USE OF CONTRACEPTIVES METHODS AMONG WOMEN IN STABLE MARITAL RELATIONS ATTENDING HEALTH FACILITIES IN KAHAMA DISTRICT, SHINYANGA REGION, TANZANIA

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USE OF CONTRACEPTIVES METHODS AMONG WOMEN IN STABLE MARITAL RELATIONS ATTENDING HEALTH FACILITIES IN KAHAMA DISTRICT, SHINYANGA REGION, TANZANIA

By

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A dissertation submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***Use of Contraceptive Methods Among Women in Stable Marital Relations Attending Health Facilities in Kahama District, Shinyanga Region, Tanzania***, in partial fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

_____

Mr. Cyprian Makwaya

(Supervisor)

Date: _____

DECLARATION

AND

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I, **Esabella Jobu Michael**, declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature…… Date……....

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DEDICATION

To my lovely husband Emmanuel Neeso and our children Rothe-Lydia, Marian, Somi, Linda, Allen and my young sister Fadina who were my strongest allies. They always kept asking me on the progress of my studies. They were and still remain a source of my dream, success and joy. They always encouraged me to achieve higher academic Excellency. I thank you GOD to have them in my life. Finally, this dissertation is dedicated to my parents, other family members and friends for their prayers and good wishes for me in pursuing my carrier.

ABSTRACT

Background: Kahama district in Shinyanga region has Contraceptive Prevalence Rate (CPR) of 16%, which is far below the national average of 27%. Little is known on factors contributing to the low level of utilization of contraceptives in Kahama district, and particularly among women in stable marital relations.

Objectives: To determine the prevalence of current use of contraceptive methods among women in stable marital relations attending health facilities; describe the types of contraceptive methods used among women in stable marital relations attending health facilities; assess socio-cultural factors (beliefs including religious, husband's approval, and spouse communication) in relation to use of contraceptive methods among women in stable marital relations attending health facilities; determine the association between socio–demographic factors (age, occupation, education level, access, number of children) and use of contraceptive methods among women in stable marital relations attending health facilities.

Methods: A cross-sectional study on contraceptive methods use was conducted among 314 women and 20 service providers in ten wards from ten health facilities. Data were collected using structured and in-depth interview questionnaires. Information gathered included socio-demographic, socio – cultural characteristics, accessibility of contraceptive methods, current use and access to information.

Results: Thirty five percent of women in stable marital relations reported to be using contraceptive methods. Highest (58%) use of contraceptives was reported among women in formal employment. Factors found to be significantly associated with contraceptive use were: education level, occupation, traditional cultural beliefs, and support from husband/partners and access to information while religion, decision maker on desired number of children in the family were not found to be significantly associated with the use of contraceptive methods.

Conclusion: Prevalence of contraceptive use among women in stable marital relations is 34.5% than that in the general population of women with the age of 15 -49 years in

Kahama district (16%, 2011 district report). Socio-demographic factors like education level and occupation were found to influence the use of contraceptive methods among women in stable marital relations. Moreover, socio-cultural factors like religious beliefs and husband/partner support were also crucial in influencing the use of contraceptive methods.

Recommendations: District Health Management teams should develop interventions that will enable women in stable marital relations to understand the importance of using contraceptive methods. Since this study did not involve men, further studies are needed to determine the extent of use of contraceptive methods among men and associated factors.

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LIST OF ABBREVIATIONS

CBDA	Community Based Distributor Agents
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plans
CPR	Contraceptive Prevalence Rate
CYP	Couple Year Protection
DAS	District Administrative Secretary
DHMT	District Health Management Team
DHS	Demographic Health Survey
FBO	Faith Based Organization
FP	Family Planning
HC	Health Center
HIV	Human Immuno deficiency Virus
HPI	Health Population Institute
ICF	Informed Consent form
IEC	Information Education and Communication
IMR	Infant Mortality Rates
LGA	Local Government Authority
MCH	Maternal and Child Health
MDG	Millennium Development Goals

MOH & SW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NFPCIP	National Family Planning Costed Implementation Plan
NGO	Non-Governmental Organization
PHC	Primary Health Care
PI	Principle Investigator
RA	Research Assistant
RCHS	Reproductive and Child Health Section
RH	Reproductive Health
RHMT	Regional Health Management Team
SPSS	Statistical Package for Social Sciences
SSA	Sub- Saharan Africa
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic Health Survey
TSHS	Tanzanian Shillings
UMATI	Family Planning Association of Tanzania

UNDP	United Nations Development Program
UNPF	United Nations Population Fund
WHO	World Health Organization

DEFINITION OF TERMS:

Family Planning: A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.

Stable marital relationship: For the purpose of this study, stable marital relationship is marriage or cohabiting relations for more than 6 months.

Contraceptive Prevalence rate: Is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

CHAPTER 1

INTRODUCTION

1.1 Background:

Family Planning (FP) in which the major component is use of contraceptive methods is a key constituent of health services and it benefits the health and wellbeing of women, men, children, families, and their communities.

The widespread adoption of family planning represents one of the most dramatic changes of the 20th century. The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has tremendous life saving benefits. Yet despite the impressive gains, contraceptive use is still low and the need for contraception high in some of the world's poorest and most populous places [1].

Contraceptive use in the United States is virtually universal among women of reproductive age: 98 percent of all women who had ever had intercourse had used at least one contraceptive method. In 2002, 90 percent had ever had a partner who used the male condom, 82 percent had ever used the oral contraceptive pill, and 56 percent had ever had a partner who used withdrawal [2].

The modern contraceptive prevalence rates (that is, the proportion of women of reproductive age who are using a modern contraceptive method) vary widely across the African region. Among women of reproductive age, CPRs for modern methods ranged from 1.2 percent in Somalia to 60.3 percent in South Africa. Countries in Southern Africa reported the highest levels of contraceptive use, followed by countries in East Africa. With a few exceptions, West and Central African countries report very low rates of family planning use. Some of the lowest contraceptive prevalence rates in the world exist in these two sub regions of Africa [3]**.**

The number of people in need of health and education, among other public goods is large and increasing which in turn requires large amounts of resources, personnel and

infrastructure. This is likely to be an impediment towards the realization of the reduction of child mortality, improvement of maternal health, achievement of universal primary education, environmental sustainability and combating HIV/AIDS, malaria and other diseases as part of the Millennium Development Goals (MDGs) To address this, many countries in the Sub Saharan Africa (SSA) including Tanzania focused their attention on birth control measures, especially the use of contraceptive methods [4].

In Tanzania, family planning services have been in use since 1950s, but provision of modern FP methods in Tanzania was started in 1959, when the Family Planning Association (UMATI) introduced services at urban clinics. The Government of Tanzania become actively involved in 1974 when integrated family planning services (for both maternal and child health services) started at urban areas [5]. The Government launched the first national family planning program in 1989. This included provision of family planning services by Government, non-governmental and faith-based organizations. In 2004, Tanzania established National policy guidelines for reproductive and child health services. This assists in making family planning which includes provision of contraceptive methods services accessible, affordable and encouraging integration and linkages with other RCH services [6]. A continuing high rate of population growth is presenting major challenges to socio and economic development in Tanzania. According to National Bureau of Statistics of 2009, at the current annual growth rate of 2.9%, Tanzania's population is projected to reach 65 million by 2025, putting increased strain on already overstretched health and education services, infrastructure, food supply and the environment [5].

The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015 (One Plan) has set a goal to increase the contraceptives prevalence rate (CPR) form 20% to 60% by 2015, by making quality family planning services more accessible to and equitable for all of Tanzania's people [5].

During the last 19 years there has been a gradual and steady increase of contraceptive methods among currently married women, from 10 percent in the 1991-1992 TDHS to

34% in 2010. The most common contraceptive methods are: the pill, injectable, permanent methods, condoms and traditional methods. According to the survey average of 8.1 contraception methods among 10 that are available were known to the respondents [7].

Studies have shown that use of family planning methods among women is strongly affected by woman's education. Other factors that play a role are urban-rural residence, woman's work status, woman's status relative to men, religion, culture and taboos, household standard of living (or economic status of the household), exposure to mass media, and community development [8].

According to TDHS, 2010 only 22% of women with no education were using modern methods of contraception as compared to 52% of women with at least some secondary education. Family planning and use of contraceptive methods also increases rapidly as the number of living children increases, picking at 41% for women with 3 to 4 children. It also increases with the wealth quintile, from 23% of women in the lowest quintile to 51% women in the highest quintile [7].

1.2 Statement of the problem:

When human reproduction is left unchecked, it results into high birth rates, bringing about large family size with the negative effects on the health of the respective mothers and children. Consequently this leads to negative impact on the family, the community and the nation at large as a result of economic overload in covering the additional demand. Indeed, uncontrolled births can destroy a nation's development aspirations and prevent its people from enjoying an improved standard of living [9]

