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Challenges Addressing Unmet Need for Contraception: Voices of Family Planning Service Providers in Rural Tanzania

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Abstract

Provider perspectives have been overlooked in efforts to address the challenges of unmet need for family planning (FP). This qualitative study was undertaken in Tanzania, using 22 key informant interviews and 4 focus group discussions. The research documents perceptions of healthcare managers and providers in a rural district on the barriers to meeting latent demand for contraception. Social-ecological theory is used to interpret the findings, illustrating how service capability is determined by the social, structural and organizational environment. Providers' efforts to address unmet need for FP services are constrained by unstable reproductive preferences, low educational attainment, and misconceptions about contraceptive side effects. Societal and organizational factors – such as gender dynamics, economic conditions, religious and cultural norms, and supply chain bottlenecks, respectively – also contribute to an adverse environment for meeting needs for care. Challenges that healthcare providers face interact and produce an effect which hinders efforts to address unmet need. Interventions to address this are not sufficient unless the supply of services is combined with systems strengthening and social engagement strategies in a way that reflects the multi-layered, social institutional problems. *(Afr. J Reprod Health 2015; 19[4]: 23-30).*

Keywords: Contraception, Unmet need for family planning, Provider perspectives, Tanzania, Quality of care.

Résumé

Les perspectives de fournisseurs ont été négligées dans les efforts pour s'occuper des défis que constituent les besoins non satisfaits de planification familiale (PF). Cette étude qualitative a été menée en Tanzanie, À l'aide de22 entretiens avec des informateurs clés et 4 groupes de discussion à cible. L'étude fait une documentation des perceptions des gestionnaires de soins de santé et des fournisseurs dans un district rural sur les obstacles à la satisfaction de la demande latente pour la contraception. La théorie sociale-écologique est utilisée pour interpréter les résultats, illustrant la façon dont la capacité de service est déterminée par l'environnement social, structurel et organisationnel. Les efforts des fournisseurs pour aborder les besoins non satisfaits en services de PF sont contraints par les préférences de la reproduction instables, le niveau bas d'instruction, et les idées fausses au sujet des effets secondaires des contraceptifs. Les facteurs sociaux et organisationnels - tels que la dynamique entre les sexes, les conditions économiques, les normes religieuses et culturelles, et les goulets d'étranglement de la chaîne d'approvisionnement, respectivement - contribuent également à un environnement défavorable pour répondre aux besoins de soins. Les défis auxquels font face les fournisseurs de soins de santé interagissent et produisent un effet qui entrave les efforts visant à répondre au besoin non satisfait. Les interventions visant à les régler ne sont pas suffisantes à moins que la fourniture de services soit combinée avec le renforcement des systèmes et l'engagement social des stratégies d'une manière qui reflète les problèmes institutionnels à plusieurs couches sociales. *(Afr. J Reprod Health 2015; 19[4]: 23-30).*

Mots-clés: contraception besoins non satisfaits de planification familiale, perspectives pour les fournisseurs, Tanzanie, qualité des soins.

Introduction

The total fertility rate in Tanzania is 5.8, a higher level of fertility that has been sustained since the mid-1990s. Overtime, contraceptive prevalence has remained low and the unmet need for contraception high at 34% and 25% in 2010, respectively[1]. As a consequence, the population growth rate ranks among the highest of any country in the world, at 3%[2].This growth offsets much of the economic and social development gains that have been achieved in recent decades[3]. Moreover, rapid population growth undermines broader health development in the country[4].

Studies in Tanzania have demonstrated that contraceptive use correlates with socio-economic characteristics, education attainment, parity, gender equality and cultural values that promote large

families[5-9]. Research has investigated the effect of supply-side factors on the demand for family planning services, drawing upon client perceptions[10], provider and facility characteristics[11,12]. Perceptions of quality, acceptability and comprehensiveness of reproductive health services influence women's use of family planning[13-15]. It follows that providers are targets for family planning interventions[16]. Nevertheless, providers are nested within the societal, cultural and organizational contexts in which they perform. Findings from Tanzania suggest this affects how family planning providers perform; however, these have drawn upon client perspectives[17]and characteristics of facilities[18-19]. The objective of this study was to fill this gap, adopting the perspectives of health care providers on factors that explain the barriers to addressing demand for contraception in rural Tanzania.

Background and Study Data

Data come from the formative research conducted in Kilombero district, Morogoro Region, as a sub-study of the *Connect Project*, a randomized trial testing the impact of deploying paid cadre of CHW that implement an integrated maternal, newborn and child health (MNCH) service package[20]. The family planning services performed by the *Connect* CHW, known as WAJA (*Wawezeshaji wa Afya ya Jamii* – Community Health Agents) include distribution of condoms, re-filling oral contraceptives to users and providing education and referrals at households. This research was conducted in 2013 to contextualize midline findings that WAJA had no effect on contraceptive utilization after two years of deployment. It employed in-depth interviews (IDI) and focus group discussions (FGD) with key informants.

