IMPLEMENTATION PROCESSES OF EMERGENCY CONTRACEPTION IN TANZANIA: THE CASE OF THREE WARDS OF NYAMAGANA DISTRICT- MWANZA

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IMPLEMENTATION PROCESSES OF EMERGENCY CONTRACEPTION IN TANZANIA: THE CASE OF THREE WARDS OF NYAMAGANA DISTRICT- MWANZA

By

Jamila E. Luziga

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Arts (Health Policy and Management) of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that she has read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled **Implementation processes of emergency contraception in Tanzania: The case of three wards of Nyamagana District- Mwanza** in partial fulfillment of the requirements for the degree of Master of Arts (Health Policy and Management) of Muhimbili University of Health and Allied Sciences.

_____

Dr. Ave Maria Semakafu

(Supervisor)

Date: _____

DECLARATION AND COPYRIGHT

I, **Jamila E. Luziga,** declare that this **dissertation** is my 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 …… Date ……..

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Above all, I thank the Almighty God who has been always my pillar of strength whenever I want to fall.

DEDICATION

I dedicate this work to all stakeholders who are struggling to ensure safe motherhood in Tanzania, to my lovely baby Maryam who suffered and died during the course of this study, to my daughter Sumayyah, who missed her mother's affection while away for this study and to all mothers who lost their breath because of child bearing processes.

ABSTRACT

Background

The reproductive health hazards of unintended pregnancies and unsafe abortions are well documented. The potential of emergency contraceptives to prevent unplanned pregnancy in developed countries has been described, but in developing countries, the awareness about the method is poor. In Tanzania, awareness and knowledge regarding emergency contraception is also reported to be poor and largely remain to serve victims of sexual violence, an indication that access to information regarding emergency contraception is poor to many women and girls who need it.

Objective

The aim of this study was to describe the implementation processes of emergency contraception service in Tanzania in order to identify the gap, reasons and challenges for low accessibility of emergency contraceptives among women and young girls.

Methods

This was a qualitative purposive study conducted at three wards of Nyamagana District - Mwanza from March to April 2013. In-depth interview, exit interviews and Focus Group Discussions were the main technique for data collection. Respondents were obtained through purposive sampling and content analysis was used to analyze the collected data.

Results

The study found that the service is passively provided. Integration of the EC service with family planning services and inadequate knowledge about ECPs were some of the factors that impede effective implementation and accessibility of EC service.

Conclusions and Recommendations

Emergency contraception (EC) is an effective and safe method of preventing pregnancy. On strength of the concerns evolving around the ECPs and family planning in general, reproductive health education should be reinforced at schools, communities and health facilities to empower people with factual information regarding family planning and ECP.

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LIST OF ABBREVIATIONS

AYA : African Youth Alliance

ASRH : Adolescent Sexual and Reproductive Health

DMO's : District Medical Officer's

EC : Emergency contraception

ECPs : Emergency contraception pills

FP : Family Planning

IUD : Intra Uterine Devices

MUHAS : Muhimbili University of Health and Allied Sciences

NBS : National Bureau of Statistics

NFPCIP : National Family Planning Costed Implementation Program

NRMSP : National Road Map Strategic Plan

OPD : Out Patients Department

PO : Progestin Only

POP : Progestine – Oestrogen Pills (Combined)

RCH : Reproductive and Child Health

TDHS : Tanzania Demographic Health Survey

THMIS : Tanzania HIV and Malaria Indicator Survey

URT : United Republic of Tanzania

WHO : World Health Organization

DEFINITION OF TERMS

Policy – is a set of decisions taken by those with responsibility for a particular area

Implementation – means to carry out, accomplish, fulfill, produce, complete or is a process of ensuring that something that has been officially decided actually happens

Policy implementation – encompasses those actions by public or private individuals or group that are directed at the achievement of objectives set forth in prior policy decision accessibility

Accessibility- refers to the degree to which individual is inhibited, or facilitated in their ability to gain entry to and to receive care service.

Unplanned/unintended pregnancy – pregnancy obtained when someone had sex without the intention of getting pregnancy for any reason

Unwanted pregnancy – is undesired pregnancy, not needed or unwelcomed which results from unplanned pregnancy

Emergency contraception – birth control modalities that, when used after unprotected intercourse within defined time limits, can prevent unwanted pregnancies.

Youth - an individual aged between 18-29 years

1.0 CHAPTER ONE: INTRODUCTION

1.1 Background Information

Emergency Contraception is one among strategies used to address problem of unplanned pregnancies in the world. It is a useful method after unprotected sexual intercourse to reduce the chance of unplanned pregnancies when used after unprotected intercourse within defined time limits (WHO, 2012). Unplanned pregnancy is associated with an increased risk of health behavior with adverse effects like increased mortality rate due to induced abortion. It is estimated that 86 million unplanned pregnancies occur each year worldwide, resulting in 42 million induced abortions, 34 million unintended births and 11 million in miscarriage (Speidel, *et. al*., 2008, Singh, *et. al*., 2010).

In developing countries more than one-third of all pregnancies are considered unplanned and about 19% are estimated to end up in abortion. In most developing countries, abortion is illegal and therefore done in unsafe ways and therefore contributing significant percent to the 13% of all maternal death globally (Guttmacher, 2012). In sub Saharan Africa, it is estimated that 14 million unplanned pregnancies occur every year, with almost half occurring among women aged 15-24 years (Hubacher, 2010). The same is reflected for Tanzania as a study done among youths showed that 27.1% of pregnancies were unplanned (Urassa, *et. al*., 2008). Mamboleo (2008), in her study done among youths further reported that 32.8% of respondents had unwanted pregnancy.

TDHS (2010) and United Nations (2010) report significant data on education depicting unplanned pregnancies among school girls in the form of high rate of school dropouts due to pregnancy (NBS, 2010). The use of modern regular contraceptive methods has great role in reducing the incidence of unintended pregnancy. However, despite the wide availability of a range of regular modern contraceptives, unplanned pregnancies continue to be a major problem in most of the developing countries including Tanzania (URT: 1, 2010). Unprotected sex

(mostly by adolescents and youths) including sexual abuse (rape) and none or improper use of regular contraceptives, often lead to an unwanted or unplanned pregnancy. The magnitude of unplanned/ unwanted pregnancies in Tanzania is also reflected in data which depicts high total fertility rate in the country, (5.4) low rate of modern contraceptives use among married women (34%) and reported abortion complications.

Abortion complications are estimated to contribute to about 16 percent of maternal deaths in Tanzania (URT: 8, 2010). It was reported that up to 30% of beds on obstetric wards are taken by women who have had unsafe abortion. These women were significantly younger, more often single, students and nullipara, 88% were less than 25 years (Rasch, *et. al*., 2009, Early, 2009). Rash and Kipingili, (2009) reported that about 62% of women in rural Tanzania and 63% of women in urban Tanzania had an unsafe induced abortion in 2009. The problem of unplanned pregnancies in Tanzania is considered to be significant though the actual data is not easily available (Kinemo, 2011). The incidences of newborn baby dumping indicate also that they are a result of unplanned or unwanted pregnancy.

Unplanned pregnancies coupled with abortions demonstrate unmet need for primary prevention of pregnancies which in such situations could be achieved through utilization of emergency contraceptives since is the only last alternative for women to prevent unplanned pregnancy from unprotected intercourse (WHO, 2010). For Tanzania abortion is still illegal, the strategy adopted to address the problem of unplanned pregnancy in the country among others is thus emergency contraception (URT: 1, 2010). Despite the presence of significant rate of unplanned pregnancies in the country and availability of contraceptives at public hospitals in Tanzania, awareness and knowledge regarding emergency contraception is reported to be poor (Luoga and Patience, 2006, Shaki, 2010) and largely remain to serve victims of sexual violence, (Kelley, 2011), an indication that access to information regarding emergency contraception is poor to many who need it since, the essence of emergency contraception aimed at expanded choice for all women to have sexual and reproductive rights over their bodies.

1.2 Problem statement

Studies on reproductive health have investigated and documented the impact of unplanned pregnancies and unsafe abortion (WHO, 2009, Guttmacher, 2010, Exavery, *et. al*., 2011). In Tanzania studies depicted the impact of unplanned pregnancies in the form of adolescent pregnancies, induced abortions, reported unintended pregnancies (resulting in school dropout and child dumping), unsafe abortions continue to be one of the threatening factor to reproductive health of women of all ages despite the fact that awareness on modern contraceptives is reported to be more than 92% in Tanzania (Rash and Kipingili, 2009, URT: 8, 2010, URT: 1, 2010, NBS, 2010, URT: 3, 2012).

Research findings indicates that despite the big impact of unplanned pregnancies, contraceptive use among women in Tanzania remain low at 28% against awareness which is reported to be about 92% (Luoga and Patience, 2006, Shaki, 2010), and therefore depict the gap between knowledge and practice. The gap however indicates unmet need for primary prevention of pregnancies which in this regard could be achieved through utilization of emergency contraceptives.

In addressing this problem, Tanzania government adopted Guidelines and Standards to address the problem of unplanned pregnancy officially in 2010 through emergency contraception, although the service had started years before (URT: 2, 2010, Kelley, 2011). The adoption of emergency contraception in Tanzania on the other hand, remains a strategy to serve victims of sexual violence (Kelley, 2011) and therefore demeans the essence of emergency contraception which aims at expanded choice for all women to have sexual and reproductive rights over their bodies (Iikkaracan and Jolly, 2007).

It is on this background that this study is founded to further explore reasons behind low or what seems to be a restricted access to Emergency contraception by women in Tanzania. This study

therefore, intended to explore the gap and reasons for low accessibility of emergency contraception in Tanzania by responding to the following questions:

1. How emergency contraception service is delivered in Nyamagana District?
2. What are the views of study population on administering emergency contraception to target population?
3. What are the challenges for accessibility of ECPs to the targeted population?
4. What are the policy options for effective accessibility of emergency contraception to many women and girls in Tanzania?

1.3 Research objectives

1.3.1 Broad object

To describe the implementation processes of emergency contraception service in order to identify the gap, reasons and challenges for low accessibility of emergency contraceptives in Tanzania

1.3.2 Specific objectives

1. To describe the practice of emergency contraception service in health care facilities in Butimba, Igoma and Nyamagana wards

2. To explore perception of the study subjects on the delivery of emergency contraception service in Butimba, Igoma and Nyamagana wards

3. To explore the challenges faced by target population to access emergency contraception service

4. To suggest the policy options for effective accessibility of emergency contraception to many women and girls in Tanzania

1.4 Study Justification

Given the significant high rate of unplanned pregnancies among women of reproductive age, school girls drop out due to pregnancies, induced abortions and low rate of regular contraceptives use in Tanzania, it is obvious that the use of regular contraceptives is very low. The low utilization therefore justifies the importance of alternative strategy, (Emergency Contraception). However, awareness, knowledge and utilization of emergency contraceptives in Tanzania are reported to be low despite the availability of family planning services at all levels of public health facilities. There is knowledge gap on the reasons for that, of which the study will bridge. The findings of this study may be useful in the following:

- Currently the MoHSW, Reproductive and Child Health section is planning to review the 1994 policy FP guidelines and standards therefore looking at the implementation processes of emergency contraception will give picture and challenges of practice in the field thus add value to this important phase of the policy process as emergency contraception is an element in reproductive health package.

- The government of Tanzania is also currently advocating and implementing the national strategy for economic growth and poverty reduction and safe motherhood initiatives. Unplanned pregnancies have implication on achieving these initiatives in terms of caring of the unplanned children, dealing with school girls drop outs due to pregnancies and caring for unsafe induced abortions. Understanding the challenges facing implementation of control measures towards prevention of unplanned pregnancies is therefore important for proper programming of the strategy.
- The existing gender inequalities and cultural norms in the society, insufficient access to or information about contraception, incorrect and inconsistent contraceptive use, or an inability to exercise autonomy over women own bodies, including being subject to rape may make women be unable to exercise choice over conception. Source of information on contraceptive options including Emergency Contraceptives plays greater role on the users' knowledge, perception and utilization of the available options. Interactions of

these domains can be explained by assessing how contraceptives services including Emergency Contraception is delivered in the field

- Putting forward the way(s) of addressing challenges associated with access and utilization of emergency contraception through multisectoral policies.

2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 The conceptual framework

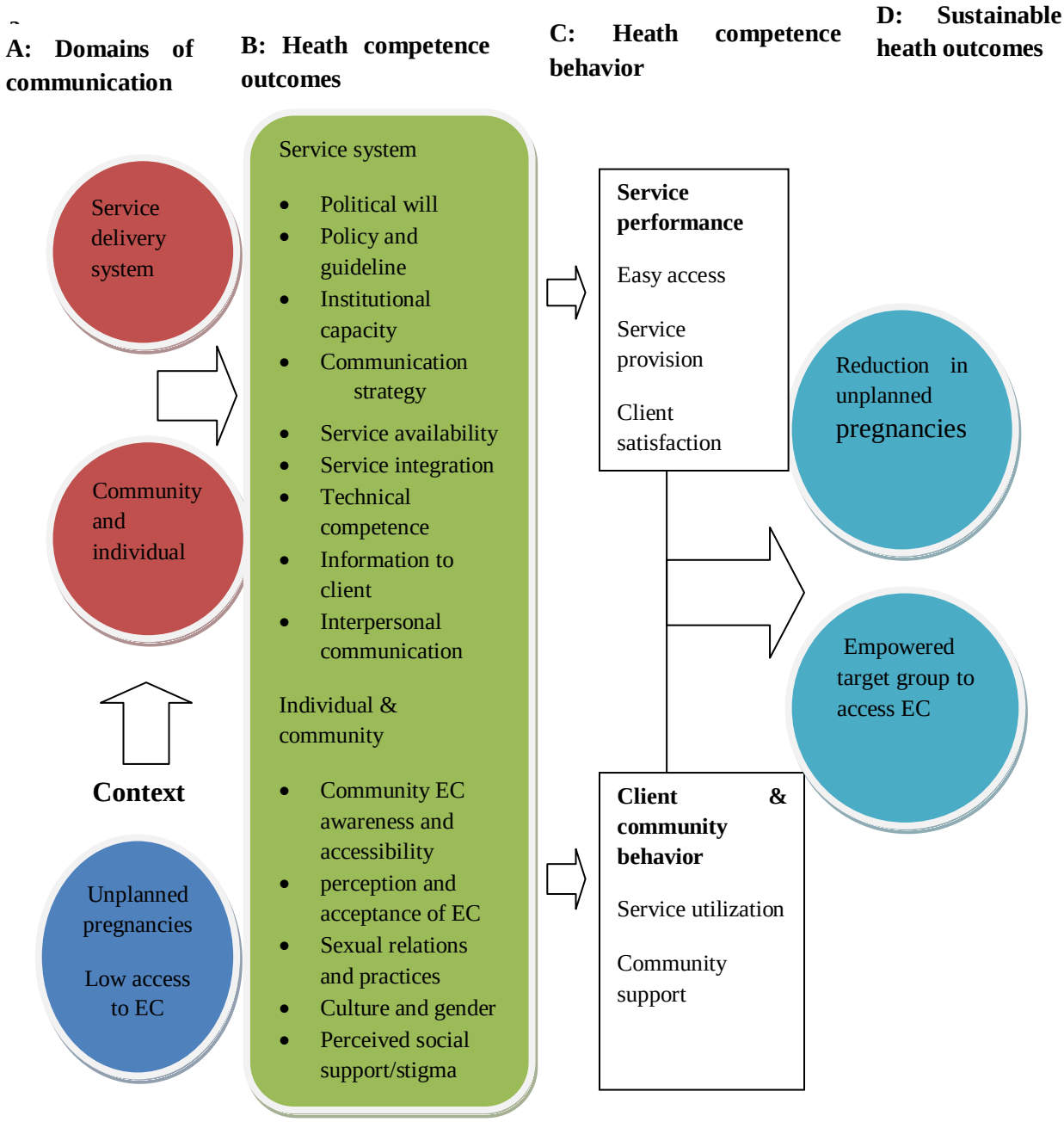


Figure 1: Pathways to a health competent society model (Source: adapted from Storey 2007)

Major portion of the contraception services involve information giving and guidance (counseling) for the client to have an informed choice and decision. This study thus adapted the Storey "pathways to a health competent society model" to analyze the gap and reasons for low accessibility of emergency contraception as shown in figure 1 above.

A pathway to a Health Competent Society model describes a process of social change influenced by communication in a variety of ways depending on program goals. Storey (2007) suggests that, such a framework is critical if capacity for local planning and implementation of health improvement efforts is to be increased and policy and community efforts are to be consistently incorporated in existing efforts, seeking to reduce mortality and morbidity.

The framework illustrates that communication interventions take place in two mutually supportive domains: the service delivery system, and among individuals and communities. (See A: in figure 1). These efforts are intended to produce "initial outcomes" at the service delivery systems level, the community, and the individual level. (See B: in figure 1). At the level of the individual and community, communication activities are expected to improve awareness, knowledge, change social cultural attitudes that constrain the use of service, and other influential factors. At the service delivery system, a great deal of communication occurs at service facilities, among providers and between clients and providers. Health service systems need to communicate norms and standards of practice through policy guidelines, service delivery strategies and training to personnel. Health workers themselves must communicate effectively with clients, sometimes in facility-based venues, sometimes through outreach. These kinds of communication extend the availability and accessibility of services, improve the technical skills of personnel, and improve the effectiveness of information delivered to and interactions with clients.