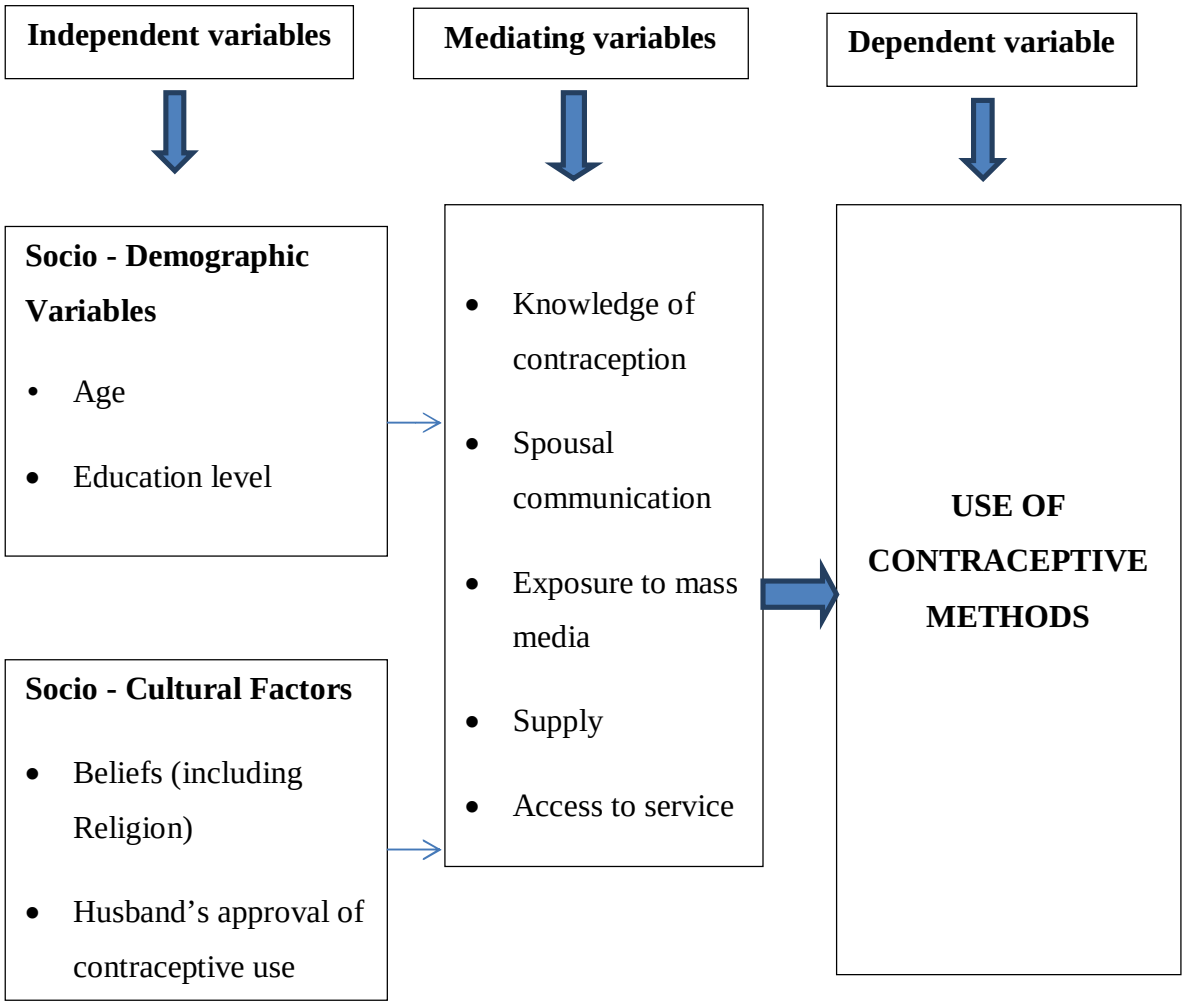
The total fertility rate in Tanzania has been consistently high and stands at 5.4 children per woman [7]. Contraceptive Prevalence Rate (CPR) stands at 29% among all women of 15-49 years old and 34% of married women age 15-49 years with 27% using modern methods [7]. There are regional variations with urban-rural disparities, where rural women have higher fertility rates than their urban counterparts [10].

Shinyanga region has a CPR of 15.1% [7] which is among the lowest in Tanzania despite the fact that knowledge of the use of modern methods of contraception was relatively high – 81% [7]. Shinyanga urban and Shinyanga rural have CPR of 23% and 20% respectively [11]. Kahama has a CPR of 16 % among all women of 15 – 49 years old [12]. Therefore Kahama was picked since it has low CPR and little is known on factors contributing to the low level of utilization of contraceptives methods, particularly among women in stable marital relations. Hence, this study aimed at determining factors that influence the use of contraceptive methods among women in stable marital relationship in Kahama district.

1.3 Conceptual Framework

Use of contraceptive methods among women in stable marital relations may be influenced by a number of factors which include but not limited to socio-demographic variables such as age, education level and occupation. Age can be associated with the use of contraceptive methods, different age groups have different contraception knowledge and needs for example women in mid- twenties who are in stable relationship are likely not to use contraceptive methods because it a period to bear the children. However, women with advanced age above forty five are likely to use contraceptives. Furthermore, women with higher education level, are better informed than women with lower education; and therefore likely to use contraceptive methods. In addition, occupation is likely to influence the use of contraceptives, because sometimes job requirement may necessitate delay in conception. Further that, religious beliefs may discourage women and their spouses/partners from using contraceptive methods. [8]. Besides, mediating factors such as spousal communication, supply, and access to service are important in facilitating the above-described linkages between independent and dependent variables. For instance, ineffective spousal communication may hinder access and optimal adherence to contraceptive methods.

Figure 1: Diagrammatic Conceptual framework: Use of Contraceptive Methods among Women in Stable Marital Relations**.**



Source: Adapted from: Gizaw and Regassa (2011)

1.4 Significance of the study

This study helped to identify socio - demographic and socio - cultural issues that are barriers to use of contraceptive methods by women in stable marital relations.

The study findings may help in developing new approaches for increasing use of contraceptive methods among women in stable marital relations.

The research helped to generate ideas for reducing women's negative perceptions and attitudes towards use of contraceptives. The recommendations made by this study may play a role towards improving effective use of contraceptives and family planning services, and thereby contribute towards reaching the millennium development goals by decreasing maternal and child motility.

1.5 Research Questions

The following questions were used to guide the study variegate complex experiences of the respondents:

1. What is the prevalence of current use of contraceptive methods among women in stable marital relations attending health facilities?
2. What are the types of contraceptive methods used among women in stable marital relations attending health facilities?
3. What are socio–cultural factors (beliefs including religious, husband's approval, and spouse communication) in relation to use of contraceptive methods among women in stable marital relations attending health facilities?
4. What is the association between socio–demographic factors (age, occupation, education level, access, number of children) and the use of contraceptive methods among women in stable marital relations attending health facilities?

1.6 Objectives

1.6.1 Broad objective

To determine the extent of use of contraceptive methods and factors that influence the use of contraceptive methods among women in stable marital relations attending health facilities in Kahama district.

1.6.2 Specific objectives

1. To determine the prevalence of current use of contraceptive methods among women in stable marital relations attending health facilities.
2. To describe the types of contraceptive methods used among women in stable marital relations attending health facilities.
3. To assess socio–cultural factors (beliefs including religious, husband's approval, and spouse communication) in relation to use of contraceptive methods among women in stable marital relations attending health facilities.
4. To determine the association between socio–demographic factors (age, occupation, education level, access, number of children) and use of contraceptive methods among women in stable marital relations attending health facilities.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Contraceptive methods use is part of a family planning package. A large and empirically verified demand for contraceptive methods to space or limit childbearing exists worldwide. Currently, about 200 million women have an unmet need for modern contraception, that is, they are sexually active, want to delay or stop childbearing, and are not using a modern contraceptives method [13]. More than 80 million unintended (mistimed or unwanted) pregnancies occur each year worldwide, contributing to high rates of induced abortion, maternal morbidity and mortality, and infant mortality [13]. Furthermore, family planning has been found to be an essential means by which countries can achieve the Millennium Development Goals (MDGs), particularly goals four and five for improved child and maternal health outcomes. The cost of averting unwanted births is miniscule compared with the costs of unwanted births at both the family and country level. Few public health interventions are as effective as family planning programs services and contraceptive methods) at reducing the mortality and morbidity of mothers and infants and have such a breadth of positive impacts [13].

Moreover, the need for contraceptive use is generally high in societies where poverty, illiteracy, and gender inequality are high. In such societies, unintended and repeated pregnancies make it difficult for women to participate in economic development and self-development [14].

The study in Kenya reveled that, the use of the contraceptive methods varied in terms of demographic and socioeconomic factors of the woman and also the woman's perception in terms of the facility/provider factors such as quality, friendliness of staff and promotion. Various factors accounted for the low use of family planning services including use of contraceptive methods. This included partner's approval, quality of the services, friendliness of the staff administering the services and the woman's knowledge

about contraceptive methods. Other factors included the woman's income level, proximity to the provider and the religious background of the woman [15].

In the empirical examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels. Urbanization and the proportion of Muslim are shown to affect schooling levels and thus contraceptive use. Polygyny, a proxy for aspects of the high-fertility rationale, negatively affects contraceptive use at the regional level, providing support for the view that African socio organization continues to influence the demand for children [13].

Contraceptive use has increased worldwide over the last decade. Yet, Africa—like many other regions of the developing world—continues to have a high unmet need for family planning approximately 25% of women and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception more than half of the people in Africa are younger than 25 years old, so unmet need is only expected to increase as these individuals enter their reproductive years [15].

Overall, rate of contraceptive use is associated with wealth, education, ethnicity, place of residence, and strength of national family planning programs within countries [14].

2.2 Use of contraceptive methods situation in Tanzania

The total fertility rate in Tanzania has been consistently high and stands at 5.7 children per women. Notable increase in the use of contraceptive methods has been registered in Tanzania. According to TDHS 2010, 29% of all women with age 15-49 are using contraceptive methods, of which 34% are currently married women; and 51% are sexually active unmarried women. The majority of women who are using a contraceptive method use modern method (24%) and also the use of modern contraceptive methods increased by 20% from 7% in 1991-1992 to 29% [7]. Five percent of women use traditional methods. The most used methods are injectable (9%), the pill (5%) and male condoms (4%). The most common family planning methods are: the pill, injectable, permanent methods, condoms and traditional methods. According to

the survey average of 8.1 contraception methods were known to all women compared to7.2 methods known among all men [7].

According to TDHS 2010 only 22% of women with no education were using modern methods of contraception as compared to 52% of women with at least some secondary education. Contraceptive use also increases rapidly as the number of living children increases, picking at 41% for women with 3 to 4 children. It also increases with the wealth quintile, from 23% of women in the lowest quintile to 51% women in the highest quintile. The use of contraceptive methods among women continues to face challenges in meeting clients' expectations and needs. Despite high knowledge on contraceptives (90%) only one third of the married women (34%) use any method of contraception. Currently usage of modern contraception is higher among sexually active unmarried women than among married women (45% and 27%, respectively). Currently, married women have 25% unmet need for family planning [7]. Other challenges include low acceptance of modern FP methods which is currently 20% for married women aged 15-49 years, erratic supplies of contraceptives with limited choices and provider biases to make informed choices. Uptake of contraceptive methods is limited by spousal communication, inadequate male involvement and misconception on the modern contraceptive methods. Shinyanga region has a CPR of 15.1% [7]. This is among the lowest as compared to other regions in Tanzania Mainland despite the fact that knowledge of the use of modern methods of contraception is relatively high (that is, 81%). Kilimanjaro has the highest CPR of 64.8% while Mara has the lowest, 11.9% [7].

