing or not accessing and choosing to use or not to use family planning methods are presented in figure 6 below.

Figure 6: Factors responsible for access and use of family planning information



Source: Field Data, 2004

4.6.1 Problems encountered in accessing and using family planning information

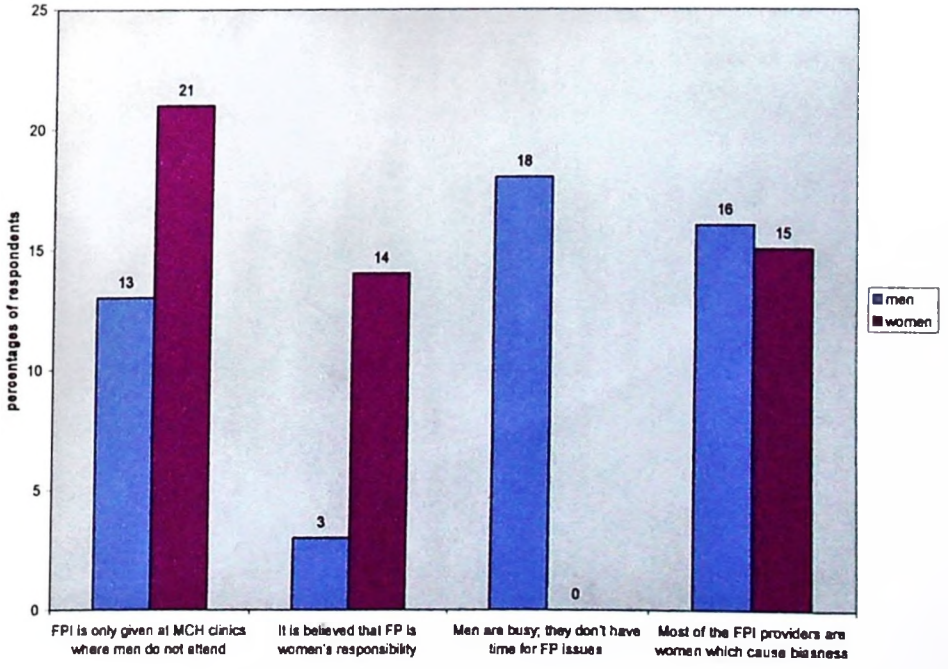
Respondents were asked if they encounter problems in accessing FPI. The study findings indicate that, 37% encountered problems in accessing FPI, 32% did not encounter problems in accessing FPI, and 31% do not know. Those who indicated that they encountered problems in accessing FPI (37%) were asked to mention those problems. The study findings indicate that, the major problem encountered by the study population in accessing FPI was long distance (more than ten kilometres) to the health facility that provide FPI (22%). Other problems were: some people are illiterate so it becomes difficult to read the family planning posters (9%) and FPI is only given to women who attend MCH clinics and by women providers, so it becomes difficult for men to access it (8%).

Respondents were also asked if they encountered problems in using FPI. 61% respondents indicated that they encountered problems, 20% indicated that they did not encounter any problem, and 19% did not know. Those who indicated that they encountered problems (61%) were asked to state the kind of problems encountered. Results showed that the main problem is that men do not want their wives to use FPI (37%). Many women complained that they get FPI but since their husbands are ignorant, it becomes very difficult to convince them to use family planning methods. This was quite a big problem to most of the women who were aware of the family planning services but do not use them. On the other hand, men complained that women who use family planning methods become unfaithful (having extramarital affairs) because of the assurance that they will not get pregnant (24%).

4.7 Opportunities of women and men in accessing family planning information

Respondents were asked to state whether they discuss family planning issues with their partners/spouses. The findings revealed that, 47% (43% men and 4% women) respondents discuss family planning issues with their partners. On the other hand 53% (46% women and 8% men) do not discuss family planning issues with their partners. Furthermore, respondents were asked to state if men and women have equal opportunities in accessing FPI. 100% respondents indicated that women and men do not have equal opportunities in accessing FPI. They were also asked to state the likely reasons for the unequal opportunity among women and men in accessing FPI. The findings are presented in figure 7 below.

Figure 7: Reasons for unequal opportunities of women and men in accessing family planning information



Source: Field Data, 2004

The findings (figure 7 on page 54) reveal that, the major reason for unequal opportunity among women and men in accessing FPI is the provision of FPI at the MCH clinics where men do not attend (34%: 21% women and 13% men). Other reasons are: provision of FPI is most of the time done by women (31%: 16% men and 15% women); men are busy (18% exclusively men); belief that family planning is the responsibility of women (17%: 13% women and 3% men).

4.7.1 Strategies for providing equal access to family planning information

Respondents were asked to provide their opinions on strategies for providing equal access to FPI for both men and women. Tables 7a and 7b below, present the recommended strategies as recommended by clients and providers respectively.

Table 7a: Strategies for providing equal access to FPI (as recommended by clients)

N = 100

Strategies	%
Family planning education to be included in primary and secondary schools curriculum	50
To provide seminars on family planning for couples before marriage	19
Family planning providers should be of both sexes, so that men might feel comfortable to attend MCH clinics	22
MCH clinics should be changed to family clinics so that men can feel comfortable to attend	9
Total	**100**

Note: frequency is equal to percentage because N is 100

Source: Field Data, 2004

Table 7b: Strategies for providing equal access to FPI (as recommended by providers)

N = 20

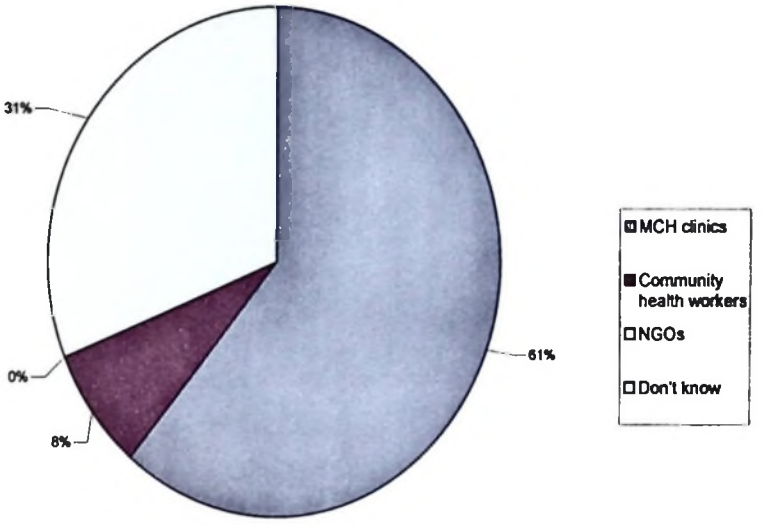
Strategies	N	%
To target both women and men when disseminating FPI	12	60
FPI should be provided in village meetings and seminars where both sexes attend	4	20
Family planning providers should be of both sexes, so that men might feel comfortable to attend MCH clinics	4	20
Total	**20**	**100**

Source: Field Data, 2004

4.8 Knowledge of local family planning providers

Respondents were asked to state the family planning providers who are involved in disseminating family planning services in their community. The findings (figure 8 on page 57) revealed that MCH clinics are the major provider of family planning services (61%) in the surveyed community. Few (8%) cited community health workers, and others were not aware (31%). The NGOs were not cited by all respondents, showing that there were no NGOs responsible for provision of family planning services in the surveyed community. However, all the ten MCH clinic staff interviewed stated that there is an NGO known as "SAFE PLAN" that provide family planning education for women in the MCH clinics as advertisement of their pill, but does not offer other family planning services.

Figure 8: Provision of family planning information and services



Source: Field Data, 2004

4.9 Strategies for effective dissemination of FPI

Respondents were given opportunity to express their opinions on strategies to be employed for effective dissemination of FPI dissemination in their community. The strategies recommended are presented in Tables 8a and 8b on page 58.

Table 8a: Strategies for effective dissemination of FPI (as recommended by clients)

N = 100

Strategies	%
To disseminate FPI through house to house outreach visit in the villages	48
More family planning programmes in the radio, so that many people can be reached	23
"*Jando and unyago*" should be encouraged so that FPI can be disseminated during the sessions	3
Use of drama in disseminating FPI, they are effective because people like to see	12
Use of posters, leaflets, and placards, to capture those who do not attend MCH clinics	14
Total	**100**

Note: frequency is equal to percentage because N is 100

"*jando and unyago*" are traditional reproductive education sessions for youth of reproductive age in Tanzania.

Source: Field Data, 2004

Table 8b: Strategies for effective dissemination of FPI (as recommended by providers)

N = 20

Strategies	N	%
To provide all the necessary facilities needed for effective dissemination of FPI e.g. transport, funds	8	40
To motivate family planning providers by giving them attractive salaries	2	10
To train family planning providers on dissemination of FPI	4	20
More advertisements in mass media and use of posters and placards, to capture all groups of people	2	10
To involve local leaders in dissemination of FPI	4	20
Total	**20**	**100**

Source: Field Data, 2004

4.10 Summary

This chapter presented the research findings by looking at research questions chronologically. The major findings presented include: demographic information of the respondents, provision and accessibility of family planning services, reasons for inaccessibility of family planning services, and strategies for improving accessibility to family planning services.

The chapter presented FPI sources, delivery systems and communication channels used by the surveyed community. It was found that radio was the most popular, most preferred and very appropriate FPI source. As far as family planning knowledge is concerned, the awareness of the family planning methods was high, but knowledge was low. Similarly the use of FPI was low. Furthermore, the chapter presented the factors that were identified as being responsible for access and use of FPI and the problems encountered in accessing and using FPI. It was found that there was unequal opportunity between women and men in accessing FPI; and majority (53%) of people did not discuss family planning matters with their partners. Finally, strategies for improving equal access to FPI were presented and the local FPI provider was found to be MCH clinics.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter discusses and interprets the research findings presented in Chapter Four. Kerlinger (1973) argues that data analysis and information do not in themselves provide answers for research questions; therefore, it is important to discuss and interpret the data to ensure that research questions have been tackled, for the proper understanding of the research findings. The discussion in this chapter is arranged according to the sequence of the research questions.