Methods

We conducted phenomenological research providers' perspective of the challenges of unmet need for contraception. The methodology employed was qualitative, comprising of focus group discussions (FGD) and in depth interviews (IDI) with key informants (KI). KI Interviews last for an hour on average, while focus group discussions last for approximately one and half to two hours each. Interviews and discussions were conducted in Swahili, transcribed and then translated to English. Purposive sampling was used to identify potential key informants to participate in IDI and FGD. These included WAJA, providers at health facilities and members of Council Health Management Team (CHMT) in Kilombero district. Data comes from 22 key informant interviews (two District Medical Officers, two District Reproductive and Child Health Coordinators, 8 WAJA, 2 District WAJA Coordinators, and 4 nurses and 4 clinical officers) and 4 focus group discussions each with 6-8 providers. Half of the IDI participants were male. All IDI respondents were currently employed; with an average of 4.5 years in their current designation. Amongst FGD participants, one-third was male. Participants had on average 5.2 years of work in their designation.

Analytical steps pursued an in-depth, inductive approach for developing theories for the effectiveness of family planning service delivery[21]. Four social scientists reviewed all transcripts. Iterative discussions were ensued, resulting in a code book, which provided a schema for further stages of analysis that explore different themes on the contextual influences on family planning service delivery: societal, health systems, and individual client influences. During coding, inter-coder reliability checks were conducted to ensure agreement on reliability, trends and patterns, inter-relationships within and across themes and between coders. Based on this, theories were generated to explain challenges in family planning service delivery. Matrices were developed arraying these theories against the data by theme. For analysis, coders and scientists used QSR International's NVivo 9 qualitative software package.

To guide the analysis, scientists drew upon 'social ecologicaltheory'[22], which illustrate that individuals are nested within different contextual domains which influence them at different levels in different ways that define individual agency. This emphasizes the multi-layered effects of (i) societal (ii) health system, and (iii) individual client contexts on health care providers' effectiveness.

Ethics

Permission for this study was accorded by the ethical review boards of the Ifakara Health Institute the National Institute for Medical Research's Medical Research Coordinating Committee) and the Internal Review Board (IRB) of Columbia University Medical Center. Research assistants administered formal informed consent procedures and obtained the signature of subjects to confirm willingness to participate. The consent forms clearly stated the participant's right to withdraw from the study at any point during the interviews.

Description of Study Population

In 2011, *Connect* conducted a household survey to capture baseline characteristics of study participants. In the *Connect* study area, the baseline total fertility rate was 5.3, compared the national level of 5.4. Contraceptive prevalence was 37% among women of reproductive age, a level of use that is similar to national estimates provided by the Demographic and Health Survey of 2010, 34%[1]. Unmet need for spacing purposes was estimated at 16% by both surveys, whereas the level of unmet need for limiting was higher in the *Connect* survey, 15%, compared with the DHS national figure of 10%[1].A 2011 health facility assessment in the study area showed that half of the 136 first-line facilities (dispensaries) in study areas lacked Clinical Officers or higher level providers, in marked contrast to national staffing requirements. Instead, over half of the facilities were staffed by Medical Attendants who lack formal health care training. Out of all facilities (136 dispensaries, 8 health centers and 2 hospitals), only 14 dispensaries and 2 health centers had a checklist for method suitability; and only 57 facilities had materials for family planning education, 22 dispensaries were currently out of stock of oral contraceptives and 78% of the dispensaries and one health center were stocked out of DMPA.

Results

Various individual, societal and health systems factors interact and influence providers' ability to provide quality family planning services.

Societal context

Providers identified a range of societal and cultural factors which hinder their work, namely gender and religious norms, and economic and livelihood factors. Providers reported that most women secretly used contraception in response to concerns about spousal opposition or extended familial discord. Such concerns lead to discontinuance, even among women who express a need for contraception. Informed choice, a guiding principle of family planning counselling, loses meaning when primary use criterion is partner permission and an undetectable method.

> *On the other hand, traditionally the power is on man, a man is the one who has a say on the number of children to be borne. He is the one who plan it all, he can decide to have let say ten or seven children depending on his will because he believes that these children may assist him in the future, so he wants to utilize the ovaries of his woman.* (WAJA, IDI)

In order to hide their contraceptive use, providers report that clients prefer to obtain family planning from drug shops, where they can avoid long waits and have more privacy.