2.3 Socio-demographic variables as predictors of use of contraceptive methods

In developing countries, use of modern health care such as maternal health services including use of contraceptive methods can be influenced by the socio-demographic characteristics of women. Indian studies have shown that woman's education emerges as the strongest predictor of use of contraceptive methods [8]. In one Yemen study, parity, age, marital status, religion, husband's education, husband's occupation, monthly family income, and woman's occupation were found to be associated with use of contraceptive methods [16]. The principal predisposing and enabling factors affecting use of

contraceptive methods by women were socioeconomic status, knowledge, and education of the mother. This leads to the conclusion that the main limiting factors to the use of contraceptive methods in the state are poverty, ignorance, and illiteracy. The study has clearly evidenced that knowledge of contraceptive use among Sudanese women is far from being universal [17]. Although education was associated with increase in the use of modern family planning methods, a drop was noticed in women with University and higher education. This might partly be explained by the fact that these women start their family life after their education, i.e. at a later age, and try to have the number of children they wish before their menopause begins [17]. The likelihood of use of contraceptive methods is higher for those with higher parity, literate [18].

Levels of knowledge of the contraceptive methods as well as communication between spouses regarding family planning issues were significantly associated with contraceptive use [9]. The long-standing forms of African social organization including the high value attached to the perpetuation of the lineage, the importance of children as a means of gaining access to resources (particularly land), the use of kinship networks to share the costs and benefits of children (primarily through child fostering) and the weak nature of conjugal bonds clearly inhibit contraceptive adoption and fertility decline. In the empirical examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels [19]

2.4 Socio-cultural factors

Studies in Sudan, an Islamic country in the developing world, very few women reported that the use of contraceptive methods was against religion or cultural beliefs [17]. Other factors include urban-rural residence, woman's work status, woman's status relative to men, religion, culture and taboos, household standard of living (or economic status of the household), exposure to mass media, and community development [8].

Contraceptive methods information provided was seldom sufficiently adapted to local beliefs and characteristics. Cultural barriers were especially noticeable when service providers were from a dominant or relatively successful ethnic group or social class, and

clients from a relatively impoverished one. In highly stratified societies, there is a tendency to underestimate the ability of lower class women to think for themselves, and thus to use family planning information to make informed decisions themselves. In addition, communication difficulties sometimes arise because of different languages or belief systems between providers and clients [20].

Women's decision about use, non-use or discontinuation of contraceptive methods can be affected by their perceptions of contraceptive risks and benefits, concerns about how side effects may influence their daily lives and assessment of how particular methods may affect relationships with partners or other family members [21].

The Nigerian study concluded that determinants of reproductive health service use, rest on the individual, household, service and community levels [21]. Therefore, when considering those influential determinants of use of reproductive health services, the household and community in which the individual lives as well as the characteristics of the health services available in the community must be taken into consideration. Providers should note that women do live in a context where they are not making unilateral decisions about their reproductive health. It is also significant to note that husbands' approval was also rated high as determinant of contraceptive use and this is consistent with literature that men are usually dominant decision makers when birth or fertility control issues are to be determined. One of the frequent reasons women gives for not beginning or continuing to use contraception is their partner's opinions [21].

2.5 Supply and demand factors

Studies have indicated that supply and demand factors have profound influence in utilization of family planning services which includes use of contraceptive methods [13]. The overarching strategy of successful supply-side family planning programs is to ensure that contraceptive methods are as readily accessible to clients as possible. This includes ensuring that a wide range of affordable contraceptive methods are offered, making services widely accessible through multiple service-delivery channels, ensuring that potential clients know about services, following evidence-based technical guidelines that promote access and quality, and providing client-centered services. These types of

supply-side interventions ensure that women and couples are able to use contraceptive methods and family planning services effectively [13].

A different study in Lesotho, Africa [22] found that the type of facilities to which women had access (e.g. hospital, clinic, community- based and employment – based) was a significant predictor of current use of contraception. Accessibility, reliability and responsiveness to women needs of contraceptives were also a predictor in the use of contraceptive methods by Iranian women [14]

A study in Ethiopia showed that, problem of availability and accessibility influenced the use of contraceptive methods [18]. The study in Bangladesh indicated that the main reasons for women not visiting MCH clinics were non availability of commodities, behavior of service providers and long waiting times [23]. This was also evident in Iranian studies where women using contraceptive methods were dissatisfied with monthly provision of contraceptives and these led to seeking services from private outlets [14].

Distance from the nearest health facility and availability of an all-weather road have a greater effect on contraceptive knowledge than they do on use. By contrast, health or family-welfare visits to the village in the previous month have a greater effect on use [8].

From the UNPF report it was observed that governments and service providers were aware of the importance of giving information as a part of family planning service delivery. Service providers are being trained to perform this function but such training did not seem to have the desired effect. Observation of consultations revealed that family planning clients often did not receive complete, accurate information about options available to them. When a method was selected, clients were only told how to use it and when to return for re-supply and/or check-up. Possible side-effects were rarely mentioned. No information was given during consultations regarding sexually transmitted diseases and HIV/AIDS and little or nothing of the relevant social situation of the client was discussed.

The central goals of demand-side family planning interventions include changing women's knowledge, men's knowledge, couples' knowledge, attitudes about contraceptive methods and increasing their knowledge of contraceptive sources and use of family planning to meet their fertility desires. Communication through mass media (radio, television, or print) is an appealing strategy for the promotion of family planning because of its potential for expansive reach and its ability to address (in entertaining or informative way) issues that in many settings are culturally taboo [13]. Other studies have shown that opposition from husbands, spousal communication had influence in the use of contraceptive methods [18].

Thus, it is evident from different studies that use of contraceptive methods and uptake of contraception is a multifactor. Socio-economic status, cultural beliefs and value attached to children, educational level of a mother plays an important role. Perceptions of risks and benefits attached to contraceptive use have influence in the use of methods. Furthermore, the studies have shown that spousal acceptance and communication contributes to acceptance of contraception. Accessibility and availability of contraception methods are the factors that have been mentioned [18].

CHAPTER 3

METHODOLOGY

3.1 The study area

The study was conducted in Kahama District. Kahama District Council is one of the eight Districts in Shinyanga region roughly situated between latitudes 3015" and 4030" south of Equator and latitude 31030" and 33000 "east of Greenwich. It covers an area of 8,477 square km. The District is administratively divided into 5 divisions, which in turn are divided into 55 wards, 232 villages and 1137 hamlets. The largest division is Mweli division (264,580.50 ha) comprising 31.2% of the total area of Kahama District, followed by Msalala division with 236,031.80 has (27.9% of the total district area). Dakama division has 210,292.20 ha (24.8% of the total district area), Isagehe division 106,736.60ha (12.6% of the total district area) and Kahama division being the smallest division with 30,053.10ha (3.5% of the total district area).

The population of Kahama District is estimated to be 848,738 representing an annual population increase of 3.3%. Distribution of population according to sex is 49% male against 51% female [24]. The majority of Kahama residents (85%) depend on subsistence agriculture and livestock rearing as main source of income. Two of the largest Gold Mines in Tanzania which are operated by Barrick Gold Mining Corporation are in Kahama.

Kahama district has a comparatively good health infrastructure with health services delivered through a network of 56 private and as well as public health facilities, 2 hospitals, 9 health centers and 45 dispensaries.

3.2 Research design

This was a descriptive cross-sectional study using both quantitative and qualitative research methods. The design was selected for this study as it was intended to establish the prevalence of contraceptive methods use and factors associated with the use. The study was conducted in facilities in the same geographical area.

3.3 Variables

3.3.1 Dependent /Outcome Variable: Use of Contraceptive Methods

3.3.2 Independent Variables: These are socio – demographic characteristics (age, level of education, occupation), and socio – cultural characteristics (religion, traditional and cultural beliefs, spouse approval).

3.4 The study population

The study population was women in stable marital relations and health service providers in Reproductive and Child Health Clinics in Kahama district.

Inclusion Criteria

The criteria included: Women in stable marital relations (i.e. having been in stable relationship for at least six months); willing to participate in the study and able to give informed consent; attending at health facilities during the study. Heath care worker providing reproductive and child health services which includes family planning.

Exclusion Criteria

1. Unwilling to participate in the study
2. Not married
3. Health /mental condition rendering it impossible to obtain informed consent or perform interview.
4. Too sick to be given consent or to be interviewed.

3.5 Sampling and sample methods

3.5.1 Sampling technique

A multistage random sampling technique was used to select the study sample. It was done in three stages as follows:

Stage 1: Cluster sampling was used to obtain three divisions out of five divisions in Kahama district. Each name of the five divisions was written on a piece of paper and three names were picked randomly. The divisions obtained were Kahama (urban division), Msalala (semi-urban) and Dakama a rural division).

Stage 2: Eight wards were randomly selected from three divisions (Mahiya, Isagehe, Mbulu, Mpera Ntobo, Igilili, Lunguya and Bugarama). Each name of the wards in urban, semi urban and rural area was written in pieces of papers. Three wards from urban, three from semi urban and two from rural area were randomly picked.

Stage 3: Eight health facilities were randomly selected from six wards and two hospitals from two administrative urban wards. Names of health facilities in urban, semi-urban and rural areas were listed in pieces of papers and two facilities picked randomly from each area. One public hospital (Kahama Hospital) and one big private hospital (Magai Hospital) were purposively picked.

To get study sample, prior arrangement was done with facility in-charge in order to get participants as they visit the facility. In-charges of the facilities were taken through the objective of the study, characteristics of participants required that they should help identify. This was done during the health talk. Women who met criteria for research were selected randomly by picking pieces of papers that were written “Yes” or “No”. Those who picked “Yes” were entered in the study after they consented. The average number was between 30 and 40 in each facility.

To get the sample for in-depth interviews, two staffs were picked randomly from each facility out of 3 to 4 who were on duty in the day of interview. Pieces of papers written “Yes” and “No” were used for picking eligible respondents

3.5.2 Sample size

The sample size (n) was calculated using the following formula: $n = z_{\alpha}^2 p\,(100\text{-}p)/\,\varepsilon^2$ [25]

Where:

z = the standard normal deviate that corresponds to some significance level, α (setting α=0.05, then z =1.96).

p = the estimated prevalence of use of contraceptive methods (this was put at 15%, according to TDHS, 2010.

ε = the margin of error on p (put at 5%).