5.2 Demographic information

Majority of respondents (84%) were aged between 15 and 45 years, which show that the study was able to capture majority of the actively reproductive group (WHO, 1995). The education level was low, where 62% had primary school education. On the economic aspect, most of the respondents (98%) depend on agriculture and they earned very little, between 100,001 and 200,000 Tanzania shillings per annum, that is merely 274 to 548 Tanzanian shillings per day, well below poverty line (standard poverty line is $1) (World Bank, 1999). However, it should be noted that most rural people are subsistence farmers and what is produced for consumption may not have been reflected in the income levels identified in the study. On the other hand, all the family planning providers were women and their education level was low. Most of them had primary school education (50%) and others had lower level certificates. The lower level certificates are certificates obtained after the graduates of primary schools attend a short course. For instance primary school graduate undertake short

course in nursing. Gender and levels of education of service providers have impact in provision of services as indicated in previous studies undertaken in other countries (Rudy *et al.*, 2001; Kim *et al.*, 2001; Hungtington *et al.*, 1990; Abdel-Tawab, 1993; Wang *et al.* 1998; Tefere and Larson, 1993; Tapsoba *et al.* 1993). When both women and men are involved in dissemination of FPI, husbands are motivated to use family planning methods.

The findings show that the fertility rate of the surveyed area is still high. Majority (54%) had 4-6 children per woman and 30% had 7-9 children per woman. This fertility rate is not very far from the documented fertility rate of 5.3 children per woman in Tanzania (TDHS, 1997). But it is quite far above the standard fertility rate for population replacement. The standard fertility rate for population replacement is 2.1 children per woman over a lifetime (Family Health International, 1996). The findings on child spacing showed the same trend throughout all the births, majority had birth interval of 2-4 years, followed by less than two years. The child spacing was within the recommended years for the majority of the population. However, a significant percent of the population had birth interval of less than two years (see Table 3 on page 41), which is less than the recommended three years and not safe for both mother and child.

Ojiambo (1989) presents the characteristics of the rural environment which include "poverty among the ruralites, geographical isolation, and low literacy level, ill served by educational, health, transportation, communication and other social services". The rural people in developing countries suffer from the poverty that restricts their

material goods and works and curtails their store of information in amount and quality. This is quite the case of all the areas surveyed. Majority of people were poor (earning very low or depending on grants from relatives), with low education or illiterate. In addition, there was poor infrastructure posing difficulty in communication and transport and limited access to most of the important social services. Therefore, even the health sector which is the one dealing with provision of family planning services in the community was only limited to few areas.

5.3 Availability and accessibility of family planning services

Family planning services were available in the surveyed area, but accessible to few people. Awareness of the availability of family planning services was found to be high (69%), but the accessibility was limited (47%). MCH clinics were found to be the major providers of family planning services in the area.

From the above findings, the family planning services are available in the surveyed area and people are aware, but majority (53%) do not access. Therefore, the findings agree with Thang and Anh (2002) and Hall and Bowerman (1996) that availability is not enough to make clients access the services. There is a need to be concerned with all important factors which may influence or limit access to services, since none of the factors which influence family planning use has primacy; instead several are essential in combination (Ross, 1995). However, availability of family planning services is a prerequisite for accessibility, relative to the spatial distribution of the population in need (Hall and Bowerman, 1996).

5.3.1 Reasons for inaccessibility of family planning services

The major reason for inaccessibility of family planning services was insufficient knowledge about family planning services (11%). Other reasons included long distance (more than ten kilometres) to reach the facility and family planning providers do not reach the rural areas/rural people. Insufficient knowledge about family planning services is a major factor to inaccessibility of family planning services. This is mainly caused by inadequate promotion of family planning services. Promoting family planning services would increase awareness and knowledge and in turn increase demand for family planning services (Upadhyay, 2001). Out of 69% who were aware of the availability of family planning services in their community, 11% were not sufficiently knowledgeable of the services. This means that, these people only knew that there are family planning services, but they do not know their benefits, why should they use the services, and how the services are offered.

5.3.2 Strategies for improving accessibility to family planning services

One of the strategies for improving accessibility to family planning services recommended by clients is to build more health facilities particularly in rural areas, so that family planning services is brought closer to the clients. For example it was proposed by one respondent that every village should have one health facility which provides family planning services. This strategy is supported by Family Health International (1994) suggesting that access is improved when service delivery points are conveniently located and can be reached by a large segment of a country's population, including underserved populations.

Another strategy is improving the working conditions of the providers and giving them all the facilities needed to reach rural communities such as reliable transport. This will enhance the accessibility of family planning services in the area. With good working conditions and all the required facilities at hand family planning providers could be motivated to work and would be able to reach the remote rural areas. For example, providing reliable transport, providers would reach more people located far from the health facilities.

It was also proposed that provision of all family planning methods at all the time will improve accessibility of family planning services. This is due to the problem which exists in this area that sometimes there is only one method (example only pills) or there is nothing at all. This was also recommended by Jain (1989) that addition of more varieties of methods to the available one would increase use of family planning methods, because clients will have more choices.

On the other hand, the providers proposed more or less similar strategies as the clients but one additional strategy was different. They recommended the government to employ more staff for provision of family planning services in the rural areas. Rural areas are characterised by few health staff. Therefore, employing more staff could help the overburdened staff who fail to meet the population needs.

5.4 Family planning information sources, delivery systems and communication channels

5.4.1 Sources

Respondents named radio (23%) as their leading source of FPI, compared to 20% who cited MCH clinic staff and 10% for community health workers. These findings agree with those of Kiragu *et al.* (1996) who found that while rural men and women are harder to reach than their urban counterparts, the use of the broadcast media is an excellent way to reach rural audiences. Thus radio continues to be one of the most important channel for communicating FPI to rural men and women. Radio may play a greater role in disseminating FPI in rural than in urban areas because in rural areas there is limited access to family planning providers and to other media, such as television and print materials.

However, Kiragu *et al.* (1996) suggests that the use of multiple mass-media channels; radio, television, posters, and other print materials, are effective in reaching a broad audience. Although the findings show that radio is the most efficient information source in reaching these rural people, the use of multiple information delivery methods is the best option. With multiple information sources it may be possible to reach all groups of people. For example, women would prefer to meet the providers than listening to the radio or men may prefer listening to the radio than going to meet the providers. Hence, using all the possible information sources for disseminating information may prove more efficient in reaching all groups of people. This is supported by Family Health International (1994) that the use of a variety of channels to disseminate the family planning messages help to ensure that

the majority of the intended audience are exposed to the messages and that many people will hear the same messages from multiple channels. Therefore, multiple exposures to family planning messages is a key factor in behaviour change among the general population.

5.4.1.1 Preferred family planning information sources

Radio was the most preferred (76%) source of FPI and the least preferred was friend/neighbour (24%). These findings supports those of Zijp (1994) who argues that mass media particularly radio, makes information available at low cost and in remote areas and can reach large numbers of people. On the other hand, friend or neighbour was the least preferred information source. This might be caused by the belief that family planning is something very personal, private and confidential, so people do not want others to know that they access or use family planning services. Due to this notion, many people would prefer just to hear it on the radio or read it from newspapers or posters, but not a friend or neighbour to be involved. The use and preference of radio in the surveyed area may also be attributed to the fact that there are very interesting family planning drama in the national radio which is very popular among the people and most likely people like to listen to these plays and drama which are broadcasted mainly in the evening and many people do gather around a radio to listen

5.4.2 Appropriate family planning information delivery methods

The findings (Table 6 on page 47) show that radio (92%) was the most appropriate delivery method, followed by MCH clinic staff (76%) and community health

workers (49%). Since these were the main source of FPI, hence they find them more appropriate than others. It might be that they are also more convenient to them (what they do is listening) since they do not have to bother of reading like in the case of newspapers and posters or leaflets. These sources also offer privacy, unlike friend/neighbour (47%) which was the least appropriate information source. With radio, a person may be listening without anyone knowing that she/he is listening. Also, radio is affordable by majority of rural people and it can be operated by batteries unlike television which needs electricity. Moreover, there is no electricity in many rural settings, and even if present majority can not afford to use it. Therefore, most rural people would choose to use radio.

5.4.3 Satisfaction with family planning information delivery methods

Majority of respondents (78%) indicated that they were not satisfied with the way FPI is disseminated, but few (22%) were satisfied. Major reasons given were: FPI is not open to all groups of people, but only those who attend MCH clinics (30%), many people in the rural areas have not been reached (24%), FPI is only given to women, men are ignorant hence do not allow their wives to use family planning methods (16%) and the use of posters and printing media were not conducive for those who are illiterate (8%).

This study shows that most people were not personally satisfied with the FPI delivery systems. Studies (Baumann and Deber, 1989; Kay and Nuttall, 1995) support these findings when they argues that personal issues such as discomfort, husband's attitudes, and inconvenience may be as important for client satisfaction as technical

issues such as effectiveness, provider's performance and safety. Therefore, many factors contribute to clients' satisfaction and all have to be taken into account for client's maximum satisfaction with the family planning services. Furthermore, clients who are welcomed, treated with respect and encouraged to ask questions and participate in their health care are more likely to be satisfied family planning users (Family Health International, 1994). As per observation, this was not the case in the surveyed MCH clinics. Most of the providers were not friendly, and treated clients with little or no respect.

