KNOWLEDGE, ATTITUDES AND PRACTICE OF MODERN CONTRACEPTIVES AMONG PUBLIC AND PRIVATE HEALTH CARE PROVIDERS IN GEITA DISTRICT COUNCIL, GEITA

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Knowledge, attitudes and practice of modern contraceptives among public and private health care providers in Geita district council, Geita

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CERTIFICATION

The undersigned certify that, she has read and hereby recommended for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled: **‘‘Assessment of knowledge, Attitudes and Practices of Modern Contraceptives among public and private Health Care Providers in Geita District Council, Geita’’,** in (partial) fulfillment of the requirements for the Degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

_____

Dr. Idda Mosha

(Supervisor)

_____

Date

DECLARATION

AND

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I, **Joel Lunyungu**, 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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DEDICATION

I dedicate this dissertation to my family for their support and encouragement which contributed to the accomplishment of this work.

ABSTRACT

Background

Health care providers play an important role in imparting health education to the public. In order to provide the awareness among public we need to be aware of the health care provider's knowledge, attitude and practices. It is important to know whether the health care providers who are the health guider to the community, they themselves are using contraceptive. Despite of this important role to the community, their knowledge, attitude and use of modern contraceptives has not been adequately investigated in Tanzania.

Objectives

To assess the knowledge, attitude and practices of modern contraceptives among health care providers in public and private facilities in Geita district council, Geita region.

Material and methods

This was a cross-sectional study design. Qualitative and quantitative methods were employednto collect data from health care providers. This study was done in Geita district, Geita Region from 18thJune to 19 July 2019. The study adopted interviewer administered questionnaire to collect data from 152 participants and used in-depth interview guide to collect data from 13 participants. Statistical Package for Social Scientist (SPSS) was used to analyse quantitative data and which are presented in terms of tabulation, frequency and graphs. Thematic approach was used to analyze qualitative data. Transcription of audio data was done and then transcripts translated from Swahili to English. Information in transcripts was categorized to develop codes (important categories). Themes were developed from codes and compiled to form main themes and presented in verbatim.

Results

This study found 82.2% of the participants had a good knowledge on contraceptive, 94.1% of the participants had positive attitudes about contraceptives and 77.6% reported to have ever used modern contraceptives methods and 77.6% reported that they will use contraceptives in future. Also this study found that only 38.2% of the participants were currently using contraceptives and condom was the most used method than other contraceptive methods.

Conclusion

Findings from this study indicate that healthcare providers have a good knowledge and positive attitude towards contraceptive methods although did not know the suitable methods for users, right time for someone to be offered contraceptive, some felt ambivalent about providing contraceptives for adolescents. Some felt the provision of contraceptives promotes promiscuity and that contraceptives lead to early sexual activity among adolescents.

This study also indicated that very few healthcare providers are using contraceptive methods and the most used method was male condom and this may cause unwanted pregnancies if not used properly and this might affect the provision of long-term methods to the community.

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LIST OF ABBREVIATIONS

CPR	Contraceptive Prevalence Rate
EC	Emergency Contraceptive
ECP	Emergency Contraceptive Pills
FP	Family planning
HIV	Human Immunodeficiency Virus
HSSP	Health sector Strategic Plan
IDI	Indepth Interview
IPD	Inpatient department
IUD	Intrauterine Contraceptive Device
MUHAS	Muhimbili University of Health and Allied Sciences
NBS	National Bureau of Statistics
OPD	Outpatient department
PI	Principal Investigator
PID	Pelvic Inflammatory Disease
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infections
SPSS	Statistical Package for social Sciences
STD	Sexual Transmitted Disease
TDHS	Tanzania Demographic Health Survey
TFR	Total Fertility Rate
USA	United States of America
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS

Health care provider: A person who is trained to care for sick or injured people and who usually works in a hospital and in a clinic (Dictionary, 2014). Health care providers are the persons who hold diplomat or baccalaureate education in medical and nursing and provide services at all level of health care system. In this study health care providers were referred to as those which prescribe clients

Contraceptive Prevalence Rate: Is the proportional of women of reproductive age who are using (whose partner is using) a contraceptive method at a given point in time (Cluster, Nations, & Nations, 2006).

Modern Contraception: A modern contraceptive method is a product or medical procedure that interferes with reproduction from acts of sexual intercourse. With a clear definition of modern contraceptive methods, the various products and approaches can be categorized easily. The methods that do not fit under the definition of modern can alternatively be labeled as “non-modern methods”. Examples of modern contraceptive methods are oral contraceptives, implants, intrauterine contraceptive devices, vasectomy, tubal ligation, condoms, emergency contraceptives and diaphragms (Hubacher and Trussell, 2015).

Unmet need: For family planning refers to those women who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/

Knowledge: Facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject (Dictionaries, 2014). In this study knowledge refers to their understanding of contraceptives method and were refered knowledgeable after being able to respond correctly to the specific questions set in the questionnaire.

Practice: The actual application or use of an idea, belief, or method, as opposed to theories relating to it (Dictionaries, 2014). In this study, practice refers to the ways in which health care providers demonstrate their knowledge and attitude through contraceptive provision and through utilization.

Attitude: A settled way of thinking or feeling about something. https://en.oxforddictionaries.com/definition/attitude. In this study, attitude refers to healthcare providers feelings towards contraceptives method as well as preconcived ideas that they may have towards it.

CHAPTER ONE

1.1 Introduction/Background

Family planning is a way of thinking and living that is adopted voluntarily upon the bases of knowledge, attitude, and responsible decisions by couples and individuals. Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Family planning deals with reproductive health, birth spacing, avoiding undesired pregnancies and abortions, preventing sexually transmitted diseases, and improving the quality of life of mother, fetus, and family as a whole.

Use of contraceptives can prevent at least 25% of all maternal deaths by preventing unintended pregnancies and unsafe abortions and also protect against sexually transmitted infections, such as Human Immunodeficiency Virus (HIV), Chlamydia, Syphilis.A lack of knowledge of contraceptive methods, source ofsupply, cost, or poor accessibility are the barriers that exist in developing countries (Rabbanie, et al; 2019)

The global population today stands at 7.7 billion and is expected to reach 9 billion by the year 2045. (Baven; 2013) Increasing population is a global problem today, uncontrolled population growth has been recognized as the most important impediment to most of national development. So, it is important at global as well as national scale to ensure that all pregnancies are wanted or intended. Currently, Tanzania has a fertility rate of 5.2 children per women and rural women have 2.2 more children on average than urban women (6.0 versus 3.8 children) (TDHS, 2015).

WHO (2018) has developed recommendations on which types of health workers can safely and effectively provide specific family planning methods. WHO based these recommendations on the evidence that a wide variety of providers can safely and effectively provide contraception. Specific competency-based training and continued educational support help all types of healthcare providers do a better job at providing family planning. If healthcare workers do not have an apt knowledge and a favorable attitude to practice family planning, the acceptance level and compliance of family planning services by their beneficiaries from those healthcare workers will be compromised. For primary healthcare physicians to comprehend the strategy that would be

required to promote family planning services they need to know the level of knowledge, attitude of their team workers, and thus having an idea about their practice, ultimately their counseling drive and intent of motivation to beneficiaries. (Rabbanie, et al; 2019)

Tanzania is very committed to ensure access to voluntary, quality contraceptive information, services and supplies. This commitment was affirmed at the 2013 Tanzania Family planning conference where the Government and other stakeholders committed to increase the contraceptive prevalence Rate (CPR) to 60% by 2015 which represents an increase from 2.4 million to 6.6 million women using contraceptive methods(Context, 2015).

Family Planning 2020 is another initiative to expand contraceptive use to 120 million additional women and girls by 2020. Tanzania is one of the Family Planning 2020 focus countries and has the policy, strategy and guidelines in place to respond to this initiative. All men and women in the country, including young people (10–24 years of age) regardless of parity, marital status, creed, race, or sexual preference are eligible to access family planning information, education and services. There is no parental, guardian or spousal consent required for adolescents (10–18 years), although such consent is required for people with severe mental disabilities and clients seeking permanent methods, this policy allows for the provision of family planning services to young unmarried women. Modern contraceptive methods approved for use in Tanzania include implants, male and female sterilization, oral contraceptive pills, progestogen-only injectables, intrauterine device - copper containing only (IUCD), male and female condoms and emergency oral contraceptive pills. (MOHSW, 2013)

Many Sub-Saharan countries have persistent high rates of unmet need for family planning and low rates of contraceptives use. The low levels of utilization are typically a function of both the limited capacity of the health system and the framework within which family services are delivered and the health care providers play an important role in making contraceptives available and can increase access through counselling clients, prescribing or advocacy (Aryeetey et al., 2010).

Despite the Tanzania government efforts, contraceptive prevalence rate is low by 32% while unmet need is still high. For example, according to WHO's fact sheet updated in July 2017; the unmet need for contraception remains too high globally. In Africa 24.2% of women of reproductive age have an unmet need for modern contraception and among the reasons for this include users and providers bias, poor quality of available services and limited choice of methods. The current (2015) Tanzania Demographic and Health Survey findings indicated that unmet need for family planning among currently married women remained between 22% and 24% and the contraceptive prevalence rate remained to be high as 32% in Tanzania. Reasons contributing to unmet need for family planning in developing countries include lack of contraceptive knowledge, poor quality of and access to family planning services, method cost, women's concerns about side effects, and women's husbands' or family members objections to contraceptive use.

Barriers to contraceptive method use occur on the demand side through the lack of awareness, or education and fear of side effects as well as on the supply side through contraceptive methods stock out, geographical distance, or through individual health care provider's biases of who should or should not obtain family planning services. Providers impose obstacles to the use of contraceptives for example inappropriate contraindications, edibility restrictions, unnecessary hurdles, overspecialization of providers, bias and unnecessary regulations. All these might restrict access to family planning services and consequently increased risk of unplanned pregnancy, unsafe abortion, and early drop out from school due to pregnancy (Schwandt et al., 2017). Such obstacles are potentially important because they can affect both access to and the quality of family planning services. They can deny women access to services, increase women's psychic and time costs for using services and restrict their choice of methods (Speizer et al., 2000).

A study conducted in Ethiopia states that, apart from reasons like cost, socio - economic status related to family planning provision, medical, and legal restrictions to use methods; providers bias and misinterpretation were among the barriers of contraception (Mekonnen & Worku, 2011). Another study in urban Nigeria found that approximately half of providers impose minimum age restrictions with a medium minimum age of 18 years and another study in Ghana found that providers restricted the provision of injectable to those 30 years and older (Schwandt et al., 2017).

Another study conducted in USA showed that, there is a considerable amount of misinformation about contraception among providers, high level of disagreement among practicing providers about the risk among users of the contraceptive and this can dramatically affect providers' ability to provide quality contraceptive care to their patients, which could have an impact on their ability to prevent unintended pregnancies (Dehlendorf et al, 2015).

Basing on the fact and explanations provided above, it appears that the advocacy and family planning campaign has given little attention to the role of health care providers in increasing family planning uptakes. Perhaps this is the reason why many interventions on the subject have shown little progress than expected. It is the assumption of this study that health care providers are very important in provision of family planning methods. According to Mustafa (2015) the role of health care provider that are female doctors, nurses, private practitioners, community-based distributors, midwives and nurse auxiliaries, pharmacists, and the assistants to all these are very important in imparting information related to contraceptive measure in reproductive health.

Health care providers play an important role in imparting health education to the public. In order to provide the awareness among public we need to be aware of the health care provider's knowledge, attitude and practices. It is important to know whether the health care providers who are the health guider to women, they themselves are practicing contraceptives. Therefore, this study is expected to fill such gap by assessing the knowledge, attitude and practices of modern contraceptives among health care providers in public and private facilities and find out the problems to practices. Moreover, this study will help identifying the value and belief of health care providers in practicing contraceptive methods.

1.2 Problem Statement

Modern contraceptive is one of the important components recommended for fertility control and improvement of maternal health through birth spacing. Use of Modern contraceptives will help to reduce mortality and morbidity due to complications of unsafe abortions following unwanted pregnancies. Use of contraceptives can prevent at least 25% of all maternal deaths by preventing unintended pregnancies and unsafe abortions and also protect against sexually transmitted infections, such as Human Immunodeficiency Virus (HIV), Chlamydia, Syphilis (Rabbanie et al; 2019). Despite this importance, the use of contraceptive is largely underutilized worldwide either because of negative attitudes or lack of accurate information about these methods to both the providers and the potential users. In Tanzania contraceptive use is still low by 32%.(TDHS, 2015)

In some settings the health care workers have been blamed for unfavorable attitudes and lack of accurate information towards modern contraceptives and this has discouraged many people to use the modern contraceptive to plan for their families (Byamugisha *et al.*, 2007; Shaki, 2010).

Several studies have been done in addressing the knowledge, attitude and practice of contraceptives among women in Tanzania and outside Tanzania and the general findings show that there was high knowledge, attitude and low use (Shaki, 2010, Somba et a; 2013, Omishakin, 2015, Rabbanie et al;2019, Nalwadda, 2011). But there are limited number of studies focusing on healthcare providers knowledge, attitude and use of modern contraceptives who are the key influential toward implementation of modern contraceptive. Nonetheless, there were limited studies particularly in the health care providers that have used both quantitative and qualitative methods to explore knowledge, attitude and practice towards modern contraceptive.

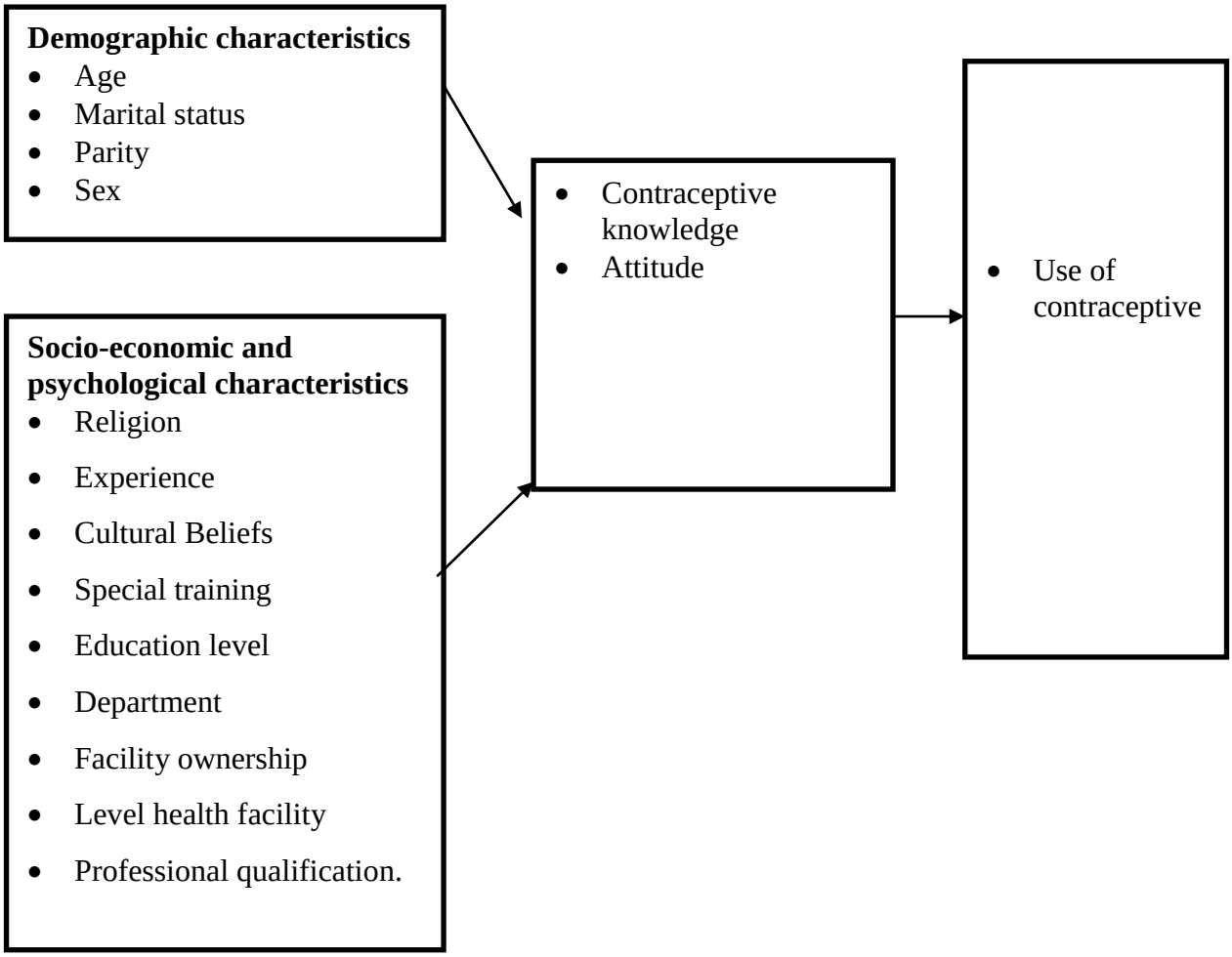
1.3 Significance of the Study

Since the society rely on the health care providers for information and provision of birth control services, health care providers can improveawareness and utilization of contraceptives among potential users through counselling, prescription or advocacy. Therefore, it is important to note that a better understanding of health care providers and their behavior could be an important strategy to designing training for means of increasing the use of contraceptive.

