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An Exploratory Study to Determine and Document Factors Affecting IUCD Use in Tanzania

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PRIME II

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ACO	Assistant Clinical Officer
ADMO	Assistant District Medical Officer
ARMO	Assistant Regional Medical Officer
BCS	Basic Clinical Skills
CAFS	Centre for African Family Studies
CBD	Community Based Distribution
CCS	Comprehensive Clinical Skills
CTT	Central Training Team
CO	Clinical Officer
DANIDA	Danish International Development Agency
DFID	Department of International Development
DMCHCo	District Maternal Child Health Coordinator
DMO	District Medical Officer
FHI	Family Health International
FPPS	Family Planning Private Sector
HCW	Health Care Worker
ICS	Integrated Clinical Skills
Intrah	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IRCH	Integrated Reproductive & Child Health
IUCD	Intra-uterine Contraceptive Device
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
MA	Medical Assistant
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aide
MCH/FP	Maternal and Child Health/Family Planning
NO	Nursing Officer
NPP	National Population Policy
OJT	On-the-Job-Training
PID	Pelvic Inflammatory Disease
PRIME	Primary Provider Training and Education in Reproductive Health
RCHU	Reproductive and Child Health Unit
REDSO	Regional Economic Development Services Office

RH	Reproductive Health
RMA	Rural Medical Assistant
RMO	Regional Medical Officer
RM	Registered Midwife
RON	Regional Office Nairobi
RN	Registered Nurse
RTI	Reproductive Tract Infection
RMCHCo	Regional Maternal Child Health Coordinator
SDP	Service Delivery Point
STI	Sexually Transmitted Infection
UMATI	Family Planning Association of Tanzania
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception

Executive Summary

The Reproductive and Child Health Unit (RCHU) of the Ministry of Health, Tanzania, and Intrah/PRIME RON conducted a study from October 1998 to January 1999 to determine and document factors affecting IUCD use in Tanzania.

Background

The IUCD is one of the most commonly used methods, protecting more than 100 million women world wide and ranking only second to voluntary sterilization in popularity. It is also amongst the most effective of contraceptive methods, with a one year theoretical failure rate of less than 0.3% that is on par with appropriately used oral contraceptives (OCs), injectables, implants and even voluntary surgical sterilization. It's use and program effectiveness is even higher than many of these methods, because it possesses higher continuation rates (80% in the first year and up to 25% in the tenth year) requiring no daily motivation to use, and being effective longer (cumulative pregnancy rate of only 1.9% in 12 years of the CuT 380A). Its safety record for well-screened couples ranks second only to that of vasectomy. However, in Tanzania, while OC use increased nearly 60% and Depo Provera use 1,200% — fold between 1991 and 1996, IUCD use stagnated country-wide, rising only modestly in a few regions but dropping to zero in many regions that had previously recorded some use prevalence. Although nearly one third of FP providers have received training in IUCD provision, a recent study showed that only 8% had inserted an IUCD in the previous three months. The factors affecting IUCD use are not well determined or documented.

The general objective of this study was to determine and document factors affecting IUCD use in Tanzania. Study findings would be used to:

- Decide on how to proceed with the IUCD skills training program.
- To advise on strategies to enhance positive factors and remove negative factors that influence IUCD use, so as to increase contraceptive prevalence and ensure choice of methods.

Methodology

This was a cross sectional descriptive study in four regions, situated in four different geographic zones. Two of the regions had the largest increase in IUCD use and two had the largest decrease between 1991 and 1996. Three RH clinics from each of the regions including one urban/government RH clinic, one rural/government and one NGO RH clinic facility were randomly selected. Two parastatal clinics were added because one pre-chosen NGO clinic did not have any clients, bringing the total number of clinics in the survey to 14.

Study Design, Data Sources, Sample Selection and Instruments

The study design was descriptive and allowed for an in-depth analysis of the factors operating at community, policy, organizational, training and workforce levels that were likely to influence utilization of the IUCD.

Data were gathered from a variety of sources. The key information sources identified were potential FP clients in the community, RH clients at clinic facilities, RH providers, RH preceptors and trainers, and RH service supervisors. Observations were also made of clinic

facilities and RH providers' skills in relation to IUCD service provision. More data was extracted from training documents and service supervision reports.

Twelve service delivery points were selected by stratified random sampling. But the NGO clinic identified in Singida did not have clients and was therefore replaced by two parastatal clinics.

The institutions selected are listed in the Appendix 1. The sample sizes reached are shown in Table 1.

Table 1: Sample targeted and achieved

Research tool (questionnaire/FGD guide)	Number fielded	Number entered
Potential clients FGD guide	8	8
RH clients	681	674
RH providers	24	24
RH preceptors/trainers	35	35
RH service supervisors	26	26
Clinic facilities	14	14
Counseling	23	23
Screening	21	21
IUCD insertion skills	19	19
Instruction for IUCD use	17	17
IUCD removal skills	18	18
IUCD follow-up	18	18
TOTAL	**904**	**897**

Several types of instruments were used for data collection. These were focus group discussion guides, interview schedules, checklists and observation schedules.

Summary Results

Potential clients

- Potential clients had poor knowledge of RTIs, and FP, especially of the IUCD. Much of their "knowledge" was based on rumour and misconception.
- Knowledge of RTI prevention was moderate.
- They had fairly positive attitudes to child spacing, rather less so for child limiting, and their partners' views were similar. Potential clients' and their partners' attitude to the IUCD was mostly negative.
- Many potential clients felt the single partner requirement for IUCD use was impractical.
- Access to and availability of FP services was poor to moderate.
- The key factors influencing potential clients in selecting a FP method were method effectiveness, convenience, long duration of action, "secrecy," and freedom from adverse effects.

RH clients

- All RH clients had fairly good knowledge of FP and RTIs. However, their knowledge of the IUCD was very poor and, as for potential clients, largely based on rumour and

misconception. RH clients reported that the IUCD was largely neglected in clinic IEC sessions.

- RH clients and their partners harboured mostly positive attitudes to child spacing and limiting, but their attitude to the IUCD was mostly negative.
- Previous, current and future use of FP was moderate for FP in general but low for the IUCD.
- Only 68.3% had ever heard of the IUCD. Fifty-nine percent of RH clients had ever seen the IUCD and only 39.3% had it discussed by a HCW at their first visit to the clinic. Twenty percent had the IUCD mentioned at today's visit.
- RH clients expressed general satisfaction with the quality of services at the RH facility, but were dissatisfied about several specific aspects such as the number and training of RH providers, access to services, information and counselling, and clinic waiting time.

RH providers

- RH providers had fairly good knowledge of FP, RTIs and the IUCD. However, even they harboured some misunderstandings and misconceptions about the IUCD.
- RH providers' (and their partners') attitude was generally very positive for using FP for child spacing and limiting, but the attitude was much less positive for IUCD use.
- RH providers' previous, current and intended future use of FP was high, but was low for IUCD use.
- Forty-two percent of the RH providers had not received training in IUCD skills, and most of them expressed need for the training. But even those who had previously received training had largely suffered erosion of knowledge, skills and confidence and now needed refresher and update training.
- Many RH providers did not receive training follow-up and supervision after training.
- Most of the providers spurned the opportunity to provide IUCD IEC to potential clients, with fifty percent discussing the IUCD with only half or less the number of clients.
- Eighty five percent of the RH providers were satisfied about supervisory support available to them.
- Fifty percent were moderately satisfied about their work environment, but many cited problems with poor infrastructure, lack of water, and lack of electric power.
- Eighty percent were moderately satisfied about availability of equipment, but most were dissatisfied about availability of expendables and IEC materials.

RH preceptors and trainers

- RH preceptors and trainers had good knowledge of FP, RTIs and IUCD. Some of them — especially designated preceptors — still harboured incorrect knowledge and misconceptions about the IUCD.
- Almost universally, the attitudes of preceptors, trainers and (reportedly) their partners were positive toward FP use; attitudes about IUCD use were much less positive.

- Previous and current use of FP was moderately high but low for the IUCD. Future use was forecast to be low for FP and IUCD (partly because of the respondents' relatively advanced age).
- Most preceptors/trainers were satisfied about their environment during training and work and also about the administrative support available to them. However, they were concerned that most supervisors did not have IUCD-related training.
- Most preceptors/trainers were generally dissatisfied with criteria for trainee selection, and some thought that the time accorded for planning training was too short.
- Preceptors/Trainers admitted that some of their trainees lacked competence or confidence at completion of training. Some trainees also encountered long delays between training and opportunities to apply their new skills and knowledge. Trainee follow-up and supervision was often inadequate.
- While availability of supplies and equipment was usually not a problem during training, it often was a significant obstacle during follow-up at preceptors/trainers workstations.
- Some of the preceptor/trainers had themselves lost competence and confidence in both basic and training skills.

RH supervisors

- Most RH supervisors had knowledge of FP, IUCD and RTIs that was intermediate between that of RH providers and RH clients.
- Their attitude and reportedly their partner's attitude to FP in general was almost universally positive, but was less so for the IUCD.
- Many had received some training related to logistics and/or management, but had received no training related to the IUCD.
- Most were happy about their work environment and administrative support available to them, although they encountered some problems related to availability of transport, finance and availability of expendables materials.

Clinic facilities

- Access and availability of services varied greatly, from very poor to very good. Generally access and availability were better in urban sites compared to rural sites. Urban sites also had better facilities to conduct practicum training on the basis of staffing, available space, client load/flow, availability of water, electric power, waste disposal, available equipment, expendables and IEC materials.
- Service statistics showed differential increases among facilities in use of preferred methods, principally OCs and injectables, while IUCD use was generally low except in the urban SDPs of Arusha and Dar-es-Salaam.

Summary recommendations

- MOH and RCHU should improve and increase IEC activities in the community and at SDPs. The activities should be proactive, concerted, and coordinated and should cover all methods, including IUCD.

- MOH should enhance IEC and preventive measures to combat RTIs for clients and health workers in the community and for RCH providers/trainers.
- MOH and RCH NGOs should increase access to and availability of IUCD services to RH clients, starting with localities of high potential and supportive facilities, staff complement and community acceptance.
- MOH and RCH NGOs should take key factors influencing clients' choice of FP method into consideration during marketing/IEC for the IUCD.
- RCHU and RCH training organisations should revive IUCD training for untrained providers, with improved trainee selection processes. RCHU and RCH training organisations should also provide refresher and update training for providers who have been previously trained, and should consider alternative training options such as formal OJT, self learning or audio and video-assisted distance learning.
- MOH and RCHU should organise adequate trainee follow-up and supervision and an adequate support system, including IEC activities and strategies to enhance client recruitment.
- MOH should strengthen the PST curricula for RCH provision and make this an examinable subject in the final year.
- MOH, RCHU and training NGOs should organise, after needs assessment, refresher and update training in basic IUCD training and in training skills for both preceptors and trainers.
- MOH and RCHU should organise logistics, management and appropriate IUCD training for supervisors.
- MOH should support training practicum and the RCH service delivery system by improving the infrastructure and availability of basic necessities such as running water and electric power. They should also ensure the availability of equipment and other supplies, including IEC and expendable materials.
- DHMTs should be empowered to supervise for quality of care.

Introduction

Conceptual Framework

Potential reproductive health clients are more likely to adopt use of RH services and to continue using them if the services are of high quality, oriented to their needs and continuously improved. Quality in the health care setting means meeting the needs and expectations of clients (the customers of health care services) with a minimum of effort, re-work and waste (Berwich, Godfrey and Wessner 1990).

Continuous quality improvement is the concerted effort to continuously do things better until they are done right the first time, every time. All quality improvement efforts rely on similar, well-accepted principles, which are based on the rights of clients and the needs of health care staff (Huezo and Diaz 1993, Quality of Care in FP: Clients Rights and Providers' Needs; *Advances in Contraception*: 129-139).

In summary, RH clients have a right to information and counselling, rights of opinion, choice of methods, safety and continuity of services. They also have a right to comfort, confidentiality, dignity and privacy and to accessible and affordable services.

Providers have a need for knowledge, training orientation and updates, supplies, equipment and basic infrastructure and for good management and supervision.

The organizational environment influences processes such as client/provider interactions at SDPs in general and specifically, service delivery attitudes, information and interpersonal/social aspects, technical competence and management processes (Table 2). These in turn could have wide-ranging outcomes at RH clients, RH provider, and RH program and community levels.

Context and Literature Review

World-wide use of IUCDs

Intrauterine Contraceptive Devices (IUCDs) have been used for nearly 40 years and have become one of the most commonly used, most available methods of family planning world wide.

More than 100 million women have used the IUCD so that it has become second only to voluntary sterilization as the most popular method in the world (1, 2). In many countries IUCD use has increased greatly since 1970s. Where voluntary sterilization and injectables are widely available, however, use of those two has often grown faster than IUCD use (3).

China accounts for about two thirds of all IUCD users in the world, and Vietnam has a similar IUCD user prevalence (30% of all MWRA) (4). In China the IUCD and voluntary female sterilization are used by approximately equal numbers of women (5).

In the Middle East and North Africa, the IUCD is a leading method in several countries including Egypt, Jordan and Tunisia, protecting 15-18% of all MWRA and accounting for about one third of all contraceptive use in each of these countries.

Table 2: Factors influencing quality of services

Environment: Organizational environment			
↓			
Process: client/provider interaction at SDP; *Service delivery attitudes*: range and availability of RH services; referral linkages; follow-up and continuity of care; range of contraceptive methods. *Informational aspects*: RH education: in-depth information on the service provided *Interpersonal aspects*: caring; dignity, privacy and confidentiality; individual acceptability, appropriate counseling *Technical competence*: technical skills, appropriate medical practices *Social aspects*: social acceptability; appropriate medical practices *Management processes*: human resources (recruitment, staffing, incentives, training, supervision); monitoring;			
↓			
Outcome			
Client	**Service provider**	**Manager/program**	**Community**
Satisfaction with services; knowledge about RH and contraception; reaching reproductive goals, using method of choice, effectiveness of treatment; improved RH; access to care	Enabling working conditions; job satisfaction and motivation; skills and knowledge; some control over work situation; perform-ance of work processes according to standards; client satisfaction; efficacy of treatment	Efficiency/cost; optimally effective care, client satisfaction; number of clients attended	Acceptability of care to individuals and society; equitable access to care; optimal care within resources available; improve-ment in health indications; lowering of RH morbidity/ mortality/domestic violence; CPR

(After AVSC International, Facilitative Supervision, 1999)

In countries of Sub-Saharan Africa, IUCD utilization levels are generally amongst the lowest in the world, as are overall contraceptive use rates. Botswana has the highest IUCD use prevalence at 6% of MWRA, or 17.1% of all contraceptive use, followed by Kenya (4% and 13% of MRWA and all contraceptive use, respectively). Mauritius and Zimbabwe, countries with some of the highest contraceptive prevalence levels in all of Africa (75% and 48%, respectively) have IUCD use rates of only 3% and 1% respectively for all MWRA. This works out as only 4% and 2%, respectively, for all contraceptors in the two countries. In European countries roughly 5-15% of MWRA use the IUCD. In Canada, the USA, Australia and New Zealand and Japan, no more than 5% of MWRA use IUCDs probably because voluntary sterilization has become widely available and popular.

IUCD effectiveness, safety, duration of use

IUCDs became popular because the models currently available offer almost complete protection from pregnancy and are both safe and effective for long periods of time. In fact, because they are so effective in preventing unwanted pregnancy they save many women's lives that would otherwise be lost due to pregnancy related complications. Maternal

mortality in Tanzania is estimated at 529 per 100,000 live births (8) and many more women suffer long term morbidity from pregnancy. The IUCD is one of the safest FP methods according to estimates of annual death rates for women using various FP methods. For almost all FP methods, pregnancy complications following method failure account for most or all of the risk. So, generally, the most effective methods, including, IUCDs, are the safest. Less than two women out of 100,000 users die from complications of IUCD use. The cumulative intrauterine pregnancy rate for the CuT 380-A after 12 years is 1.9 per 100 women, a rate comparable to the 10 year overall failure rate associated with voluntary sterilization as reported by the Centers for Disease Control, Atlanta (CDC). The cumulative ectopic pregnancy rate was 0.4. After the first eight years of use in one study (9, 10) no women using the Cu T 380A IUCD reported a pregnancy. Attention is now shifting towards identifying appropriate IUCD users and providing good quality medical care and counselling to maximize effectiveness, safety and acceptability.

International donor agencies are now providing second-generation copper IUCDs for use in developing country programs. The USAID, one of the major international donors of IUCDs, began supplying the Cu T 380A in 1985; the year after the IUCD was approved by the US Food and Drug administration. Because this IUCD is highly effective and long lasting, USAID now supplies only the Cu T 380A in response to programs that request IUCDs. The CuT 380A is now the most widely available IUCD, distributed in more than 70 countries. Some other donor agencies provide the Nova Cu T and Multi load as well as the Cu T 380A.

IUCDs have amongst the highest continuation rates of all reversible contraceptive methods, 80% first year rates being quoted from Kenya (11) and 70-90% in large multi center trials from other developing countries (1). These rates compare to those of Norplant® Implants (12) and are higher than for OCs, condoms or injectables. A WHO study in 13 centers showed a 10-year continuation rate of 25% for the CuT 380A (13).

There does seem to be an increased risk of PID concentrated in the first month after IUCD insertion, which persists amongst women exposed to RTIs. Less frequent replacement by using long life-span IUCDs, reduces the risk of PID, perforation, and other complications that mainly occur at or soon after insertion. Additionally, less frequent insertions cost less in time and money for clients and programs and are more convenient. Some studies show no increased risk of infertility for a woman using a copper IUCD who has a mutually monogamous relationship and is thus not exposed to RTIs (1).

A WHO Scientific Group convened in 1986 to review safety of IUCDs, concluded "The use of IUCDs in both developed and developing countries should continue to be supported as a reliable and safe method of fertility regulation." More recently in 1995 the International Medical Advisory Panel of the IPPF reaffirmed support for the IUCD as "an effective and safe method of contraception for properly screened women" (14).

The IUCD offers excellent protection against early pregnancy that might disrupt breastfeeding, and it has no effect on breast milk quality or quantity.

IUCDs and association with PID, HIV/AIDS

A WHO study in 12 countries found that in developing countries IUCD users had 2.3 times the relative risk of developing PID compared to women who were using no contraception (15). Having multiple partners — and, as a result, greater exposure to RTIs — is a major

PID risk for IUCD users, as it is for all women regardless of contraceptive use. Also, as for all other women, if an IUCD user's partner has more than one sexual partner this increases her risk for PID. IUCD users in mutually faithful sexual relationships face minimal risks. Indeed, the low long-term risks of PID seen in many studies raise doubt whether, beyond the first few weeks after insertion, PID risk is really any greater among users of currently available IUCDs than among women with the same RTI risk factors who do not use contraception (16).

PID risk is reduced by good counselling, screening for RTI (both by asking questions and conducting a pelvic examination) and by good infection prevention procedures. It is not certain whether prophylactic antibiotics before IUCD insertion reduce the risk of PID (17, 18).

Since IUCDs do not protect against AIDS, a woman at risk should use male or female condoms or at the very least a spermicide or diaphragm. Nonetheless, any such woman using another effective FP method should continue to use it to prevent pregnancy, while she continues with the dual protection. In one study conducted in Kenya there was no evidence that IUCD use makes a woman more susceptible to HIV infection (19). Also, IUCD use did not seem to pose any special risk to a woman already infected with HIV (20). In practice however, some programs preclude the use of IUCDs in women with HIV infection or those at high risk of HIV infection (1, 22).

There are no reports that HIV has been transmitted to a woman during an IUCD procedure or that a health provider has been infected with HIV while performing an IUCD procedure. Nevertheless, a study in Kenya suggested that concern about HIV transmission had affected provider practices and fear of AIDS could be creating a reluctance to insert IUCDs (23).

Role of service providers and training in IUCD programs

Providers play a crucial role in IUCD programs. Each provider needs good training, skills and judgement to help ensure:

a. Screening to see that women who have RTIs or at high risk of RTIs do not use IUCDs;

b. Careful and gentle insertion using sterile or high-level disinfected instruments, a sterile IUCD and correct handling technique so as to minimise chances of the client suffering pain, infection, uterine perforation, IUCD expulsion or pregnancy. On return to their jobs, trainees need to continue IUCD procedures immediately so as to avoid erosion of skills, knowledge and confidence;

c. Use of the longest-lasting IUCD that meets a woman's needs in order to minimise the PID risk and other risks and costs associated with frequent re-insertions;

d. Insertion of an IUCD while it is still within its valid shelf life.

e. Informative and empathetic counselling, effective communication and quality of care. The kinds of counselling and support women receive and their attitudes towards using the IUCD influence rates of method adoption and continuation.

The Tanzania Situation

Tanzania FP policy

Tanzania Ministry of Health National Policy Guidelines and Standards for Family Planning service Delivery and Training (Revised Edition, September 1994), states the following:

a. On government commitment

The Government of Tanzania endorses the principle enshrined in the World Population Plan of Action that:

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. The responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children and their responsibility towards the community.

The Government of Tanzania is committed to providing comprehensive health services to all citizens equitably and has adopted the Primary Health Care (PHC) approach in which Family Planning and its components is a basic service fundamental to the provision of health for all.

b. On eligibility for services

All males and females of reproductive age, including adolescents, irrespective of their parity and marital status have the right of access to FP information, education and service.

Any woman or man shall be provided with a FP method of her/his own choice after appropriate and adequate counselling without requiring the consent of the spouse.

c. On service delivery

FP information and services will be provided through government, non-government and private health facilities including MCH and FP clinics (urban and rural) and through community based and commercial social marketing program outlets.

d. On contraceptives

The Ministry of Health will ensure the availability and accessibility of a wider range of FP methods in order to facilitate wider choice for the user. The methods should include those that offer temporary, long term and permanent contraception.

e. On IEC

Recruitment of FP clients will involve creating more awareness through IEC and motivation on all FP methods without bias for any method.

Tanzania RCH strategy: 1997-2001

The Tanzania RH strategy has been developed on the basis of the ICPD 1994 program of action whereby the government of Tanzania committed itself to take part in implementing the agreed resolutions. The strategy states the following:

- Reproductive Health services in Tanzania are provided by the Government, Parastatal Organisations, Voluntary Agencies and Private Institutions.

- The government of Tanzania emphasises equality in the provision of comprehensive health services and views access to services as a basic human right.
- The broad objective of the strategy is to provide high quality, sustainable and comprehensive RCH services in all service delivery points and at community level by the year 2001 through a multi-sectoral approach using communities and NGOs.

It is evident, therefore, that most of the elements of Tanzania's FP Policy and RCH strategy, including access to FP method mix, are closely linked to the Rights of Clients and Needs of Providers as depicted in the IPPF/WHO materials.

Contraceptive use in Tanzania

The findings of four national surveys: the 1992 Tanzania Demographic and Health Survey (TDHS), the 1994 Tanzania Knowledge Attitude and Practice Survey (TKAPS), the 1996 Tanzania Demographic and Health Survey (TDHS) and the 1996 Tanzania Service Availability Survey (TSAS) indicated an overall increase in contraceptive use (24, 25, 26). The 1996 TDHS data showed that country- wide contraceptive use had increased by sixty percent in five years from 10% in 1991 to 16% in 1996 for all women and doubled from 6% to 12% for all women using modern methods (27). The 1996 TSAS data also confirmed the striking increase in new acceptors of modern contraceptives between 1991 and 1996, with almost a doubling of use amongst MWRA.

However, the four surveys revealed very large differentials in current use of modern contraceptives by method and IUCD use remained much lower than use of some other contraceptive methods. Increased use of injectables, male condoms and the pill account for most of the increase in modern method use. OC use increased almost 60% and Depo Provera use increased a staggering 1200%. Prevalence rates also varied by rural/urban status, by educational status and by geographic zone.

Unmet need for FP in Tanzania

Overall, 24% of currently married women had unmet need for family planning services: 15% for spacing and 9% for limiting births (24). The unmet need for family planning among currently married women in Tanzania declined from 30% in 1991 to 24% in 1996 and the total demand satisfied increased from 26% to 44% during the same period. However, the 1996 TSAS results showed that the rate of increase in the number of new FP acceptors that occurred between 1991 and 1994 was not sustained between 1994 and 1996.

IUCD use in Tanzania compared to other modern methods

The 1996 TDHS results indicated that the most popular modern methods of contraception were condoms and injectables, while IUCDs were not popular at all. Amongst currently married women who were using contraception, the most common method used was the pill (5.5%), injectables (4.5%) and condom (0.8%). In this group IUCD use was very low (0.6%).

For sexually active unmarried women the modern methods most commonly used were pills (9.5%) injectables (3.8%) and male condoms (6.3%), while IUCD use remained very low (1%).

Trends in IUCD use

A comparison of contraceptive prevalence rates of the 1991/92 TDHS and the 1996 TDHS show that IUCD user rates stagnated at 0% in seven out of twenty regions of mainland Tanzania, rose slightly in five regions, and decreased to around zero in most of the remaining regions (Table 3).

Even Kilimanjaro region, which in 1991 had the country wide record of 4.8% user prevalence, showed an almost 50% drop to 2.5% in 1996.

Table 3: Use prevalence of IUCD in Tanzania, 1991 and 1996

Region	Percentage of IUCD Users of all Family Planning Users	
	TDHs 1991/1992 %	TDHs 1996 %
Morogoro	0.0	0.0
Kilimanjaro	4.8	2.5
Dar-es-Salaam	0.5	2.0
Arusha	0.8	1.3
Coast	0.0	0.6
Dodoma	0.0	0.4
Tanga	0.0	0.3
Lindi	0.0	0.3
Iringa	0.9	0.3
Singida	0.9	0.3
Kigoma	0.0	0.0
Shinyanga	0.0	0.0
Ruvuma	0.0	0.0
Mtwara	0.0	0.0
Tabora	0.2	0.0
Rukwa	0.0	0.0
Kagera	0.0	0.0
Mara	0.2	0.0
Mwanza	0.0	0.0
Mbeya	0.9	0.0
Total Tanzania Mainland	0.4	0.5
Total Zanzibar	0.3	0.2

IUCD insertion skills training in Tanzania

In Tanzania approximately one third of the service providers trained since 1992 have received IUCD insertion skills training (27). However the findings of the 1992 Tanzania Situation Analysis study indicated that only 8% of the 535 trained providers interviewed had inserted an IUCD in the three months preceding the study. Intrah's July 1994 MOH Family Planning Training Project Evaluation Report showed that FP providers exit means knowledge of 83% dropped to a mean of 65% within two years. The mean scores for counselling for informed choice skills for pelvic examination and IUCD insertion were 59%, 62% and 65% respectively, with cut-off scores of 65%.

The training section of the National Reproductive and Child Health Program received a number of reports from regional and district clinical skills training between 1994 and 1996 indicating a lack of popularity and acceptance of the IUCD method among the clients.

The Comprehensive Clinical Skills curriculum (Revised 1993) for training service providers in IUCD insertion required each trainee to insert up to 15 IUCDs to be considered competent in this skill. However this requirement had to be reduced in 1994 due to lack of clients accepting the IUCD in practicum sites. Hence, in the review of the curriculum (in 1996) the requirement was reduced to 10 actual and five simulated IUCD insertions. In spite of this reduction, the number of new IUCD users was still too low for the time allowed for this activity during training in the integrated curriculum. As a result, during the 1998 revision of the curriculum the IUCD insertion component was removed from the curriculum and set apart as a separate module (28). It was hoped that this would decrease overloading of contents resulting from the integration of Reproductive and Child Health contents.

Problem Statement

The level of IUCD utilization is very low in Tanzania. Unlike other modern methods IUCD user prevalence has not increased significantly countrywide since 1991 and has, in many regions, dropped to zero. The factors that affect IUCD use in Tanzania have not been adequately explored or documented.

Study Justification

Many of the estimated two million MWRA with an unmet need for family planning could be protected by IUCD use. Women form an especially vulnerable part of the community, and threats to their health as posed by unwanted pregnancy are of grave consequence not only to themselves but also to their children and entire family. Extensive facility, equipment, and training resources have already been put into the program for IUCD service provision and information as to whether they can be gainfully utilized is important. Other special groups who have a stake in the problem are health care workers, RH trainers and training organizations, the local community and international donors.

Hypothesis

Anecdotal and indirect evidence from small-scale investigations indicate that factors, which could affect IUCD use in Tanzania, fall under the following general categories:

- The knowledge attitudes and practices of clients and potential clients in the community regarding FP and RTIs, and their perceptions of access, availability and quality of FP services.
- The knowledge, attitudes, training skills and practices of RH providers, training skills and practices of RH preceptors, trainers and clinic supervisors regarding RTIs, IUCD service provision and counselling, RTIs, their working environment, and the administrative support available to them.
- The set-up of clinic facilities, availability of appropriate equipment, IEC materials, supplies and trained personnel.

- The training strategies and methods employed to enable IUCD providers to develop the necessary KAP, skills, and confidence for IUCD provision and counselling, and for managing clients who adopt the method.

Goal and Objectives

The goal of the study was to generate findings that could be used to decide on how to proceed with IUCD training, to advice on strategies to enhance the factors having a positive influence on IUCD use and to remove or ameliorate factors with a negative influence. This would ensure choice of methods, improve contraceptive prevalence rates and ultimately reduce maternal morbidity and mortality.

General Objective

The general objective of this study was to determine and document the factors that affect IUCD use in Tanzania.

Specific Objectives

The specific objectives of this study were to assess:

- Potential RH clients' KAP on FP, IUCDs and RTIs;
- Potential RH clients' access to and availability of FP services;
- The key factors influencing potential clients in making FP method choices;
- RH clients' KAP on IUCDs and RTIs;
- RH clients' perception on quality of care at the RH facility;
- RH providers' KAP, level of training, skills and service provision including counselling;
- RH providers' working environment and availability of IEC materials;
- The administrative support available to RH providers;
- RH preceptors' KAP on IUCD and RTIs;
- RH preceptors' level of skills and experience in preceptorship;
- RH Preceptors' working environment for service provision and training;
- Administrative support available to IUCD preceptors during training;
- RH trainers' KAP on IUCD and RTIs;
- RH trainers' skill and experience in training for IUCD provision;
- Training environment for trainers;
- Administrative support available to trainers;
- RH supervisors' KAP on IUCD and RTIs;
- RH supervisors' skills and experience in supervision;
- Work environment for supervisors;
- Administrative support for RH supervisors;
- Availability of practicum sites that meet the criteria for ensuring learning as per standards;

- The availability of basic equipment, IEC materials and supplies; and
- Service statistics for IUCD services.

Methodology

Study Design -This was a cross-sectional descriptive study.

Target populations

The sampling unit was the RH clinic and the community in the clinic's catchment area. Data were collected from the following sources:

- Potential FP clients in the community;
- New and revisiting FP clients at exit from the clinic;
- RH providers (both male and female were eligible);
- RH preceptors and trainers;
- RH supervisors;
- Clinic records, facilities and observations of IUCD procedures and simulations;
- Training reports of trainees' records of pre- and post-training skills assessment scores; and
- Records and comments on proficiency levels for IUCD insertion and counselling, trainers' conclusions on how many trainees are safe to practice.

Sampling and sample size

Four regions were chosen from the five geographic zones of mainland Tanzania. Two of the regions selected were the ones that had shown the largest decrease in IUCD use prevalence (identified from the 1991 and 1996 DHS as Mbeya and Tabora). The other two regions selected had the largest percentage increase in IUCD user prevalence (identified as Dar-es-Salaam and Arusha). Although Kilimanjaro region had a higher IUCD user prevalence (2.5%) than Dar-es-Salaam in 1996, this was a nearly 50% drop from the 1991 user prevalence, so it was not be chosen. Unfortunately, Tabora was inaccessible during the data collection period due to collapsed infrastructure. As a result, Singida was substituted, a region bearing very similar study features.

One urban and one rural government clinic with IUCD facilities and one NGO clinic were chosen randomly from each of these regions. Two FP providers and the supervisor from each of the facilities and district/region were chosen. Providers were chosen randomly but at least one had to be trained in IUCD service. If providers were two or fewer at any of the clinics, all of the providers were included in the study. Four preceptors and four trainers were randomly chosen from each of the regions. The total number was therefore 12 clinics, 24 providers, 16 preceptors and 16 trainers. Five supervisors in each region were interviewed: one in each SDP, the district supervisor and the regional supervisor (or assistant in absence of the supervisor). However, the number of clinics was eventually increased from 12 to 14 because the NGO site in Mbeya was inadequate. Parastatal clinics were added to the sample to address this deficiency.

A group of eight to 12 potential clients for focused discussion was formed from the community of each government clinic's catchment area, for a total of eight focus groups. The investigators consulted with the clinic staff and community leaders to assist them in

recruiting suitable participants. A facilitator, an observer and a recorder led each FGD team. Where it was not possible to get three team members, the observer doubled as recorder. About 50 new or revisiting clients were interviewed in each of the clinics at exit. Since the proportion of men is very low in the clinics, they were not recruited in the study. Men's KAP were assessed only indirectly through interview schedules administered to their female partners. Investigators observed providers' knowledge and skills during counselling and during IUCD insertion, follow-up and removals. Simulations were used if clients were not available. The investigators also scrutinized service delivery records and facility set-up, equipment and supplies.

Study instruments

Study participants were asked for verbal informed consent before participating. Structured questionnaires were used to interview new and revisiting clients at exit. The questionnaires had closed-ended and open-ended questions. In-depth interviews were used for providers, preceptors/trainers and supervisors. Focus group discussion guides were necessary for the community data collection.

Appropriate checklists, adopted from the PTSA tools for comprehensive training, were used for procedure observations in the clinics, for collecting data on clinic facilities and for records review.

The instruments were pre-tested and refined in Morogoro, a non-study region, before the study. The respondents for pre-testing were not included in the study. Each trainer-preceptor pair covered three SDPs in their catchment areas and devoted about one week per site.

Data collection

Four trainer/preceptor pairs from non-study regions and experienced in data collection were trained for this study. They collected data over a five-week period under supervision by the main study investigators.

The Study Team

The principal investigator was a consultant obstetrician/gynecologist and a senior lecturer in Nairobi University. A trainer from RCHU Central Training Team assisted him. The reference team included the IEC Research officer at RCHU, the RCHU Training Coordinators, the RCHU Deputy Program Manager, the Intrah/PRIME RTMA at RCHU, the Evaluation/Research Officer and the Regional Clinical Program Officer at Intrah RON.

Inclusion criteria

All eligible sampled respondents were included.

Exclusion criteria

Respondents who did not or could not give informed consent were excluded.

Pre-Study Activities Included

- RCHU/Intrah Planning Meeting.
- Developing Research Proposal and the data collection instruments.
- Training data collectors.

- Pre-testing data collection instruments.
- Translation and back-translation of three of the instruments and submission to RCHU/Intrah for feedback.
- Finalizing of the proposal and research instruments.

Data Processing and Analysis

Data was audited in the field and then centrally to ensure validity.

Pre-analysis activities included: (Appendix 4)

- Preparation of screen for data entry, and preparations of data entry dictionary.
- Collapsing and coding open ended questions for translation of FGD from Kiswahili back to English.
- Preparing theme summaries for the qualitative data.