From the findings, the dissatisfaction is mainly caused by the limited access to FPI. The provision of FPI in the community was done by MCH clinic staff at the facilities. This has limited many people to access FPI, because unless the person attends the education sessions at MCH clinics he/she will have no chance to access FPI. Since the facilities offering family planning services are very few and far from majority of the population in these rural areas, then many people (particularly men who do not attend MCH clinics) miss the opportunity of getting FPI.

5.5 Knowledge and use of family planning information

5.5.1 Knowledge of family planning methods

The study findings indicate that at least 47% had adequate family planning knowledge, while 53% did not have adequate family planning knowledge. Reasons given for inadequate family planning knowledge include: not attending MCH clinics where the family planning education was provided, lack of interest on family planning matters, and poor performance of family planning providers.

A study on oral contraceptives in Vietnam by Thang and Huong (2001) indicated that the major reason clients would never use a certain family planning method is that they had no knowledge about the method. Since clients would be more ready to adopt and use family planning methods which they are knowledgeable, it is important to provide information about the range of methods available, their scientific documented contraindications, advantages and disadvantages associated with each method (Bruce, 1990). This will increase family planning knowledge and as a result increase the use of family planning in general. To the contrary, none of this is achieved in Kilombero District where this study was conducted. It was observed that inadequate information was provided even to those who attended the MCH clinics, in most cases there were no education sessions. Clients were asked to state which method they wanted to use (after reading posters on family planning methods in MCH clinics) without being informed of the choices and advantages and disadvantages of each. If enough information were given to the clients or prospective clients, more people would use family planning. This problem was also observed by Kopoka (1999: 8) who argues that, one of the basic reproductive rights that is not being adequately provided to family planning users in Tanzania is "the right to proper, adequate information about family planning methods that are being provided". Therefore, provision of adequate information about family planning and specific family planning methods is essential to increase family planning knowledge, and in so doing increase use of family planning methods. Therefore, with adequate provision of information and promotion of family planning in rural areas, people would be more knowledgeable of family planning in general and specific family

planning methods including their advantages and disadvantages hence more people would be in a position to make decisions on which family planning method to use.

5.5.2 Awareness and use of family planning methods

Awareness was very high for condoms (98%), calendar rhythm (92%), pills (88%), and female sterilization (85%) and very low for jelly or foam (6%), and mucus method (5%). However, all the respondents were not aware of tubal-ligation method. The high levels of awareness of condom may be attributed to the HIV/AIDS campaigns which in most cases promote the use of condom as a way of protecting oneself against the disease.

On the other hand, 44% of the respondents indicated that they use family planning methods, while 56% indicated that they do not use family planning methods. These findings agree with those of Chen and Guilkey (2002: 13) who found that the use of family planning methods in rural Tanzania was still quite low.

The pill (17%) was the most commonly used method, followed by the Depo-Provera injection (11%), condoms (9%), calendar rhythm (5%), female sterilization (1%), and intra-uterine device (1%). None indicated to use jelly or foam, tubal-ligation, withdrawal, mucus method and vasectomy.

Ross *et al.* (2002) argue that limited choice of family planning methods has constrained the opportunity of couples to obtain a method that suits their needs, resulting in lower levels of use. However, studies (Phillips *et al.*, 1988; Jain, 1989)

have found that broadening the choice of family planning methods increase overall use of family planning. Moreover, the option to switch methods is central to continued use of family planning (Cottingham, 1997). Having a range of methods helps people switch methods when their needs change, rather than use one that has become inappropriate or unsatisfactory or else to discontinue use of family planning altogether. Offering a range of methods also helps ensure that at least some methods will always be available, even where shortages occur because the supply chain is erratic (Bruce and Jain, 1991).

From the study findings, majority of clients chose the method because it was the only one available, for example only pill and Depo-Provera injection were available in the surveyed MCH clinics. Therefore, the clients chose pill and Depo-Provera injection since they were the only choices available. On the other hand, other clients did not use any family planning method because the methods were not continuously available. For example, in Mang'ula health centre, the pill was out of stock for more than four months, which discourage its use. This means that continuous availability of the methods was the main determinant of use.

On making decision of which method to use, those methods which were widely available in the facilities were the one used most and those which were not available were little used or not used at all. For example, pills were widely available and the most preferred; not because it is the best method, but because it was widely available, and could be obtained from other sources such as pharmacies. The results here confirm earlier studies indicating that information on family planning is given

only on three or four family planning methods with each new client, on average, with the pill and injectables most often mentioned (Miller *et al.*, 1991; Population Council, 1995). Therefore, to increase use of family planning methods, there should be provision of a full range of family planning methods and information about each, on a continuous basis.

Ross *et al.* (2002: 3) argue that, "method availability is distinct from method use, the condom for example, may be easily available but little used". Study findings show that condoms were widely available and awareness was very high, but extremely unpopular to be used as a family planning method. Therefore, awareness may be due to wide promotion by many NGOs dealing with HIV. Since they are recognized as a way to protect against sexually transmitted diseases, condoms may be associated with extramarital sex or unfaithful people. This explains its unpopularity as family planning method.

The IUD use was very low; probably due to few trained providers because "the competence and educational level of providers available at a particular facility are likely to be an important determinant of the choice of the method available there" (Speizer *et al.*, 2000) only because some of the methods, IUD for instance, need technical training. In addition, some of the methods cannot be situated at the dispensaries in the rural areas, for instance, IUDs and sterilization methods, because of inadequate facilities and trained personnel (Kessy, 2001).

Awareness of calendar rhythm was high but the use was low. First, this method is traditional; hence many people have knowledge about it. Second, the main hospital in Kilombero District (St. Francis Hospital) is owned by Roman Catholic Church and it provides family planning services but strictly education and counselling on calendar rhythmic method which explains the high awareness of the method. The belief that the number of children is for God to determine is still prevalent among religious beliefs. Many of them do not accept the use of family planning for the purpose of limiting births, hence being a stumbling block to the advocacy of family planning. As far as use of calendar method is concerned, majority of respondents when probed reported that the method is practically difficult particularly because of unstable or irregular menstruation period. Not only that, it may be a source of misunderstanding and violence between the partners if the husband wish to have sexual intercourse during the unsafe period.

Therefore, these findings have shown that the more family planning methods are made available, the more people can choose a suitable method from, and the better they can switch methods as their needs change. Offering a variety of methods through as many service delivery facilities or outlets as possible would help to ensure better choices for everyone, hence increase the use of family planning methods.

5.6 Factors responsible for access and use of family planning information

From the results, factors responsible for access and use of FPI include among others: availability of the family planning methods, convenience, influence from a friend and knowledge of family planning methods. On the other hand, barriers to accessing and

using FPI include: inadequate family planning knowledge, belief that family planning methods causes cancer and sterility, husbands not trusting their wives (men believing that their wives will engage in promiscuous life after using family planning methods and being able to control pregnancy), facilities which offer family planning services are situated very far, the need to have more children and unavailability of the family planning method in the health facility.

These findings concur with those of Cohen (2000) who found that mass media exposure (awareness and knowledge of family planning), increased availability of variety family planning methods, improved accessibility of family planning services and improved quality of family planning services have independent influence and contribution to the use of family planning methods. Grady *et al.* (1993) found evidence of the positive effects of ready access to FPI and services to be associated with family planning use effectiveness in the United States. Moreover, geographic proximity and convenience of local family planning providing facility is an important determinant of family planning use and encourages use (Entwistle *et al.*, 1997; Pullum, 1991). Similarly, WHO (2001) suggests possible factors which affect access and use of family planning and these include: poor access to quality services, limited choice of methods, lack of information, concerns about safety or side-effects and partner disapproval.

These factors could however be reduced or eliminated if providers counselling and information provision sessions would be improved and be more friendly. This statement is supported by Bruce (1990) who stated that by offering clients courtesy,

respect, reassurance, and empathy, providers may allay clients' concerns, increase clients' confidence in their choices, increase their satisfaction with services, and make it more likely that clients will use family planning. Moreover, providers may identify and clear client doubts and reduce any unrealistic expectations, so that clients have a better understanding of their options and make more realistic choices (Young and Klingle, 1996).

In addition, the findings show that availability of a full range of family planning methods all the time without stock-outs is the major factor which encourages continuous use of family planning in the surveyed area. On the other hand, unavailability and/or stock-outs of family planning methods in the facilities discourage use. Therefore, ensuring continuous supply of a wide range of family planning methods in the facilities will improve the access and use of FPI and services. This is in agreement with Katende *et al.* (2003) who suggested that "maintaining regular supplies of all family planning methods may be important in promoting and sustaining the use of modern family planning".

Furthermore, the findings show that location of a health facility is an important factor which affects levels of access and use of FPI. If the facility is located in a remote area which is difficult to reach then access and use may be affected. These results agree with studies by Pullum (1991); Levin *et al.*, (1999); and Magnani *et al.*, (1999) who found that geographic proximity of the facility which provides family planning services is an important determinant of family planning use. A nearby source can make the difference by increasing use of family planning. People are less likely to

use family planning methods if the travel time to fixed clinics is longer. For example, Magnani *et al.*, (1999) conducted a survey in Morocco: women who in 1992 had not intended to use family planning found that by 1995 those who lived close to a hospital, clinic, doctor, or pharmacy were more likely to be using family planning than those who lived further away.

Generally, the findings reveal that factors which contribute to access and use of family planning include among others, lack of reliable and accurate information, inconsistency in availability of family planning methods, and poor providers' performance. These factors have been noted by other studies to be of great importance in accessibility and use of family planning. Bruce (1990) stressed the importance of providing information about the range of family planning methods available, their scientifically documented contraindications, and advantages and disadvantages associated with each method. Also Thang and Anh, (2002) concluded that access to information on individual family planning methods is essential for their effective use. Greenwell, (1996) insisted the issue of reliable supplies indicating that offering many choices on available family planning methods at a continuous base encourages use of family planning services, making it easier for people to choose a method they prefer and to switch methods as they wish or as needs arise. On providers' side, studies (Dimatteo, 1994; Donabedian, 1988; Hall *et al.*, 1988) have found that when counseling is a partnership, in which clients and providers communicate openly, share information, express emotion, and ask and answer questions freely, clients are more satisfied, understand and recall information better, use family planning more effectively and live healthier lives.