$n = 1.96^2 \times 0.15\ (1 - 0.15)/0.05^2$

$= 200$

Since the study sample was obtained through multi-stage cluster random sampling, it was adjusted to control for the design effect. The calculated sample size was multiplied by 1.5 = 200 x 1.5 = 300. Clustering necessitates a much larger sample size [26]. The sample size for in-depth interview was 20 healthcare workers.

3.6 Data collection techniques and tools

The data were collected using structured questionnaire and in depth interview guide. The questionnaire was used to collect information on use of contraceptives, personal and socio- demographic factors influencing the use of modern contraceptive methods. In-depth interview guide was used to collect information on the supply and service delivery. The English version questionnaire was translated to Swahili language. The Swahili version was used to collect data. Prior to data collection it was pretested to 50 women in stable marital relations attending different health facilities in the study area to assess appropriateness, content clarity and comprehensiveness of the questions and time taken to fill the questionnaire. Pretest was conducted in Bugarama and Ntobo wards of Msalala Division in Kahama district. The questionnaire and the in-depth interview guide were found to be suitable for the study. Therefore, in this research the reliability was supported by a pilot study, during which a pre-testing of the Kiswahili version questionnaire was performed to identify any ambiguities and inaccuracies. Pilot study also gave an estimate of the time to interview each individual. The participants in the

pilot study were similar to those in the main study and were done in the similar settings, but they were not included in the final study.

3.7 Data collection tasks

The study was conducted during the routine health facility visits where participants were receiving normal services. The invitation to participate in the study was done in collaboration with respective health facilities providers. The introduction was conducted during a short briefing health talks held every morning prior to commencement of routine health facilities activities. The Informed Consent forms (ICF) were distributed to all study participants for being signed. They were also signed by the research assistant (or PI) prior to commencement of the interview. Interviews were conducted in the separate room with assurance of confidentiality. Afterwards the completed questionnaires were collected and kept in the proper place. Two research assistants were recruited and trained on the aim of the study and the meaning of questions. They were further taught on how to complete the questionnaires and how to provide assistance to study participants when required. The maximum duration spent by participants in completing the questionnaire was 45-50 minutes.

3.8 Data quality control

Supervision of the completed questionnaires was well maintained by the PI for the aspect of data quality control. At the end of the day (in each end of the day), research team conducted a review meeting to discuss issues raised during the day for conducting a quick assessment of the completed tools. During the field work, PI was available for any needed clarifications based on the study. The PI visited each site to oversee data collection process and checked all previously completed questionnaires for consistence and completeness.

3.9 Ethical Considerations

Human research ethics rest on three basic principles that fully considered the foundation of all regulations or guidelines governing research ethics. These principles were respected for persons who were interviewed.

Beneficence and justice: These principles were considered universal, transcending geographic, cultural, economic, legal, and political boundaries [27].

1. Ethical clearance for this research was requested and accredited by Muhimbili University of Health and Allied Sciences (MUHAS), MUHAS ethical committee.

2. Permission letter for doing research and collecting data was obtained from Kahama District Administrative secretary and officer. All measure to maintain human rights including informed consent; the right to participate in the study, right to privacy and confidentiality and right to prevention from any type of harm were taken into consideration.

3. All Participants were informed about the objectives of the study and that their participation was on voluntarism and none rock-solid for participation. It was also clearly clarified that the information to be provided whether orally or in writing were for research purposes and were strictly confidentially.

3.9.1 Process of Collecting Data

The interviewee's information was recorded using the structured questionnaires that were administered to 314 women in stable marital relations attending health facilities. The in-depth interviews were administered to 20 heath care workers. The sorting and ordering of responses from in-depth interviews was done and grouped into themes. The recurring statements and narratives were well summarized. Most of in-depth interview questions were open ended. The main objective was to provide an insight of contraceptive utilization, availability of contraceptive methods and what should be done to improve access and therefore utilization.

3.10 Data analysis

3.10.1 Data Analysis Process

Quantitative Data Analysis

Data from the structured questionnaires entered and cleaned using Epi-Info, The analysis was performed using both Epi-Info and SPSS. Data have been presented using frequency tables and cross tabulations. Important summary statistics were obtained and associations were examined using chi-square test. Significance level of 0.05 (i.e. $P< 0.05$) was used to determine the significance of associations being examined.

Qualitative Data Analysis

In-depth interview questionnaires were analyzed manually. Transcriptions and summaries of emerging issues in the discussion were documented. The responses from healthcare providers were grouped into the themes. The recurring statements and narratives where then summarized and analyzed.

CHAPTER 4: RESULTS

This chapter presents the study findings. It is organized under the following sub-headings: socio-demographic characteristics of the respondents, prevalence of current use of contraceptive methods among women in stable marital relations attending health facilities, types of contraceptives methods used, and socio-cultural factors influencing the use of contraceptive methods in Kahama district.

4.1 Socio-demographic characteristics of the respondents

The mean age of study participants was 29.4 years with standard deviation of 7.5 years. Range of age = (14 - 51 years). Table 4.1 shows that most (55.8%) of respondents belonged to the age category of 20 to 29. Moreover, about two thirds (60.8%) of respondents had primary level of education. Also, almost three quarters (70.3%) of the respondents were peasants as shown in Table 4.1.

Table 4.1 Socio-demographic characteristics of the respondents

Socio-demographic characteristics	Total (%)
Age Category	
-19	9 (2.9)
20 – 29	174 (55.8)
30 – 39	98 (31.4)
40+	31 (9.9)
Total	312
Level of education	
No formal education	31 (10)
Not completed Primary School	72 (23.2)
Completed Primary school	189 (60.8)
Completed secondary school	13 (4.2)
Others (College/University)	6 (1.9)
Total	311
Occupation	
Unemployed	23(7.4)
Self employed	50 (16.1)
Peasants	218 (70.3)
Student	1(0.3)
Employed	14(4.5)
Others (casual laborers)	4 (1.3)
Total	310

4.2 Prevalence of current use of contraceptive methods in stable relations attending health facilities

Out of 314 respondents, 111 (35%) reported to be using contraceptive methods; hence the prevalence of contraceptive methods use is 35%, with 95% CI: [0.3, 0.41].

4.3 Types of contraceptives methods use among women in stable relations attending health facilities

The most common contraceptive method reported to be used was modern contraceptives (about 66%), followed by traditional method “Mpigi” which is a string out of a tree worn in the waist and is believed to provide contraception (15.3%), while the least

reported types were withdraw (1.8%) and abstinence (0.9%) as shown in Table 4.3 below.

Table 4.3: Types of contraceptive methods being used (N=111)

Type of contraceptive methods	Frequency	Percent
Modern contraceptives	73	65.8
Withdraw	2	1.8
Calendar	7	6.3
Prolonged Breast feeding	11	9.9
Abstinence	1	0.9
Others (Mpigi)	17	15.3
Total	111	100

4.4 Socio-demographic factors associated with the use of contraceptive methods

Age

There was no significant association between age and contraceptive method use among women in stable marital relations (p=0.76).

Educational level

Use of contraceptive methods among those with primary (39.2%) and secondary education was higher (61.5%) than those who did not attend (16.1%) or completed primary education (26.4%). There is a significant association between contraceptive methods use and level of education; in particular, contraceptives methods use increases with increasing level of education (p=0.02).

Occupation

Peasants is the largest group of non-users of contraceptive methods (71%) followed by unemployed (78.3%). Among the largest group of users are Peasants (29%) followed by

self-employed (58%). There is a significant relationship between study participant occupation and contraceptives methods use ($p<0.001$) as shown in Table 4.4

Table 4.4: Socio–demographic factors associated with the use of contraceptive methods

Characteristics	Use of Contraceptive Method		Total (%)	P value
	Yes (%)	No (%)		
Age				0.76
-19	3 (33.3)	6 (66.7)	9 (2.9)	
20 – 29	57 (32.8)	117 (67.2)	174 (55.8)	
30 – 39	38 (38.8)	60 (61.2)	98 (31.4)	
40+	12 (38.7)	19 (61.3)	31 (9.9)	
Total	110	202	312	
Level of Education				0.01
No formal education	5 (16.1)	26 (83.9)	31 (10)	
Not completed Primary School	19 (26.4)	53 (73.6)	72 (23.2)	
Completed Primary school	74 (39.2)	115 (60.8)	189 (60.8)	
Completed secondary school	8 (61.5)	5 (38.5)	13 (4.2)	
Others (colleges/University)	3 (50.0)	3 (50.0)	6 (1.9)	
Total	109	202	311	
Occupation				< 0.001
Unemployed	5 (21.7)	18 (78.3)	23(7.4)	
Self employed	29 (58.0)	21 (42.0)	50 (16.1)	
Peasants	63 (28.9)	155 (71.1)	218 (70.3)	
Student	1 (100.0)	0(0)	1(0.3)	
Employed	8 (57.1)	6 (42.9)	14(4.5)	
Others (casual laborers)	3 (75.0)	1 (25.0)	4 (1.3)	
Total	109	201	310	

4.5 Socio-cultural factors associated with the use of ccontraceptive methods

Almost sixty five percent of the users reported that traditional and cultural beliefs did not influence the use of contraceptive methods while 75.8% of non-users of contraceptive methods reported that traditional and cultural believes influenced the use of contraceptive methods. About 89% of the users of contraceptive methods indicated

that they had partner support. This shows that there was a significant association between husband/partner support and the use of contraceptive methods (P<0.001) as shown in table 4**.5**

Table 4.5: Response on whether socio-cultural factors influences the use of contraceptive methods

Response on Traditional/Cultural beliefs on the use of contraceptives	Use of Contraceptive Method		Total (%)	P value
	Yes (%)	No (%)		
Yes	32 (24.2)	100 (75.8)	132 (42.6)	
No	48 (64.9)	26 (35.1)	74 (23.9)	<0.001
I do not know	27 (26.0)	77 (74.0)	104 (33.5)	
Total	107	203	310	
Husband/Partner support				< 0.001
Yes	71 (88.8)	9 (11.3	80 (25.9)	
No	30 (17.9)	138 (82.1)	168 (54.4)	
I do not know	10 (16.4)	51 (83.6)	61(19.7)	
Total	111	198	309	

4.6 Source of information on contraceptive methods

Most of the users of contraceptive methods got information from health facilities or reproductive and child health clinics (65.8%). There is a significant association between source information and the use of contraceptive methods (P<0.001) as shown in Table 4.6.