The findings of this study will ultimately contribute to information about methods to reduce unintended pregnancies, unintended childbirth, unsafe abortions eventually reduce maternal and child morbidity and mortality rate in our country. Also, this study will help identifying the value and belief of health care providers in practicing contraceptive methods. It can be used as background information for improvement strategies to comply with national plans, commitments of increasing contraceptive prevalence rate through the use of contraceptives.

The findings will also be used as reference and provide insight to other researchers who might be interested in the area of modern contraceptive especially providers.

1.4 Conceptual Framework



Source: Researcher (2018)

As indicated in the conceptual framework, the study focused on the association between demographic characteristics, socio-economic and psychological characteristics and health care providers knowledge, attitude and practice of modern contraceptive, the study associated provider's knowledge, attitude and practice with their personal beliefs, values, and experiences, age, marital status, professional qualification. This means that the providers experience, cultural values, religion, myth and their cognitive may influence the level of use of modern contraceptive among health care providers.

1.5 Research Questions

1. What is the level of knowledge on modern contraceptive among health care providers in public and private facility in Geita District council?

2. What is the attitude towards modern contraceptive among health care providers in public and private facility in Geita District council?

3. What is the practice of modern contraceptive among health care providers in public and private facility in Geita District council?

1.6 Study Objective

1.6.1 Broad objectives

The broad objective of this study was to assess the knowledge, attitude and practices of modern contraception's among private and Public Health care providers in Geita district Council.

1.6.2 Specific Objectives

1. To assess the level of knowledge of modern contraceptives among private and public health care providers in Geita district council

2. To assess the attitude on modern contraceptives among private and public health care providers in Geita district council

3. To assess the practices of modern contraception's among private and public health care providers in Geita district council

CHAPTER TWO

2.1 Introduction

The objective of this chapter was to review some relevant literatures relating to the topic of the study. The purpose of the review was to develop a good understanding and insight into relevant previous research and the trends that have emerged in order to fill the knowledge gap identified. The review further, focused on assessing the knowledge, attitude and practices of modern contraceptives among health care providers in public and private facilities. The section drawn some examples from Tanzania and other part of the world.

2.2 Providers Knowledge and Attitude towards Modern Contraceptives

According to Mbando, et al., (2011) knowledge about contraceptives is very significant in order to use the appropriate method of spacing between children. Health care providers are the key persons who can provide awareness and can guide for better choices among contraceptive to the general population, it is important to know the preferred method of practices of contraceptives among health care providers because they are the health educators. In most of the studies it was found that education is the prime influencing factor. It may have a direct influence on fertility, since education affects the attitudinal and behavioral patterns of the individuals.

Several studies have examined knowledge, awareness attitude and practice towards the use of contraceptives method and came up with different viewpoints. Among them include the following. A study by Shaki revealed that 59% of the health care providers were aware of emergency contraceptives. This is low as they are the ones who are supposed to provide this service tothose who need it, which also might reflects the underutilization of contraception (Shaki, 2010).

Another study indicated that both public and private providers are ignorant about the effect and mechanism of action, side effects, indications and effectiveness of emergency contraceptive pills. Most believe that repeated use poses a health risk although the available evidence indicates that repeated use is safe (Sychareun, Phongsavan, Hansana, & Phengsavanh, 2010). On the same study showed that most providers have ambivalent attitudes. They agree that emergency contraceptive should be introduced in the public

sector, but they want to limit its use to married couples. Both public and private providers also expressed concern that increased access to the method could encourage unprotected sexual intercourse or reduce routine contraceptive use. In general awareness about emergency contraceptive pills (ECP) among providers and policy makers is low, and knowledge about ECP among health providers is inadequate.

Likewise, a study conducted by Alam *et al.,* 2015 revealed that the attitude of Doctors is positive towards EC but their knowledge and practice are poor. There is misconception that emergency is an abortifacient. Only 30% of the study subjects answered that emergency is not an abortifacient while 29% were unsure. More than half (68%) of the participants felt that emergency contraception was not an appropriate topic to discuss at routine consultation probably because of religious reason and therefore, seldom inform or prescribe emergency contraception. This finding has significant implications on; first, those women who need to use these methods may not be able to obtain adequate information from family physicians. Second, they may not provide adequate information during counselling.(Alam *et al.,* 2015)

In the similar manner, another study has showed that 99% of the providers were familiar with the emergency contraception but only one third of them had a good knowledge of these methods in details. About half of the providers believed that awareness about emergency contraception methods will reduce the use of condoms and inevitably, will increase the rates of unprotected sex and the sexually transmitted diseases by seeking access to these methods (Mohammad-alizadeh-charandabi, et al., 2011).

Another study suggested that participants had overall positive attitude toward emergency contraceptives (EC,) but lacked correct knowledge. Knowledge about effectiveness, mechanism, and specific information regarding protection from sexual transmitted diseases/respiratory track infections (STDs/RTIs) was lacking (Dogra & Wankhede, 2017).

Moreover, a study conducted by Ahanonu (2014) showed that 57.5% of the respondents reported that providing contraceptives to unmarried women, adolescent promote sexual promiscuity. And 42.7% reported that unmarried adolescents should not be provided with contraceptives because the culture does not support premarital sex and about half of all the respondents (51.7%) responded that it is better to tell sexually active unmarried

adolescents to abstain from sex when they ask for contraceptives rather than give them contraceptives when they request for it. This perception is not in line with the realities of adolescent sexual activities as reflected in the high rates of STI's and unplanned pregnancies reported among this group.

A study on provider's perspective on provision of contraceptives, most said that they were not prepared to provide contraceptives to young people, more than third said that they would not provide contraceptives to those less than 18 years of age, unmarried, still in school and those without children, they believed that if young women used contraceptives early in life, they could have long term side effects such as infertility. Some providers revealed that as parents, it was impossible to give contraceptives to young people because it was morally unacceptable. The study indicates that the behavior of providers might influence young peoples' use or non-use of contraceptives. Many providers required parental or spousal consent and did not respect young people's choices, thereby denying them access to contraceptives also showed that contraceptive service providers imposed non-evidence-based age restrictions for certain contraceptive methods (Nalwadda et al., 2011).

Providers were more competent in provision of pills, progestin only injections and condoms, however on average providers did not feel competent enough to provide IUDs, implants and emergency contraceptives. Also, this study showed that 45% of providers lacked knowledge about contraceptives. 40% of providers had negative attitude due to fears, myths, and health and safety concerns related to certain contraceptive methods (Nalwadda et al., 2011).

A study conducted by Dehlendorf *et al,* (2015) also showed that, there is a considerable amount of misinformation about contraception among providers, high level of disagreement among practicing providers about the risk among users of the contraceptive and this can dramatically affect providers' ability to provide quality contraceptive care to their patients, which could have an impact on their ability to prevent unintended pregnancies.

A study on Provider's perspective on provision of family planning to HIV positive individuals found that the providers interviewed had extremely limited knowledge and uncertainty about the safety of contraceptive methods, hormonal and non-hormonal, and whether or not to recommend contraception to people living with HIV (Newmann et al., 2013).

Another study showed that knowledge of the practical aspects of insertion were lacking among all of the providers, largely due to lack of experience. And due this this discomfort with IUD insertion impacted the providers' ability to effectively counsel women regarding IUD as a contraceptive option (Robinson & Owusu-ansah, 2016).

2.3 Practice of Providers towards Modern Contraceptives

Provision of contraceptives:

A study conducted by Calcagno et al., (2016) showed that 58% of providers impose minimum age restrictions on different methods, many refused to provide injectable to women younger than 20 years. 41% of Providers under study reported they would not offer one or more methods to nulliparous women and in the same study more than one in four providers reported they would not offer the injectable to women without at least one child. In the same study providers at the private facilities were significantly more likely to impose barriers across all methods types, and those without in service training on family planning provision had a significantly higher prevalence of imposing parity, marital, and consent barriers across most methods.

Another study showed that most of clinicians interviewed were willing to offer IUC to a 35 – year old multiparous patient who is married, that means they do not provide contraceptives to any person who need it, and according to the study, clinicians show that the number of clinicians who will offer IUC declines dramatically with patients age, parity and non-married status, only 19% would offer IUC to 17 year old who is not married and has never been pregnant, this show the misconceptions about associations between IUC, PID an elevated risk of pelvic inflammatory disease and infertility continue exist (Madden et al., 2011). In the same study 18% of respondents reported that they "always" discussed IUC with their patients, 76% reported that they discussed IUC most or some of the time. The majority of providers (67.9%) reported they had counseled more than 50 patients

about IUC in the past year, and almost 66% reported that they had inserted greater than 10 IUCs in the past year. Less than 2% reported not counseling patients about intrauterine contraception within the past year and 12.4% reported not inserting IUC. Most respondents (79.6%) reported that they did not refer patients for IUC insertion; while 17.6% reported that they had referred 1 or more patients for IUC insertion (Madden et al., 2011).

A study conducted by Nalwadda et al., (2011) on constraints and prospects for contraceptive service provision to young people revealed that Some providers (14%) revealed that as parents, it was impossible to give contraceptives to young people because it was morally unacceptable. More than a fifth of providers said that they did not feel positive about giving contraceptives to young people but considered that they had no choice. In addition, some providers felt too busy to attend to young people with contraceptive needs since they also had to deal with immunization and other services. According to the study only a quarter of providers were comfortable giving contraceptives to sexually active young people, the other three quarters believed that contraceptives should not be provided to young people.

A study onevidence based IUD practice among Family Physicians and Obstetrician – Gynecologists also found that most physicians providing contraceptive care were not offering methods with top-tier effectiveness and according to the study, the low provision of contraceptives with top-tier effectiveness contributes to high unintended pregnancy, the study showed that for common conditions such as obesity, family physicians were unnecessarily restrictive about UIC use and fewer than half of clinicians considered nulliparous women, adolescents or history of PID as UIC candidates. The study suggests a need for improved medical education to ensure that women are not restricted from a full range of effective methods. This could help to build and maintain insertion skills and updated knowledge (Monahan, Steinberg, & Mulvey, 2010).

A study done by Nalwadda et al., (2011) on constraints and prospects for contraceptive service provision to young people showed that the providers rated their own level of competence as rather low, particularly regarding comprehensive counseling, management of contraceptive side effects, provision of emergency contraception, fertility awareness and barrier methods, and long-acting methods such as IUDs and implants.

In the same study, 45% providers mentioned lack of knowledge about contraceptive, negative provider attitudes due to fears, myths, and health and safety concerns related to certain contraceptive methods (40%), and providers' denial or restrictions to provide all or some methods to young people (11%). Providers mentioned, for example, the risk that contraceptives would cause infertility (Nalwadda et al., 2011).

They also mentioned structural factors as poor service quality, long waiting hours (32%), a limited number of qualified personnel, and high staff turnover (32%), as well as policy restrictions (17%). Constraints on funding for community sensitization, outreach, and support supervision were also considered barriers (34%) (Nalwadda et al., 2011).

Use of contraceptives:

A study conducted in Nigeria by Omishakin (2015) showed that more than half of the health care providers participated in the study use family planning themselves. This could be due to the fact that a reasonable number of them have heard about family planning though the knowledge might not be in-depth. 34.3% of the respondents that practiced family planning used intrauterine contraceptive device, 8.6% used barrier method, 28.5% used injectable contraceptives, 2.9% combined natural and behavioral methods, 17.1% used oral contraceptive pills and 2.9% used withdrawal method. (Omishakin, 2015)

The same study by (Omishakin, 2015) showed that, cultural beliefs, religious beliefs, contraceptive failure and ignorance were identified as factors that negatively affect the practice offamily planning (Omishakin, 2015)

Another study conducted in Kaduna state, Nigeria among among Community Health Extension found that 115 (74.7%) have used at least one method and this was more among the married women. Most common used method were injectable contraceptive (57.4%), OCP (47.0%), and IUCD (22.6%), also fifty percent of females were current users. Non-current users were likely to be between the ages of $25-29$ years especially when not married, and $35-39$ years when married. Also, this study found side effects, not being married, not being sexually active and religious beliefs reasons for the non-use of family planning **(**Onwuhafua, et al., 2005).

A study conducted in Kashmir, India among Health care workers found that around three-fifth (60.3%) of respondents were currently practicing a family planning method and around two-fifth (41.8%) of respondents intended to use a family planning method in future. Around two-fifth of respondents were using condoms as a family planning method (Rabbanie et al., 2019).

Other studies from different areas showed the reasons for non-use of contraceptives; husband's disapproval was the main factor for not using any family planning method among married women and attitude of husband was found to be an important factor for contraception use. Religion and culture could be another predictor for contraceptive use. According to Yadav et al. (2015) contraceptive use is likely to be affected by the fundamental cultural and social traits of a society (Robina et al., 2015).

Also, Robina et al., (2015) identified constraints as partner by 54 percent, ill health 35 percent and religion contributed to 28 percent. According to Manzoor, 2013 a choice of contraceptive method can be influenced by the partner choice, self- health, family choice, religion and number of children.

Robina, et al., (2015) have argued that self- health of the women hold them to practice contraceptives followed by the influence of religious practices that is 8.3 and 5.6respectively. A study conducted by Lincoln J, et al. (2018) reveals that barriers to the use of contraceptive use among the participants were linked to religious beliefs as well; similarly, cultural beliefs were a considerable force in demotivating women from using contraceptives.

Overall, several studies done in developing and developed countries have indicated poor knowledge, low awareness of some of contraceptives among health care providers, had negative attitude due to fears, myths, and health and safety concerns related to certain contraceptive methods and showed low provision and utilization rates of these useful way of preventing unwanted pregnancies.

The present study aimed to assess the knowledge, attitude and practice of contraceptive methods among Health care providers in Tanzania to enhance the contraceptive practice in future. The contraceptive prevalence rate (CPR) is defined as the percentage of married women, aged 15-49 years, using modern and traditional methods of contraception

(Mustafa, et al., 2015). Contraceptive prevalence rate of Tanzania is 32% as it shows that the prevalence rate of Tanzania is comparatively less than the neighboring countries that are Uganda and Kenya. There is an immense need to know the awareness, practice and attitude of the providers because they play a key role in health industry. The preferences of health care providers and family planning educators directly influence the information provided to clients, thus swaying women's decisions concerning method adoption.

CHAPTER THREE

3.1 Introduction

In order to find answers for the developed research objective and subsequently research questions raised by this study, this chapter highlights the data collection in this study. The section covers the aspects related to research design, study area and the targeted population, sample size determination and its selection, methods of data collection and method of data analysis.

3.2 Study Design

This was a cross-sectional study involving healthcare providers in public and private facilities in Geita district council. Both quantitative and qualitative methods was employed to collect data from health care providers. The use of mixed method was based on the supposition that the combination of both quantitative and qualitative methods in a study, provide a better understanding of the research problem and question than if only qualitative or quantitative method is used (Creswell, 2012).

3.3 Study Area

This study conducted in Geita district council. Geita region was selected purposely by virtue of being a leading region with lowest Contraceptive Prevalence Rate (CPR) by 13% (TDHS, 2015) Geita District Council was also selected because it had more health facilities (57 facilities) and high population (807, 619 people) than other Geita Districts.

According to the Tanzania national population census of 2012, the council has the population of 807,619 people (National Bureau of Statistics, 2012). The district is bordered to the southeast by Shinyanga Region, to the north and east by Mwanza region, to the northwest by Kagera region to the south by Bukombe district and to the southwest by Chato district.

The distribution of health care facilities in Geita District council shown in the table below, with a total of 57 health facilities including One Government Hospital, health centers and dispensaries.

Table 1: Distribution of Health facilities in Geita District council

Health Facility type	**Government owned**	**Private owned**	**Total**
Hospital	1	0	1
Health Center	4	0	4
Dispensary	45	7	52
Total	**50**	**7**	**57**

3.4 Study Population

The study population was public and private health care providers in Geita District council including Enrolled Nurses, Nurse Midwives, Medical attendant, and Clinicians.

3.5 Sampling Procedure

This was a facility-based study which was conducted in Geita District Council. Geita region was purposefully selected by virtue based on low contraceptive prevalence rate, high percentages of unmet need and high fertility rate. Geita Region has low contraceptive prevalence rate by 13% and unmet need leads by 35% in Lake Zone and Tanzania while the unmet need in Tanzania ranges from low of 10% in the southern zone to a high of 30% in the lake zone. Total fertility rate ranges from low of 3.8 in southern zone and 6.4 in Lake Zone, and Geita has 7.1% above national average and according to Tanzania population census of 2012 (National Bureau of Statistics 2012) Total Fertility Rate (TFR) ranges from 8.5 for Geita to 3.6 for Dar es Salaam. Geita district council was selected based on the number of facilities and population. It had high population and number of facilities than other five districts in Geita region.

3.5.1 Selection of health facilities and Providers

Stratified random sampling was used to select health facilities. Health facilities were stratified into two strata that is private and public and under each stratum, sub stratification was done to obtain Hospital, Health centres and dispensaries. The list involved public and private health facilities and then were selected randomly through ballot method whereby the name of each facility was written on a piece of paper and placed on box then picked one after another until the required sample obtained.In total, 17 health facilities were

selected (5 private owned facilities and 12 Governement owned facilities). For each selected facility Health care workers were selected randomly from the list obtained at a facility.