Changes in these initial outcomes lead to increased adoption of the desired behavior: provision of service, community support to the service, client satisfaction and increased use of service in question (emergency contraception) (see C: in figure 1). In turn, behavior change leads to achieving the objective, reducing unplanned pregnancies and target group empowerment to access service. (See D: in figure 1)

2.2 The context

The reproductive health impact of unplanned pregnancies and unsafe abortions are well documented (WHO, 2009, Guttmacher, 2010, Exavery, *et. al*., 2011). The potential of emergency contraceptives to prevent unplanned pregnancy in developed countries has been described, but in developing countries, the awareness about the method is poor and counseling and provision of emergency contraceptives is lagging behind (Judge, *et. al*., 2010). The use of emergency contraceptives in Tanzania seems not to be popular due to remarkable trend of unplanned pregnancies manifested in adolescent pregnancies, induced abortions and child dumping. This is an indication that emergency contraception is not accessible to many women and girls who need it.

The WHO defines emergency contraceptives as those contraceptive methods that provide a woman with a safe means of preventing an unplanned pregnancy, following unprotected sexual inter course or in the event of potential contraceptive failure (WHO, 2012). Unprotected sex (mostly by adolescents and youths) including sexual abuse (rape) and none or improper use of regular contraceptives, often lead to an unwanted or unplanned pregnancy, which may end up as unwanted pregnancy. In such situations emergency contraception is the only alternative for all women to prevent unplanned pregnancy from unprotected intercourse.

2.2.1 Why are emergency contraceptives (ECPs) important?

An estimated 86 million unplanned pregnancies occur each year worldwide, resulting in 42 million induced abortions 34 million unintended births and 11 million in miscarriage (Speidel, *et. al*., 2008, Singh, *et. al*. 2010). These unintended pregnancies have grave consequences for the health and well-being of women and families, particularly in low- and middle-income countries where maternal mortality is high and abortions are often unsafe. Three hundred and fifty-eight thousand women die of pregnancy-related causes every year, many resulting from unintended pregnancies that were unsafely aborted (WHO, 2009, Guttmacher, 2010). Women who carry unintended pregnancies to term may be less likely to seek antenatal care and delivery assistance (Marston and Cleland, 2003 Gipson, *et. al*., 2008, Exavery, *et. al*., 2011) resulting in

additional maternal deaths, and contributing to more than one million preventable stillbirths (Bhutta, *et. al*., 2011) and 3.6 million neonatal deaths annually (Black, *et. al*., 2010) that may have been prevented with proper care. If they survive the neonatal period, evidence suggests that children born as a result of unintended pregnancies are less likely to be breastfed and more likely to be stunted than wanted children, and are at higher risk for child mortality (Gipson, *et. al*., 2008). At the national level, unintended pregnancies slow progress toward achieving the Millennium Development Goals and other health and socioeconomic objectives, contribute substantially to population growth that in many cases is unwanted, make it more difficult for countries to provide education for all and to eradicate extreme poverty and hunger, and inhibit progress toward improving maternal health and child survival.

Contraceptive use is clearly a critical determinant of abortion given the fact that behind nearly every induced abortion is an unwanted or unintended pregnancy. In fact, abortion is lowest where contraceptive use is high, despite the fact that abortion services also may be legal and widely available. For example, the abortion rate is low at 10 per 1000 women of reproductive age in Belgium, Germany and the Netherlands, where access to safe abortion is widespread and modern contraceptive use is high. (Byamugisha, 2007) In contrast, in Africa including Tanzania, rates of modern contraceptive use are low, at approximately 30%, and abortion rates are high, at 30 per 1000 women of reproductive age, despite the legal restrictions on abortion. (Shannon and Winikoff, 2006) What is more, the cost of providing effective family planning is significantly lower than providing either abortion or post-abortion care services. For example, a study done in Nigeria estimated that the cost of contraceptive services that would have enabled women to avoid the unintended pregnancies that ended in unsafe abortions would have been one-quarter that of the post-abortion care provided by health facilities (Aziken, *et. al*., 2009). Emergency contraceptives provide a unique opportunity for preventing pregnancy after unprotected sex that no other contraceptive method can provide. They can reduce the incidence of unintended pregnancy, which may otherwise result in an unsafe abortion (WHO, 2010) and emergency contraceptives are an important element in post-rape care as well as an essential component of reproductive health.

The need for propagating the use of emergency contraception particularly in Tanzania base in the fact that, unplanned pregnancies are still one of determinants of unsafe motherhood reflected in induced abortion complications cases and rape (sexual violence) cases. It is reported that in Tanzania 20% of women have ever experienced sexual violence and 10% of women had their first sexual intercourse forced against their will (NBS, 2010). Further more Population based survey of 1993- 1999 revealed that 29% of adolescents were forced to sexual initiation against their will (Muganyizi, 2010).

The need for propagation of emergency contraception is also reflected in education data which depicts school dropout due to pregnancy as a major reason for primary and secondary school girls dropping out of school. Every year more than 8000 Tanzanian girls drop out from school due to pregnancy (United Nations, 2011). In 2009 a total of 4965 secondary school girls' dropped out of school due to pregnancy (www. http//lenana.net/blog p=209). This figure excludes non secondary school girls who are also the victims of having unplanned pregnancies.

Currently there have been incidences of newborn baby dumping an indication that they are a result of unplanned or unwanted pregnancy. Researchers estimate that widespread use of EC could prevent up to half of the approximately 3 million unintended pregnancies that occur annually in the U.S. One study suggests that broader use could prevent as many as 700,000 pregnancies that now result in abortion (ACOG, 2012).

2.2.2 When does a woman need to use ECPs?

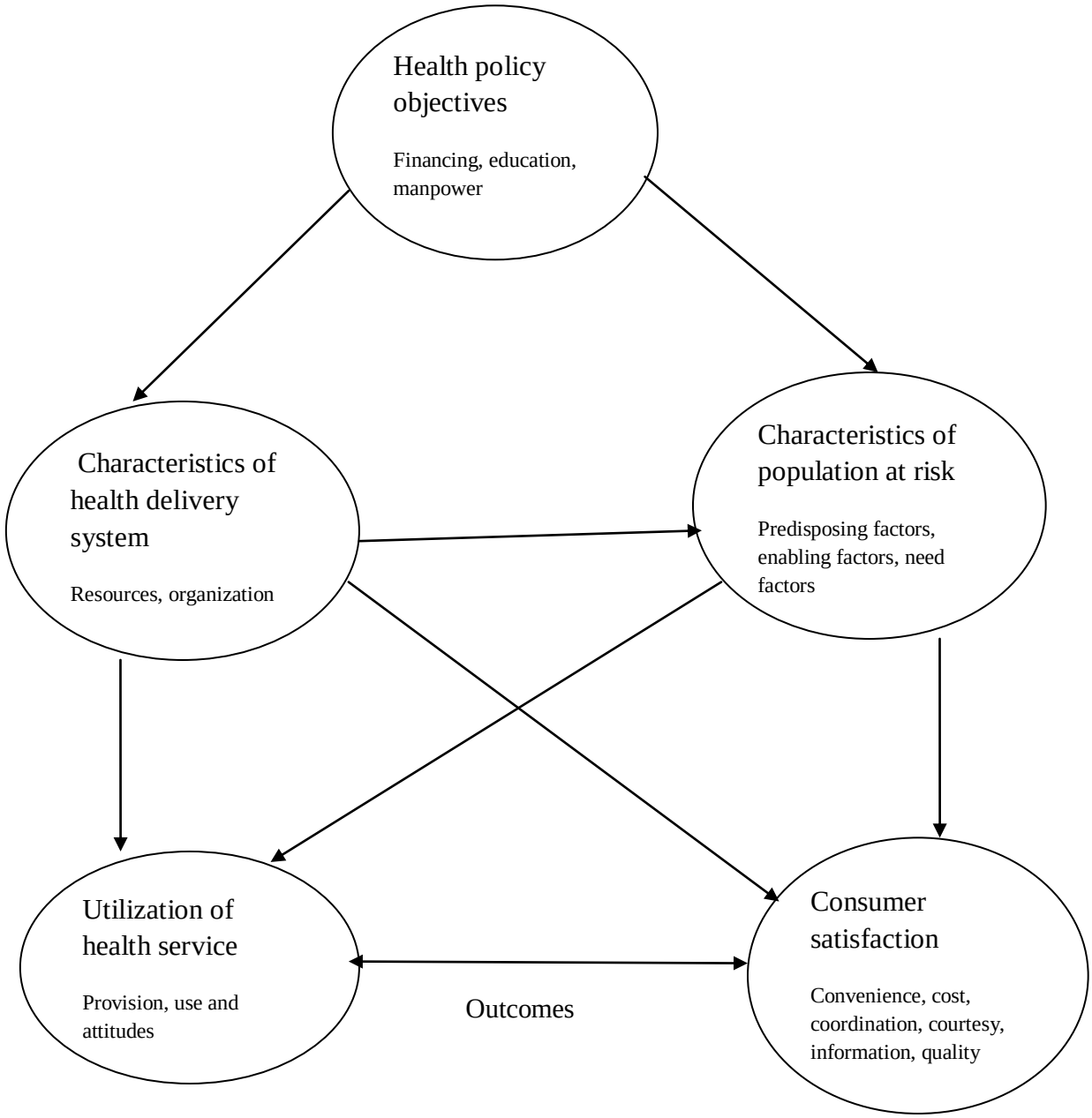
ECPs can be used any time a woman is worried that she might become pregnant. For example, after: Any unprotected sex, Rape/coerced into sex and is not currently using contraception or contraceptive mistakes, such as: when barrier method was used incorrectly, slipped or broke, couple incorrectly used a fertility awareness based method (e.g. failure to abstain, withdraw as intended or to use another method during the fertile days). When a woman has missed 3 or more combined oral contraceptives or has started a new pack 3 or more days late and when a woman is more than 4 weeks late for her repeat progestin only injection (Byamugisha, 2007, URT: 1,

2010, WHO, 2012). Thus every woman of reproductive age is a client for EC under such situations as so far no contraindications for use of EC are reported (WHO, 2010, URT: 1, 2010)

2.3 Concept and factors influencing accessibility of health service

The term "access" has been described in different ways in literatures depending on the context. For example access has been taken as synonymous with the availability of financial and health system resources in an area (Gibson, *et. al.*, 1970). Access may also mean that services are available whenever and wherever the patient needs them and that the point of entry to the system is well-defined (Bodenheimer, 1970). According to Freeborn and Greenlick (1973), access implies that people in the population at risk use services at rates proportional and appropriate to their existing need for care. Aday and Andersen (1995), through a review of efforts to conceptualize and operationalize access to medical care describes a basic framework for the study of access to medical care. To them, the accessibility to health care precedes from health policy objectives through characteristics of the health care delivery system and of the population at risk to the outcomes as shown in the figure 2.

Figure: 2. Framework for the factors that influence access to medical care



(Source Aday & Andersen, 1995)

Interrelation of Factors

The hypothesized relationships among the components to be considered in operational of the access concept are indicated by the arrows in the diagram. Thus health policy may be seen as intended to directly affect characteristics of the delivery system, as by increasing the supply of physicians in an area, materials or programs may be directed to changing characteristics of the population at risk either directly or through the delivery system.

The delivery system in turn may directly affect utilization patterns and the satisfaction of the consumers with the system. Further, the system may also impact on the characteristics of the population and thereby indirectly affect its utilization of services and the consumer's satisfaction with care, as through effective public health education programs. The delivery system is characterized by two main elements-resources (e.g. staff, materials and structures in which health care and education are provided) and organization which encompasses the process of gaining entrance to the system and characteristics of the systems that determines what happens to the client following entry to the system.

On the other hand, the characteristics of the population at risk (described as individuals determinant of service utilization categorized as having predisposing factors (e.g. social demographic characteristics and values concerning health and illness), enabling factors (e.g. income, information, community attributes) and need factors as perceived by an individual or as evaluated by the delivery system) may directly affect use and satisfaction independent of system properties.

The double-headed arrow between utilization and satisfaction in the diagram suggests a sequence in which, over time, the utilization of services is apt to influence a consumer's satisfaction with the system, and in turn, the satisfaction or dissatisfaction he/she experiences from this encounter influences his subsequent use of services. Dimensions of satisfaction that seem relevant to consider in eliciting subjective perceptions of access are satisfaction with the

convenience of care, its coordination and cost, the courtesy shown by providers, information given to the client about dealing with his/her illness, and his/her judgment as to the quality of the care he/she received.

2.4 The implementation concept in relation to health service accessibility

Implementation means to carry out, accomplish, fulfill, produce, complete or is a process of ensuring that something that has been officially decided actually happens (Eriklane, 2012). For the implementation phase of a program to be effective, it requires the dissemination of the program package (e.g. guidelines, materials) to implementing organization and continues with intervention training, technical assistance, and evaluation. This fosters understanding and advocacy of the service among purchasers and sellers of the service (Kilbourne, 2011).

Storey (2007), acknowledges that regardless of all factors that might influence implementation process of any program, social and behavior change would not take place without effective use of communication. Thus to him, access describes the ability to get information and knowledge of community resources related to health. The other access dimensions are availability, affordability and acceptability. Storey (2007) and Aday and Andersen (1995), models depict that they support each other in terms of policy and service organization, levels of service delivery and criteria for service achievement.

2. 4 Family Planning Policy Environments in Tanzania

The Tanzania government's dedication to promote Family Planning over the past several decades dates back to the 1970s. In 1974, the government acknowledged the role of the Family Planning Association of Tanzania (UMATI) established in 1959, and allowed it to expand Family Planning services to public sector maternal and child health (MCH) clinics throughout the country. Several national policy documents have been developed targeting improvement of reproductive and child health services, which include maternal and newborn health. Apart from ensuring that Family Planning was integrated into maternal and child health services in the 1980s and 90s, the government put in place a number of policies, guidelines and frameworks to ensure that Family

Planning including emergency contraception become integral to socio-economic development. These policies include:

1. The National Health Policy (2007)

The underlying goal of the policy is to ensure that health services focus on those most at risk and to satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians. The National Health Policy Plan outlines specific governmental objectives such as ensuring the availability of drugs, reagents and medical supplies and infrastructures, improving the partnership between public, private and faith-based sectors, ensuring that the health services are available and accessible to all the people in the country and training and making available competent and adequate number of health staff to manage health services with gender perspective at all levels.

While the national health policy has given broad guidelines on the health services delivery system in Tanzania, the Primary Health Care (PHC) strategy has outlined how the policy is to be implemented. In PHC Family planning and its components is a basic service fundamental to the provision of health for all.

The strength of the national health policy in delivery of EC service lies on its dedication to:

- Remove financial barrier to maternal health services including family planning. This cost exemption, however, is not uniformly applied across health facilities, and varies whether a patient is visiting a private, government-run, or faith-based medical facility. Government facilities appear to be the most equitable in their fee exemptions, although some consumers' preference for private and faith-based organizations that provide family planning services demonstrates the need for further research on the quality of services in these organizations. This shows that even with policy in place, continued efforts are needed at all levels to ensure policy goals are being met and realized.
- Partner with FBOs and the private sector to achieve greater efficiency and responsiveness to the public's needs. The National Health Policy of 2007

recognized the contribution of the private sector in health service provision. Out of this, stemmed the objective to increase participation of the private sector in achieving access to health services at all levels. As the government comments, Public-Private Partnerships allow the government to streamline responsibilities in providing social services, effectively enhancing efficiency, accountability, quality of service and wide outreach (URT4, 2009). As the matter of fact, through this strategy, private sectors and nongovernmental organizations have proved a greater contributions in provision of family planning services including emergency contraception

- Promote Youth –friendly services (YFS) to improve access to reproductive health information and services. Far long in many countries including Tanzania, lack of youth friendly services has been associated with low intake of reproductive health services to youth especially contraceptive use. This commitment opens the door for easy access of reproductive services particularly family planning and emergency contraception as youths are reported to be the most victims of unplanned pregnancies. AYA/Pathfinder in Tanzania, together with the Ministries of Health of the mainland and Zanzibar Island, demonstrated that it is possible to integrate youth-friendly SRH services in public health facilities. However the challenges like interruptions in supplies such as contraceptives and peer providers, community misperceptions of ASRH, heavy workload of facility staff, lack of understanding of the term YFS by youth clients, and lack of adequate monitoring and supervision of facilities and peer providers still exists, that may negatively influence delivery of EC service. (Pathfinder international, 2005)

2. National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn & Child deaths in Tanzania (2008-15)—The One Plan

The One Plan's main objectives are to increase the contraceptive prevalence rate from 20 to 60% by 2015; reduce maternal mortality; and improve the quality of Family Planning services, making them more accessible to all Tanzanians.

- The plan acknowledges the persistent high fertility level in the country in relation to contraceptive use as it states that, the total fertility rate in Tanzania has been consistently high over the past ten years and currently stands at 5.7 children per woman. Despite having high knowledge of contraceptives (90%), only 26 % of married women use any method of contraception, with only 20% using a modern method. No use of contraceptives is associated with unplanned pregnancies.
- The plan also recognizes the high maternal mortality rate and contribution of abortion complications to maternal death in Tanzania. Abortions in Tanzania reflect the magnitude of unplanned pregnancy due to its illegal restrictions.
- To complement on that the plan adds: A high percentage of adolescents are sexually active and practice unsafe sex. Consequently, the majority of them are highly vulnerable to SRH problems that include adolescent pregnancy and early child bearing, the complications arising from unsafe abortion, and STIs including HIV/AIDS. In Tanzania, more than half of young women under the age of 19 are pregnant or already mothers, and the perinatal mortality rate is significantly higher for young women under the age of 20 (at 56 per 1,000 pregnancies) than it is for women aged 20-29 (at 39 per 1,000 pregnancies), and older women aged 30-39 (32 per 1,000 pregnancies).

Addressing the accessibility to RH services, the plan mentions obtaining permission to access services, not knowing where to go as barriers to access. Thus comments that adolescent health is an area that must be given high priority in the country's development plans, and a focus of care on high coverage effective interventions like family planning.