Table 4.6: Source of information on contraceptives (N=202)

Source of Information	Use of Contraceptive		Total (%)	P value
	Yes (%)	No (%)		
Media	14 (35.0)	26 (65.0)	40 (19.8)	<0.001
Peers	10 (30.3)	23 (69.7)	33 (16.3)	<0.001
Husband/Partner	1 (33.3)	2 (66.7)	3(1.5)	<0.001
Seminar/Training	3 (100.0)	0 (0)	3 (1.5)	<0.001
Health Facility/RCHC	79 (65.8)	41 (34.2)	120 (59.4)	<0.001
Others (local events)	1 (33.3)	2 (66.7)	3(1.5)	<0.001
Total	108	94	202	

4.7 Additional factors that hinder the use of contraceptives

Users of contraceptive methods (30.7%) reported that refusal by husband/partner as one of the factors that hinder the use of contraceptive methods while 69.3% of non-users reported it was because of refusal by husband or partner. Non availability of contraceptive methods for users (93%) was also reported as a factor that will hinder the use of contraceptives. As for non-users 78% reported that religious beliefs will hinder their use of contraceptive methods. There was a significant association between availability, religious beliefs and refusals by husband and partner and contraceptive methods use ($p<0.001$) as shown in Table 4.7

Table 4.7: Additional factors that hinder the use of contraceptives (N=293)

Additional factors that hinder Contraceptive Use	Use of Contraceptive Method		Total (%)	P value
	Yes (%)	No (%)		
Refusal husband/partner	46 (30.7)	104 (69.3)	150 (51.2)	< 0.001
Religion beliefs	13 (22.0)	46 (78.0)	59 (20.1)	< 0.001
Non availability of contraceptive methods	13 (92.9)	1 (7.1)	14 (4.8)	< 0.001
Inadequate financial support	6 (26.1)	17 (73.9)	23 (7.8)	<0.001
Others (distance)	14 (29.8)	33 (70.2)	47(16.0)	<0.001
Total	92	201	293	

4.8 Accessibility of contraceptive methods

About 50.0% of contraceptive methods users reported to prefer accessing their contraceptive methods from the hospital/health center. During the study nninety four percent of contraceptive methods users reported that they preferred to purchase contraceptives from the pharmacies when they are out of stock in the health facilities . There was a significant relationship between the use of contraceptive methods and alternative source of contraception (P<0.001) as shown in Table 4.8

Table 4.8: Sources of accessibility of contraceptive methods

Sources of Accessibility of Contraceptive Methods	Use of Contraceptive Method		Total (%)	P value
	Yes (%)	No (%)		
Preferred Source				<0.001
Hospital/Health center	62 (49.6)	63 (50.4)	125(47.9)	
RCHC	14 (60.9)	9 (39.1)	23 (8.8)	
Pharmacy	6 (75.0)	2 (25.0)	8 (3.3)	
At home/CBD	18 (27.7)	47 (72.3)	65 (24.9)	
Others (peers)	6 (15.0)	34 (85.0)	40 (15.3)	
Total	106	155	261	
Alternative source				<0.001
Purchase from Pharmacy	48 (94.1)	3 (5.9)	51 (21.2)	
Use of alternative method	28 (37.3)	47 (62.7)	75 (31.1)	
Do not use any method	11 (15.5)	60 (84.5)	71 (29.5)	
Others (peers)	10 (22.7)	34 (77.3)	44 (18.3)	
Total	97	144	241	

4.9 In - depth interview for health care workers in 10 health facilities:

A total of 20 service providers were interviewed in order to provide an insight of contraceptive utilization, availability of methods and what should be done to improve access and therefore utilization.

Majority of service providers said that, availability of contraceptive methods is not a problem although enough stocks and some specific methods like injectable should be made.

Distribution of contraceptive methods in all health facilities including private health facilities was mentioned by service providers as one way of increasing accessibility.

Majority of service providers were of the opinion that delivery of family planning education should be strengthened, including in rural areas in order to increase utilization of contraceptive methods.

Most of services providers mentioned that wrong cultural believes, spouse refusal and sometimes unavailability of contraceptive methods as challenges that hinders utilization.

This information from the in-depth interviews complements the results from other study participants on factors that influence utilization of contraceptive methods.

CHAPTER 5

DISCUSSION

This chapter discusses the extent of use of contraceptive methods and factors that influence the use among women in stable marital relations attending health facilities in Kahama district. It helps to identify socio - demographic and socio - cultural, and issues that are barriers to use of contraceptive methods and lead in developing interventions services.

5.1 Contraceptive prevalence rate among women in stable marital relations

The study revealed that 35% of women in stable marital relations in Kahama district use contraceptive methods. This is consistent with the national average 34% [7]. Findings also indicated that 66% of women instable marital relations used modern contraceptives methods. While the majority of study participants indicated to be using modern contraceptives, a significant percentage of women said they were using traditional method “Mpigi” which is a string out of a tree worn in the waist and is believed to provide contraception.

5.2 Socio–demographic factors associated with the use of contraceptive methods

In the current study, it was observed that the use of contraceptives increased with level of education. These findings are consistent with other studies in Tanzania [9], India [8] and [18] which showed strong association between education level and contraceptive use. This is also supported by the findings of TDHS 2010 where only 22% of women with no education were using modern methods of contraception as compared to 52% of women with at least some secondary education. With formal education it is easier to make informed choices because of wide understanding of issues, including health as compared with ones without formal education. With education it is easy to put information delivered by health workers in the right context.

5.3 Socio–cultural factors associated with the use of contraceptive methods

Husband/partner support has been documented as key in acceptance of contraceptive use. Findings in this study are consistent with other studies elsewhere [21]. About 89% of users of contraceptive methods indicated to have husband/partner support. Sixty nine percent of non- users also indicated partner support is important in the use of contraceptive methods.

Traditional and cultural believes were mentioned to influence the use of contraceptive methods. This is consistent with other studies [8, 17]. Large portion of non-users (76%) indicated that traditional and cultural beliefs would influence the use of contraceptives. This was supported by service providers who mentioned wrong cultural believes as a hindrance in the utilization of contraceptive methods.

5.3 Access to information

Source of information on contraceptive methods was significantly associated with contraceptive use acceptance. Findings revealed that a big portion of users in this study relied on information from health facilities or reproductive health clinics. Further findings revealed the importance of getting information to potential users of contraceptive methods. Eighty nine percent of non-users did not get information on contraceptive methods. Findings also indicated that big portion (71%) non users would prefer female service providers. Further findings from the study revealed that peasants were the largest group of non-users of contraceptive methods (71%). However, peasants are likely to be far from health facilities and far from accessing information on contraceptives. It was also revealed that a relatively big portion of non- users would prefer service provision at home through community based distributors. This is consistent with other studies [22].

Availability and accessibility of contraceptive methods influence the use of contraceptive methods. Findings of this study showed a significant association between availability and accessibility of contraceptive methods and use. This was also supported by observation from service providers and suggested that contraceptive methods should

be available to all health facilities including private ones. This is consistent with other studies in Iran [14] and Ethiopia [18] and Bangladesh [23].

5.4 Limitation of the study

There was a language barrier as most of the women interviewed were only conversant with local language which is *kisukuma*. This was overcome by prior recruitment of research assistants who could speak the language since this challenge was observed during pre-testing of the tools. In Kahama, like in other patriarchal societies, contraceptive use is considered a sensitive matter that the user [woman] would not want her spouse/ partner to be aware of. Consequently, it is likely that some users of contraceptives might have concealed the truth about their uptake of contraceptives. On the other hand, the study might have suffered social desirability bias. This is because it was conducted at the health facility and respondents might have falsely indicated that they use contraceptives thinking such an answer would have pleased the researcher. However, these shortfalls were minimized by providing adequate information on the importance of the study and reassurance on confidentiality.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents conclusion and recommendations of the study.

6.1. Conclusion:

This study has been useful in identifying some of the factors which hinder some women in stable marital relations not to use contraceptive methods. Socio-demographic factors like education level and occupation were found to influence the use of contraceptive methods among women in stable marital relations. Moreover, Socio-cultural factors like religious beliefs and husband/partner support were crucial in influencing the use of contraceptive methods. However, there was also a large portion of those who were not using contraceptive methods. These were mainly peasants. This is an indication of unmet need of contraceptive methods in this group.

6.2 Recommendations.

Basing on the study, the following are recommended:

1. District Health Management teams should develop interventions that will enable women in stable marital relations to understand the importance of using contraceptive methods.

2. Programs with clear messages need to be developed to curb a tendency of preferring use of untested traditional contraceptive - *mpingi- to the existing scientifically sound contraceptives methods.* Community leaders and influential people can be used as catalyst to bring change. Moreover, further study will be needed to learn more *about* use of Mpigi as one of the contraceptive methods.

3. Since this study did not involve men, further studies are needed to determine the extent of use of contraceptive methods among men and associated factors.

REFERENCES

1. Smith R, Ashford L, Crible J and Clifton D. Family Planning Saves Lives, Population Reference Bureau, 4th Edition 2009, pg 3.
2. Mosher WD, Martinez GM, Chandra A, Abama J.C and Wilson, SJ. Division of Vital statistics; Use of Contraception and use of Family Planning Services in the United States 1982 – 2002) Advance data.
3. United Nations. Department of Economic and Social Affairs. Population Division, World Contraceptive Use Report 2009.
4. The United Republic of Tanzania, Ministry of Health and Social Welfare; Health Sector Strategic Plan III "Partnerships for Delivering the MDGs" July 2009 – June 2015. Final Version.
5. The United Republic of Tanzania, Ministry of Health and Social Welfare; National Family Planning Costed Implementation Program 2010-2015, Reproductive and Child Health Section, 2010.
6. The United Republic of Tanzania, Ministry of Health and Social Welfare; National Package of Essential Reproductive and Child Health interventions (NPERCHI 2004).
7. The United Republic of Tanzania, Tanzania Bureau of Statistics; Demographic Health Survey, Final report 2010.
8. Das NP, Mishra VK, and Saha PK. Does Community Access Affect the Use of Health and Family Welfare Services in Rural India? National Family Health Survey Subject Reports Number 18, May 2001.
9. Kessy TA and Rwabudongo N. Utilization of modern family planning methods among women of reproductive age in a rural setting: the case of Shinyanga rural district, Tanzania. East African Journal of Public Health 2006.
10. The United Republic of Tanzania, Ministry of Health and Social Welfare; National Road Map to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania; 2008-2015.