Summary of the selection are as presented in the table below:

Name of Region	**Name of District**	**Facility ownership**	**Facility type**	**Number of Health Providers**
Geita Region	Geita District Council	Public	Hospital	30
			Health Centre	23
			Dispensary	67
		Private	Hospital	0
			Health Centre	0
			Dispensary	32
TOTAL				**152**

For qualitative part, participants were recruited using a purposive sampling technique. In-depth interviewees were selected purposely from a specific population of interest to study health care providers who were on duty. This method enabled the researcher to gain an insight into individual assessment and give reasons for his or her individual point of views. The researcher conducted 13 in-depth interviews from 13 health facilities, this was due to saturation point. To allow convenience in participation among Health care Providers some of these IDs were conducted after working hours to be able to get enough time that did not interfere with their works during working hours.

3.6 Sample size

Quantitative

Since we didn't get the estimate of proportional of health care providers with knowledge of modern contraceptive from the literature, we took 50% as the assumed proportional of Health provider with knowledge of modern contraceptive in estimation of sample size,

with 95% confidence level and 0.04% of being precise when estimating the population parameter.

Formula:

$$N=\frac{(Z_{\alpha/2})^2 * P(1-P)/d^2}{1+1/N\,(d^2P(1-P/\,d^2)-1)}$$

Where:

n = minimum required sample size

P =: The prevalence of the condition/ health state (50%)

d =: The degree of being precise in estimating the population parameter (0.04%)

Z =: The statistic corresponding to level of confidence

α= : The probability of making an error when estimating the population parameter, the maximum probability that can be tolerated is 5%

The minimum sample size was **130** health care providers but 8.5% was added in order to maximize the power and cover for expected non-response.

Hence for quantitative part a total number of 152 questionnaires were administered to health care providers in Geita District.

For Qualitative:

The sample size of this study was based on the saturation principle that, data collection stopped when there was saturation of the collected information. The researcher stopped collecting data when new data no longer bring additional insights to the research questions.A total of 13 health care providers from 13 facilities participated in the study.

3.6.1 Variables for quantitative part

Dependent variables

1. Use of contraceptives

Independent variables

1. Health care worker's Profession/Cadre
2. Health care worker's Level of education
3. Training on modern contraceptive

4. Age, Sex of the provider, work experience
5. Partner approval
6. Belief, personal values

3.7 Data Collection Tools

Healthcare providers in private and public health facilities were visited in their facilities and consented to participate in this study, those who were willing to participate were interviewed using structured questions which was administred by principal investigator and other two assistant data collectors (Research assistants) and their response were entered into a questionnaire. A two-days training workshop was conducted before data collection commenced. The data collectors (Research assistants) were oriented to the study objectives, procedures to interact well with study participants and to handle well the study tools. 152 provider's information's was collected using a questionnaire.

In the part of qualitative, data collection tools used were research in-depth interview guide. A research assistant engaged during this study was trained on the respective tools.

The developed IDIs guide was developed based on the research objectives. Principle investigator pre-tested the tools to ensure elaborations and messages remain appropriate and are clearly understood. Tools review helped to regulate length of each IDIs. Few modifications were made on the questions and probing observed as the result of the pre-test.

A total of 13 in-depth interviews were conducted and the number of IDI's decreased depending on the saturation point. The information generated through IDI's were recorded and transcribed verbatim. The IDI's informants was purposively selected basing on experience and age of the respondent inorder to get different insights and perspectives.

3.9 Data Management and Analysis

The collected data were rechecked for completeness and consistency of information on daily basis by Principal investigator.

3.9.1 Quantitative data analysis

The collected data were entered, cleaned and analysedusing Statistical Package for social Sciences (SPSS) program version 20.Descriptive statistics/ cross tabulation was used to determine the description characteristic and level of knowledge, attitude and practice of modern contarceptices among healthcare providers.

The degree of association between the variables was tested by using pearson chi square test. A value of $p>0.05$ at 95% confidence interval was considered statistically significant. Factors associated with the update of contraceptives was determined byregression models while adjusting for potential confounding factors. Binary logistic regression analysis was first conducted to examine the factors associated with the use of contraceptives among healthcare providers.

Knowledge was measured using 12 questions which were designed to test the knowledge of health care workers regarding the FP. For each item/question, a respondent was assigned the value 1 if the answer was correct and 0 otherwise. Variable to measure overall knowledge was computed by summing the scores for all 12 items. Scoring 7 and above (above 50%) was regarded as “knowledgable” and scoring below 7 (below 50%) was regarded as “not knowledgable”.

Attitude of health care providers for FP methods was measured using 12 likert scale items with four levels of measurements (Strongly disagree, Disagree, Agree, Strongly Agree). For positive statements, the codes used were; Strongly disagree=-2, Diagree=-1, Agree=1, Strongly agree=2. For negative statements the coding were in opposite direction such as; Strongly disagree=2, Disagree=1, Agree=-1 and Strongly agree=-2. The overall attitude was computed by summing the scores for all 12 likert scale items. The score of above 0 was regarded as “positive attitude” and that at 0 and below was regarded as “negative attitude”.

Practice of contraceptives was measured using five questions constructed to assess the practical utilization of contraceptive methods. The sought were (i) wheather FP services were being offered, (ii) If the respondent has ever used FP methods, (iii) If the respondent were current using FP methods, (iv) If the respondent is going to use FP methods in the future, and (v) If the respondent would advice people to use FP methods.

3.9.2 Qualitative data analysis

Qualitative analytical approach was employed to interpret qualitative data from which the researcher provided this analytical narrative study report. After data collection, the researcher and researcher assistant listened to the audios and read the field notes and transcripts several times to ensure clarity of the collected data. In each objective, all interesting features of the data from IDIs were coded systematically across the data set.

Six-phase approach thematic analysis by Braun & Clarke (2006) was applied in transcribing the study data. Thematic analysis is a method of identifying, analyzing, and reporting patterns (themes) within data. These are: (i) familiarizing with the data, (ii) generating initial codes (iii) searching for themes (iv) reviewing themes (v) defining and naming themes, and (vi) producing the report.

Step 1: Becoming familiar with the data

In the first step, the researcher familiarized with collected data by reading and reading the transcripts and the interview notes and listening to the recordings several times.

Step 2: Generate Initial Codes

Under second step, data were organized in a more meaningful and systematic manner, open coding were used to develop and modify during coding process. The researcher scrutinized the data in order to identify codes that described the contents of a line or even a paragraph. The researcher coded the chunks of data by using highlighters and inserting comments in the text to identify sections of the data.

Step 3: Search for themes

The third is more about themes searching from the codes that were previously determined from the data. The researcher organized various codes into possible themes by looking for patterns in the coding and categorized them into tentative themes.

Step 4: Reviewing the themes

In the fourth phase, the researcher reviewed the tentative themes by re-reading the entire data set to ascertain whether some possible themes were not really themes or whether other themes required breaking down into further distinct themes. During this step some themes were abandoned, some were modified or subdivided, and new themes were generated.

Step 5: Defining the themes

The researcher identified subthemes which could be defined and labeled. Under this step the researcher considered how each theme could be fitted into the general picture being presented about the data in relation to the research objectives.

Step 6: Writing-up

The final step involved the report writing. Under this phase the researcher described and explained the themes in the form of a dissertation.

3.10 Validity and Reliability

3.10.1 Quantitative

In quantitative, the questionnaire was developed and translated in local language (Swahili) to ensure clear understanding of questions by the interviewer and interviewee. The questionnaire was also pre-tested before actual data collection and corrections was done accordingly. To improve on validity, the structured questionnaire was checked to ensure all variables were included and then checked for consistency and omissions.

3.10.2 Qualitative

Evaluating the quality of research was essential if findings were to be utilised in practice and incorporated into care delivery. In ensuring the dependability and trustworthness of qualitative data the reseracher did the following to ensure dependability and trustworthenss of qualitative data, use of local language, this enabled to obtain data easily since participants were comfortable with the language hence active participation; Pilot study was done where few interviews were conducted with health providers and the responses obtained helped to improve the instruments by adding some of the questions and modifying other questions to avoid ambiguity; also Checks relating to the accuracy of the data was applied on the spot during data collection, and at the end, of the data collection dialogues; respondents were given opportunities to agree or refuse to participate in the interview to ensure that the data collection sessions involved only those who were genuinely willing to take part and prepared to offer data freely; the use of probes to elicit detailed data and iterative questioning so as to reduce contradictions of the information obtained from participants. Informants were also asked to listen audios which they had

participated to validate the information provided, this enabled the respondents to correct and add some information where it was necessary and increase accuracy of data.

Inclusion and Exclusion criteria

Participant's inclusion criteria

- Eligible healthcare providers (i.e. Clinical officers, Enrolled Nurses, Nurse midwives, Medical officers) who are available on the day of data collection.
- Working within Geita district council either in public or private facilities.

Participant's exclusion criteria

- Health care providers with only administrative roles. This means those who do not provide direct patient care.
- Health care providers from the departments of radiology, pharmacy and laboratory personnel. These do not have first encounters with patients as they usually work on prescriptions.
- Intern health providers: clinical officers and nurses who are working under supervision.
- Those who were away during the study period.

3.11 Ethical Considerations

Before data collection, ethical clearance to implement the study was sought from Muhimbili university of Health and Allied Sciences (MUHAS) Institutional Review Board. Also consent to do the study was sought from the local authority within the study area – The office of Regional Administrative Secretary who sent letter to District Executive Director in Geita District Council and then District Medical Officer to approve the principal investigator and research assistants to interview healthcare workers in the facilities. Furthermore, consents was sought from all study participants after explaining about the nature and objectives of the study, benefit and risks of involving in the study. To ensure confidentiality of participants no name was taken or indicated, and all collected information ramained confidential and used for academic purpose only.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter deals with data presentation of the findings on the knowledge, attitude and practice of modern contraceptive among Healthcare providers. Presentation of data in this chapter contains descriptive statistics and the respondents' actual voices. The findings of this study, which based on both qualitative and quantitative data, are presented by using side-by-side comparison method which involve presentation of quantitative results followed by qualitative results then comments describing how quantitative and qualitative confirm or disconfirm. The findings of the study presented in this chapter are in line with the research objectives and questions set in chapter one.

4.2 Demographic Characteristics of the Respondents

A total of 152 healthcare providers from public and private facilities participated in this study. Their age ranged from 19 to 76 years with a median of 27 years. About 27.6%) were below the age of 25, 63.8% were between the age of 25 - 39 years and 8.6% were older adults above the age of 40 years. About half of the participants (50.7%) were married and 49.3% were not married. Almost two-thirds (77%) had certificate while 23% had diploma and degree education. Also, about 75.7% of the respondents were Nurse midwives, 17.8% were Nurse officer and the rest were Assistant Medical officer and Medical Officer. About 43.4%) of the respondents were Catholic, 41.4% were protestant and the rest were Muslim (15.1%).

About 64.5% of the respondents were working from dispensaries, 13.8% were from Health centres and 21.7% were working in Hospital while 73.7% were under Government owned facilities and the rest were from private owned facilities. 42.8% of the respondents had no children, 16.4% had one child, 22.4% had two children and the rest had more than 2 children. Also, about half (50.0) of the respondents had less than 2 years of experience, 36.2 had 2 to 4 years of experience and the rest had more than 4 years.

Table 2: Demographic characteristics of the respondents:

		Frequency	Percent
Age	Below 25	42	27.6
	25-39	97	63.8
	40+	13	8.6
Sex	Male	73	48.0
	Female	79	52.0
Marital status	Married	77	50.7
	Not married	75	49.3
Education level	Certificate	117	77.0
	Diploma+	35	23.0
Professional qualification	Nurse officer	27	17.8
	Nurse midwife	115	75.7
	Other	10	6.6
Religion	Catholic	66	43.4
	Protestant	63	41.4
	Muslim	23	15.1
Health facility	Dispensary	98	64.5
	Health center	21	13.8
	Hospital	33	21.7
Department	Inpatient	46	30.3
	outpatient	90	59.2
	RCH	16	10.5
Facility ownership	Government	112	73.7
	Private	40	26.3
Parity	0	65	42.8
	1	25	16.4
	2	34	22.4
	3+	28	18.4
Working Experience (years)	Less than 2	76	50.0
	2-4	55	36.2
	5+	21	13.8

For qualitative part, a total of 13 Health care providers in the in-depth interviews. 15% were below 25 years of age, 69% were between 25-39 and 15% were above 40 years old. 31% were male and 69% female, 46% were married, 23% had certificate and 77% had diploma and above, 23% were Nurse Officers, 69% Midwives and 8% others, majority

(85%) of the respondents were from dispensaries and the remained percent were from Health centre and Hospital, 15% of the respondents had experience of below 2 years, 54% were between 2-4 years and the rest were above 5 years.

4.3 Knowledgeof Modern Contraceptives among Healthcare Providers

Almost all respondents i.e 151 (99.3%) knew at least one contraceptive method. About (98.7%) of the respondents believed that both man and woman are responsible for contraceptive. Only (7.9%) of the respondents were on opinion that right time for someone to use and to be offered contraceptives is when a client wants it, the rest had other criteria like should be married and should be above 18. More than half (69.1%) affirmed that using both condom and pills is effective. Only 25% of the participants responded correctly that IUCD don't have a higher risk of pelvic inflammatory disease. 32.2% were correct about the right time and effectiveness of emergency contraceptives. 78.9% of the respondents were clear that IUD does not cause infertility, the rest believed that IUD increases the risk of infertility. 82.9% were clear that contraceptive does not cause cancer.

Table 3: Knowledgeof modern contraceptives among Healthcare providers

	Frequency	**Percent**
Knowledge of at least one contraceptive method	151	99.3
Meaning of Modern contraceptive methods	25	16.4
Suitable contraceptive method	9	5.9
Right time for someone to use or to be offered modern contraceptive methods	12	7.9
IUCD has a higher risk of pelvic inflammatory disease	38	25.0
Emergency contraceptive timing	49	32.2
IUCD increases the risk of infertility	120	78.9
Pills leads to weight gain	88	57.9
If side effects of pills switch to another type might help	127	83.6
Pills increases the risk of cervical cancer	126	82.9
Using both condom and pills is effective	105	69.1
Both man and woman should be responsible for contraceptive	150	98.7

4.4 Respondents' awareness of Different Types of Contraceptive Methods

Almost all respondents (99.3%) reported to know modern contraceptive methods. Male condom and oral pills were the most commonly mentioned methods (98.0%) followed by IUCD (96.7%). Implants (95.4%) Injectable (94.7%), Female condom (88.8%) and emergency contraceptive (82.2%) were the least known among the modern methods of contraception.

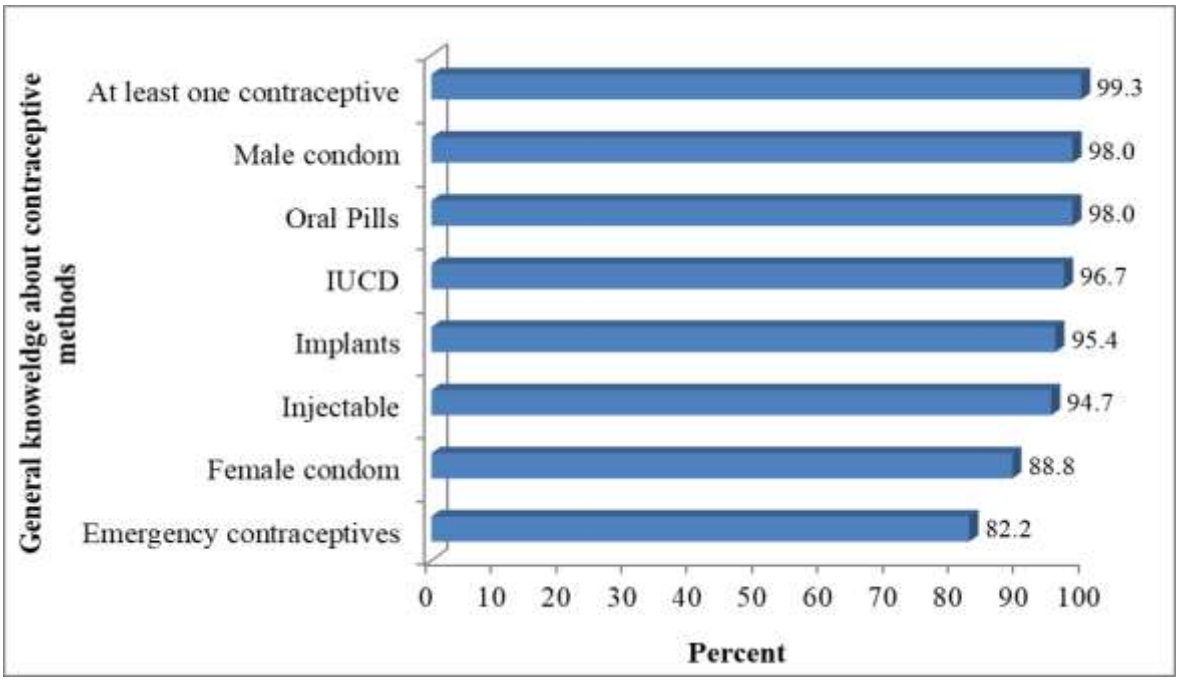


Figure 1: Respondents' awareness of different types of contraceptive methods.