Data from the interviews and checklists was entered and analyzed using EPI Info Version 6 Computer Software. Proportions, percentages and frequency tabulations and cross tabulations were made.

Data from focus group discussions was entered and analyzed using Ethnograph software, and put into categories.

Problems during study implementation

- The railway line to Tabora, an original study region, broke down following a derailment. It was necessary to substitute this region with a neighbouring region carrying similar study characteristics, i.e., Singida
- Cholera epidemic and subsequent quarantine in Arusha necessitated change of study site from Monduli to Elongero
- There was an inadequate number of clients at NGO SDPs available in Singida, so study investigators picked two available parastatal SDPs
- High RTI prevalence rates in Mbeya were associated with low IUCD utilisation in Kyela; not a single client for IUCD insertion skills assessment was recruited. Furthermore, even models for IUCD insertion simulation were not available in the SDP or even in the region.
- Total client loads were low in all NGO clinics (some see only two clients for hours compared to nearly 50 per hour in some government clinics) so recruitment was slow.
- Due to financial and time constraints during training for data collectors, the period for practising focus group discussion techniques and probing was curtailed, as was the extent of pre-testing study tools, back translations and field editing.
- Due to low male involvement in FP, men were not accessed directly and their views could only be addressed indirectly through the female participants' perception of how the men felt.
- Due to financial and time constraints preceptors/trainers skills could not be evaluated as providers and as trainers.

Ethical considerations

- The study team sought and received approval from the relevant authorities, and letters of introduction from regional authorities
- All respondents gave verbal informed consent before participation.
- Potential respondents who did not or could not give informed consent were not penalised, nor did they lose the privileges and routine care they were entitled to as clients or health care workers.
- Confidentiality and privacy were maintained for all respondents. Specific identifiers such as names were not used on any study instrument and will not be quoted on any study report.
- Respondents did not receive direct incentives or disincentives to participate in the study. However, they were assured that the unbiased information they gave would be useful in improving family planning and reproductive health services for women and families in Tanzania. FGD participants were offered tea and snacks for refreshment.

Study limitations

The study validity depended a great deal on the truthfulness and openness of respondents and the accuracy and completeness of clinic and training records. This may not always have been so because the information sought may have been considered personal and sensitive. Also, respondents may have feared victimization or hoped for reward based on their responses. However, the confidential and incentive-free nature of the study was explained to respondents before administering study instruments. The observations for IUCD procedures could not be guaranteed due to low user rates, but a reasonably long duration — three weeks — was allowed to observe at least one insertion and or removal and follow-up procedure for each provider in the study. In the absence of suitable clients, simulation was used. As a result, the data collectors carried pelvic models with them. Male FP clients were not recruited because they formed a very small proportion of clinic clients. However, men's KAP was assessed indirectly through the questionnaire administered to female FP clients.

Dissemination of study findings

The findings will be disseminated to all the stakeholders. The findings will advise on how to proceed with IUCD training and strategies to enhance positive factors and to remove factors hindering IUCD use in Tanzania. The findings will be timely in relation to the revision of the RHU training strategy and the need for modifying RH practices in the third millennium amongst all sectors/stakeholders of the human resource development for performance improvement in RCH service quality. The stakeholders include:

- The Reproductive and Child Health Unit - MOH
- PRIME/Intrah
- District Medical Authorities
- USAID and USAID co-operating agencies
- Reproductive Health collaborating Agencies like UMATI, Marie Stopes, SUWATA DFID, SDA, OTTU, TOHS, AMREF, AFRICARE (T), CARE International, PSI, FHP, TAMWA, etc.

Dissemination will be done at the training coordination events, during which agreements will be sought on how to proceed with the IUCD program.

Other formats for disseminating the results will include:

- During trainers/supervisors annual meeting;
- During the annual MCH Coordinator's meeting;
- During the gynaecologists annual meeting;
- Through public health journals and bulletins;
- Through paper presentations at national conferences.

Results

Focus Group Discussions (FGDs) with Potential Clients in the Community

Introduction

During the data gathering stage of the study eight FGDs were conducted in the four regions of Singida, Mbeya, Arusha and Dar-es-Salaam. In each region, two FGDs were conducted, one with potential clients in the urban community and the other one with potential clients in the rural community.

Participants who attended the FGDs were all females of childbearing age and who were not FP clients but were potentially FP clients. The views of male partners were gathered indirectly by asking their female partners. Participants age ranged between 19 to 48 years, 80% of them were housewives, 10% were peasants, 5% were toilers, 3% of them were business women and the rest (2%) were secretaries. Seventy-five percent among them were married/cohabiting while the rest (25%) were single.

Venues used for the FGDs included hospital premises, play grounds, schools and community social halls.

Knowledge, attitude and practice of potential FP clients in general

- ***Concept of family planning***

  Participants were familiar with the term family planning although they demonstrated limited understanding of the concept when they were asked to define it. Participants were more familiar with the concept of spacing and limiting family size for the health of the mother and child and for the welfare of the family. Women in urban settings had more detailed ideas about family planning than their counterparts in rural communities.

  Some examples of what family planning meant included “Decisions made by couples or individuals on how many children one should have and when to have them according to their capacity to care for them” (FGD in Singida urban). “Resting from births” (FGD in Chanika, Dar-es-Salaam rural). “Limiting because of economic hardship” (FGD in Arusha rural).

- ***Views about child spacing***

  Correct knowledge

  Women in urban settings were more positive in their views about child spacing than their counterparts in rural settings. Views expressed in favor of child spacing included: “It allows a woman to participate in productive activities so as to raise family income” (FGD in Mbeya urban). “It enables parents to meet needs of children in education” (FGD in Singida urban). “Good for the health of mother and child” (FGD in Singida urban). “Enables parents to bring up their children” (FGD in Singida urban).

  Incorrect knowledge

  Less favorable and skeptical expressions were made by women in rural settings such as: “Child spacing is difficult to practice for women who have not borne some boys” (FGD in Arusha rural). “It is a good idea although the majority of people are still opposed”

(FGD in Singida rural) and “Family planning methods cause sterility” (FGD in Chanika, Dar-es-Salaam rural).

- ***Views about limiting child birth***

  Limiting the number of births was viewed as a joint consideration after meeting desired reproductive goals with the advice of a service provider. Most FGD participants thought it was good to stop at three to four children, so that a couple could afford to educate the children. Specific examples of the views expressed in favor of limiting child birth to three to four children were: “After reaching a number of four children I will discuss with my husband and decide to see service provider for advice on permanent sterilization” (FGD Mbeya urban). “Because of the current life hardship, I better limit childbirth to three so that we can afford to educate them” (FGD Mbeya rural); “Because my partner is still opposed, it is important to look for an agreement with him” (FGD in Arusha rural).

- ***Perceived advantages and disadvantages of limiting child births***

  The only advantage that was mentioned for limiting child bearing was “It enhances parents’ capacity to care for their children." No group mentioned the health benefits to the mothers and children as expected. It seems that these are not well known among the participants.

  As a concern for couples who have undertaken permanent methods, FGD participants in Mbeya rural and Arusha rural mentioned the death of children as irreparable loss.

- ***Partner’s view about FP***

  Some partners were supportive of family planning because they thought it could help them to provide better care to the family.

  However, the number and spacing of children was often not discussed and decided on among couples and some partners, especially in rural settings, still considered family planning a responsibility of the women. Typical quotes:

  “He wants more children than myself (six vs. four) including some boys “(FGD in Arusha urban).

  “Family planning is women’s business” (FGD in Chanika, Dar-es-Salaam rural).

- ***Knowledge of FP methods***

  FP methods

  The most commonly known methods were injectables and OCs (mentioned in all groups), followed by condoms. IUCD and Norplant® Implants were mentioned in just over half of the groups.

  Other methods that were mentioned in fewer groups were calendar, female sterilization, spermicide and the diaphragm.

Sources of information

The most frequently mentioned source of information was the clinic, while radio was the second. Few groups mentioned other sources like friends, newspapers, CBD agents and social events like songs and drama.

Popular methods in the study area

The most popular methods mentioned by the groups were injectables, OCs and condoms (this also includes participants' knowledge of methods used by others in the community). Less used methods mentioned were IUCDs, spermicide, Norplant® Implants and VSC.

Reasons advanced for the popularity of the methods included: ease of use, reversibility, effectiveness in preventing pregnancy, availability, few side effects and confidentiality. Rather similar answers were given later with regard to "main factors in determining choice of method." For example, regarding injectables some women said: "Injection provides secrecy preferred by women whose husbands are not supportive" (FGD in Singida rural).

For the less popular methods some of the reasons advanced include; "Condoms are preferred by young unmarried women for RTI/HIV prevention" (FGD in Mbeya urban), or "Other methods like Norplant® Implants are too new" (FGD in Arusha rural).

- ***Peoples' Views on Methods of FP***

Generally, peoples' views about FP could be divided into two categories.

Positive views

Few participants had positive impressions about peoples' views regarding specific methods or their experience in using specific methods. Examples of statements that held FP positively were:

"Allows women to participate in productive activities" (FGD Mbeya urban).

"Allows mothers to rest and the baby to grow" (FGD in Magomeni, Dar-es-Salaam).

Negative views

The majority of participants expressed fears and misconceptions about specific methods or their experience in using specific methods. Typical views included:

"Pills accumulate in the stomach" (FGD in Arusha urban).

"Family Planning methods destroy woman's eggs" (FGD in Chanika, Dar-es-Salaam rural).

"FP methods cause cancer" (FGD in Arusha urban).

"Injections and pills usually have serious side effects and that is why husbands do not allow wives to take them" (FGD in Singida urban).

"Tubal ligation is not approved because it hurts the womb as the eggs will have nowhere to go after the procedure" (FGD in Singida rural).

"Condoms are safe but during intercourse sperms penetrate into uterus, causing abdominal pain" (FGD in Singida region). When this was stated the rest of the group members fell about laughing, as if this was common knowledge.

Other negative views expressed the cultural conflict

"Some people are opposed to FP methods because they want to have many children like their grandfathers and mothers" (FGD in Mbeya urban).

"Some people are opposed to FP for fear of losing libido (FGD in Arusha rural).

Knowledge, Attitude and Practice by Potential Clients on IUCD in Particular

- ***Peoples' views about the IUCD***

  Negative views on IUCD

  People's views on the IUCD expressed fear and rumors. Most of the participants in all the eight FGDs expressed misconceptions about the IUCD, especially about mechanism of action, side effects and complications.

  Generally people in the community wanted more information and education on the IUCD.

  Rumors on the IUCD

  "Very often, women get pregnant with the IUCD inside (FGD in Singida Urban).

  "If the threads get separated you can get pregnant" - FGD in Mbeya rural.

  "A baby can be delivered holding an IUCD in it's hand, which is a symbol of accusing its mother" (FGD in Mbeya rural).

  "Threads reduce sexual pleasure, as they are kept inside" (FGD Singida rural).

  "IUCD can rust inside the uterus because it has chemicals causing abdominal pain which is acute" (FGD in Arusha urban).

- ***Some of the fears expressed include:***

  "Very often the IUCD is dislodged into the stomach, necessitating an operation" (FGD in Mbeya rural).

  "No adequate and accurate information about the IUCD, so it is not popular in our community" (FGD in Singida rural).

  Positive views on IUCD

  The positive comments from all of the groups about the IUCD were:

  – It is a reversible method

  – It is a long acting method that can be used for a long time. It has no hormone-related side effects.

Positive or perceived advantages about the IUCD

- Participants shared ideas their thoughts on the IUCD. The ideas included the following positive or perceived advantages.

  "It works for long time, up to three years!" (FGD in Singida rural)

  "Fewer routine clinic visits are required" (FGD in Mbeya rural)

  "Unlike the pill, you can not forget taking it" (FGD in Arusha and Mbeya urban)

Negative or perceived disadvantages about the IUCD

- On the other hand participants also shared the following negative or perceived disadvantages which were more widespread, and insistent than the positive messages.

  "Ineffective in preventing pregnancy because very often women get pregnant with the IUCD inside (FGDs in Dar-es-Salaam rural, Arusha rural and urban, Mbeya rural and urban and Singida urban).

  "Interferes with sexual intercourse by reducing sexual pleasure due to presence of threads inside the vagina" (FGD in Singida urban). When this was mentioned most of the participants laughed.

  "IUCD use requires repeated checking of threads which causes discomfort to the user" (FGDs in Mbeya and Singida urban settings).

  "Single partner is recommended, hence limiting freedom in deciding on sexual partners" (FGD in Mbeya urban and Mbeya rural). When this was mentioned most participants murmured in agreement, others laughed.

  "Very often, IUCD gets expelled during menses" (FGD in Arusha urban).

  "Causes corrosion of uterus due to copper chemical coated on it" (FGD in Arusha urban).

  "IUCD facilitates RTI transmission for those with multiple partners" (FGDs in Mbeya and Arusha urban settings).

  "Causes RTIs including HIV" (FGD Mbeya urban).

  "Introduces infection into the womb leading to lower abdominal pains and foul vaginal discharge" (FGDs in Singida rural, Mbeya rural and Mbeya urban).

  "Very often the IUCD gets dislodged necessitating an operation' (FGDs in Mbeya urban, Dar-es-Salaam rural and Mbeya rural).

  "Can not be used anonymously because of its habit of causing acute lower abdominal pain necessitating the user to seek help from others" (FGD in Arusha rural).

- Some of the side effects mentioned by participants indicated that they were confusing them with PID symptoms which included: backache, severe pain in the uterus, lower abdominal pain, and foul vaginal discharge (FGD in Mbeya, Dar-es-Salaam and Arusha urban settings). Other side effects mentioned were allergy and headache.

- Fears and Misconceptions about the IUCD

  "Gets dislodged if user changes partner to one with a penis longer than that of the husband or the usual partner" (FGD in Mbeya urban). *At this statement, other participants hooted and fell about laughing*.

  "A method inserted in the fallopian tube using very sophisticated technique and equipment" (FGD Mbeya rural and Arusha urban).

  "IUCD can not prevent pregnancy; but it is just another way of causing abortion" (FGD in Arusha urban)

  "IUCD penetrates to traumatize the uterus" (FGD in Singida).

  "Causes heavy bleeding leading to anemia and weight loss (FGD in Mbeya urban)

Women views about IUCD procedures and partner support
Some women expressed reservations on the IUCD due to problems associated with its procedures and the need for partner support. Typical quotes:

"Not a very good method because you need support of partner" (FGD in Mbeya rural).

"Not a good method compared to the pills and injection because of its effects on the uterus and the need to expose private parts whenever attending its service" (FGD in Mbeya rural).

Partners' views about the IUCD
Sex partners generally harbored negative views as perceived by the female participants. These views stemmed from fear of side effects, rumors and interference with sexual intercourse. Typical quotes:

"They prefer methods other than IUCD because of its adverse effects including prolonged bleeding" - (FGD in Mbeya rural).

"They think that because it has chemicals (Copper) it will cause cancer of the womb" (FGD in Arusha urban).

"They say that having an IUCD in the female partner's womb will make the male partner not to want sex, as the device will hurt his penis during intercourse" (FGD in Mbeya). *This comment was strongly supported by many of the groups' members*.

"They don't like even to hear about it because of it's threads which protrude in the vagina" (FGD in Mbeya urban). *Again many participants concurred with this comment*.

"IUCD kills the female eggs leaving the user with permanent infertility and chronic lower abdominal pain and foul smelling vaginal discharge (FGD in Mbeya urban and Dar-es-Salaam rural).

The only positive view from the participants' partners was:

"If it is inserted correctly, it stays longer and reduces number of clinic visits" (FGD in Arusha and Dar-es-Salaam urban).

Knowledge of sources of IUCD services
All women mentioned the clinic as a source of IUCD services regardless of whether the clinic has a trained service provider, equipment or supplies.

Several of the participants mentioned District and Regional Hospitals as source of IUCD services, and their reasons included the need for expertise, skilled and experienced providers and the need for sophisticated equipment.

- ***Views and suggestions on how to improve IUCD services***

Women noted that providers were "good" friendly and helpful, and that services were provided free of charge. However some of the participants complained that staff provided the method without conducting examination or screening clients. They related lack of screening to subsequent effects that occur to the user after IUCD insertion.

Suggestions made on how to improve IUCD services included training and refresher courses for service providers.

"*Wahudumu wenyewe wanatakiwa wawe wanapigwa msasa mara kwa mara*" (FGD Mbeya urban) or "Service providers need to be sandpapered from time to time", i.e., to undergo regular refresher and update training.

"Use a variety of IUCDs, and not only Copper bearing IUCD, so that women will have a wider range of choice" (FGD in Singida urban).

"Involvement of men should be emphasized because some of the women cannot decide on their own to use IUCD without support from their partners. They may not have support or help in case of adverse effects of the IUCD (Like severe bleeding or abdominal pain) or the partner or husband may not adhere to the IUCD requirement of being faithful." (FGD in Arusha urban).

"Train and improve the skills of providers so that they improve on how to "set" the IUCD in the woman's womb" (FGD in Arusha urban).

- "CBD agents to provide adequate and accurate information on IUCD in rural areas, like they do with condom and oral pills." (FGD in Dar-es-Salaam rural and Singida rural).
- "Strengthen education and distribute more information on IUCD to the community" (FGD in Arusha urban).

Knowledge of RTIs
RTIs known by all groups are gonorrhea, AIDS, syphilis and chancroid. Other RTIs mentioned were genital ulcers, fungus and herpes.

Although the majority of participants apparently associated the symptoms of RTIs like lower abdominal pain, foul vaginal discharge, backache and severe pain of the uterus as being adverse effects of IUCD, five out of eight groups were aware that IUCDs prevent pregnancy only, not RTIs.

In one of the three groups it was noted that IUCD use could facilitate acquiring RTIs including AIDS for women with multiple partners.

Suggestion for RTI prevention included having one sexual partner, condom use, avoiding prostitution and promoting abstinence.

Relationship between IUCD and sexual act
Problems associated with sexual intercourse and IUCD use, according to participants, included the partner's feeling of threads during sex, and increased vaginal secretions that reduce sexual pleasure and make some partners suspicious that their female partners are unfaithful.

Future use of IUCD
Most women said they would not use the IUCD for fear of adverse effects and lack of adequate and accurate information about its effectiveness, mechanism of action and lack of faithfulness among their male partners.

"I will not use IUCD because people say it deforms unborn children" (FGD Singida urban).

"IUCD is not good because other people say it may perforate the uterus" (FGD Mbeya rural and Dar-es-Salaam urban)

Suggestion/Preconditions for using IUCD
A few women affirmed that they would use the IUCD if some preconditions were met.

Women suggested that providers of IUCD should provide adequate information, encourage clients to seek partner support and exercise professionalism. They also suggested that education, information and communication about the IUCD should be strengthened deliberately to let people understand the good and bad experiences to be expected by women who opted to use it.

- ***Typical quotes***

  "I will not use IUCD because I don't know how it works and whether it is really effective" (FGD Mbeya rural).

  "Unless they improve its services and provide adequate information on its use and effectiveness otherwise I will not use it" (FGD Arusha urban).

  "Male involvement should be strengthened to promote partner support because most of our husbands have multiple partners while the providers said that IUCD requires the user to have one faithful partner" (FGD Mbeya urban).

  "There is a need to get adequate information about the method before I decide to use if because I do not have much information about it." (FGD in Arusha rural).

  "I would only use it if providers improve their skills and check whether the client is suitable before they insert the IUCD" (FGD in Dar-es-Salaam).

  "Providers should be adequately trained on how to "set" the IUCD and to examine/screen the user to exclude RTIs before they decide to insert the device (FGDs Singida rural, Arusha rural and Mbeya rural).

Potential Clients: Findings and Implications

KAP on FP

All of the potential clients interviewed were of childbearing age and most were unmarried housewives and peasant farmers. The participants' level of education was generally low especially for rural participants and most were Moslem (unlike their service providers who had better education and were mostly Christian).

Potential clients had some knowledge of FP, though this knowledge was often inadequate and/or inaccurate.

Their attitudes and their partner's attitude to FP and spacing were positive in general. Urban respondents gave a more comprehensive definition and cited more advantages to FP and had more positive attitudes to spacing and limiting than rural respondents. Their ideal family size was also relatively small at three to four children. Rural respondents had a more limited definition of FP, a larger ideal family size of five to six children and were more positive about spacing but not about limiting, mostly from fear of high infant mortality.

KAP on IUCD

Potential clients had little knowledge of IUCD and this knowledge was mostly inadequate and inaccurate. In fact, a few respondents thought that the IUCD is inserted into the fallopian tubes and causes cancer.

Although most of them opined that the IUCD does not cause RTIs (or AIDS), they very often confused signs and symptoms of PID with side effects of IUCD, thus concluding that the IUCD per se routinely causes severe "uterine" and "waist" pains, backache and foul vaginal discharge. If a woman complained of any of these, the first thought was that she was using the IUCD. So they expressed fear about what they misconstrued to be adverse effects of the IUCD.

Their attitudes were often based on rumors — almost all of them negative — and misconceptions. Misinformation was worse for the IUCD than for FP in general. A few concluded that IUCDs cause RTIs from the fact that IUCD clients were advised not to have multiple partners. Others thought a woman passed on an RTI when she "lent the IUCD to her friend."

Their partner's approval for IUCD was perceived to be low.

The requirements for IUCD use were "too much", e.g., need to check for threads monthly, also, threads in vagina distract the man and reduce his sexual pleasure, or hurt him. Requirement for a single sex partner is also "too much" especially for the men.

Some thought the caveat on multiple partners was necessitated by the fact that a new partner endowed with a penile length different from the index partner's could dislodge the IUCD — unless the FP service provider re-examined, re-assessed and replaced the IUCD accordingly to suit the size (and vigor) of the new penis.

Some potential clients found the insertion procedure unpleasant, e.g., that one had "to expose private parts" whenever she needed an IUCD service such as counselling, insertion, follow-up (ironically, others said that providers did not screen them/examine them well enough, or

often enough). There may be a religion-cultural dichotomy or simply incomplete awareness of why particular procedures and examinations are necessary and what their implications are.

The IUCD cannot be used secretly and needs male involvement and support, because the man can feel the threads during sex. Also, if the woman develops adverse effects she will need the man to take her to an SDP and also to pay treatment changes, especially if she needs an operation (surgery is perceived to be a frequent necessity, to remove a lost or "stuck" IUCD). This would put her in problems if she had "been hiding."

If the IUCD fails (and this was perceived to happen frequently) the baby could be born with the IUCD "in it's hand." There seemed to be something disproportionately disturbing about a baby being born with an IUCD in it's hand; one, it might have a physical deformity, and even if it did not, it was somehow an abnormal/taboo baby. Secondly, the IUCD in its hand was symbolic, it was accusing its own mother of not having wanted it or, worse, having tried to abort it.

Potential clients thought that the IUCD makes one prone to "womb" infection even if they only had one sex partner and that was the very reason that IUCD users were advised not to have multiple partners.

Many IUCD users develop a watery vaginal discharge. It reduces desirable sexual friction and pleasure. Furthermore, it makes the male partner suspicious that the client has been unfaithful to him. Both these factors can lead to marital discord, domestic violence and even divorce.

KAP on RTIs

Potential client's knowledge of RTIs was moderate: they knew the main preventive measures were having one mutually faithful partner and use of male condom, but some thought the single-partner requirement was unrealistic or impractical. None of the respondents mentioned dual method use and, other than the male condom, other barrier methods were not widely known or used.

Main Factors in Determining Choice of Method

Potential clients would mostly seek methods that were safe, effective, long acting, convenient and accessible.

Whether or not a particular method was used would also depend on competition from other available methods, e.g., Depo Provera was popular because other than being effective and safe, it could also be used secretly, and could not much interfere with sex.

Perception of Accessibility and Availability of Services

Potential users felt that FP services were fairly accessible but some suggested increasing accessibility through mobile clinics. The quality of services was perceived to be good because the providers were "homies," neighbors and local residents socially known to them. Some potential clients thought that IUCD insertion (and removal) was a complicated procedure — actually an operation — requiring sophisticated equipment and could therefore only be accessible in district level or regional hospitals.

Recommendations

MOH RCHU and RCH NGOs should institute innovative, proactive IEC strategies in the community. The IEC activities should be widespread and detailed, and will therefore take concerted effort, and need major financing.

MOH, RCHU should train providers to improve IUCD information and counselling in clinics

MOH, RCHU should explore rumors and their sources, causes and effects and work out effective strategies to counter them. Advocacy in awareness creation on IUCD should be promoted to counter rumors and address misconceptions and misinformation.

MOH, RCHU should explore and implement "new" training approaches for service providers to ensure adequate screening of FP/IUCD users, competent service provision and prompt and adequate management of side effects.

MOH, RCHU should sensitize the community to demand and participate in the establishment and sustenance of quality services.

MOH, RCHU should conduct a study to determine what cultural attitudes and practices impact on RH behavior and FP use and their implications.

RH Facility Clients

General observations

An interviewer-assisted questionnaire was administered to 674 clients in Reproductive Health (RH) clinic facilities from November to January 1999. The list of clinics is shown in Appendix 1.

The number of clients per clinic ranged from one to 70, with a mean of 48.1. The clients were drawn from two relatively high IUCD prevalence regions (Arusha, Dar-es-Salaam) and two relatively low IUCD prevalence regions (Mbeya, Singida). Clinic types were rural government (34.7%), urban government (36.1%) and non-government (NGO) (19.8%).

Clinic or RH facility level clients were recruited from hospitals (18 % clients), health centers (46.9%), dispensaries (30.8%) and other clinics such as UMATI and Marie Stopes (4.2% of clients).

Recruitment from the four regions was fairly well balanced: 26.9% of the clients were recruited in Arusha, 27.3% from Dar-es-Salaam, and 21.5% and 24.2% from Mbeya and Singida respectively. About 23.5% of the clients were new to the RH facility and 76.5% were revisiting.

Socio-demographic characteristics of RH facility clients

Table 4 shows the clients' age range of 8-48 years with a mean of 27.2 (SD 6.2 years) and mode of 28 years. Only seven percent were 19 years of age and younger. The majority (78.2%) were 20-34, 3.7% were 40-44 and 0.7% were 45 years of age or older.

Table 4: Socio-demographic characteristics of RH clients (N = 674)

Characteristic	%	Mean (range)
Age in years		
<19	7.4	
20-24	30.6	
25-29	29.9	
30-34	17.7	
35-39	9.8	
40-44	3.7	
>45	0.9	
	100	27.2 (8-48)
Education		
None	6.6	
Primary	76.9	
Secondary	12.9	
A - Level	2.5	7.0 (0.0 - 16.0)
College/Prof./Univ.	1.0	
	100	
Marital status		
Single	10.1	
Marriage/cohabiting	84.2	
Separated	3.0	
Divorced/widowed	2.7	
	100	
Religion		
None	0.4	
Catholic	18.9	
Protestant	30.7	
Moslem	45.1	
Others	4.8	
	100	

Most of the clients (89.8%) had attended primary (76.9%) or secondary schools (12.9%). Only 6.6% had had no education at all, while 2.5% had received advanced secondary education and few (1%) had received college, professional or university education.

The majority of clients (84.2%) were married or cohabiting, but 10.1% were single, 3% were separated and 2.7% were divorced or widowed.

Most clients (49.6%) were Christian with 18.9% being Catholics and 30.7% being Protestants. Moslems made up 45.1% while 0.4% professed no religion.

The mean number of pregnancies was 3.2 (SD 2.4) with a range of zero to 22. The mode was two and the median was three (Table 5). The mean number of abortions suffered was 0.2 (SD 0.7) with a range of 0-12, mode of zero and median of zero.

The mean number of live births was 2.7 (SD 2.1) with a range of 0-20, mode one and median two. The mean number of still births was 0.1 (SD 0.4), with a range of 0-4, mode zero and median zero.

Table 5: Selected pregnancy history characteristics of RH clients (N = 674)

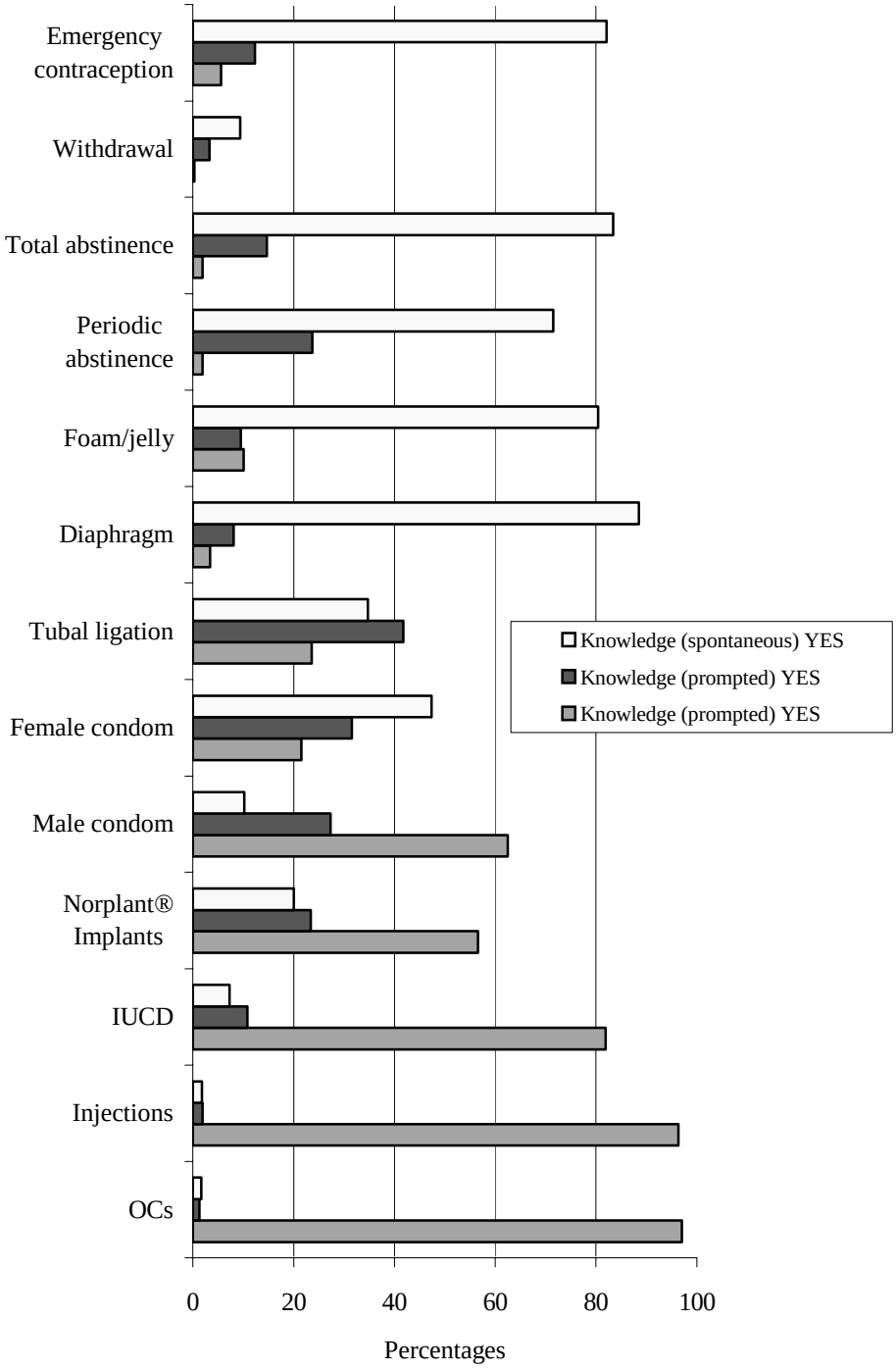
Characteristics	%	Mean (range)
No. of pregnancies		
0		
1-4	1.2	
5-9	17.4	
10-14	1.7	
15-19	0.6	
20-2	0.2	3.2 (0.0 - 22.0)
	100	
No. of children alive		
0		
1-5	92.0	
6-9	4.9	
10-14	1.6	2.7 (0.0 - 14.0)
	100	
Age of youngest child in years		
(No living child)	1.2	
0.1-0.5	16.6	
0.5-1.0	22.1	
1.1-2.0	29.4	
2.1-3.0	13.9	
3.1-4.0	7.2	
4.1-5.0	3.0	
5.1-6.0	2.4	
6.1-7.0	1.3	
7.1-8.0	1.2	
9.1-23.9	1.6	2.0 (0.0 - 23.8)
	100	

The mean number of living children was 2.7 (SD 1.9), range 0-14, mode two, median two. The age of the youngest child was a mean of two years (SD 2.1) with a range of 0-23.8, mode of two and median of 1.3 years.

RH client's knowledge of FP

RH clinic client's unprompted general knowledge and source of information on FP was assessed (Table 6 and Figure 1).

Figure 1: RH clients' FP knowledge (N = 674)



RH clinic clients were asked which family planning methods they knew. The mean number of methods mentioned was 6.1 with a range of 0-15 and a mode of one.

The least mentioned methods were diaphragm, foams and jelly and withdrawal, in 2.6%, 3.5% and 3.9% of responses, respectively. The most often mentioned were OCs, injectables and IUCDs (in 10.5%, 10.5% and 10.5% of responses, respectively). Spontaneous responses

were made in 51.3% of all cases. Nearly 80% had spontaneous knowledge of IUCD, OCs and injectables. More than 80% lacked even prompted knowledge of IUCD while more than 80% had spontaneous knowledge of OCs and injectables. More than 80% lacked even prompted knowledge of emergency contraception, diaphragm or total abstinence each.

The female condom was known spontaneously by 7.7%, the most for any female barrier method, and almost similar to the male condom.

RH client's source of FP information

The predominant source of information by far was Nurses (84%) followed by radio (51.3%) and live drama/community events (16%). Doctors/AMO/ACO (12.7%), television and newspapers/magazines (10.2% each), billboards/posters (10%) and TBAs/Community Health Workers 7.9 %) were relatively minor sources of FP information (Table 6)

Table 6: RH client's sources of FP and IUCD information (N = 674)

Source:	FP Information	IUCD Information
	%	%
Radio	51.3	13.8
Television	10.2	1.3
Posters/Billboards	10.0	3.6
Newspapers/magazines	10.2	1.1
Community events/live drama	16.0	11.3
Doctor/AMO/CO/ACO	12.7	15.1
Nurse	84.0	67.6
TBA/Community Health Worker	7.9	3.7
Others	0.1	5.2

Percentages do not sum to 100% because of multiple responses

The adequacy of FP information from these sources was generally low. Fifty percent said that they had not received adequate information or that the adequacy varied with the source of information and type of FP method. Only 46.8% said that they had enough information.

Preferred source of FP information

The most preferred source for information about FP was a RH clinic provider (96.2%) followed by the TBAs/Community Health Workers (5%) (Table 7). The least popular sources were relatives (preferred by 0.8%) and, rather interestingly, spouses and sexual partners (at only 1.1%). Friends were preferred by 2.7% and religious leaders were preferred by 1.4% of respondents.