11. Shinyanga Regional Planning Report 2011.

12. Kahama District Council Reproductive and Child Health Report 2011.

13. Mwaikambo L, Speizer IS. Schurmann A, Morgan G and Fikree F. What Works in Family Planning Interventions: A Systematic Review, Studies in Family Planning, Vol.42 No. 2, June 2011.

14. Mackenzie H, Drahota A, Pallikadavath SW and Dean T. What kind of family planning delivery mechanisms increase family planning acceptance in developing countries? A mixed method Systematic Review.

15. Okech T, Dr.Wawire NW and Dr. Mburu T. Contraceptive Use among Women of Reproductive Age in Kenya's City Slums, International Journal of Business and Social Science Vol. 2 No. 1; January 2011 p 22.

16. Almualm YKA. Knowledge, Attitude and Practice of Husbands towards Modern Family Planning in Mukalla Yemen, University Sains Malaysia 2007.

17. Ibnouf H, van den Borne HW and Maars JAM e. Utilization of Family Planning services by married Sudanese Women of Reproductive Age. Eastern Mediterranean Health Journal Vol. 13, No.6, p1376 – 80 2007.

18. Gizaw A and Regassa N. Family planning service utilization in mojo town, Ethiopia: a population based study. Journal of Geography and Regional Planning Vol. 4(6) 2011

19. National Research Council Working Group. Factors Affecting Contraceptive Use in Sub-Saharan Africa (Free Executive Summary. http://www.nap.edu/catalog/2209.html).

20. United Nations Population Fund. Evaluation Findings, Quality of Family Planning, Issue number 3, January 1994.

21. Moronkola A, Ojediran MM and A. Amosu. Reproductive health knowledge, beliefs and determinants of contraceptives use among women attending family planning clinics in Ibadan, Nigeria. African Health Sciences Vol. 6 No 3 September 2006.

22. Tuonane M, Nyovani JM and Diamond I. Provisions of family planning services in Lesotho. Vol. 30, No. 2 June 2004.

23. Zainab B, Sharmin S and Islam MN. Factors Affecting Utilization of MCH Services in Bangladesh. The Journal of Family Welfare, Vol. 47, No. 1 April 2001 p 1385.

24. National Bureau of Statistics, Tanzania Population Census Report 2002.
25. Kothari C. Research Methodology, Methods and Techniques, 2nd Edition 2004
26. Shackman, G., 2001. Sample size and Design effect. NYS DOH, Presented at Albany Chapter of American Statistical Association. Available at: http://faculty.smu.edu/slstokes/stat6380/deff%20doc.pdf (Retrieved 20th April 2011)

27. Ministry of Health -Kenya Research guideline, 2006.

APPENDICES

Appendix I: Key informant interview guide for service providers from health facilities - English version

Hello, my name is _____. I'm from_____.

We are interested in what is the extent of contraceptive use among women in stable marital relations attending health facilities and factors that drives you to use or not to use contraceptive methods. I would like to ask you a few questions and would be very grateful if you would spend a little time talking with me. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to answer. Do I have your permission to continue?

ID NO _____

Date:……

Name of the HF:……

Level of the HF service provider…….

Title of the HF service provider……

Sex……

Age…….

KEY QURESTIONS

1. How many service providers are you in this facility? Is the number adequate to meet the demand from the clients you are attending?
2. How many clients does your facility serve per day?
3. How long have you been working in this facility and this section/unit?

4. How would you describe the quality of contraceptive methods offered from this health facility?

5. How would you describe availability of contraceptive methods?

6. Do female/women in stable marital relationship who use contraceptive methods visit your facility?

    a. What is the estimated proportion of women in stable relation using contraceptive methods in this health facility?

    b. What contraceptive methods does a woman in stable relation usually seek in in this health facility?

    c. What are the challenges in providing contraceptive methods to women in stable relation attending health facilities?

    d. Why do you think it is important for women to use contraceptive methods? Why?

7. What suggestions can you make to improve women in stable relation to use of contraceptive methods at this facility?

8. What would you propose as an alternative approach to increase the use of contraceptive methods among women in stable marital relationship attending health facilities in your areas?.....

THANK YOU VERY MUCH.

Appendix II: Mwongozo maswali kwa watoa huduma katika vituo vya afya - Swahili version

Habari, jina langu ni _____. Ninatokea_____.

Tumevutiwa na suala la kiwango cha matumizi ya njia za kuzuia mimba miongoni mwa wanawake wenye ndoa au wanaoishi kinyumba kwa muda mrefu na wanaopata huduma za afya katika kituo hiki. Tungependa kujua sababu zao za kuzitumia au kutozitumia njia za kuzuia mimba. Hivyo, ningependa kukuuliza baadhi ya maswali na nitashukuru ikiwa utanipa muda wako kidogo kuongea nami. Sitaandika jina lako, na kila utakachoniambia kitabaki kuwa siri kubwa. Ushiriki wako si wa lazima na, haulazimiki kujibu swali lolote usilotaka kujibu. Je, unaniruhusu kuendelea?

Kumbukumbu Na: _____

Tarehe:……..

Jina la kituo:……

Ngazi ya mtoa huduma katika kituo…….

Wadhifa wa mtoa huduma kituoni……

Jinsia……

Umri…….

MASWALI:

1. Je, mpo watoa huduma wangapi katika kituo hiki? Idadi hiyo inakidhi ukilinganisha na mahitaji ya wateja mnaowahudumia?
2. Je, kituo chenu kinahudumia wateja wangapi kwa siku?

3. Umekuwa ukifanya kazi kwa muda gani sasa katika kituo hiki hasa katika kitengo hiki?

4. Unaweza kuuelezeaje ubora wa njia za uzazi wa mpango zinazotolewa na kituo hiki?

5. Unaweza kuelezeaje upatikanaji wa njia za kuzuia mimba?

6. Je, wanawake walio katika ndoa /wanaoishi pamoja kwa muda mrefu na ni watumiaji wa njia za kupanga uzazi wanatembelea kituo chako?

    a. Ni kadirio la wanawake wangapi walio katika ndoa/huisi pamoja kwa muda mrefu wanaofuata huduma za uzazi wa mpango katika kituo hiki?

    b. Ni njia zipi za kuzuia mimba ambazo mwanamke hao huwa wanazitumia/huchukua sana kwenye kituo hiki cha afya?

    c. Ni changamoto zipi zinatokea wakati wa utoaji wa njia za uzuiaji mimba kwa wanawake walio kwenye ndoa/wanaoishi kwa pamoja kwa muda mrefu wakati wa kuja kwenye hiki kituo cha afya?

    d. Je, ni muhimu kwa wanawake kutumia njia za kuzuia mimba? Kwa nini?

7. Ni mapendekezo gani ungetoa kuboresha matumizi ya njia za kuzuia mimba kwa wanawakes walio katika ndoa kwenye kituo hiki?

8. Ni njia zipi mbadala ambazo ungepekeza ili kuwe na ongezeko la matumizi ya njia za kuzuia mimba kwa wanawake walio katika ndoa wanaopata huduma kwenye kituo hiki?

AHSANTE SANA.

Appendix III: Questionnaires to women in stable marital relations - English Version

Hello, my name is _____. I'm from_____.

We are interested in what is the extent of contraceptive use among women in stable marital relations attending health facilities and factors that drives you to use or not to use contraceptive methods. I would like to ask you a few questions and would be very grateful if you would spend a little time talking with me. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to answer. Do I have your permission to continue?

A. SOCIO - DEMOGRAPHIC DATA

ID. No._____ Date of Interview:……

1. Ward ……
2. Village/street…….
3. District…….
4. Address……..
5. Age……..
6. Ethnicity……
7. Religion 1. Christian 2. Islamic
8. Health Facility Name:…….

9. Level of Facility where interview took place*:* Please, Circle the right answer

    1. Hospital;

    2. Health Centre;

    3. Dispensary

    4. Others…….

10. Type of Facility:

    1. Government

    2. Family Planning Association Clinics

    3. FBO

    4. Private

    5. CBO

    6. Other

11. Locality:

    1. Rural

    2. Urban

    3. Peri-Urban

    4. Village

    5. Others ……

12. How many children do you have? _____

13. At which age did you get your 1st child? ----------

14. Can you read and write in any language?

1. Yes
2. No

If Yes,

15. What is the level of education?

1. Never
2. Not completed primary school
3. Completed Primary school
4. Secondary school or more
5. others

16. What is your occupation?

1. Unemployed
2. Self employed
3. Farmer
4. Student
5. Employed
6. Retired
7. Others (specify) _____

17. What is your husband's/spouses occupation

1. Unemployed
2. Farmer

2. Self employed

3. Student

4. Employed

5. Retired

6. Other (specify)

B: CONTRACEPTIVE METHODS KNOWLEDGE AND USE

18. Have you ever heard of Contraceptive methods?

1. Yes

2. No

19. If your response to Q.18 above is "Yes", where did you get information about the contraceptive methods?

1. Media

2. from peer

3. from husband/partner

4. Seminar/training

5. Health facility

20. Why did you come to this facility?

1. Contraceptive counseling

2. Contraceptive collection

3. Prenatal care

4. Postnatal care

5. Other

21. What are the ways of avoiding pregnancy?

1. Use of contraceptives
2. Avoiding coitus
3. Douching
4. Other

22. Do you know about contraceptive methods?

1) Yes
2) No

23. If your response to Q 22. Above is "yes" Which types of contraceptive method do you know***? Put circle against respondents' answer***

1. Pills Yes …….No……
2. Intrauterine device (IUCD) Yes …….No……
3. Injectable (Depo - Provera) Yes…… No……
4. Condom (female) Yes…… No……
5. Condom (male) Yes……..No……
6. Vasectomy/Male sterilization Yes……No…….
7. Tubal ligation/female sterilization Yes……. No……
8. Periodic abstinence Yes …… No……
9. Prolonged breast feeding Yes……. No……
10. Natural methods Yes…… No……

11. Others (specify)_____

24. Are you using any contraceptive method?

1. Yes

2. No

If Yes,

25. What type of contraceptives methods are you using?

1. Modern FP methods

2. Withdraw

3. Calendar

4. Prolonged feeding

5. Abstinence

6. Nothing

7. Others (Specify)_____

26. Do you think that there are any advantages with the use of contraceptive methods?

1. Yes

2. No

27. If your response to Q.26 above is" Yes" what are advantages with use of contraceptive methods? ***Please write the responses to the space provided.***