The qualitative results on the awareness of contraceptives methods also support the result above as all interviewed providers were able to mention atleast four and above methods.

4.5 Respondents' Knowledge towards Contraceptives by the Selected Charecteristics

Good knowledge was found among 82.2% of the Healthcare providers. Although it was not significant (P value >0.05,) but knowledge appeared to increase according to age of the respondents <25 had 78.6%, 25 – 39 had 82.5% and 40+ had 95.3%. Those with more than 5 years of experience appeared to be more knowledgeable (95.2%) than those below 5 years 84.2% and 74.5% respetively. Married respondents (85.7%) were more knowledgeable than not married (78.7%). Almost 90.5% of the respondent from Health centres were more knowledgeable then followed by 83.7% from Dispensary and 72.7% from Hospital.

Table 4: Association between knowledge and Selected Variables

		Knowledge		
		Poor	Good	p-value
Overall		27 (17.8%)	125 (82.2%)	
Age years (years)	Below 25	9 (21.4%)	33 (78.6%)	.524
	25-39	17 (17.5%)	80 (82.5%)	
	40+	1 (7.7%)	12 (92.3%)	
Marital status	Married	11 (14.3%)	66 (85.7%)	.256
	Not married	16 (21.3%)	59 (78.7%)	
Education level	Certificate	20 (17.1%)	97 (82.9%)	.693
	Diploma+	7 (20%)	28 (80%)	
Professional qualification	Nurse officer	5 (18.5%)	22 (81.5%)	.973
	Nurse midwife	20 (17.4%)	95 (82.6%)	
	Other	2 (20%)	8 (80%)	
Religion	Catholic	11 (16.7%)	55 (83.3%)	.684
	Protestant	13 (20.6%)	50 (79.4%)	
	Muslim	3 (13%)	20 (87%)	
Parity	0	13 (20%)	52 (80%)	.851
	1	3 (12%)	22 (88%)	
	2	6 (17.6%)	28 (82.4%)	
	3+	5 (17.9%)	23 (82.1%)	
Working experience	Less than 2	12 (15.8%)	64 (84.2%)	.088
	2-4	14 (25.5%)	41 (74.5%)	
	5 and above	1 (4.8%)	20 (95.2%)	
Facility type	Dispensary	16 (16.3%)	82 (83.7%)	.206
	Health center	2 (9.5%)	19 (90.5%)	
	Hospital	9 (27.3%)	24 (72.7%)	
Department/unit:	Inpatient	9 (19.6%)	37 (80.4%)	.061
	outpatient	12 (13.3%)	78 (86.7%)	
	Reproductive and Child health	6 (37.5%)	10 (62.5%)	
Ownership	Government	23 (20.5%)	89 (79.5%)	.135
	Private	4 (10%)	36 (10%)	
Training	Yes	12 (23.5%)	39 (76.5%)	.196
	No	15 (15%)	85 (85%)	
Accessibility of resources	Yes	24 (20.3%)	94 (79.7%)	.136
	No	3 (9.1%)	30 (90.9%)	

The qualitative results on the suitability of contraceptives methods support the result above as most of the interviewed providers mentioned few methods which they thought are suitable but in real sense all the methods are suitable.

> "*The first is IUD and second is implant and may be condom because their side effects are few compared to others"* (Healthcare Provider, Female IDI, 2019).

4.6 Responses to Statements on Attitudes towards Modern Contraceptives

Almost (68.4%) of the respondents were against the statement that it is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives. 39.5% of the respondents reported that use of emergency contraceptive encourages unprotected sexual intercourse. Almost 37.5% of the respondents reported that **c**ontraceptives lead to early sexual activity among adolescent contrary to 62.5% who were against also 69.7% believed that **c**ontraceptives do not make its users promiscuous/infidelity contrary to 30.3% who believes it makes its users promiscuous.

Qualitative results on who should use contraceptive methods show that most of the interviewed healthcare providers were on opinion that should be provided to all who need it even those below 18 years old.

> "*Yes, Now there is friendly services which insist even 12 years old, even if she/he is student, you choose the best method for her/him, called youth friendly services"* (Healthcare Provider, Female IDI, 2019).

Another provider responded that:

> *"Any person who need it without age category, at least from 18 years of age, but there are some of adolescent who come even below 15 years and we serve them"*(Healthcare Provider, Female IDI, 2019)

This also, shows positive attitude towards provision of contraceptives to adolescents.

On the other hand, both quantitative and qualitative results show that family planning is very important and can reduce unwanted pregnancies; almost all respondents (96.7%) were on opinion that, there are more benefits/adavantages of offering modern contraceptive than disadvantages.

Almost all respondents (95.7%) were agreement that if modern contraceptive is effectively provided, unwanted pregnancies will be reduced, majority (87.5%) and (86.2%) of the respondents disagreed with the statement that contraceptives cause infertility and cancer respectively.

Table 5: Responses to statements on attitudes towards modern contraceptives

	Strongly Disagree	Disagree	Agree	Strogly Agree	-ve	+ve
There are more benefits/adavantages of offering modern contraceptive than disadvantages.	2 (1.3%)	3 (2%)	56 (36.8%)	91 (59.9%)	5 (3.3%)	147 (96.7%)
Contraceptives make its users promiscuous/infidelity	9 (5.9%)	97 (63.8%)	33 (21.7%)	13 (8.6%)	46 (30.3%)	106 (69.7%)
Contraceptives lead to early sexual activity among adolescents	4 (2.6%)	91 (59.9%)	43 (28.3%)	14 (9.2%)	57 (37.5%)	95 (62.5%)
Contraceptive cause infertility	4 (2.6%)	129 (84.9%)	12 (7.9%)	7 (4.6%)	19 (12.5%)	133 (87.5%)
Contraceptives cause cancer	2 (1.3%)	129 (84.9%)	17 (11.2%)	4 (2.6%)	21 (13.8%)	131 (86.2%)
If modern contraceptive is effectively provided, unwanted pregnancies will be reduced	0 (0%)	2 (1.3%)	33 (21.7%)	117 (77%)	2 (1.3%)	150 (98.7%)
Contraceptives are harmful because of their side effects	4 (2.6%)	126 (82.9%)	18 (11.8%)	4 (2.6%)	22 (14.5%)	130 (85.5%)

Use of Emergency contraceptive encourage unprotected sexual intercourse	1 (0.7%)	91 (59.9%)	45 (29.6%)	15 (9.9%)	60 (39.5%)	92 (60.5%)
Emergency contraceptive is an abortifacient	4 (2.6%)	131 (86.2%)	13 (8.6%)	4 (2.6%)	17 (11.2%)	135 (88.8%)
Contraceptives is effective in planning families	0 (0%)	0 (0%)	25 (16.4%)	127 (83.6%)	0 (0%)	152 (100%)
Healthcare providers should provide Contraceptive services for both married and unmarried clients at the healthcare facilities	0 (0%)	8 (5.3%)	87 (57.2%)	57 (37.5%)	8 (5.3%)	144 (94.7%)
It is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives	2 (1.3%)	46 (30.3%)	89 (58.6%)	15 (9.9%)	104 (68.4%)	48 (31.6%)

Source: Field data 2019

Table 6: Respondents' attitudes towards contraceptives by the selected characteristics

		Attitude		**p-value**
		Negative attitude	Positive attitude	
Overall		9 (5.9%)	143 (94.1%)	
Age years (years)	Below 25	4 (9.5%)	38 (90.5%)	.446
	25-39	4 (4.1%)	93 (95.9%)	
	40+	1 (7.7%)	12 (92.3%)	
Marital status	Married	3 (3.9%)	74 (96.1%)	.284
	Not married	6 (8%)	69 (92%)	
Education level	Certificate	8 (6.8%)	109 (93.2%)	.381
	Diploma+	1 (2.9%)	34 (97.1%)	
Professional qualification	Nurse officer	1 (3.7%)	26 (96.3%)	.762
	Nurse midwife	7 (6.1%)	108 (93.9%)	
	Other	1 (10%)	9 (90%)	
Religion	Catholic	5 (7.6%)	61 (92.4%)	.749
	Protestant	3 (4.8%)	60 (95.2%)	
	Muslim	1 (4.3%)	22 (95.7%)	
Parity	0	5 (7.7%)	60 (92.3%)	.569
	1	0 (0%)	25 (100%)	
	2	2 (5.9%)	32 (94.1%)	
	3+	2 (7.1%)	26 (92.9%)	
Working experience	Less than 2	5 (6.6%)	71 (93.4%)	.937
	2-4	3 (5.5%)	52 (94.5%)	
	5 and above	1 (4.8%)	20 (95.2%)	
Facility type	Dispensary	4 (4.1%)	94 (95.9%)	.001*
	Health center	5 (23.8%)	16 (76.2%)	
	Hospital	0 (0%)	33 (100%)	
Department/unit:	Inpatient	1 (2.2%)	45 (97.8%)	.423
	outpatient	7 (7.8%)	83 (92.2%)	
	Reproductive and Child health	1 (6.3%)	15 (93.8%)	
Ownership	Government	6 (5.4%)	106 (94.6%)	.622
	Private	3 (7.5%)	37 (92.5%)	
Attended training	Yes	1 (2%)	50 (98%)	.138
	No	8 (8%)	92 (92%)	

*Statistically significant at $p < 0.05$

Majority of the nurse officer (96.3%), nurse-midwives (93.9%), medical officers and assistant officers (90%), had positive attitudes towards modern contraceptive as shown on table 5. Also, majority of the respondents from Hospital (100%), Dispensary (95.9%) and Health centre (76.2%) had positive attitude, however respondents from Health centre seemed to have low percentages of attitude compared with those from Hospital and Dispensary. Almost all respondents from government facilities (94.6%) and private facilities (92.5%) had positive attitude towards modern contraceptives.

4.7 Association between Selected Demographic Characteristics and Respondents' Attitudes towards Modern Contraceptives

The relationship between attitude towards modern contraceptive and selected characteristics is presented above (Table 5). A statistically significant relationship was demonstrated between the facility type of the respondents and their attitude (p=0.01). However, there was no statistically significant relationship between sex, age or marital status, training, department, working experience, education, parity of the respondent (p >0.05).

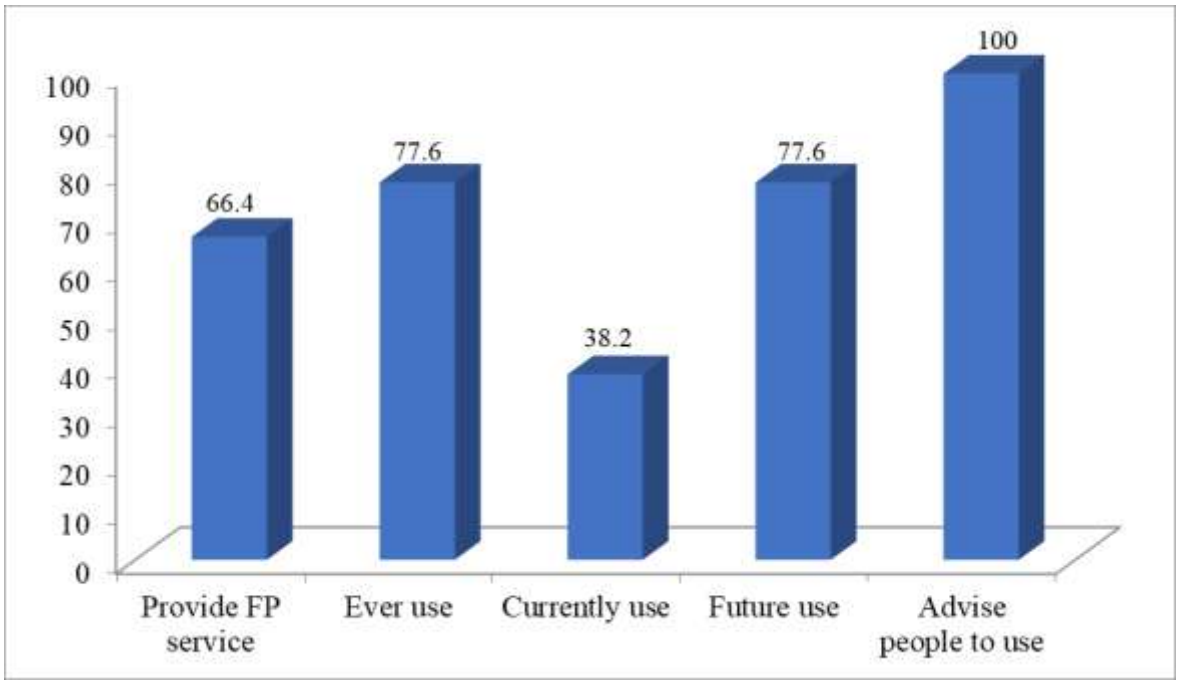


Figure 2: Modern contraceptive provision and use among health care providers

38.2% of the respondents use family planning. 66.4% of the respondent provide modern contraceptives to clients. 77.6% ever used and will also use in future. As shown in figure 2, 100% of the respondents reported that they could recommend use of contraceptive methods to the community.

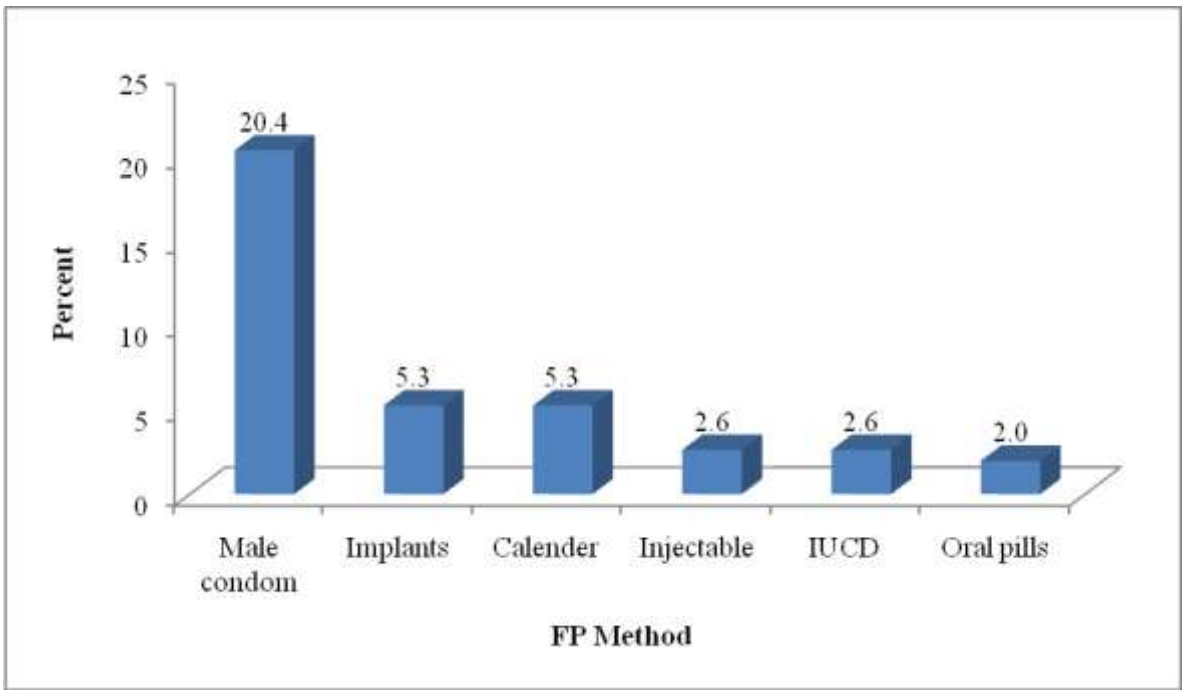


Figure 3: Type of methods used by the respondents

As shown in figure 3 above, 20.4% of the respondents that practiced family planning used male condom, 5.3% used implants, 5.3% used calendar, 2.6% used injectables, 2.6 % used intrauterine contraceptive device, 2.0% used oral pills. On other hand, 64.4% of the respondent reported that they offer family planning to their clients and injectables and oral pills were the most offered methods followed by male condom (61.8%), IUD, Implants, EC (59.9%), female condom (58.6%) and calendar (1.3%).

Although the reported reasons for non-use of contraceptives were diverse, the main reported reason was fear of side-effects, (50.8%), followed by other reasons, (22.0%), Partner approval, (15.3%), Other reasons for non-use of contraceptives are presented in Figure 4.