On the other hand, although the plan admits the risk of unplanned pregnancies through low contraceptive use rate and adolescents sexual behavior, it does not put emphasis on primary prevention of these pregnancies but at secondary level through post-abortal care.

3. National Family Planning Costed Implementation Plan (2010-2015)

The National Family Planning Costed Implementation Plan, launched in March 2010, builds on the substantial investments recommended in other strategic plans and documents such as the Health

Sector Strategic Plan III (HSSPIII) July 2009-June 2015; the Primary Health Services Development Programme (PHSDP 2007-2017; and the Human Resources for Health Strategic Plan (HRHSP) 2008-2013. The NFP CIP guides development partners and implementing partners on areas of need and informs policy dialogue, planning and budgeting to strengthen Family Planning in Tanzania. The goal is to achieve 60% Contraceptive Prevalence Rate (all methods) by 2015.

According to the NFPCIP, Tanzania has a young population, with early childbearing and high rates of fertility continuing throughout reproductive life. These factors account for the projected near-doubling of the population by 2025, placing increasing stresses on health and education systems, availability of food and clean water, natural resources and the environment, and economic growth and development.

Early initiation of childbearing and numerous, closely-spaced pregnancies throughout a woman's reproductive life contribute not only to rapid population growth but also to adverse social consequences such as gender inequity. Girls who experience their first pregnancy during adolescence often terminate their education, limiting their future participation in positive social and productive economic activity. In addition, early and frequent childbearing has serious health consequences for girls and women, contributing to higher rates of complications such as eclampsia, abortion, obstructed labour, haemorrhage, anaemia, premature delivery, and death. Abortion complications are estimated to contribute to about 16 percent of maternal deaths.

With adolescents constituting almost a third of Tanzania's population, early sexual debut, and high rates of pregnancy and childbearing among teenage girls, the needs for contraception are clear. Despite the obvious need of contraception, the uses of modern regular contraception methods are still low. NFPCIP therefore aims to reposition and reinvigorate access to and use of family planning services in Tanzania (URT: 2, 2010).

The strategy acknowledges the impacts of adolescents' pregnancies, (most of which are unplanned) and early and frequent child bearing and the significance of family planning services

in reducing unintended pregnancies and maternal mortality from unsafe abortions. However the use of regular contraceptive methods for so long has been faced with challenges as indicated by low uptake of the methods. This calls for another supporting strategy to prevent pregnancies like emergency contraception. Emergency contraception service is unique in terms of its time frame and situations for use. It is argued that it could be addressed separately for it to be effectively addressed. Further more the strategic activities have not addressed vividly the actions towards contraceptives acceptability and use of adolescents/ youths as for men. This impedes the gaining of picture from adolescents regarding the actual service needed.

One of the strategy specific aims is to expand methods availability through pharmacies, drug shops, social marketing and other community outlets. However these groups are not mentioned in capacity building along the strategic activities. While the aim has positive outcome in accessibility, the gap remains on uniformity of information given to clients through these outlets.

4. ***National policy guidelines and standards for family planning service delivery and training***

The guideline ensures service and training quality by spelling out among others, where the service should be provided, who should provide the services, what type of training service providers should get and direction for service planning. It builds from the national health policy statements on service provision which includes eligibility for services to males, female and youths/ adolescents and rights to information about family planning methods to all people.

The strength of the guideline on provision of Emergency contraception is implied through its:

- Priority in client recruitment which involves adolescents, the common reported group with high risk to unplanned pregnancies.
- Eligibility criteria that a client shall be provided with a family planning method of her/his own choice after appropriate and adequate counseling without requiring the spouse consent. Fortunately, emergency contraceptives are short term drugs, reversible and gives a woman the whole mandate to decide on its use

- Wide spread delivery sites of contraceptive pills and the service providers, ranging from community based outlets or homes to hospital clinic. This would ease accessibility of pills at all levels as in Tanzania, oral contraceptive pills are also used as emergency contraceptive pills in defined doses.

On the other hand, while addressing the issues of counseling and screening clients; instructions and follow up schedules for contraceptive use, the use of oral contraceptives as emergency contraception method is not pointed out as one of the instructions or information to be given to client. This may blind health care providers on delivering information about emergency contraception during routine counseling.

2.5 Emergency contraception and family planning policy in Tanzania

Tanzania National Family Planning policy, guidelines and standards strives to ensure that all persons (women, men and adolescents) have access to comprehensive, high quality family planning services including information and education so that they can make decision on any contraception option or service of their choice (including emergency contraception) (URT: 5, 1994). Emergency contraception is unique service compared to the normal regular contraceptives in terms of its time frame for use and situations for use.

In 2010 development of guidelines and standards was adopted to address the problem of unplanned pregnancy through emergency contraception officially (URT: 1, 2010, Kelley, 2011). Recently emergency contraceptives are also being sold in pharmacies and private hospitals in Tanzania. Access to information regarding the method is however remains poor (Shaki, 2010, Kelley, 2011). Hesitation to advocating the method in other countries has been reported to evolve on some concerns like decreasing use of regular contraceptives, abortificient qualities, promotion of risky sexual behavior and promotion of routinely use of emergency contraceptives (Gichangi, *et. al.*, 1999, Byamugisha, 2007, Aziken, *et. al.*, 2009, Cleland, *et. al.*, 2009).

2.6 Perceptions and views of emergency contraception

Studies show that, emergency contraception is associated with various views and perceptions ranging from favorable perceptions, cautious opinions, negative perceptions and concerns. Favorable opinions includes positive attitudes towards EC pills where by people consider them acceptable. Studies done in Chile, Nigeria, Uganda, India and Mexico report that participants holding these opinions were adolescents, most adult women, women's health advocates, some health care providers, authorities on adolescents' issues, health authorities, and particularly providers of care for victims of sexual violence. (Diaz, *et. al*., 2011, Singh, 2011, Byamugisha, 2007, Lisa, *et. al*., 2010)

The most frequent negative opinion is that EC might be a "micro-abortion" method. People holding these opinions are clearly against EC on religious grounds. Some think that its introduction would be associated with more health risks than benefits. In Chile, this opinion was held by a few adult women and some health care professionals and schoolteachers; and in Mexico by a few health care providers and mothers of adolescents as well as religious leaders (Diaz, *et. al.*, 2011).

An issue mostly mentioned as concern is that EC might lead to undesirable behaviors, such as a decrease in the use of regular contraceptives and/or condoms for STD/HIV prevention. This is especially emphasized in relation to adolescents, who could become more reluctant to use preventive measures on a regular basis. Others are about side effects and risk of misuse of EC.

Those with cautious opinions take a more conservative view, including health care providers, schoolteachers, and leaders of professional health associations, adult women, and mothers of adolescents. They view EC as a form of contraception for specific situations, such as rape or unprotected sexual initiation, or considered it a "lesser of two evils" compared to induced abortion and unwanted pregnancy.

2.6.1 Emergency contraceptives, sexually transmitted infection (STIs) and use of regular contraceptives

There have been concerns that EC users will use ECPs as contraception and put themselves at risk for STIs and HIV infection (Harvey, *et. al*., 2009). However studies have shown that the use of ECPs does not increase the risk of clients acquiring STI and clients who use EC are not less likely to use other methods of contraception rather gives a client an opportunity to learn about other contraception methods (Byamugisha, 2007, Harvey, *et. al*., 2009). On contrary Sarkar (2008), argues that the extensive use of EC is directly proportional to the volume of unprotected sexual intercourse, which is too directly proportional to the quantum of risk for contacting sexually transmitted infections (STIs)/ and/ or HIV.

Literatures suggest that in order to harmonize EC integration and STD prevention, use of barrier methods should be emphasized with EC promoted as a backup especially for youth and unmarried women. EC should also be promoted and distributed with barrier methods. Messages should reinforce mutual monogamy, protected intercourse and delaying onset of sexual intercourse. Choice is central to improving health so harm reduction strategies should be employed in STI/HIV prevention campaigns.

2.6.2 Method effectiveness, safety and side effects

Literatures on emergency contraceptives suggest that effectiveness depends on intercourse treatment interval and the regimen used. The sooner ECPs are taken after unprotected intercourse, the better they prevent pregnancy. If 100 women each had unprotected sex once during the second or third week of menstrual cycle, 8 pregnancies are likely to occur if no ECP is used, one pregnancy if progestin only pill is used and two pregnancies if combined ECPs is used (URT: 1, 2010, WHO, 2010).

The reported pregnancy rates are 0.2-3.0 percent with the yuzpe regime and levonogestrel, 0.3 to 1.6 percent with high dose oestrogen (Byamugisha, 2007). Although frequent use of ECPs is not recommended, repeated use poses no risks to users and should never be cited as a reason for

denying women access to treatment and because the short term nature of their use, there are no medical conditions that make ECPs unsafe for any woman (URT:1, 2010, WHO, 2010).

The main side effects caused by hormonal ECPs are reported to be nausea, vomiting, abdominal pain, headache, breast tenderness, slightly irregular bleeding (URT:1, 2010, WHO 2010) Recent trials on emergency contraception (EC) have indicated that levonorgestrel (LNG) used alone has fewer side-effects and is more efficacious than the Yuzpe regimen (high dose combined oral contraceptive pills). However, the experienced side-effects and acceptability may vary between different groups or societies (Byamugisha, *et. al*., 2007).

2.6.3 Acceptability of Emergency Contraception among users

If any new contraceptive technology is to become a viable option for prevention of unwanted pregnancies users must be willing to use the method and find it acceptable. However because the ECPs have not been widely used especially in developing countries little has been known regarding acceptability of this option (Harvey, *et. al*., 2009).

In a study carried out in Nigeria on 235 women in order to assess their experience and satisfaction with ECPs, more than two-thirds of the women (70%) were using a contraceptive method prior to their need for emergency contraception, and 73% of these users were relying on condoms. When asked about the situation that led to unprotected intercourse, 45% reported that their condom broke or slipped, while 23% said they had had unplanned sex as reported also by Shaki (2010), as the reason by 62.5% of the medical students who responded to the question. More than three-quarters of the sample (81%) experienced at least one side effect.

The overwhelming majority was satisfied with emergency contraceptive pills (91%) and would recommend them to friends and family members (97%). Just one-quarter of the sample (28%) believed that emergency contraceptive pills should be dispensed over the counter, and an even lower proportion (6%), agreed that they should be available from vending machines (Shaki, 2010, Harvey, *et. al*., 2009)

2.6.4 Potential users of EC

Most studies done to assess perceptions and attitudes regarding EC have not reported the views of respondents on whom they perceive as potential users of EC. But a study done in three countries Mexico, Chile and Brazil reports that all participants agreed that the method was necessary in case of rape or incest. In the three countries, most participants agreed that EC would be necessary for certain groups such as young women or young couples, as well as adult women without a stable partner or with many children. They also agreed that it was needed in some specific situations such as unprotected or unplanned intercourse, condom breakage, or partner's refusal to use a condom, as well as incorrect use of periodic abstinence or other contraceptives (Diaz, *et. al*., 2011).

2.7 Challenges for accessing EC

2.7.1 Misconceptions

A common misconception is that emergency contraception causes an abortion. Review of evidence however suggests that EC is not effective after implantation of a fertilized egg (ACOG, 2012). Another misconception is that making EC more readily available promotes risky sexual behavior and increases the rate of unintended pregnancies especially to adolescents (ACOG, 2012). The concern also has been raised among adult women. However, numerous studies have shown that this concern is unfounded (ACOG, 2012). Other concerns are safety of repeated use and side effects.

2.7.2 Knowledge, practices and information regarding emergency contraception among health care providers and users

Knowledge of Emergency Contraception (EC) among health care providers is crucial since users must know that there is a method that can prevent pregnancy after unprotected intercourse in order to seek treatment (Byamugisha, 2007). It is important that potential users have information and are educated about EC before they actually need it (Harvey, *et. al.* 2009).

Several researches have examined the knowledge, attitudes and practices pattern regarding EC in developed countries. In Africa much had been done in Nigeria, South Africa, Ethiopia, Kenya and Uganda. Studies have shown that EC option is underutilized because of lack of client awareness (Aziken, *et. al*., 2009), limited health care providers' knowledge on EC ranging from obstetricians/gynaecologists (Judge, *et. al*., 2010), nurses and midwives (Gichangi, *et. al*., 1999) to potential users (Myer, *et. al*. 2011).

Emergency contraception has been regarded as the 'best kept secret' (Byamugisha, 2007). However in high income countries is no longer a secret as opposed to the low income countries (Judge, *et. al.*, 2010). Such gaps in provider knowledge have been shown to result in the limited provision of emergency contraception in health facilities (Judge, *et. al*. 2010). Research has shown that the use of emergency contraception is also likely to be influenced by the attitudes of providers and their reluctance to prescribe it (Dovey and Sanfilippo, 2011). Several studies done in developed countries, South Africa, India, Ethiopia, Uganda and Kenya have found that health providers perceive that access to emergency contraception could promote promiscuity, increase the incidence of STIs and decrease the use of barrier methods. In turn, the belief that greater access to emergency contraception results in risky sexual behavior is likely to serve as a significant obstacle to the willingness of health professionals to provide it.

In Tanzania, Shaki (2010), in her study conducted in Dar es Salaam to assess knowledge, attitudes and practices of emergency contraceptives among health care providers and medical students report that, 59% of health care providers and 53.7% of the medical students were aware of EC. A lack of knowledge about EC was found as only 30.4% of the health care providers and 32.9% of the medical students were found to have adequate knowledge on EC. ECs provision was reported by 31% of the providers and EC utilization among medical students was found to be 14.9%. Majority of providers (94.9%) and medical students (90.7%) had positive attitudes towards EC provision and utilization. Shaki further reports that despite the fact that in Tanzania setup the nurses are the ones who mainly deal with provision of family planning services which includes EC, 77.3% (n=110) of the nurses were found to be unaware of EC. Of those who were aware of EC 67.2% (n=62) of nurses had poor knowledge on EC, and 22.4% of nurses among

health care providers who had provided ECs (n=49) provided ECs to clients (Shaki, 2010). According to Tanzania demographic health survey EC knowledge among women of reproductive age is 11.8% and who ever used EC is only 0.2% (NBS, 2010).

Awareness and knowledge level has been associated with demographic characteristics of users. In South Africa, women over the age of 20 are reported to be more likely to have heard of EC than teenagers or women 40 or older. More educated women and women whose most recent pregnancy was not unintended were also more likely to have heard of EC. Knowledge of EC was also associated with the type of method used at last sexual intercourse: women using the oral contraceptive pill were more likely to have heard of EC than other women. Knowledge of EC was lowest among women who used a condom alone for pregnancy prevention at last sexual intercourse. The strongest independent predictors of EC awareness were location in an urban area and having a higher level of education (Myer, *et. al*., 2011).

2.7.3 Financial status

Studies on access to emergency contraception in other countries have shown that women's financial resources impede access to emergency contraception regimes. It is reported that the cost of EC adversely affected its use by many women in USA, UK, Canada, Chile Australia, and some provinces of South Africa (Westley, 2012). Nanda argues that, the cost barrier goes as far as at the national level in terms of promoting a dedicated product for EC, training, communication methods and supervision at public sector as it competes with other priority areas for fund (Nanda, 2011).

2.7.4 Facilities

Not all facilities carry EC, citing either commercial or religious concerns (ACOG, 2012). A paucity of educational material or literature available in health facilities is also likely to be contributing to the low take up of emergency contraception products and services. In the Durban study, Naher (2009) found that few pharmacists reported having literature on emergency contraception to provide to clients. More recent studies have supported this finding and have

added that few health care providers have reproductive health material on emergency contraception available to clients (Myer, *et. al*., 2011, Nanda, 2011, Westley, 2012).

2.7.5 Perceived vulnerability to pregnancy

Acknowledging the need to use EC requires recognition of pregnancy risk. Many factors affect women's vulnerability to pregnancy (e.g. the menstrual cycle, contraceptive failure and unprotected intercourse). While women may know that the menstrual cycle affects fertility, there is confusion or a lack of specific knowledge about when they are most fertile (Lisa, *et. al*., 2010).

Others believe that a woman's vulnerability to pregnancy is related more to "luck" than to physiology. The use of contraceptives may thus have no impact on women's getting pregnancy or not (Free, 2009). Relationship status is also reported to affect women's perceptions about their vulnerability to pregnancy and use of contraceptives. Longer-term relationships are translated into less worry about pregnancy and reduced use of emergency contraception and other forms of contraception (Shoveller, *et. al*., 2007).

2.7.6 Policy and regulations

One of the major reported barriers to women accessing emergency contraception is a prescription requirement, age restrictions policy to obtain the drug and emergency contraception protocol at health facilities and reluctance to register products for EC (Dovey and Sanfilippo, 2011). For example, Costa Rica has never allowed an EC product to be registered, and in Honduras, EC was banned by presidential decree following a coup in 2009. Similarly in the Philippines, EC's regulatory approval was reversed in 2001 and no additional EC product has entered the market (Westley, 2012). Even where there has been progress at the federal level (e.g. Mexico), some states have refused to implement Mexican federal law, which requires that EC be offered as part of post rape care.

2.7.7 Gender relations and cultural norms

Review of literature suggests that gender power inequality still exist in decisions regarding contraceptives and fertility issues. Study in Uganda reveals that, young people experience resistance and opposition to contraceptive use by adults including religious, political, and cultural leaders. (Nalwadda, *et. al*., 2010) The leaders are pro-natal and spread negative messages that scare people from using contraceptives and contribute to spread of rumors, misunderstandings and criticisms in the communities. Findings from the Uganda study reveal that young women are still bound by cultural norms that equate marriage and motherhood with female status and value, creating pressure on them to prove their fertility as reported in other studies (Lisa, *et. al*., 2010). Surprisingly, unprotected sex for men is reported to enhance their reputation in contrast to the situation for women. But men would deny the pregnancy and blame the woman for becoming pregnant (Singh, 2011). A pleasing advantage with EC is that women can use EC without needing their partner's consent, as opposed to condoms.