Table 7: RH client's preferred source of FP information (N = 674)

Source:	%
Friend	2.7
Relative	0.8
Husband/Sexual partner	1.1
Religious leader	1.4
Health clinic staff	96.2
TBA/Community health worker	5.0
Others	0.3

RH client's knowledge of IUCD

Among clients who were asked whether they had ever seen the IUCD, only 58.9% had while 41.1% had not. As to whether clients had ever heard of the IUCD, about two thirds had

(67.3%), rather more than those who had previously volunteered knowledge of IUCD, but 32.7% had not. The most common source of IUCD information by far was Nurses (67.6%), followed by doctors and the various cadres of clinical officers (15.1%), radio (13.8%), and live drama/community event (11.8%) (Table 6). None of the other sources accounted for as much as 4.1% singly, with TBA/community workers at 3.7%, billboards/posters at 3.6%, TV at 1.3% and newspapers/magazines at 1.1%. Other minor sources included books, friends, relatives, MCH clinics and dispensaries.

When asked whether anyone discussed the IUCD with them at their first visit to that clinic only 39.3% said yes. Asked whether any health worker had even mentioned the IUCD on that particular day's visit (the day when the interview was conducted), only one fifth (20.1%) said that a health worker had even mentioned the IUCD.

When asked if they had requested the IUCD themselves, 7.6% of respondents replied yes, 76.9% of respondents said no and 15.4% of the clients said that the HCW had mentioned the IUCD first.

Clients were asked why they had asked or not asked for the IUCD at that day's visit. A little fewer than half the number of clients (43.2%) said they had not asked for it because they were on another FP method. Of the other respondents, 13.6% stated that they hadn't asked for the IUCD because they did "not need it," 5.4% because they had "contraindications" and 1.5% because they "had heard rumors" or they had religious or spousal objection (0.3% each). However, 13.6% of the clients did not ask about the IUCD purely because they were "not aware of it."

Table 8: Reasons for RH client asking or not asking about IUCD at today's visit (N = 674)

Reason	%
No reason	6.4
Does not need it	13.6
IUCD is my choice	6.9
I am on other FP	43.2
I am not aware of IUCD	18.3
IUCD is not a safe method	0.3
IUCD is a good method	0.8
IUCD is a long term method	0.3
I have contraindications to IUCD	5.4
Religion against IUCD	0.3
I do not want another pregnancy	0.8
Husband objection	0.3
Cannot expose my private parts	0.2
I am pregnant/want to get pregnant	1.2
Other reasons	0.4
	100

The percentages regarding clients who had asked about the IUCD on that day were smaller than for those who had not, with 1.4% asking because it was a "good" or "safe" or "long term" method. Others asked because they did not want another pregnancy (0.8%) or because the IUCD was their "choice" (6.9%).

RH Clients' Perception of IUCD Benefits and Adverse Effects

Clients were asked if they knew any benefits of the IUCD. More than three-quarters of respondents (79.1%) did not know of any but 20.6% mentioned high effectiveness. Others mentioned that the IUCD was convenient, was not bothersome or did not require constant remotivation, or that there was almost nothing that the client needed to remember while using it. The high level of safety of IUCDs and the fact that there were no chemicals introduced into the blood stream was mentioned by 13.9%. Also, 24.4% said that the IUCD required few revisits and acted for a long time and it does not interfere with sex (6.4%). Other benefits included that it was reversible 0.9%, secret 0.6% and does not interfere with breastfeeding (0.2%).

Table 9: Benefits of IUCD as perceived by RH client (N = 674)

Benefits	%
None mentioned	79.1
Highly effective	20.6
Convenient	17.7
Low bother or need for re-motivation	9.9
Nothing or little to remember	1.8
Very safe	8.7
Few visits needed	3.5
Acts a long time	20.9
Does not interfere with sex	6.4
No chemicals enter blood stream	5.2
Others	1.7

Percentages do not sum to 100% because of multiple responses

The clients were asked what adverse effects of the IUCD they knew. IUCD expulsion was the most widely known event by the clients (16.7%), followed by abdominal/menstrual pain and heavy, prolonged or irregular vaginal bleeding. That the IUCDs caused RTIs (1.8%) and cancer (0.2%) or made RTIs worse (1.8%) were also mentioned (Table 11).

Table 10: Adverse effects of the IUCD as perceived by RH client (N = 674)

Adverse effect	%
IUCD can be expelled	16.7
Moves around in the body	0.6
Difficult/painful to insert	2.2
Difficult/painful to remove	0.6
Abdominal/menstrual pain	8.6
Heavy or prolonged as irregular bleeding	6.2
Causes STDs	1.8
Makes STDs worse	1.4
Causes cancer	0.2
Others/displaces uterus/causes obesity	5.5

When pressed to mention more negative aspects about IUCDs (Table 12), 13.8% of respondents raised the perception that the IUCD fails often. Furthermore, the IUCD was feared to cause causes birth defects when it fails (6.5%). Less than 3% (2.8% and 2.6% of clients, respective) said that the IUCD makes a hole in the uterus or causes allergy.

Table 11: Other negative aspects of IUCD as perceived by RH client (N = 674)

Other negative aspects	%
It often fails	13.8
Causes AIDs	0.5
Makes AIDS worse	0.3
Causes abortion	0.9
Causes birth defects when it fails	6.5
Causes infertility	1.1
Makes a hole in the uterus	2.8
Causes allergy	2.6
Against religion	1.4
Other/dislodgment/cervical wound/weight loss	5.5

RH client's knowledge of IUCD service sites

Clients were questioned on where IUCDs can be inserted. The majority of respondents (93.9%) knew of a service site. The clients knew that the IUCD could be inserted in hospitals (60.6%), in health centers (70%), in some dispensaries (43.7%), private doctors' clinics (10.6%) and NGO facilities (5.1%). Almost all clients (99.1%) knew that the IUCD is not provided at TBA/Community Health Worker sites or at pharmacies (99.9%).

RH client's knowledge of relationship between IUCD and AIDS

RH clients were asked the question "What could a person do to avoid getting the virus that causes AIDS?" According to the RH clients, the mainstay of prevention was sticking to one faithful partner (70.4%) and using male condoms (69.3%). Female condoms were mentioned by a good number of clients (13.7%) as was total abstinence from sex (25.7%). None of the other preventive measures accounted for more than 1.5% singly. These included avoid contaminated instruments, blood transfusion and frequent pregnancies (1.5%), avoid some types of FP methods (0.2%) and the IUCD (0.5%) and use traditional medicines (0.8%). RH clients also advised that one should have "self-respect" (0.1%) and "use withdrawal method" (0.1%).

RH client's knowledge of relationship between IUCD and RTIs

When asked, "Is there any relationship between RTIs and the IUCD?" Only 7.2% said that there was while 70.1% said that there was not. A few (1.4%) said that the IUCD prevents RTIs while 11.4% said that it does not prevent STIs. Indeed, 0.6% said it actually transmits RTIs, especially if the client has multiple partners (2.6%) because both the IUCD and RTIs "go to the uterus."

RH client's knowledge on RTIs

Clients were asked whether they knew of any diseases that were transmitted through sexual intercourse. Most clients (94.6%) replied that they did. When asked to name such a disease, the largest proportion of clients listed AIDS (89.4%), followed by gonorrhea (88.4%) and syphilis (86%). Genital sores and genital warts were mentioned by 10.1% and 7.6% of RH clients, respectively.

A few clients mentioned tuberculosis, bilharzia and skin diseases as being sexually transmitted.

Clients were asked whether they had ever heard of AIDS or HIV. Almost all of them (96.8%) had. The most prominent source of information was the radio (81.4%), followed by

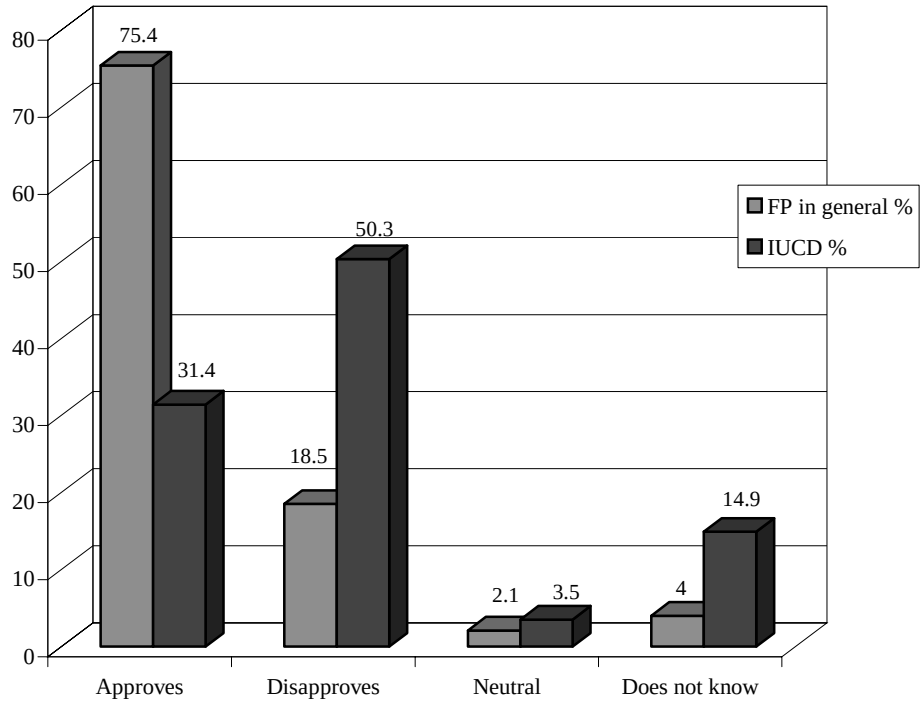
Health Care Workers (66.7%), relatives/friends (44.3%) and posters/billboards (21.7%). Minor sources included church/mosques (16.9%), television (19.3%) and school/workforce (7.2%). A combination of minor sources accounting for a total of 10.2% was newspapers, magazines, books, poetry, drama, and actually seeing AIDS patients in person.

RH Client's attitude

Attitude of RH client's partner to FP

Clients were asked whether they thought that their sexual partners would approve or disapprove of their using a method to avoid or delay pregnancy. Most (75%) said their partner would approve, but 2.1% of partners were neutral and some clients were just not sure (4%) of partner's attitude. Only 18.5% of clients' said that their partners would disapprove (Figure 2).

Figure 2: Partner's approval or disapproval of RH client using FP methods (N = 658)



RH client's attitude to IUCD

The clients were asked whether they had ever considered using the IUCD. Over three-quarters (76.6%) of them had not while only 23.4% had. When asked why they had never considered using the IUCD, the largest single group response (37.9%) was because the client was on another method of FP. However, if this group is excluded, the largest group (21.8% of all clients) was one responding that they were "not aware of it."

Partners' reported approval ratings were much lower for the use of the IUCD: only 31.4% would approve while 50.3% would disapprove and 3.5% were neutral. Many clients (14.9%), however, did not know their partners' attitude.

Table 12: Reason why RH client has never considered using IUCD (N = 674)

Reason	%
No reason	5.8
On other FP method	32.1
Religion	1.0
Partner objection	4.3
Not aware of IUCD	21.8
Rumors against IUCD	8.2
Has contraindication in IUCD	8.2
"I do not like it"	8.8
Fear IUCD will fail	2.1
Desires pregnancy	0.2
Cannot expose genitalia	0.2
Requirements for single partner	1.0
Wants permanent method	1.4
No partner	0.4
Too old/too young, not yet menarche	1.0
Other reasons/method acts too long/ how many partners	1.0
TOTAL	**100**

Other reasons for not considering the IUCD were that the client had contraindications to the IUCD (10.7%) or just did "not like it" (8.8%), rumors against the IUCD (8.2%), partner's objection (4.3%) and fear that the IUCD was not effective in preventing pregnancy (2.1%).

Of clients who ever considered using the IUCD, 22.9% had actually used the method. The reasons why they did not start using reflected to some extent the reasons why other clients had not considered the IUCD. These included that the client went onto another FP method (42.8%), was not adequately aware/informed about IUCD (9%), just did not like it (7.7%), rumors and contraindications (6% each) and partner objection.

Table 13: Reason why RH client is not currently using IUCD (N = 674)

Reason	%
On other FP method	63.1
No partner	1.7
Inadequate information	6.8
Rumors against IUCD	2.1
"I do not like it"	7.6
Pregnant/lactating	1.3
Has contraindications	13.6
Clients "too old"	1.7
Desires pregnancy	1.7
No service provider to insert IUCD	0.4
Others/method fails/has many partners	0.1
TOTAL	100

Less frequently mentioned reasons included, client lacked sex partner (2.3%), client wanted permanent method (2%), lack of right size of IUCD for client (0.7%), IUCD may cause RTI, religious objection and fear of exposing genitalia (all at 0.3%).

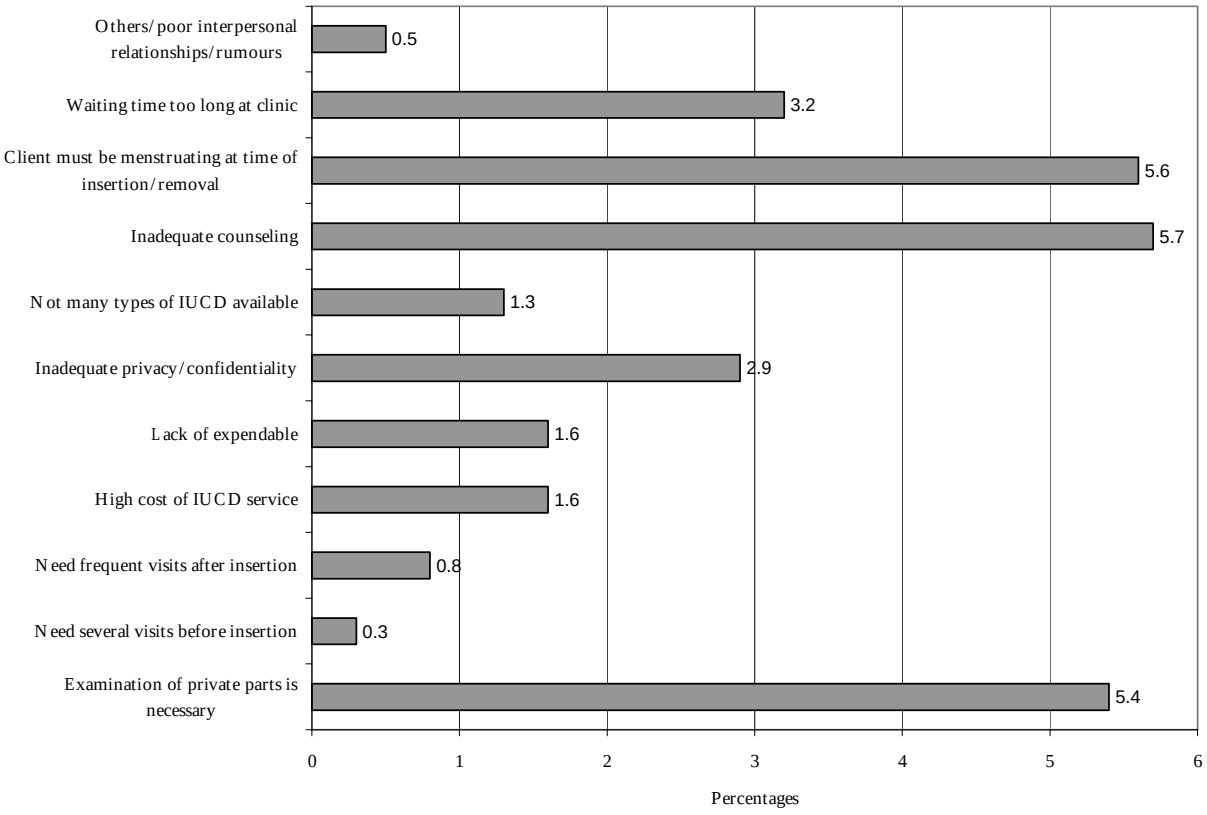
Clients were asked whether, when they ever used the IUCD, their partner knew. More than 10% (10.7%) stated that their partner knew, while 1% said that they could not tell and 5.3% said that he did not know.

If he knew, did he approve? Sixty percent of the clients said he approved, 20.6% that he did not approve.

RH client's perception of IUCD services

Many clients did not mention any negative aspects. The most common negative aspect about IUCD services as perceived by clients was inadequate counselling (5.7%) followed by the requirement that a client be menstruating at the time of IUCD insertion/removal (5.6%) and the need for examination of the clients' genitalia (5.4%). Clients also found the waiting time at the clinics to be too long (3.2%) and the privacy/confidentiality inadequate (2.9%).

Figure 3: Negative aspects of IUCD service as perceived by RH client (N = 674)



RH client's perception of relationship between IUCD and coitus

Similarly, most clients (58.8%) did not know of any negative relationship between the IUCD and sex. Nine percent thought the IUCD would hurt a partner during coitus and 1.1% that it may reduce sexual feeling. Two percent noted that the IUCD does not protect against RTIs. It may cause a watery vaginal discharge, which would be taken by her partner as indicative that she was unfaithful. Also, some respondents feared that a different sexual partner could dislodge the IUCD if the length of his penis was not identical to that of the initial partner's penis.

Probed for what else they had heard about the IUCD and what they believed of it, 12.2% did not know anything else, 10.4% had heard sex would be painful and the IUCD hurts the uterus and the man may feel it (2.6%). Eleven percent had heard that one might easily conceive with IUCD. Conversely, 1.4% had heard that it destroys fertility, is a bad method (2.1%) with many contraindications (18.9%), it causes cancer (10.7%), must be inserted during menses (0.9%) and it causes a watery vaginal discharge (4.3%)

RH client's attitude to RTIs

– *RH client's self-assessed risk for RTIs*

Clients were asked at what level of risk they thought they were for RTIs. Self-assessed risk was nil for 55.9% of clients, slight to moderate for 20.4% and high for 5.9%. A good number of clients (17.8%) could not self-assess their level of risk.

Those with self-assessed nil or low risk made this assessment because they either had no sex at all (2.4%) or had one partner (35.9%) who was also faithful (36.2%). Condom use was a reason for reassurance to 7.8% and 1% said their reason was that they had "never had infections." Five percent just could not explain why they felt as they did — they just felt their risk was low.

For those with self assessed moderate or high risk, reasons given were that the client had multiple partners (1.6%) or that, much more commonly, their male partner had multiple sex partners and/or was polygamous (21.4%).

– *RH client's perception of RTI risk from IUCD use*

Clients were asked what a woman should do if she wanted to use the IUCD and wanted to avoid getting an RTI. Forty five percent responded the woman ought to use condoms or other barrier methods and 15.3% that she should avoid multiple sex partners. However, not even one respondent said that her male partner should avoid other sex partners. Four percent said that nothing could be done to avoid RTIs, 8.9% that nothing need be done and 10.5% that they did not know what could be done. Body hygiene, use of medications and avoidance of contaminated instruments were advocated by 0.3%, 0.8% and 0.8% of clients respectively.

Asked whether using an IUCD can cause one to contract an RTI, 84.9% responded that it could not, 7.5% that it could and 6.6% were not sure. The explanations for possible transmission of RTI were that IUCD prevents pregnancy only, not RTIs (20%), if one has multiple partners (5.2%) or use of contaminated instruments (3.6%) and no barrier protection (1.3%). But the clients said IUCDs cannot cause RTIs because they carry no germs (2.8%), RTIs are only transmitted through sex with an infected person (17%) and RTIs are caused by men (0.6%).

– *RH client's perception on AIDS risk from IUCD use*

Asked whether using an IUCD can cause one to get AIDS, 18.2% said it could, 73.3% that it could not and 7.7% that it would depend on various circumstances, such as presence of multiple sexual partners (8.1%). Those who said that it could not noted that the IUCD does not carry germs or viruses on them (5.9%) and that AIDS is transmitted

through sex (7.9%). But the others noted that the IUCD prevents only pregnancy and does not protect one from getting AIDS (18.7%).

RH Client's Practice

RH client's practice of FP

RH clients were asked whether they had previously used any method to avoid or delay pregnancy. Most of the women had (79.9%) had but 20.1% had not (Table 14). The most previously used methods were OCs and injectables (39.2% and 37.3%, respectively), followed by the IUCD (8.7%) and the male condom (6.7%). No other method had been used by more than 2.4% (as for Norplant® Implants) with the least previously used being LAM/Diaphragm, tubal ligation and withdrawal (0.1, 0.2, 0.2% respectively). It was surprising that the use of vasectomy was identical to that of tubal ligation (0.5%) and that LAM had previously been used by only one person.

Table 14: RH client's previous, current and future use of FP

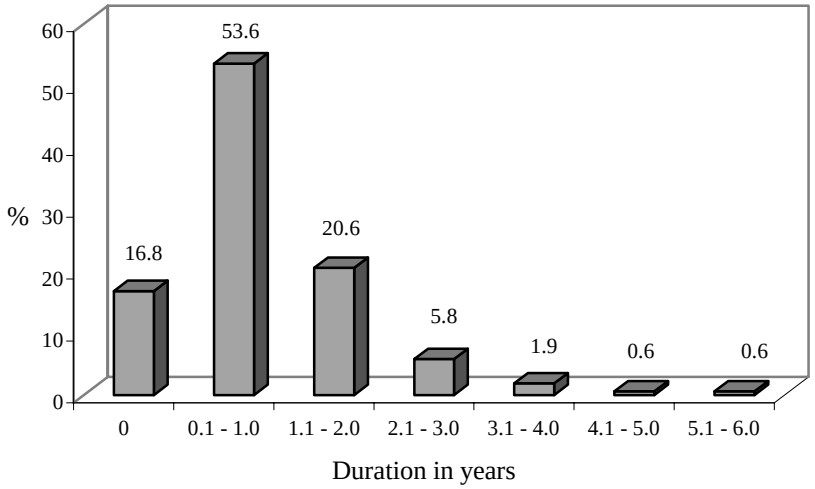
FP Method	Previous use	Current use	Future use
OCs	39.2	27.1	23.0
Injectables	37.3	53.1	45.8
IUCD	8.7	5.5	10.5
Norplant® Implants	3.4	2.4	5.1
Male condom	5.5	6.7	4.4
Female condom	0.5	0.3	1.4
Vasectomy	0.5	0.6	0.4
Tubal ligation	0.5	0.2	7.6
Diaphragm	0.0	0.1	0.1
Foam/jelly	0.9	0.8	0.6
Periodic abstinence	0.7	1.2	0.4
Total abstinence	0.5	0.3	0.0
Withdrawal	0.2	0.2	0.0
Emergency contraception	1.9	1.7	0.6
LAM/others	0.0	0.0	0.0

As to whether for the last pregnancy client wanted to get pregnant just then, more than one third did not. Sixty-four percent said, yes they had wanted to become pregnant, but 45.5% had wanted to either wait (32.1%) or had never wanted to get pregnant again (3.4%).

Eighty-four percent of the RH clients were current users of FP. Eighty percent of the 584 contraceptors were either on injectables (53.1%) or OCs (27.1%). These were followed by male condoms and the IUCD (each at 5.5%) and then Norplant® Implants(3.4%). None of the other methods were currently used by even 1% of the contraceptors. Dual method use (mostly condom and other method) was very low.

The duration for continuous use of the current method was 0.1-20 years for 74.2% clients, the mean was one year with a median of 0.8 years (Figure 4).

Figure 4: Duration of continuous use of current FP method (N = 674)



RH client's future reproductive intentions

The RH clients were asked whether they intended to deliver again. Just over two thirds (69.9%) said that they did, 17.5% did not and 12.7% were uncertain. When asked when they intended to deliver, 6.8% intended to deliver within a year, 5.3% in 1-2 years, 59.3% after two years and 14.2% were unsure.

Clients were asked whether they intended to use a method of family planning in the future. Most of the respondents did (71.1%), 26.8% said they were already on a method and 0.3% did not know. Only 1.8% said they would not try to avoid or delay pregnancy in future. Clients were asked what method they would use next. Nearly half of the responses (45.8%) were for injectables, followed by OCs (23%) and then the IUCD was third at 10.5%. Tubal ligation, Norplant® Implants and the male condom came next at 7.6%, 5.1% and 4.4%, respectively. None of the other responses accounted for more than 0.6% except for the female condom (1.4%). There was a small degree of dual method use mentioned for the future.

When asked why they intended to use those particular methods, the most frequent response, rather non-specifically, was that it was a "good" method. Other relatively common attributes mentioned were that the method was long-term (19.3%), safe (11.1%), and "secret" (10.2%). Some clients also opted for a particular method because they were "forgetful" (6.1%) and the method required little remembering or the method was easy to use (3.3%). Other responses, mentioned by less than 2% each, included that a method was highly effective (1.6%), did not interfere with menses (1.2%), prevents RTIs (0.8%), is reversible (0.8%), or was the method allowed by clients' religion or by her husband (0.4% each).

RH Client's Views on IUCD Services

The clients were asked what their main consideration would be before deciding where to go for IUCD service (Table 15). The main considerations were privacy/confidentiality (22%), adequate information/counselling (17.2%) and dignity/respect accorded the client (16.6%). Staff competence and friendliness were also important (15.7% and 11.9%, respectively), as

was closeness of service site to home/market/work. Some clients suggested having mobile clinics to bring services closer to the community.

Table 15: RH client's main consideration before deciding where to go for IUCD (N = 674)

Main consideration	%
Would not consider	19.3
Closeness to home/market/work/transport	12.9
Privacy/confidentiality	22.0
Dignity/respect	16.6
Staff competence	15.7
Staff friendliness	11.9
Low cost services	7.8
Longer/convenient working hours/short waiting time	4.6
Wide choice of methods	8.7
Adequate information/counseling	17.2
Others/clinic space/fewer visits before insertion/variety of IUCD	2.7

RH Client's Satisfaction with Quality of Services at Clinic

Most clients reported satisfaction with all of the main aspects of quality of care (Table 16). More than ninety percent of all clients were satisfied with the dignity/respect accorded them (93.3%), staff friendliness (91.2%) and staff competence/safety of services (90%). Even the service characteristics that scored relatively poorly — continuity of services, availability of supplies, cost of services — all scored nearly seventy percent and above (69.4, 73.1 and 79.1% respectively).

Table 16: RH client's satisfaction with quality of service in clinic (N = 674)

Quality	%
Continuity of services	69.4
Closeness: home/market/work	82.5
Privacy/confidentiality	85.2
Dignity/respect for client	93.3
Staff competence/safety of services	90.0
Staff friendliness	91.2
Low cost of services	79.1
Convenient hours of operation/short waiting time	82.8
Wide choice of methods	83.3
Adequate information/counseling	81.1
Availability of supplies	73.1
Others	

However, when clients were asked how services could be influenced in that clinic 13.6% had significant suggestions. They suggested increasing the number of competent providers/improve selection for providers to be trained/give providers update training, increase provider motivation and supervision. Another six percent of clients suggested improving quality of services, reducing clinic waiting time, increasing service hours and days (including weekends) and starting mobile clinics to villages. Yet another eight percent of clients wanted the clinic space increased, improved confidentiality, improved

information/counselling, improved inter-personal relationships and male involvement so that their partners could be supportive.

RH Client's Reasons For Not Using IUCD

The main reason why clients would not use the IUCD was predominantly partner objection (42 %). Other reasons for non-use reasons given were subfertility (9.6%), poor IUCD services (9.3%) and health provider advice against IUCD (5.9%).

Table 17: Main reasons why RH client would not use IUCD

Reason	%
Would not need contraception	23.0
Not married	2.8
Not have sex/or having infrequent sex	1.0
Afraid may get STIs	1.8
Subfertile/menopause/had hysterectomy	9.6
IUCD services are poor	9.3
Wants more children	1.8
Partner objection	42.0
Service provider's advice	5.9
Other	2.8

RH client's practices relating to IUCD

RH Clients were asked if they were *Not currently using the IUCD, why not?* The main reason given was that the client was on another method of FP (63.1%) or that she had contraindications to IUCD use (13.6%), did not "like it" (7.6%) or did not have enough awareness/information about it (6.8%). Three percent said either that they were pregnant, lactating or trying to get pregnant and 0.4% that there was no service provider to insert the IUCD.

RH client's practices relating to RTIs

When asked is your partner living with you most of the time or is one of you staying elsewhere most of the time? 7.1% said they had no partner, 75.8% lived together most of the time while 17.1% did not.

As to whether their husband/partner had any other wives, 71.8% replied that he did not, but 14.6% said that he did and 13.7% did not know whether he did or not.

Did the RH client think her husband/partner had any other sexual partners (other than wives)? The majority (52.1%) were not sure, only 8% said that he did and 39.9% said that he did not. As for the clients themselves when asked whether they had a regular sex partner other than their husband, only 8.4% said that they did. This figure is at slight variance to a supplementary question as to the number of sexual partners they had aside from the husband, in whom 18.9% said they did have such partners, a minimum of one (8.2%) to a maximum of four (0.2%) partners.

Clients were also asked the number of different non-regular/non-husband sexual partners that they had had sex with in the preceding 12 months. One hundred and sixty (27%) of the clients had a minimum of one (20.4%) to a maximum of 36 sex partners (0.2% of clients).

Table 18: RH client's number of different non-regular/non-husband sex partners in the preceding 12 months (N =674)

Number of partners	%
0	73.0
1	20.4
2	3.4
3	1.5
4	0.8
5-10	0.4
11-20	0.2
21-30	0.2
	100

Clients were asked whether they used condoms the last time they had sex with a non-regular/non-husband partner. Only 7.4% had used, 41.8% had not, while 50.8% did not have such sex.

History of RTIs

Clients were asked whether they had had any sexually transmitted infection in the preceding 12 months. Six percent said that they had, 91.9% had not, and 2% did not know. These figures appeared at some variance with those from the follow-up question that asked inquiring which diseases they had had. Granted some may have had multiple infections, the responses to this latter question suggest that 18.5% of clients had had an RTI in the previous 12 months. Of those, 3.1% had suffered gonorrhea, 1.8% syphilis, and 0.5% AIDS. Other afflictions were genital sores, genital warts, foul vaginal discharge or pruritus and others infections were not specific/known.

Clients were asked whether they took steps so as not to infect their partners when suffering from these infections. Almost ten percent (9.7%) of all clients did not take any steps, 5.3% took some steps and for 1%, the partner was already infected (incidentally these figures also indicate the incidence of RTIs was higher than 6%). Steps taken included abstaining from sex (1.3%), obtaining treatment (3.8%) and asking partner to go for treatment (3%).

RH Clients: Findings and Implications

KAP on FP

RH clients had a good breadth of awareness on available methods. Previous use was low but current use was high, partly due to the sample selection process of the study. The most popular methods being used currently were OCs and injectables. This was also true for previous use and intended future use.

KAP on IUCD

Awareness of the IUCD was poor — some clients had never considered using the IUCD because they were “not aware of it." The IUCD was mentioned to less than half of all RH clients at their first visit or even at the interview-date visit. Information and counselling for IUCD was deficient.

Even RH clients, despite being exposed to RH services, harbored negative views based on unfounded rumors and misconceptions. Such misconceptions included that the IUCD fails often, is easily and frequently expelled, causes cancer and copper causes erosion in the uterus. Previous use, current use and intended future use of IUCD was low.

Most RH clients did not think that the IUCD specifically causes RTIs or AIDS — “unless you lend your IUCD to your friend." A few felt that the single partner requirement was an unbearable constraint. Some respondents also felt that a variety of IUCDs types and sizes were required. However the variety in sizes was not because of different uterine sizes, but because of different penile sizes of their partners which, if not compatible could cause dislodgment of the IUCD. A few also thought the setting of the IUCD inserter, tenaculum and placement of IUCD depends on estimated penile size.

The majority said they would not use the IUCD, because they knew little about it, its mode of action and effectiveness, safety or even the insertion procedure. Also, they felt that screening was usually inadequate and an IUCD that did “not want you” could be inserted leading to severe complications. (This is partly borne out by respondents from RH provider’s questionnaire in which providers are ignorant of absolute contraindications to use of the IUCD).

While some clients are put off by the necessity for pelvic examination, many more are concerned that pelvic examination is not done routinely as part of screening and general examination to rule out contraindications.

Other than poor screening (providers have poor technical know-how they “just insert” without ruling out problems), some clients knew little of the insertion procedure and worried that it may be complicated and painful or require insertion in a sophisticated hospital set-up.

RH clients felt that male involvement and support should be sought actively to ensure male partners do not themselves indulge in multiple partner sex, that they allow client to use the IUCD, that they offer moral and financial support in case of adverse effects.

KAP on RTIs

RH client's knowledge of RTIs was moderate. They knew of the most common ones, but also took some non-RTIs to be sexually transmitted. Most respondents were aware of two main preventive measures, avoidance of multiple sexual partners and use of the male condom. Other barrier methods were not widely proposed to be protective measures.

Views on quality of services

Most RH clients stated that, in general, the quality of services was good. Periodically, though, many of them then went on to detail aspects of service delivery that were quite deficient, most notably information and counselling, privacy, confidentiality, dignity and, most notably, information and counselling.

Lack of expendables was also an intractable problem, necessitating clients being referred elsewhere, being forced to use other FP, being given another appointment or receiving substandard services.

RH clients: Subsidiary views, implications and findings

Access to services was not perceived to be a major problem.

Restriction to a single sex partner was felt to be impractical, even for married or cohabiting respondents.

Some RH clients, especially in Arusha believed the IUCD is actively used to procure abortion.

While there were many IUCD clients in 1992 when the training program was new, some clients may have been discouraged by complications. When the menstruation requirement was removed as a criterion for time of insertion — obligating the provider to rule out pregnancy, mostly from the clients' history — many providers found screening for pregnancy difficult and pregnancies resulted. The problem was made worse by inadequate skills for fundal placement, resulting in pregnancy and/or IUCD expulsion, pain and bleeding abnormalities.

RH clients' male partners refuse to use condoms. Although OCs and injectables do not protect against RTIs either, IUCD is more feared as exposing clients to the risk of PID and they fear problems will be worse if they are on the IUCD.

Most clients have the nurse as their main, source of FP information. Furthermore, it is their preferred source of information, too. So when the nurses do not provide information on a FP method the first time, clients may never get to hear of it. Additionally, if nurses give inadequate or incorrect information, clients are disadvantaged. Many clients say they are not aware of the IUCD, and IUCDs were not mentioned at first visit or today's visit.

Recommendations

- MOH, RCHU and RCH NGOs should strengthen IEC on IUCD (not just on pills, condoms and injectables) by a specific program. They should improve distribution of IEC materials including those related to IUCD such as posters and leaflets, alongside the general FP program already started by JHPIEGO.
- Once a year, when the Uhuru torch is taken round the country with a key message, and also radio and TV plays could help disseminate IUCD and other FP messages relatively widely.
- The MOH program should inform all staff and clients what is being undertaken to alleviate IUCD related problems. This will reassure the community and promote program credibility.
- MOH, RCHU and training NGOs should shift attention, as is happening elsewhere, to identifying appropriate IUCD users and providing good quality care, counselling and screening so as to maximise safety, effectiveness and acceptability. Only facilities with adequate equipment and trained service providers should provide the IUCD service.