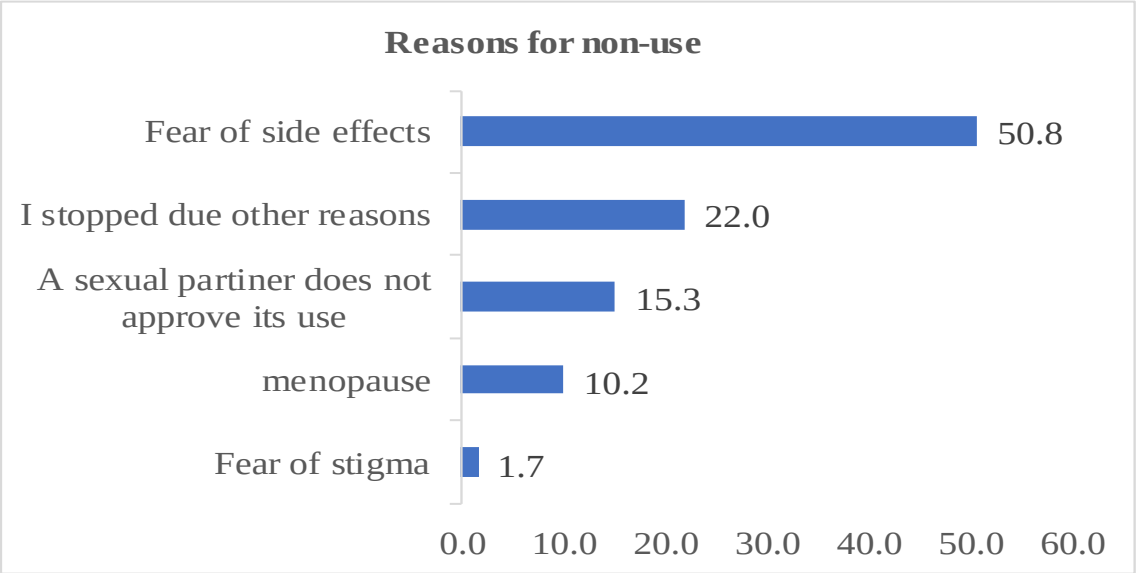


Figure 4: Reasons for not using modern contraceptives

The in-depth interviews provided far-reaching analysis of the dynamics of contraceptive use among health care providers. The reasons for non-use of contraception is arranged and discussed under the following three themes:

Side effects

The fear of side effects of modern contraception was the most reported reason for non-use of modern contraception. Some providers believe that modern contraceptives are harmful to the body. The response of a 29-year-old provider said:

> "*For me it destroys my menstrual cycle, you experience a long cycle and for others they become fat" (Healthcare Provider, Female IDI, 2019).*

Another response from provider, 36 years old respondent said;

> *"If you use injections, you find yourself bleeding than normal and for some they take time to conceive"*(Healthcare Provider, Female IDI, 2019)

Response from provider, 33 years old.

> *"I am not using modern contraceptive methods and they are not good. The challenges associated with it has worried me to use such methods, such as overbleeding resulting to family instability"* (Healthcare providers, IDI, 2019)

Even the response from one user was also concerned on the side effects of some of the methods.

> "I *am using implants because it has few side effects, it improves my health, I do not get any challenge and its hormonals is not the same with those from injection, and its good for any person who is still in reproductive age"*(Healthcare Provider, Female IDI, 2019)

> *"Pills are better, for example, those who are using injections, they say,they experience legs pain, and others if they use implants, they experience nonstop menstruation"*(25 years, healthcare Provider, Female IDI, 2019)

Marital status:

During in-depth interview health care providers revealed that they were not using contraceptives because they are not married. That means marital status is the determinants of using contraceptives. A 25-year-old described her reason for not using modern contraceptive.

> *"I'm not using it yet, right now I can't use it because I am not married, I cannot use other methods than calendar"*(Healthcare Provider, Female IDI, 2019)

Another provider, aged 26-year-old said:

> *"I am not married; I cannot use other methods than calendar"*
>
> (Healthcare Provider, Female IDI, 2019).

Misconceptions to some of contraceptive methods:

Some providers were not using any contraceptive methods because of the misconceptions they have about some of the methods. A 29-year old provider who had two children but and not married corroborated this:

> *"On my side I cannot use IUC because you are supposed to be careful to touch the strings, if you don't it disappears inside"* (Healthcare Provider, Female IDI, 2019).

4.8 Association between Practice and Demographic Characteristics

The results show that practice was associated with marital status, health facility, and department, ownership of health facility, parity, experience, special training and availability of resources at 5% (P-value <0.05) level of significance as shown in the table 7 below:

Table 7: Association between practice and selected variables

		Practice		
		No	**Yes**	**p-value**
Age years (years)	Below 25	20 (47.6%)	22 (52.4%)	.545
	25-39	37 (38.1%)	60 (61.9%)	
	40+	6 (46.2%)	7 (53.8%)	
Sex	Male	30 (41.1%)	43 (58.9%)	.933
	Female	33 (41.8%)	46 (58.2%)	
Marital status	Married	25(32.5%)	52 (67.5%)	**.023**
	Not married	38 (50.7%)	37 (49.3%)	
Education level	Certificate	50 (42.7%)	67 (57.3%)	.556
	Diploma+	13 (37.1%)	22 (62.9%)	
Professional qualification	Nurse officer	9 (33.3%)	18 (66.7%)	.128
	Nurse midwife	47 (40.9%)	68 (59.1%)	
	Other	7 (70%)	3 (30%)	
Religion	Catholic	26 (39.4%)	40 (60.6%)	.582
	Protestant	29 (46%)	34 (54%)	
	Muslim	8 (34.8%)	15 (65.2%)	
Health facility	Dispensary	46 (46.9%)	52 (53.1%)	**.029**
	Health center	10 (47.6%)	11 (52.4%)	
	Hospital	7 (21.2%)	26 (78.8%)	
Department/unit:	Inpatient	13 (28.3%)	33 (71.7%)	**.001**
	outpatient	48 (53.3%)	42 (46.7%)	
	Reproductive and Child health	2 (12.5%)	14 (87.5%)	

		Practice		
		No	**Yes**	**p-value**
Heath facility owenreship	Government	37 (33%)	75 (67%)	**.000**
	Private	26 (65%)	14 (35%)	
Parity	0	36 (55.4%)	29 (44.6%)	**.000**
	1	12 (48%)	13 (52%)	
	2	3 (8.8%)	31 (91.2%)	
	3+	12 (42.9%)	16 (57.1%)	
Experience	Less than 2	42 (55.3%)	34 (44.7%)	**.002**
	2-4	14 (25.5%)	41 (74.5%)	
	5 and above	7 (33.3%)	14 (66.7%)	
Special training	Yes	13 (25.5%)	38 (74.5%)	**.004**
	No	50 (50%)	50 (50%)	
Availability of contrraceptive resources	Yes	42 (35.6%)	76 (64.4%)	**.004**
	No	21 (63.6%)	12 (36.4%)	
Knowledge	Poor	10 (37%)	17 (63%)	.608
	Good	53 (42.4%)	72 (57.6%)	
Attitude	Negative attitude	6 (66.7%)	3 (33.3%)	.113
	Positive attitude	57 (39.9%)	86 (60.1%)	

4.9 Predictors/Factors Associated with Practice

The results of odds ratio (OR) show that those who were married were 2.136 times more likely to practice contraceptive methods as compared to unmarried. Those working in hospital were 3.302 times more likely to practice family planning as compared to those working in Health centre and Dispensary. Those working in RCH unit were 5.693 more likely to practice Family planning compared with those from outpatient and inpatient unit.

At the same time those working in Government owned facilities were 3.764 times more likely to practice family planning compared with those from private facilities. Those with more than 2 children were 3.581 likely to practice than those with one or those who do not

have a child. Those who attended special training on family planning were 2.923 more likely to practice than those who did not and in areas where contraceptive resources available were 3.167 more likely to practice family planning.

However, the adjusted odds ratio (after adding all variables as shown in the table 8 below), only one variable (working in hospital) was found to be significant predictor of practice indicating that working in hospital is the main determinant of family planning practice among health care providers. (P-value=0.036)

Table 8: Predictors/Factors Associated with Practice

Variables	**OR**	**95% C.I.for OR**		**p-value**	**AOR**	**95% C.I.for AOR**		**p-value**
		Lower	Upper			Lower	Upper	
Married	2.136	1.107	4.123	**.024**	.856	.325	2.258	.754
Working in hospital	3.302	1.330	8.193	**.010**	3.055	1.078	8.653	**.036**
RCH department	5.693	1.246	26.022	**.025**	4.014	.788	20.449	.094
Facility owned by government	3.764	1.761	8.047	**.001**	1.347	.350	5.193	.665
Parity at 2 and above	3.581	1.754	7.310	**.000**	2.139	.773	5.921	.143
At least 2 years of experince	3.235	1.645	6.362	**.001**	1.845	.736	4.630	.192
Attended special training on FP	2.923	1.392	6.138	**.005**	1.511	.591	3.858	.389
Availability of resources	3.167	1.418	7.070	**.005**	1.275	.326	4.992	.727

CHAPTER FIVE

5.0 DISCUSSION

A good knowledge of family planning and contraceptive methods with positive attitude can increase contraceptive prevalence rate of a country and can make family planning program more successful and it is essential that the healthcare workers themselves have sound knowledge, favorable attitude, and practice family planning.

This study aimed to assess the knowledge, attitudes and practices of contraceptive methods among health care providers to see if they use themselves and enhance the contraceptive practice in their community in future. Results from both quantitative and qualitative showed that almost all the health care providers were knowledgeable about contraceptive methods.

More than 99.3% of the respondents knew about all the methods of family planning listed in the questionnaire this was almost the same with the study conducted in India and Nigeria which revealed that all respondents had ever heard family planning methods (Rabbanie,2019), Omishakin, 2015), and the commonest source of information about contraceptive methods was through lectures 92.2% from college/university followed by special training on contraceptives which was only 14%. This result is similar from a study conducted in India which revealed the source of information been trainings.

82.2% had a good knowledge on contraceptive. This is good as they can successfully address targeted population and correctly advise them about use of specific contraceptive methods. (Mbando, et al., (2011) in his study about contraceptive choices argued that knowledge about contraceptives is very significant in order to use the appropriate method of spacing between children. Health care providers are the key persons who can provide awareness and can guide for better choices among contraceptive to the general population.

Other study argue that, health care providers armed with adequate information and the right attitude, will be able to dish out every piece of information required about family planning and all its methods to their clients and offer them the opportunity to make informed choices and encourage the practice of family planning. This will eventually

reduce the rate of unplanned pregnancies, improve maternal health, strengthen family bonds and better our society at large (Omishakin, 2015).

About 98.7% of the respondents believed that both man and woman are responsible for contraceptive. Only 7.9% answered correct that the right time for someone to be offered contraceptives is when she/he wants it, some said should be above 18 and married. This findings is similar with a study from Uganda about constraints and prospects for contraceptive service provision to young people which indicated that more than third said that they would not provide contraceptives to those less than 18 years of age, unmarried, still in school and those without children (Nalwadda et al.,2011). This means that they do not know that all sexaully active men and women are eligible to be offered contarceptive.

This study revealed that, approval from parents, guardin or husband is not required. It differs with the study from Uganda which indicated that many providers required parental or spousal consent and did not respect young people's choices, thereby denying them access to contraceptives.The findings from qualitative differ with the above findings as some providers ask their clients if they have an approval from their partner then continue with other process of telling her the cons and prons of each method. This means that, if she does not have an approval provider are more likely to refuse to provide the service to their client.

The qualitative findings on the perspectives of what methods are more used in their locality revealed that, most clients use injection just because they are not easily seen by their partner/husband. This shows that some husband/partner are not approving the use of contraceptive methods.

Only 32.2% of the health care providers were correct about the right time and effectiveness of emergency contraceptives, this finding is consisntent with a study conducted in Dar es Salaam which found only 30.4% of health care providers had adequate knowledge on the timing of emergency contraceptive (Shaki, 2010).

More than 75% of the respondents reported that IUD have a high risk of pelvic inflammatory diseases. This finding is consisted with the study conducted in Latin America on knowledge and attitude of Latin America obstetricians and gynaecologists regarding IUD,where it was found that they were influenced by misconception that IUD

use is linked with the risk of pelvic inflammatory disease (PID) hence did not offer method to clients. (Monahan, 2010). This might reduce the family planning program of encouraging the community to use the highly effective contraceptive methods, including the IUCs.

The health care providers showed different attitudes to modern contraceptive. Overall, 94.1% were positive about contraceptives basing on attitude statements provided. This was also revealed in other studies (Khan, et al., (2017), Ahanonu, (2013), Rabbanie, et al (2019). Those working in hospital (100%) were more likely to have positive attitude than those working in Health centres and dispensaries. This favourable attitude will have a positive impact on improvement of provision of contraceptives to clients.

This study found that more than (68.4%) of the respondents believed that it is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives. Another study from Nigeria revealed the same by 51.7%. (Ahanonu, 2013), this could be because of cultural values and norms which prohibit engaging in sexual activities before married. Another study in Senegal (Sidze, 2014), found that providers in both the public and the private sectors required clients to be at least 18 for most of the contraceptive methods studied, which presents a major barrier to contraceptive access not only for young adolescents, but for most teenagers and some young adults as well. Providing sexually active adolescents with contraceptives will assist them to avoid unwanted pregnancies, STI's, safeguard their lives and future because the fact remain that they engage in sexual intercourse.

Some participants from this study believed it does not make users promiscuous. This is in congruence with the study from Nigeria which reported that 76% of healthcare providers believed it does not make users promiscuous. Omishakin, et al (2015). However, another study on attitudes of Healthcare Providers towards Providing Contraceptives for Unmarried Adolescents from Ibadan, Nigeria revealed that over half of providers believed that it makes them promiscuous. (Ahanonu, 2013). There is no scientific evidence to this belief. All clients should be given contraceptives basing on the scientific criteria set. Providing sexually active adolescents with contraceptives will assist in safeguarding their lives and future because the fact remain that they engage in sexual intercourse

More than half of the respondent believed that contraceptivesdoes not lead to early sexual activity among adolescents. This finding was against with that from Pakistan where majority of healthcare providers were against the FP education to unmarried who are mostly adolescents thinking it may lead to pre-marital sexual relations. (Khan, et al 2017). This variation might be due to the fact that Pakistan is stricklier in cultural issues especially on sexual relations before married compared to this study area.

Almost 94.7% of health providers felt that contraceptive services should be provided for both married and unmarried clients. The possible explanation for this might be that healthcare providers believe that providing equal access for both married clients and unmarried will decrease unwanted pregnancies and increase unmet need. This finding is against another study from Nigeria whereby only 41.5% supported thisstatement and this might be due to cultural factors among the health care providers, this result is also against findings from Pakistan, Nigeria and Uganda where Health care providers were against family planning education and provision to unmarried because they believed it could lead to early sexual relations (Khan, et al 2017, Ahanonu, 2014, Nalwadda, 2011).

This study revealed that more than 66.4% of the respondent offer contraceptive methods to clients, 77.6% ever used and 77.6% will use in future. This result is similar with a study conducted in India which shows that 72.3% of the study participants practiced one or other method of family planning and 41.8% intended to use in future (Rabbane, *et al* 2019). This variation might be due to age of respondents and experience with contraceptive use.

Surprisingly, despite of more than half are providing contraceptive services, current use is only 38.2%. Side effects was among of the identified factors which affect practice. This could be due to the fact that, despite of having good knowledge and positive attitude they still might be afraid of side effects, and other unrevealed facts. This is similar with a study from Uganda which revealed that 40% of providers had negative attitude due to fears, myths, and health and safety concerns related to certain contraceptive methods (Nalwadda et al., 2011). A study conucted in Kashmir India revealed that 60.3% of health care workers were using contraceptives (Rabbane, et al., 2019), this is different from this study and the reason behind might be due to fact that study participants were residing in large

cities and this may help them to have a better access for contraceptives compared with this study.

The findings from the qualitative also shows that the main reason for non-use of contraceptive methods was fear of side effects. The narratives of health care providers in the study setting suggest that fear of modern contraceptive side effects is the main reason for not using modern contraceptive. This finding thus illustrates that empowering providers and women in general with adequate information about the effectiveness of each contraceptive method, mechanism of action and side effects would enable women to make informed choices. Providers should provide clientfocused, quality, Counselling women about contraceptive side effects would be crucial to allay the fears they have about contraceptive side effects.

This study show that 100% of the respondents from quantitative and qualitative were more likely to recommend use of contraceptives to others. This could be due to the fact; they are supposed to recommend, and it is their responsibility to do so as healthcare providers.

In my study male condom was the most used method (20.4%), followed by 5.3% of implants and calendar, 2.6% of IUD and injection and 2% of oral pills. This study shows that short term methods are more used than long term methods. This might also affect the kind of method they provide to their clients. The study is similar with another study conducted in India which showed that condom was the most common contraceptive used (47.6%) (Rabbane, *et al*2019), (Renjhen, et al; 2010)

However, this study is different with a study conducted in Nigeriawhereby out 34.3% of the respondents that practice contraceptive, 28.5% used injectables, although both are short terms methods,

In this study, it is also revealed that there is a significant relationship between respondents' marital status, type of health facility, department, parity, experience, availability of resources and practice of contraceptive methods. However, there is no significant relationship between religion, qualification, sex, age, knowledge, attitude and practice and use of contraceptive methods.

Also, during indepth interview this study, some providers showed that most of clients are using injection methods than other methods because they are not seen by their pertner/husband. This result show that, there are still some men who are against contraceptives and remained to be the role of women only instead of being a shared responsibility between men and women for their family health.

Since one research setting was used for this study, caution should be exercised in generalizing the findings reported here to all health care providers in Geita District or Tanzania as a whole. Also, due to the nature of the cross-sectional study design it was difficult to establish the nature of the association of contraceptive between variables.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Findings from this study indicate that healthcare providers have a good knowledge and positive attitude towards contraceptive methods although did not know the suitable methods for users, right time for someone to be offered contraceptive, some felt ambivalent about providing contraceptives for adolescents. Some felt the provision of contraceptives promotes promiscuity and that contraceptives lead to early sexual activity among adolescents.