> *They go and buy it in shops. Because of [husbands'] harshness their wives decided to do it secretly, and they go to the drug shops because there is no any education and check-ups there, and this led to problems.* (Nurse, IDI)

Without an understanding of proper adherence, clients who obtain services from drug shops administer methods in a way that may reduce effectiveness. For example, they may remove oral contraceptive pills from original packaging and place in another container that it appears like other medicines, which promotes behavior that may lead to method failure. Providers frequently link this challenge with the health system's failure to adequate reach men.

> *With the maternal and child health services men's involvement is not satisfactory may be because the system*

> *didn't include them initially, they have much influence on this since they are the head of the family and bread winner.* (Clinical Officer, FGD).

Providers at all levels remarked on the influence of religious attitudes and leaders. They frequently described how invocation of religion in clinical encounters undermined their ability to provide sound, effective counseling. Instead, providers have to address misconceptions about family planning and the status of contraceptive use vis-à-vis tenets of Christianity and Islam.

> *There are influential people, for example, elders and religious leaders. They normally convince people that condoms contain some microorganisms and contraceptive pills cause cancer. As a result some people in the community stop using family planning methods.* (WAJA, FGD)
>
> *'Some can start using then after they have attended churches and Mosque and they are convinced and stop using. You know everyone has his/her belief and we have a different way of perceiving things.'* (Nurse, FGD)

Frequently, these misconceptions would corroborate with perceptions concerning the prestige of large families. Providers do not feel prepared to address these issues because of gaps in their training and, also, because they do they have time to provide the extensive, individual counseling required to challenge norms.

> *Sukuma tribe who are the majority here, they believe that bearing many children is good because these children will assist you when you get old without considering the wellbeing of upbringing them for example education.* (Nurse, IDI)

Agrarian patterns of the population also challenge provider efforts. Women migrate to farmlands, at great distance from their homesteads, and even farther from facilities. Periods of harvest are frequently linked with more income, celebrations and, consequently, sex. Providers explain this as a prominent cause of contraceptive default and unintended pregnancies.

> *For example, there is a place very far so it not possible to go from there to the health center and most of [harvesters] don't think it's possible for them to stop their activities to go to the health center… When you talk of harvesting we are just going to same issue of income, during this season men have more money therefore they think they have enough money to even marry second wives and bear many children* (Clinical Officer, IDI).

The increased time required for service seeking during the most lucrative season of the year, in turn, increases the opportunity cost of care seeking. Harvesting migrations, for adolescents that often remain home, has a different effect; however, it also makes them vulnerable.

> *Parents are in the farms for almost six months and children don't have food and are tempted to involve themselves in love affairs so as to get money, and they may get pregnant or sexual diseases* (WAJA, IDI).

Health system context

Availability of methods and supplies, staff shortages, skill levels, and constraining regulations were identified as factors adversely influencing service quality. Logistics and commodity security problems were frequently cited, and not only of family planning products, but also shortages in basic equipment and supplies as well as deficient counseling and educational materials.

> *There is a delay in the Government processes on how to procure. Sometimes you can wait and wait for [the Medical Supplies Department] and find that they are out of stock. So you forced to buy locally, and it takes a long time to process. Locally, we do not have the money either, so you have to wait. And then you sometimes find that [facilities] do not have the BP machine or sometimes*

> *no thermometers* (Reproductive and Child Health Coordinator, Council Health Management Team, IDI).

To procure essential supplies locally, districts often use funds which had been allocated for other primary health care activities or resort to imposing fees for services that should be free. But even with these ad hoc measures, the provisions of care were often interrupted by stock outs that extend for several weeks.

> *We reach a stage that all family planning methods are not available for example we have two types of family planning methods here, we have Depo and pills and sometimes we are running out of them at once…..*(Nurse, FGD).

Supply chain bottlenecks intersect with human resource inefficiencies. Providers often reported a mismatch between client needs and staff skills.

> *For example, if there is only one person to provide the service of implants and when she is on leave, you will find no body can replace her and people cannot get this service* (Nurse, IDI).
> *A mother is coming and wants to remove the implant here at the facility because she knows that here we can do it, but you find out that we do not have equipment which can help to remove the implant* (Clinical Officer, FGD).

Providers reported that their facilities were understaffed and felt that they were overloaded with work. Many respondents discuss how they, or others, cannot provide family planning services for lack of training.

> *Shortage of the Medical Attendant that is a challenge, we are not able to attend big number of [clients], also we don't have enough education which make us not to be able to provide women the methods they want* (District Medical Officer, IDI).

WAJA interviews confirmed these accounts. Women prefer these village workers over facility-based providers because of convenient proximity and a more private and intimate connection; yet, WAJA often cannot address women's needs due to policies which they perceive as counterproductive.