However, it should be noted that information and knowledge are very important factors among the various factors which facilitate access and use of family planning services. If people had information on the benefits of using family planning, they would become knowledgeable on different methods, their advantages and disadvantages; and hence it would be easier to look for services irrespective of other factors. The findings show that 47% have knowledge about various family planning methods and out of these 44% use family planning methods. Therefore, knowledge about family planning has an influence on the use of family planning services rather than availability and awareness.

5.6.1 Problems which hinder access and use of family planning information

Majority of respondents reported to have encountered problems in accessing and using FPI. These problems included: long distance of more than ten kilometres to the facility; low level of education; ignorance (particularly men's ignorance); provision of FPI at MCH clinics; and belief that women using family planning engage in promiscuous life. A study by Ali (2001) found that problems which hinder use of family planning methods are associated with three factors: smaller numbers of health personnel trained in family planning, limited access to facilities, and limited range of available family planning methods.

From this study, the problems in accessing and using FPI are broadly divided into two categories: first, failure of access (distance to the facilities and the FPI being provided at the MCH clinics where only few could attend); and second, illiteracy or low level of education causing people to believe on rumours about family planning

and ignorant men who did not want their wives to access or use FPI. Therefore, these findings support those of previous studies (Ali, 2001, Kamal 2001). For instance, Kamal (2001) argues that although women may be better informed, they are without the power and the financial resources to act on the new knowledge they have because men control the decision to seek health care as well as the money to pay for it. Moreover, failure to access services is mainly caused by long distance or inaccessibility of the facilities. In order to see a provider, a prospective client has to travel long distances and give up her/his household responsibilities for the day. Given the paucity of alternative service delivery mechanisms in the rural areas; this usually means exposure to unwanted pregnancies.

5.7 Opportunities of women and men in accessing family planning information

The findings indicate that discussion of family planning matters between spouses is rare. It was also noted that discussing such matters is embarrassing especially to men. The responsibility of family planning is left to women, and men prefer not to be involved in decision about family planning, most of them prefer not to think about it at all.

Improving communication between partners on sexual and fertility-related matters improves family planning use (Salway, 1994). Even in areas where the prevailing culture emphasizes men's authority over women, many couples report discussing matters related to family size and family planning use (Renne, 1993). Therefore, a better way to involve men in family planning matters is to improve communication

between the partners. If they talk about family planning, it will make them more anxious to know more and make a better decision.

The study found that there was unequal opportunity in accessing FPI between men and women. As far as gender is concerned, this study shows that the main reason for unequal opportunity in accessing FPI is the patriarchal, cultural and religious beliefs in most African societies particularly in rural areas which portray reproductive responsibilities as women's role. This is highlighted by Kiondo (1998) that patriarchal gender relations found in most rural societies impede development in rural areas. It is also observed that male respondents reported to have discussed family planning matters with their partners than female respondents. On the other hand, female respondents reported that they did not discuss family planning matters with their partners. From this observation, it is not surprising to think that men were feeling embarrassed to talk about it so they decided to say that they discuss, while women were telling what was really happening. This is because the difference was so huge that out of 47%, who were discussing family planning matters, 43% were men and out of 53% who did not discuss, 46% were women.

Raju and Leonard (2000) stressed that there could be only very small improvement in women's access and use of FPI without men's support and active involvement. Therefore, it is very important that women and men have equal opportunity in accessing FPI. Studies (Wang *et al.* 1998; Tefere and Larson, 1993; Tapsoba *et al.* 1993) have shown that involving men in family planning matters can increase family

planning adoption, client satisfaction, family planning use-effectiveness, and continuation. "In most instances a couple approach can be more successful than serving individuals" (Becker, 1996: 3). That is why men and women should have equal opportunities in accessing FPI to increase adoption and use family planning.

Reasons given for unequal opportunities in accessing FPI (figure 7 on page 54) included the provision of FPI at the MCH clinics where men do not attend (34%: 21% women and 13% men); providers of FPI being exclusively women (31%: 16% men and 15% women); men being busy (18% exclusively men); and belief that family planning is the responsibility of women (17%: 13% women and 3% men). Men said that they are busy so it is not easy for them to have time for listening to FPI, but none of the women mentioned this as the reason. On the other hand, women feel obliged that family planning is their responsibility and some of the men felt the same. In addition, women were not allowed to use the FPI they accessed without their husband consent, hence without men being well informed on family planning, neither will women use family planning. Therefore, it is important to increase men's awareness and family planning knowledge in order to promote the use of family planning. This can only be achieved if women and men will have equal opportunities in accessing FPI.

5.7.1 Strategies for providing equal access to family planning information

Clients recommended introducing family planning education in primary and secondary school curriculum. This is because "young adults need to have accurate

information on reproductive health and family planning and access to services" (Nare *et al.*, 1996: 1). There is a need to increase efforts and develop better ways to educate young women and men about reproductive health and family planning (Nare *et al.*, 1996: 3). Providing family planning education to young people at school would be the better way of making sure that women and men have equal access to FPI.

They also recommended conducting family planning seminars for couples before marriage; family planning providers should be of both sexes, so that men might feel comfortable to attend MCH clinics; MCH clinics should be changed to family clinics so that men can feel comfortable to attend. Family planning providers recommended targeting both women and men when disseminating FPI; provision of FPI in village meetings and seminars where both sexes attend. These recommendations agree with few studies (Wang *et al.*, 1998; Tefere and Larson, 1993; Tapsoba *et al.*, 1993) which have shown that involving men can increase family planning adoption, client satisfaction, family planning use-effectiveness, and continuation. Furthermore, using men as family planning providers may encourage men to share responsibility for family planning more equally with women and may increase the acceptability and use of family planning methods (Green *et al.*, 2002).

5.8 Knowledge of local family planning information and service providers

The results (figure 8 on page 57) revealed that MCH clinics are the major provider of FPI (61%) in the surveyed community. There were no NGOs responsible for provision of family planning services in the surveyed community. However, all the ten MCH clinic staff interviewed stated that there is an NGO known as "SAFE

PLAN" that occasionally provides family planning education for women who attend in the MCH clinics as part of advertisement of their pills, but does not offer other family planning services.

Katende *et al.* (2003) argue that private and informal sectors are playing an important role in overall provision of family planning services. However, unlike the situation in the urban setting, health and family planning services in the rural areas are in most cases provided predominantly by government providers. In addition, the rural areas feature a considerable presence of less trained providers and a much smaller number of modern commercial providers and facilities (Routh *et al.*, 2001). The findings of this study support the conclusions made by the two studies (Katende *et al.*, 2003; Routh *et al.*, 2001) that, although the private sector plays an important role in provision of family planning information and services, they only concentrate in urban areas, leaving the burden of serving the rural areas to the government. Moreover, rural health services are served by the less educated staff because most of the well trained would not like to work in unfavourable working environment. Most of the family planning providers had primary education and others had lower level certificates. Therefore, with less trained providers and overburdened government, the family planning services in rural areas are more often less satisfactory.

5.9 Strategies for effective dissemination of FPI

Clients recommended dissemination of FPI through outreach programmes in the villages; more family planning programmes on the radio, so that many people can be reached; "*Jando and unyago*" (see Table 8a on page 58) should be encouraged so

that FPI can be disseminated during the sessions; use of drama in disseminating FPI because people like to watch; and use of posters, leaflets, and placards, to capture those who do not attend MCH clinics. Since radio was found to be the most preferred and appropriate source of FPI, then broadcasting of family planning programmes which are more dramatic and can capture the interests of rural population is important. These programmes could be broadcasted during the evening when most of the family members are at home, so that majority can listen. Though it is not easy for all poor people to afford a radio and batteries all the time, but at least some can afford unlike the unaffordable television. Radio can be listened by a group of neighbours, so even those who would not afford could get opportunity of listening to programmes during friendly gatherings in neighbourhoods.

Providers recommended provision of all the necessary facilities needed for effective dissemination of FPI, for instance, transport, adequate funds; motivating providers by giving them attractive salaries; training providers on dissemination of FPI; more advertisements in mass media and the use of posters and placards, to capture all groups of people and involving local leaders in dissemination of FPI because they are respected.

In Tanzania, like in many developing countries, the most successful programs are those which have strong government support. Without strong and active government support, the chance of success is minimal. This is particularly true in rural areas, because authority plays an important role in the lives of the rural population. The opinion of the local administrators and community leaders can be a determining

factor in their reproductive behaviour (Haile *et al.*, 2000). Therefore, involving local leaders in dissemination of FPI is very important for a successful outcome.

To promote informed choice, providers need to learn how to guide clients through the decision-making process, for example, by clearly describing how various methods would affect the client's life and by encouraging clients to consider more than one method (Kim *et al.*, 1997). Hence, training of family planning providers in interpersonal communication skills is an important consideration for effective dissemination of FPI. Providers trained in interpersonal communication skills are able to involve clients in health decision-making (Rudy *et al.*, 2001). For example, in Egypt women who received counselling from providers trained in interpersonal communication knew more about how to use their methods and expressed more satisfaction with services than those counselled by other providers (Abdel-Tawab, 1993). Also, in Ghana a study found that specially trained providers offered a wider choice of family planning methods, gave clients more information about side effects, and were more likely to leave the final choice to the client than providers who were not similarly trained (Hungtington *et al.*, 1990). In Indonesia providers trained to foster rapport and encourage client participation doubled their facilitative communication in counselling, and clients asked twice as many questions (Kim *et al.*, 2001). Therefore, in order to improve the performance in dissemination of FPI, it is very crucial to have short and long term training for family planning providers in interpersonal communication skills.