This study also indicated that very few healthcare providers are using contraceptive methods and the most used method was male condom and this may cause unwanted pregnancies if not used properly and this might affect the provision of long-term methods to the community.

6.2 Recommendations

Based on observations of our study, it was concluded that knowledge and attitude of family planning methods were directly related to each other. The level of knowledge and attitude toward family planning was relatively high, however the level of family planning utilization was quite low.

Positive provider attitudes are a key element in enhancing contraceptive use among people. It is important that attitudes opposing the use of contraception by sexually active adolescents be reviewed in line with the realities of adolescent sexuality. Sexually active clients should be promoted for those willing to practice it and providers has a big role to play to influence the use of contraceptive. For those who are sexually active and want to use contraceptives, access to contraceptive services should not be denied because it is better to prevent unwanted pregnancies and STIs than to be faced with the consequences that may result.

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APPENDICES

Appendix I: English Questionnaire

KNOWLEDGE, ATTITUDE AND PRACTICE OF MODERN CONTRACEPTIVE AMONG HEALTH CARE PROVIDERS IN GEITA DISTRICT COUNCIL, GEITA

Serial No. [___|___|___]

Name of health facility: _____

Department/unit: 01= in patient [ ] 02= Outpatient (OPD) [ ] 03= Reproductive and Child health [ ]

Please put the appropriate number of a response in the given box.

SN	Questions	Responses	Code	No.
SECTION A: SOCIAL DEMOGRAPHIC INFORMATION				
1.	(a) Sex	1. Male 2. Female	01 02	[ ]
	(b) Marital status	1. Single never married 2. Cohabiting 3. Married 4. Separated 5. Divorced 6. Widowed 7. Others (please specify)	01 02 03 04 05 06 07	[ ]
	(c) How old are you	[_____]		
	(d) How many children do you have? Write the number.	[_____]		
	(e) Expected	[_____]		

	number of children			
2.	What is your religion?	1. Muslim 2. Catholic 3. Protestant 4. Hindu Traditional 5. Others (please specify) ____	01 02 03 04 05	[ ]
3.	(b)How often do you usually attend religious services?	1. Everyday 2. At least once a week 3. At least once a month 4. At least once a year 5. Less than once a year 6. Never	01 02 03 04 05 06	[ ]
4.	Highest level of education	1. Certificate 2. Diploma 3. Advance diploma 4. University degree 5. Masters 6. Other (Please specify)_____	01 02 03 04 05 06	[ ]
5.	What is your professional cadre?	1. Nurse officer 2. Nurse midwife 3. Clinical officer 4. Assistant Medical officer 5. Medical officer 6. Medical specialist 7. Other (please specify)_____	01 02 03 04 05 06 07	[ ]
6.	Type of health facility where you work?	1. Dispensary 2. Health center 3. Hospital 4. Others (please specify)_____	01 02 03 04	[ ]

7	Is this facility owned by	1. Government 2. Private	01 02	 [ ]
8.	How long have you been working in your current job?	[_____]		[ ]
SECTION B: GENERAL KNOWLEDGE ON MODERN CONTRACEPTIVE METHODS				
9.	Do you know about contraceptive methods?	1. Yes 2. No	01 02	[ ]
10.	Which methods do you know?	1. Oral Pills 2. Injectable 3. Intrauterine Contraceptive Device (IUCD) 4. Implants 5. Emergency contraceptives 6. Male Condom 7. Female Condom Others (please specify) _____	01 02 03 04 05 06 07	[ ] [ ] [ ] [ ] [ ] [ ]
11.	Where did you get the knowledge?	1. Colleague 2. Self study 3. Manuals (guidelines) 4. College 5. University 6. Practical experiences 7. Training on modern contraceptives 8. Clinical conferences 9. Mass media 10. Others (specify)_____	Yes No Yes No Yes No Yes No Yes No	01 02 01 02 01 02 01 02 01 02	[ ] [ ] [ ] [ ] [ ]

12.	What does Modern Contraceptive Method in family planning really mean? (circle only one)	1. Child spacing. 2. Poverty alleviation 3. Improving children health 4. Improving reproduction health of a mother 5. Improving a health of a mother and children 6. All of the above 7. I don't know	01 02 03 04 05 06 07	[ ]
13.	(a) Have you ever attended any special training on Modern Contraceptive Methods?	1. Yes 2. No If No go qn:14	01 02	[ ]
	(b) What was the duration of the training?	1. one week 2. two weeks 3. three weeks 4. more than three weeks	01 02 03 04	[ ]
	© When did you attend the training?	1. One year ago 2. Two years ago 3. Three years ago 4. More than three years ago 5. Others specify …….	01 02 03 04	[ ]
	d) Which methods were you trained on?	1. IUD 2. Implants 3. Injectable 4. Oral contraceptive pills 5. Emergency contraceptives 6. Male and Female condoms	01 02 03 04 05 06	[ ] [ ] [ ] [ ] [ ] [ ]
14.	Are contraceptive resources easily available to you?	1.Yes [***continue qn 15***] 2.No [***go to qn 16***]	01 02	[ ]

<table>
<tr><td>15.</td><td>If yes what are the resources place?</td><td>1. Health centres
2. Family planning clinic
3. Hospital
4. Drug store
5. General store
6. Other(Please specify)_____</td><td>01
02
03
04
05
06</td><td>[ ]</td></tr>
<tr><td>16.</td><td>What is the recommended space between each pregnancy: Please check the appropriate one.</td><td>
<table>
<tr><th></th><th>1 year</th><th>1-2 years</th><th>2-3 years</th><th>3-4 years</th><th>4 years or above</th></tr>
<tr><td>After 1st child</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>After 2nd child</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>After 3rd</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>After 4th</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>After 5th</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Any more</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td><td></td><td>[ ]
[ ]
[ ]
[ ]
[ ]</td></tr>
<tr><td>17.</td><td>Which method is suitable for women and girls of any age?</td><td>1. IUD
2. Implants
3. Injectable
4. Oral contraceptive pills
5. Emergency contraceptives
6. Male and Female condoms
7. Other specify_____</td><td></td><td>[ ]
[ ]
[ ]
[ ]
[ ]
[ ]</td></tr>
</table>

18.	When is a right time for someone to use/to be offered Modern Contraceptive Methods?	1. Should be married	Yes No	01 02	[ ]
		2. Any time when a client wants it	Yes No	01 02	[ ]
		3. When the parent, guardian or husband approve it	Yes No	01 02	[ ]
		4. Should be 18 years above	Yes No	01 02	[ ]
		5. Other specify_____			[ ]
19a	Can the partner refuse for his/her partnerto use modern contraceptives?	1. Yes 2. No	01 02	[ ]	
19 b	Can the parent/guardian/ partner refuse his/her Child to use modern contraceptives?	1. Yes 2. No	01 02	[ ]	
20.	A woman who uses intrauterine Contraception has a higher risk of pelvic inflammatory disease than if she were not to use intrauterine Contraception.	1. Yes 2. No 3. Not sure	01 02 03	[ ]	

21.	Emergency contraception is only effective up to 48 hours after intercourse?	1. Yes 2. Not 3. Not sure	01 02 03	[ ]
22.	There is an increased risk of infertility associated with the use of Intrauterine contraception.	1. Yes 2. No 3. Not sure	01 02 03	[ ]
23.	Common side effects of contraceptive pills include weight gain	1. Yes 2. No	01 02	[ ]
24.	If a woman is having side effects of one kind of contraceptive pill, switching to another type might help	1. Yes 2. No	01 02	[ ]
25.	Using the pill increases a woman's risk of cervical cancer	1. Yes 2. No	01 02 03	[ ]
26.	Using both a condom and the pill is considered	1. Yes 2. No	01 02	[ ]

	to be a very effective contraceptive.			
27	Who should be response for contraception?	1- Man 2-Woman 3-Both of them have responsibility 4- Both of them without responsibility		

SECTION C: QUESTIONS ON ATTITUDE TOWARDS MODERN CONTRACEPTIVES METHODS				
28.	There are more benefits/advantages of offering modern contraceptive than disadvantages.	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
29.	Contraceptives make its users promiscuous/infidelity	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
30.	Contraceptives lead to early sexual activity among adolescents	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
31.	Contraceptive cause infertility	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
32.	Contraceptives cause cancer	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]

33.	If modern contraceptive is effectively provided, unwanted pregnancies will be reduced	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
34.	Contraceptives harmful because of their side effects	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
35.	Uses of Emergency contraceptive encourage unprotected sexual intercourse	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
36.	Emergency contraceptive is an abortifacient	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
37.	Contraceptives are actually effective in planning families	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
38.	Healthcare providers should provide Contraceptive services for both married and unmarried clients at the healthcare facilities.	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]
39.	It is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives rather than give them contraceptives when they request for it.	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	01 02 03 04	[ ]

SECTION D: QUESTIONS ON PRACTICE				
40.	Do you provide family planning services to your clients?	1. Yes 2. No If No, please skip to question 43	01 02	
	If yes; What kind of method do you provide to clients?	1. Oral Pills 2. Injectable 3. Intrauterine Contraceptive Device (IUCD) 4. Implants 5. Emergency contraceptives 6. Male Condom 7. Female Condom 8. Others (please specify) ____	01 02 03 04 05 06 07 08	[ ]
41.	Is there any criteria you put in consideration before providing certain modern contraceptive method to a client?	1. Yes 2. No	01 02	[ ]
	If yes_ What are the criteria **If No_ Why?**	_____		[ ]
42.	Have you/your partner ever used any contraceptive methods?	1. Yes 2. No	01 02	[ ]
43.	Which methods have you/your partner ever used?	1. Oral Pills 2. Injectable 3. Intrauterine Contraceptive Device (IUCD) 4. Implants 5. Emergency contraceptives 6. Male Condom 7. Female Condom 8. Others (please specify) - _____	01 02 03 04 05 06 07 08	[ ]

44.	Are you or your partner currently using any contraceptive method?	1. Yes 2. No If **yes**. Go Qn 46,48,49,50 & 51	01 02	[ ]
45(a)	If Yes, Which method?	1. Oral Pills 2. Injectable 3. Intrauterine Contraceptive Device (IUCD) 4. Implants 5. Emergency contraceptives 6. Male Condom 7. Female Condom 8. Others (please specify) - _____	01 02 03 04 05 06 07 08	[ ]
	If No why?	1. I stopped 2. Menopause 3. Fear of stigma 4. Fear of side effects 5. A sexual partner does not approve its use 6. Culture 7. Always not available 8. Religion does not allow 9. Others_____(Please specify	01 02 03 04 05 06 07 08 09	[ ]
45(b)	**Do you think this method is safe?**	1. Yes 2. No	01 02	[ ]
45(c)	**Is this method convenient to use?**	1. Yes 2. No	01 02	[ ]
45(d)	**What is the price?**	1. Free 2. Cheap 3. Expensive	01 02 03	[ ]

45(e)	**Do you use this method regularly?**	1. Yes 2. No	01 02	[ ]
46. 46(a) 46(b)	**Would you use contraceptive in future?** If yes please explain_____ If No please explain _____ Others specify_____	1. Yes 2. No	01 02	[ ]
47. 47(a) 47(b)	Would you advice people to use contraceptives? If yes why? _____ If No why?	1. Yes 2. No _____	01 02	[ ]
47(a).	**Is there any constrain to practice contraceptive method?**	1. Yes 2. No	01 02	
47(b).	If yes specify constrain.	1. Family 2. Religious 3. Culture 4. Self health 5. Partner 6. Side effects	01 02 03 04 05 06	

END OF QUESTIONNAIRE

Appendix II: Swahili Questionnaire

DODOSO

Namba ya dodoso. [___|___|___]

DODOSO LIMEANDALIWA KWAAJILI YA UTAFITI WA KUPIMA UELEWA, MTAZAMO NA VITENDO JUU YA NJIA ZA KISASA ZA UZAZI WA MPANGO MIONGONI MWA WATOA HUDUMA WA AFYA KWENYE VITUO VYA AFYA VYA SERIKALI NA BINAFSI KATIKA WILAYA YA GEITA, MKOANI GEITA"

Jina la kituo: _____

Idara/Kitengo: 01=Wodini [ ] 02= Kliniki ya wagonjwa wa nje [ ] 03= Kitengo cha afya ya mama na mtoto[ ]

Tafadhali jaza nambari ya jibu lako katika kisanduku kilichoko kulia kwako

Na.	**Maswali**	**Majibu**	**Namba**	**Kisanduku**
SECTION A: TAARIFA BINAFSI				
1.	(a) Jinsi	1. Mwanaume 2. Mwanamke	01 02	[ ]
	(b) Hali ya ndoa	1. Haujaolewa 2. Kuishi unyumba 3. Umeolewa 4. Mmetengana 5. Mmepeana talaka 6. Mjane/mgane 7. Nyingine (tafadhari sema)	01 02 03 04 05 06 07	[ ]
	(c) Una umri gani?	[_____]		
	(d) Una watoto wangapi?	[_____]		
	(e) Unategemea kuwa na Watoto wangapi?	[_____]		

2.	Wewe ni muumini wa dini gani?	1. Muislamu 2. Mkatoliki 3. Protestant 4. Hindu 5. Nyinginezo (Tafadharitaja) _____	01 02 03 04 05	[ ]
3.	(b) Ni mara ngapi huwa unajihusisha na shughuli za kidini?	1. Kila siku 2. Angalau mara moja kwa wiki 3. Angalau mara moja kwa mwezi 4. Angalau mara moja kwa mwaka 5. Chini ya mara moja kwa mwaka 6. Sishiriki	01 02 03 04 05 06	[ ]
4.	Kiwango chako cha juu cha elimu	1. Cheti (Certificate) 2. Stashahada (Diploma) 3. Stashahadayajuu(Advance diploma) 4. Shahada ya kwanza(Bachelor degree) 5. Shahada ya uzamili (Masters) 6. Nyingine(Tafadhari taja)_____	01 02 03 04 05 06	[ ]
5.	Kada yako?	1. Afisa muuguzi 2. Muuguzi mkunga 3. Afisa tabibu 4. Afisa tabibu msaidizi 5. Mganga 6. Mganga bingwa 7. Nyingine (Tafadharitaja)_____	01 02 03 04 05 06 07	[ ]

6.	Aina ya kituo unachofanyia kazi?	1. Zahanati 2. Kituo cha afya 3. Hospitali 4. Nyingine (tafadhari taja)_____	01 02 03 04	[ ]
7	Kituo kinamilikiwa na?	1. Serikali 2. Binafsi	01 02	[ ]
8.	Kwa muda gani umekuwa ukifanya kazi hii ya uuguzi/uganga?	[_____]		[ ]
SECTION B: MASWALI KUHUSU UFAHAMU JUU YA NJIA ZA KISASA ZA UZAZI WA MPANGO				
9.	Unajua lolote kuhusu njia za kuzuia ujauzito?	1. Ndiyo 2. Hapana	01 02	[ ]
10.	Njia zipi za kuzuia ujauzito unazozifahamu?(unawezakuchagua jibu Zaidi ya moja)	1. Vidonge 2. Sindano 3. Kitanzi 4. Kipandikizi 5. Njia za dharura 6. Kondomu za kiume 7. Kondomu za kike 8. Nyingine (Tafadhari taja) _____	01 02 03 04 05 06 07 08	[ ] [ ] [ ] [ ] [ ] [ ]
11.	Ulipata wapi taarifa kuhusu njia za kuzuia ujauzito?	1. Kwa rafiki 2. Kujisomea mwenyewe 3. Miongozo 4. College 5. Chuo kikuu 6. Mafunzo kwa vitendo	Ndiyo Hapana Ndiyo Hapana Ndiyo Hapana	01 02 01 02 01 02

		7. Nimehudhuria mafunzo ya njia za uzazi wa mpango 8. Washa za njia za uzazi wa mpango 9. Vyombo vya habari 10. Nyingine (Taja)_____	Ndiyo Hapana Ndiyo Hapana Ndiyo Hapana Ndiyo Hapana	01 02 01 02	[ ] [ ]
12.	Je, njia za kisasa katika uzazi wa mpango zinamaanisha nini? (Chagua jibu moja)	1. Kuacha nafasi baina ya watoto 2. Kuondoa umaskini 3. Kuboresha afya ya mtoto 4. Kuboresha afya ya mama 5. Kuboresha afya ya Mama na Mtoto 6. Majibu yote ni sawa 7. Sijui	01 02 03 04 05 06 07	[ ]	
13.	(a) Usahawahi kuhudhuria mafunzo maalumu ya njia za kisasa za uzazi wa mpango?	1. Ndiyo 2. Hapana Kama jibunihapananendaswalinamba 14	01 02	[ ]	
	(b) Mafunzo yalikuwa ya muda gani??	1. wiki moja 2. wiki mbili 3. wiki tatu 4. zaidiya wiki tatu	01 02 03 04	[ ]	
	© Ulihudhuria lini mafunzo hayo?	1. Mwaka mmoja uliopita 2. Miaka miwili iliyopita 3. Miaka mitatu iliyopita 4. Zaidi ya miaka mitatu iliyopita 5. Nyingine (Taja) …….	01 02 03 04 05	[ ]	
	d) Ulijifunza njia zipi za uzazi wa	1. Kitanzi 2. Vipandikizi	01 02	[ ] [ ]	

	mpango?	3. Sindano 4. Vidonge vya majira 5. Njia za dharura za uzazi wa mpango 6. Kondomu za kiume na kike 7. Nyinginezo(Taja)…….	03 04 05 06 07	[ ] [ ] [ ] [ ] [ ]
14.	Je, taarifa/vifaavinavohusiana na uzazimpangovinapatikanakirahisi?	1. Ndiyo (Endeleaswali 15) 2. Hapana (Nendaswali 16)	01 02	[ ]
15.	Kama ndiyo, vinapatikana wapi?	1. Vituo vya afya 2. Clinic za uzazi wa mpango 3. Hospitali 4. Stoo za dawa 5. Nyingine (Tafadhari taja)_____	01 02 03 04 05	[ ]
16.	Ni muda gani sahihi wa kuachanisha/kusubirikati ya mimba moja na nyingine? Tafadhari chagua jibu moja tu			[ ] [ ] [ ] [ ] [ ]