3.0 CHAPTER THREE: METHODOLOGY

3.1 Study design

This study employed a qualitative study design conducted from March to April 2013. A qualitative methodology was chosen in order to capture participants' thoughts, experiences, challenges and their views on the implementation process of emergency contraception so as to explore gaps and reasons as to why emergency contraception is not accessible to many women and girls who need it in Tanzania.

3.2 Study location

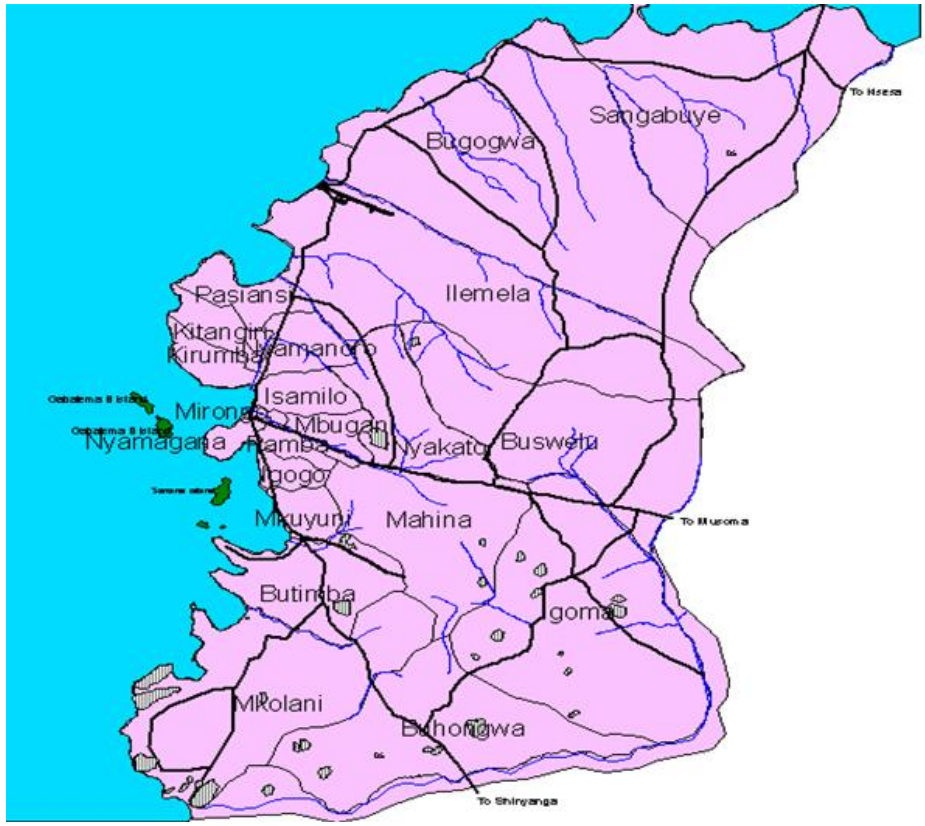
The study was conducted at Nyamagana District one of the eight districts of the Mwanza region. The district comprises the northern half of the Mwanza city. It is bordered to the North West by Lake Victoria, to the south by Ilemela district and to the east by Magu district. Nyamagana district is made up of twelve administrative wards namely Buhongwa, Butimba, Igogo, Igoma, Isamilo, Mahina, Mbugani, Mirongo, Mkolani, Mkuyuni, Nyamagana and Pamba (figure 3). Each ward is further divided into sub-divisions and further into smallest administrative units. According to the 2012 Tanzania National Census, the population of the Nyamagana district was 363,452 (NBS, 2013).

Nyamagana was selected for the study because; it occupies the large part of Mwanza urban. Like other urban cities has environment resulted from urbanization that favors vulnerability to unplanned pregnancies and illegal abortion like an increase number of street youths, unemployment, mobile activities like fishing and mining, and urban poverty.

Nyamagana is one among districts in Mwanza region where there is still high unmet need for family planning with fertility rate of 6.3 and 12 percent use of modern regular contraceptive methods. Low contraceptive use rate and high fertility rate reflects a magnitude of unplanned pregnancies which have an increased possibility of becoming unwanted and ending up with induced abortion.

Three wards of the district namely Butimba, Igoma and Nyamagana were selected out of twelve wards of the district for this the study. These wards were purposely selected because of the following factors: inclusion of health facilities that are known to be active for reproductive health services, to represent urban and rural wards and easy access due to limited financial capacity of the researcher.

Figure: 3. Map of Mwanza city showing distribution of wards



Source (proposed Mwanza regional social economic profile 2010)

3.3 Study respondents

Accessibility of emergency contraception service through its implementation process was the focus of the study. The study therefore included the following categories of subjects:

3.3.1 Reproductive health care providers working at family planning clinics and at youth reproductive health clinics/centers of the selected facilities

This group involved nurses working at family planning clinics. This was in recognition of the fact that nurses play a great role in family planning clinics and other reproductive health services. Due to their responsibilities in health facilities, nurses have close interactions with clients. Nurses are therefore assumed to be the key implementer of the emergency contraception strategy at health facilities as is integrated in the family planning program. The selection thus based on their potential capacity to provide information on the range of reproductive health services and of particular emergency contraception. They were expected to generate invaluable information about availability, service organization, barriers and constrains in promotion and provision of EC service. Nurses working at youth centers/clinics were expected to add valuable information pertaining to youth's utilization of ECPs and challenges in providing service to them.

3.3.2 Women aged between 15-49 attending at reproductive health clinics for reproductive health related services

These included pregnant and non pregnant women who attended the selected facilities for any reproductive health service including family planning. Users of family planning methods were expected to provide information related to their experiences of nature of family planning counseling at points of service, use, effects, challenges faced when in need of family planning service and use of EC (s) and situations that led them to use ECs. The assumption regarding these women was that, they would have information about emergency contraception; experiences on regular contraceptives methods failure or methods misuse. Being at reproductive age are also at risk of unplanned pregnancy depending on the method(s) they use. Pregnant women were expected to supplement information about contraceptive use and planning of their pregnancy (ies).

3.3.3 Policy and guidelines issues key experts

Policy and guidelines issues key experts are those closely related to the policy directives, organization and coordination of family planning services in the district. Key informants involved here were the district RCH coordinator and District Nursing Officer. They were expected to give views about reproductive health programs in the district and the extent to which the programmes addressed the unplanned pregnancies issue and emergency contraceptives use. They were also expected to contribute information about health policies and guidelines that influence promotion, provision and use of EC service in the district.

3.3.4 Young women aged between 18-29 years in the community in three wards of the Nyamagana district.

Youths have been chosen due to their highly and frequent reported risk to unplanned pregnancies. In addition of them being at more risk of unplanned/unwanted pregnancies, literatures and studies reveal that this group is overwhelmed with physiological, social and economic issues in relation to reproduction and reproductive health especially on family planning accessibility and use. This group in the study was therefore expected to give information regarding youth's sexual practices, preventive measures to unplanned pregnancies, challenges to emergency contraceptives use and family planning methods in general and perceived effective strategy for implementing emergency contraception service.

Most studies involving youths considered youths at schools or colleges settings, this study wished to gain views of youths at community setting. Tanzania's youth policy categorizes individuals aged 15-24 as youths as defined by the United Nations, however according to literatures the youth definition in terms of age range is still under discussion (Nangiri, 2011). In Tanzania individual aged from 18 years is considered as mature enough to make his or her own decisions, since contraceptive use involves informed choice and decision making, 18 years were opted as lower age limit for this study category. For upper limit an average age defined in various literatures was determined and used.

3.4 Respondents recruitment procedures

3.4.1 Recruitment of nurses and policy and guidelines experts

Purposive sampling was applied in this study. This method was chosen because of its high capability of selecting information rich participants on the topic being studied. To obtain nurses working at family planning clinics, facilities providing reproductive health services including family planning services in the three wards of the districts were identified with the help of the RCH coordinator. Ten facilities among them were then purposely selected from which health care provider providing family planning services on those ten facilities were involved. Policy and guidelines issues key experts were identified through the help of District Medical Officer, who cited them as dealing more often with family planning issues organization and operations in the district.

3.4.2 Recruitment of women at the selected health facilities

All women who had received reproductive health services including family planning service on the day of data collection at the selected facilities were eligible for the study. Recruitment criteria based on their ability to express themselves freely willingness to participate in the study and information saturation points. To select these women, exit interview was conducted to all willing women coming out from the selected facilities after receiving the service. Before collecting information from these women, preliminary talks and questions were initiated to determine the strength and potential capacity of the respondents to participate in the study. The information then was collected from the identified women by using the developed interview guide. Twenty respondents were identified due to saturation point.

3.4.3 Recruitment of young women in the community

The youths were also purposely selected from three wards which were obtained from twelve wards of the district. Within each ward one street was selected. Street leaders were identified by the use of the wards executive officers, explained about the study objectives and the importance of getting participants who could express themselves openly on family planning issues. With the help of these leaders participants were identified in the streets.

3.5 Data collection methods and procedures

In- depth interviews (IDIs), exit interview (EI) and Focus Group Discussions (FGDs) were the main methods used to collect data. In-depth interview was opted for the study to elicit a vivid picture of the respondents' perspective on the study topic. Mack, *et. al*., (2005) suggests that in-depth interviews are an effective qualitative method for getting people to talk about their personal feelings, opinions, and experiences. They are also an opportunity for the interviewer to gain insight into how people interpret and order the world. Exit interview were meant to gather information about women experiences while attending family planning clinics and nature of information giving process about emergency contraceptives between health care providers and clients.

Focused group discussion was used to capture information about social norms and the variety of opinions or views within a community. Because not everyone would have the same views and experiences – because of differences in education, marital status, sexual relations, access to resources and other factors – many different viewpoints were expected to be expressed by participants.

In-depth interviews

These were in person interviews conducted to 12 interviewees. The interviewees involved 10 nurses working at family planning clinics and 2 policy and guidelines key experts of family

planning program in the district. The policy and guidelines experts interviewed were District Nursing Officer and District RCH coordinator.

Each in- depth interview was carried out using semi- structured interview guide. Two different interview guides were developed through questions based on the research questions, objectives and information gained from the literature. The two different interview guides were for: health care providers and key informant at administrative level. Interview guide for health care providers were developed in Swahili for easy expression. However, the guide were translated into English during an interview if need raised. The guides for key policy experts were in English but were translated in Swahili language during sessions.

Nurses' guides composed of description of the respondent, questions regarding physical delivery of EC at health facilities, accessibility of EC service and challenges on provision and utilization of the EC service. The key informants guide revolved around a set of key themes, including description of key informant and his/her role in family planning services including Emergency Contraception in the district, participation in family planning policy guidelines and standard formulation, views on the need and current provision and utilization of emergency contraception towards reduction of unplanned pregnancies in the district and challenges associated with provision and utilization of Emergency Contraception within the district.

The interviews were freely structured around the themes with more detailed questions (probes) listed under each theme to ensure that sub-topics are discussed at some point, depending on the specific area of strength of the informant. They took between 40 to 60minutes depending on the responding capacity of the respondent. A tape recorder with respondent consent and handwritten field notes were used to capture information during in depth interviews.

Exit interview

Exit interview was conducted to 20 willing women aged between 15-49 years coming out from the selected facilities for reproductive health services including family planning service. The

interview was conducted by using an interview guide (in Swahili language) which composed of description of the respondent, questions regarding physical delivery of EC at health facilities, accessibility of EC service and challenges on provision and utilization of the EC service. Conducive places were secured to provide privacy and free conversation between the interviewer and the informants. Interview session lasted between 20 to 30 minutes. The interview was tape recorded after seeking consent from participant and hand written notes were taken to capture the wide range of respondents' responses.

Focused group discussions

The focused group discussion involved 14 young women aged between 18-29 years at community setting to allow their perspective on provision and utilization of emergency contraceptives to be heard. Two focused group discussions were conducted. One group composed of six married young women and the other group composed of eight unmarried young women to facilitate discussions among the study participants. Each focus group session lasted, on average, one and a half hour. The discussions were carried out freely following focus group discussion guide created with additional questions derived from responses or trends observed from interview. The guide focused on family planning and emergency contraceptives use perception of emergency contraceptives provision and use in Tanzania, physical delivery of emergency contraception at health facilities and accessibility challenges. The discussions were conducted in Swahili the national language of Tanzania in all sessions; the notes were taken in the notebook and audio taped. The validity was enhanced through summarizing the key points that arouse during the discussions at the end of FGD sessions and reflected back to participants who then either confirmed or corrected them.

Table: 1 Summary of data collection methods and procedures.

Method	Respondents involved	Number of respondents	Tool(s) used to collect data	Session duration
IDIs	Nurses at health facilities Key policy experts	10 2	Semi-structured interview guide (Appendix IV & Appendix VII) Tape recorder Field note	40 – 60 minutes
EI	Women aged between 15 – 49 years at health facilities	20	Semi-structured interview guide (Appendix VI) Tape recorder Field note	20 – 30 minutes
FGDs	Young women aged between 18-29 years	14 divided into two groups: 6 married and 8 unmarried young women	FGD interview guide (Appendix VIII) Tape recorder Field note	On average one and a half hour

3.6 Data management and analysis

3.6.1 Data management

Data generated from the interviews and focus group discussion were cleaned daily, verified and checked for quality and consistency against the tape recorded data, sorted, transcribed and organized carefully.

3.6.2 Data analysis

For this study content analysis approach was used. According to Hancock, (1998), the major steps of content analysis are;

- In depth reading of the transcript and marking the relevant information
- Making a list of different types of information that have been found
- Categorizing each item according to what it describes
- Linking the similar categories to form major categories and minor categories
- Linking the similar information from other transcripts into the existing categories
- Forming major themes when two or more categories seem to fit together

3.6.2.1 Analysis of in-depth interview and exit interview data

This involved reading through the transcribed texting of each interview and identifying responses relevant to the main questions raised by the study and creating categories, aiming at identifying from the transcripts the extracts of data that are informative and sorting out the important messages available in each interview.

The recorded audio files were transferred from the digital audio recorder to the computer and then labeled. Each day after fieldwork, data was transcribed in Kiswahili language. Then the transcripts were translated into English, typed into computer and labeled. The relevant information was copied and pasted to a category according to what it describes in relation to the study objectives. When all transcripts were typed the recorded interviews were deleted to protect the identity of interviewees.

3.6.2.2 Analysis of focus group discussion data

After data collection, tape recordings were transcribed and all handwritten notes from the discussion, and notes from the debriefing session held after the focus group discussion were expanded into more complete narratives. Phrases or words with similar meaning were searched from the transcripts according to participants' responses to each objective question.

3.7 Trustworthiness of the study findings

To address the trustworthiness of the study findings the following were ensured:

- Key points that arouse during the focused group discussion were summarized at the end of the sessions and reflected back to participants who then either confirmed or corrected them
- Triangulation of data collection methods
- Provision of detailed portrait of the participants and setting in which the study was conducted to give readers enough information for them to judge the applicability of the findings to other settings
- Inclusion of data collection tools in the report document to give other researchers the ability to transfer the conclusions of this study to other cases, or to repeat, as closely as possible the procedures of this project.

3.8 Ethical considerations

Ethical clearance was south from Muhimbili University of Health and Allied Sciences Research and Publication Ethical Committee. Nyamagana District Medical Officer was consulted for permission to conduct study in his administration district. Permission also was sought from the Mwanza City Council Executive Director, Ward Executive Officers, in-charges of the selected health facilities and street leaders. All subjects voluntarily participated in the study after being informed about the objective of the study, confidentiality of the results and signing of consent form or upon verbal agreement.

4.0 CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents the results of the interviews and Focus Group Discussions. The chapter is based on the data obtained from 10 in-depth interviews conducted among nurses (HCP), 2 in depth interview conducted among policy and guidelines issues key experts, (PE), 20 exit interviews conducted among women at facilities (W) and 2 focused group discussion sessions conducted among 14 young women in the community (YW). A total of 46 respondents were therefore involved in the study. The chapter describes the demographic characteristics of respondents and the results are presented thematically focusing on the research specific objectives.

4.2 Interviews sessions findings

In this section findings from both in depth interview and exit interview are presented. Demographic characteristics of policy and guidelines experts are not tabulated because of them being few and they shared most of the characteristics. They were all female with an average of 43 years, married and nurse midwives with nursing education training post ordinary level education.

4.2.1 Demographic Characteristics of nurses working at FP clinics

All interviewed nurses were female with median age of 42 years (range 36-54). All had nursing education training post ordinary level education. Majority were married and did not use any modern family planning method (Table 2).

Table 2: Social demographic characteristics of nurses working at FP clinics

variable	Number (%)
Age group (years)	
36-40	1 (10)
41-45	3 (30)
46+	6 (60)
Title	
Registered nurses	3(30)
Enrolled nurse midwives	7(70)
Current marital status	
In relationship (married)	8 (80)
Not in relationship	2 (20)
Use of family planning methods	
Yes	4 (40)
No	6 (60)

4.2.2 Demographic Characteristics of women aged between 15-49 years

Of the interviewed women, 8 visited the facilities for antenatal care and 12 for family planning service. The women's median age was 29 (range 25 - 37) and most had primary level education. In terms of occupation 60% were into business and only 10% were employed. 60% reported to use/be using family planning methods (Table 3).