1……

2……

3……

B. **FACTORS ASSOCIATED WITH THE USE OF CONTRACEPTIVE METHODS.**

28. If your response to Q.26 above is “No”, why are you not using any contraceptives?

1. Spouse does not approve
2. It is against religion teaching
3. Afraid of side effects
4. I do not know where to access them
5. Other
   (specify)_____

29. What would be the reasons for you to use contraceptives methods?

1. Child spacing
2. No need for more children
3. Delay due to employment
4. Delay due to school
5. Other(specify)_____

30. Where do you always get the contraceptives?

1. Hospital/Health institutions
2. Drug vender/pharmacy
3. Shop
4. Community Based Distributors agents (CBDs)
5. Other (specify)_____

31. Do you get your contraceptive method when you are due?

    1. Yes
    2. No

32. If your response to Q.31 Above is “No”, why?

    1. Clinic stocked out
    2. Bus fair to travel to clinic
    3. Busy
    4. Other

33. What do you do when you do not get your contraceptive method from the clinic?

    1. Purchase from the Pharmacy
    2. Use of alternative method
    3. Do not use any method
    4. Others (specify)…….

34. Where would be the most convenient place for you to get contraceptives?

    1. Hospital/health institutions
    2. Reproductive and Child Clinic
    3. Pharmacy
    4. At home /community based distributors
    5. Other (Specify)

35. Does your husband/partner support if you want to use contraceptive methods?

1. Yes
2. No
3. I don't know

36. What would you regard as factors that will hinder you from using contraceptives?

1. Refusal by husband/partner
2. Religion believes
3. Non availability of FP methods
4. Inadequate financial support – for transport to visit health institution
5. Other (specify)

37. Does your society you are living in support use of contraceptive methods?

1. Yes
2. No
3. I don't know

38. Do you think your traditional /cultural believe are against use of contraceptive methods?

1. Yes
2. No
3. I don't know

39. Do you get information on contraceptive methods?

1. Yes
2. No

40. If yes, where do you get information from? If the answer to the Q.39 is “NO” go to the question No. 41

1. Health institutions/FP clinics
2. Radio
3. TVs
4. Newspaper
5. From Friends
6. Family members
7. Other

41. Do you discuss contraceptive methods with your husband?

1. Yes
2. No

42. If your response to Q. 42 above is “NO” why?

1. He does not approve
2. It is against cultural norms
3. Others
   (specify)……..

43. Whom do you prefer as service provider?

1. Female service providers for women
2. Male service provider for men
3. Community Based Distributors (CBDs)
4. No sex preference

44. Whom would you comfortably talk to when you need to ask something about contraceptive methods?

1. Husband/Partner
2. Relatives
3. Friends of opposite sex
4. Friends of the same sex
5. Health care providers
6. Others (specify)_____

45. Who decides on the number of children you have?

1. Husband/partner
2. My self
3. Family members/Close relatives
4. Parents
5. Others (specify) _____

46. Have you ever informed your partner of using contraceptive methods?

1. Yes; If the answer is “yes” give reasons to support your answer
……
……

2. NO; If the answer is “No” give reasons to support your answer
……
……

47. If you want to use contraceptive methods, which make decisions on the use of contraceptive methods?

1. Husband

2. Wife

3. Husband and wife jointly.

4. Others……

THANK YOU VERY MUCH.

Appendix IV: Maswali kwa wanawake walio katika mahusiano thabiti ya ndoa- Swahili version

Habari, jina langu ni _____. Ninatokea_____.

Tumevutiwa na suala la kiwango cha matumizi ya njia za kuzuia mimba miongoni mwa wanawake wenye ndoa au wanaoishi kinyumba kwa muda mrefu na wanaopata huduma za afya katika kituo hiki. Tungependa kujua sababu zao za kuzitumia au kutozitumia njia za kuzuia mimba. Hivyo, ningependa kukuuliza baadhi ya maswali na nitashukuru ikiwa utanipa muda wako kidogo kuongea nami. Sitaandika jina lako, na kila utakachoniambia kitabaki kuwa siri kubwa. Ushiriki wako si wa lazima na, haulazimiki kujibu swali lolote usilotaka kujibu. Je, unaniruhusu kuendelea?

A.TAARIFA BINAFSI

Kumb. Na._____ Tarehe ya mahojiano:……

1. Kata……
2. Kijiji/Mtaa…….
3. Wilaya…….
4. Anuani……..
5. Umri……..
6. Kabila……
7. Dini……
8. Jina la kituo cha afya:……

9. Ngazi ya kituo, mahojiano yalipofanyika: Tafadhali, zungushia duara jibu sahihi

    1. Hospitali;

    2. Kituo cha afya;

    3. Zahanati

    4. Nyingine .....

10. Aina ya kituo:

    1. Serikali

    2. Chama cha kliniki za kupanga uzazi mpango

    3. Vituo vya mashirika ya dini

    4. Binafsi

    5. Asasi za kiraia

    6. Nyinginezo

11. Eneo:

    1. Kijijini

    2. Mjini

    3. Pembezoni mwa mji

12. Una watoto wangapi? _____

13. je unakumbuka mtoto wako wa kwanza umemzaa ukiwa na umri gani? .....

14. Je, unaweza kuongea au kundika kwa lugha yoyote?

    1. Ndio

    2. Hapana

Kama ni ndio,

15. Ni kiwango gani cha elimu umefikia?

1. Sijawahi
2. Sikumaliza shule ya msingi
3. Nilimaliza shule ya msingi
4. Shule ya upili na zaidi
5. Nyinginezo

16. Unafanya kazi gani?

1. Sijaajiriwa
2. Nimejiajiri
3. Mkulima
4. Mwanafunzi
5. Nimeajiliwa
6. Nimestaafu
7. Nyinginezo (bainisha) _____

17. Mume/mchumba wako anafanya kazi gani?

1. Hajaajiriwa
2. Mkulima
2. Ajira binafsi
3. Mwanafunzi
4. Ameajiriwa

5. Mstaafu

6. Nyinginezo (bainisha)

B: UFAHAMU NA MATUMIZI YA NJIA ZA KUZUIA MIMBA

18. Je, umewai kusikia juu ya njia za kuzuia mimba?

1. Ndio

2. Hapana

19.Ikiwa jibu lako kwa swali la 18, hapo juu ni “Ndio”, je, ulipata wapi taarifa kuhusu njia za kuzuia mimba?

1. Vyombo vya habari

2. kutoka kwa rafiki

3. kutoka kwa mume/mchumba

4. Semina/mafunzo

5. Kituo cha afya/kiliniki ya afya ya uzazi na mtoto.

6 Nyinginezo.....(Taja)

20. Ni kwa nini ulikuja kwenye kituo hiki?

1. Ushauri nasaha wa kuzuia mimba

2. Mfumo wa kuzuia mimba

3. Huduma kabla ya kujifungua

4. Huduma baada ya kujifungua

5. Nyinginezo

21. Ni njia gani za kuepuka na kutopata mimba?

1. Matumizi ya njia mbalimbali za kuzuia kupata mimba.
2. Kuepuka kuingiliana kwa via vya uzazi
3. Kusafisha uke
4. Nyinginezo

22. Je, unafahamu kuhusu njia za kuzuia kupata mimba?

1) Ndio
2) Hapana

23. Ikiwa jibu lako kwa swali la 22, hapo juu ni “Ndio” Je, ni aina gani ya njia ya kuzuia mimba unayoifahamu? Weka duara kando ya jibu la mshiriki

1. Vidonge Ndio ….. Hapana…
2. Vifaa vya kuingiza akeni Ndio ……Hapana…
3. Sindano Ndio…… Hapana…
4. Kondomu (ya kike) Ndio…… Hapana…
5. Kondomu (ya kiume) Ndio…… Hapana….
6. Upasuaji kwa mwanaume/vasektomi Ndio…… Hapana….
7. Kufunga mirija/upasuaji kwa mwanamke Ndio……Hapana….
8. Kusubiri kufanya ngono kwa vipindi Ndio……Hapana….
9. Kunyonyesha kwa kipindi kirefu Ndio…… Hapana….
10. Njia asilia Ndio…… Hapana….
11. Nyingine (bainisha)_____

24. Je unatumia njia yoyote ya kuzuia mimba?.

1. Ndio

2. Hapana

Kama ni ndio,

25. Je, ni aina gani ya njia za kuzuia mimba ambazo unatumia?

1. Njia za kisasa za kupanga uzazi
2. Kuchomoa uume haraka kabla ya kumwaga mbegu/manii
3. Kutumia kalenda
4. Kunyonyesha kwa kipindi kirefu
5. Kuepuka/kuacha kufanya ngono
6. Hakuna
7. Nyinginezo (Bainisha)_____

26. Unafikiri kuna faida zozote za kutumia njia za kuzuia mimba?

1. Ndio

2. Hapana

27. Ikiwa jibu lako kwa swali la 26, hapo juu ni ” Ndio” je , ni faida zipi ambazo anapata mtu kwa kutumia njia za kuzuia mimba? Tafadhali andika majibu kwenye nafasi zifuatazo.

1……

2……

3……

B.MAMBO AMBAYO YANAAMBATANA NA MATUMIZI YA NJIA ZA KUZUIA MIMBA.

28. Ikiwa jibu lako kwa swali la 26, hapo juu ni “Hapana” Je kwa nini hautumii njia za kuzuia mimba?

1. Mwezi hakubaliani na suala hilo
2. Ni kinyume cha mafundisho ya dini
3. Naogopa athari ambatano
4. Sijui mahali napoweza kuzipata
5. Nyinginezo

(Bainisha)_____

29. Ni sababu zipi zinaweza kukufanya utumie njia za kuzuia mimba?

1. Kutenga mtoto mmoja na mwingine
2. Kusitisha uzazi zaidi
3. Kucheleweshа kutokana na ajira
4. Kucheleweshа kutokana na shule
5. Nyinginezo (bainisha)_____

30. Je, ni mahali gani ambapo daima unazipata njia za kuzuia mimba?

1. Hosipitali/Kituo cha afya
2. Wachuuzi wa dawa/famasia
3. Duka
4. Wasambazaji wa dawa katika jamii
5. Nyinginezo (bainisha)_____

31. Je, huwa unapata njia yako ya kuzuia mimba pindi unapoihitaji?

    1. Ndio
    2. Hapana

32. Ikiwa jibu lako kwa swali la 31, hapo juu ni "Hapana", ni kwa nini?

    1. Kliniki inaishiwa njia hizo
    2. Nauli ya basi kuelekea kliniki
    3. Kazi nyingi
    4. Nyinginezo

33. Je, unafanya nini baada ya kuikosa njia yako ya kuzuia mimba kutoka kliniki/kituo cha afya?

    1. Kununua kutoka kwenye famasi
    2. Kutumia njia mbadala
    3. Kutotumia njia yoyote
    4. Nyinginezo (bainisha) .....