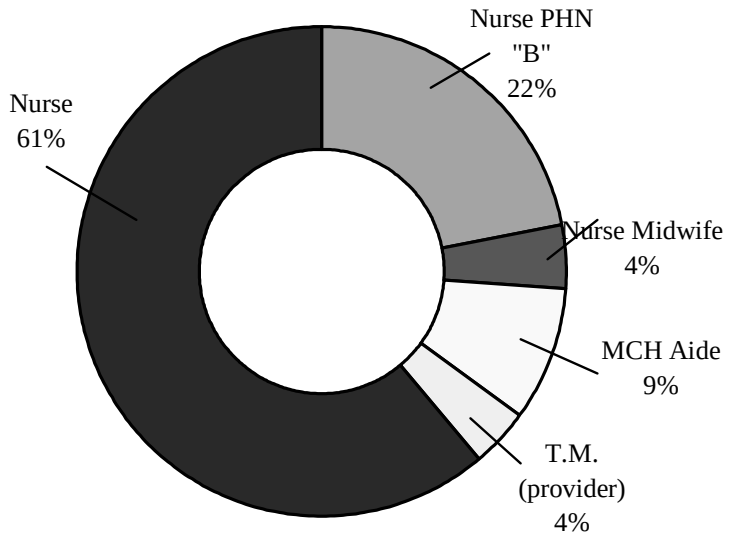
RH Providers

General observations

Twenty-four RH providers were interviewed, approximately two from each of the 14 selected clinics in November 1998 to January 1999. Twenty-five percent were from NGO clinics and 37.5% each from urban government and rural government sites.

The largest job group designation was Nurse, representing 60.9%, followed by Nurse PHN "B" (17.4%), MCHA (8.7%), then Nurse PHN "B," Nurse NM and T.N. Provider, all at 4.3% each (Figure 5).

Figure 5: RH providers' job designation (N = 24)



Most of the service providers (45.8%) worked in Health Centers, 37.5% in dispensaries and 16.7% in hospitals. The providers were quite evenly distributed across the four regions with 25% of them coming from Arusha, Dar-es-Salaam, Mbeya and Singida each.

RH providers' demographic characteristics

All the RH providers except one, were female. Most (54.2%) were 30-39 years of age, 16.7% were 25-29 years and 4.2 were 45 years and older. The majority of providers (70.9) had attained secondary or advanced secondary level education (Table 19). Half of the providers (50%) were married or cohabiting, 41.7% were single, 8.4% were divorced or widowed, and none were separated.

Figure 6: RH providers' age in years (N = 24)

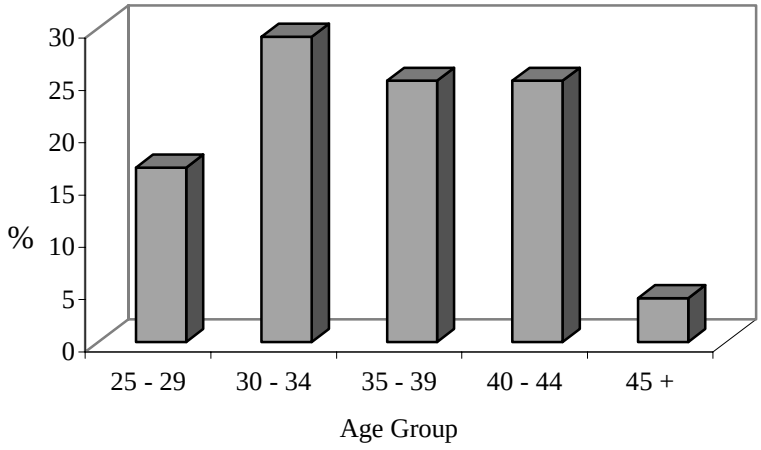


Figure 7: RH providers' level of education

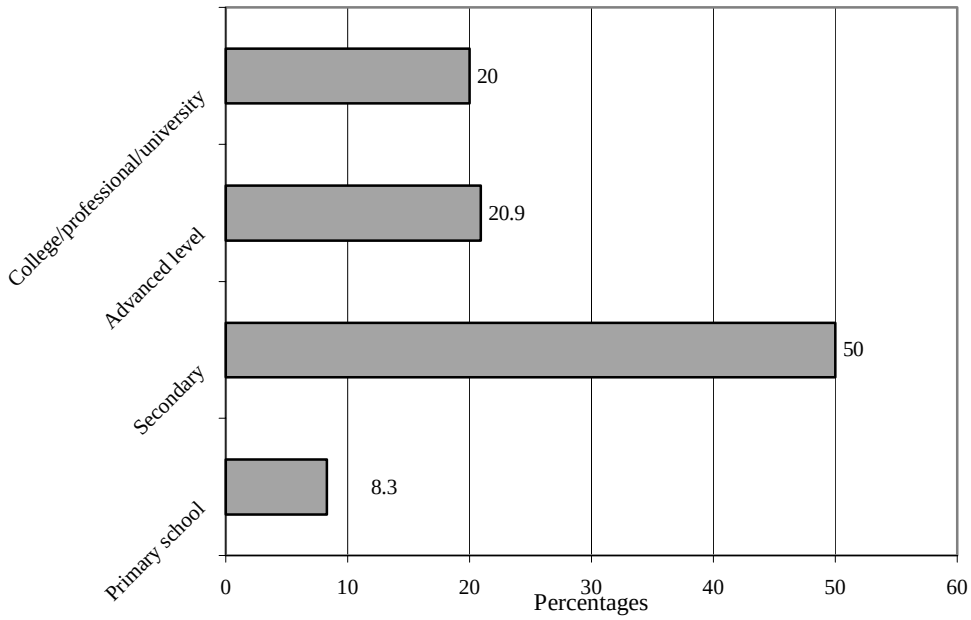
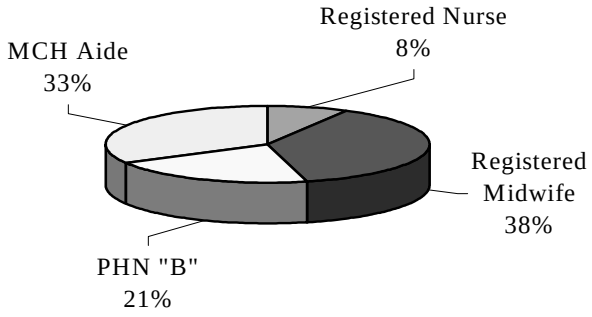


Figure 8: RH providers' professional certificate or diploma



Seventy five percent were Christian (Catholics, 16.7%, Protestants 58.3%), 8.3% were Moslem and 4.2% professed no religion.

The mean number of pregnancies the providers (or partner) had carried was 2.6, with a range of zero to six, a mode of one and a median of two. No pregnancies were reported by 8.3%. The reported pregnancies had resulted in a mean of 0.1 abortions (range zero to one), 2.5 live births (range zero to six) and 0.1 stillbirths (range zero to one).

RH providers' knowledge on FP

The RH providers were asked for FP methods they knew in the Tanzania program. Seventy-eight percent of them were able to name at least one method spontaneously, unprompted (Table 19).

Table 19: RH provider's knowledge of FP methods (N = 24)

Method	Spontaneous YES %	Prompted YES %	Prompted NO %
OCs	87.5	0.0	12.5
Injectables	91.7	0.0	8.3
IUCD	72.2	4.2	23.6
Norplant® Implants	79.2	8.3	12.5
Male condom	25.0	12.5	62.5
Vasectomy	75.0	0.0	25.0
Tubal ligation	75.0	0.0	25.0
Diaphragm	33.3	25.0	41.7
Foam/jelly	50.0	16.7	33.3
Total abstinence	8.3	33.3	58.4
Withdrawal	8.3	16.7	85.0
Emergency Contraception	8.3	37.5	54.2

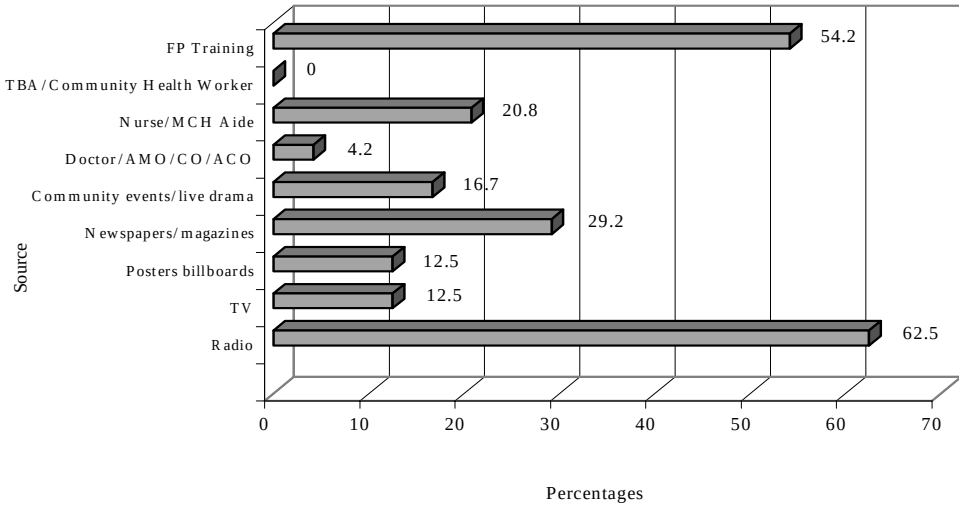
Each FP method was mentioned by at least half the number of providers, and at least half the methods were mentioned by three-quarters or more the providers.

The methods best known spontaneously were injectables, OCs and Norplant® Implants (by 91.7, 87.5 and 79.2% of providers respectively). The IUCD was mentioned spontaneously by only 72.2% of providers, and by 76.4% even after prompting, i.e., 23.6% professed to have no knowledge of the method at all. Of the least known methods were emergency contraception (8.3%, spontaneous knowledge) and both total abstinence and withdrawal (by 8.3% of providers each, spontaneously). Prompted responses were worse with more than half of providers professing no knowledge of withdrawal, total abstinence and emergency contraception (85, 62.5, 58.4 and 54.2% respectively). (*It should also be noted that emergency contraception, principally ECP rather than post coital IUCD, has only been taught since 1998 to participants of the new integrated RCH Clinical Skills Training. Also it is taught as for emergency use only, not for regular FP*).

Source of FP knowledge

Surprisingly for providers, radio (62.5%) came out ahead of FP training (54.2%) as a source of FP knowledge (Figure 9). Other significant sources were newspapers/ magazines (29.2%), Nurse or MCH Aides (20.8%) and community events/live drama (16.7%). Minor sources included TV posters/billboards, doctors and various Clinical Officer cadres, school, college and on-job-training.

Figure 9: RH providers' source of FP knowledge



FP training

Most providers (87.5%) had received FP training. One third of all providers (33.4%) had received FP training in the previous 1-2 years, 45.8% in the previous 3-4 years, and 12.5% five to seven years before.

Adequacy of FP training

Providers were asked whether they felt they had received enough information during training to be able to effectively provide FP services. Two-thirds of all providers (66.7%) said that they did, but 25% felt they had not and 4.2% said that it varied with the method.

When asked what other FP information they would need to effectively provide FP services, the majority (67.6%) required refresher training and updates in FP, followed by updates in IUCD insertion skills (20.8%) and RTI management (16.7%). Additionally, preceptorship, counselling and youth/adolescent RH skills were each required by 4.2% of providers (Table 20).

Table 20: Other FP information that RH providers would need to provide effective services (N = 24)

Other information	%
Refresher Training in FP	20.8
Updates in FP	45.8
Preceptorship skills	4.2
Update in IUCD insertion skills	20.8
Youth/Adolescent in RH	4.2
Counseling skills	4.2
RTI management	16.7

RH providers' knowledge of RTIs

RH providers were asked whether they had heard of diseases transmitted through sex. Rather surprisingly, only 82.6% had heard of such diseases. Gonorrhea and syphilis were mentioned

by 16.7%, AIDS by 12.5%, genital sores and chlamydia by 4.2% each. Other RTIs not frequently mentioned were Trichomoniasis, candidiasis, chancroid and “malengelenge." Genital warts and bacterial vaginosis were not mentioned at all

RH providers’ knowledge on what a person can do to avoid HIV/AIDS

Two-thirds of the providers (66.7%) said the couple should use male condoms, 50% said a woman should stick to one faithful partner, 45.8% said one should avoid sex completely and 16.7% advocated use of the female condom. One provider each mentioned avoiding use of contaminated equipment and early treatment of RTIs.

If a woman wanted to use the IUCD but needed to avoid getting RTIs, 4.2% of providers said the client did not need to do anything, and no one said nothing can be done, or that the client should avoid using the IUCD. The main preventive measures were to use condoms (and or other barrier methods, 83.3%) to avoid many sex partners (79.2%) and for her own partner to avoid other sex partners (45.8%). No provider mentioned use of medications, but one provider recommended personal hygiene and cleanliness when checking IUCD threads during menses, and one provider did not know what to answer.

Relationship between IUCD and RTIs/AIDS

When providers were asked whether they thought using an IUCD could cause a client to get RTIs, 25%, said yes, it could, but 75% said it could not.

Similarly, as to affirming whether the IUCD can cause a client to get AIDS, 25% again said it could while 75% demurred. Transmission could be through contaminated instruments or “if the provider was infected.”

RH Providers’ Attitude

RH providers’ attitude to IUCDs

RH providers were asked whether they had ever considered using the IUCD. Most (54.2%) had never considered it. The most frequent reason for not having considered IUCD use was that the provider had been on another FP method (17.4%) followed by “I do not have sex” (8.7%). The other reasons were “Nulliparity," “Do not like FP methods," “Do not like the IUCD," “Religion against it” and “Afraid IUCD may fail," each mentioned by 4.3% of providers.

Of those who had ever considered using the IUCD, 30% (or 25% of all providers) had used it. The others had not used it because they never had sex (21.1%). Other reasons each given by 5.3% of providers were “currently on other FP method," “Too many cesarean sections," “Afraid IUCD may fail," “Nulliparity," and “Partner’s objection."

A few of the providers (8.3%) said they were still using the IUCD. Others had stopped using it because they no longer had sex, were sub-fertile, decided to use other FP methods, including condoms and/or permanent methods or “did not have time for it."

Providers’ general views about the IUCD

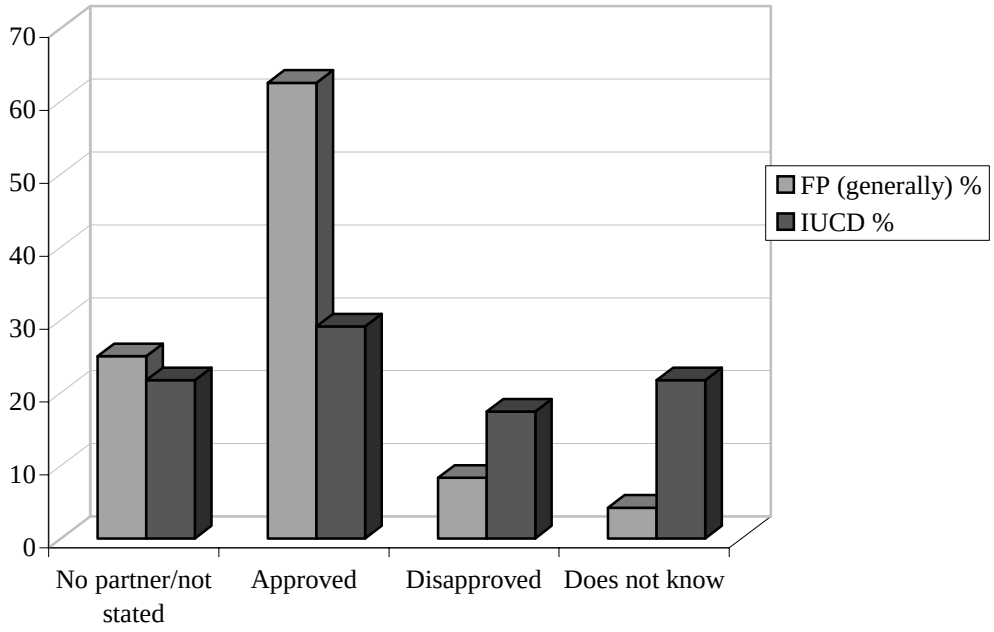
Positive views included that the IUCD is “a good method” (47.8% of providers) and long term (17.4%). Other less frequently mentioned but positive views were that it contains no hormones, return of fertility is immediate on discontinuing use, and it is good for forgetful persons or for those with hormone related problems. The most frequently cited negative view was that the IUCD requires extra body cleanliness and hygiene (8.7%). Other less

frequent views were that the IUCD often fails, clients are uncomfortable with it, it needs highly motivated clients, requires mutual “honesty” by both partners, can cause transmission of RTIs and it is the “same as abortion."

Partner support for use of FP and IUCD

Twenty-five percent of the providers said they had no partners, 62.5% of providers had partners who approved of FP use within their relationship, 8.3% had partners that disapproved and 4.2% did not know.

Figure 10: Partner support for use of FP and IUCD by RH provider (N = 24)



Approval for IUCD use by providers’ partners was much less than for FP as a whole, with only 39.1% reporting approval, 17.4% reporting disapproval and many providers (21.7%) not knowing what their partner’s attitude was.

Health risk to the provider from IUCD provision

While 45.8% of service providers thought there was no risk, just over half (54.2%) of them thought that there were health risks to the provider associated with providing IUCD services. A total of 39.4% were concerned about transmission of RTIs (28.6%) and AIDS transmission (9.5%) and 14.3% of providers felt this risk was exacerbated by inadequate or complete lack of required equipment, running water, electric power and expendables.

RH providers’ information to clients on IUCD benefits

Most of the providers routinely told their clients of at least one benefit of IUCD use. The most frequently mentioned benefit was convenience (83.3%) followed by long term effectiveness (66.7%), lack of interference with sex (62.5%) and low need/bother for remotivation (58.2%).

Other benefits were mentioned by half or fewer than half the providers including requirement for only a few routine visits (50%), safety (45.8%) and user having little or nothing to remember (25%).

RH providers' perceptions on community rumors about IUCD

The RH providers were asked what common adverse effects of the IUCD were discussed in the community and which of these the providers believed themselves (Table 21).

Table 21: RH provider's perceptions on community rumors about IUCD (N = 24)

Rumor	%	Provider believes %	Provider does not believe %
Easily expelled	33.3	12.5	0.0
Moves around in body	4.2	0.0	0.0
Difficult/painful to insert	8.3	4.2	0.0
Difficult/painful to remove	12.5	8.3	4.2
Causes abdominal/menstrual pain	37.5	20.8	0.0
Causes heavy/prolonged/irregular bleeding	29.2	25.0	0.0
Causes RTIs	8.3	0.0	4.2
Makes RTIs worse	12.5	8.3	0.0
Causes cancer	20.8	4.2	0.0

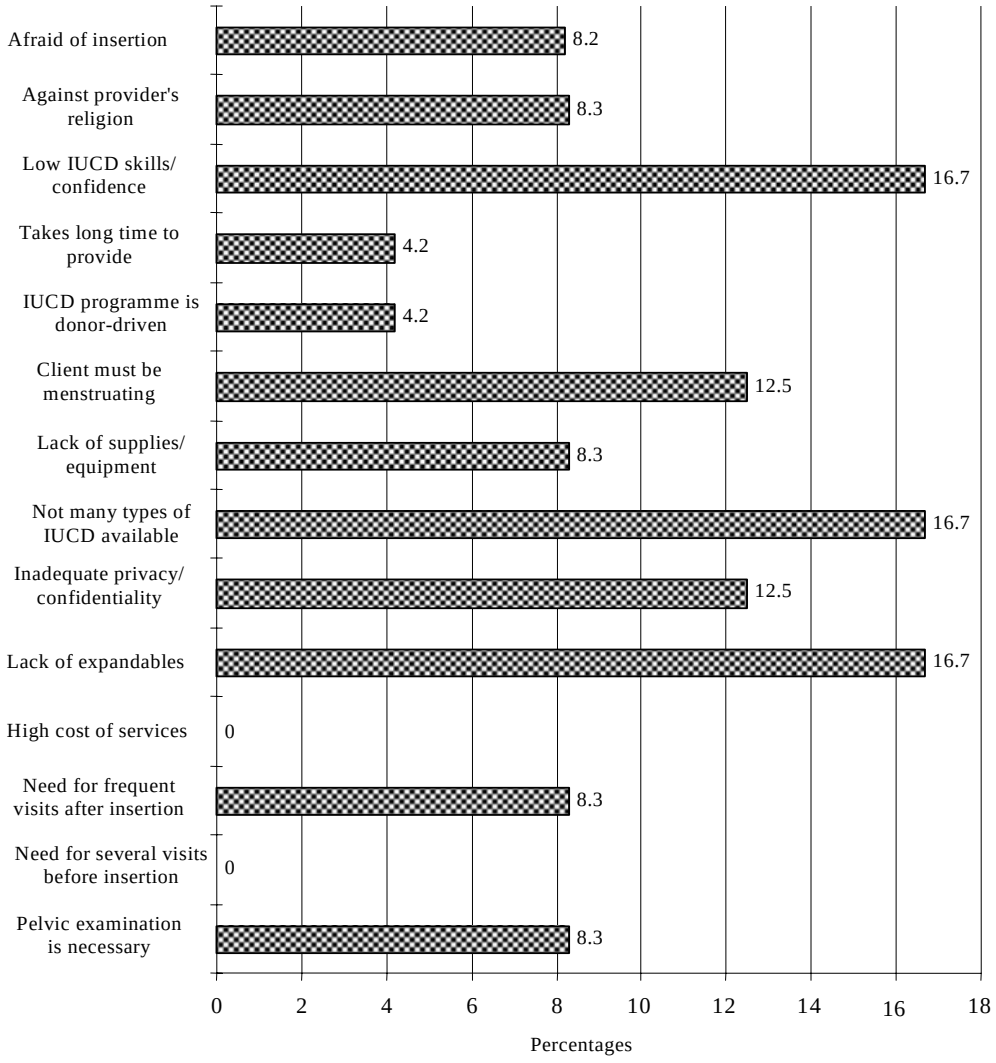
The most commonly mentioned adverse effects were that the IUCD causes abdominal pain (37.5%), is easily expelled (33.3%), causes heavy/prolonged/irregular bleeding (29.2%) and causes cancer (20.8%). These were believed by 20.8, 12.5, 25 and 4.2% of the providers respectively. That the IUCD is difficult to remove (mentioned by 12.5% providers) and causes RTIs (8.3%) was believed by 8.3% and nil providers, respectively, while 4.2% of providers in both instances did not know whether to believe those rumors or not.

Other rumors in the community included that coitus was painful to the client or her male partner, hurting his penis (4.2%). Others were that the IUCD may perforate the uterus, and be "lost inside," threads may be misplaced or the IUCD may be dislodged if her partner's penis was too long (4.2%). Also because the man can feel the threads at coitus, the IUCD can reduce sexual pleasure and also it cannot be a "secret" method. Other community concerns were that the IUCD causes "waist pains," requires exposure of the genitalia during insertion, inspection for threads is troublesome, removal is difficult and often requires a "D & C" operation and the IUCD can cause infertility. The IUCD also causes a watery vaginal discharge, which rouses suspicion by the male partner that the client is promiscuous. Furthermore, it "fails" often.

RH providers' perception of negative aspects of IUCD services

Three factors tied as the most common negative aspects of IUCD services, each mentioned by 16.7% of the providers: lack of expendable materials, low provider IUCD skills and confidence, lack of variety in types of IUCD (Figure 11). It is interesting that such a significant proportion of RH providers (16.7%) felt that there should be more variety in IUCD types, that the currently available CuT 380 is not enough.

Figure 11: RH providers' perception of negative aspects of IUCD service (N = 24)



Lack of equipment and supplies (8.3%) was not as frequently mentioned as lack of expendables (16.7%). Necessity for pelvic examination, need for frequent visits post-insertion and religious objection by providers were scored by 8.3% of providers each. The requirements that a client be menstruating for IUCD insertion/removal was a negative aspect for 12.5% of providers as was inadequacy of privacy/confidentiality. No provider mentioned a need for several visits pre-insertion or high cost of services.

RH provider's perception on client's main consideration before deciding where to go for IUCD services.

In the RH provider's view, the most important considerations by far for the client were staff competence and adequacy of information/counselling (mentioned by 91.7% and 75% of providers, respectively, Table 22). Other moderately frequent considerations were perceived to be client's privacy/dignity/confidentiality (58.3%), staff friendliness (54.2%) and wide choice of methods (50%). Closeness to home/work (16.7%), cost of transport (20.8%) and services (33.3%) appeared of less prominence.

Table 22: RH provider's perception on client's main consideration before deciding where to go for IUCD services (N = 24)

Main Consideration	%
Close to home/work/market	16.7
Privacy/dignity/confidentiality	58.3
Availability/low cost transport	20.8
Staff competence	91.7
Staff friendliness	54.2
Low cost services	33.3
Longer/convenient waiting hours	41.7
Wide choice of methods	50.0
Adequate information/counseling	75.0
Other: short wait/many providers/space/integrated services	29.2

RH Provider's Practice

RH provider's practice of FP

- ***FP use by RH provider***

  A rather large number of service providers (41.7%) reported that they have never used a FP method (coincidentally, this is identical to the proportion of providers who were single, 41.7%). Only 58.3% had used a method before.

Table 23: FP use by RH provider

Method	Previous use %	Current use %	Future use %
OCs	29.2	0.0	4.7
Injectables	29.2	12.5	8.3
IUCD	16.7	8.3	8.3
Norplant® Implants	0.0	0.0	8.3
Male condom	16.7	25.0	8.3
Female condom	0.0	0.0	0.0
Vasectomy	0.0	0.0	4.7
Tubal ligation	4.2	4.2	25.0
Diaphragm	0.0	0.0	0.0
Foam/jelly	0.0	0.0	0.0
Periodic abstinence	4.2	4.2	0.0
Total abstinence	0.0	8.3	0.0
Withdrawal	4.2	0.0	0.0
Emergency contraception	0.0	0.0	0.0
LAM	0.0	0.0	0.0

Many had used either OCs or injectables (29.2% each), while male condoms and the IUCD were the second most popular methods (16.7% each). Diaphragm, tubal ligation, periodic abstinence and withdrawal were each previously used by 4.2%. No one had previous use of Norplant® Implants, vasectomy, female condom, foam/jelly, emergency contraception or LAM.

Providers' current use of FP was 58.3%, identical to previous use. However, there was some shift in emphasis on particular methods, notably a decrease in OCs from previous use of 29.2% to current use of 0% and a decrease in injectables from 29.2 to 12.5%. IUCD use decreased from previous use of 16.7% to current use of 8.3% and male condoms decreased from previous use of 16.7% to 0.01%. Conversely, there was an increase in total abstinence from previous use of 16.7 to 25%. Utilization rates for other methods were unchanged.

The duration of continuous use of the current method ranged from 0.3-6 years with a mean of three years and a mode also of three years. Most of the users (59%) had been on the method continuously for three to six years.

- ***Provider's future reproductive intentions***

  Most providers (70.8%) did not intend to become pregnant again, 20.8% did want more children and 8.3% were unsure. Less than 10% of providers (8.3%) intended to become pregnant within one year, 4.2% after 1-2 years and 12.5% after two years.

- ***Provider's future use of FP***

  Exactly half of the providers intended to use a FP method in future (although as many as 70.8% of all providers had said they did not intend to get pregnant again).

  The method most sought for the future was tubal ligation (25% of all providers) followed by injectables, IUCD, Norplant® Implants and male condom (each at 8.3%), then vasectomy and OCs (both at 4.7%). No other method was mentioned. It therefore appears that all currently used methods would stagnate or drop in future use by providers except for OCs and tubal ligation.

RH provider's training and service provision

- ***IUCD training and competence in service provision***

  Just over half the number of providers (58.3%) had been trained to provide IUCD services. Twenty-five percent had been trained 1-2 years before, 18.2% had been trained three years before, and 22.6% four or more years before the survey. Two-thirds (66.7%) of the trained providers had felt confident to provide IUCD services after the training, but 23.8% had not, either because they had not been able to combine adequate theory and practical training, or had experienced a long delay after training before inserting the first IUCD. One provider reported it had taken her six months before inserting the first IUCD and she had subsequently inserted less than one a month.

  When asked whether they now felt confident in service provision, their level of even fewer providers (54.5%) said they felt confident.

The main reason for erosion in confidence was inadequate practice (19%). This could start a vicious cycle in which low confidence leads to low practice leading to lower confidence. One provider said that she had been inserting IUCDs but without gaining confidence due to low frequency; one was learning slowly through OJT and another had spurned IUCD provision and was concentrating on VSC counselling.

Duration after training before inserting first IUCD

One-third of trained providers had taken one month before inserting the first IUCD, 16.7% had taken two months while another 17.7% had taken longer, 6-18 months. The mean duration before first insertion was three months.

The number of IUCDs inserted in the preceding one year ranged from 0-25 with a mean of six. Twenty-seven percent of all providers had inserted no IUCDs in the previous year, 31.7% had inserted 1-2, 13.5% had inserted 4-8, and 27% had inserted 10-25 IUCDs.

IUCD information given to client

RH providers were asked with what proportion of clients they discussed the IUCD. Fifty percent discussed this method with less than half their clients. The other fifty percent discussed with most (29.2%) or all (20.3%) clients. None of the providers said that she/he never discusses the IUCD with any clients.

RH provider's training to prepare for service provision

Most providers (81.8%) had had at least one of four such training courses. The course attended most frequently was Comprehensive Clinical Skills (by 29% of the providers) followed by Basic Clinical Skills (20.8%), Contraceptive Technology Update (16.7%) and Integrated Reproductive Child Health Course (8.3%). Other courses attended included VSC counselling, preceptorship and Norplant® Implants insertion.

The duration since training ranged from two to eight years.

Confidence after RH training

Asked whether they had learnt all that they needed to be effective in providing RH services only 41.7% of providers answered yes, but 58.3% said they had not. On probing what else they needed to learn in order to be effective, 31.8% said they needed IUCD training, 27.3% IUCD updates, and 9.1% counselling skills, 4.5% FP clinical skills, 4.8% management of RTIs.

When asked whether they had had special/specific RTI training, only 12.5% had ever received such training.

RH Provider's Working Environment

Factors that facilitate IUCD services at RH providers' sites

The two main facilitative factors were adequate information/counselling and skilled/competent providers, mentioned by 59.1% and 18.2% of providers, respectively. Providers' positive attitude to IUCD was mentioned by 9.1%, and 4.5% of providers gave each of the following responses: confidentiality/privacy, interpersonal relationships, and variety of IUCDs/other methods, aseptic techniques and adequate equipment. One provider said she could not answer the question because her clinic had only one client on the IUCD.

Factors that hinder IUCD services at RH providers' sites

The main concerns hindering IUCD services were rumors and misconceptions and inadequate information/counselling, mentioned by 41.7% and 12.5% of providers respectively. Each of the following was mentioned by 8.3% of providers: religious objections, inadequate number of providers, inadequate equipment and supplies and clients' fear/dislike of exposing genitalia. Others mentioned by 4.2% of respondents: community resistance, poor provider skills, male objection, IUCD side effects and complications, RTI transmission, and poor interpersonal relationships.

Health assessment conducted for potential IUCD clients

Eight percent of the providers did not carry out health assessments. Only 54.2% and 25% performed a pelvic exam and a general physical examination, respectively, and 8.3% conducted a speculum and an abdominal examination. Four percent of providers mentioned each of checking medical and social history, checking clients' weight and checking clients' blood pressure.

RH provider's knowledge of IUCD

Provider's knowledge of main mode of action of Copper IUCD

The most commonly known (50%) was that the IUCD acts as a foreign body, 29.2% said it changes the lining of the uterus and 20.8% said the copper kills sperm. Less frequent responses were that the IUCD changes movements of the tubes (12.5%) or uterus (8.3%). That the IUCD hinders sperm movement or prevents implantation were each offered by 12.5% of providers. On the other hand, the IUCD causes abortion, "upsets" the uterus or prevents ovulation were each mentioned by 4.2% of providers. Some of the providers (12.5%) did not have any idea about the IUCD's mode of action.

RH provider's knowledge of common side effects of the IUCD

All providers knew of at least one side effect, the most commonly mentioned being lower abdominal pains (69.6%), irregular vaginal bleeding (65.2%), heavy vaginal bleeding (43.5%) and menstrual cramps (39%). Less frequent response were that the IUCD hurts the partner during coitus, increases vaginal discharge, and causes abortion once a month; each of these responses was mentioned by 4.2% of providers. No provider thought that amenorrhoea or allergies were common side effects of the IUCD.

RH provider's perception of negative association between IUCD and sex

Most providers (60.9%) said there were none. The others said IUCD may hurt the man during coitus or decrease sexual pleasure and that it does not protect against RTIs.

RH provider's knowledge of IUCD complications

As many as one-third (34.8%) of providers knew no complications. The complications mentioned most frequently were IUCD expulsion (27.3%), pregnancy, uterine perforation, or severe lower abdominal pain (each by 13.6%).

Other complications were anemia and hurting either the client or the partner during coitus (9.1%), while 4.5% mentioned missing threads, amenorrhoea and transmission of AIDS/RTIs to client. However, none said that transmission of AIDS/RTIs to the service provider was a possible complication, or that IUCD threads can trap a man's penis during coitus.

RH provider's knowledge of absolute contraindications to IUCD use

Of all providers, 4.2% did not know any absolute contraindication. Significantly, many providers did not know several important absolute contraindications. These included active PID, recurrent PID, high risk of PID and pregnancy which a staggering 54.2%, 29.2, 83.3 and 41.7% of providers respectively, failed to list as absolute contraindications. Most providers were correct about multiparity, marital status and previous IUCD expulsion not being absolute contraindications.

In the Tanzania National Program guidelines (1994), nulliparity is also indicated as an absolute contraindication, but 75% of the providers did not list it as such. This is a moot point, however, because the Tanzania National Guidelines revision in 1999 should follow the 1996 WHO Medical Eligibility Criteria and adopt/adapt the 1997 Revised Family Planning Procedures that excluded nulliparity from category 4. (See also Figure 18).

Table 24: RH provider's knowledge of absolute contraindications to IUCD use

	Not mentioned (%)
Active PID	54.2
Multiparity	83.3
Recurrent PID	29.2
High risk of PID	83.3
Unmarried client	95.8
Pregnancy	41.7
Previous expulsion of IUCD	91.7
Multiparity	72.0
Others	56.7

Providers mentioned other absolute contraindications including undiagnosed irregular bleeding, allergy to Copper, HIV sero-positive status and “an aged woman/cancer/cesarean/cervical wounds (mentioned by 13, 8.7, 4.3, and 4.3%, respectively).

Timing of IUCD insertion

Almost two-thirds of providers (65.2%) still instruct their clients that it is obligatory to be menstruating at the time of IUCD insertion. Other suggested timings are 6-8 weeks after delivery (suggested by 17.4% of providers), immediately postabortion and when changing method (each at 4.5%). Others (by only 4.3% each) said that the IUCD can be inserted any time the client decides, so long as pregnancy can be ruled out, client does not have RTIs, there is a vacant service room available, and the client comes in before one p.m.

Central/Regional IUCD Training Compared to OJT

Advantages

The most prominent advantage was an opportunity to discuss and exchange views with several other providers (63.6% of respondents). The change in environment helps learning (9.1%) and along with the per diem allowance, motivates trainees (5%). It is useful to train large numbers of providers in a short time, thus reducing costs (9.5%), it is easier to train in both theory and practical at the same time (4.5%) and it allows for pre and post test to verify learning (4.5%).