5.10 Summary

This chapter discussed the study findings. The discussion was based on the literature reviewed and the researcher's views on the findings of the present study. The major issues discussed included demographic information of the respondents, availability and accessibility of family planning services, reasons for inaccessibility of family planning services, and strategies for improving accessibility to family planning services.

The study found that FPI source which was used by majority in accessing FPI was radio followed by MCH clinic staff. Radio was also the most preferred and most appropriate FPI source. However, majority of the respondents were not satisfied with the way FPI is disseminated. Awareness of family planning services was high, but there was inadequate family planning knowledge and use of family planning methods was low. The study identified factors responsible for access and use of FPI; and problems which hinder access and use of FPI. The problems in accessing and using FPI were broadly divided into two categories: failure of access (distance to the facilities and the FPI being provided at the MCH clinics where only few could attend) and illiteracy or low level of education causing people to believe on rumours about family planning and ignorant men who did not want their wives to access or use FPI. It was also found that there were unequal opportunities among women and men in accessing FPI. Strategies for improving equal access to FPI were recommended. The main local providers of family planning services were MCH clinics. Finally the study recommended strategies for effective dissemination of FPI.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the summary, conclusions and recommendations based on the study findings. It also presents the suggestions for further studies related to the subject.

6.2 Summary

The study investigated accessibility and use of family planning information (FPI) among rural people in Tanzania particularly Kilombero District. The problem was stated on the grounds that, in spite of all the government efforts to promote family planning at no monetary cost, the total fertility rate in Tanzania has remained high at 6.3 children per woman. The situation is more prevalent in rural areas than their urban counterparts. The study reviewed related literature and found that little research has been done as far as accessibility and use of FPI in Tanzania is concerned. This situation made the researcher to be interested in investigating the accessibility and use of FPI in rural Tanzania, using Kilombero District as a case study.

The survey method was used to investigate the problem. A multi-stage sampling method was used which comprised of three-stage sampling design and simple random sampling methods. Data gathering instruments were questionnaires, interview schedule and observation guide. A total of 120 respondents were involved in the survey. Data collected were analysed using manual analysis for structured

questions; and content analysis for open ended questions and data from interviews and observations.

The study found that there was limited access (22%) and use (44%) of FPI. The situation was mainly caused by a number of factors which include: insufficient awareness of family planning services, ignorance, inadequate family planning knowledge, inaccessibility of family planning services, few staff (providers) with limited training, and patriarchal gender relations. Several problems which hinder accessibility and use of FPI were identified. The problems were broadly divided into, first, failure of access (distance to the facilities and the FPI being provided at the MCH clinics where only few could attend) and second, illiteracy or low level of education causing people to believe on rumours about family planning and ignorant men who did not want their wives to access or use FPI. These factors could however be reduced or eliminated if all important factors which may influence or limit access to services are taken in combination rather than one at a time. Promoting family planning services would increase awareness and demand for family planning services, educating both women and men would reduce ignorance and impart family planning knowledge, building more health facilities and employing more trained staff would improve the accessibility of family planning services.

Furthermore, the study found that rural communities access FPI through radio (23%) and MCH clinic staff (20%). Radio was the most popular, most preferred and very appropriate FPI source. Although the findings show that radio is the most efficient information source in reaching rural people, the use of multiple information delivery

methods is the best option. With multiple information sources, it may be possible to reach all groups of people.

There were unequal opportunities between women and men in accessing FPI. Involving men in family planning matters can increase family planning adoption, client satisfaction, family planning use-effectiveness, and continuation. Therefore, if men are actively involved in family planning education, there could be remarkable improvement (Raju and Leonard, 2000). Finally, the study recommended strategies for improving accessibility and use of FPI and strategies for effective dissemination of FPI.

6.3 Conclusions

The conclusion of the study is based on the research findings, and it is presented chronologically according to the research questions.

6.3.1 Nature of survey population

The study concludes that the surveyed population was of the actively reproductive group, with low education, depended on agriculture and earned very little, far below poverty line. All the family planning providers were women and their education level was low. Fertility rate was high, far above the standard fertility rate for population replacement. However, the child spacing was quite reasonable at 2-4 years.

6.3.2 Availability and accessibility of family planning services

Family planning services were available in the surveyed area, but accessible to few people. Reasons for inaccessibility of family planning services include insufficient knowledge about family planning services and long distance to the facility. The respondents were of the opinion that there is need to build more health facilities in rural areas, so that family planning services is brought closer to the clients, improving the working conditions of the providers and giving them all the facilities needed to reach rural communities, constant supply of all family planning methods, and government to employ more staff to provide family planning services in the rural areas.

6.3.3 Sources of FPI and family planning knowledge

The study established that radio was the most popular, most preferred and most appropriate source of FPI in the rural areas, followed by MCH clinic staff. As far as far as family planning knowledge is concerned, the study concludes that, there was inadequate family planning knowledge in the surveyed area. The major causes for the inadequate knowledge include among others, lack of interest on family planning matters, many people not attending MCH clinics where the family planning education is provided, and poor performance of family planning providers. The family planning providers are few and overworked with other health duties in the MCH clinics, which lead to provision of inadequate information and knowledge about family planning.

6.3.4 Factors and problems associated with accessibility and use of FPI

The study established factors which influence the access and use of FPI. These factors include: inconsistent availability of the family planning methods, convenience of getting the service and using the method. Other factors include: insufficient knowledge about family planning methods, rumours that certain family planning methods cause cancer and sterility, husbands not trusting their wives that they may turn into promiscuous life because they can control pregnancy, and desire to have more children. Moreover, the major problems associated with accessing FPI are ignorance and difficulty in accessing health facilities. The major problem associated with the use of FPI is ignorance of men, therefore could not allow their wives to use the FPI, either because they do not know the benefits of family planning or because they do not trust their wives.

6.3.5 Opportunities of women and men in accessing FPI

There was unequal opportunity between women and men in accessing FPI. The provision of FPI at the MCH clinics where men do not attend is one of the major reasons for the observed situation. Other reasons include provision of FPI by women creating gender bias, men being busy, and believing that family planning is the responsibility of women.

6.3.6 Opportunities of women and men in accessing FPI

The major provider of family planning information and services in surveyed community was MCH clinics. Therefore, the government is the main provider of FPI and FPS because the MCH clinics are owned and managed by the government.

6.4 Recommendations

If implemented, the following recommendations will enhance better FPI dissemination and delivery, which in turn, will improve the accessibility and use of FPI in rural areas. The study, therefore recommends:

i. Provision of more health facilities in rural areas to bring family planning services closer to the people.

ii. Airing of family planning programmes on the radio, which are relevant to rural people.

iii. Providing short and long term training to family planning providers on dissemination of FPI.

iv. Raising public awareness and imparting family planning knowledge to clear rumours on bad side effects of family planning methods to improve use of FPI.

v. The government and other providers of family planning services should take all factors influencing access and use of FPI into consideration when promoting family planning.

vi. Ensuring constant availability of all the family planning methods in the health facilities.

vii. Provision of family planning education in schools for both sexes will be a sustainable way to ensure both women and men access FPI.

viii. NGOs should be encouraged to open new facilities for provision of family planning services in rural areas to supplement government efforts.

ix. Provision of all the necessary facilities needed for effective dissemination of FPI in the rural settings.

6.5 Suggestions for further studies

This study has contributed to the general understanding of accessibility and use FPI among rural people in Kilombero District, Tanzania. However, there are number of areas which need to be investigated in order to improve dissemination and utilization of FPI. These include the following:

i. A study to investigate the information needs of family planning clients in rural areas. This will provide baseline information for provision of FPI that is relevant to the needs of the people. Family planning use often entails a lengthy process of information-seeking and decision-making, and continued use requires regular reinforcement and renewed commitment. Therefore, it is important to determine how to meet information needs most efficiently and how to provide a continuous flow of information that is lively and interesting.

ii. A study on training and staffing needs of family planning providers particularly for rural areas. This will provide information for the policy makers in making decisions regarding improvement of family planning services though provision of training.

iii. To investigate information seeking behaviours and information dissemination behaviours of clients and providers of family planning respectively. Studying the behaviours of clients would bring light on what should be served according to their preferences.

iv. A study to evaluate in depth effectiveness of information sources preferred by rural people in dissemination and delivery of FPI so that they can be promoted and used more efficiently.

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APPENDICES

Appendix I: Questionnaire for the MCH clinic staff

To whom it may concern:

Re: Accessibility and Use of Family Planning Information (FPI) among Rural People in Kilombero District, Tanzania

Reference is made to the above heading. Please be informed that Grace Emmanuel, a Masters student in Information studies at the University of Dar es Salaam is carrying out a study to investigate accessibility and use of FPI in Kilombero district. The study intends to examine the entire infrastructure required for accessing and using FPI in rural settings. Basing on the findings, the study intends to make recommendations that will enhance better dissemination and delivery of FPI, which in turn, will improve the accessibility and use of FPI in rural areas.

You are kindly requested to fill the attached questionnaire to enable me to get relevant information for the study. All information that you are going to provide will be treated as confidential and used for research purpose only.

Sincerely yours,

Grace Emmanuel

Student, M.A. Information Studies

University of Dar es Salaam.

QUESTIONNAIRE FOR THE MCH CLINIC STAFF

ON

ACCESS AND USE OF FAMILY PLANNING INFORMATION AMONG RURAL PEOPLE IN KILOMBERO DISTRICT, TANZANIA

1. Name of the MCH clinic.....

2. Position of the staff.....

3. Education level of the staff

(i) Primary education

(ii) 'O' level secondary education

(iii) 'A' level secondary education

(iv) Higher education (please specify)

(v) Others (Please specify)

Availability of Family Planning Information and Services

4. Do you provide family planning services in your clinic?

(i) Yes

(ii) No

5. Do you think providing timely and comprehensive family planning information will help in reducing rapid population growth problem facing the country?