34. Ni mahali gani panakufaa, kwa ajili ya kupata vizuia mimba?

    1. Hosipitali/kituo cha afya
    2. Kliniki za uzazi na mtoto
    3. Famasi
    4. Nyumbani/wasambazaji wa dawa katika jamii
    5. Nyinginezo (bainisha)

35. Je, mume/mwenzi wako anakuunga mkono unapotaka kutumia njia ya kuzuia mimba?

1. Ndio
2. Hapana
3. Sifahamu

36.Ni mambo gani ungeyachukulia kuwa sababu za kukuzuia wewe kutumia vizuia mimba?

1. Kukataliwa na mume/mwenzi
2. Imani za kidini
3. Kutopatikana kwa njia za kupanga uzazi
4. Msaada mdogo wa kifedha – kwa ajili ya kutembelea kituo cha afya
5. Nyinginezo (bainisha)

37. Je, jamii yako inaunga mkono kutumia njia za kuzuia mimba?

1. Ndio
2. Hapana
3. Sijui

38. Je, unafikiri imani zako za kiasili /kitamaduni zinapingana na matumizi ya njia za kuzuia mimba?

1. Ndia
2. Hapana
3. Sijui

39. Je, huwa unapata taarifa juu ya njia za kuzuia mimba?

1. Ndio
2. Hapana

40. Kama ni ndio, unapata wapi taarifa? Ikiwa jibu lako kwa swali la 39, ni “Hapana” hamia swali la 41.

1. Kituo cha afya/Kliniki ya kupanga uzazi
2. Redio
3. Runinga
4. Gazeti
5. Kutoka kwa marafiki
6. Wanafamilia
7. Nyinginezo

41. Je, unajadili na mume wako juu ya njia za kiuzuia mimba?

1. Ndio
2. Hapana

42. Ikiwa jibu lako kwa swali la 41 hapo juu ni “Hapana” ni kwa nini?

1. Haafiki
2. Ni kinyume cha maadili ya kitamaduni
3. Nyinginezo

(bainisha)……..

43. Ni nani unayempendekeza kuwa mtoa huduma wako?

1. Watoa huduma wa kike kwa ajili ya wanawake
2. Watoa huduma wa kiume kwa ajili ya wanaume
3. Wasambazaji wa huduma ndani ya jamii
4. Kutozingatia jinsia

44. Ni nani ungeweza kuongea naye kwa uhuru wakati unapohitaji kuuliza juu ya njia za kuzuia mimba?

1. Mume/mwenzi
2. Ndugu
3. Marafiki wa jinsia tofauti
4. Marafikiwa jinsia moja
5. Watoa huduma za afya
6. Nyinginezo (bainisha)_____

45. Ni nani anaamua idadi ya watoto unaopaswa kuzaa?

1. Mume/mwenzi
2. Mwenyewe
3. Wanafamilia/Ndugu wa karibu
4. Wazazi
5. Nyinginezo (bainisha)_____

46. Je, umewai kumtaarifu mwenzi wako juu ya matumizi ya njia ya kuzuia mimba?

1. Ndio; kama jibu ni “Ndiyo” toa sababu ya jibu lako …….
2. Hapana; kama jibu ni “hapana”toa sababu ya jibu lako ……
   ……

47. Ikiwa unahitaji kutumia njia za kuzuia mimba, nani hufanya maamuzi juu ya matumizi ya njia za kuzuia mimba?

1. Mume
2. Mke
3. Mume na mke kwa pamoja.
4. Nyingine …….

AHSANTE SANA.

Appendix V: Informed consent - English Version

ID. No _____

Consent to participate in this study

Greetings! My name is **Esabella Job Michael**. I am a Postgraduate student at Muhimbili University of Health and Allied sciences in Dar es Salaam.

Purpose of the Study

Dear respondent I would like to inform you that this is research study titled “use of contraceptive methods among women in stable marital relations attending health facilities in Kahama District. “I would like to give you information about your participation in the study.

This study is aiming at determine factors that influence use of contraceptive methods among women in stable marital relations in Kahama district Shinyanga Regional. Please be honest and true for betterment of the results that lead to better intervention and recommendations for future.

Benefits

The information you provide will help to increase our understanding on factors influencing use of contraceptive methods among women in stable marital relations in Kahama district and prepare effective interventions/programs of this population group.

In case of injury.

We do not anticipate that any harm will occur to you or your family as a result of participation in this study.

Confidentiality

We will protect your confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any report/documents that might let someone

identifies you. Your name will not be linked with the research information in any way. The investigators will take care of the data.

Right and withdrawal alternatives

Your participation is voluntary. You may decline from participation to the study at any time during the interview even if you have consented to participate. Your decision to participate or not will not be associated with your right to get public services from your ward or village /street. There is no penalty in this study. If any damage will occur, it is not expected that there will be any damage for your participation as the respondent to this study.

Risks

You will be asked questions about factors that associated with the use of contraceptive methods among women in stable marital relations. Some questions could potentially make you feel uncomfortable. You may refuse to answer any particular question on the records of the information you provide.

Who to contact

If you have any questions about this study, you should contact the study **Coordinator OR the Principal Investigator, Esabella Jobu. Michael,** Muhimbili University and Allied Sciences (MUHAS), P.O Box 65001, Dar es Salaam **(Mobile 0767 515112 OR 0784 515112**) If you ever have questions about your rights as a participant, you may call **the Chairman of the University Research and Publications Committee, at Muhimbili University of Health and allied sciences; his name is Prof. M. Abood,** P.O. Box 65001, Dar es Salaam. Tel: 2150302-6 and **Mr. C.K Makwaya who is the supervisor of this study (Mobile No.0788- 750431)**

Signature

Do you agree?.....

Participant Agrees …….

Participant disagree …….

I _____ have read/understood the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of Participant _____

Signature of witness (if participant cannot read) _____

Signature of research assistant _____

Date of signed consent _____

Appendix VI: Informed consent - Swahili version

FOMU YA RIDHAA

Namba ya Utambulisho …….

Ridhaa ya Kushiriki katika utafiti huu.

Jina langu naitwa **Esabella Jobu. Michael** , mwanafunzi wa shahada ya udhamili katika Chuo Kikuu cha Sayansi ya Afya Muhimbili, Dar es Salaam.

Dhumuni la Utafiti:

Mpendwa mshiriki, ninapenda kukujulisha kuwa tunafanya utafiti wenye kichwa cha habari " Matumizi ya njia za kisasa za uzazi wa mpango miongoni mwa wanawake waliokatika mahusiano au wamefunga ndoa katika mkoa wa Shinyanga, wilaya ya Kahama.

Ningependa kukupa taarifa kuhusu ushiriki wako katika utafiti huu.

Utafiti huu unalengo la kuanisha vipingamizi katika kuwahusisha na kuwashirikisha wanawake waliokatika mahusiano ya …….na pia kuanisha vigezo vitakavyo mshawisi mwanamke kutumia njia za kisasa za uzazi wa mpango.

Tafadhali nakuomba uwe muwazi na mkweli kwani matokeo ya utafiti huu yatakuwa sehemu ya mapendekezo ya takayoweza leta utekelezaji bora wa masuala ya matumizi ya njia za kisasa za uzazi wa mpango.

Usiri:

Tunakuhakikishia usiri wa hali ya juu kwa kadri ya uelewa wetu. Hatataandika jana lako katika dodoso au katika ripoti au nyaraka zozote ambazo zinaweza kumfanya mtu mwingine kukufahamu. Taarifa zote zitakazokusanywa zitatunzwa na mtafiti mkuu.

Haki ya kujitoa kwenye utafiti:

Kushiriki kwenye utafiti ni hiari. Uamuzi wako wa kushiriki au kutoshiriki hautaathiri haki yako kama raia. Unaweza kujitoa kushiriki katika utafiti wakati wowote, hata ikiwa umekwishafanya ukubali. Uamuzi wako wa kushiriki au kutoshiriki katika utafiti hauambani na adhabu yeyote na wala hautapoteza mafao yeyote ambayo unastahili kupata.

Kama kukitokea madhara:

Hatutarajii uwepo wa madhara yeyote juu yako ukiwa kama mshiriki kwenye utafiti huu. Hata hivyo kama madhara yatatokea kwako kutokana na wewe kushiriki katika utafiti huu, tuna ahidi kutoa ushirikiano wa hali na mali kwa kadiri ya uwezo wetu.

Mawasiliano na wahusika:

Ikiwa una maswali yeyote kuhusiana na maswali yeyote wewe kama mshiriki katika utafiti huu. Unaweza kuwasiliana na **Mratibu mkuu wa mradi, Esabella Jobu. Michael** Chuo Kikuu cha Muhimbili, SLP 65001, Dar Es Salaam **(simu. no. 0767 515112 au 0784 515112).** Kama utakuwa na maswali yeyote kuhusu haki zako kama mshiriki unaweza kupiga simu **kwa Prof. M. Abood, ambaye ni Mwenyekiti wa kamati ya chuo ya utafiti na machapisho**, wa Chuo Kikuu cha Sayansi ya Tiba na Afya Muhimbili P.O. Box 65001, Dar es Salaam. Simu: 2150302-6 **na Mr. C.K Makwaya ambaye Msimamizi mkuu wa huu utafiti** (Simu yake ya kiganja ni Namba; **0788- 750431)**

Sahihi:

Unakubali?

Mshiriki amekubali ……..

Mshiriki amekataa ……..

Mimi …….. nimesoma/nimeielewa hii fomu, maswali yangu yamejibiwa. Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki _____

Sahihi ya shahidi (kama hawezi kusoma na kuandika)_____

Sahihi ya Mtafitimuandamizi _____

Tarehe ya makubaliano _____