Table 3: Social demographic characteristics of women aged between 15-49 years

variable	Number (%)
Age group(years)	
25-29	8 (40)
30-34	10 (50)
35+	2 (10)
Occupation	
Housewife	6 (30)
Business (of any form)	12 (60)
employed	2 (10)
Current marital status	
In relationship (married)	15 (75)
In relationship (not married)	5 (25)
Use of family planning methods	
Yes	14 (60)
No	6 (40)
Education level	
Primary	17(85)
secondary	3 (15)

4.3 The practice of emergency contraception service in health care facilities

4.3.1 Service provision

Ideally all health care facilities providing family planning services were expected to be providing the emergency contraception service too since emergency contraception is an integral part of family planning program in Tanzania. However only few facilities reported to be

providing this service despite the availability of family planning services at those facilities. The common reasons given for not providing EC service were: unawareness of the EC technology, lack of proper knowledge regarding EC service scope and ECPs action and lack of clients who demands for the service. The participants' statements below are illustrative:

> "We don't provide such service…..to be frank I personally don't know clearly about those pills though I am working in FP clinic for four years now but I know that there is such a thing……..if clients would be coming perhaps I could have known them more because of dispensing them to people (HCP 2)

While the above respondent had knowledge gap about ECPs, another respondent missed not only knowledge but also awareness of the presence of the EC service as she said:

> "…..it was only the day before yesterday when I got a client whom from today's information I think I could had helped her but I did not know of this (referring to EC)……..”(HCP 10)

Limited knowledge on EC service scope was demonstrated by other providers as represented by the following respondent:

> "I heard of it at nursing school, but I don't remember it well. To my understanding and the way I have been experiencing, I knew this service is for raped people and because these rape cases are rarely reported at our facility, I think that is why we don't provide it here”(HCP 3)

While some health care providers at facilities reported of not being providing emergency contraception service in their facilities, policy and guidelines experts had general idea that all facilities provide emergency contraception as long as they had family planning service as stated by the following respondents:

> "……of course, this service is there but the delivery details you are going to get in facilities, I can not explain it to you because we deal with many activities in the district”…….(PE1)

Another respondent had the following to say:

> "We do provide family planning services in all of our public facilities; emergency contraception is part of it so it should be part of service too…… (PE 2)

4.3.2 Procedure (process) to be followed to get the EC service

It was reported from the facilities providing EC service that there is no specific procedure to follow to get the service. In most cases clients go direct to family planning clinic or reproductive health clinic to seek an advice on what to do after doing sexual act and worry of conceiving, except the rape cases where by the victim and/ or her supporter should get the police note before seeing or being attended by the health care provider. Some of the reporters said:

> " EC is integrated in family planning services even if the client goes to the doctor or health care provider in RCH clinic and see that there is a need to get these pills, he or she will direct the client with a note to family planning section for the pills" (HCP 6)

Another respondent insisted that FP clinic saves as an entry point to ECPs by saying:

> "Most client come here (referring to at family planning clinic) though they usually don't come for EC but for an advice on what to do following an incidence……...for the raped ones is a bit different because rape is a police case so there should be a report from police station before attending this client" (HCP 1)

4.3.3 Drugs used

No public facility reported to have special package for emergency contraception service rather the same contraceptive pills are used when the need arises. The frequent mentioned pills used as EC were microgynon and microlut. In contrary, the youth center visited at UMATI reported to have been using special package previously postinor-2 which disappeared from the market and then followed norlevo which is used to date. The shortage of drugs was reported to be low in both cases. Either it was reported that there is no prescription requirement to get the pills within the facility or in other facility often verbal referral is used for a client to get pills (service) at another health facility if there is no pills at that particular facility as reported by this respondent:

> "…. for us here our clients are referred to (name of facility) as it is near and pills there are constantly available ……we usually tell them by mouth to go for service when we run shortage of the contraceptive pills…….(HCP 4)

4.3.4 Common users of emergency contraception service

There was variation between the visited facilities regarding the common users of EC service. However, apart from rape victims, the breastfeeding mothers regardless of age and marital status were mentioned to be the most common saved people with ECPs at public health facilities. Other mentioned groups were unmarried college students and hardly ordinary and advanced secondary school youths. It was reported that most of these clients came to just seek an advice on what to do after having unprotected sex with the worry of conceiving. Through this need, those who seem to benefit from the service are given the service.

> "I remember I have given the ECPs to four women and all were breastfeeding……they were not using any contraceptive methods following delivery……." (HCP 10)

It was reveled that few youths sometimes benefit with the use of ECPs as stated by the following respondent:

> "We usually do not get youth clients not only for EC service, but also the regular contraceptive methods though they sometimes come…….if it happens she comes we never deny her the service…….we say FP is for every eligible person…….. (HCP 6)

Another health care provider added that:

> "….married women, unmarried women and youths though they are few comparing to married or unmarried breastfeeding women" (HCP 3)

4.3.5 Providers of emergency contraception pills (service)

EC is mostly given at FP clinic or section. This was evidenced in all visited facilities as the investigator was always directed to FP sections after explaining the objective of the study. Therefore those working at those clinics are the common dispensers of these pills. This is also supported by the statement from an interviewee.

> " EC is integrated in family planning services even if the client goes to the doctor or health care provider in RCH clinic and see that there is a need to get these pills, he or she will direct the client orally or with a note to family planning section for the pills" (HCP 6)

During interview sessions all met health care providers at FP clinics were female nurses aged between 36 and 50s, and with an ordinary secondary education level. Their titles differed but most were enrolled nurse midwives and few registered nurses.

Some of these nurses reported to have training on EC while in service through non-government organizations but majority of the interviewed nurses reported not to be trained while in service rather at nursing school. Doctors also play part in provision of this service especially to rape victims who pass through them while seeking medical care after the incidence. Even though, the actual providers of the pills were mostly reported to be those working at FP clinics.

4.3.6 EC service propagation strategies at facilities

The Tanzania family planning procedure manual (2010) categorizes EC in the short term family planning methods when explaining about the contraceptive pills. It was expected that when a client is being counseled about contraceptive pills could also be given information regarding EC as one of the strategy to propagate it. Although some of the health care providers from facilities that provide EC service reported to be giving information to clients during routine counseling of FP methods, none of the interviewed women at public facilities reported to be told of the ECPs during counseling sessions. Some providers stated:

> " we tell them when we counsel them about contraceptive pills during FP counseling even to mothers who bring their children to clinic and these mothers go and tell others……..(HCP 5)

Though some providers reported to educate mothers about ECPs at regular counseling sessions, hesitation to educate people out of health facilities was expressed as demonstrated by the following respondent:

> "As health care provider, I can't go to the public and talk about ECPs but I tell those who come for FP service…….. (Smile) how can I start? Well, to me these pills are like telling girls to un limit their sexual behavior …… (HCP 7)

Interviewed women on the other hand had contradicting statements regarding routine counseling on ECPs at facilities as illustrated by these respondents:

> "….. I have been using pills for three years now from this facility but I have never been told that these pills can be used the way you are saying today……..our professionals

> (wataalam) are the ones who know what to tell us, you can not know of what you are not told…….we see these things written on boards yes but (silent) what I can read perhaps is this one with green star and people are laughing on it (laughs)…… (W 6)

Reasons of not being told (counseled) were considered by other interviewees as one of them said:

> " They don't say…..nurses have many things to do and they are few I think, they don't have time to talk much…….I was not told of such pills perhaps because I came for injection direct (W2)

The need for information was expressed to some respondents while showing that routine counseling is hardly done as stated by this woman:

> "…… if this could be happening, perhaps I could not conceive this pregnancy….I stopped using contraceptives…….but I did not want to be pregnant for now….."(W12)

It was observed that some of the facilities had posters posted on notice boards explaining about ECPs and leaflets kept at reception section. Some facilities reported to be conducting outreach programs to communities and schools but none reported to include EC promotion as planned activity. Outreach activities mostly involved immunization and provision of long term FP methods especially vasectomy and tubal ligation as reported by the following interviewees:

> "We do not have a schedule for outreaches but I participated in a certain program to promote long term family planning methods at 'Ukerewe'……." (HCP 10)

Resources constrains was reported to hinder outreach programmes, though still outreach for EC services was not of priority during the few outreach done by some facilities as stated by the following respondent:

> "…….the problem is outreaches need resources and we don't have much but we sometimes go though not for EC issues……we are client based, whenever we go out there we never hesitate to talk whatever seems beneficial to our people……I have been going out to do minilap for sterilization because I had training on that but not for EC campaign or program…." (HCP 8)

At schools level, health care providers do limit their services with the assumption that other health issues like reproductive health is integrated in schools' curriculum as said by this respondent:

> "what we do at schools mostly is to give immunization that is tetanus and general health education……..we have not talked of reproductive health as we heard nowadays they are taught by their teachers about those issues……"(HCP 1)

4.3.7 FP guidelines, manuals and policy documents at heath facilities

In all visited facilities, the interviewee mentioned at least one document that guides their daily FP service delivery. The common mentioned document was the manual titled "kitendea kazi cha mhudumu wa afya ya uzazi na mtoto katika jamii na mteja" others were: planning your family; A teaching aid for use in family planning education, The essentials of contraceptive technology, medical eligibility criteria for FP methods use and " MTUHA: kitabu cha 8: kitabu cha kila siku cha uzazi wa mpango" despite this mentioning only few providers managed to show the mentioned document(s) to the interviewer for different reasons like misplacement and being closed somewhere where they could not be accessed at the time of interview session.

No interviewed health care providers reported to have seen or use the Tanzania FP policy standards and guidelines nor the current (2010) FP procedure manual except one health care provider who had seen the current FP procedure manual. This was also demonstrated at the administrative level as evidenced by these statements from the administrative officers:

> "……mmmmm, this policy is present but I think it might be at the DMO's office, I don't have it here…….frankly speaking I am here, but if you ask me about most of the things regarding policies and some of the programs, I can not tell. I am not involved……my roles often base on nurses affairs in terms of employment, distribution and reports processing. (PE 1)

The statement above was supported by the following statement from another administrative officer:

> "I have heard that there is new FP procedure manual but I haven't seen it personally…….most of the time we work through experiences. Can you imagine I do coordinate all reproductive health activities in the district including family planning program, but I have never been trained on comprehensive family planning….(smile) at the same time I am supposed to give technical assistance to direct providers…. (PE 2)

It was reported that these documents reaches the facilities in different ways like during supervisions of district administrators, when health care providers' send reports to the district health offices and when people come back from trainings.

4.4 Accessibility of EC service among targeted groups

4.4.1 Awareness of the EC service

Nurses interviewed from health centers and hospitals showed to be aware of (heard of) the service compared to those from dispensaries. Most of the interviewed nurses who knew of EC reported to hear about EC at nursing schools, some at FP workshops and colleagues. Those who were aware of EC at all levels were at least able to describe the dose and time frame for EC. However knowledge on mechanism of action and eligibility criteria for ECPs was demonstrated to be inadequate as most of them considered EC is mostly for rape victims.

> "…….I knew these pills are for raped people…….we receive very few cases of such kind……" (HCP 3)

Another respondent had similar understanding as she said:

> "We provide EC service but the service is not active because raped clients who come to our facility are few" (HCP 2)

The interviewee at higher administrative level reported to be aware of the service and they knew that it is provided at health facilities though they admitted that trainings on EC to health care providers is not efficient as there is limitations of trainings to pool fund for other activities considered more essential.

> "As district we haven't planned for that (EC) trainings because nowadays the trainings have been limited by the government so that money can be used to other critical issues……some of our health care providers have been trained through non government organizations which we work together like UMATI and engender health…this helps us but the service is given because they are trained at schools too, they know" (PE 2)

The term emergency contraception was new concept to all women till the description of the concept was made. After description some women reported to have heard of the use of contraceptive pills after unprotected intercourse to prevent pregnancy. However no one reported to self ever used contraceptive pills as ECPs. Peer stories, friends and hear sayings in the community were commonly mentioned as source of information. The knowledge on actual dose of the pills to be taken was demonstrated to be not known as illustrated by these statements:

> "People do use these pills in such a way but how many should be taken I don't know, some say four, some ten……" (W 4)

Another woman stated:

> "I once heard my young mother telling her friend of such a thing….I can not explain how to take them because I did not bother it much for that time…..(W 7)

The majority others reported not to hear of such practice (service) even after description.

4.4.2 Availability and cost of ECPs

Regular contraceptive pills were reported to be available at almost all public health facilities, some private health facilities and in pharmacies in different brands. These pills are given for free at public health facilities and are sold at private health facilities and pharmacies. The cost of the pills was reported to be between Tsh. 500 to Tsh. 2000 per box with 3 cycles. At all visited public facilities, the contraceptive pills were kept in FP clinics/sections and can be accessed during the operating hours or days of the clinic. However, it was noted from one of the facilities that the pills were also available at one of the doctor's office and at another facility were found at OPD pharmacy.

> "These pills (CPs) are found at all facilities providing reproductive and child health services…….I know they are sold in some private and pharmacies but I am not sure of the cost…(HCP 2)

While the above respondent was not aware of the cost, another respondent confessed that:

> "My sister sells Tsh.500 per single box…… (W 5)

Variation of the ECPs cost at pharmacies and private hospital was demonstrated as reported by the following respondent:

> "You can get them even in pharmacies at around Tsh.1000 or Tsh.2000 in others… (W 3)

Despite the availability of these pills for free some participants felt that as long as the pills are related to family planning program their use might be problematic due to social cultural context associated with reproductive issues in African countries especially to youths. The statements below are illustrative:

> "we say family planning is for everyone but still there is an elements of attitude that young people are not supposed to be associated with love and sexual affairs, for that matter we hardly get them not only for EC but also even regular contraceptive methods……."(HCP10)

Though youths are looked negatively in relation to the use of family planning methods, a couple relations were also reported to influence the use of ECPs as illustrated by the statement below:

> "People still have negative feelings to family planning methods, what I see for example most women prefer injections to pills worrying how if their partners finds the pills, looking at youths they have no courage to attend these clinics due to what is usually in the community regarding them and family planning methods use…..even if these pills are free, using them may be difficult…..people find it better to buy pills in pharmacies even if 500Tsh is much to a normal Tanzanian (W 14).

4.4.3 Perceptions of health care providers and clients on provision and utilization of ECPs in Tanzania

All people participated in the interview considered EC service wealth to be provided with various reasons as illustrated by some of the respondents' statements:

> "The service is important especially to youths who are sexually active and usually, because of different reasons have low or no knowledge on proper condom use or family planning methods …."(HCP 8)

The need of the service was emotionally expressed as demonstrated in this statement:

> "If I knew of the service, I would be the first to go for it because the day I got pregnancy I often don't want to remember…… (W 10)

Another respondent supported the service demand in other perspective as follows:

> "Considering the life style today, this service is obvious needed because sexual issues are everywhere like in televisions, computers and peer stories…….for that matter unplanned/unwanted pregnancies are to be expected……we do not have actual figure for the magnitude of unplanned pregnancies in our district but we care for patients with induced abortions, this is a simple indicator that we also have these kind of pregnancies…….(PE 2)

However overlapping concerns to ECPs provision and use were highlighted during interviews:

> "They say these drugs (ECPs) have no effects to the existing pregnancy but the secret of creation lies to God, as long as they are given after the sexual act I doubt if they are not killing"(HCP 9)

Other participants had similar concern as they said:

> "I don't think I can give this service to client, to my belief this is killing…….how far are we sure that the creature (kiumbe) is not formed?.....yes, the service may be good but the government should give emphasis on condom use to protect people with diseases too"(HCP1)

> "They say these drugs (ECPs) have no effects to the existing pregnancy…… as long as they are given after the sexual act I doubt if they are not killing" (HCP 3)

Worries of side effects were also stated:

> "……the contraceptive pills are associated with the belief that if used, they accumulate in the uterus to cause cancer and infertility, so using them too as ECPs may be difficult to some people…..may be because they are taken only for some hours people can accept……"(HCP 4)

4.4.4 Challenges on provision and use of EC service

Although the emergency contraception service was considered to be useful backup methods after unplanned sexual act without protection, the study found that its provision and use is challenging as sexuality issues are complex. The challenges rose during interviews were categorized as follows:

4.4.4.1 Lack of adequate knowledge regarding the EC scope and action among the health care providers working at FP clinics

Health care providers met demonstrated the knowledge gap as to who should be given ECs and how do they work. One of the respondents said:

> "……..to be frank I personally don't know clearly about those pills though I am working in FP clinic for four years now but I know that there is such a thing……"(HCP 2)

To add on the idea, another respondent had the following to say:

> "…….to my understanding and the way I have been experiencing, I knew this service is for raped people……..."(HCP 3)

This was reported to be attributed by lack of in service trainings and unavailability of emergency contraception service guiding manual or documents at health facilities.

4.4.4.2 Integration of EC service with family planning services

Far long family planning program has been surrounded by perceptions which hinder some of people especially youths to seek for the service. This was also highlighted during the interview as an area to be reworked out as it might affect the utilization of EC service too. The statements below are illustrative:

> "People still have negative feelings to family planning methods, what I see for example most women prefer injections to pills worrying how if their partners finds the pills, looking at youths they have no courage to attend these clinics due to what is usually in the community regarding them and family planning methods use…..will they come for these pills? (W 14)

> "we say family planning is for everyone but still there is an elements of attitude that young people are not supposed to be associated with love and sexual affairs, for that matter we hardly get them not only for EC but also even regular contraceptive methods……..."(HCP10)

To add on this another woman had this to say:

> " ……to my understanding service for emergencies should be available whenever it is needed, but most of contraceptive pills in public facilities are at family planning clinics which do not operate 24 hours, during weekends and holidays are closed, how will people be protected then during this time……(W 5)

4.4.4.3 Personal attitude regarding EC service among health care providers

While clear information and knowledge formed a basis for EC provision among health care providers, some providers expressed feelings that may prevent them to directly provide the service as reported by this health care provider:

> "As health care provider, I can't go to the public and talk about ECPs…….. to me these pills is like telling girls to un limit their sexual behavior …… is like condoms, I don't prefer these things but because we are employed and we are supposed to talk about these issues, otherwise if I had to decide on my feelings (shake head)…… (HCP 7)

Feelings to others were grounded from religious beliefs that service provision to them is considered to be a sin:

> "Me as me, I will not give a client this service, I better prefer to somebody else…….I am saved, if God had created a baby after such act that means I will be supporting killing…….that is my belief……(HCP 1)

Another respondent had similar feelings:

> "…… I can not give this service to client…….if God wants a baby to be born it will, and if not it won't I believe……..."(HCP 9)

4.4.4.4 Limited political influence on EC provision and use

Some pointed out that EC is given less priority at government level compared to other methods:

> "We work under the influence of the government and political people, so far I don't see much influence to EC as say condoms and long term methods…..we follow where the wind goes…..(HCP 3)

Another participant commented that less priority is attributed by limited funds within competing issues.