(i) Yes

(ii) No

5. To what extent have you been successful in providing family planning information to the community?

(i) Very successful

(ii) Successful

(iii) Uncertain

(iv) Less successful

(v) Not successful

Family Planning Information Delivery Systems & Access

5. If yes, what materials do you use in delivering family planning information?

(i) Posters

(ii) Brochures

(iii) Leaflets

(iv) Others (please mention them)

.....

.....

.....

6. Do you have outreach programmes for those who do not attend MCH clinics?

(i) Yes

(ii) No

7. If yes, how do you conduct them?

(i) Seminars and workshops

(ii) Going house to house

(iii) Group discussion

(iv) Others (please specify)

.....

.....

8. If no, what is your plan for reaching those who do not attend MCH clinics?

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9. What else do you do to ensure people get family planning information?

(i) Providing education sessions in the clinic

(ii) Campaigns

(iii) Seminars

10. What ways do you think will be more effective in disseminating family planning information in this community? (Indicate all which are effective as 1= most effective, 2= effective, 3= fairly effective, and 4= least effective)

(i)	Radio	1	2	3	4
(ii)	Posters	1	2	3	4
(iii)	Friend/neighbour	1	2	3	4
(iv)	Leaflets	1	2	3	4
(v)	Newspapers	1	2	3	4
(vi)	Television	1	2	3	4
(vii)	Community health workers	1	2	3	4
(viii)	MCH clinic staff	1	2	3	4
(ix)	Films	1	2	3	4
(x)	Drama	1	2	3	4
(xi)	Songs	1	2	3	4
(xii)	Others (please specify)				

.....

.....

.....

11. Whom do you target in provision of family planning information and services?

(i) Mothers who attend clinic

(ii) Young girls

(iii) Young girls and boys

(iv) Men and women

(v) Others (please specify)

.....

.....

12. Do you think both men and women have equal opportunity to access family planning information?

(i) Yes

(ii) No

13. What strategies should be employed to make family planning information and services more accessible to people in the community?

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14. Do you encounter any problems in disseminating family planning information?

(i) Yes

(ii) No

15. If yes, what are those problems? (Please mention them).

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Different Levels of Intervention in Provision of family planning Services

16. What agencies provide family planning services in your community? (Please mention them).

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.....

Knowledge on Family Planning

17. Do you think people understand and use the family planning information they get in this clinic?

(i) Yes

(ii) No

18. If no, what steps have you taken to make sure they understand and use the family planning information they get?

(iii) Making follow ups

(iv) Visiting their house

(v) Involving their partners during education sessions

(vi) Other (please specify)

.....

.....

19. If no, what do you think are the factors that affect use of family planning services?

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20. What is your opinion on the levels of awareness and knowledge of family planning information and services?

(i) Very High

(ii) High

(iii) Low

(iv) Very low

Appendix II: Questionnaire for selected women and men

To whom it may concern:

Re: Accessibility and Use of Family Planning Information (FPI) among Rural People in Kilombero District, Tanzania

Reference is made to the above heading. Please be informed that Grace Emmanuel, a Masters student in Information studies at the University of Dar es Salaam is carrying out a study to investigate accessibility and use of FPI in Kilombero district. The study intends to examine the entire infrastructure required for accessing and using FPI in rural settings. Basing on the findings, the study intends to make recommendations that will enhance better dissemination and delivery of FPI, which in turn, will improve the accessibility and use of FPI in rural areas.

I shall therefore, be grateful if you will complete the questionnaire attached. All information that you are going to provide will be treated as confidential and used for research purpose only.

Sincerely yours,

Grace Emmanuel

Student, M.A. Information Studies

University of Dar es Salaam.

QUESTIONNAIRE FOR WOMEN AND MEN IN SELECTED HOUSEHOLDS ON ACCESS AND USE OF FAMILY PLANNING INFORMATION AMONG RURAL PEOPLE IN KILOMBERO DISTRICT, TANZANIA

Demographic Information

1. Sex

   (i) Female

   (ii) Male

2. Age (years)

   (i) 15-20

   (ii) 21-24

   (iii)25-34

   (iv)35-45

   (v) Over 45

3. Education level

   (i) None

   (ii) Primary education

   (iii) 'O' level Secondary education

   (iv) 'A' level Secondary education

   (v) Adult education

   (vi) Vocational training

   (vii) Higher education (Please specify)

   (viii) Others (please specify).....

4. What are your sources of income (tick all which are appropriate)?

(i) Salaries

(ii) Business

(iii) Agriculture

(iv) Grants from relatives

(v) Others (please specify)

.....

.....

.....

5. What is your income level per annum?

(i) Less than 100,000

(ii) 100,000– 200,000

(iii) 200,001– 300,000

(iv) 300,001 – 400,000

(v) More than 400,000

6. How many children do you have?

(i) 1 – 3

(ii) 4 – 6

(iii) 7 – 9

(iv) Over 10

7. What are the birth intervals between the children? Put the number indicated as appropriate

(i) 1st and 2nd ( ) 1 = Less than two years

(ii) 2nd and 3rd ( ) 2 = 2 – 4 years

(iii) 3rd and 4th ( ) 3 = 5 – 6 years

(iv) 4th and 5th ( ) 4 = over 6 years

(v) 5th and 6th ( )

(vi) Others (please specify)

.....

.....

.....

Accessibility of Family Planning Services

8. Are you aware of the family planning services?

(i) Yes

(ii) No

9. Do you access family planning services?

(i) Yes

(ii) No

If no, go to question no. 11

10. If yes, where do you access family planning services?

(i) Local hospital

(ii) MCH clinics

(iii) Community health workers

(iv) Others (Please specify)

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11. If no, please explain

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12. What is your opinion on making family planning services more accessible to people in your community?

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Family Planning Information Sources and Delivery Systems

13. How did you access family planning information? (Tick all that are appropriate)

(i) Radio

(ii) Posters

(iii) Friend/neighbour

(iv) Leaflets

(v) Newspapers

(vi) Television

(vii) Community health workers

(viii) MCH clinic staff

(ix) Films

(x) Drama

(xi) Songs

(xii) Others (please specify)

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.....

.....

14. Which of the following family planning information source do you prefer most? (Please circle the number as appropriate, 1 = most preferred, 2 = preferred, 3 = least preferred, 4 = not preferred)

(i)	Radio	1	2	3	4
(ii)	Posters	1	2	3	4
(iii)	Friend/neighbour	1	2	3	4

(iv)	Leaflets	1	2	3	4
(v)	Newspapers	1	2	3	4
(vi)	Television	1	2	3	4
(vii)	Community health workers	1	2	3	4
(viii)	MCH clinic staff	1	2	3	4
(ix)	Films	1	2	3	4
(x)	Drama	1	2	3	4
(xi)	Songs	1	2	3	4
(xii)	Others (please specify)				

.....

.....

.....

15. What methods do you think are more appropriate in disseminating family planning information to you and the community at large? (Indicate all which are appropriate as 1= very appropriate, 2= appropriate 3= least appropriate 4= not appropriate)

(i)	Radio	1	2	3	4
(ii)	Posters	1	2	3	4
(iii)	Friend/neighbour	1	2	3	4
(iv)	Leaflets	1	2	3	4
(v)	Newspapers	1	2	3	4
(vi)	Television	1	2	3	4
(vii)	Community health workers	1	2	3	4

(viii)	MCH clinic staff	1	2	3	4
(ix)	Films	1	2	3	4
(x)	Drama	1	2	3	4
(xi)	Songs	1	2	3	4
(xii)	Others (please specify)				

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.....

16. Are you satisfied with the way family planning information is disseminated?

(i) Yes

(i) No

17. If no, please explain why

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General opinion

18. Which strategy do you think should be used to make family planning information dissemination and delivery more appropriate for you and the community?

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.....

Knowledge and Use of Family Planning Information

19. What family planning methods are you aware of? (Tick all appropriate)

(i) Pills

(ii) Intra-uterine device (IUD)

(iii) Depo-Provera

(iv) Jelly or foam

(v) The injectable

(vi) Condoms

(vii) tubal ligation

(viii) Withdrawal

(ix) Calendar rhythm

(x) Mucus method

(xi) Vasectomy

(xii) Female sterilization

(xiii) Others (Please specify)

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.....

.....

20. Do you use any of the methods you identified?

(i) Yes

(ii) No

If no, go to question no. 25

21. If yes, which method you or your partner use?

(i) Pills

(ii) Intra-uterine device (IUD)

(iii) Depo-Provera

(iv) Jelly or foam

(v) The injectable

(vi) Condoms

(vii) tubal ligation

(viii) Withdrawal

(ix) Calendar rhythm

(x) Mucus method

(xi) Vasectomy

(xii) Female sterilization

(xiii) Others (Please specify)

.....

.....

22. Do you have adequate knowledge on the various methods of family planning?

(i) Yes

(ii) No

23. If no, what are the reasons?

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Factors Responsible for Access and Use of Family Planning Information

24. What influenced your choice of family planning method you/your partner is using?

(i) Availability of the method

(ii) Convenience of the method

(iii) Influence from a friend

(iv) Knowledge on the method

(v) Others (please specify)

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25. If you do not use any of the above methods, what are the reasons?

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26. Do you encounter any problems in accessing family planning information?

(a) Yes

(b) No

27. If yes, what are the problems?

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.....

.....

.....

28. Do you encounter problems in using family planning information?

(c) Yes

(d) No

29. If yes, Please explain?

.....

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.....