	Mwakam moja	**Mwaka 1-2**	**Miaka 2-3**	**Miaka 3 -4**	**Miaka4 na kuendelea**
Baadaya mtoto wa kwanza					
Baadaya mtoto wa pili					
Baadaya mtoto wa tatu					
Baadaya mtoto wa nne					

		Baadaya mtoto wa tano								
		Any more								
17.	Ni njia ipi ya uzazi wa mpango ambayo ni salamana nzuri kwa wanawake na wasichana wa rika zote?	1. Kitanzi 2. Kipandikizi 3. Sindano 4. Vidonge 5. Njia za dharula za uzazi wa mpango 6. Kondomu za kiume na kike 7. Nyingine (Taja)_____					01 02 03 04 05 06 07		[ ] [ ] [ ] [ ] [ ] [ ] [ ]	
18.	Ni wakati gani sahihi wa mtukutumia au kupewa njia za kisasa za uzazi wa mpango?	1. Akiwa ameolewa					Ndiyo Hapana		01 02	[ ]
		2. Wakati wowote mtu akihitaji kutumia					Ndiyo Hapana		01 02	[ ]
		3. Wakati mme, mlezi au mzazia kiruhusu					Ndiyo Hapana		01 02	[ ]
		4. Awe na umri wa miaka 18 na kuendelea					Ndiyo Hapana		01 02	[ ]
		5. Nyingine (Taja)_____								[ ]
19(a).	Je, Mwenzi anaweza kukataa/kumzuia mwenzi wake kutumia njia za kisasa za uzazi wa mpango?	1. Ndiyo 2. Hapana					01 02		[ ]	
19(b).	Je, Mzazi au mlezi anaweza kukataa/kumzuia	3. Ndiyo 4. Hapana					01 02		[ ]	

	mtoto wake kutumia njia za kisasa za uzazi wa mpango?			
20.	Mwanamke anayetumia kitanzi yupo kwenye hatari Zaidi ya kupata magonjwa ya PID tofauti na asingetumia?	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
21.	Njia za dharula za uzazi wa mpangoni nzuri/bora tu mpaka masaa 48 baada ya kujamiana ?	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
22.	Kuna hatari zaidi ya kuwa mgumba kwasababu ya matumizi ya kitanzi?	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
23.	Moja ya madhara/maudhi madogo madogo ya vidonge vya uzazi wa mpango ni kuongezeka kwa uzito wa mwili	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
24.	Kama mwanamke anapata madhara au maudhi madogo	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]

	madogo kutokana na matumizi ya vidonge vya aina fulani, kubadili kwenda aina nyingine kutasaidia			
25.	Matumizi ya vidonge yanamuongezea mwanamke hatari Zaidi yakupata kansa ya mlango wa kizazi?	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
26.	Matumizi ya pamoja kati ya kondomu na vidonge ni njia bora zaidi/kuaminika ya uzazi wa mpango.	1. Ndiyo 2. Hapana 3. Sina uhakika	01 02 03	[ ]
27.	Nani anapaswa kuwajibika kwa maswala ya uzazi wa mpango?	1. Mwanaume 2. Mwanamke 3. Wote wawili wanawajibu 4. Wote wawili hawana wajibu	01 02 03 04	[ ]

SECTION C: MASWALI KUHUSU MTAZAMO KUHUSU NJIA ZA KISASA ZA UZAZI WA MPANGO

28.	Njia za uzazi wa mpango zinafaida zaidi kuliko hasara	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
29.	Njia za uzazi wa mpango zinawafanya watu kutokuwa waaminifu au malaya	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
30.	Njia za uzazi wa mpango zinasababisha mabinti kuanza mahusiano yangono mapema	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
31.	Njia za uzazi wa mpango zinasababisha ugumba	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
32.	Njia za uzazi wa mpango zinasababisha kansa	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
33.	Njia za kisasa za uzazi wa mpango zikitumika vizuri zitapunguza mimba zisizotarajiwa	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
34.	Njia za uzazi wa mpangonihatarikwasababuyamadharayake.	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]

35.	Matumizi ya njia za dharula za uzazi wa mpango zinasababisha/zinapelekea kufanya ngono isiyo salama	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
36.	Njia za dharula za uzazi wa mpango zinatoa mimba	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
37.	Njia za uzazi wa mpangoninzurikatikakupangafamilia	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
38.	Watoahuduma wa afya wanapaswa kutoa huduma za uzazi wa mpango kwa wateja walioolewa na ambao hawajaolewa.	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
39.	Ni vizuri kuwashauri mabinti na vijana barehe kuacha ngono badala ya kuwapanjia za uzazi wa mpango wanapoomba njia hizo.	1. Sikubali kabisa 2. Sikubali 3. Nakubali 4. Nakubali kabisa	01 02 03 04	[ ]
40.	Unakubaliana kuwa "Elimu ya Ngono inasababisha/inepelekea tabia zaidi za kufanya/kujihusisha na ngono"	1. Nakubali 2. Sikubali		

SEHEMU D: MASWALI JUU YA UTENDAJI NA MATUMIZI

41.	Unatoahudumaza uzazi wa mpango?	1. Ndiyo 2. Hapana Kama hapana, Nenda swali namba 43	01 02	
42.	Kama jibu ni ndiyo, Ni aina gani ya njia unazotoa?	1. Vidonge 2. Sindano 3. Vitanzi 4. Vipandikizi 5. Njia za dharula za uzazi wa mpango 6. Kondomu za kiume 7. Kondomu za kike 8. Nyingine (Taja) _____	01 02 03 04 05 06 07 08	[ ]
43.	Kuna vigezo vyovyote vinavyowekwa/unavyoweka kabla kutoa njia za kisasa za uzazi wa mpango?	1. Ndiyo 2. Hapana	01 02	[ ]
44.	Kama ndiyo_ Ni vigezovipi_____ _____ Kama hapana_ kwanini?			[ ]
45.	Wewe binafsi au mwenzi wako amewahi/umewahi kutumia njia yoyote ya uzazi wa mpango?	1. Ndiyo 2. Hapana	01 02	[ ]

46.	Ni njia zipi?	1. Vidonge 2. Sindano 3. Vitanzi 4. Vipandikizi 5. Njia za dharula za uzazi wa mpango 6. Kondomu za kiume 7. Kondomu za kike 8. Nyingine (Taja) _____	01 02 03 04 05 06 07 08	[ ]
47.	Wewe binafsi au mwenzi wako anatumia/unatumia njia yoyote ya uzazi wa mpango kwa sasa?	1. Ndiyo 2. Hapana	01 02	[ ]
48(a).	Kama ndiyo, Ni njiazipi?	1. Vidonge 2. Sindano 3. Vitanzi 4. Vipandikizi 5. Njia za dharula za uzazi wa mpango 6. Kondomu za kiume 7. Kondomu za kike 8. Nyingine (Taja) _____	01 02 03 04 05 06 07 08	[ ]
48	Kama hapana, Kwanini?	1. Niliacha kutumia 2. Sina hedhi 3. Naogopa kutengwa 4. Maudhi madogo madogo 5. Mwenzi haruhusu 6. Utamaduni hauruhusu 7. Hazipatikani 8. Dini hairuhusu 9. Nyinginezo(Taja)……..	01 02 03 04 05 06 07 08	[ ]
48(b).	Unadhani njia hiyo ni salama?	1. Ndiyo 2. Hapana	01 02	[ ]

48(c).	Njia hii ni rahisi kuitumia?	1. Ndiyo 2. Hapana	01 02	[ ]
48(d)	Gharama yake ikoje? ?	1. Bure 2. Nafuu 3. Gharama	01 02 03	[ ]
48(e).	Unatumia njia hii mara kwa mara?	1. Ndiyo 2. Hapana	01 02	[ ]
49.	Utakuja kutumia njia za uzazi wa mpango?	1. Ndiyo 2. Hapana 49(a)Kama ndiyo, tafadhari eleza kwanini _____ 49(b)Kama hapana, elezea kwanini_____ Nyinginezo(Taja)	01 02	[ ]
50.	Je, unaweza kuhamashisha wengine watumie njia za uzazi wa mpango?	1. Ndiyo 2. Hapana 50(a)Kama ndiyo, kwanini? _____	01 02	[ ]
		50(b)Kama hapana, kwanini? _____		
51 (a).	Kuna vikwazo vyovyote katika kutumia njia za uzazi wa mpango?	1. Ndiyo 2. Hapana	01 02	
51(b).	Kama ndiyo. Tafadhari taja vikwazo	1. Familia 2 Dini 3. Utamaduni 4. Afya yangu 5. Mwenzi 6. Madhara au mauzi madogo madogo 7. Nyingine…..	01 02 03 04 05 06	

ASANTE KWA USHIRIKIANO WAKO

Appendix III: English In-depth interview guide

Opening discussion

Before we start I would like to remind you that there are no right or wrong answers inthis discussion. We are interested in knowing what you think, so please feel freeto be frank and to share your point of view, regardless of whether you agree or disagreewith what you hear. It is very important that we hear all your opinions.

- ✓ *(Explain the general purpose of the study: To assess the knowledge, attitude and practice of modern contraceptive among Health care providers)*
- ✓ *(Expected duration: 30 to 45minitus)*
- ✓ *(Why the participant's cooperation is important)*
- ✓ *(What will happen with the collected information and how the participant/target group will benefit)*
- ✓ *(Confidentiality)*
- ✓ *(Any questions?)*
- ✓ *(Consent)*
- ✓ *(The moderator turns on the digital recorder and, for the record, notes the date and time, activity to be conducted, the name of the study, and re-affirms that the participant has consented to be interviewed.)*

	(QUESTIONS AND PROBES)
Demographic characteristics	1. Record name of the facility …… 2. Type of health facility where you work? If it is a I. Dispensary II. Health centre III. Hospital 3. Is this facility owned by Government or private? ……. 4. Your cadre …….

	5. Record sex of respondent: …… 6. How old are you? ……. 7. Marital status ……. 8. How many children do you have? …… 9. Expected number of children …… 10. Your education background. …….. 11. For how long you have been working as a health provider? …… 12. What is your religion? …….. And how often do you usually attend religious services ……
Knowledge, attitude, practice and barriers	*I.* What do you understand by Family Planning? *II.* What is modern contraceptive? *III.* What type of contraceptive do you/your partnerwas using/ you were using *IV.* Could you please explain to me the modern contraceptive methods that you know *V.* Tell me where did you get the knowledge about those methods? *VI.* Have you ever attended any special training on Modern Contraceptive Methods? If yes, For how long and what methods included in the training?
	1. Do you use Modern contraceptive methods? *Probe i: if yes, what method and why?* *Probe ii: if no, what methods and why?* 2. Which family planning method do you think is the best

	Modern contraceptive method to use? And why? *Probe i: Who should use/be offered Modern Contraceptive Methods? Probe for explanations? And why?* *Probe ii: Is there any contraceptive methods that you cannot use? If yes and is no And why?* *Probe iii: Can you recommend to other people on the use of modern contraceptive methods? And why?* 3. How do you feel when using modern contraceptives? And why 4. How long have you been using modern contraceptive? What motivated you to use contraceptives? 5. What are the merits of using modern contraceptives 6. What are demerits of using modern contraceptive? *Probe i: Do you know someone who has been affected by modern contraceptive (what happened?)* **7.** What is your opinion on the side effect of contraceptives? 8. In your experiences whom do you think is responsible for making decision on contraceptive use and why? 9. What are the barriers towards the use of modern contraceptives? Probe; religion, culture, etc
Final comments: Modern contraceptive-related issues in the Health care providers)	10. Basing on your experiences, what are the most important things for health stakeholder's especially health care providers to consider when making interventions on contraceptive use? 11. Do you think there is anything that we have not explored on the use of modern contraceptives that you want to add?
Thanks session	Thanks the participant for her/his time and information, ensure him/her the confidentiality of the information given

Appendix IV: Swahili version - In-depth interview guide

Kufungua majadiliano:

Kabla hatujaanza napenda kukukumbusha kwamba katikamajadiliano haya hakuna jibu sahihi walalisilo sahihi. Tunapenda kujua nini unafikiria, hivyo kuwahuru na tuambie mtazamo wako, ni muhimu tusikie maoni yako.

- ✓ *(Elezea malengo ya jumla ya utafiti: Kutathimini ufahamu na mitazamo juu ya matumizi ya njia za uzazi wa mpango katika watoahuduma wa afya)*
- ✓ *(Nategemea kutumia muda kati ya dakika 30 mpaka 45)*
- ✓ *(Kwanini ushirika wa wahusika ni muhimu?)*
- ✓ *(faida za ushiriki)*
- ✓ *(Usiri)*
- ✓ *(swali lolote?)*
- ✓ *(ridhaa)*
- ✓ *(Msaili awashe rekoda kwaajili ya kurekodi, aandike tarehe na muda wa kazi inayofanyika, pia aandike jina la mradi. Hakikisha mshiriki amekubali kushiriki)*

	(Maswali na dodoso)
Taarifa binafsi	1. Andika jina la kituo ……. 2. Idara/Kitengo: Kama Wodini, Kliniki ya wagonjwa wa nje, Kitengo cha afya ya mama na mtoto._____ 3. Aina ya kituo; Kama o Zahanati o Kituo cha afya o Hospitali 4. Kituo hiki kinamilikiwa na serikali au binafsi? …….

	5. Kada ……. 6. Andika jinsi ya mhojiwa: kama ni me au ke……. 7. Una umri gani? ……. 8. Hali ya ndoa ……. 9. Una watoto wangapi? …… 10. Unatarajia kuwa na Watoto wangapi? …… 11. Kiwango chako cha juu cha elimu. …….. 12. Kwa muda gani umekuwa ukifanya kazi hii ya uuguzi/uganga? …… 13. Wewe ni muumini wa dini gani? …….. Ni mara ngapi huwa unajihusisha na shughuli za kidini?
Ufahamu, mtazamo, matumizi na vikwazo	I. Unaelewa nini kuhusu uzazi wa Mpango? II. Nini maana ya uzazi wa mpango wa kisasa? III. Ni aina gani ya uzazi wa mpango inayotumika mara kwa mara katika jamii hii? IV. Nini maana ya uzazi wa mpango wa kisasa? V. Unaweza kunitajia njia za uzazi wa mpango unazozijua? VI. Ulisikiawapikuhusunjiahizo? VII. Umewahi kuhudhuria mafunzo maalumu ya uzazi wa mpango, Kama ndiyo ni kwa muda gani na njia zipi ulizojifunza

	1. Unatumia uzazi wa mpango wa kisasa? *Dodoso i: kama ndiyo, ni njia gani unatumia na kwanini?* *Dodoso ii: kam ahapana, kwanini?* 2. Unafikiri ni njia gani bora Zaidi kutumia na kwanini? *Probe i: Nani anapaswa kutumia njia za uzazi wa mpango? Hoji kwamaelezo zaidi? Na kwanini?* *Dodoso ii: kuna njia yoyote ya uzazi wa mpango wa kisasa usiyoweza kutumia? Na kwanini?* *Dodoso iii:* Je, unaweza kuhamashisha/kupendekeza wengine watumie njia za uzazi wa mpango? 3. Unajisikiaje unavyokuwa unatumia njia za kisasa za uzazi wa mpango?Kwanini? 4. Kwa muda gani umekuwa ukitumia uzazi wa mpango wa kisasa? Na nini kilichokufanya/kilichokuvutia kutumia njia za uzazi wa mpango? 5. Ninif aida za matumizi ya njia za uzazi wa mpango wa kisasa? 6. Nini hasara za matumizi ya njia za uzazi wa mpango wa kisasa? *Dodoso i: Unamjua mtu yoyote ambaye amewahi kuathirika/kudhurika na matumizi ya njia za kisasa za uzazi wa mpango? Nini kilitokea?* 7. Nini maoni yako/mtazamo wako juu ya madhara madogo madogo ya njia za uzazi wa mpango? 8. Kwa uzoefu wako unafikiri nani ana maamuzi ya kutumia uzazi wa mpango wa kisasa katika familia? *Dodoso i: kwanini?* 9. Je, Ni vikwazo vipi katika kutumia njia za uzazi wa mpango? **Dadisi:**Dini? Utamaduni?etc

Maoni ya mwisho kuhusu matumizi ya njia za kisasa za uzazi wa mpango	10. Ni vitu gani muhimu vya kuzingatia miongoni mwa wadau wa afya hasa watoa huduma wa afya wanapohitaji kuielimisha jamii juu ya matumizi ya kisasa ya uzazi wa mpango? 11. Unadhani kuna kitu chochote hatukugusia kuhusiana na matumizi ya uzazi wa mpango ambacho ungependa kukiongeza?
Shukrani	Asante kwa kushiriki, asante kwa muda na taarifa ulizozitoa. Nakuhakikishia kuwa taarifa zako zitabaki kuwa siri

Appendix V: English Consent Form

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS,

INFORMED CONSENT FORM

ID NO: …….