> "……..nowadays the trainings (on FP hence EC) have been limited by the government so that money can be used to other critical issues……" (PE 2)

4.4.4.5 Sexual behavior and misuse of ECPs

Worry about the misuse of the service that might bring about raising rate of STIs and drugs effects to the users was another challenge raised. This was raised pointing out the sexual relations, behaviors and level of perceived vulnerability among users. Some respondent considered users' behavior at individual level like in this statement:

> " Some people may afraid of pregnancy to HIV at first stand…. these pills then may be taken as sweets especially to people of this kind…...the issue now is how to protect them from pregnancies and HIV especially when condoms are not accepted and preferred..(W 8)

Others looked at the societal level:

> "…….the society is morally corrupt, sexual actions nowadays are known like beans in boarding schools……..I wonder what mechanism will be used to control the use of these pills…..(W3)

4.5 Focused group discussions findings

Two focused group discussions were conducted. Young women participated in both of these discussions. Like the interview sessions, the focused group discussion revolved around similar themes: EC service delivery, accessibility and challenges to accessibility.

4.5.1 Demographic characteristics of young women aged between 18-29 years

The youth's median age was 21 years (range 18-28 years) and education of mainly primary level. Majority were not married but in sexual relationship with no use of any family planning method. 3 of them were employed, 2 housewife, 6 students (just form four leavers) and 3 were engaged into business (Table 3)

Table 4: Social demographic characteristics of young women aged between 18-29 years

Variable	Number (%)
Age group	
18-22	9 (64.3)
23-27	4 (28.6)
28-32	1 (7.1)
Occupation	
Student	6(42.9)
Housewife	2(14.3)
Business	3(21.4)
Employed	3(21.4)
Current marital status	
In relationship (married)	6 (42.9)
In relationship (not married)	8 (57.1)
Family planning use while in relationship	
Yes	5 (35.7)
No	9 (64.3)

Table 5: Demographic characteristics of young women aged between 18-29 years by FGD groups

Variable	Number	
	Married young women	Unmarried young women
Age group		
18-22	2	7
23-27	4	0
28-32	0	1
Occupation		
Student	0	6
Housewife	2	0
Business	2	1
Employed	2	1
Family planning use while in relationship		
Yes	2	3
No	3	6

4.5.2 The practice of EC service at health facilities

Young women (who reported to be using family planning methods) were asked whether they had received information on emergency contraception during any of their visits at health facility or whenever they received the service. All reported to get service at health facility. However no respondent in both groups reported to have been informed on emergency contraception.

4.5.3 Accessibility of EC among youths

4.5.3.1 Awareness of ECP

Like clients at health facilities emergency contraception was not a common concept to young women. However after description some young women reported to be aware of the practice through friends or hear sayings. No respondent reported to ever use the pills.

Awareness of the pills was demonstrated through stories as illustrated by these respondents:

> "I remember we were in form two when my friend took a number of those pills……she did mistake when we went to nearby school graduation (laughs)……. I don know where she got them but I knew she had taken them because she started vomiting when we went back to our school and she then told me what and why she had done……..there is where I knew of those pills…….we send her to hospital but we did not say what she had done, she recovered and fortunately she did not get pregnant…… (YW 2, unmarried)

> **"**I had a colleague of mine whom her boyfriend was giving her two pills after the act. They were written 'postiiiii'…… (i.e post…) I don't remember well. I think they were the one we are discussing today….. (YW 7, unmarried)

> **"** I once heard my young mother telling her neighbor that if you do unprotected sex and take all brown pills of the CPs at once you will not get pregnant…."(YW 6, married)

Others mentioned emergency contraceptive pills though not directly:

> "When they finish, her person (referring to her boy partner) gives her the pills called after or before I don't know…… two tablets." (YW8, unmarried)

> "I know of the pills called after period…….my colleague was given by her boyfriend after they did but I don't know how many are they she were taking……I never asked her……."(YW 1, unmarried)

4.5.3.2 Availability and cost of ECPs

All participants reported to be aware that contraceptive pills are available at public facilities for free. Those who reported of availability of these pills at pharmacies and private clinics had variation in cost ranging from Tsh. 300 to Tsh. 2000.

4.5.4 Perceptions of youths on provision and utilization of ECPs in Tanzania

4.5.4.1 Perceived need for EC

Provision and utilization of emergence contraceptive pills was strongly and emotionally supported by young women during both group discussion sessions.

> "unplanned pregnancies are there not only to youths but also to married couples……and they sometimes bring a number of difficulties in our families…….this service will help to reduce these pregnancies……(YW 13, married)

The need was also expressed emotionally as demonstrated by this respondent:

> " if I knew of this service……(pause and start crying)……..(after consoling her) she continued….I got pregnancy while in form two…….if I knew of this perhaps I could have prevented myself from that pregnancy because even the act was like unexpected on that day……..(YW 4, unmarried)

The need was also evidenced by the practices occurring at communities to prevent pregnancy after sexual intercourse as reported by some of the participants. These practices were categorized as EC techniques as they included particular time frame for action and they were performed after sexual act, characteristics of modern ECPs. These included use of ashes, salt, aspirin tablets, fragyl tablets, tea leaves and laundry dye (blue) as the following statements illustrate.

> " if there are pills will be better because some girls die if they use these ashes and salt……I don't know if they take them in much amount or……what I know is ashes is mixed with salt and you take one cup soon after act and you take another after six or eight hours……(YW 12, married)

> "I asked my friend, 'how do you prevent yourself from pregnancy while you are saying your boyfriend doesn't want to use condom?' she said, she takes two tablets of aspirin after they meet or two flagyl tablets after and six tablets the next day divided into two$_s$……"(YW10 unmarried)

> "there is one way my young mother told me… you take in three aspirin tablets or small packet of tea leave mixed in a quarter cup of warm water after sexual act…."(YW14, married)

Other participants had opposite opinions on the need of emergency contraceptives as commented by this married young women:

> "……..there are a number of contraceptives, if people have failed to utilize all these options, they can't do to others even a thousands other drugs are introduced unless their heads are changed…….(YW 5, married)

4.5.4.2 Concerns about ECPs

The study explored the views of young women on the concerns about ECPs as reported by other studies and respondents in the interview sessions. On contrary to respondents from interview

sessions, an opinion that ECPs might cause abortion was not displayed. An issue mentioned by most participants was that EC might promote uncontrolled sexual behavior among youths.

> "I believe these pills are very important especially to those who have no defined person (boy partner) but I have one worry that people may go vaguely (hovyohovyo) knowing that I will take the pills…… (YW 1, unmarried)

Other negative or conflicting aspects mentioned by a few participants were that there might be a risk of misuse of EC, due to the spread of incorrect information regarding these pills as with other family planning pills.

> "……unplanned pregnancy to a young girl say, school girl is very confusing event….if someone tells you take the whole packet and things will be ok, you will just do even if is not right…… (YW 8, unmarried)

There also were concerns about side effects, which could scare potential users as stated by this participant:

> "I better keep my pregnancy and bear the consequences, the way I hear about these pills (regular contraceptive pills) mmmmmm…….some say you can get cancer, what is better cancer or loosing school and deliver a baby?"(YW 11, married)

4.5.5 Challenges on accessibility and use of EC

Although most participants displayed positive attitudes towards EC pills, there was expression of unfavorable environments that might impede accessibility of these pills especially to young girls.

4.5.5.1 Low social support to youths on contraceptives use

Confidentiality in family planning counseling and provision is among the essential guiding principle in practice. However the participants displayed opposite opinion and lack of support regarding confidentiality in practice among health care providers. These statements are illustrative:

> "May I ask, is family planning service needs confidentiality (usiri)? I am saying this because our service providers come from our communities and they might know you, once you have gone to the clinic and if you go to these clinics while you are young they

> will wonder at you (watakushangaa) even if they can give you the service. Now if you go for these pills and suppose you meet someone who knows you eeeeeeh…….you are finished! (Laugh) ……" (YW2, unmarried)

Some participants expressed the missing support from parents or guardians:

> "…..it would be better if parents would be telling their daughters about these pills because they go to clinics and hear about them…….instead like my mother when I was growing up she was always harsh, you can not even dare tell her that you have stomach ache!....."(YW 13 married)

4.5.5.2 Integration of EC with family planning program

Almost all participants showed an element of hesitancy to attend the family planning clinics, with perception that youths are regarded as not clients for family planning methods.

> " it is like our custom I see, people who go to family planning clinic are those older mothers, how will you go for these pills if you are still young at those places……"(YW 9 unmarried)

4.5.5.3 Limited reliable source of information

Other participants thought that most people especially youths in the community setting lack or have limited source of information. They stated most of the programs are done at schools or colleges, in hospitals like to mothers who visit antenatal or postnatal clinics. This strategy misses those who do not attend these settings.

Others commented on the role of media as a widespread form of information giving. However, strong argument was raised to this was its inability to ask for clarification or questions.

> "mothers who attend clinics are luck, they have a chance to be informed of these pills……we hear some of the advertisements concerning family planning issues on televisions and boards but how can you ask a board or television a question?.....(YW3 unmarried)

Another argument based on the knowledge of the pharmacies sellers regarding these pills in relation to correct use of ECPs by users:

> "……most young people who know about these pills obtain them from the pharmacies or friends whom not all know how these pills works as a result they may be taking them wrongly and get effects……"(YW 12 married)

4.6 Advice on EC service provision and utilization

To make emergency contraception service effective as required, respondents in interviews and FGD suggested much on education about the method and reproduction processes.

Some emphasized on the transparency of information about ECPs so as the users have informed decision as suggested by these respondents:

> " everything has its good and bad outcomes, what required is to let people know each and everything openly about these drugs…….to a person who understands will not do against what has been said…….we talk about condoms, some do use and some don't but it is said now and then everywhere……tell people and let them decide……" (YW 8, unmarried)

> "…..this service should be as open as AIDS (UKIMWI), though there are people who might be going vaguely, still it will help those who real need it, and we cannot miss such people in the society….."(YW6, married)

Others suggested on the strategies to use. The statements below are illustrative:

> "Before even talking about this service, I think there is one thing should be emphasized (pause) reproductive education in schools, to parents, in community and whenever possible…..I believe if people will understand about this and then the service comes which is also will be explained well, people can understand……..(HCP 9)

> " for it to be used as planned, education should be given through media as other campaigns….if this is not possible those who work in pharmacies be educated because people usually go to these pharmacies to buy most of drugs before even going to hospitals or seeing health professionals…." (W 3)

5.0 CHAPTER FIVE: DISCUSSION

5.1 The practice of emergency contraception service in health care facilities

According to Storey (2007), at the service delivery system, a great deal of communication occurs at service facilities, among providers and between clients and providers. Health service systems need to communicate norms and standards of practice through policy, guidelines, service delivery strategies, availability of supplies and training to personnel. Health workers themselves must communicate effectively with clients, sometimes in facility-based venues, sometimes through outreach. These kinds of communication extend the availability and accessibility of services, improve the technical skills of personnel, and improve the effectiveness of information delivered to and interactions with clients.

5.1.1 Service provision

The study found that the service is available and passively provided at few public health facilities. The reasons for not being actively provided varied from technical to social dynamics as respondents mentioned lack of knowledge on the method, lack of rape clients in the facilities and social concerns like the relationship of ECPs with family planning program. Various studies have reported similar findings though the most mentioned reasons are lack of knowledge and awareness regarding EC service among the health care providers and clients (Shaki, 2010, Byamugisha, 2007, Harvey, *et. al.*, 2009)

5.1.2 Procedure (process) to be followed to get the EC service and drugs used

One of the major reported barriers to women accessing emergency contraception is a prescription requirement, age restrictions, emergency contraception protocol at health facilities and reluctance to register products for EC (Dovey and Sanfilippo, 2011). Contrary to this study, no prescription requirement was required to clients who visited the family planning clinic directly. Likewise no age restriction policy to obtain the drug exists in Tanzania. In Tanzania context thus lack of restrictive policy is a positive influential factor to accessibility of emergency contraceptives. This positive influence is proved by research done in other countries like Ethiopia and Malaysia where, lack of doctor's prescription requirement removed a significant barrier to EC access for youths (Gold, 2011). However, the respondents' responses represented

expressions of cultural and operational feelings about family planning and EC, as revealed by their concerns about family planning utilization by youths, family planning and religious beliefs among health care providers and negative correlation between policy in place and actual practice at facilities. This study thus gives an insight that the cultural environment and coordination of policies in Tanzania still has an influence on family planning that would lead to an unfavorable environment for accessibility of EC service too. Cultural norms like religious beliefs, beliefs on side effects of modern contraceptives, provider gender and ethnicity, value of children and place of service outlet have been reported in other studies to impede accessibility of EC (Shoveller, *et. al.*, 2007).

5.1.3 EC Service providers

All service providers met during study were female nurses. This reflects the Tanzania setup that nurses are more involved in family planning services compared to other medical professionals. Despite the fact that in Tanzania setup the nurses are the ones who mainly deal with provision of family planning services which includes EC, yet the study found that the awareness and clear knowledge about EC was low as very few nurses were able to describe the method with confidence during interview. This finding is supported by Shaki, (2010), who reports that 77.3% (n=110) of the nurses in Dar-es- salaam were found to be unaware of EC. Of those who were aware of EC 67.2% (n=62) of nurses had poor knowledge on EC.

Doctors' also were reported to play role in provision of emergency contraception especially to rape victims. Although this study did not focus on the doctors' role, other studies show that doctors' especially obstetricians and gynecologists have sufficient knowledge on EC than nurses (Shaki, 2010, Myer, *et. al.*, 2011). These findings concur with the nature of their specialty. However, the nature of job descriptions of these doctors in Tanzania settings make them not to be working so close to clients thus impacting on the easy accessibility of EC. This demonstrates the urgent need of training nurses on EC for it to be implemented as a reproductive right to all women. This is because, it has long been acknowledged that nurses play a pivot role in the reproductive health services not only family planning but also in other health services at clinical

and community settings. The role that makes nurses to be more close to clients compared to other medical professionals.

5.1.4 Common users of EC service

Common people who were saved with ECPs in this study at public facilities are reported to be breast feeding mothers who were not using any contraception method. This is expected as breastfeeding mothers might be aware of the service through antenatal visits in which one of the components of care is to inform mothers about family planning methods after delivery. On the other hand, these clients were reported to visit health facilities to seek an advice which resulted in EC service receiving. This shows low level of EC awareness among women and adds value to the status of unmet need for family planning education in Tanzania.

The study could not elicit characteristics of the users due to lack of documented data at all public facilities. On the other hand, the youth centre visited had documented data on the users. These data revealed that the saved women three months prior to the study aged between 16 to 36 years and most were using condoms. This implies that education on correct use of condoms is to be further emphasized.

Studies in other countries demonstrate variations on the profiles of ECPs users. For example in Ethiopia it is reported that "youths" were the most common ECPs users, usually between the ages of 15-25. Students and commercial sex workers (CSWs) were named as the most common users. Travelers and migrant workers were also noted as frequent customers (Gold, 2011). In Hong Cong, Lo (2012), reports that, the mean age of the users was 30 years. Two thirds (65.6%) were nulliparous and 64.9% had not had a previous abortion. Their major reasons for requesting emergency contraception were: omission of contraceptive at the index intercourse (38.9%), condom accidents (38.0%), and non-use of any regular contraceptives (20.6%). Non-users of contraceptives were more likely to have had a previous abortion (Lo, 2012). In South Africa, married women were reported to be the common users of ECPs than unmarried women; high social economic status and high education level were also associated with the use of ECPs

(Myer, *et. al*., 2011). These findings suggest that there is a need to bridge the gap of users' characteristics so as to meet the real target in Tanzania.

5.1.5 Propagation of EC service at health facilities

There was contradicting statements on service propagation during counseling sessions. This shows that health care providers are aware that they are supposed to provide a wide range of information when counseling clients for contraceptive methods. However, as suggested by some respondents this gap may be attributed by work load, attitudes or knowledge gap and unclear policies and guidelines as revealed in the National policy guidelines and standards for family planning service delivery and training.

According to this guideline, contraceptive pills are provided at a wide range of outlets from community to clinical settings. On the other hand, while addressing the issues of counseling and screening clients; instructions and follow up schedules for contraceptive use, the use of oral contraceptives as emergency contraception method is not pointed out as one of the instructions or information to be given to client. (URT:5, 1994). This may blind health care providers on delivering information about emergency contraception during routine counseling.

Information giving at facilities in this study is found to be most influenced by the awareness and knowledge about EC scope (that is for rape victims) and action as revealed in responses from health care providers. With this notion it is argued that, the EC information to client and accessibility will remain low as it is reported that despite the efforts for elimination of violence against women, the prevalence of rape disclosure in Tanzania is still low: only 10% of rape victims contact the healthcare or the police (Muganyizi, 2010). Thus, in order to guide future EC interventions on the basis of sexual assault, the barriers to disclosure in the Tanzania setting need to be worked upon.