Opportunities of Men and Woman in Accessing Family Planning Information

30. Do you discuss family planning issues with your partner?

(i) Yes

(ii) No

31. Do you think women and men have equal chances of accessing family planning information?

(i) Yes

(ii) No

32. If no, what do you think are the reasons?

.....

.....

.....

.....

.....

33. In your opinion, what should be done in order to make sure men and women get equal access to family planning information?

.....

.....

.....

.....

Knowledge of local family planning services

34. Who is involved in disseminating family planning services?

(i) MCH clinics

(ii) Community health workers

(iii) Non-governmental organisations (please specify)

.....

(iv) Others (please specify)

.....

.....

.....

Appendix III: Swahili translation of questionnaire in Appendix II

Kwa yeyote anayehusika:

Yahusu: Utafiti wa Upatikanaji na Utumiaji wa Habari za Uzazi wa Mpango kwa Watu Waishio Vijijini Wilayani Kilombero, Tanzania

Kichwa cha habari chahusika. Tafadhali, unajulishwa kuwa Grace Emmanuel, mwanafunzi wa shahada ya pili ya masomo ya habari katika chuo kikuu cha Dar es Salaam, anafanya utafiti wa kuchunguza upatikanaji na utumiaji wa habari za uzazi wa mpango katika wilaya ya Kilombero. Utafiti huu unategemea kuchunguza mwaswala yote yanayohitajika katika kupata na kutumia habari za uzazi wa mpango kwenye sehemu za vijijini. Kutokana na matokeo ya utafiti huu, yatatolewa mapendekezo ambayo yanaweza kusaidia katika usamabazaji na ufikiswaji wa habari za uzazi wa mpango, kutokana na hayo, hali ya upatikanaji na utumiaji wa habari za uzazi wa mpango kwenye maeneo ya vijijini zaweza kuboreshwa.

Nitashukuru kama utajaza dodoso lililoambatanishwa. Habari zote utakazozitoa kwenye dodoso hili zitakuwa ni siri, na zitatumika kwa ajili ya utafiti tu.

Wako mwaminifu,

Grace Emmanuel

Mwanafunzi, Masomo ya habari

Chuo Kikuu cha Dar es Salaam.

DODOSO LA WANAWAKE NA WANAUME KATIKA NYUMBA ZILIZOCHAGULIWA KWA AJILI YA UTAFITI WA UPATIKANAJI NA UTUMIAJI WA HABARI ZA UZAZI WA MPANGO KWA WATU WAISHIO VIJIJINI WILAYANI KILOMBERO, TANZANIA

1. Jinsia yako

   (i) Mwanamke

   (ii) Mwanamme

2. Umri wako ni miaka

   (i) 15-20

   (ii) 21-24

   (iii) 25-34

   (iv) 35-45

   (v) Zaidi ya 45

3. Kiwango chako cha elimu

   (i) Sijasoma

   (ii) Elimu ya msingi

   (iii) Elimu ya sekondari (darasa la 12)

   (iv) Elimu ya sekondari (darasa la 14)

   (v) Elimu ya watu wazima

   (vi) Elimu ya ufundi

   (vii) Elimu ya juu (tafadhali fafanua)

   (viii) Elimu nyingine (tafadhali fafanua)

   .....

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4. Mapato yako yanatokana na nini? (Chagua yote yanayofaa)

(i) mshahara

(ii) Biashara

(iii) Kilimo

(iv) Misaada kutoka kwa ndugu

(v) Nyingine (tafadhali fafanua)

.....

.....

5. Mapato yako kwa mwaka ni kiasi gani?

(ix) Ndogo kuliko 100,000

(x) 100,001– 200,000

(xi) 200,001– 300,000

(xii) 300,001 – 400,000

(xiii) Zaidi ya 400,000

6. Una watoto wangapi?

(i) 1 – 3

(ii) 4 – 6

(iii) 7 – 9

(iv) Zaidi ya 10

7. Watoto wako wamepishana kuzaliwa kwa miaka mingapi? Chagua namba kati ya hizo zilizoorodheshwa pembeni ujaze kwenye mabano

(i) mtoto wa 1 na 2 ( ) 1 = chini ya miaka miwili

(ii) mtoto wa 2 na 3 ( ) 2 = miaka 2 – 4

(iii) mtoto wa 3 na 4 ( ) 3 = miaka 5 – 6

(iv) mtoto wa 4 na 5 ( ) 4 = zaidi ya miaka 6

(v) mtoto wa 5 na 6 ( )

(vi) wengine (tafadhali fafanua)

.....

.....

8. Je unafahamu kuhusu huduma za uzazi wa mpango?

(i) Ndio

(ii) Hapana

9. Je unapata huduma za uzazi wa mpango?

(i) Ndio

(ii) Hapana

Kama hapana, nenda swali la 11

10. Kama ndio, unapatia wapi huduma za uzazi wa mpango?

(v) Hospitali

(vi) Kliniki ya kinamama na watoto

(vii) Wahudumu wa afya ya jamii

(viii) Mahali pengine (tafadhali pataje)

.....

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11. Kama hupati huduma za uzazi wa mpango tafadhali elezea.

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12. Je ushauri wako ninini kuhusu kuboresha upatikanaji wa huduma za uzazi wa mpango katika jamii yenu?

.....

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13. Ulipataje habari kuhusu upatikanaji wa huduma za uzazi wa mpango katika jamii yenu? Kupitia

(i) Redio

(ii) Vichapisho

(iii) Rafiki/jirani

(iv) Vipeperushi

(v) Magazeti

(vi) Luninga

(vii) Wafanyakazi wa afya ya jamii

(viii) Wahudumu wa kliniki ya kinamama na watoto

(ix) Sinema

(x) Michezoya kuigiza

(xi) Nyimbo

(xii) Mahali pengine (tafadhali fafanua)

.....

.....

14. Ni njia zipi unazipendelea zaidi katika kupata habari za uzazi wa mpango?

(Tafadhali chagua zile uzipendeleazo kwa kuweka 1= unaipendelea zaidi,

2=unapendelea, 3=unaipendelea kidogo na 4=huipendelei)

(i)	Redio.....1	2	3	4
(ii)	Vichapisho.....1	2	3	4
(iii)	Rafiki/jirani.....1	2	3	4
(iv)	Vipeperushi.....1	2	3	4
(v)	Magazeti.....1	2	3	4
(vi)	Luninga.....1	2	3	4
(vii)	Wafanyakazi wa afya ya jamii.....1	2	3	4
(viii)	Wahudumu wa kliniki ya kinamama na watoto....1	2	3	4
(ix)	Sinema.....1	2	3	4
(x)	Michezoya kuigiza.....1	2	3	4
(xi)	Nyimbo.....1	2	3	4
(xii)	Mahali pengine (tafadhali fafanua).....			

15. Ni njia zipi unafikiri zinaweza kutumika katika kueneza habari za uzazi wa mpango ambazo zinapendwa na kukubaliwa zaidi na jamii yenu? Taja zote zinazokubalika kwa kuzungushia namba, 1= inakubalika sana, 2= inakubalika kiasi, 3= inakubalika kidogo, na 4= haikubaliki

(i)	Redio.....1	2	3	4
(ii)	Vichapisho.....1	2	3	4
(iii)	Rafiki/jirani.....1	2	3	4
(iv)	Vipeperushi.....1	2	3	4
(v)	Magazeti.....1	2	3	4
(vi)	Luninga.....1	2	3	4
(vii)	Wafanyakazi wa afya ya jamii.....1	2	3	4
(viii)	Wahudumu wa kliniki ya kinamama na watoto.....1	2	3	4
(ix)	Sinema.....1	2	3	4
(x)	Michezoya kuigiza.....1	2	3	4
(xi)	Nyimbo.....1	2	3	4
(xii)	Mahali pengine (tafadhali fafanua).....			

16. Unaridhika na jinsi ambavyo habari za uzazi wa mpango zinavyoenezwa?

(ii) Ndio

(ii) Hapana

17. Kama hapana, tafadhali elezea

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18. Unatoa maoni gani ili kufanya uenezwaji na ufikishwaji wa habari za uzazi wa mpango bora zaidi ili jamii ielewe kirahisi?

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19. Ni njia gani ya uzazi wa mpango unayoifahamu (Chagua zote unazozifahamu)

(i) Vidonge

(ii) Kitanzi

(iii) Sindano

(iv) Povu

(v) Mipira

(vi) "tubal ligation"

(vii) Kutoa nje

(viii) Kutumia kalenda

(ix) Kuangalia ute

(x) Kufunga uzazi (mwanaume)

(xi) Kufunga uzazi (mwamke)

(xii) Nyingine (tafadhali fafanua)

.....

.....

20. Je unatumia njia yoyote kati ya hizo ulizozitaja?

(iii) Ndio

(iv) Hapana

Kama hapana, nenda swali la 25

21. Kama ndio, ni njia gani unayotumia au anayotumia mwenzako?

(i) Vidonge

(ii) Kitanzi

(iii) Sindano

(iv) Povu

(v) Mipira

(vi) "tubal ligation"

(vii) Kutoa nje

(viii) Kutumia kalenda

(ix) Kuangalia ute

(x) Kufunga uzazi (mwanaume)

(xi) Kufunga uzazi (mwamke)

(xii) Nyingine (tafadhali fafanua).....

22. Je una ujuzi wa kutosha kuhusu njia mbalimbali za uzazi wa mpango?

(i) Ndio

(ii) Hapana

23. Kama hapana, tafadhali elezea sababu

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24. Ninini kimekufanya ukachagua njia hiyo unayotumia au anayotumia mwenzako?

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25. Kama hutumii njia yoyote kati ya hizo hapo juu, una sababu gani?

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26. Je unapata matatizo yoyote katika kupata uzazi wa mpango?

(i) Ndio

(ii) Hapana

27. Kama ndio, tafadhali elezea matatizo hayo

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28. Je unapata matatizo yoyote katika utumiaji wa habari za uzazi wa mpango?