Disadvantages

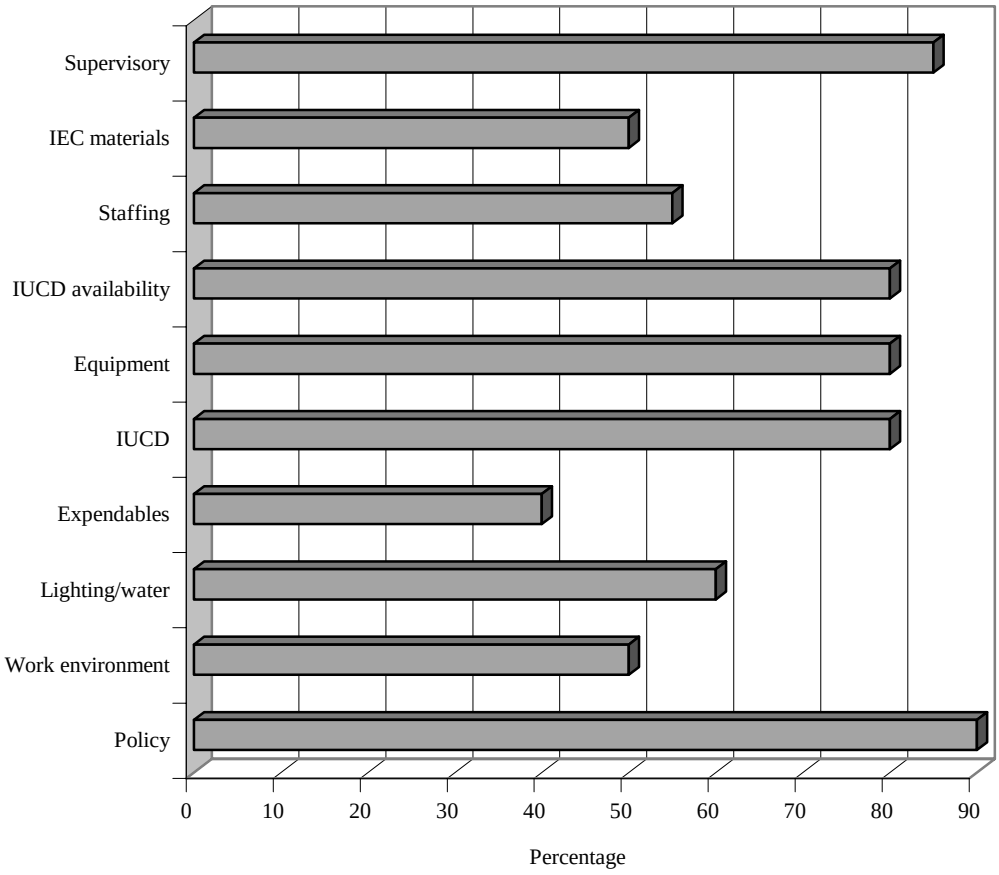
While 14.3% said there was no disadvantage at all, 23.8% felt it consumes more of the service provider's time, and that the duration of training is too short (19%) and client load may be inadequate for practicum (4.8%). Furthermore, it is costly (14.3%), and there may be a difference in ability to understand between different cadres of trainees (8.3%) thus hindering pace of learning. Also the content may be too much, concentration too little because life style is interfered with. Also, it reduces manpower at the base sites.

Support to RH Providers

Administrative support

RH providers were asked whether they were satisfied with administrative support regarding IUCD services (Figure 11). Satisfaction was very high for policy (90%) and supervisory support (85%), and moderately high for availability of IUCD- related equipment and the IUCD itself (both about 80%). Satisfaction was less with availability of water/lighting (60%) and with staffing (55%). The picture was even gloomier with regard to the work environment, availability of IEC materials and expendables, with satisfaction rates of only 50%, 50% and 40%, respectively.

Figure 12: RH provider's satisfaction with administrative support for IUCD services



Availability of IUCDs, equipment and expendables

Eighty-seven percent of providers stated that they always had enough IUCDs in their clinics. However, 43.5% of the providers conceded their clinics did not always have enough expendables or IUCD equipment, the main reason being poor supplies from central stores (34.8%). Because of inadequate supply, providers sometimes ask clients to buy expendables, referred them to other SDPs, or asked them to choose alternative or CBD methods.

RH provider's attitude to FP

- ***What other providers say about the IUCD***

As reported by the providers interviewed, 59% of their provider colleagues had positive views about the IUCD, with 45.5% saying it was "a good method," that it was safe (4.5%), long acting (4.5%) and "did not have problems on insertion" (4.5%).

Some of the provider colleagues had negative views, including that it was donor-driven by White people for their own benefit (4.5%), necessity for genital exposure causes embarrassment (4.5%), IUCD causes trauma to the uterus (4.5%) and they just did 'not like it' (4.5%). Other views were that more training is needed to improve the number and the skills of providers (13.6%) and that lack of expendables hinders services, (4.5%). Some providers (18.2%) said they did not know their colleagues' views.

- ***IUCD recommendation to a friend***

Almost all the RH providers (95.7%) said they would recommend the IUCD to a friend. The reasons given were that it was a "good" method (19%), safe (4.8%), long-term (4.8%), not bothersome (4.8%) and did not raise the blood pressure (9.5%). One provider averred she would recommend the IUCD to her own daughter and another one that she was even using it herself.

- ***Perceptions on IUCD use in the clinic***

Nearly three-quarters of the providers (73.9%) opined that IUCD users over the last year had declined in their clinic, 17.4% thought it had remained constant and only 4.3% thought it had increased.

- ***Ways to improve training for IUCD skills***

More than one-third (39.1%) of respondents said that IUCD training, refreshers and updates should be conducted, 26.1% thought health education related to IUCD should be considered and 21.6% said providers should be trained in counselling, including counselling for all other methods and for benefits of IUCD. A few respondents (8.7%) said they did not know how training could be improved.

- ***Ways to improve service provision***

In the viewpoint of 21.7% of providers, IUCD training should be revived and the number of competent providers increased (8.3%). Other providers (21.7%) suggested improving the provision of supplies and equipment (so that clients are not asked to buy anything) and 8.3% wanted increased privacy and even a special room for IUCD services and reduced waiting

time for services. Interpersonal relationships should be enhanced according to 4.3% of providers, with emphasis on proper counselling (8.3%), helping client select a method, regardless of what method she initially asked for, and health education (17.4%).

RH Providers: Findings and implications

KAP on FP

RH providers had wide awareness of most methods of FP available in the Tanzania program. They had positive attitudes to family spacing and limiting, and their mean family size approached the Tanzania ideal. Their previous, current and intended future use of FP were moderate.

KAP on IUCD

While most RH providers were aware of the IUCD, some still had inadequate/incorrect knowledge of the IUCD, such as that it fails often, causes cancer or that spontaneous expulsion is frequent. This may be based on poor screening (to rule out pregnancy, PID) and incompetence in IUCD service provision (for proper fundal placement of IUCD) resulting in high pregnancy and expulsion rates, thus ironically reinforcing providers' beliefs that the IUCD itself is at fault.

While providers' partner approval is quite high for FP in general, it is much lower for IUCD use in their relationship. In addition, most providers had never considered using the IUCD, and of those who did, many did not go on to use it because of misconceptions and rumors.

Of utmost concern was the glaringly inadequate knowledge on absolute contraindications to IUCD use, a fact that, if not adequately addressed during screening, would result in frequent and severe complications arising from IUCD use.

Provider KAP on RTIs

RH providers had moderate awareness of RTIs. They knew the main preventive measures against transmission including a mutually monogamous sexual relationship and/or consistent use of the male condom. Most providers stated that the IUCD does not cause RTIs or AIDS, but several felt that the IUCD could make these conditions worse. Providers also felt that RTIs are not well addressed during training.

Providers' training, skills, counseling

Most providers had never been trained in IUCD service provision, and felt that they needed to be. Nearly half of those who had been trained suffered loss of knowledge, of skills and of confidence over time for various reasons, and were now in dire need of refresher and update training. Trained RH providers skills may have been high when IUCD training was very topical, and in the news, and logistics were better and DMOs were better able to support financial shortfalls — now they are not.

Many of the trained providers felt that the duration of training was inadequate, especially in the practicum, and the number of clients was insufficient. Additionally, while equipment and expendable materials were sufficient during training, they were subsequently deficient during routine service provision. Post-training follow-up and supervision were often inadequate.

On balance, central/regional training was better perceived than OJT. However, most RH providers had not benefited from a specific RTI training course or counselling and they called for changes in curricula so as to include these topics in future courses.

Administrative support to providers

RH providers were generally satisfied with administrative support available for service provision. However, lack of expendables, equipment, room partitions and even basic necessities like water and electricity were a hindrance to quality service delivery. Furthermore, lack of rooms, space and privacy and expendables forced even highly trained providers to perform like CBD agents, distributing only condoms and OCs even inside clinic setups.

Trainee selection for FP/IUCD courses was thought to be poor or even biased, and some providers selected for training were uninterested or patently incapable of offering the services they were being trained for.

RH providers skip a truly crucial step in counselling. While they are generally good in educating about a method already chosen by the client, they neglect the earlier step of determining what the client's reproductive needs and goals are along with her knowledge and previous practice of other FP methods. This is what providers misconceive as a way saving time during counselling and to avoid long queues, but it presupposes that clients come from their communities already with considerable knowledge of most methods of FP and that the providers then need only zero in on details for a particular method. This presupposition is often incorrect. The client may come in knowing something about OCs or the injectables, for instance and she will leave the clinic knowing a lot more but only about these methods.

RH Providers: More findings, implications

During the study, for instance, there were six IUCD insertions in Dar-es-Salaam and four in Arusha, while there were three IUCD simulations in Singida and four in Mbeya. Providers in Singida and Mbeya could find it difficult to sharpen their skills and knowledge due to inadequate practice. When providers' skills are poor, single procedures such as inserting the "*mdomo wa bata*" or duck's bill (speculum) or cervical tenaculum can cause inordinate discomfort and even pain. This occurrence may be exaggerated as it is narrated in the community to discourage other potential IUCD clients.

Some providers perceive the frequency of spontaneous IUCD expulsion to be high. Several explanations for spontaneous IUCD expulsion were suggested including: the client's male partner could be too muscular or strong or too vigorous during coitus, the woman could gyrate her hips too much, or the couple could adopt a "different" style (position) of coitus. Most clients have the nurse as their main and also preferred source of FP information. She is to some extent the gatekeeper to the clients' true FP knowledge.

Recommendations for providers

MOH RCHU should improve the quantity, quality and access to IEC material for providers especially on IUCD. IEC materials targeted at health workers should be developed and disseminated to them.

MOH, RCHU, R/DHMT and training NGOs should train untrained providers in IUCD insertion skills in the areas designated for IUCD service provision.

MOH, RCHU and Zonal Training Centers considered adopting/adapting alternative innovative training approaches, including formal OJT, self learning via handbook and multi-media and update or Health Attendant's RH training using audio/video assisted distance learning as deemed appropriate. On-site training can be conducted by the IRCH trained ACO/CO in charge of the health facility or MCHA where the targeted trainee works.

Trainee selection should be based on interest, willingness and competence and not merely on possession of basic clinical skills.

IUCD training curricula should include expanded sections on targeted health education, establish a new RH (IUCD) service in a community RTIs and counselling process with intensified practicum.

MOH should strengthen all PST curricula for IRCH provision and make this an examinable subject in the final year. *(Currently the PHNB has incorporated the IRCH content addressed inservice training.*)

Those already trained should receive refresher and update training using innovative training approaches suggested above. Some emphasis needs to be placed on complications, contraindications, screening, counselling and management of complications, including referral.

MOH RHU should combine developing the capacity and capability of zonal Training Centers (ZTC) so that they can conduct IRCH updates. The ZTC should involve the trained RCH providers and RTT/DTT in all phases of the training.

MOH RCHU should explore and implement a mechanism of assisting Regional and District Health Management Teams (R/DHMT) to:

- introduce/strengthen the self assessment techniques for example, using the MOH made quality assurance tool and/or COPE (Client Oriented Provider Efficiency) or procedure manual, in health service provision sites; AND
- assist the on-site supervisors to conduct supportive/facilitative supervision based on self-assessment and use of service data collected.

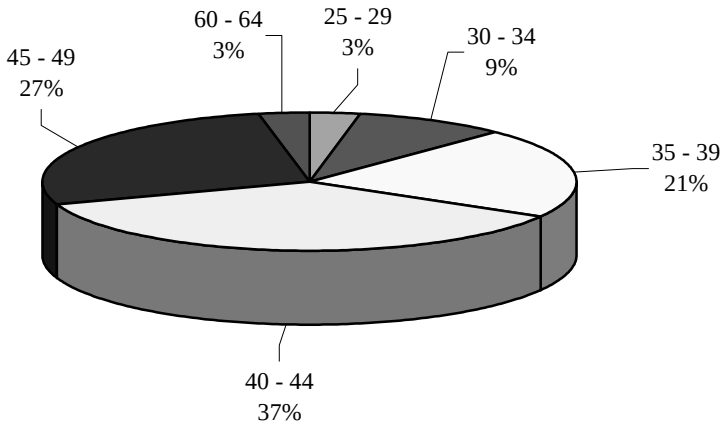
R/DHMT in collaboration with MOH, RCHU, the appropriate local government authority and other regional/district based RCH organizations should explore and implement approaches addressing the scarce equipment and consumable supplies needed for quality IUCD and other RCH services.

RH Preceptors/Trainers

General observations

Thirty-five preceptors and trainers from seven different sites were interviewed from November 1998 to January 1999. Their ages ranged from 26 to 61 years. Eight percent of them were in the age groups 35-49 (Figure 13). Twenty-two of them (62.8%) were married or cohabiting, 22.9% were single, 2.9% separated and 11.4% widowed.

Figure 13: Age of preceptors/trainers (N = 35)



Twenty-five percent were designated preceptors and a similar proportion was certified preceptors. Six percent were certified trainers.

Most of them (78.8%) were from urban government sites, but 3% were from rural government, 6.1% from NGO (UMATI, Seventh Day Adventist) and 12.1% were from other sites (such as CTT).

Most of the preceptors/trainers (51.9%) were associated with hospitals, 33.3% with health centers and 14.8% with dispensaries. Dar-es-Salaam region contributed the largest population of respondents, (31.4%) followed by Mbeya, with 28.6%, and then Arusha and Singida with 20% each.

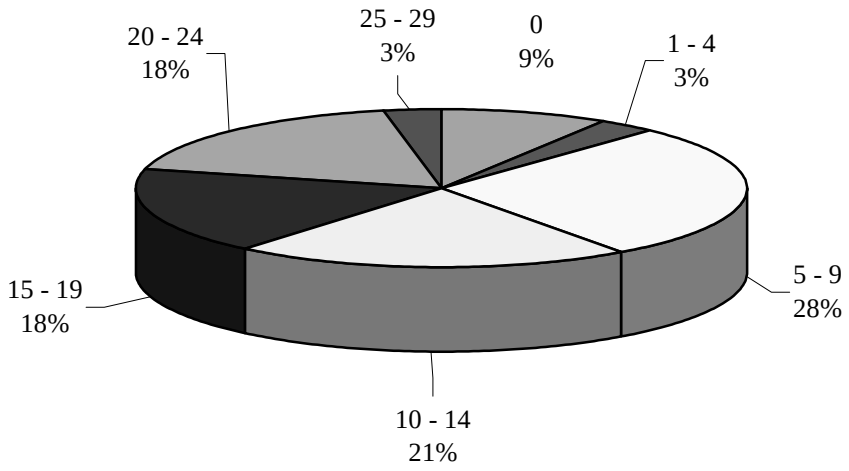
Most of the respondents (88.6%) were female. Nearly half of them (45.7%) had reached secondary or advanced level education and 51.4% had college/professional or university education.

Professional certificate or diploma

Nearly one third (31.7%) had PHNA/diploma, 29.3% had PHN B, and 17.1% had an NO, while 9.8%, 2.4% and 9.8% had certificate NMWB/NMW, ACO/RMO and AMO diplomas, respectively. *(Note: NOs are registered nurses or nurse/midwives, diploma level)*

These diplomas/certificates had been earned a mean of 12.3 years before, with a range of 1.1-28. Two thirds (66.7%) of the awards had been won 5-19 years before (Table 26).

Figure 14: Duration since preceptor/trainer attained professional certificate/ diploma (N = 35)



Preceptor's/trainer's pregnancy history

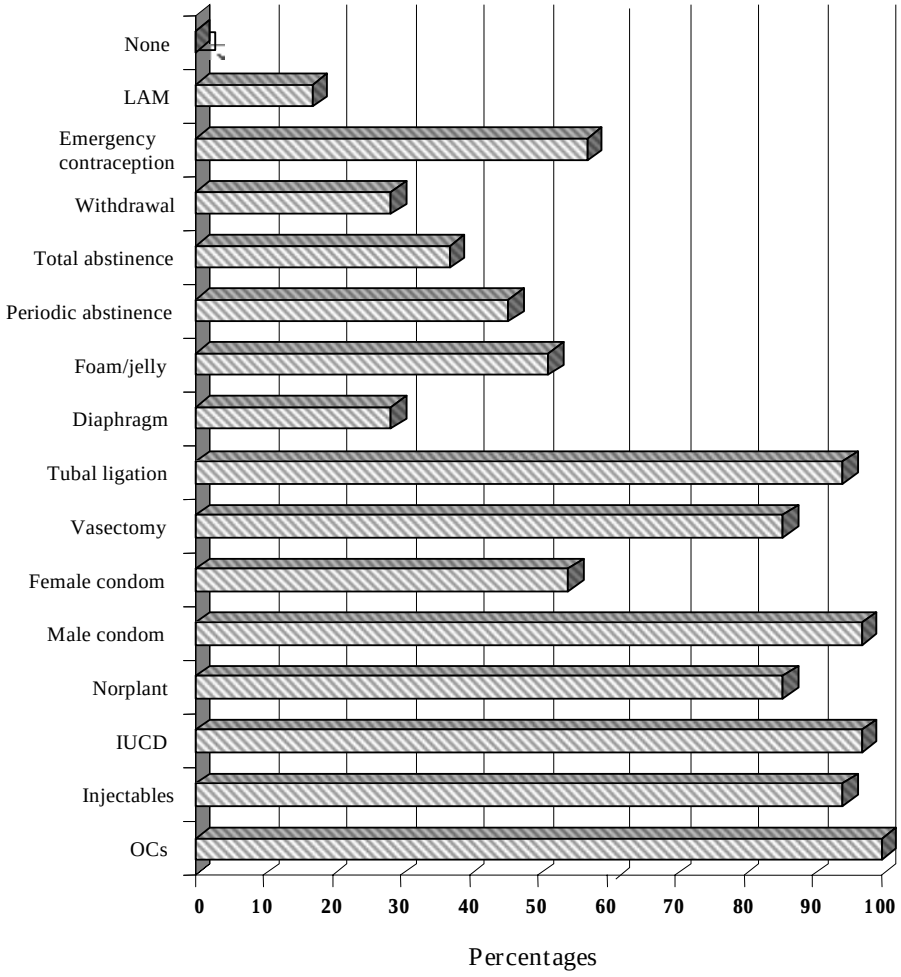
Most respondents (54.3%) had been pregnant 1-4 times and 17.2% 5-14 times. The mean number of pregnancies was 3.3 with a range of 0-12 and a mode of 3. The pregnancies had resulted in one stillbirth, a mean of 0.2 abortions (range 0-2, mode 0) and a mean of 2.8 live births (range 0-6, mode 3) per respondent.

The age of the youngest child was a mean of 0.8 years range 0-3 years, mode 0.3 years. Youngest child age of 0.3 years formed 52.9% of the group.

RH Preceptor/Trainer Knowledge of FP

Every preceptor/trainer had trained HCWs in at least one method of FP; 84.8% of the methods were mentioned spontaneously and 15.2% after prompting (Figure 15). More than 90% of the respondents stated they had trained HCWs in the following areas: OCs, IUCD, male condoms, injectables and tubal ligation (100, 97.1, 97.1, 94.3 and 94.3% respectively). Other commonly trained in methods were Norplant® Implants and vasectomy, both by 85.7%. The least trained in methods were LAM (17.1%), withdrawal and diaphragm both at 28.6%, and total abstinence (37.1%). Seventeen percent of respondents also mentioned each of calendar and mucus observation methods.

Figure 15: FP methods in which preceptor/trainer has trained HCWs (N = 5)



Administrative support to conduct FP training courses

Almost all preceptors/trainers (94.3%) said they felt they had received adequate administrative support to conduct the training courses (these courses may occur at sites away from the preceptor/trainer's usual site of work, and away from his/her usual supervisors). Only 5.7% respondents felt that they had either not received adequate administrative support or that the adequacy of support varied (e.g., with the particular training course, or site).

The main reasons respondents were satisfied (42.9%) were that they were provided with adequate material and supplies for the trainings, along with technical and moral support. However, 5.7% of respondents complained of an inadequate duration between being informed of scheduled training and the training itself. Occasionally, supplies were inadequate, even during training (2.9%).

Types of training preceptor/trainer went through in preparation to work in training
All respondents had benefited from at least one of twenty-one RH-related courses, some several (Table 25). The cumulative number of courses attended was 98, an average of 2.8 per respondent.

Table 25: Types of training preceptor/trainer underwent in preparation for work in training (N = 35)

Course	%
Preceptorship	42.9
Basic Clinical Skills	71.4
Comprehensive Clinical Skills	34.3
Integrated Reproductive Health	28.6
Logistics Management	14
RTI	.3
Infection prevention	8.6
OJT	28.5
Advanced Training Skills	17.1
Training Skills Update	17.1
CTST Update	14.3
CTU	31.4
Teaching Methodology	11.4
TOT	14.3
IEC	24.0
IUCD insertion	88.6
Norplant® Implants Insertion	22.9
Voluntary Surgical Contraception	11.4
VSC Counseling	22.9
PST	24.0

One eighth of the courses (12.5%) had been attended 1-2 years before, 32.3%. Three to four years, 41.7% five to six years, 11.4%, seven to eight years and 2% nine or more years before.

Preceptor's/trainer's confidence as an effective trainer
Respondents were asked whether they felt confident that they had learnt all they needed to learn to be effective as trainers. Only slightly more than half of them (51.4%) answered affirmatively. The rest (48.6%) were not confident and said that, to be confident, what they further needed to learn was Preceptorship Training (11.4%) and Consultation Skills (2.9%). Each of 5.7% of respondents opined that they needed IEC and integrated RH Training update, while each of 8.6% needed FP Update, Training Skills update and Infection Prevention skills.

Preceptor's/trainer's conduct of IUCD training
Respondents were asked whether they had conducted any clinical skills training which included content on IUCD insertion. More than four-fifths (82.9%) had, but only 17.1% had

not. Specifically, (74.3%) had conducted Contraceptive Clinical skills, 17.1% had conducted IUCD insertion training, 8.6% had had Contraceptive Technology Update and 2.9% had conducted each of the following: Basic Training Skills, Comprehensive Clinical Skills, preceptorship skills and integrated Reproductive Health Training.

Preceptor's/trainer's knowledge on client types suitable for IUCD

The most frequent response (31.4%) was multipara, followed by client seeking long-term protection (22.9%), who has no contraindications (11.4%) and who selects it 8.6%. A small proportion (5.1%) of respondents either gave no response or cited each of the following: a client free of RTI, not pregnant, in a stable sexual relationship, client who cannot use hormonal FP, who does not have recurrent vaginal bleeding, who is breastfeeding and is 6-8 weeks post-delivery.

Regarding client types who are unsuitable for the IUCD, similar proportions of respondents (22.9%) cited nulliparity, pregnancy and presence of RTIs or AIDS. Further, 17.1% mentioned multiple sex partners and 5.7% mentioned cancer of the cervix. A similar proportion (5.7%) gave no response. A small proportion (2.9%) cited each of the following: nulliparity, abnormal vaginal bleeding, anemia, recurrent PID, uterine abnormality, allergy to Copper, recurrent abortion, history of uterine operations and client's dislike of the method.

RH Preceptor's/Trainer's Knowledge of IUCD

IUCD benefits that preceptors/trainers expound to trainees

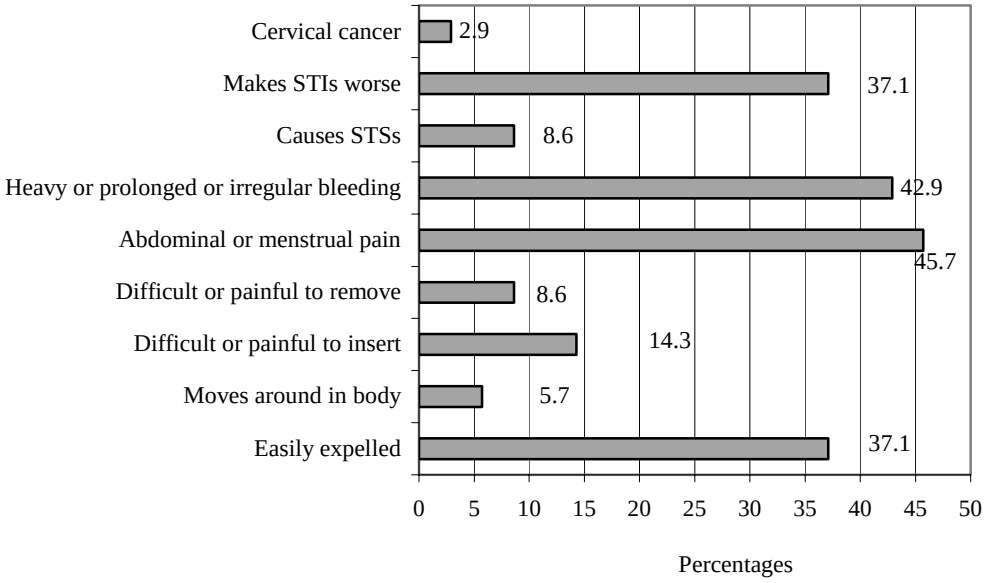
The data indicate that the benefit discussed by almost all respondents (94.3%) was the long-term effectiveness of the IUCD (Table 26). Other benefits were mentioned less often, but important ones included that no chemicals enter the blood stream (54.3%) that the IUCD does not interfere with sex (48.6%), that it is convenient and easy to use (45.8%) and that the IUCD requires nothing or little to remember (40%). Just over one third (34.3%) of respondents mentioned that the IUCD is highly effective, that few revisits are needed routinely (31.4%), there is no need for re-motivation/and it does not interfere with breast milk (each at 22.9%).

Table 26: IUCD benefits that preceptors/trainers expound to trainees (N = 34)

Benefit	%
High effectiveness	34.3
Convenience/ease of use	45.8
Low need for re-motivation/bother	22.9
Nothing/not much to remember	40.0
Very safe	11.4
Few revisits needed	31.4
Acts a long time	94.3
Does not interfere with sex	48.6
No chemicals enter blood stream	54.3
Is confidential/secret	11.4
No effect on breast milk	22.9
Other: immediate return to fertility/ comfortable/low cost	31.5

What preceptors/trainers present to trainees as common adverse effects of the IUCD
The adverse effects that respondents most frequently told trainees about as being common were occurrence of abdominal/menstrual pain (45.7%) and heavy prolonged/irregular bleeding (42.9%). Easy IUCD expulsion and worsening of RTIs were each mentioned by 37.1% (Figure 16). Only 8.6% taught that the IUCD actually causes RTIs, but the same number taught that the IUCD is difficult or painful to remove. Even more respondents (14.3%) taught that it is difficult or painful to insert an IUCD, others that it moves around in the body (5.7%), and that it causes cancer (2.9%).

Figure 16: What preceptors/trainers present to trainees as common adverse effects of IUCD



Other common negative aspects of IUCD use
About one-third of preceptors/trainers also taught their trainees that the IUCD fails often (37.1%) and is effective for only a short time (31.5%). A similar number of respondents (14.3%) taught that IUCD use is against their religion, and it causes allergy or watery vaginal discharge. Respondents also taught that IUCDs do not protect against RTIs (8.6%) and that partners can feel them (2.9%). No preceptor/trainer taught that IUCDs cause AIDS, but 11.9% taught that IUCDs make AIDS worse or cause birth defects. While 5.7% taught that the IUCD perforates the uterus, the same number said it makes the clients infertile and causes abortion.

Table 27: Other common negative aspects of IUCD use that preceptors/ trainers tell their trainees about

Negative aspects	%
Fails often	37.0
Causes AIDS	0.0
Makes AIDS worse	11.4
Causes abortion	5.7
Causes birth defects when it fails	0.0
Makes client infertile	5.7
Perforates uterus	5.7
Causes allergy	14.3
Against religion	14.3
Effective only short time	31.5
Watery PV discharge	14.3
Others: partner feels threads/no RTI protection	14.3

Preceptor's/trainer's knowledge on main mode of action of Copper IUCD

All respondents said they knew of at least one main mode of action. The most prominent ones mentioned were that the IUCD acts as a foreign body (45.1%), that it changes the lining of the uterus (40%) or that the Copper is spermicidal (34.3%) and slows down the sperm (31.4%). Other main modes of action mentioned were prevention of ovulation (14.3%) and change in movement of uterus or tube (by 5.7% each). Thickening of cervical mucus was mentioned by 2.9% of respondents.

Table 28: Preceptor's/trainer's' knowledge on main mode of action of Copper IUCD (N = 35)

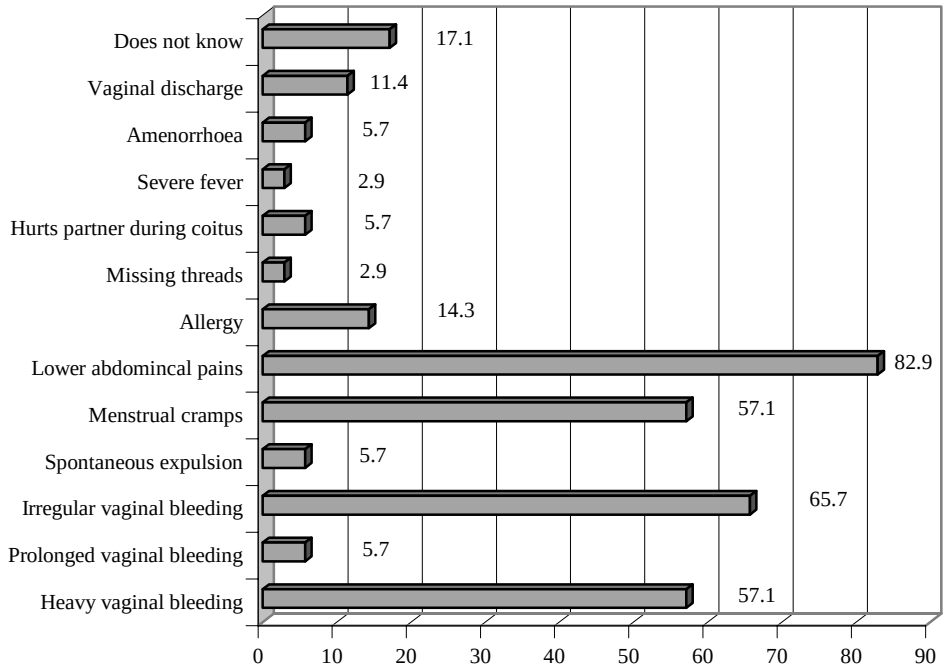
Main mode of action	%
Causes abortion	0.0
Acts as a foreign body	45.7
Prevents ovulation	5.7
Changes lining of uterus	40.0
Changes movement of tubes	5.7
Does not know	0.0
Copper acts as spermicide	34.3
Slows down sperm	31.4
Prevents fertilization	14.3
Thickens cervical mucus	2.9

What preceptor/trainers recount to their trainees as common side effects of IUCD

Surprisingly, some respondents (17.1%) did not know any common side effects (Figure 17). The most frequently recounted common side effects were lower abdominal pains (82.9%) irregular vaginal bleeding (65.7%) and heavy vaginal bleeding/menstrual cramps (each by 57.1%).

Other common side effects less frequently cited were vaginal discharge and prolonged vaginal bleeding (11.4%). Others, mentioned by 5.7% of respondents each, were IUCD expulsion, hurting of sex partner, backache and amenorrhoea. Only 2.9% of respondents mentioned missing threads and “severe fever."

Figure 17: What preceptors/trainers recount to their trainees as common side effects of IUCD (N = 35)



What preceptors/trainers recount to trainees as complications of IUCD use
Almost all respondents knew of at least one complication of IUCD use (Table 29).

Table 29: What preceptors/trainers recount to trainees as complications of IUCD use (N = 35)

Complication	%
Expulsion	71.4
Uterine perforation	17.1
Pregnancy	40.0
Threads trap man's penis	0.0
Causes RTIs/HIV infection to client	14.3
Causes HIV infection to provider	0.0
Don't know	0.0
Severe bleeding	33.3
Missing strings	3.0
Vaginal discharge	20.0
Severe lower abdominal pain/backache	29.7
Ectopic pregnancy	3.3
Fever	6.6
Pelvic infection	14.7

What preceptors/trainers teach as absolute contraindications to IUCD use

Spontaneous responses made to this question were disappointing. Although, correctly, none of the respondents thought that spontaneous expulsion of an IUCD was an absolute contraindication, 97.1% did not think being unmarried was either and 12% did think multiparity was an absolute contraindication. Three-quarters (74.3%) did not know nulliparity is an absolute contraindication (which it is, though debatably, under the Tanzania FP guidelines and standards).

Even more seriously, high risk of PID, recurrent PID, pregnancy and even presence of active PID were not mentioned by 68.6%, 65.7, 45.7 and 40%, respectively.

Absolute contraindications mentioned by 14.3% of respondents each included: history of ectopic pregnancy, abnormal uterus, cancer and undiagnosed genital bleeding. Also, by 2.9% each: AIDS, previous cesarean sections, copper allergy, recurrent abortion and dysmenorrhoea.