5.1.6 FP guidelines, manuals and policy documents at heath facilities

With respect to the introduction of EC, contraception policy formulation in Tanzania has also coincided with an increased global understanding of the importance of EC to the reproductive rights and the health of women as is acknowledged in many Tanzania's documents (URT: 2, 2010, URT: 6, 2007, URT: 7, 2008, URT: 8, 2007, URT: 9, 2009, URT: 10, 2005).

The study however revealed that, most of these documents are not available at the implementation points. Furthermore the available family planning guidelines used at health facilities have no contents about EC except the book titled "Essentials of contraceptive technology". Unavailability of these documents contributes to the lagging behind of updates to these implementers hence blinding the providers on what facts to deliver to clients regarding EC. Alike findings have been reported by other studies (Diaz, *et. al.*, 2011, ACOG, 2012).

5.2 Accessibility of EC service

5.2.1 Awareness of EC service

Consistent with other findings in Africa (Aziken, *et. al*., 2009, Judge, *et. al*., 2010, Gichangi, *et. al*., 1999, Myer, *et. al*., 2011), the study revealed that awareness of emergency contraception is generally low among health care providers working at dispensaries, women at health facilities and community youths. Health care providers working at health centers and hospitals were more aware (heard of). In this study, the providers' awareness gap could be explained in two ways: first it was reported that rape cases are hardly reported or attended at dispensaries and since EC is considered a service for these victims those who save them are likely to be aware compared to those who don't. Secondly, none of the interviewed healthcare provider from dispensaries reported to attend family planning training while in service, this could also be a contributing factor. Unavailability of documents that provides information about EC at health facilities further contributes to the lagging behind of updates to these implementers.

Most studies report factors associated with EC awareness among users to include education level, age, location of residence, prior use of contraceptives and easy availability of source of

information (Myer, *et. al*., 2011, Nallwada, *et. al*., 2010, Aziken, *et. al*., 2009, Cleland, *et. al*., 2009). In this study, awareness of EC among women and youths was influenced by social networks and interactions in which peer stories, friends and community sayings were reported to be main sources of information. In light of this finding, peer education approaches may be useful in increasing EC awareness.

More generally these findings indicate a substantial unmet need among women for information on EC and a need for greater client-health care provider dialogue regarding EC, including the existence of EC, its availability at public sector clinics, and the timeframes involved in its use after unprotected sex. Relaying basic information on EC needs to become part of routine reproductive health counseling. And specific health service interventions to improve EC awareness need to be designed, implemented and evaluated in Tanzania.

5.2.2 Availability and Cost of EC pills

The study found that the service is available at free of charge in public facilities through the use of regular contraceptive pills and at 'low cost' in private health facilities and pharmacies. This finding supports a policy of free access to maternal health in Tanzania and its implementation in public health facilities. Unlike other countries where costs of ECs are seen as barrier to contraceptive use at individual level (Westley, 2012), this study revealed that it is not in Tanzania as all participants knew and reported of fee free availability of contraceptives at public facilities. The cost barrier as suggested by Nanda (2011) can be at the system level since so far there is no product specific for EC found at public facilities but normal regular contraceptive pills.

On the other hand, the cost barrier can be taken into account considering that, despite availability of free of charge pills at public facilities; this study found that women especially young unmarried ones felt it easier to obtain these pills at pharmacies and private clinics where pills are not free of charge than at public health facilities. This shows that payment is not a

primary challenge at individual level. This finding is also supported by other studies mostly done in India, Nigeria and Ethiopia (Singh, *et. al.*, 2010, Diaz, *et. al.*, 2011)

5.2.3 Acceptance of EC

If EC is to become a viable option for prevention of unwanted pregnancies users must be willing to use the method and find it acceptable. No respondent in this study reported to ever use the ECPs and since the respondents were purposely selected the acceptability and general community perception could not be fully elicited. Harvey *et. al.* (2009) report that ECPs have not been widely used especially in developing countries so little has been known regarding acceptability of this option. However, from the general view even though the study found that the service was perceived as wealth to be provided, more views need to be found from the different community groups to elicit the acceptability level of this service.

The studies done in Nigeria to assess the experience and satisfaction with ECPs show that the overwhelming majority (91%) were satisfied with ECPs and would recommend them to friends and family members (Harvey, *et. al.*, 2009). Contrary to this finding from Nigeria, studies from Kenya show that the major obstacles regarding the utilization of ECs were low acceptability and hence underutilization of services and the impression among the clientele that ECs are a form of abortion (Muia, *et. al*., 2008).

5.3 Perceptions of study subjects on provision and utilization of EC in Tanzania

5.3.1 Perceived need of EC

All respondents displayed favourable opinion that emergency contraception is wealth to be provided pointing out its role in prevention of unplanned pregnancies especially to young women without defined partner. This finding concur with many other studies in other countries (Diaz, *et. al*., 2011), although some studies report that the role of ECPs to reduction of unplanned pregnancies rate is still questionable (Westley, 2012). This calls for the need of further study on ECPs and reduction of rate of unplanned pregnancies.

The need of EC in this study is further supported by sexual relations and contraception use among youths. Nine out of fourteen (64.3%) young women in the community in this study were involved in sexual relations and not married showing that abstinence strategy is not effectively followed. Again six (66.8%) out of these nine young women were not using any family planning methods indicating that they are at risk of unplanned pregnancy. The most common reason given to not using the method was worries of the heard side effects. Evidence shows that sexual education and knowledge to this group is also lagging behind due to social- cultural reasons (WHO, 2012). Although this gives a positive sign of the need of the EC to this special group, education on other contraceptives and STIs prevention is recommended.

5.3.2 Concerns about EC

As reported in many other studies, this study revealed that the implementation and use of EC service is surrounded by concerns that pose worries to both providers and users. Many participants in focused group discussion were concerned that EC could have a negative impact on sexual behavior while health care providers' concern lied on the mechanism of action of EC pills. In both cases, the expressions were associated with lack of correct information regarding ECPs among potential users and clear knowledge among health care providers.

To minimize this possibility, it is suggested that the dissemination of information on EC be part of a broader sex education effort and that accurate and complete information on contraception be provided together with specific information on EC. In addition to this, One strong suggestion is that studies should be conducted and evidence based practices should be adhered to help elucidate the exact mechanism of action of EC pills.

5.4 Challenges for provision, accessibility and use of EC

5.4.1 Lack of adequate knowledge regarding the EC scope and action among the health care providers working at FP clinics

Knowledge of emergency contraception among health care providers and facility capacity is crucial to service providers and users since providers must be competent to correctly counsel about and provide the service, similarly the users must know that there is a method that can prevent pregnancy after unprotected intercourse in order to seek treatment (Byamugisha, 2007).

Integration of EC service into family planning and the possibility of using regular contraception pills as ECPs mean that every public facility has the capacity to provide EC service in Tanzania since family planning clinics are widely distributed in the country. However, this study as supported by various other studies on emergency contraception demonstrated that most health care providers especially nurses are not sufficiently knowledgeable with this technology (Shaki, 2010, Gichangi, *et. al.,* 1999) despite that, according to this study, clients sake advice to nurses which made them receive the service and nurses were found to be the common dispenser of oral contraceptive pills as emergency contraception pills.

Lack of training regarding emergency contraception both at college and in service, infrequent practice of the service to those who are trained, unavailability of guidelines at facilities, perceived scope of EC service, personal attitudes towards learning and seeking for updates and individual perceptions regarding EC were found to be some of the factors that influenced knowledge level at providers side. It is argued that if emergency contraception strategy is adopted there is an urgent need to improve the knowledge of emergency contraception among health care professionals particularly nurses.

5.4.2 Integration of EC service with family planning services

The study shows that emergency contraception utilization is likely to be affected by it being under the umbrella of contraception and family planning program both positively and

negatively. On the positive side, the study showed that most saved people with ECPs apart from the raped ones were those who visited the family planning clinic for an advice. On the other side, knowledge and attitudes surrounding contraception, emergency contraception and family planning among providers, community members and users pose challenge on the provision and use of EC service especially by young women.

Similar finding is also reported from South Africa that emergency contraception service in South Africa is likely to be affected by its integration into the primary health care system (Maharaj and Rogan, 2007). Existing evidence suggests that, in order to be effective, emergency contraception should be integrated into programmes and sectors beyond the normal scope of family planning (e.g. school and community outreach, law enforcement, sexual violence crisis support, and STI treatment and prevention) (Westley, 2012).

5.4.3 Limited Political influence on EC

With respect to the introduction of EC, contraception policy formulation in Tanzania has also coincided with an increased global understanding of the importance of EC to the reproductive rights and the health of women as is acknowledged in many Tanzania's political and policy documents. (URT: 2, 2010, URT: 6, 2007, URT: 7, 2008, URT: 8, 2007, URT: 9, 2009, URT: 10, 2005). This shows the government commitment to family planning and emergency contraception in the country.

Despite the formulation and development of these documents, the study revealed that most of these documents are not available at the implementation points and there is no direct observed political influence on the provision and use of EC service though the reasons were not fully stipulated. Furthermore the available family planning guidelines used at health facilities have no contents about EC except the book titled "Essentials of contraceptive technology". The finding reveals the gap between the commitment and it being put into action.

Most research into the low take up of emergency contraception has focused, at the micro-level, on the attitudes towards and knowledge of emergency contraception products by providers of reproductive health services and by clients (Byamugisha, 2007, Shaki, 2010, Gichangi, *et. al*., 1999, Aziken, *et. al*., 2009, Cleland, *et. al*., 2009) Still missing, however, especially in Tanzania is a contextual analysis of the macro-level determinants of emergency contraception use, in particular, and of the effectiveness, more generally, of the national reproductive health policy.

5.4.4 Limited reliable source of information to clients

Tanzania National Family Planning policy, guidelines and standards strives to ensure that all persons (women, men and adolescents) have access to comprehensive, high quality family planning services including information and education so that they can make decision on any contraception option or service of their choice (including emergency contraception for that matter). Harvey, *et. al*., (2009) add that it is important that the potential users have information and are educated about EC before they actually need it.

In contrary to these statements, the study revealed that the clients at health facilities are not often given information about EC unless the need arises, rather the information were found posted on boards in some facilities. To youths, it is worse as their accessibility even to facilities is surrounded by social barriers. Interestingly respondents had most of the information from friends, peers and community sayings. This proves the statement that emergency contraception has been regarded as 'best kept secret' as it is not widely advertised or promoted by the credible and reliable sources of information like health professionals (Byamugisha, 2007).

5.4.5 Low social support on EC use

It was revealed that, particularly during focus group discussions, most youths have reproductive problems and they have no place to explicitly express their concerns as they stated worries of unknown regarding ECPs and family planning methods in general. To some they felt their families are not supportive due to harsh responses especially when they mature, others considered lack of confidentiality in health facilities as problem and others perceived that the family planning clinics are not theirs but for grown up and married mothers.

Social stigma pertaining to youths, sexual relations and family planning clinics use was another concern that would impacts the effective use of EC especially to youths. Various studies have reported the obstacles facing youths in relation to reproductive health (ACOG, 2012). Basing on those Tanzania like many other countries took initiatives to promote youth friendly services especially in health facilities; however youths are not fully self empowered to take up the initiatives or the available services are not needy based, for example in Nyamagana district there is a dispensary special for service in schools. It was stated that this dispensary was meant for students who need fast service and go back to school as early as possible. Surprisingly, the study found that no any reproductive health section or service given there but other medical services and the saved people were mostly not students.

5.5 Limitation of the study

The purposive selected sample may not be wholly representative of the target population. More focused groups discussions among potential users and other stakeholders such as NGOs, doctors, dealers in pharmacies and private facilities should have been included so as to capture views and experiences which could be different from the studied subjects' perspectives. Representation of more potential users and providers could have provided a broader picture of issues related to utilization of family planning particularly emergency contraception. Further research using quantitative methods is also needed to provide a clearer picture of emergency contraceptives utilization rates for youths, unmarried women and married women so as to win the target. However time and financial resources allocated to the study could not allow for these to happen. Nevertheless, the findings from the study do provide important insights into the challenges involved in the provision of and utilization of emergency contraception service in relation to the national family planning policy, guidelines and standards.

6.0 CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

Emergency contraception (EC) is an effective and safe method of preventing pregnancy. EC pills access is limited, particularly in Tanzania, because of factors grounded from individual level, community level and the health delivery system. Interrelation of these domains brought about lack of information and training in ECP provision, misperceptions, worries and negative attitudes that prevent ECP from being offered to the clients.

Potential users of EC service are still overwhelmed with challenges from their informal social networks in the process of addressing sexual and reproduction relations that are influenced by society culture that cut across all the levels of service implementation. Social, cultural, political and economical networks are likely to be impacting on the availability and accessibility of emergency contraception pills in Tanzania. A focus on the delivery of emergency contraception services in Tanzania is thus represents an important new avenue for interdisciplinary public health research teams, including social scientists, epidemiologists, health services researchers and clinicians as well as intensive community members involvement.

Basing on the findings of this study, the following would thus be recommended:

1. The actual prevalence and distribution of unplanned pregnancies and their associated factors should be determined to identify the root causes of the problem and the EC needy group(s) in Tanzanian context.

2. The approach to administration of EC service should be reworked out considering the legislation process of the dedicated product, supportive administrative actions, litigations and legal liability and level of voluntary change at all levels of implementation

3. On strength of the concerns evolving around the ECPs and family planning in general, reproductive health education should be reinforced at schools, communities and health

facilities to empower people with factual information regarding family planning and ECPs

4. It has long been acknowledged that nurses play a pivot role in the reproductive health services but also in other health services at clinical and community settings. Endorsement of EC knowledge to this group is important for scaling up of this service at all sections of health facilities.

5. Further studies should be conducted focusing on ECPs delivery processes at other outlets like pharmacies, private hospitals and community outlet.

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APPENDIX I: INFORMED CONSENT FORM- ENGLISH VERSION

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

INFORMED CONSENT FORM

Interviewee no. ☐☐

Consent to Participate in a Study

Greetings! My name is Jamila Luziga. A student of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences (MUHAS), School of Public Health and Social Sciences. I am working on a study titled "**Implementation processes of emergency contraception in Tanzania: The case of Nyamagana, Butimba and Igoma wards- Mwanza"**

Purpose of the study

The study is conducted in partial fulfillment of the requirements for the degree of Master of Arts, Health Policy and Management of MUHAS. This study is aiming at evaluating the implementation of the national family planning policy, guidelines and standards with special focus on utilization of emergency contraception aiming at decreasing unplanned pregnancies

You are being asked to participate in this study because your information, contribution and suggestions will be of tremendous importance to the study. Please be honest and fair as that will lead to a clear picture of implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement of the service.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the interview guide prepared for the study. The interviewer will be taking notes and tape recording the interview session so that to capture anything you have to say.

Confidentiality

I assure you that all the information collected from the interview will be respected, treated confidentially, and used for the purpose of the study only. Your answers, opinion and suggestion will be valued for the improvement and better implementation; your name will not be written in the report/document. All information collected from the interview will be entered into computers with only the interviewee number. All recorded tapes will be deleted after transcription and analysis.

Risks

We do not expect that you will come to any harm as a result of participating in this study. There may be some questions you are not able or comfortable to answer. Please feel free to say "I don't know", or you can refer the researcher to a subordinate with the required information including data to support the answer. You may decline to answer any particular question and may stop the interview at anytime.

Right to withdraw and alternatives

Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve any penalty.

Benefits

The information you provide will contribute towards a clear picture of the implementation of the national family planning policy, guidelines and standards with special focus on utilization of emergency contraception aiming at decreasing unplanned pregnancies

This report will create awareness and inform the management of the MOHSW on the implementation, reveal strengths and challenges of providing and utilizing emergency contraception service, which could be used as lessons for the future planning of strategies to deal with unplanned pregnancies in the country.

Who to contact

If you ever have questions about this study, you should contact:

1. The Researcher, Jamila E. Luziga of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam (Tel. 0755-086-142/ 0716-413050, E-mail address jelmbuke@yahoo.com)

2. The study supervisor, Dr. Ave Maria Semakafu, of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam. (Tel: 0784-600416 E-mail address asemakafu@gmail.com/avemaria.semakafu@demofinland.)

3. The director research and publications, Prof. M. Aboud, of Muhimbili University of Health and Allied Sciences, P. O. Box 65001 Dar es Salaam.(Tel : 022- 2152489, E-mail drp@muhas.ac.tz)

Signature:

Do you agree to participate in the study?

I ……. have read the contents in this form. My questions have been answered.

I agree ☐ I DO NOT agree ☐

Signature of participant ……

Date of signed consent …….

APPENDIX II: INFORMED CONSENT FORM- SWAHILI VERSION

CHUO KIKUU CHA SAYANSI ZA AFYA NA TIBA MUHIMBILI KURUGENZI YA UTAFITI NA MACHAPISHO

FORM YA RIDHAA

Namba ya utambulisho ☐☐ Tarehe**……**

Salaam!

Jina langu ni Jamila E. Luziga, mwanafunzi wa shahada ya uzamili katika Sera na Uongozi wa Huduma za Afya , katika Chuo Kikuu cha Sayansi za afya na Tiba Muhimbili, Shule ya Afya na Sayansi za Jamii. Nafanya utafiti kuhusu utekelezaji wa huduma ya uzuiaji mimba wa dharura (emergency contraception) katika wilaya ya Nyamagana-Mwanza.

Madhumuni ya Utafiti.