Greetings,

My name is ……working for school of public health and social sciences 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 a research study titled "Knowledge, attitude and practice of modern contraceptives among public and private health care providers in Geita District Council, Geita."

This study seeks to assess level of knowledge, attitude and practice on modern contraceptives. Kindly be honest and true for good results that could lead to better intervention and recommendations in future.

Confidentiality

We will protect and treat information you will provide with high confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any reports/documents that might let someone identify you. Your name will not be linked to research information in any way.

The investigator will take care of information to be collected. However, final results after the analysis will be shared with national stakeholders and I will submit the manuscript for publications in scientific journals.

Right and withdraw alternatives

Your participation is voluntary. You may decline from participation from participation to the study at any time even if you have consented to participate. Your decision to participate or not to participate will not be associated with the right to get services in the facility. There is no penalty for refusing to participate in the study. You will not experience loss of your refusal to participate in this study

Benefits

The results will help us understand the knowledge, attitude and practices of contraceptive use and constraint in practices. The gained experience and results could be utilized to evaluate the need and identify the ways to motivate the women and men to practice the same.

Risks

There is no harm for participating in the study. However, you are free to stop participating as the respondent at any time during the discussion in the event you feel uncomfortable.

Person to contact

If you have any questions about this study you should contact the principal investigator, (Joel Lunyungu Mob: 0756 380 773) of MUHAS, Dar es Salaam.

If you have any questions about your participation rights please contact, Supervisor, Dr. IddaMosha Mob: (0787 122 568) MUHAS Dar Es Salaam.

OR

Dr. Bruno Sunguya: The Chairperson, Directorate of Research and Publications (DRP) at the Muhimbili University of Health and Allied Sciences (MUHAS): Phone: + 255 -022-2152489.

DECLARATION

I have read or being read by the researcher and understood the contents in this form. My questions have been answered. Do you agree?

Participant agreed ☐ Participant disagreed ☐

The above document describing benefits, risks and procedures for research titled "Knowledge, attitude and practice of modern contraceptives among public and private health care providers in Geita District Council, Geita." I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or stamp of the respondent……Date…….

Signature of the researcher ……..……Date……...

Appendix VI: FomuyaRidhaa

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

IDARA YA UTAFITI NA MACHAPISHO

FOMU YA RIDHAA

ID NO:……

Salaam,

Jinalangunaitwa ……. Nafanyakazi na Shule Kuu ya Afya na Umma na Sayansi ya Jamii katika Chuo Kikuu cha Tiba na SayansiyaMuhimbili Jijini Dar es Salaam.

MadhumuniyaUtafiti

Ndugu mhojiwa napenda kukujulisha kuwa somo hili la utafiti lenye jina "**Uelewa, mtazamo na utumiaji au utoaji wa njia za kisasa za uzazi wa mpango miongoni mwa watoahuduma wa afya kwenye vituo vya afya vya serikali na binafsi katika wilaya ya Geita, mkoani Geita"**

Usiri

Sisi tutalinda na kuziweka taarifa zako kwa usiri wa hali ya juu na kadri ya uwezo wetu. Sisi hatutaandika jina lako katika ripoti yoyote/nyaraka ambazo zinaweza kuruhusu mtu kukutambua wewe. Jina lako halitakuwa na mahusiano na habari za utafiti kwanjia yoyote.Watafiti watatunza takwimu na taarifa zitakazokusanywa. Hata hivyo matokeo yautafiti yatawasiliswa kwaajili yauchapishaji katika majarida ya kisayansi.

Haki na uondoajimbadala

Ushiriki wako ni wa hiari. Unaweza ukajiondoa katika ushiriki katika utafiti wakati wowote, wakati wa mahojiano hata kama ulikuwa umekubali kushiriki. Uamuzi wako wa kushiriki hautahusishwa na haki yako kuendelea na matibabukatikakituo. Hakuna adhabu

ya kukataa kushiriki katika utafiti. Hutapata hasara yoyote kama ukikataa kushiriki katika utafiti huu.

Faida:

Utafiti huu utawawezesha kusaidia kujua uelewa, mtazamo na utumiaji au utoaji wa njia za kisasa za uzazi wa mpango miongoni mwa watoahuduma wa afya na kugundua kama kuna matatizo au vikwazo yanayosababisha kutotoa na kutumia njia hizo Pia utafiti huu unaweza kusaidia kutoa mapendekezo ya kusaidia kuboresha utoaji wa huduma za uzazi wa mpango.

Hatari:

Hakuna madharakwakushirikikatikautafiti. Hata hivyo wewe uko huru katika kuacha kushiriki kwa wakati wowote katika mjadala huu katika tukio unalojihisi kuwa na wasiwasi.

Endapo utapata madhara: Hutegemei kupata madhara yoyote kutokana na ushiriki wako katika utafiti.

Nani wa kuwasiliana naye: Kama una maswali kuhusiana na utafiti hut afadhaliwasilianana mtafiti mkuu, Joel Lunyungu (0756 380 773) wa Chuo Kikuu cha Tiba na sayansi Muhimbili,S.L.P 65001,Dar es Salaam.

Kama una swali juu ya haki zako za msingi kama mshiriki, unaweza kuwasiliana na Dr. Idda Mosha (0787 122 568)ambaye ni msimamizi wa utafiti huu.

Au, unaweza pia kumpigia Dr. Bruno Sunguya,mwenyekiti wa seneti, kamatiyatafiti na uchapishaji, S.L.P 65001, Dar es Salaam, Phone: + 255 -022-2152489

Je unakubali

Mshiriki anakubali……Mshiriki hakubali……...

Mimi …… nimesoma maelezo ya fomu hii. Nakubali kushiriki katika utafiti huu.

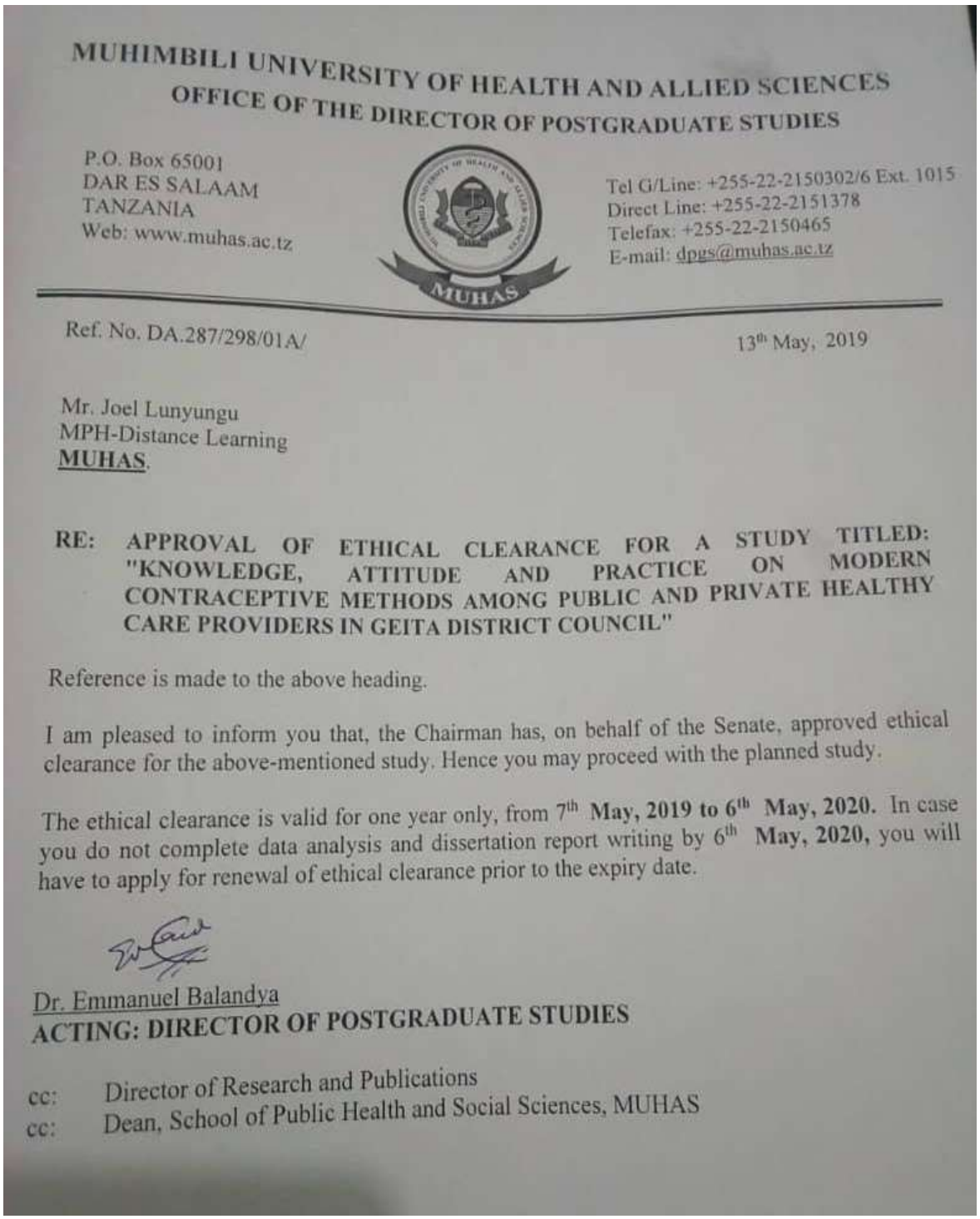
Saini ya mshiriki……

Saini ya Mtafiti……. Tarehe ya kusaini ……

Appendix VII: List Of Facilities in Geita District Facilities

KATORO	ISIMA
KASHISHI	BUKONDO
CHIKOBE	KASOTA
NZERA	LWENZERA
BUKOLI	MHALAMBA
KASEME ZAHANATI	KAKUBILO
NYAKAGWE	KIFUFU
NDELEMA	MWAMITILWA
BUYAGU	NYAKADUHA
CHIGUNGA	IZUMACHELI
NYANSEMBE	NYAMILYANGO
KASANGWA	KATORO TCMC
BUGULULA	NYUMBANI ZAHANATI
FULWE	IHEGA
NKOME	MAGEREZA
SENGA	RUBONDO
KAGU	SISI KWA SISI
KISHINDA	MNEKEZI
LUBANGA	LWANGASA
BUTWA	IBONDO
KATOMA	NYARUGUSU
INYALA	MSASA
KATORO TMRC	BUSANDA
LISABONI	NYAMALIMBE
MNEKEZI	NYALWANJAJA
NYAMWILOLELWA	CHIBINGO

Appendix VIII: Approval of ethical clearance



MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

P.O. Box 65001
DAR ES SALAAM
TANZANIA
Web: www.muhas.ac.tz

Tel G/Line: +255-22-2150302/6 Ext. 1015
Direct Line: +255-22-2151378
Telefax: +255-22-2150465
E-mail: dpgs@muhas.ac.tz

Ref. No. DA.287/298/01A/

13th May, 2019

Mr. Joel Lunyungu
MPH-Distance Learning
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: "KNOWLEDGE, ATTITUDE AND PRACTICE ON MODERN CONTRACEPTIVE METHODS AMONG PUBLIC AND PRIVATE HEALTHY CARE PROVIDERS IN GEITA DISTRICT COUNCIL"

Reference is made to the above heading.

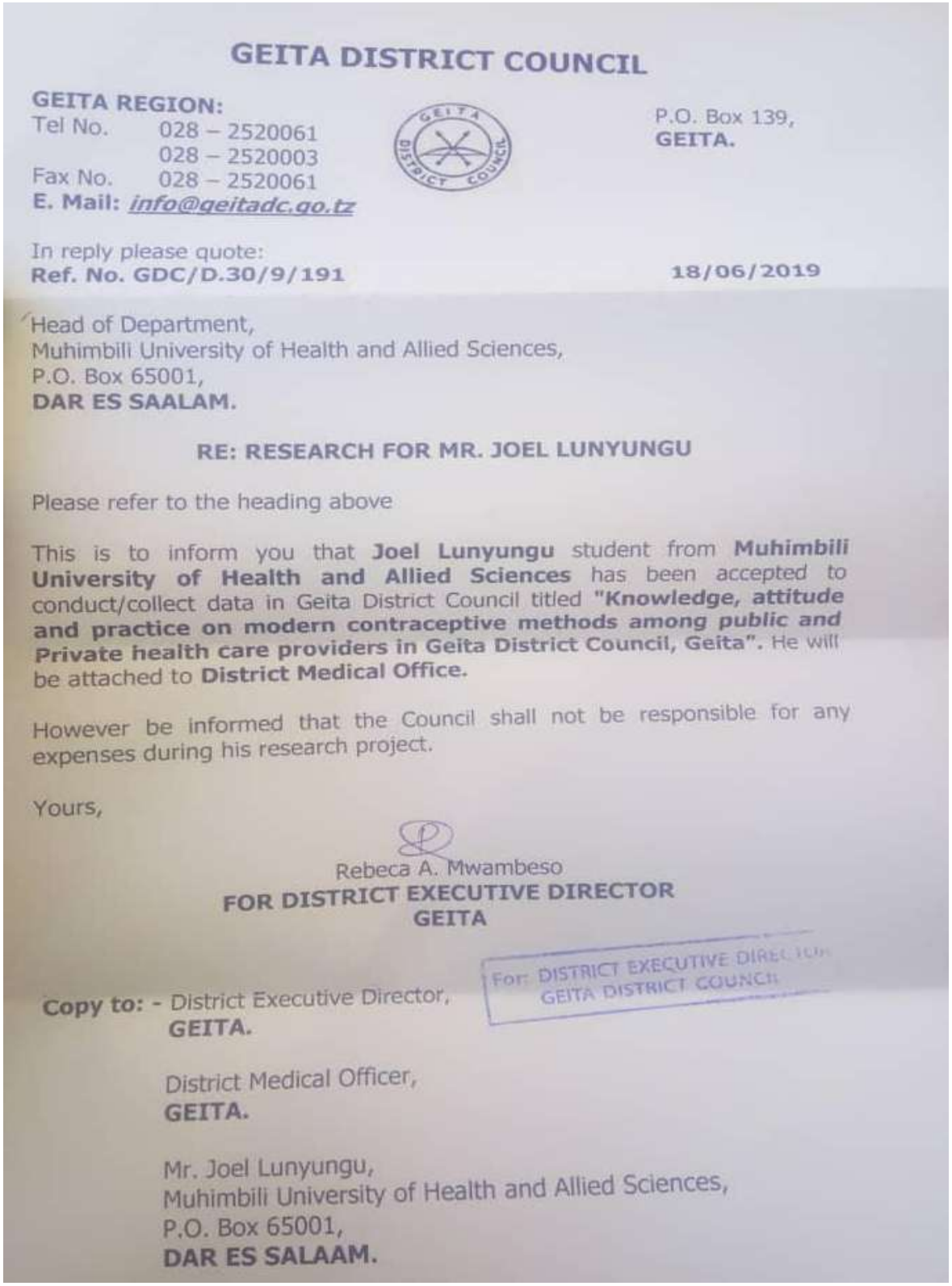
I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from 7th **May, 2019 to 6th May, 2020.** In case you do not complete data analysis and dissertation report writing by 6th **May, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Balandya
ACTING: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences, MUHAS

Appendix IX: Introduction letter from Regional Administrative Secretary



GEITA DISTRICT COUNCIL

GEITA REGION:
Tel No. 028 – 2520061
028 – 2520003
Fax No. 028 – 2520061
E. Mail: info@geitadc.go.tz

P.O. Box 139,
GEITA.

In reply please quote:
Ref. No. GDC/D.30/9/191

18/06/2019

Head of Department,
Muhimbili University of Health and Allied Sciences,
P.O. Box 65001,
DAR ES SAALAM.

RE: RESEARCH FOR MR. JOEL LUNYUNGU

Please refer to the heading above

This is to inform you that **Joel Lunyungu** student from **Muhimbili University of Health and Allied Sciences** has been accepted to conduct/collect data in Geita District Council titled **"Knowledge, attitude and practice on modern contraceptive methods among public and Private health care providers in Geita District Council, Geita".** He will be attached to **District Medical Office.**

However be informed that the Council shall not be responsible for any expenses during his research project.

Yours,

Rebeca A. Mwambeso
FOR DISTRICT EXECUTIVE DIRECTOR
GEITA

For: DISTRICT EXECUTIVE DIRECTOR
GEITA DISTRICT COUNCIL

Copy to: - District Executive Director,
GEITA.

District Medical Officer,
GEITA.

Mr. Joel Lunyungu,
Muhimbili University of Health and Allied Sciences,
P.O. Box 65001,
DAR ES SALAAM.