Figure 18: What preceptors/trainers teach trainees as absolute contraindications to IUCD use (N = 35)

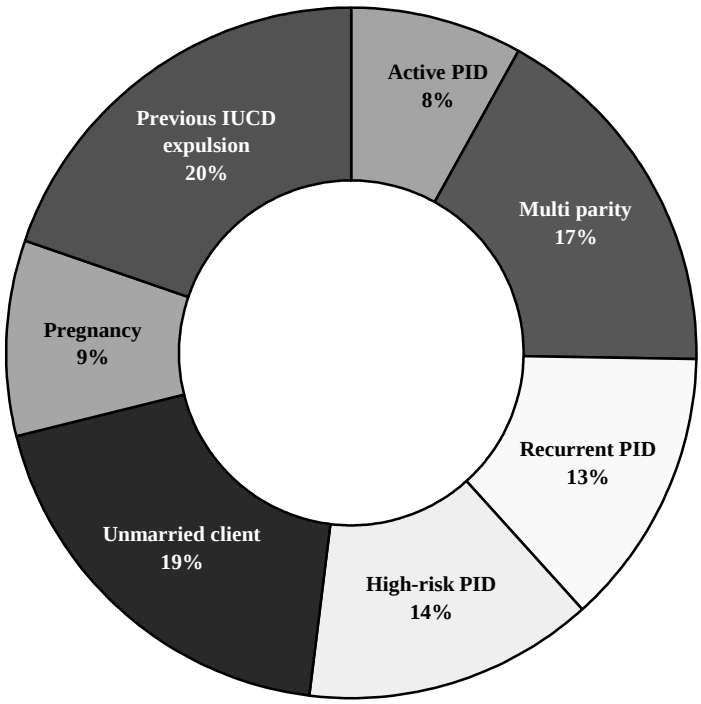


Figure 18 presents wrong and correct absolute contraindications as per WHO medical eligibility criteria and Tanzania Procedure Manual (1997)

Preceptor's/trainer's knowledge of RTIs

Preceptors/trainers were asked whether they taught their trainees about diseases that could be transmitted through sex. All of the respondents did. The RTIs most often taught were syphilis and gonorrhea (each by 97.1%), followed by AIDS (91.4%). Sixty percent taught on each of chlamydial infection and bacterial vaginosis, while 57.1% taught on genital sores,

and 45.7% on genital warts. Fewer respondents (22.9-2.9% in descending order), taught on Trichomoniasis, candidiasis, Herpes infection, bulbo inguinalis, Chancroid and “vaginal discharge."

Necessary health assessments that preceptors/trainees instruct their trainers to perform on clients requesting IUCD

A few respondents (5.9%) did not instruct their trainees to perform any assessment, but about one fifth of them (20.5%) instructed on a social and medical history, while double that number (41.2%) asked for a “pelvic assessment” and 17.6% for an abdominal palpation (Table 30). Other assessments were each mentioned by only 2.9% of respondents: general physical examination, blood pressure, speculum examination and assessment of vaginal muscle tone.

Table 30: Necessary health assessment that preceptors/trainers instruct their trainees to perform for clients requesting IUCD (N = 35)

Health Assessment	%
None	5.9
Social and medical history	20.5
Ask if on menses	2.9
General physical examination	2.9
Blood pressure	2.9
Abdominal palpitation	17.6
Pelvic assessment	41.2
Speculum exam	2.9
Vaginal muscle tone	2.9
Assess counseling	2.9

Table 31: Preceptor's/trainer's knowledge on what a person can do to avoid getting HIV/AIDS (N = 35)

Preventive measure	%
Do not have sex at all	37.1
Use male condom	94.3
Use female condom	17.1
Have one faithful partner	97.1
Avoid IUCD	0.0
Avoid other types of FP	2.9
Use traditional medicines	0.0
Does not know	0.0
Other	11.4

All respondents knew of at least one preventive measure. The predominant measures by far were to have one faithful sexual partner (97.1%) and to use male condoms (94.3%). Just over one third opted for not having sex at all, and 17.1% mentioned use of the female condom. Others mentioned were avoidance of using contaminated instruments (20%), avoidance of anemia (2.9%), of blood transfusions, and of sex at an early age. They also advised on care of wounds and counselling/treatment of both partners in case of RTI (2.9%). Not a single respondent cited avoidance of IUCDs or other FP methods as a preventive measure.

Preceptor's/Trainer's Attitude to FP

Partner's approval for using FP

Partner's approval was assessed indirectly by asking the preceptor/trainer whether they thought their partner approved or disapproved of the two of them using a method to avoid or delay pregnancy. The responses were that just over two-thirds (67.6%) of partners approved, 8.8% did not and the attitude was not known for 2.9%. Regarding the IUCD however, approval was reportedly positive for only half the partners, while 14.7% disapproved 5.9% were neutral and the attitude was unclear for 8.6%.

Preceptor/Trainer Attitude to IUCD

Respondents were asked whether they had ever considered using the IUCD, 62.9% had, but 37.1% had not.

The reasons for not considering IUCD use were: history of ectopic pregnancy or recurrent lower abdominal pain (11.4%), unmarried or husband away most of the time (11.4%) or on another FP method (2.9%). However, some preceptors/trainers said that they just “did not like it," or that they were “negative” (each by 2.9% or respondents).

Of those who had considered using the IUCD, 56.3% had actually used it, the others went on to different FP methods (15.2%), or lost their steady partner (6%) or developed a contraindication or suffered ectopic pregnancy (3%).

Some preceptors/trainers, surprisingly, were unable to use the IUCD because they were unable to get adequate information about it (3%). Three percent were afraid the IUCD could perforate the uterus and others developed “negative ideas” (6.1%).

Some of those who were previously using the IUCD were no longer using it currently because they decided to go on other FP mentioned (25.1%) including a permanent method, or developed complications (6.3%), “became infertile” (3.1%), or no longer had sexual exposure (6.3%).

Future use of IUCD

Respondents were asked if they would use the IUCD if they needed contraception in future. One-third (33.3%) said that they would use it, 33.3% would not, 6.1% were unsure and 21.2% would not need contraception.

Those who would not use it said they were on other FP methods (including permanent contraception) (25.1%), were now old or infertile or history of ectopic pregnancy (6.3%). Others had developed complications on previous use of IUCD (6.3%) or were not getting regular coitus (6.3%). Some just “did not like” (3.1%). One respondent complained that she had once conceived on the IUCD and was therefore not going to try it out again.

Partner’s approval of IUCD use

Female respondents were asked whether, if they ever used the IUCD, their partner knew about it. Almost the same number answered affirmatively, negatively and uncertainly (36.4, 31.8, and 31.8%, respectively).

Just over half of the partners who knew approved (56.3%), 12.5% disapproved and for 31.3% of partners the respondent was uncertain.

Preceptor's/trainer's general views about the IUCD
Most of the views were positive, including that it is a “good” method (by 48.6%) of providers), is effective long-term (28.6%), is safe/has no hormones (5.7%) and does not interfere with coitus and is associated with immediate return to fertility after removal (2.9%).

Caveats and negative views included the requirement for single sex partners (8.6%), the need for “a lot of self discipline," unsuitability for regions with high RTI prevalence rates (2.9%), and requirements for proper screening, counselling and competent providers (11.4%). Also the IUCD may cause heavy vaginal bleeding (2.9%).

Other negative views were occurrence of provider bias, the unpleasant need to keep checking vaginally for IUCD threads, the consideration that IUCD is a foreign body, and the fear that a contaminated IUCD can carry infection into the uterus.

Negative aspects of IUCD service that preceptors/trainers tell trainees about
Forty percent of preceptors cited inadequate counselling as the most common negative aspect of the IUCD service, 37.1% cited inadequate expendables and 22.9% the necessity for a pelvic examination (Table 32). The lack of variety in IUCD types was quoted by 14.3% and that IUCD service provision takes much time by 11.4%. No respondent mentioned any requirement that the client is menstruating at the time of IUCD insertion or removal nor that the IUCD program is donor driven or forced on Tanzania. Only a few (2.9-5.9%) mentioned any need for frequent visits pre and/or post-insertion or the cost of IUCD services. Again, only 8.6% talked of inadequate privacy/confidentiality as a negative aspect. Other aspects mentioned negatively were inadequate knowledge of the IUCD by potential clients and providers, inadequate screening, and also bias even by trainers and preceptors against the IUCD.

Table 32: Negative aspects of IUCD services that preceptors/trainers tell their trainees

Negative aspects	%
A pelvic examination is necessary	22.9
Need several visits pre-insertion	5.7
Need frequent visits post-insertion	2.9
High cost of IUCD service	5.7
Shortage of expendable	37.1
Inadequate privacy/confidentiality	8.6
No variety in types of IUCD	14.3
Inadequate counseling	40.0
Requirement that client be menstruating for insertion/removal	0.0
IUCD service provision taken much time	11.4
Program donor driven/forced on Tanzania	0.0

What preceptors/trainers recount to trainees as the main consideration for a client on deciding where to go for IUCD

The most commonly quoted features (Table 33) were staff competence (by 77.1% of respondents), availability of adequate information counselling and screening (by 71.5%), staff friendliness and good interpersonal relationships (65.8%) and privacy/confidentiality (60%). Nearly half the number of respondents (46.9%) cited dignity and respect, while 40% quoted wide choice of methods. Relatively few respondents mentioned low cost of services

(28.6%), closeness to work/home/market or short waiting time (each at 22.9%). Only one respondent felt that the clients opt for a service site because it has female providers.

Table 33: What preceptors/trainers recount to trainees to be main consideration for a client on deciding where to go for IUCD

Main consideration	%
Dignity/respect	46.9
Closeness to home/work/market	22.9
Privacy/confidentiality	60.0
Availability and cost of transport	5.7
Staff competence	77.1
Staff friendliness/good interpersonals	65.8
Low cost services	28.6
Longer/convenient hours of operation	20.0
Wide choice of methods	40.0
Adequate info/counseling available/screening	71.5
Short waiting	22.9
Female provider	2.9
Availability of equipment and supplies	8.6

What preceptors/trainers teach their trainees to be negative associations between IUCDs and sex

While 28.6% of respondents felt that there was no association between IUCDs and sex, 45.7% said the association was that the IUCD does not protect against RTIs, 17.1% said the IUCD hurts the partner during sex, or hurts the client and reduces sexual pleasure (5.7%). The IUCD also causes a watery vaginal discharge (5.7%) which may reduce desirable sexual friction and pleasure during coitus. The presence of this watery discharge also leads some men to impute promiscuous behavior on their partners.

Some 2.7% of respondents mentioned each of the following: constraints on variety of coital positions, IUCD can be pushed through the uterus by penis, client must abstain from sex seven days pre-insertion, and client must abstain five days post-insertion.

Preceptors/Trainers Attitude Towards RTIs

Preceptors/trainers views on whether there is any relationship between RTIs and the IUCD

Just over one-half the number of respondents (51.4%) said that there was no relationship between RTIs and the IUCD. The reasons were that the IUCD is sterile/does not carry germs. The rest (48.6%) said that there was a relationship in that the IUCD can worsen RTIs, a woman with RTIs cannot use the IUCD and a woman on the IUCD is constrained to one sex partner.

Preceptors/trainers thoughts on what a woman wishing to use IUCD should do so as to avoid RTIs

None of the respondents thought that she need not do anything or that nothing can be done (Table 34), although 11.8% did not know what could be done. Almost all respondents (91.4% each) said the client ought to stick to one faithful sexual partner or use a condom or other barrier method.

Table 34: Preceptors/trainers thoughts on what a woman wanting to use IUCD should do in order to avoid RTIs (N = 35)

Preventive measure	%
Need not do anything	0.0
Nothing can be done	0.0
Not have the IUCD	2.9
Use condoms/other barrier method	91.4
Avoid multiple sex partners	91.4
Partner to avoid multiple sex partners	37.1
Use medications	2.9
Does not know	11.8
Other/personal hygiene/treat RTIs completely	8.7

Just over one third (37.1%) said the male partner should avoid multiple sex partners, but only 2.9% thought the woman should not have the IUCD inserted.

Attitude to IUCDs, AIDS, RTIs

Respondents were asked whether they thought using the IUCD could cause one to get AIDS. Only 14.3% thought that it could, 82.9% did not think so, and 2.9% did not know. Respondents who said it could not cause AIDS noted that the IUCD is sterile in its package, and insertion is an aseptic technique (11.4%). However, 5.7% of respondents said the IUCD can “accelerate AIDS."

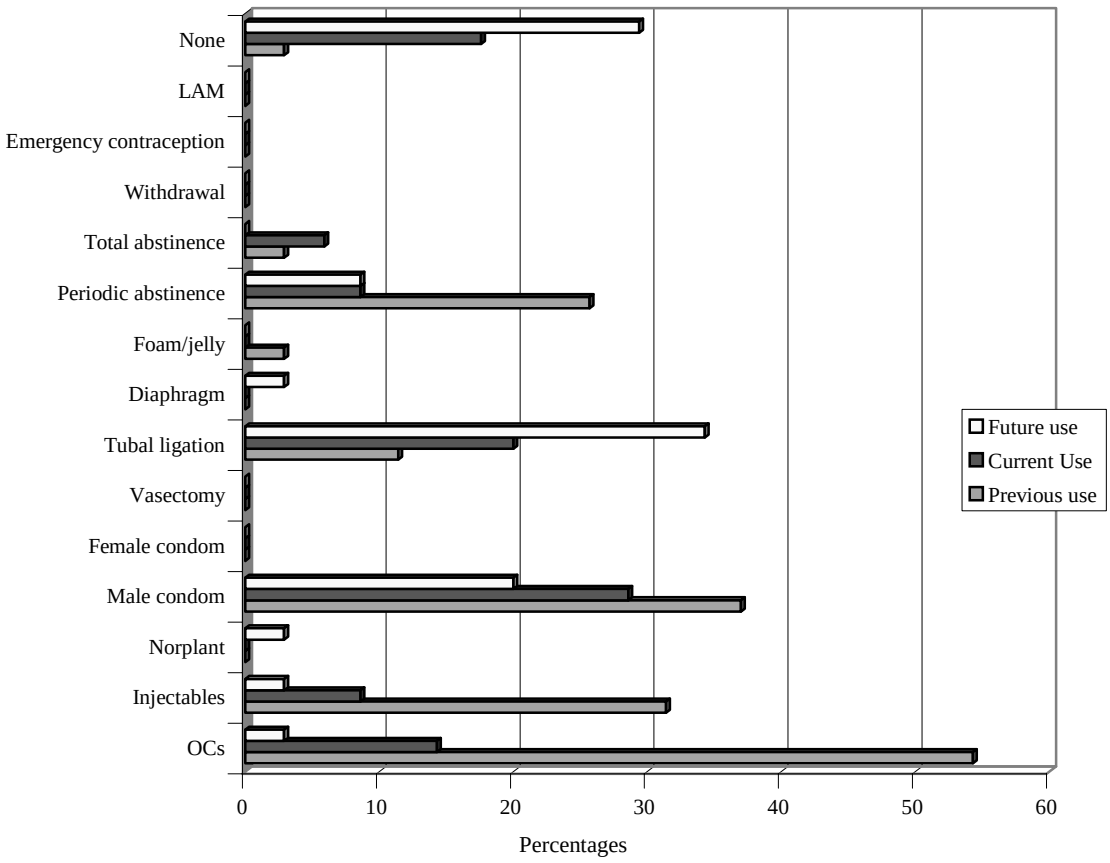
Asked whether they thought using the IUCD could cause one to get RTIs, only 5.7% of respondents thought it could, due to “ascending infection," 2.9% did not know, or said it depended on insertion technique. The vast majority (91.4%) said it could not cause RTIs because the IUCD has no germs and an aseptic technique is used.

Preceptors/Trainers FP Practice

Previous use of FP

Almost all preceptors/trainers (97.1%) or partners had previously used at least one FP method. The total number of methods previously used was eight. The methods most frequently used previously were OCs, the IUCD, male condom and injectables, by 54.3, 45.7, 37 and 31.4% of respondents, respectively (Figure 19). Six of the questionnaire-listed methods had never been used: Norplant® Implants, diaphragm, female condom, LAM, emergency contraception, withdrawal and vasectomy.

Figure 19: Preceptors/trainers previous, current and future use of FP (N = 35)



Current use of FP

Current use of FP methods was less than previous use, at 79.4%. Seven methods were in current use, the most frequent ones being male condom, tubal ligation and OCs at 28.6, 20 and 14.3% respectively (Figure 19). Eight listed methods were not in current use, including Norplant® Implants, LAM, emergency contraception, diaphragm, foams/jelly, female condom, withdrawal and vasectomy.

Future use of FP

Two-thirds of preceptors/trainers (67.6%) intended to use a FP method in future or were already using one but 29.4% of them did not intend to, and 2.9% were unsure whether they would. About one-third (34.3%) intended to use tubal ligation, making it the most popular method for future use followed by the IUCD and the male condom, each at 20%. Other methods would be much less popular; with OCs, injectables, Norplant® Implants and diaphragm each being the method of future choice for only 2.9% of respondents and periodic abstinence for 8.9%. No respondent intended to use LAM, emergency contraception, total abstinence, withdrawal or vasectomy.

When asked why they would use a particular method, the most common attributes were safety/no hormones (17.1%), high effectiveness (2.9%) and long-term action (8.6%). Other responses included double protection or "no regular partner" (8.6%). The facts that respondents were of "old age" or had completed family were also important (25.8%). Irregular menses was mentioned by 2.9% and "it helps me meet my RH goals," also by (2.9%).

Future reproductive intentions

The preceptors/trainers were asked whether they intended to have another child in the future. More than four-fifths (82.9%) of them did not, 14.3% did, while 2.9% were unsure. Only 8.7% of the respondents intended to have a pregnancy within one year, the same number in 1-2 years and yet the same number after two years.

Preceptors/Trainers Attitude to IUCD Training

The problems cited most frequently were that trainees find it difficult to master IUCD skills "practicals" (68.6%) and that there were few IUCD acceptors to practice on (45.7% of respondents, Table 35).

Table 35: Preceptors/trainers perception on most common problems interfering with their conduct of IUCD insertion skills training (N = 35)

Problem	%
Trainees find it difficult to grasp theory	22.9
Trainees find it difficult to master practicals	68.6
Few IUCD acceptors to practice on	45.7
Poor training environment	8.6
Inadequate administrative support	0.0
Inadequate training materials, equipment	5.7
Others	2.9

Nearly one-quarter of respondents (22.9%) thought that trainees find it difficult to grasp the theory content, but only 8.6% and 5.7% mentioned poor training environment and inadequate training materials/equipment, respectively. Other problems mentioned by 2.9% of respondents each were inadequate duration for practicum; MCHAs find it difficult to learn at the same rate as other trainees, rumors and poor trainee confidence. Not a single respondent said that inadequate administrative support was a common problem.

Perspective on factors which facilitate IUCD skills training

Conversely, the facilitating factors that were most prominent were trainees' easy grasp of theory, adequate training materials/equipment and good training environment at 88.6, 82.6 and 82.9%, respectively (Table 36).

Table 36: Preceptors/trainers perspective on what factors facilitate IUCD insertion skills training (N = 35)

Facilitating factors	%
Trainees find it easy to grasp theory	88.6
Trainees find it easy to master practicals	17.1
Adequate number of IUCD acceptors to practice on	20.0
Good training environment	82.9
Adequate administrative support	68.6
Adequate training materials/equipment	82.9
Team work/support from providers	11.5
Integration with MCH service	5.7
Adequate information/counseling	2.9
Adequate number and size of rooms	2.9

Less prominent facilitating factors were: number of IUCD acceptors to practice on (20%), trainees' mastery of skills/practicals (17.1%), teamwork and support from service providers, integration with MCH services (5.7%) and, lastly, adequate information/ counselling and adequate number/size of rooms at 2.9% each. Administrative support, again, scored highly at 68.6% (Table 36).

Preceptors/trainers self-perceived competence in conducting courses which include IUCD insertion

When respondents were asked whether they thought they were adequately prepared to conduct courses which included IUCD insertion, 82.4% said they were and 17.6% said they were not. Concerns voiced by 11.4% were: they possibly untrained and needed Preceptorship Skills training, 2.9% felt they should have started practicing immediately after training but they did not, and 2.9% did not have adequate ongoing practice in IUCD service provision.

Those who felt adequately prepared said it was because they had undergone IUCD insertion training (25.7% of all respondents), that they had acquired enough experience after training (11.4%) and they had all necessary equipment or had learnt the procedure themselves (each at 2.9%). One respondent had even participated in reviewing and refining the IUCD skills curriculum.

When asked how competent they now felt to facilitate their task as preceptors/trainers in IUCD service provision just over half (54.3%) felt very competent, 34.3% felt quite competent while 11.4% felt just a little competent.

Trainee competence on completion of IUCD training

Preceptors/trainers were asked how competent most of their trainees were by the time of completion of IUCD training. About half the number of preceptors/trainees said trainees had little (42.4%) or no (6.1%) competence, while 45.5% thought trainees were quite competent and 3% thought trainees were very competent at completion of training.

When asked whether, in their experience, there were instances when some FP trainees did not achieve the set standard for competence in (general) FP jobs, 75.8% said that there were. In such circumstances, 26.5% of all respondents would send feedback to base site, recommend close supervision (17.6%) and attach the failed trainee to a competent provider

as OJT including simulations or work extra hours, (19.3%). In 8.8% of cases the trainee still received the training qualification/certificate.

Regarding IUCD insertion training specifically, 70% of preceptors/trainees said some trainees did not meet the set clinical objectives and management skills. In these circumstances 11.8% of respondents did not know what was ever done, 29.4% recommended extra supportive supervision, and 20.6% extra simulations. Few respondents (2.9% each) recommended OJT, or recommended assessing the quality not quantity of the IUCD insertions, not certifying the trainee or allowing the trainee to perform IUCD insertions.

Whether the IUCD clinical skills training curricula should be changed

Nearly one-third of respondents (31%) felt that the curricula should be changed, 10.3% were unsure but 58.6% thought the curricula should be left as they are.

While 11.4% said they were "not aware" of the curricula and what should be changed, 45.7% said the IUCD insertion skills curriculum should be changed to allow more time for the training (5.7%) and especially for practicum (5.7%) or to have options for OJT and central/regional training. Others said the RCHU curriculum for ACOs and COs should be changed: equal numbers of respondents (2.9% each) called for increased content on RTIs/HIV, counselling and for separation of the Empowerment topic from Infertility and Menopause.

How to improve training for IUCD services

Preceptors/trainers were asked what they thought should be done to improve IUCD training for IUCD services. While 8.6% of respondents did not have any thoughts on it, 42.8% called for increased duration of training and especially for practicum and simulations (11.4%).

Recruitment of IUCD acceptors should also be increased (8.6%), possibly by using mobile clinics (2.9%). Practicum and practicum sites should be improved in general (mentioned by 20% of respondents) including specifically, counselling (14.3%) and privacy (2.9%) and more supplies/equipment (14.3%).

Other respondents called for separate IUCD training courses (8.6%) and also IUCD updates (8.6%). Trainees should also be required to perform 3-5 pelvic examinations before being allowed to perform their first IUCD insertion (2.9%).

Preceptor/trainer perspective on advantages of central/regional training compared to OJT for IUCD provision

While 14.3% of respondents did not know, 45.7% said central/regional training allows time and opportunity to discuss and share experiences, and to practice in groups. Other advantages mentioned included many trainees are trained in a short time (5.9%), the message spreads faster in a short time (2.9%), and the competitiveness encourages learning (2.9%). It is also easier to standardize the procedures and to also benefit from a group of trainers who possess different expertise.

Other respondents, (11.4%) felt that trainees concentrate better, there is more time for both theory and for putting theory into practice, it is less expensive (5.7%), and the daily allowance motivates trainees (2.9%).

There are disadvantages to central/regional training compared to OJT for IUCD provision. Twenty percent of respondents said concentration is inadequate, sometimes due to change in

environment (2.9%), 17.2% felt that time for training is too short, while it takes long to achieve mastery and the low client load interferes with learning (2.9%). Central/regional training is also more expensive (8.6%), reduces staffing and temporarily inconveniences sites where trainees originate from (5.7%). Trainee selection is sometimes poor or biased (5.7%), trainees sometimes get invitation letters late (2.9%), follow-up and supervision are inadequate (2.9%), and trainees can be dangerous to their clients (2.9%).

How to improve IUCD service provision

Preceptors/trainers were asked what they thought should be done to improve service provision for IUCD use. Most of the respondents (60%) mentioned measures related to IUCD training, including revival of IUCD insertion courses (11.4%) conduct more IUCD insertion courses (25.7%), OJT on IUCD (2.9%), IUCD updates (2.9%), improved screening and counselling skills (17.1%) and maintain aseptic techniques (2.9%).

Health education related to IUCD use should also be emphasized in the community (14.2%) and client recruitment for IUCD use enhanced (2.9%). Follow-up supervision of trainees should be improved (2.9%) and they should have adequate supplies and equipment even after training (11.4%) including IEC kits (2.9%). It will also be necessary to improve management of IUCD related side effects and complications (2.9%) and to fight the high prevalence rates of RTIs in the community (2.9%).

Table 37: Preceptors/trainers satisfaction with administrative support for IUCD skills training

Support aspects	%
Training policy	97.1
Recruitment of trainees	25.7
Availability of training rooms/space	74.3
Expendable materials	85.7
Supervision	74.3
Availability of clients for practicum	57.1
IEC materials	51.7

Respondents were generally satisfied with most aspects of administrative support (Table 37) for IUCD skills training. Almost all of them (97.1%) were satisfied with training guidelines, although 2.9% said the guidelines should be in Kiswahili language. Availability of expendable materials was satisfactory for 85.1% of respondents, but some noted that these materials were only available so freely during training; they were much less available for routine service provision afterwards.

Three quarters (74.3%) of respondents were satisfied with availability of a training room and space and a similar proportion were satisfied with supervision. Supervision support was thought to be inadequate by only 2.9% of respondents. However, 11.4% of respondents were concerned that supervisors were not competent in IUCD skills.

Only 57.1% of respondents were satisfied with support for client recruitment during practicum. Availability of IEC materials was also satisfactory to 57.1% of respondents, but others were dissatisfied about the quantity, variety and accessibility of IEC materials and 11.4% noted that some of the IEC materials do not have IUCD content.

Recruitment of trainees was a major area of dissatisfaction. Only 25.7% of preceptors/trainers were satisfied with administrative support for recruitment. Bias and poor selection were cited (2.9%), as were difficulty in training mixed cadres (2.9%), inadequate planning for training (2.9%), inadequate involvement of trainers during trainee selection (2.9%) and recruitment of trainees who were incapable of or uninterested in acquiring IUCD service provision skills.

What other preceptors/trainers say about the IUCD
Nearly one-third (31.4%) of respondents reported that other preceptors/trainers say that the IUCD "is a good method." But competent providers and good screening are required (5.7%) and IUCD trainings should be revived. Reportedly, some preceptor/trainer colleagues had "negative attitudes," and some other of these colleagues would say nothing.

Other respondents (14.3%) said their colleagues were concerned about the falling IUCD utilization rates, 11.4% thought high RTI prevalence rates were a major constraint on IUCD use, along with inadequate client screening (2.9%), and poor community education levels which contributed to easy spread of rumors.

The constraint to single sex partners requires a lot of self-discipline and only highly motivated clients would accept it.

IUCD recommendation to a friend
The preceptors/trainers were asked whether they would recommend the IUCD to a friend. Overwhelmingly, the response was affirmative (97.1%), only one respondent answered in the negative.

What trainees should tell women regarding timing of IUCD insertion
The preceptors/trainers were asked what their trainees should tell women who request the IUCD regarding the timing of insertion. About one-quarter of respondents (25.7%) said insertion should be during menses so that the cervix is open and insertion is easy. The same proportion (25.7%) said any time the client selects the method if she is not pregnant, 17.3% said post-delivery/abortion, on LAM, 4-8 weeks postpartum or changing FP methods.

Preceptors/Trainers: Findings and Implications

Preceptors/Trainers KAP on FP
They had wide awareness of most FP methods available in Tanzania.

Their attitudes were positive to FP use and to FP service provision.

Their mean family size was small.

Previous, current and intended future use were moderate.

KAP on IUCD
They had wide but not universal knowledge of the IUCD.

Some respondents, especially preceptors, and more specifically — untrained preceptors, still harboured inadequate and incorrect knowledge of the IUCD.

Very worryingly, even some preceptors/trainers were not exempt from the woeful deficiency of knowledge regarding absolute contraindications to IUCD use such deficiency if/when

passed on to future providers during training could in the long term carry dire consequences for client's health and for the viability of the program.

KAP on RTIs by preceptor/trainers
They had wide awareness of most common RTIs, and several uncommon ones.

They did not think the IUCD causes STIs or AIDS but some said contaminated instruments (e.g., due to lack of expendables, water, electric power) could carry infection into a client's reproductive tract.

Level of training/skills
Nearly half of respondents self-assessed themselves as having inadequate knowledge skills and confidence in both basic and in training skills.

Many trainers need refresher training themselves, both in basic service provision skills and also in training skills.

Many called for changes in curricula; those that did not include IUCD insertion skills to do so, increase duration of practicum, also STI management and counselling content. Whereas most service providers, regardless of being trained practice informal OJT, trainer or preceptor experience with formal OJT is limited.

Working environment
The working environment was generally satisfactory for training, but a few respondents complained of inadequate space. This may also impact on OJT.

Administrative support
Most respondents felt they received adequate administrative support.

However, they felt trainee selection was often poor or biased and called for more involvement of trainers in the selection.

Trainee follow-up and supervision after training was inadequate.

There was a vicious cycle in which new training graduates with inadequate skills did not get enough clients, their skills/confidence eroded faster and they got even fewer clients. DHMT need to establish and maintain an IUCD client local to allow training and maintaining of trained provider's first IUCD skills

Recommendations for preceptors/trainers
MOH, RCHU should revive IUCD insertion skills training.

MOH RCHU will need to base the training where there are more IUCD clients initially, supported by simulations and good logistics and follow-up.

MOH should phase out untrained preceptors (e.g., by training them) and replace with trained preceptors and trainers. Train only those who are interested in IUCD service provision.

MOH, RCHU should give trained preceptors and trainers refreshers and update training every two to three years or use innovative training approaches suggested in this report. The training should continue to have theory and practicum and also address any negative attitudes that participants may harbour against IUCD and other methods.

MOH, RCHU in collaboration with R/DHMT and NGO partners in RCH field test the OJT materials prepared in 1999 and establish the IUCD OJT at selected/designated institutions/sites.

DHMT should deploy RCH trainers in service sites in order to put into practice the IUCD and other skills acquired during training and to act, as model to others, what they train others to do.

In preparation for IUCD training, the DHMT should assist RH trainers to work with the community in the catchment area to establish a system of promoting the benefits of the IUCD and other FP methods while dispelling the rumours and misconceptions about the method.

RH Clinic Supervisors

General observations

Twenty-five RH supervisors were interviewed in November 1998-January 1999.

Table 38: RH supervisor's job title, assigned position and professional certificate/diploma (N = 25)

Job Title	%
PHNO, PHNA	36.0
PHN "B"	20.0
NO (Registered Diploma Nurse or Nurse Midwife)	16.0
NMB, BNMW	12.0
MA/CO	12.0
ACO/RMA	4.0
	100
Assigned position	
National level coordinator/director	4.2
Clinic supervisor/in-charge clinic	3.7
SDP in-charge	8.3
DMCHCo or acting DMCHCo	29.2
RMCHCo or acting RMCHCo	20.8
	100
Professional certificate/diploma	
RN	20.0
RM	12.0
PHN "A"	40.0
PHN "B"	16.0
MCH AIDE	4.0
CO	4.0
MO	4.0
	100

RH supervisor's job titles

Slightly over half of the respondents were PHNO/PHNA (36%) or PHN"B" (20%), while 16% were NO and 12% each were NMB/BNMW or MA/CO (Table 38). Only 4% were ACO/RMA.

RH supervisor's assigned positions

Just over one-third (37.5%) were clinic supervisors/in-charge of clinics, while 29.2% were DMHC Coordinators and 20.8% were RMCH coordinator/acting RMCH coordinators (Table 38). SDPs-in-charges and national level coordinators made up 8.3 and 4.2% of respondents,

respectively. The number of years that respondents had held the assigned position ranged from 1-36, with a mean of 7.3 (SD 7.3) and a mode of 3. The largest group (40.2%) had spent 5-9 years in the assigned position, 37.6% had spent 1-4 years, 8.3% had spent 10-14 years and 8.4% had spent 15 or more years.

The largest group of respondents (40%) had PHNA as the professional certificate or diploma awarded, while RN and PHN"B" made up 20 and 16% respectively and RM made up 12% (Table 38). Other certificate/diplomas — MCH AIDE, CO, MO — each made up 4% of the total.

The clinic types were urban-government, NGO and rural government in 39.1, 30.4 and 17.4% of the cases, respectively. Others types made up 13%.

The clinic levels were dispensary, health centre, hospital and other in 30.4, 26.1, 17.4 and 8.7% of instances, respectively. The rest made up 17.4%.

Twenty percent of respondents came from each of the regions of Arusha and Dar-es-Salaam, 24% were from Mbeya and the rest, 36%, from Singida.

The clinic names are shown in Appendix 1.

RH Supervisor's Socio-Demographic Characteristics

Table 39: RH supervisor's age, education, marital status and religion (N = 25)

Age in years	
30-34	20.9
35-39	29.2
40-44	25.0
45-49	20.9
50-54	4.2
	100
Education	
Secondary	20.0
Advanced level	40.0
Professional/college/university	40.0
	100
Marital status	
Single	20.0
Married/cohabiting	64.0
Divorced	12.0
Widowed	4.0
	100
Religion	
Catholic	28.0
Protestant	56.0
Moslem	16.0
	100

Sixteen percent of the RH supervisors were male and 84% were female. They were aged 33-50 years with a mean of 40.1 and mode of 34 years (Table 39). Over half (54.2%) of them were in the decade of 35-44 years. Eighty percent of respondents had achieved advanced or professional/college/university education level (40% for each level).

Sixty-four percent were married or cohabiting, 20% were single and 16% divorced or widowed. None were separated. More than four-fifths (84%) were Christians-28% Catholic, and 56 Protestant. The rest, 16%, were Moslem.

Pregnancy history

RH supervisors were asked how many times they had ever been pregnant. All of the respondents had been pregnant at one time or other with a range of 2-6 pregnancies, a mean of 3.3 and a mode of 2. Eighty-four percent had been pregnant 2-4 times. The pregnancies resulted in one abortion for every two respondents. One-eighth (12.5%) of respondents had a pregnancy outcome of five to six live births, and 87.5% had 2-4 live births. One pregnancy had resulted in a stillbirth.

RH Supervisor's knowledge of FP

Table 40: RH supervisor's knowledge of FP methods used in Tanzania (N = 25)

Methods	%
OCs	100
Injectables	100
IUCD	100
Norplant® Implants	100
Male condom	100
Female condom	72
Vasectomy	100
Tubal ligation	100
Diaphragm	92
Foam/jelly	84
Periodic abstinence	92
Total abstinence	88
Withdrawal	92
Emergency contraception	80
None	0

RH supervisors were asked which FP methods were used in Tanzania. In general, 72% of the responses were spontaneous, 18% prompted while 10% failed even on prompting. All (100%) respondents had prompted knowledge of at least half the methods on the list: OCs, injectables, IUCD, Norplant® Implants, Male condom, vasectomy and tubal ligation (Table 40). Prompted knowledge for other methods, other than the female condom (at 72%) was at least 80%; diaphragm, withdrawal and periodic abstinence (each 92%) total abstinence (88%) (LAM and NFP were not on the list).

Table 41: RH supervisor's source of FP knowledge (N = 25)

Source	%
Radio	69.6
Television	12.5
Posters/billboards	20.8
Newspapers magazines	29.2
Community events/live drama	25.0
Doctor/NMO/CO/ACO	4.2
Nurse	33.3
TBA/Community/Health Worker	4.2
FP Training	15.0
College/school	45.0
Seminars/workshops	30.0
Worksite	5.0
Church	5.0

Respondents were asked from what source they had learnt of the FP methods (Table 41). The most frequently cited source was radio (69.6%) followed by college/school (45%), Nurse (33.3%) and seminars/workshops (30%). FP training was only cited by 15% of respondents, while doctors and clinical officer cadres, TBAs/community health workers were cited by only 4.2% each. Worksites and churches (5%) each also fared even worse than newspapers/ magazines (29.2%) and live drama/community events (25%).