(i) Ndio

(ii) Hapana

29. Kama ndio, tafadhali fafanua matatizo hayo

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30. Je huwa mnaongea kuhusu masuala ya kupanga uzazi na mzazi mwenzako?

(iii) Ndio

(iv) Hapana

31. Unafikiri wanaume na wanawake wana nafasi sawa katika kupata habari za uzazi wa mpango?

(iii) Ndio

(iv) Hapana

32. Kama hapana, unafikiri sababu ninini?

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33. Kwa maoni yako, unafikiri nini kifanyike ili kuhakikisha watu wa jinsia zote wanapata nafasi sawa katika kupata habari za uzazi wa mpango?

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34. Ninani anayehusika na kutoa huduma za uzazi wa mpango katika jamii yenu?

(i) Kliniki za kinamama na watoto

(ii) Wafanyakazi wa afya ya jamii

(iii) Mashirika yasiyo ya kiserikali (tafadhali yataje).....

(iv) Wengine (tafadhali wataje)

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Appendix IV: Interview schedule for community health workers/other agencies

Interview Schedule for Community Health Workers/Other Agencies

on

Access and Use of Family Planning Information among Rural People in Kilombero District, Tanzania

Introduction

The purpose of this study is to find out the views and opinions on the status of accessibility and use of family planning information (FPI) in rural areas, and to get suggestions on how to improve the accessibility and use of FPI. The interview intends to find out the community health worker's views on the topic of study.

1. Do you have any programmes for dissemination of family planning information in your community?
2. Who support/fund dissemination of family planning information in your community?
3. Do you offer any support for the MCH clinics in dissemination of family planning information?
4. What strategies should be employed to ensure effective dissemination of family planning information in your community, so that people can easily access, understand and use it?
5. Do you think women and men have equal access to family planning information? If no, please explain why?
6. What problems do you face in disseminating family planning information? What solutions do you propose to solve the problems?
7. What factors hinder effective use of family planning services?

Appendix V: Observation guide for MCH clinics

Observation Guide for MCH Clinics Visited

on

Access and Use of Family Planning Information among Rural People in Kilombero District, Tanzania

Introduction

The purpose of this study is to find out the views and opinions on the status of accessibility and use of family planning information (FPI) in rural areas, and to get suggestions on how to improve the accessibility and use of FPI. The observation method intends to witness the activities of family planning services taking place in MCH clinics. This information is expected to validate the information given in the questionnaire.

There will be observation of:

- Information dissemination activities in the MCH clinics
- Family status of selected respondents as far as family planning is concerned
- Information dissemination materials used

Appendix VI: Letters of introduction

Appendix VI (A): Letter from the Vice-Chancellor, University of Dar es Salaam

Appendix VI (B): Letter from Regional Administrative Officer, Morogoro Region

Appendix VI (C): Letters from District Administrative Officer, Kilombero District

Appendix VI (A): Letter from the Vice-Chancellor, University of Dar es Salaam

UNIVERSITY OF DAR ES SALAAM
OFFICE OF THE VICE-CHANCELLOR
P.O. BOX 35091 • DAR ES SALAAM • TANZANIA

Ref. No: AB3/12(B)
Date: 4th October, 2004
To: Regional Administrative Secretary,
Morogoro Region.

UNIVERSITY STAFF AND STUDENTS RESEARCH CLEARANCE

The purpose of this letter is to introduce to you **Ms Grace Emmanuel** who is a bonafide student of the University of Dar es Salaam and who is at the moment conducting research. Our staff members and students undertake research activities every year especially during the long vacation.

In accordance with a government circular letter Ref.No.MPEC/R/10/1 dated 4th July, 1980 the Vice-Chancellor was empowered to issue research clearances to the staff and students of the University of Dar es Salaam on behalf of the government and the Tanzania Commission for Science and Technology, a successor organization to UTAFITI.

I therefore request you to grant the above-mentioned member of our University community any help that may facilitate her to achieve research objectives. What is required is your permission for her to see and talk to the leaders and members of your institutions in connection with her research.

The title of the research in question is "**Access and use of family planning information among rural people in Kilombero District, Tanzania.**".

The period for which this permission has been granted is **October, 2004** to **March, 2005** and will cover the following areas/offices: **Kilombero District..**

Should some of these areas/offices be restricted, you are requested to kindly advise her as to which alternative areas/offices could be visited. In case you may require further information, please contact the Directorate of Research and Publications, Tel. 2410500-8 Ext. 2087 or 2410743.

Prof. M.L. Luhanga
VICE-CHANCELLOR

VICE CHANCELLOR
UNIVERSITY OF DAR ES SALAAM.
P. O. BOX 35091
DAR ES SALAAM

Direct: + 255 22 2410700/2113654
Telephone: + 255 22 2410500-8 Ext.2001
Telefax: + 255 22 2410078/2410514

Telegraphic Address: UNIVERSITY DAR ES SALAAM
E-Mail: vc@admin.udsm.ac.tz
Website address: www.udsm.ac.tz

Appendix VI (B): Letter from Regional Administrative Officer, Morogoro Region

THE UNITED REPUBLIC OF TANZANIA
PRESIDENT'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

Telegraphic Address: "REGCOM"
Phones: 023 260 4237/260 4227
2 601000
Fax No: 2 60 09 73

Regional Commissioner's Office,
P.O. Box 650,
MOROGORO.

In Reply please quote:

Ref. No: R.10/20 Vol. V/ 46 **22 November 2004**

District Commissioner,
KILOMBERO

REF: PERMISSION FOR MS GRACE EMMANUEL A UNIVERSITY STAFF AND TUNDENTS RESEARCH CLEARANCE

The above named student from the University of Dar es Salaam has been cleared by her Institution to conduct research in Morogoro.

The title of the research in question is **" Access and use of family planning information among rural people in Kilombero District.**

The permission is grated from November, 2004 to March, 2005.

By this letter you are kindly asked to grant every sort of assistance to enable her to carryout her research successfully.

Thanking you in advance for your kind cooperation.

Sincerely yours,

G.W. Kikwesha
FOR REGIONAL ADMINISTRATIVE OFFICER
MOROGORO

C.C. Vice Chancellor
University of Dar es Salaam
P.O. Box 35091,
DAR ES SALAAM

C.C. MS. Grace Emmanuel

Appendix VI(C): Letters from District Administrative Officer, Kilombero District

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS
TAWALA ZA MIKOA NA SERIKALI ZA MITAA

Ofisi ya Mkuu wa Wilaya,
S.L.P. 34,
IFAKARA.

Kumb.Na. E.10/19/170

15/12/2004

Katibu Tarafa

- **IFAKARA,**
- **MANG'ULA.**

YAH: **KIBALI CHA UKUSANYAJI TAKWIMU ZA UTAFITI**

Kibali kimetolewa kwa BI. **GRACE EMMANUEL** ambaye ni mwanafunzi katika Chuo Kikuu Dar es Salaam, ili aweze kukusanya takwimu za utafiti wake hapa wilayani kuhusu **MAPOKEZI NA MATUMIZI YA TAARIFA KUHUSU UZAZI WA MPANGO KWA JAMII YA WILAYA YA KILOMBERO "ACCESS AND USE OF FAMILY PLANNING INFORMATION AMONG RURAL PEOPLE IN KILOMBERO DISTRICT"**

Takwimu hizi anategemea kuzikusanya kutoka kwenye Vituo vya Afya, (MCH – Kibaoni na Mang'ula) na jamii katika vijiji alivyvichagua kutoka kwenye Kata za **KIBAONI, IFAKARA, IDETE, LUMEMO na KIBEREGE.**

Tafadhali mpatieni mwanafunzi huyo ushirikiano unaostahili ili aweze kukamilisha utafiti wake.

H. Mbegu
KAIMU KATIBU TAWALA WILAYA
KILOMBERO.

Nakala: Katibu Tawala Mkoa,
MOROGORO.
: Makamu Mkuu wa Chuo,
CHUO KIKUU DSM.
: Mganga Kiongozi,
Vituo vya Afya, **Kibaoni na Mang'ula.**
: Watendaji Kata, **Kibaoni, Ifakara, Lumemo, Idete na Kiberege.**
: Bi Grace Emmanuel
MTAFITI.

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS

TAWALA ZA MIKOA NA SERIKALI ZA MITAA

Ofisi ya Mkuu wa Wilaya,
S.L.P. 34,
IFAKARA

Kumb. Na. E.10/19/171 13/1/2005

Makatibu Tarafa wote,
WILAYANI KILOMBERO

YAH: KIBALI CHA UKUSANYAJI TAKWIMU ZA UTAFITI

Kibali kimetolewa kwa BI. GRACE EMMANUEL ambaye ni mwanafunzi katika Chuo Kikuu Dar es Salaam, ili aweze kukusanya takwimu za utafiti wake hapa Wilayani kuhusu MAFOKEZI NA MATUMIZI YA TAARIFA KUHUSU UZAZI WA MPANGO KWA JAMII YA WILAYA YA KILOMBERO _ ACCESS AND USE OF FAMILY PLANNING INFORMATION AMONG RURAL PEOPLE IN KILOMBERO DISTRICT.

Takwimu hizi anategemea kuzikusanya kutoka kwenye ZAHANATI ZOTE.

Tafadhali mpatieni mwanafunzi huyo ushirikiano unaostahili ili aweze kukamilisha utafiti wake.

M.O. Mandawa

kny. KATIBU TAWALA WILAYA,
KILOMBERO

Nakala:- Katibu Tawala Mkoa,
MOROGORO

KATIBU TAWALA WILAYA
KILOMBERO / IFAKARA

" Makamu Mkuu wa Chuo,
Chuo Kikuu,
Dar es Salaam

" Bi. Grace Emanuel,
MTAFITI