> *We are not allowed to inject people even we only assist nurses and doctors, even though injection are most wanted by women* (WAJA, FGD).

> *[WAJA] have been educated with clinical IMCI, they have trained much on family planning but they cannot initiate someone with the method, they only serve those who have already started using, those who have been introduced from health facilities.* (District WAJA Coordinator, IDI).

Individual, client-related context

Providers identified a number of challenges. They believe their clients' encounters and that hinder their efforts, many of which related to the broader societal and organizational environment in which clients are embedded. According to family planning providers, it is challenging for them to counsel clients because clients' ambivalent and fluctuating pregnancy intentions.

> *They do not understand the meaning of the word family planning but when we sit together with them they understand and appreciate that we taught them about it. Then you may plan that you want to give birth after every three or five years but a husband can come and say that he want a child. When we talk to [women] they understand but they still cannot make the decision* (Clinical Officer, FGD).

Even after adopting a method, respondents report that women often overreact to side-effects or change their reproductive intentions altogether.

> *[Women] do not stay with it for long because… we insert [the method] lasting for three years, she won't stay with it. She comes back and says to me "I have come because i bleed a lot of bloods, so please remove it." Also, there are those who in two or three days after inserting, comes and says I want to get married, please remove it* (Nurse, IDI).

Experience of side-effects negatively corroborates with myths about contraceptive use that are propagated by influential persons in clients' communities.

> *When we give education you may find mother has heard that injection destroys eggs and once these are destroyed you will not bear again. From that you start to educate her by telling her that injection cannot destroy eggs, and she says someone told her that pill can lead to stomach inflammation or pills just are going to get lung gestation. You again explain to the woman and she promise to come back after she had made a decision. Then again you come back and it is the discussion again* (Clinical Officer, IDI).

Discussion and Conclusion

Much attention has been aimed at improving aspects of service quality that client's experience[12]. Nevertheless, this analysis suggests that managerial and organizational structural constraints impede the delivery of high-quality services. Social constraints to the implementation of reproductive preferences are compounded by organizational constraints to the effective implementation of services. This is consistent findings from studies elsewhere in sub-Saharan Africa[23] and developed countries[24].

There are opportunities to improve the quality of services; however, the study illustrates how social context, individual factors, and organizational malaise overlap, synergistically, and explain how providers perform. At the organizational level, providers are insufficiently trained to give thorough counseling to women to work through their weak pregnancy intentions. Efforts to build provider capacity will work better if they are coordinated with socio-behavioral interventions to educate women and couples, interventions to sensitize and mobilize communities to redress norms, particularly if activities are targeted on the needs and concerns of men. Systems level interventions to prevent logistical bottlenecks and other supply chain problems are essential to the effective implementation of family planning services. Clients choose methods based on unequal relationships, and where they decide to seek services is based on fears of stigma and retaliation. They often forgo method counseling, mindful that clinics are often out of stock, lack privacy, or deprived of qualified staff. Myths and misunderstandings about methods use are widely influenced by what clients are told by partner's and religious leaders. Given the interaction of problems hampering both demand for contraception and the effective supply of care, there is a need to identify strategies that marshal male governance and religious leadership structures to promote family planning, increase the participation of male partners and strengthen spousal relationships. Socio-behavioral interventions should be coordinated with organizational improvements, nationally and locally. Managers attribute supply-side problem to macro-, national-level factors that are beyond their control, while providers point out mismatches between service availability and provider readiness within facilities in close proximity. The barriers providers attributed to the social milieu cannot be alleviated if the system is not responsive to emergent needs, and, to work, systems interventions should be coordinated at all levels.

Spanning the client-individual, health system and societal contextual domains, concatenating challenges confront providers. Simply training and deploying clinical and community health workers will only partially contribute to a solution. Human resources are essential to effective programming, but if training and worker deployment is pursued in isolation of essential health systems strengthening and social interventions, the capabilities of the work force will be neutralized by factors beyond their control. Interventions to reduce unmet need for family planning in Tanzania can succeed if strategic planning addresses the multi-level, factors that enable providers to achieve their potential.

Note on Study Participants Consent

Detail has been removed from this case description/these case descriptions to ensure anonymity of study participants. The authors, editors and reviewers have seen the detailed information available and are satisfied that the

information backs up the case the authors are making.

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Contribution of Authors

Below are the authors and their contributions to the manuscripts. All authors mentioned approved the manuscripts.
Jitihada Baraka: Collected and analyzed data
Asinath Rusibamayila: Analyzed data
Admirabilis Kalolella: Analyzed data
Colin Baynes: Conceived and designed the study and analyzed data

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