RH supervisor's FP training

Respondents were asked whether they had ever had FP training. Just over half (56%) had but 44% had not. Most of those trained (78.5%) had received the training 2-4 years before, with a range of 1-10 and a mean of four years.

Regarding whether they had received adequate information about family planning, only 25% of all respondents said that they had. Fifty percent opined that they had not while 8.3% were unsure and 16.7% said that it varied (presumably by topic/method).

Table 42: Reported proportion of new clients RH supervisor's/staff discuss IUCD with most or all clients (N = 25)

Proportion	%
Never	4.2
With less than half the number of clients	41.7
With most clients	16.7
With all clients	20.8
Does not know	0.0
	100

Almost half the number of RH supervisors (45%) reported that their staff discusses the IUCD with half or less of all clients. Slightly above one-third of the respondents (37.5%) said that their staff discusses the IUCD with most or all clients (Table 42).

Table 43: IUCD benefits that RH supervisors tell their staff (N = 25)

Benefit	%
Highly effective	52.0
Convenient	52.0
Low need for re-motivation	24.0
Nothing/not much to remember	48.0
Very safe	28.0
Few revisits needed	32.0
Acts for a long time	52.0
Does not interfere with sex	24.0
Non-hormonal	12.0
Secret method	4.0
Low cost	4.0
Only few contraindications	4.0
Immediate return to fertility on removal	12.0

Fifty-two percent of respondents listed the benefits of high effectiveness, convenience and long duration of action. The combined benefits of the IUCD having nothing/not much to remember and few revisits needed were mentioned by 80% of respondents. Nearly one-quarter (24%) added that there is a low need for remotivation (Table 44) and that the method is safe. That the IUCD has few contraindications was mentioned by a total of 32%, and 4% of respondents mentioned the benefits of low cost and secrecy of the method. The immediate return of fertility was important to 12% of respondents.

Table 44: RH supervisor's knowledge of IUCD adverse effects (N = 25)

Adverse effect	%
IUCD can be expelled	36.4
IUCD moves around in baby	0.0
Difficult/painful to insert	9.1
Difficult/painful to remove	0.0
Abdominal/menstrual pain	40.9
Heavy/prolonged/irregular bleeding	50.0
Causes STIs	13.6
Women dislike a foreign body inside	8.0
Causes cancer	18.2
Causes cervical erosion	4.0
Causes watery vaginal discharge	16.0
Hurts sex partner/partner declines coitus	8.0
Sticks to the uterus	4.0
Tightens fallopian tubes	4.0
Causes infertility	4.0

The most widely known, adverse effects were reported to be occurrence of heavy/ prolonged irregular bleeding, abdominal/menstrual pains and that the IUCD can be expelled (by 50, 40.9 and 36.4% of respondents, respectively (Table 44). Eight percent said that the IUCD causes STIs, 27.3% that it makes STIs worse and 22.2% that it causes cervical cancer and erosion.

Although 9.1% said that IUCD insertion was difficult or painful, none said that removal was difficult/painful nor that the IUCD moves around in the body. But 4% reported each of the

adverse effects of: the IUCD sticking to the uterus, "tightening" the fallopian tubes and causing infertility.

Table 45: RH supervisor's knowledge of other negative aspects about IUCD (N = 25)

Negative aspect	%
IUCD fails often	53.3
Causes AIDS	0.0
Makes AIDS worse	13.3
Causes abortion	13.3
Causes birth defects when it fails	13.3
Makes client infertile	6.7
May perforate uterus	26.7
Causes allergy	26.7
Against religion	13.3
Effective only a short time	0.0
Difficult to fulfill requirement to avoid multiple partners	4.0
Missing threads are a problem	4.0

Over half the number of respondents (53.3%) were under the impression that the IUCD fails often, 26.7% that it perforates the uterus and a similar number that it causes allergy (Table 46). An equal number (13.3%) thought that its use is against religion, that it causes abortion, causes birth defects when it fails and makes AIDS worse, although no respondent said that the IUCD causes AIDS or is effective for only a short time. Four percent felt that the requirement constraining IUCD users from having multiple sex partners was a difficult one to fulfil.

Table 46: RH supervisor's perspective on negative points regarding IUCD service provision (N = 25)

Negative point	%
A pelvic examination is necessary	43.5
Need several visits before insertion	0.0
Need frequent visits after insertion	0.0
High cost of services	4.3
Lack of expendables	47.8
Inadequate privacy/confidentiality	8.7
Lack of variety in types of IUCD	21.7
Inadequate counseling	47.8
Negative rumors interfere	8.0
Client must be menstruating for insertion/removal	4.3
Inconveniences other customers	8.0
IUCD service provision takes much time	21.7
Needs specialized providers	4.0
IUCD is forced on Tanzania/is donor driven	0.0
Poor infection prevention practices	8.0
Inadequate equipment/supplies	4.0
Cumbersome to use two specula	4.0

Inadequate counselling for FP use and lack of expendable supplies were the main constraints, each mentioned by 47.8% of respondents (Table 47). The necessity for a pelvic examination

was perceived as a negative feature by 43.5%, as were lack of variety in IUCD types and that IUCD service provision takes much time (each mentioned by 21.7% of respondents). IUCD service provision inconveniences other customers (8%) and it is "cumbersome" to use two examination speculae for each client (4%). No respondent mentioned the need for several pre- or post-insertion visits or the IUCD method being donor driven as an adverse aspect.

Table 47: RH supervisor's knowledge on Copper IUCD's main mode of action (N = 25)

Main mode of action	%
Causes abortion	8.7
Acts as a foreign body	60.9
Prevents ovulation	8.7
Changes uterine lining	39.1
Changes movement of uterus	4.0
Changes movement of tubes	0.0
Don't know	0.0
Slows down sperm movement	20.0
Copper kills sperm	4.0

Each respondent gave at least one answer for the IUCDs main mode of action (Table 47), the most frequent being that it acts as a foreign body, changes uterine lining or slows sperm movement (by 60.9, 39.1, and 20% respectively). Only 8.1% each thought it causes abortion or prevents ovulation, and only 4% that it changes uterine movement or that copper kills sperm or prevents sperm "penetrating the uterus." None thought that it changes tubal movement.

RH supervisor's knowledge of IUCD complications

Nearly one-quarter (23.8%) of respondents could not name a single complication of IUCD use. The most frequently listed complications were expulsion, IUCD failure/pregnancy, and uterine perforation (by 61.9, 38.1 and 33.3% of respondents, respectively). The client was thought to be at risk of STIs/HIV by 23.8% of respondents, and the service provider to be at risk of HIV infection by 9.5%. The man's penis was in danger of being trapped by IUCD threads, according to 4.8% of the RH supervisors. Other complications mentioned equally infrequently were backache, abdominal pain, and foul vaginal discharge. Also infrequent were heavy/prolonged bleeding, amenorrhoea, obesity, cervical erosion and cancer, infertility, hormonal imbalance and missing threads.

Table 48: RH supervisor's knowledge of absolute contraindications to IUCD use (N = 25)

Absolute contraindication NOT mentioned	%
Active PID	68.2
Multiparity	68.2
Recurrent PID	72.7
High risk of PID	86.4
Unmarried client	100
Pregnancy	56.5
Previous expulsion IUCD	95.7
Nulliparity	52.2

RH supervisor's knowledge, like that of RH providers and even preceptors/trainers, was deficient in this regard. High risk of PID, recurrent PID, active PID and pregnancy were not listed as absolute contraindications (by 86.4, 72.1, 68.2 and 56.5% of respondents, respectively). Conversely, 31.8% and 4.3% respectively thought multiparity and previous IUCD expulsion were absolute contraindications. Nulliparity is a special case since it is indicated as an absolute contraindication in the 1994 Tanzania FP guidelines and standards, but 52.2% of respondents did not know it was.

Other conditions listed as absolute contraindications included varicose veins, previous caesarean sections, previous ectopic pregnancy, cervical erosion, dysmenorrhoea, chronic disease, **cardiac disease**, vaginal discharge and congenital diseases (each by 4% of all respondents). The underlined conditions are on the MCH5 family planning client card, which is also used for IUD clients history taking.

RH supervisor's knowledge of RTIs
Respondents were asked which diseases they knew that could be transmitted through sex.

Each one of them knew of at least one STI. Twelve percent of respondents knew about Chancroid, 8% about genital fungal infection, and 4% mentioned each one of the following: PID, Herpes and Trichomoniasis.

RH supervisor's knowledge on what type of clients are suitable for IUCD services
Suitable clients were reported to be those free of STIs (20%) with a steady partner/non-multiple partners (8%), who were “aged” (4%) and needed long term contraception (8%). They should be of childbearing age (20%), should have delivered (8%), not be pregnant, (8%), should be married (4%) and should have a normal uterus (4%). She should also have chosen the IUCD as the preferred method (8%).

RH supervisor's knowledge on what type of clients are unsuitable for IUCD services
Unsuitable clients were reported to be those with active (12%) or recurrent PID (12%), those unmarried (4%), those nulliparous (12%) and those multiparous (12%). Other unsuitable clients were those who were pregnant (4%) or had “contraindications” (8%) or multiple sex partners (20%), were menopausal (4%), had genital cancer (4%), history of ectopic pregnancy (4%) or caesarean section (4%).

RH Supervisor's Attitude to FP

RH supervisor's future reproductive interventions
The respondents were asked whether they/their partners intended to get pregnant again. Only sixteen percent of them answered affirmatively, 8% of all respondents intended to get pregnant within one year, 8% after two years. Four percent were unsure and 80% answered that they did not intend to.

Table 49: Approval of FP and IUCD use by RH supervisor's partner

	FP %	IUCD %
No partner	12.0	12.0
Approves	64.0	52.0
Disapproves	12.0	16.0
Would not care/neutral	0.0	4.0
Does not know	4.0	12.0
	100	100

Nearly two-thirds (64%) of RH supervisors said their partners approved of FP use; only 12% disapproved and 4% did not know (Table 49).

Regarding the IUCD however, only slightly over half the number of respondents (52%) answered that their partner approved, 16% said their partner disapproved, 4% did not care, and the partner attitude was unknown by 12% of respondents.

RH supervisor's attitude to IUCD

Asked whether RH supervisors/or partners ever considered using IUCD, forty percent of respondents had never considered using the IUCD, 56% had. The main reasons for not considering the IUCD was (unspecified), dislike/does not even want to hear of IUCD (36.4% of those who had never considered). Eighteen percent said they had not had a sex partner. All other responses were each given by 9.1% of those who had never considered and included dislike of foreign body in the uterus, necessity for genital exposure, on other FP method, history of caesarean section and “scared of IUCD."

Those who had considered but not used the IUCD said the reason for not using was that they were scared of the IUCD (40%), disliked the IUCD (40%) or decided to use another method of FP.

Those who had previous use of IUCD but stopped use gave the following reasons for stopping: disliked the IUCD or decided to go on to other FP method (28.6% each), allergy to copper, desired pregnancy or did not have sexual intercourse (each by 14.3%).

Whether RH supervisors would consider future use by IUCD

Nearly two-thirds (64%) of respondents said that they would not consider IUCD use in future. Only 36% said that they would, because it was convenient and had no chemicals (12% of all respondents) or because they were already using it with satisfaction (4%).

Those who would not consider it gave the following reasons: they just “disliked it” (12%); were allergic to copper had no sex partner (each at 4%) were “too old” (8%) wanted to “rest” (8%). Surprisingly, some (4%) gave “no knowledge of IUCD” as the reason.

RH supervisor's general view on IUCD

Positive views included that the IUCD is convenient/good (64%), safe (24%), non-hormonal (12%), acts a long time (8%), is very effective (4%) and there is immediate return of fertility on its removal (4%).

However, the insertion procedure is unpleasant/painful (8%) and the caveat on multiple sex partners is difficult to fulfil (8%). Also it often causes complications, requires too much body hygiene/cleanliness, and there is insufficient information about it (each mentioned by 4% of respondents).

Whether RH supervisors would recommend IUCD to a friend
Almost all (92) respondents said they would, none said they would not, and 8% said it would depend on the friend's need or whether the friend was at high risk of STIs.

RH supervisor's perspective or negative association between IUCD and sex
Most supervisors (54.2%) reported no negative association, but 37.5% said the IUCD hurts the partner during coitus, 29.2% that it does not protect against STIs, and 16.7% that it reduces sexual pleasure. Eight percent reported a watery vaginal discharge as a negative association.

What RH supervisors emphasize to staff on clients' perception of quality of care
Eighty-four percent of respondents mentioned the most prominent factor as adequate information and counselling, while each of three other aspects was emphasized by 52%: privacy/confidentiality, low cost services, and staff friendliness (Table 50). Wide method choice was important to 44 and availability/cost of transport to 40%. Only 16% mentioned of staff competence and convenient hours of operation and even fewer (8 and 4% respectively) talked of short waiting time and transparency to all clients.

Table 50: RH supervisor's perspective to staff on client's perception of quality of services (N = 25)

Quality aspect	%
Dignity/respect	33.3
Privacy/confidentiality	52.0
Availability/cost of transport	40.0
Staff competence	16.0
Staff friendliness	52.0
Low cost services	52.0
Long/convenient hours of operation	16.0
Wide choice of methods	44.0
Adequate information/counseling	84.0
Short waiting time	8.0
Transparency to all clients	4.0

What other supervisors say about the IUCD, overall
Twelve percent did not know, but more than half the number of supervisors (56%) said their supervisor colleagues took the IUCD to be good, long acting, and a "quality" method. It was "secret" (4.5%), safe (9%) and did not interfere with coitus (4.5%) or the blood circulation (4.5%).

However, high STI prevalence (8%) and low availability of expendables, IUCDs and equipment (16%) hinder service provision, along with inadequate counselling (16%) and the requirement that clients have only one partner (8%). It is also associated with several complications (13.6%) including prolonged bleeding and high failure rate.

RH supervisor's views on availability of supplies at clinics under their care
Ninety-six percent of respondents reported that the clinics under their care always had enough IUCDs, but only 76% said the clinics always had enough IUCD equipment and less than half (48%) said the clinics always had enough expendable materials (Table 51). A similar deficiency was reported regarding IUCD-related materials in which only 48% said

their clinics always had enough, 4% were uncertain and 48% said they did not always have enough.

Table 51: Whether clinics under RH supervisor's care always have enough supplies (N = 25)

Supplies	Yes %	No %	Don't know %
Enough IUCDs	96.0	4.0	0.0
Expendable supplies	48.0	48.0	4.0
IUCD equipment	76.0	20.0	4.0
IUCD related IEC materials	48.0	48.0	4.0

Respondents were not able to pinpoint the root cause of these deficiencies, 23.1% saying it was a "problem for the whole program" and 7.7% saying it was a National Problem caused by inadequate finances, IEC and expendable materials and equipment. Due to inadequate supplies and faulty or absent equipment, staff usually gave the client another appointment (4.3%), put her on a different FP method (8.3%), referred her to a different SDP (4.3%), asked her to buy the missing items or gave her sub-standard service putting her and provider at risk of ill health (21.7%).

IUCD utilization in clinics under RH supervisor's care in the previous year

More than two-thirds (68%) felt that IUCD use had decreased, 16% that it had stagnated and only 8% thought it had increased, or were not sure.

Despite this 54.5% of respondents felt that the IUCD ranked first in preference when compared to other FP methods, 9.1% felt it ranked second, third and fourth respectively, and 18.2% ranked it fifth. This ranking would be even higher except for Depo Provera and OCs (18.8%), which are more popular methods. Other factors that interfered with preference for IUCD were religion (6.3%), inadequate numbers of skilled and trained providers (18.8%) or their inappropriate deployment (e.g., as telephone operators, etc. 6.3%). Additional negative factors were inadequate privacy, information and counselling (18.8%), requirement for single sex partner, necessity for pelvic examination (18.8%) and corrupt RMOs (6.3%). The RH supervisors also mentioned negatively the inadequate funding available to them.

RH Supervisor's Attitude to RTIs

Health risk to RH supervisor's staff offering IUCD services

When asked whether there were any health risks to their staff offering IUCD services, 54.2% of respondents thought there were not but 45.8% thought that there were. Likelihood of HIV infection to the providers was cited by 18.2% of those who said that there was some risk especially if the provider was "not careful" (45.5%) or was working under conditions of inadequate equipment and supplies (27.3%). Those who thought there was no risk did not explain their answers.

Self-perceived risk of contracting STI

More than two-thirds (68%) of the respondents opined that they were at little or no risk. Eight percent felt that they were at moderate risk, 20% at high risk, while 4% could not self-assess (Table 52).

Table 52: RH supervisor's self-perceived level of risk for contracting STIs (N = 25)

Level of risk	%
No risk	32.0
Slight risk	36.0
High risk	20.0
Don't know	4.0

Those who felt at little or no risk gave the reasons that they had only one sex partner, used condoms or did not have coitus at all (each at 5.9% of respondents who said they were at little or no risk).

Respondents who felt at moderate to high risk gave the reasons that they were inescapably and actively in RH service provision, or that their partner was unfaithful (42.9 and 14.3% respectively, of those self-assessed at moderate to high risk).

Avoidance of contracting AIDS/HIV

Sixty-eight percent of the respondents said one should not have sex at all (Table 53). However, more frequent responses were that a person should use male condoms (92%) or — even more widely acknowledged (by all respondents) — have one faithful partner.

Table 53: RH supervisor's perspective on what a person can do to avoid getting AIDS/HIV (N = 25)

Preventive measure	%
Do not have sex at all	68.0
Use male condoms	92.0
Use female condoms	16.0
Have one faithful partner	100
Avoid IUCD	0.0
Avoid other types of FP	0.0
Use traditional medicines	0.0
Don't know	0.0

Four percent each called for avoidance of contaminated clinic instruments, sharing of needles/blades, multiple sex partners, premarriage screening and, if HIV positive, to avoid pregnancy.

Use of the female condom was advocated by 16% of respondents, but no one suggested avoiding the IUCD or other FP methods, nor use of traditional medicines. No respondents said they did not know what a person ought to do.

Relationship between STIs and the IUCD

Fifty-two percent of RH supervisors thought that there was no relationship. Forty- four percent who thought there was a relationship said it makes STIs worse (8%) and is troublesome if a woman has multiple sex partners (20% of all respondents). Those who felt there was no relationship said it was because the IUCD is sterile (4%) and its job is to prevent pregnancy only (4%).

Table 54: RH supervisor's perspective on what a woman should do if she wanted to use the IUCD and not have STIs (N = 25)

Preventive measure	%
Need not do anything	0.0
Nothing can be done	0.0
Not have the IUCD	4.2
Use condom/other barrier	66.7
Avoid multiple sex partner's	91.7
Use medications	4.2
Body hygiene	8.0
Frequent tests for infection	4.0
Early treatment of STI	4.0

No respondent thought that she need do nothing or that nothing can be done (Table 54). Nearly all (91.7%) suggested she avoid multiple sex partners and 66.7% that she use condoms or other barrier methods. Her partner, too, ought to avoid multiple partners (37.5%). Only 4.2% thought the woman ought not to have the IUCD.

The IUCD and AIDS

RH supervisors were asked whether they thought that using an IUCD could cause a woman to get AIDS. Nearly three-quarters (72%) of them said it could not, but 28% said it could if the speculum were contaminated (4% of all respondents) or if inserting in an infected person (4%), or because the IUCD does not protect against AIDS. Those who said that using an IUCD could not cause AIDS gave the reason that the IUCD is sterile (4%), prevents pregnancy only (4%) and has no relationship to STIs or AIDS.

The IUCD and STIs

RH supervisors were asked whether they thought that using an IUCD could cause a woman to get STIs. Sixty-eight percent said it could not, 28% said it could and 4% were not sure. The reasons given were similar to those for the question on whether using an IUCD can cause a woman to get AIDS.

RH Supervisor's Practice of FP

RH Supervisor's previous use of FP

Ninety-two percent of the respondents reported previous use of FP of at least one of seven methods (Table 55). Sixty-eight percent had used OCs, 48% the IUCD, 36% injectables and 16% the male condom. Eight percent of respondents had used each of Norplant® Implants, foam/jelly and periodic abstinence. None reported previous use of vasectomy, tubal ligation, total abstinence, emergency contraception, and diaphragm or female condom.

Table 55: RH supervisor's previous, current and future use of FP (N = 25)

Method	Previous use %	Current use %	Future use %
OCs	68.0	12.0	0.0
Injectables	36.0	8.0	4.0
IUCD	48.0	0.0	28.0
Norplant® Implants	8.0	4.0	4.0
Male condom	16.0	16.0	16.0
Female condom	0.0	0.0	4.0
Vasectomy	0.0	0.0	4.0
Tubal ligation	0.0	0.0	32.0
Diaphragm	0.0	0.0	0.0
Foam/jelly	8.0	4.0	0.0
Periodic abstinence	8.0	20.0	4.0
Withdrawal	0.0	0.0	0.0
Emergency contraception	0.0	0.0	0.0
None	8.0	44.0	32.0

Current use was only 56%, with the most currently used method/being periodic abstinence (20%) followed by female condom, OCs, injectables and Norplant® Implants at 16%, 12%, 8% and 4% respectively. No respondent was currently using the IUCD.

RH supervisor's future use of FP

Respondents indicated a tendency to use a more permanent method for the future, with 32% saying they would use tubal ligation and 4% vasectomy (Table 55). OCs and injectable use would drop to 0% and 4%, respectively. Condom use would remain at 16%, the same for current and previous use. Twenty-eight percent intended to use the IUCD and 4% each to use Norplant® Implants, female condom or periodic abstinence. Thirty-two percent planned on using nothing. (NB: 50.1% of all respondents including males were aged 40 years and above, 25.1% were aged 45 and older).

RH Supervisor's Training and Service Provision

RH supervisor's training in preparation to work as supervisors

- All RH supervisors had attended at least one course in the last 1-7 years, with a mean of 2.7 years before (Table 56).

Table 56: RH supervisor's training in preparation to work as a supervisor (N = 25)

Training course	%
Tubal ligation	4.0
Communication and counseling	4.0
Comprehensive Clinical Skills	32.0
Logistics/Management	32.0
Norplant® Implants provision	4.0
Training methodology	4.0
Data collection/data management	12.0
New comers course	4.0
EPI orientation	4.0
FP supervision and monitoring	4.0

RH supervisor's confidence after training

Respondents were asked whether they felt confident that they learnt all they needed to learn to be effective as supervisors. Overwhelmingly, the answer was "NO" (91.7%), only 8.3% felt confident. Respondents felt they most needed further training in FP logistics and management (12%), management skills (8%), Norplant® Implants training (8%), VSC training (4%), EPI orientation (4%) and IEC training (4%).

Attendance of specific STI training

More than four-fifths (82.6%) of the RH supervisors had not attended specific/special STI training and only 17.4% had. Of the few who had attended, they had all attended in the previous five years.

RH supervisor's views on factors hindering IUCD services in their area/site

The most frequently mentioned were adverse rumors (32%), inadequate information/counselling, (20%), community attitudes to FP (12%), inadequate numbers of skilled service providers/heavy work load (12%), and inadequate expendables and equipment (8%). Other negative factors were high prevalence of STIs (16%), religion (8%) need for pelvic examination (4%), long time for the service provision (4%) competition from "newer" methods (4%) which were "more accessible" than the IUCD.

There were also many untrained providers while the trained ones were inefficiently utilized or had negative attitudes to IUCD. Sometimes there was a conflict between providers and other officers in-charge.

RH supervisor's views on factors which would facilitate IUCD services in their area/sites

The main factors mentioned improved IEC (16%) training adequate numbers of providers (20%) and with update training and improving their attitudes. Improved health education related to IUCD (16%) and strategies to counter negative rumors and misconception against the IUCD (8%).

Others called for improved logistics and supply of expendables and equipment (16%). Other respondents said client recruitment should be increased by improving quality of services (16%) including privacy/confidentiality, clinic space interpersonal relationships, adherence to clients' rights and accessibility (e.g., through mobile clinics). Male involvement would also facilitate IUCD use.

IUCD clinical skills curricula

About one-third to one-half of respondents gave a "don't know" response to each of the curricula when asked whether it should be changed or not (Table 57). Forty percent felt the IR/CH curricula should be changed, 33.3% demurred. The IUCD insertion training curriculum should be changed, according to 37.5%, but 31.3% thought not.

Table 57: RH supervisor's perspective on whether IUCD clinical skills curricula should be changed (N = 25)

Curriculum	Change %	Change %	Change %
Integrated R/CH clinical skills curriculum	40.0	33.3	26.7
IUCD insertion training curriculum	37.5	31.3	31.3
RCHU Curriculum for CO/ACO	18.8	31.3	50.0
RCHU curriculum for nurses	18.8	25.0	56.3
Supervisory and monitoring skills	20.0	26.7	53.3

Twenty percent wanted the supervisory and monitoring skills curriculum changed and 18.8% wanted both the RCHU curricula for CO/ACO and Nurses changed, but 26.7%, 31.3% and 25% respectively thought they should not be changed.

The integrated curriculum should incorporate a section on STIs, according to 14.3%, and a similar number felt that IUCD insertion skill training should be revived. Others said IUCD insertion skills should be added to the integrated curriculum, and the curriculum should be in Kiswahili (16.7%). The IUCD insertion skills curriculum should also emphasize prevention of STIs (16.7%), and the duration of training should be increased to four weeks.

RH supervisor's views on what should be done to improve training for IUCD skills
Common suggestions were to train a larger number of staff, revive IUCD insertion training and increase the duration of training especially the practicum (36.4%).

Updates and adequate follow-up post-training should be emphasized (18.2%). Trainee selection should be improved (18.2%), so that only those with sufficient interest and ability are trained. Counselling skills, screening, use of IEC materials, and STI prevention should be included in the training (27.3%). Health education should be enhanced in the community while paramedical staff would benefit from seminars on IUCD (27.3%). Different types of IUCD should be available (9.1%). Sufficient equipment and expendable materials should be made available not only at the time of training but also at the time of service provision (18.2%). Even the trainers themselves will need refresher in basics and in training skills.

RH supervisor's view on advantages of central/regional training compared to OJT for IUCD provision

Although 9.1% said there was no difference, the largest group of respondents (36.4%) mentioned the increased opportunity for discussing and sharing experiences with fellow trainees and providers and also the presence of a large number of trainers with varied expertise who can coach the trainee and answer trainers' queries promptly (27.3%). Respondents also felt that it was easier to standardize, (9.1%) trainees are more motivated then (9.1%) and have higher concentration and commitment (45.5%), and many of them can be trained in a short time (9.1%). Furthermore, it is a waste of time trying to train one person alone (9.1%).

RH supervisor's views on disadvantages of central/regional training compared to OJT for IUCD provision

The disadvantages were that it was difficult to train mixed cadres whose rate of understanding, especially of theory content, varied greatly (27.3%). Some trainees ended up

being reticent, withdrawn and not actively participating in the training or learning from others (18.2%).

The training is also in an artificial or 'foreign' working environment (33.3%), trainees find it difficult to concentrate due to other duties (9.1%) or because trainers scold/discourage them in front of their peers (9%). The training is expensive (9.1%), is too brief in duration (27.3%) and there is little time or enough clients for practicum or group discussion: few trainees can benefit from it at a time (27.3%). Many trainers also suffer erosion of knowledge and skills especially if it takes them long to start IUCD provision due to lack of clients, equipment or expendables (18.2%).

RH supervisor's views on what should be done to improve IUCD service provision

More than half (56%) the respondents called for improved information/counselling and interpersonal relationships. IUCD insertion training should be revived and more staff trained and updated (30%). Provider bias should be investigated and eliminated while motivation to providers should be improved (12%). Quality of services should be enhanced (24%) including privacy, accessibility, convenient waking hours and short waiting time. Expendable supplies and equipment should be readily available at all times (24%) and also different IUCD types (4%). Finally, men should be involved (4%).

Support that RH supervisors give to staff so that they can offer effective RH services

RH supervisors gave technical support (24%), availed equipment/supplies/ contraceptives (32%) and ensured standards were observed (4%) including standards for proper client recruitment. They also encouraged good interpersonal relationships (20%) and a supportive work environment (8%). They identified and organized training for appropriate staff (20%).

Support that RH supervisors give to staff so that they can offer effective IUCD services

RH supervisors ensured availability of IUCDs and IUCD related equipment (36.4%), encouraged client education/case discussion/counselling related to IUCD (27.3%) and organized OJT when necessary (13.6%). They also ensured standards, especially aseptic technique were observed (4.5%) and encouraged good interpersonal relationships (13.6%) and privacy for clients (4.5%). Some (4.5%) also ensured all clients were served, irrespective of spousal objection.

Support that RH supervisors get from their supervisors

Four percent received no support but 36% received support in acquiring equipment, supplies and contraceptives, and also with transport. Twenty-four percent received support for basic and update training plus deployment of staff. They benefited from teamwork, moral support and sharing during meetings and seminars (32%).

RH Supervisors: Findings and Implications

RH supervisors KAP on FP

RH supervisors had fairly wide awareness of FP methods currently available in Tanzania. Their attitudes to FP use and service provision were positive. They had moderate levels of previous, current and intended future FP use.

KAP on IUCD
Knowledge and skills related to IUCD were poor. Most importantly, although these respondents were expected to supervise IUCD service provision, they felt quite inadequate to provide appropriate supervision. They also harbored inadequate knowledge and had misconceptions about the IUCD.

KAP on RTIs by RH supervisors
RH supervisors had moderately wide awareness of RTIs. Most knew IUCDs do not cause STIs or AIDS, but several felt IUCDs can carry germs or IUCD exacerbate infection if instruments are not sterilized. They knew the two main preventive measures, i.e., mutually monogamous sexual relationship and/or use of male condom.

Supervisor's training/skills
Many RH supervisors were not trained in FP or IUCD. Several had been trained in supervisory skills, logistics and management, but many had not. They felt they needed training in IUCD skills, counselling, STIs and logistics management.

They felt more staff should be trained in IUCD skills and that those already trained should have refresher and adequate training. IEC should be incorporated in the community.

RH supervisor's working environment
Most supervisors were satisfied about their working environment.

Administrative support for supervisors
In general, RH supervisors acknowledged that they received enough administrative support unless they themselves were at the top of the hierarchy. The received more support from government/Ministry of Health organs especially adequate training, support, training of personnel, implementing, instituting and IEC strategies.

Recommendations for RH supervisors
- MOH should assist R/DHMT to be updated in supervisors on supportive supervisory skills, COPE IEC, sensitize them on IUCD service and on emerging programs. In order to plan approaches which have potential to improve IUCD access and quality, where the service is needed.
- MOH should assist R/DHMT to mobilize financial and non-financial resources in order to ensure effective, supportive supervision including availability of supplies equipment and expendables, training and deployment of personnel.
- R/DHMT should devise innovative approaches to ensure uninterrupted availability of expendable supplies.
- MOH, RCHU in collaboration with R/DHMT and relevant zonal training centres devise innovative approaches of or use existing formats to ensure continuing education of supervisors of all levels in IUCD and other reproductive health services.

Observation of clinic facilities

- A total of 14 RH clinics were observed with regard to their set-up, availability of appropriate equipment and supplies, availability and accessibility of IEC materials and availability of trained personnel cadres.

- At least three RH clinic facilities in each of Dar-es-Salaam, Arusha, Mbeya and Singida regions, including one urban/government, one rural/government and one NGO RH clinic were assessed (Appendix 1).
- In Dar-es-Salaam region, the study team assessed Magomeni - urban/government RH clinic which has been used as practicum site, Chanika - rural government RH clinic and Marie Stopes Kariakoo - NGO RH clinic.
- In Arusha region the team assessed Ngarenaro - urban/government RH clinic which has been used as practicum site, Longido - rural/government RH clinic and SDA Njiro - NGO RH clinic.
- In Mbeya region, the study team assessed Ruanda - urban/government RH clinic which has been used as practicum site, Kyela - rural/government RH clinic and UMATI Mbeya - NGO RH clinic.
- In Singida region, the team assessed Singida Regional Hospital - urban/government RH clinic which has been used as practicum site, Ilongero - rural/government RH clinic, Uhasibu NGO RH clinic, Police rural/government RH and Sokoine urban/government clinic. In this region, two more RH clinics were observed because of low client load among the clinics visited.
- Among the fourteen clinics visited during the study, two were at the level of hospital, six at health centre level, five at dispensary level and one at the clinic level. Those at Hospital level were Singida Regional Hospital and Kyela District Hospital. Those at Health Centre level are Magomeni, Ngarenaro, SDA Njiro, Longido, Ruanda and Sokoine Health Centres. Those at dispensary level were Chanika, Marie Stopes, Uhasibu, Police and Ilongero dispensaries. The one at clinic level was UMATI - Mbeya clinic.
- During the visit, the team used the designed checklist for assessing the status of clinic facilities to observe, interview the clinic incharge and verify the clinic set up, availability of space and privacy for different type of RH procedures. The checklist was also used to verify number of staff available and their qualification, staff training needs with regards to RH service provision indicators for maximising access and quality of care during RH service provision. It also assessed the availability of basic equipment and supplies for provision of IUCD services (including screening for STIs, client education and counselling materials, records and stationery), RH client load by method (new and revisit clients) for the previous three months and quantity of each type of contraceptive supply available in the clinic stock.
- The following are the findings of the clinic facilities observation:

1. Clinic Set Up

a) Distance from district center

Distance from the district centre varied from 0.25 to 120 kilometres among the clinics visited for the study. Of the clinics visited, 7.7% were located 0.25 kilometres away from the district centre; six clinics (46.2%) were located two to three kilometres away and 15.4% as far away as 30 and 120 kilometres from the district centre, these two clinics are among the rural government clinics, while

most of the urban/government and NGO RH clinics are located near the District Centres.

b) ***Total population served***

The lowest total population served by one RH clinic is 6,151 while the highest is 508,885. Most of the rural/government RH clinics serve populations of about 6,000 to 16,000 people, most of the rural/government and NGO clinics serve populations of about 90,000 to 510,000 people (to the nearest one thousand).

c) ***Women of child bearing age***

The highest number of women of child bearing age reported during the study is 102,000 in one RH clinic's catchment area while the lowest is 1,000 women in another RH clinic's catchment area. Most of the rural/government RH clinics had low number of women of child bearing age (ranged from 1,000 to 6,000 per clinic, while urban/government and NGO RH clinic had the highest numbers that ranged from 3,000 to 102,000 women per clinic.

d) ***Adequate waiting area***

Fifty percent of the clinics visited for the study did not have adequate waiting area. One NGO clinic had inadequate areas while the other three had enough waiting space.

Three of both rural and urban/government clinics had inadequate waiting area. This indicates the problem of inadequate waiting space is worse in government facilities than in NGO clinics.