Utafiti huu unafanyika kama sehemu ya hitaji la ukamilifu wa mafunzo ya shahada ya uzamili katika sera na uongozi wa huduma za afya-MUHAS. Utafiti unalenga kubaini utekelezaji wa sera na miongozo ya huduma za uzazi wa mpango katika kupunguza mimba zisizotarajiwa kupitia huduma ya uzuiaji mimba wa dharura. Unaombwa kushiriki katika utafiti huu kwa sababu taarifa, mchango na maoni utakayotoa yana umuhimu mkubwa. Tafadhali kuwa mkweli na muadilifu ili kutoa picha halisi ya utekelezaji ambayo itachangia kutoa mapendekezo ya uboreshaji wa huduma hii.

Kitakachofanyika wakati wa ushiriki

Endapo utakubali kushiriki katika utafiti huu, utahojiwa maswali yaliyoandaliwa katika dodoso la mwongozo. Utarekodiwa na mhojaji atakuwa anaandika dondoo wakati wa mahojiano ili kunukuu yote utakayotamka kwa umakini.

Usiri

Nakuthibitishia kuwa taarifa zitakazokusanywa katika mahojiano zitaheshimika na kutumika kwa usiri mkubwa kwa lengo la utafiti huu tu. Maswali na maoni yako yatathaminiwa katika uboreshaji wa huduma. Jina lako halitoandikwa popote katika ripoti hii, na nakala za rekodi zitafutwa baada tu ya uyakinifu wa taarifa.

Madhara

Hatutegemei upate dhara lolote kwa sababu ya ushiriki wako. Inawezekana kuna maswali ambayo huwezi au hujisikii vyema kuyajibu. Tafadhali kuwa huru kusema “sijui” au kuelekeza mtu ambaye anaweza kutoa jibu hilo. Unaweza kutojibu swali lolote au kusitisha mahojiano wakati wowote.

Haki ya kujitoa au kutoshiriki katika utafiti

Ushiriki wako katika utafiti huu ni wa hiyari. Unaweza kujitoa/ kuacha kushiriki katika utafiti wakati wowote na bila ya kupata madhara. Kukataa kushiriki au kujitoa katika utafiti hakutaathiri stahili zako zozote. Hutapata malipo yeyote kwa kushiriki kwako kwenye utafiti huu.

Faida ya ushiriki

Taarifa utakayotoa itachangia katika kutoa picha ya utoaji na utumiaji wa huduma ya uzuiaji wa mimba wa dharura kwa lengo la kupunguza mimba zisizotarajiwa. Ripoti hii itatoa mwanga kwa uongozi wa wizara ya afya juu ya changamoto za utoaji na utumiaji wa huduma ya uzuiaji wa mimba wa dharura ambao utatumika kama somo katika mipango ya baadaye ya kupambana na mimba zisizotarajiwa.

Watu wa kuwasiliana nao ikiwa una swali au jambo lolote kuhusu utafiti Huu

1. Jamila E. Luziga, Mtafiti mkuu, Chuo Kikuu cha Sayansi za Afya na Tiba, Muhimbili, Shule ya Afya na Sayansi za Jamii, S. L. P 65015 Dar es Salaam. (Namba ya simu 0755- 086142 na barua pepe jelmbuke@yahoo.com)

2. Dk. Ave Maria Semakafu, Msimamizi wa utafiti huu, Chuo Kikuu cha Sayansi za Afya na Tiba, Muhimbili, Shule ya Afya na Sayansi za Jamii, S. L. P 65015 Dar es Salaam. Namba ya simu na barua pepe asemakafu@gmail.com/avemaria.semakafu@demofinland.

3. Prof. M. Aboud, Mkurugenzi wa Tafiti na Machapisho, Chuo Kikuu cha Sayansi za Afya na Tiba, Muhimbili, S. L. P 65001 Dar es Salaam. Namba ya simu 022- 2152489 na barua pepe drp@muhas.ac.tz

Je umekubali kushiriki katika utafiti huu? Ndiyo ☐ Hapana ☐

Mimi, …….. Nimeelewa maelezo yaliyomo katika fomu hii na kwa kwa ridhaa yangu nimekubali kushiriki katika utafiti huu.

Saini ya Mshiriki. ……..

Saini ya Mtafiti……

APPENDIX III: INTERVIEW GUIDE FOR THE HEALTH CARE PROVIDERS

ENGLISH VERSION

Interviewer name……Date……Time: Start……..End…….

Part I: Identification particulars of the interviewee and Socio demographic data:

a) Facility ID……..
b) Job title ……
c) Education level: ……..……
d) Age (years)…….....
e) Sex: Female/Male……
f) How long have you been working in family planning clinic? Years…… months.……
g) In What section were you working prior to the family planning clinic?.....

Part II: Physical delivery of EC service at health facilities

a) Does your facility provide emergency contraception service? If so, can you please explain the process that a client should follow to get the service *(probe about contraceptives used as EC, prescription requirement, referral system if no service)*

b) From your experience which groups of people usually come to seek Emergency contraception service? (*Probe about the groups: unmarried women, youths and why those groups)*

c) Emergency contraception service seems to be not popular and most of the family planning health care providers are not advocating it while supporting policies and guidelines are in place; why do you think this is so? (*probe for the interviewee perceived need for EC in Tanzania)*
d) What challenges do you face in relation to counseling and /or providing emergency contraception service? (*probe challenges related to policy& guidelines)*

Part III: Emergency contraception service delivery system in Tanzania

a) What policy, guidelines, standards, manual or any other document that guide your daily family planning service delivery in your facility? (*probe to be shown the document available to support the answer, probe how the documents are distributed and interpreted in the facility before use)*

b) Have you been trained about emergency contraception while at working place? (*probe about any training on family planning, family planning training background, other staff trained on emergency contraception)*

c) Have you ever run shortage of emergency contraceptives (ECPs)? If so how often is the situation

Part IV: Accessibility of emergency contraception service among targeted population

a) From your experience and understanding where else can clients get emergency contraception service apart from public clinics in Tanzania (*probe in relation to cost, availability of drugs*) and after working hours of the family planning clinic?

b) What are the factors that hinder women from seeking emergency contraceptive services in health facilities (*probe group wise: unmarried, youths non users of regular family planning)*

c) What would be the best ways to make emergency contraceptives easily available and utilized to prevent unplanned pregnancy as required?

Part V: Conclusion and the way forward:

a) What advice would you give to MOHSW management that may help to promote effective utilization of emergency contraception service aiming at reducing unplanned pregnancies?

b) Is there anything else you would like to add, regarding family planning policy, guidelines, standards, emergency contraception and unplanned pregnancies?

Thank you very much for your participation!

APPENDIX IV: INTERVIEW GUIDE FOR THE HEALTH CARE PROVIDERS

SWAHILI VERSION

Jina la mhojaji……Tarehe……Muda: Mwanzo……Mwisho…….

Sehemu ya I : Taarifa binafsi za mhojiwa

a) Utambulisho wa kituo……..
b) Cheo ……
c) Elimu……..……
d) Umri (miaka)……....
e) Jinsi: ke/me……
f) Kwa muda gani umekuwa ukifanya kazi katika kliniki ya uzazi wa mpango? Miaka…….. miezi……
g) Ni kitengo kipi ulikuwa ukifanya kazi kabla ya kliniki ya uzazi wa mpango.....

Sehemu ya II: Huduma ya uzuiaji wa mimba wa dharura katika vituo vya afya

a) Kituo chenu kinatoa huduma ya uzuiaji mimba wa dharura? Kama ndiyo, tafadhali eleza mchakato ambao mteja anatakiwa kuufuata kupata huduma (*dodosa aina za dawa zitumikazo, ulazima wa hati za ununuzi wa dawa, mfumo wa rufaa kama hakuna huduma)*

b) Kwa uzoefu wako ni makundi yapi huja kwa ajili ya huduma ya uzuiaji wa mimba wa dharura? (*dodosa makundi: vijana, wanawake wasioolewa, vijana na kwa nini makundi hayo)*

c) Huduma ya uzuiaji wa mimba wa dharura si maarufu na watoaji wa huduma ya uzazi wa mpango hawaihamasishi wakati sera na miongozo ipo; kwa nini unadhani hali ipo hivyo(*dodosa juu ya uhitaji wa huduma ya uzuiaji wa mimba wa dharura Tanzania)*

d) Ni changamoto gani huwa unazipata katika utoaji ushauri au huduma ya uzuiaji mimba wa dharura (*dodosa changamoto zinazohusiana na sera na miongozo*)

Sehemu ya III: Huduma ya uzuiaji wa mimba wa dharura Tanzania

a) Ni miongozo ipi mnayotumia katika utendaji kazi wa kila siku wa huduma za uzazi wa mpango katika kituo chenu?(*thibitisha miongozo iliyopo, dodosa jinsi miongozo hiyo inavyosambazwa katika vituo na ufasili wa miongozo hiyo kabla ya kutumia*)

b) Umeshawahi kupata mafunzo ya uzuiaji wa mimba wa dharura ukiwa kazini? (*dodosa kuhusu mafunzo yoyote ya uzazi wa mpango, wafanyakazi wengine waliopata mafunzo)*

c) Mmeshawahi kuishiwa dawa za uzuiaji mimba wa dharura? Kama ndiyo, hali hiyo hutokea mara ngapi kwa kawaida?

Sehemu ya IV: Upatikanaji wa huduma ya uzuiaji mimba wa dharura

a) Kwa uzoefu wako, zaidi ya vituo vya afya vya umma ni wapi wateja wanaweza pia kupata huduma ya uzuiaji wa mimba wa dharura (*dodosa kuhusu gharama na upatikanaji wa dawa)*

Sehemu ya V: Hitimisho

a) Ushauri gani unaotoa ili huduma ya uzuiaji wa mimba wa dharura uweze kutumika kikamilifu kwa lengo la kuzuia mimba zisizotarajiwa?

b) Una lolote jingine unalotaka kuongeza kuhusiana na sera ya uzazi wa mpango, miongozo, mimba zisizotarajiwa na huduma ya uzuiaji mimba wa dharura?

Ahsante sana kwa ushiriki wako!

APPENDIX V: INTERVIEW GUIDE FOR WOMEN-ENGLISH VERSION

Interviewer name……..Date…….. Time: Start…….End……..

Part I: Identification particulars of the interviewee and Socio demographic data:

a) Interviewee ID……..
b) Education level……
c) Age (years)…….....
d) Occupation…….
e) How long have you been using family planning methods? years …….. months……
f) Marital status: married/not married.....

Part II: Awareness and accessibility of emergency contraception service

a) Have you ever heard of emergency contraception? (*probe source of information*)

b) Have you ever personally use emergency contraceptives? (*If so probe source of contraceptives and cost if any)*

c) From your experience and understanding where else can women get emergency contraception service apart from public clinics in Tanzania (*probe in relation to cost, availability of drugs*)

d) What would be the best ways to make emergency contraceptives easily available and utilized to prevent unplanned pregnancy as required?

Part III: Physical delivery of EC service at health facilities

a) Did you receive information on emergency contraception during this visit or previous visits?

b) On your opinion, why do you think emergency contraception service/ information is not given in most of the health facilities?

c) What are the factors that hinder women from seeking emergency contraceptive services in health facilities (*probe groupwise: unmarried, youths non users of regular family planning)*

Part IV: Conclusion and the way forward:

c) What advice would you give to MOHSW management that may help to promote effective utilization of emergency contraception service aiming at reducing unplanned pregnancies?

d) Is there anything else you would like to add, regarding family planning policy, guidelines, standards, emergency contraception and unplanned pregnancies?

Thank you very much for your participation!

APPENDIX VI: INTERVIEW GUIDE FOR THE WOMEN-SWAHILI VERSION

Jina la mhojaji……Tarehe…….Muda: Mwanzo……Mwisho…..

Sehemu ya I : Taarifa binafsi za mhojiwa

a) Utambulisho wa mhojiwa……..
b) Elimu……
c) Umri (miaka)…….....
d) Kazi……..
e) Kwa muda gani sasa umekuwa ukitumia njia za uzazi wa mpango? Miaka……. miezi….
f) Hali ya ndoa: umeolewa/haujaolewa.....

Sehemu ya II: Uelewa na upatikanaji wa huduma ya uzuiaji mimba wa dharura

a) Umeshawahi kusikia kuhusu uzuiaji wa mimba wa dharura(dodosa chanzo cha taarifa)

b) Wewe binafsi umeshawahi kutumia dawa za kuzuia mimba kwa dharura? (dodosa alikopata dawa na gharama)
c) Kwa uzoefu na ufahamu wako, zaidi ya kliniki za umma ni wapi wanawake wanaweza kupata huduma ya uzuiaji mimba wa dharura(dodosa gharama na upatikanaji wa dawa)

d) Unadhani ni njia zipi zitumike ili dawa za uzuaji wa mimba wa dharura zipatikane kirahisi wakati kliniki za uzazi wa mpango hazifanyi kazi kama vile baada ya muda wa kazi, siku za sikukuu n.k?

Sehemu ya III: Huduma ya uzuiaji mimba wa dharura katika vituo vya afya

a) Umepewa taarifa yeyote kuhusu uzuiaji wa mimba wa dharura leo au katika mahudhurio ya nyuma?

b) Kwa mtazamo wako unadhani kwa nini huduma ya /taarifa kuhusu uzuiaji wa mimba wa dharura hauhamasishwi katika vituo vingi vya huduma za afya?

c) Kwa uelewa wako, ni sababu zipi zinawafanya wanawake washindwe kwenda vituo vya afya kupata huduma ya uzuiaji mimba wa dharura?(*dodosa kwa makundi: wasioolewa, vijana na wale wasiotumia njia za kawaida za uzazi wa mpango)*

Sehemu ya IV: Hitimisho

a) Ushauri gani unaotoa ili huduma ya uzuiaji wa mimba wa dharura uweze kutumika kikamilifu kwa lengo la kuzuia mimba zisizotarajiwa?

b) Una lolote jingine unalotaka kuongeza kuhusiana na sera ya uzazi wa mpango, miongozo, mimba zisizotarajiwa na huduma ya uzuiaji mimba wa dharura?

Ahsante sana kwa ushiriki wako!

APPENDIX VII: INTERVIEW GUIDE FOR KEY POLICY EXPERTS

Interviewer name……Date……Time: Start……..End…….

Part I: Identification particulars of the interviewee and Socio demographic data:

a) Interviewee ID……..
b) Job title……
c) Education level: ……..……
d) Age (years)…….....
e) Sex: Female/Male……
f) How long have you been working in this district? years …… months.……
g) In What section were you working prior to the recent position/title?.....

Part II: Physical delivery of EC service at health facilities

a) Do public health facilities in your district provide emergency contraception service? If so, can you please explain the process that a client should follow to get the service *(probe about contraceptives used as EC, prescription requirement, referral system if no service)*

b) How public health facilities are structured to provide Emergency contraception service to all targeted groups? (*Probe about the groups: unmarried women, youths)*

c) Emergency contraception service seems to be not popular and most of the family planning health care providers are not advocating it while supporting policies and guidelines are in place; why do you think this is so? (*probe for the interviewee perceived need for EC in Tanzania, rate of unplanned pregnancies in the district, current provision and utilization status of EC in the district)*

Part III: Emergency contraception service delivery system in Tanzania

a) What policy, guidelines, standards, manual or any other document that guide family planning service delivery in your district? (*probe to be shown the document available to support the answer, probe how the documents are distributed and interpreted in the facility before use)*

b) Have you been involved in development of any of these documents? (*probe level of participation)*

c) What are your roles in family planning services including emergency contraception in your district?

d) What challenges do you face in relation to promoting provision of emergency contraception service in your district? (*Probe challenges related to policy& guidelines)*

Part IV: Accessibility of emergency contraception service among targeted population

a) From your experience and understanding where else can clients get emergency contraception service apart from public clinics in Tanzania (*probe in relation to cost, availability of drugs*)

b) What would be the best ways to make emergency contraceptives easily available and utilized to prevent unplanned pregnancy as required?

Part V: Conclusion and the way forward:

a) What advice would you give to MOHSW management that may help to promote effective utilization of emergency contraception service aiming at reducing unplanned pregnancies?

b) Is there anything else you would like to add, regarding family planning policy, guidelines, standards, emergency contraception and unplanned pregnancies?

Thank you very much for your participation!

APPENDIX VIII: FOCUSED GROUP DISCUSSION GUIDE

Moderator name…….Place……Date……..Time: Start……End……

FGD No……

Part I: Identification particulars of the participants and Socio demographic data:

a) Participant ID……..
b) Education level……
c) Age (years)…….....
d) How long have you been using family planning methods? years ……
months……non user……
e) Marital status: married/not married.....

Part II: Awareness and accessibility of emergency contraception service

a) Have you ever heard of emergency contraception? (*probe source of information*)

b) How many among you have ever used emergency contraceptives? (*If so probe source of contraceptives and cost if any)*

c) From your experience and understanding where else can women get emergency contraception service apart from public clinics in Tanzania (*probe in relation to cost, availability of drugs*)

d) What would be the best ways to make emergency contraceptives easily available when family planning clinics are not operating e.g. after working hours, public holidays etc?

Part III: Physical delivery of EC service at health facilities

a) (*For those using regular family planning method*) Have you ever received information on emergency contraception during family planning visits at health facility? (*probe the situation that facilitated information giving by health care provider)*

b) On your opinion, why do you think emergency contraception service/ information is not given in most of the health facilities? (*probe on concerns about EC: e.g promiscuity, STIs, decrease use of regular family planning methods, promoting risky sexual behavior*

c) What challenges do you face when seeking for EC service at health facilities?

Part IV: Conclusion and the way forward:

a) What advice would you give to MOHSW management that may help to promote effective utilization of emergency contraception service aiming at reducing unplanned pregnancies?

a) Is there anything else you would like to add, regarding family planning policy, guidelines, standards, emergency contraception and unplanned pregnancies?

Thank you very much for your participation!