When staff members of the visited clinics were asked to comment on waiting area, 42.8% of the clinics were reported to have inadequate space and 7.1% was reported to have waiting areas which are far from FP rooms. Most of the staff members who complained that their clinics had inadequate space were from government RH clinics (both urban and rural government RH clinics).

e) ***Assessment of waiting area***

Fifty percent of the clinics visited were assessed as not having adequate waiting area. Staff members were themselves asked to comment on waiting area, 42.8% of the clinics were reported to have space that was either inadequate or was being encroached on by other services; also 7.1% of the clinics were reported to have waiting areas which were too far away from FP rooms.

While 92.9% of the clinics were assessed as having clean surroundings, 57.1% were reported to have poor client flow. Fortunately, 85.8% of the clinics also had rooms or areas for client education, 71.4% had adequate water supply and a similar proportion, 71.4%, possessed hand-washing facilities.

Table 58: Staff assessment of the waiting area (N = 14)

Staff Comments	Percentage
Inadequate space	35.7%
The space is used for other/multiple services	7.1%
The area is far from FP room	7.1%
The space is enough	14.3%
No comment	35.7%
Total	100%
Designated room or area for examination and IUCD insertion in 14 clinics	
There is only one room for IUCD services	7.1%
There is plenty of room but not well organized	7.1%
There is no room for IUCD insertion	21.4%
There is only one small room used for all FP activities	7.1%
Total	**100%**

IEC Materials: IUCD information (e.g., posters, leaflets shared with clients) was not available or accessible in 69.2% of the clients. Nine out of fourteen clinics assessed during the study (69.2%) had no information accessible to clients on IUCD like posters and leaflets. Staff members of 71.3% of the visited clinics reported to have inadequate information and IEC materials on IUCD as indicated in Table 59.

Table 59: Staff assessment of adequacy of IEC materials in 14 clinics

Staff comments	Percentage
Inadequate IUCD IEC materials	50%
Inadequate information at all on IUCD	14.3%
No information at all on IUCD	7.1%
No comment	28.6%
Total	100%
Clinic education rosters inclusion of FP topics in the clinics	
No comments	28.6%
No roster at all for client education	50%
The roster does not include IUCD related topics	7.1%
Client education is given according to client's identified problem	14.3%
Total	100%
Designated room or area for counseling in the clinics	
Inadequate rooms for counseling	21.4%
Rooms have no doors	14.3%
One room used for multiple services	21.4%
No comment	42.9%
Total	100%

*a) **Client education roster***

Client education rosters did not include topics related to IUCD, in 71.4% of the clinics. In affirmation, and staff in 57.1% of the clinics also commented that their clinics did not have client education rosters with IUCD content topics.

b) ***Availability of designated room or area for counselling***

Although eight of the 14 clinics visited were observed to have designated rooms/areas for counseling, when asked to comment about the counseling rooms, 57.1% of staff members revealed that the rooms were either not adequate, have no doors or are used for other/multiple services, as depicted in Table 59.

c) ***Designated room or area for examination and IUCD insertion***

Fifty percent of the assessed clinics had rooms/area for client examination and IUCD insertion, the others did not. However, when asked to comment on the availability of examination/IUCD insertion room, staff members from 42.9% of the study clinics complained of inadequacy of space in the rooms, disorganisation of the available rooms and use of one small room for all the FP activities.

d) ***Accessibility of other services for providing integrated R/CH services***

Nearly three quarters (71.4%) of the clinics observed had good accessibility of other R/CH services and were providing integrated R/CH services.

e) ***Place for disposal of waste and functioning toilet facilities***

Only 15.4% of the study clinics had a place for waste disposal, the others did not. Furthermore, most of the clinics (78.7%) did not have functioning toilet facilities.

When asked to comment about toilet facilities, staff members from 35.8% of the observed facilities pointed out problems related to sharing of one toilet among clients and staff, and amongst male and female clients, especially when the only available toilet was out of order.

2. Staffing

- Number of available staff and their qualifications

  – *MCH Aides*

  The number of MCH Aides working in the 14 clinics ranged from zero to nine. Each of 35.7% of the clinics visited had only one MCHA, while each of 21.4% had two MCHAs. Number of clinics with no MCH Aider at all was 7.1% and those with nine of them also made up 7.1%.

  – *Health Attendants*

  The number of Health Attendants working in the study clinics ranged from zero to nineteen per clinic. 14.3% of the clinics had no Health Attendant at all, while 28.6% had only one HA per clinic. (7.1% of the assessed clinics had nineteen Health Attendants, the highest number of HA's observed in one clinic. Each of the remaining 49.9% of clinics had two to eleven Health Attendants. Among the assessed clinics NGOs had four Health Attendants in four clinics, rural/government had 18 Health attendants in five clinics and urban/government RH clinics visited had 39 Health Attendants in five clinics.

– *Nurse Midwives*

The number of Nurse Midwives employed in the visited clinics ranged from zero to eight. Each of 21.4% of the clinics visited had no Nurse Midwives at all while each of the other 21.4%, had only one. Each of the remaining 49.9% of clinics had two to seven Nurse Midwives. Among the visited clinics, NGOs had three Nurse Midwives in four clinics, rural/government had six Nurse/Midwives in five clinics, and urban/government had 30 Nurse Midwives in five clinics.

– *Public Health Nurse "A"*

The number of Public Health Nurse A in each of the study clinics varied from zero to four. In each of the clinics observed, 58.4% had no Public Health Nurse "A" at all. The remaining 41.6% of the observed clinics had only one to four Public Health Nurse "A"s. Among clinics visited, NGOs had no Public Health Nurse "A," in all the four clinics. Rural/government had one in five clinics and urban/government RH clinics had 11 Public Health Nurse "A" in five clinics visited.

– *Public Health Nurse "B" (upgraded MCHA)*

The number of Public Health Nurse "B" working in the study clinics varied from zero to five. In each of the clinics observed, 38.5% had no Public Health Nurse "B" at all, while 30.8% of the clinics had only one Public Health Nurse "B." 30.8% of the assessed clinics had two to five Public Health Nurse "B"s. NGO RH clinics had one PHN "B" in four clinics, rural/government had six PHN "B" in five clinics and urban/government had 12 PHN "B" in five clinics visited.

– *Assistant Clinical Officers*

38.5% of the assessed clinics had no Assistant Clinical Officer at all, while 46.2% had only one Assistant Clinical Officer. The remaining 15.4% had two to five Assistant Clinical Officers.

– *Clinical Officers*

7.7% of the observed clinics had no Clinical Officer at all, while 46.2% had only one Clinical Officer. The rest 38.5% of the observed clinics had two to ten Clinical Officers.

– *Nursing Officers*

54.5% of the observed clinics had no Nursing Officer at all, while 27.3% had only one. The rest, 18.2% of the assessed clinics had three to six Nursing Officers.

– *Assistant Medical Officers*

Two thirds, 66.7% of the clinics assessed had no Assistant Medical Officers at all, while 25% of the clinics had only one. The rest, 8.3%, had seven Assistant Medical Officers.

– *Other staff*

Other staff members working in the study clinics included Assistant Dental Officers, Obstetricians/Gynaecologists, Health Officers, Medical Officers, Red Cross Staff, Dental Auxiliaries, Laboratory Assistants and Watchmen.

- Number of staff trained in RH

– *Basic clinical skills training (BCS)*

Basic Clinical Skills training equips service providers with most of the FP Clinical skills necessary for service provision, but without IUCD insertion skills. Participants of BCS training receive only theoretical knowledge on IUCD to equip them to educate IUCD clients and thereafter refer them to the IUCD service provider for insertion.

During the study it was observed that a total of 35 staff members of the visited clinics were trained in BCS between 1991 and 1998. However the numbers of BCS trained staff varied from zero to fifteen per clinic.

Of the clinics visited, 41.7% had none of their staff trained in BCS, where as 25% had three people trained in BCS, 16% had four people trained, 8.3% had two and the rest 8.3% of the clinics visited had 13 people trained in BCS.

Assessment on the cadre of those trained in BCS revealed that 28.5% of the visited clinics had PHNB trained in BCS while 14.3% of them had MCH Aiders trained. The other 14.3 clinical officers trained in BCS 21.3% of them had Nursing officers and the rest 21.4% had Nurse midwives trained in BCS.

Duration since training ranged from one to eight years between 1991 to 1998.

Table 60: Percentage of clinics with staff trained in BCS

Percentage of clinics with staff trained in BCS	Number of people trained
41.7%	1
8.3%	2
25.0%	3
16.7%	4
8.3%	13

– *Comprehensive clinical skills training (CCS)*

CCS is one of the trainings that impart both knowledge and skills to service providers on IUCD. It also gives participants theory and practical inputs necessary for all the FP service provision including IUCD insertion.

During the study it was revealed that a total of 25 staff members in the study clinics were trained in CCS between 1992 to 1997. However, the number of staff trained in this course per clinic varied from one to four.

Over three-quarters (77.8%) of the observed clinics had only one person trained in CCS instead either two CCS trained or one CCS and IBCS trained. 11.1% of them had two people, 5.6% had four people and the rest 5.6% had three people trained in CCS.

When examining the cadre of those trained in CCS, the study revealed that 28.5% of the study clinics had Nurse Midwives trained in CCS, 14.3% of them had MCH Aides trained in CCS, 14.3% of them had clinical officers, 2.8% had Nursing officers, 9.5% had Public Health Nurse A and the remaining 23.8% of the observed clinics had Public Health Nurse B trained in CCS.

Duration since training ranged from two to seven years.

Table 61: Percentage of clinics with staff trained in CCS (N = 14)

Percentage of clinics with staff trained in CCS	Number of people trained
77.8%	1
11.1%	2
5.6%	3
5.6%	4

– *FP communication and counseling skills training*

FPC Course is designed to equip participants with knowledge and skills on counselling and communication. It provides only theoretical knowledge on IUCD to enable its participants to educate IUCD clients and thereafter refer them the trained IUCD service provider for insertion/further management.

During the study it was observed that only four staff members were trained in FPC in the visited clinics and the courses were conducted between two to five years earlier. Two-thirds (66.7%) of the visited clinics had only one person trained in FPC while the rest (33.3%) of the clinics had two people.

Assessment on the cadres of those trained in FPC revealed that 33.3% of the visited clinics had Nurse/Midwives trained in FPC while the remaining 66.7% of the clinics had Nursing officers trained in FPC.

– *Preceptorship training*

This training equips selected practising and trained service providers with updated family planning and other RH knowledge and skills, how to plan, conduct, monitor skills acquisition, and evaluate training at clinic level based on national service standards. It also strengthens and perfects service providers' skills in IUCD insertion.

During the study it was observed that only three staff members in the clinic visited were trained in Preceptorship three to six years before.

21.4% of the visited clinics had one person trained in Preceptorship each, while the rest 78.6% of the clinics had none.

Examining the cadre of those trained shows that 33.3% of the clinics had trained clinical officers, 33.3% had Nurse Midwife and 33.3% had PHN "B" trained in Preceptorship.

– *Contraceptive technology update (CTU)*

This skills training imparts knowledge and clinical skills' updates including IUCD insertion, in addition to other family planning/RH service provision. Skills based on identified weak skills of the previously RCH trained service providers or trainers.

During the study it was reported that a totals of five staff members of the visited clinics were trained in CTU, 75% of the visited clinics had one person and the rest 35% of the clinics observed had two people trained in CTU.

Assessment of the cadres of those trained in CTU showed that 25% of the clinics visited had clinical officers trained in CTU, 25% of them had Nurse Midwives, and the rest 50% were Nurse officers.

The training was conducted between 1993 and 1996.

– *Other types of training*

Other members of staff in the clinics were trained in the following:

Integrated Reproductive and Child Health (IRCH) Health Clinical Skills training	(22.1%)
VSC surgery	(7.7%)
Basic Training Skills	(7.7%)
FP Logistic Management	(7.7%)
Norplant ® Implants Insertion	(22.1%)
STD Syndromic Management	(30.8%)
VSC Counselling	(21.4%)

Note:

- The Integrated R/CH clinical skills training which accounted for 22.1% of the visited clinics is another course like BCS which has no IUCD insertion component. It includes family planning as major service to which STI, child health, gender related RH, post-abortal and postpartum care, are integrated.
- None of the clinics visited had staff trained in the three-week IUCD insertion short course.
- STI Syndromic Management training which was reported in 30.8% of the visited clinics equips service providers with knowledge and skills on how to prevent and manage STIs, which is an important component in IUCD services. All the courses which include IUCD insertion component, that is CCS, CTU,

Preceptorship and IUCD insertion course have only one theory session of three hours on STI followed by STI integration to family planning during practicum.

3. Indicators for maximizing access and quality of care during IUCD services

All the 14 clinics reported that RH clients were treated with dignity and respect by all staff.

Only 38.5% of the assessed clinics reported that clients are offered IUCD without restrictions. The rest 61.5% of the clinics reported restrictions based on age, marital status, parity and or menstruation.

When asked to comment on the restrictions, staff members from 15.4% of the study clinics visited revealed that they instruct IUCD clients to come only while on menses, while 15.4% of the clinics had no information on IUCD, and unmarried clients were discouraged.

More than two thirds (69.2%) of the assessed clinics had unnecessarily long client waiting period before getting IUCD services. When asked to comment on clients waiting time before getting IUCD services, staff from 14.3% of the visited clinics conceded that they did ask IUCD clients to wait until clients for other methods have been served first.

The study team observed that 30% of the visited clinics had inadequate and inaccurate information on IUCD given to clients. Table 62 below summarizes comments from the study clinic's staff members.

Table 62: Adequacy and accuracy of IUCD information (N = 4)

Staff Comments	Percentage
No accurate information on IUCD	53.8%
Client get information on IUCD rarely	15.4%
There is religion barrier to FP	7.7%
Information is only given on the method chosen	7.7%
No information on IUCD at all	7.7%
No comment	7.7%
TOTAL	**100%**

All the assessed clinics were observed to have evidence of adherence to FP policies and standards as per observation and reviewing the clinic records. Only 50% of the clinics assessed during the study had all the clients identified to have RH need through history that showed IUCD eligibility being counseled on IUCD; the rest did not.

Two-thirds of the clinics had an IUCD insertion/removal tray ready for use; only 33.3% of the clinics did not have.

More than four-fifths (83.3%) of the observed clinics did not have a standby provider trained through OJT by graduate of clinical skills training. Only 16.7% of the visited clinics had their providers explaining IUCD factually during client education/counseling session. The rest of the visited clinics did not.

4. Availability of basic equipment and IEC materials

- Availability of equipment for provision of IUCD services and screening for STIs
  - *Autoclave sterilizers*

    The visited clinics had varying quantities of autoclave sterilizers varying from zero to six. While 7.7% of the clinics had autoclave sterilizers that were not in good working order, 7.4% had no autoclave sterilizers at all. Also while 46.2% of the clinics had one autoclave sterilizer, 22.1% had two and 7.7% had three, four and six sterilizers respectively.

  - *Cheatle forceps jar*

    Number of cheattle forceps jars observed in the clinics visited ranged from zero to six, with 7.7 of the clinics having none 30.8% having one, 38.5% having two, 15.4% having three and 7.7% having six.

  - *Sterilizer drum*

    The study clinics had different numbers of sterilizer drums that varied from zero to eight. One (33.3%) of the clinics had only one drum, where as 8.3% of them had no drum at all, 25% had three each and another 8.3% had four, six and eight drums respectively.

  - *Lighting source*

    The study clinics were observed to have one to ten lighting sources. However, 21% of them had one source, while 7.1% had ten. The rest of the clinics had two to six.

  - *Kerosene stove*

    The study clinics had kerosene stoves varying from zero to four. While several clinics had no kerosene stove, 15.5% had non-functional kerosene stoves, 46.2% of the clinics had only one which was functional, 23.1% had two, and 7.7% had three and four respectively.

  - *Boiling electrical sterilizer*

    Visited clinics had different numbers of boiling electrical sterilizers ranging from zero to four, 7.1% of the clinics had no boiling sterilizer, while 14.3% of the clinics had their boiling sterilizer not in good working order. While 78.6% of the clinics had only one sterilizer, 7.1% had two and four, respectively.

  - *Plastic pan or bucket for soaking soiled equipment*

    While 38.5% of the visited clinics had no bucket/pan, 53.8% of them had only 1. The rest (7.7%) had two buckets/pans.

  - *Clock/timer*

    The clinics observed had one to seven timers, with 38.5% of them having two, 23.1% having one, and the rest (38.5%) having three to seven timers. However, 7.7% of the clinics had faulty timers.

- *BP machine*

  Study clinics had zero to ten BP machines, with 21.4% of them having no BP machines at all. Fifty percent of the clinics had only one, 14.3% had two and 7.1% had three and 10 respectively. Faulty BP machines were encountered in 7.7% of the clinics.

- *Stethoscope*

  Stethoscopes ranged from zero to eight among the visited clinics, in which 7.1% had none while 7.1% of them had eight. 42.9% of the clinics had only one, 28.6% had tow and 7.1% had three and four respectively. However, 14.3% of the clinics had stethoscopes.

- *Examination couch*

  Numbers varied from zero to eight among the study clinics. While 7.1% had none 7.1% had eight and 42.9% had one 28.6% had two and 7.1% had three and four couches, respectively. However 7.1% had faulty couches.

- *Speculum*

  Number of speculae varied from two to 31 among the study clinics. While 25% of the clinics visited had two speculae, 8.3% had eight. The rest (66.7%) had three to thirteen specula.

- *Uterine sound*

  Number of uterine sounds ranged from one to 14 among the assessed clinics, whereby 23.1% of the clinics had only one uterine sound. The other 23.1% had 10 uterine sounds and a varied proportion of 2, 3, 5, 6, 7, 11 and 14 uterine sounds, each accounted for 7.7% of the clinics visited. However, 8.3% of the clinics had a uterine sound, which was unusable.

- *Tenacula*

  Number of tenacula ranged from one to 12 in the study clinics, where as 30.8% of them had only one, 7.7% had 12 tenacula. The rest of clinics had three to ten tenacula, 8.3% of the clinics had three tenacula which were out of order.

- *Scissors*

  Numbers ranged from zero to 28 in the observed clinics. While 7.7% of the clinics had no scissors at all, 7.7% had 28. The rest of the clinics had two to 20 pairs of scissors.

- Client Education and Counseling Materials
  - *Hand-held uterine model*

    Numbers varied from zero to three per clinic assessed. 33.3% of the observed clinics had none, 8.3% had one, 41.7% had two and the rest 16.7% of the clinics had three uterine models.

– *Hand-held breast models*

Number varied from zero to seven among study clinics. Fifty percent of the clinics had none, 10% had one, while the other 10% of the clinics had seven. The rest of the clinics had two to four breast models.

– *Penile models*

Varied from zero to two among the clinics. The study clinics had none in 16.7%, 25% had some while 58% of the clinics had two penile models.

– *Posters*

More than half of the assessed (57.1%) had no posters at all, while the rest of the clinics (42.9%) had two to 10 posters. On the variety of the posters, 50% of the visited clinics had no variety of the posters, 50% had two to 10 posters. On accessibility of the posters, all the assessed clinics (100%) had no accessibility.

– *Pamphlets*

Half of the assessed clinics (50%) had no pamphlets at all, while 16.7% of the clinics had only one pamphlet. The rest had 20 to 300 pamphlets. Again, half of the clinics (50%) had no variety of pamphlets and 33.3% of them had only one type of pamphlets. On accessibility of pamphlets, all the visited clinics (100%) had no accessibility.

– *Flip charts*

28.6% of the visited clinics had no flip charts at all while 42.9% of them had only one flip chart. The rest 28.6% of the clinics had three flip charts. However, there was no accessibility to flip chart clients and service providers.

- Reference Materials/Job Aids
  – *Procedure manual*

  62.5% had no copies of procedure manual at all. The rest of the clinics had one, two and six copies accounting to 12.5% for each. Again, nearly three quarters of the assessed clinics had no access to procedure manuals.

  – *Handouts/skills application plan*

  More than half (60%) of the surveyed clinics had no Handouts/Skills application plans. Forty percent of the clinics had one skills application plan.

  – *Client management wall charts*

  More than half of the assessed clinics (55.6%) had no wall charts on client management while 33.3% of them had only one chart, and the rest of 11.1% of the clinic had 13 wall charts.

5. Client load by method for the three months preceding data collection: (August, September and October 1998)

- Pills

  Pills were the 2nd most popular method (new and revisit clients) after Depo Provera. The number of new clients for the previous three months before the study was one to 94 clients, for the first month, one to 52 for the second month and two to 88 for the third month (Table 63). Total new clients were 1085 (mean of 36.2 per month or 26 per clinic) and total revisits were 4630 (mean of 1545 per month).

- Depo Provera

  Depo Provera had the highest client load (new and revisit). The number of new clients for the previous three months before the study ranged from aero for the second month to 177 for the third month.

  Total revisits were 7840 (mean of 2615 per month). The mean number of new clients was 62.8 per month (38 per clinic every month).

- IUCD

  The number of new IUCD clients for the previous three months varied from zero to nine in the second month and zero to 13 only during the third month. Total new clients were 76, an average of 25 per month; with a revisit average of 20 monthly.

  The 76 new clients in the three previous months before data collection (August, September and November 1998) works out as just about two new clients per clinic every month, comparable to Norplant® Implants and female VSC.

- Male condom

  Among the clinics visited, new acceptors of male condom varied from zero to 100 per clinic for the first month, zero to 141 of the second month and zero to 80 for the third month.

  New clients averaged 188 per month (13 per clinic monthly) and revisit clients averaged 275.

- Spermicides

  Among the visited clinics, the number of spermicide users recorded per clinic ranged from zero to four for the first month, zero to 16 for the second and zero to 24 for the last month. New clients averaged 16 per month (one per clinic per month) and revisits averaged 15.

- Female VSC

  New and revisits clients averaged 24 (2 per clinic) and 18 per month, respectively.

- Norplant® Implants

  New clients in the visited clinic varied per clinic from zero to six (first month), zero to four (second month) and zero to eight (third month).

  Number of revisit clients ranged from zero to six (first month), zero to four (second month) and from zero to eight (third month).

New and revisit clients averaged 12 (one per clinic) and 10, respectively, every

- NFP (CMM and LAM)

  Utilization of these debatably non-clinical methods was low in all clinics. New client in the study clinics ranged per clinics from zero to five in the first month, zero to four in the second month and from zero to three in the third month.

  There were no revisit clients in the first two months, while in the third month, the number of revisit clients varied from zero to two.

Table 63: FP/RH clients by method for the previous three months study (August, September and October 1998)

Contraceptive Method	Type of Client	Total 1st month (Aug. 1998)	Total 2nd month (Sept. 1998)	Total 3rd month (Oct. 1998)	Total
Pills	New Clients	378	298	409	1085
	Revisit Clients	1995	1264	1372	4631
Depo Provera	New Clients	595	561	700	1885
	Revisit Clients	2616	2537	2687	7840
IUCD	New Clients	29	21	26	76
	Revisit Clients	23	16	22	61
Condom	New Clients	168	268	124	560
	Revisit Clients	223	344	259	826
Spermicides	New Clients	7	6	34	47
	Revisit Clients	21	3	21	45
VSC	New Clients	7	36	28	71
	Revisit Clients	9	19	27	55
Norplant® Implants	New Clients	12	5	18	35
	Revisit Clients	9	4	16	29
• NFP • CMM • Calendar • LAM	New Clients Revisit Clients	6 0	5 0	3 2	14 2
TOTAL		6098	5387	5748	17232

6. Quantity of each type of contraceptive supply available in the clinic stock (as per clinic ledger book)

   - COC

     The highest stock of COC available in one of the visited clinics was 29,800 cycles while the lowest was 30 cycles.

   - POP

     The highest stock of POP available in one of the clinics during the study was 1,200 cycles while the lowest was 22 cycles.

- Depo Provera

  The highest stock of Depo Provera which was available in one of the clinics was 1,400 vials while the lowest was 25 vials.

- IUCD (Copper 7380A)

  The highest stock of IUCD that was available in one of the clinics was 200 units while the lowest was two units.

- Male condom

  The highest stock of condoms that was available in one clinic during the study was 13,123, while the lowest was zero.

- Spermicides

  The highest stock of spermicides that was available in one of the study clinics was 4.200 while the lowest was 0.

- Norplant® Implants

  The highest stock available in one of the study clinics was 290 while the lowest was 0.

Table 64: Total contraceptive supply available in the stock of the 14 clinics visited during the study

Contraceptive Method	Stock on hand during the study	(average)
COC	37,755 cycles	(2,696)
POP	2,629 cycles	(188)
Depo Provera	4,443 vials	(318)
IUCD	361 units	(25)
Condom (male)	24,810 pieces	(1,771)
Spermicides	340 pieces	(25)
Norplant® Implants	290 sets	(21)

Findings and Implications

Counselling New Clients for Informed Choice

There were eight jobs assessed. The opening and closing sessions and establishing rapport were performed impressively, with almost all respondents being above cut off point.

While in total, only four were at or below cut off (with 18 out of 22 above) this paints an unrealistically rosy picture. Respondents performed very poorly when it came to establishing clients' reproductive goals and FP needs and helping them to select appropriate methods. In an otherwise commendable effort to avoid “wasting” time telling clients about all available methods, providers short-circuited on an important part of the counselling process. The unsubstantiated reason for this was the pre-supposition that clients already had enough general information from the community and only needed specific counselling for the specific method they selected. But the reality is that clients did not have adequate information from their communities to make informed choice without further general information and counselling in the clinic.

Screening of RH Clients

All respondents responded correctly about the necessary examinations and investigations. Unfortunately, they also added several unnecessary ones. Unnecessary procedures ultimately result in waste of time and resources for clients, providers and programmes. Sometimes the procedures are just not possible to do under certain circumstances thus denying the client a potentially suitable method.

IUCD Insertion Skills

While in total 15 of 17 scored above cut off with only two below cut off, this picture is misleadingly good. The critical jobs were not well done and respondents had inadequate skills for many of the jobs and tasks. Preparing and setting equipment and maintaining asepsis throughout the procedure were as described problematic. But it was worse for preparing clients for insertion, with 10 of 17 at or below cut off, and much worse for application of the tenaculum and loading the IUCD; not a single one of the respondents scored above cut off. This would probably result in unnecessary discomfort and pain for the clients undergoing procedures, ultimately discouraging other potential users.

While IUCD insertion itself was competently done, the explanation of checking for the strings was partly done: if clients cannot check for strings well, they may fail to notice IUCD displacement early, with resultant high pregnancy rates.

Instructions for IUCD Use

In general, these jobs were fairly well performed with seven below and 10 above cut off. However, regarding explanation on when client should come back for review or removal of IUCD, nine were at or below cut off. This causes a problem in that complications may not be identified and treated early to avoid long term costly disability, and dissatisfied clients will go around unnecessarily long, expressing their displeasure to potential clients.

IUCD Removal Skills

The removal tasks were generally well performed, except for verifying the menstrual history, in which eight respondents were at or below cut off.

IUCD Follow-up

Most of the tasks were fairly well performed. However, regarding checking and managing side-effects, all respondents were at or below cut off. Also only 15 of 18 respondents scored above cut-off for verifying whether clients check for IUCD expulsion. This has implications related to IUCD displacement, risk of lower abdominal cramps, infection, abnormal uterine bleeding and unwanted pregnancy.

Quality of Services

This study found that while some of potential and actual RH clients' rights are well addressed, most of them are not, and specifically as regards IUCD.

The findings were relatively positive for friendliness of services, dignity, and confidentiality. No direct data was sought regarding right to opinion.

However, there were gross omissions regarding clients' rights to information, adequate counselling, choice of available/accessible methods and continuity of services. Some of the omissions could be due to lack of adequately trained/updated staff for IUCD provision. This method was relatively inaccessible, IEC related to it was inadequate, and comfort/freedom from pain and safety of use was compromised.

- **Cost consciousness and efficiency**

  In a health care setting, poor quality is costly, both financially and in terms of the health of individuals and the community. "When processes are made better, total costs usually fall" (30). If something is not done correctly the first time, it has to be fixed and repeated and may require costly treatment of resultant complications.

  Incorrect aseptic technique increases the incidence of post-procedure infections among IUCD clients thus requiring treatment of complications (necessitating additional staff time, medications and other supplies). Clients are dissatisfied with the services and warn family and friends to go away from them. The SDP's reputation suffers and the number of clients who go to the site decreases. Some clients may suffer permanently, e.g., infertility, as a result of the infections they receive.

- **Performance of unnecessary tests**

  Unnecessary and needless tests waste time, money and resources. Clients and service providers may waste additional time and supplies repeating unsatisfactory tests that were not necessary in the first place, e.g., Pap smears in some service sites.

- **Clinical training in the diagnosis and management of RTIs**

  Some staff misdiagnose infections and diseases and provide ineffective treatment. Client suffers adverse health consequences and complications that require expensive treatments. Clients do not understand how to protect themselves and their partners so as to contain the spread of infection and the likelihood of serious complications increases.

- **Ordering of supplies**

  A haphazard system causes untimely ordering of unnecessary equipment. Supplies expire before they can be used, or run out before the next shipment arrives, impacting negatively on continuity of services.

- **RH information and counseling**

  Clients who receive poor information and counselling do not use methods at all, or use them incorrectly. They may then suffer unnecessary complications, including unintended pregnancy, discontinue early, and do not achieve their reproductive health intentions.

- **Ensuring needed training opportunities for staff**

  Although not all quality of service problems can be solved by training, it is sometimes the case that problems have arisen because of or in association with neglecting refresher training and training in new processes and procedures. The supervisor should not only enable staff to identified training needs, but also assist staff to identify training mechanisms or opportunities to meet those needs.

  When a service provider goes away for a month to central or regional technical training in IUCD provision she may return to her clinic and months go by and she does not use her new skills. One reason is that there is no demand for the service. This is because there has been inadequate effort to provide IEC on IUCD to the community. Also the trainee returns and does not find support systems needed to use new skills, e.g., water, electricity, expendables, equipment and educational materials on IUCD in SDP itself. Additionally, few other staff of different cadres have orientation on the IUCD, so they do not refer potential clients'. Trainers lack the resources to stay in contact with distant trainees, and ongoing technical assistance and supervision are also unavailable. Quite soon, the provider has not only failed to use her new skills but also lost some of her proficiency and confidence in the technique. Furthermore, trainees may have been selected inappropriately in the first place, because managers may use the trip away from site as reward or because it is "their time" to travel, rather than on the basis of the needs of the site or the qualifications and interests of the trainee.

  Innovative approaches to improve client recruitment and/or training which may help solve above problems include OJT, Whole Site Training (WST) and In-Reach, self-learning, and audio/video-assisted distance learning (31).

Clinic Facility Recommendations

- MOH should assist R/DHMT to work out strategies to improve staff motivation, training and updating on RCH, IUCD, counselling, screening and management of complications.
- MOH RCHU should improve availability of IEC materials, anatomic models, expendables and equipment.
- MOH RCHU in collaboration with R/DHMT explore and implement innovative approaches that will should improve infrastructure, communication and availability of clinic space, electric power, running water, expendables and basic equipment needed for IUCD and other reproductive health services.

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Appendix 1

Data Collection Sites in the Four Regions

Region	SDP: Name	SDP: Level	SDP Type	District
Dar-es-Salaam	Magomeni MCH/FP Clinic	Health Centre	Urban-Gov't	Kinondoni
	Marie Stopes Clinic - Kariakoo	Clinic	NGO	Ilala
	Chanika MCH/FP Clinic	Dispensary	Rural-Gov't	Ilala
Arusha	1. Ngarenaro MCH/FP	Health Centre	Urban-Gov't	Arusha Urban
	2. Njiro SDA MCH/FP	Health Centre	NGO	Arusha Urban
	3. Makuyuni MCH/FP Clinic	Dispensary	Rural-Gov't	Monduli
Mbeya	1. Ruanda MCH/FP Clinic	Health Centre	Urban - Gov't	Mbeya - Urban
	2. UMATI Clinic	Clinic	NGO	Mbeya - Urban
	3. Kyela MCH/FP Clinic	Hospital	Rural - Gov't	Kyela
Singida	1. Singida Hospital	Hospital	Urban - Gov't	Singida Urban
	2. Ilongoro MCH FP Clinic	Health Centre	Rural - Gov't	Singida Rural
	3. Uhasibu college	Dispensary	NGO	Singida Urban
	4. Police	Dispensary		Singida Urban
	5. Sokoine	Health Centre		Singida Urban

Appendix 2

Summary of Data Collection Sources

November-December, 1999

1. **Focus Group Discussion**
   - Total of eight FGDs in communities around selected RH facilities
   - Two FGDs per region; one rural, one urban,
   - Women 18-49, regardless of marital status or
   - Occupation in the community
   - Potential FP clients, eight to 12 in each group
2. **RH clinic facility clients**
   - Total of 674 interviews assisted questionnaires administered
   - Female clients, new or revisiting
   - 50 clients per each of three SDPs in each region
3. **RH providers - interview assisted questionnaire**
   - Two per SDP
   - At least one of the two providers trained with IUCD skills
   - Male and female providers equally eligible.
4. **Preceptors and trainers**
   - Preceptors: total of 16, four per region
   - Trainers: total of 18, i.e., four per region, plus two key Trainers.
5. **Supervisors: total of five per region x four + 12**

   Interviewer assisted questionnaire

   One clinic supervisor per each of the three SDPs in each region

   One district supervisor

   One regional supervisor

   Two key supervisors (one SD, one training) in main collaborating institutions
   - RCHU
   - SDA
   - UMATI
   - SUWATA
   - OTTU/TOHS
   - Marie Stopes
6. **Clinic facility status**
7. **IUD service provision and counseling skills**

   Checklists

Appendix 3

The Study Team

Research Consultant

Dr. Joseph Ruminjo - Intrah/PRIME, Consultant

Tanzania Team Leader

Mr. Maurice Hiza - CTT Member, RCHU

Reference Group

Mr. Clement Kihinga, IEC Research officer, RCHU

Mr. Alto Simime, RTMA, Intrah PRIME, at RCHU

Ms. Joy Bategereza, Training Coordinator, RCHU

Dr. Catherine Sanga, Deputy Programme Manager, RCHU

Ms. Gaudy Tibaijuka. Assistant Training Coordinator, RCHU

Data Collectors

Five RH Trainers

Three RH Preceptors

Appendix 4

Pre-analysis Activities

Preparation of screen for data entry and data entry dictionary and screen

Mr. Julianus Thomas, Consultant, Standard Consulting Group - Dar-es-Salaam

Mr. Clement Kihinga, IEC Research officer, RCHU

Collapsing and coding open ended questions for data entry

Mr. Maurice Hiza, CTT Member, RCHU

Rose Mapunda. CTT Member, RCHU

Ms. Renalda Ndono, CTT Member, RCHU

Data entry

– *Supervision*
Mr. Cyprian Mpenda - MIS Programme Officer, RCHU

Mr. C. Kihinga - IEC Research Officer RCHU

– *Three contracted Data entry clerks*
Mr. Ruvandiko Manumbu

Mr. Claud John

Mr. E. Nkiligi

– *Translation of FGD from Kiswahili to English*
Ms. Martha Malolela - Nurse Tutor, Muhimbili Nursing College, Dar-es-Salaam

– *Preparing theme summaries of the qualitative data*
Mr. Clement Kihinga, IEC research Officer, RCHU

Mr. Peter Riwa, Research and Evaluation officer, RCHU