

Access to Family Planning Services in Rural Tanzania: Barriers and Policy Options

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Abstract: *This article explored how quality of care and attitudinal and behavioural issues of the potential users merge together to influence adoption of family planning methods. Data were collected from providers of health services, clients, and non-clients of family planning services in two districts in rural Tanzania. Although family planning services are generally available, the range of options available at the primary healthcare level tends to be limited, which limits the ability of users to switch methods. Proper management of clients was also found to be weak. Inadequate information on modern contraceptives, misunderstandings on possible side effects and problems of male inclusion stand out as important demand side constraints to adoption. Deliberate efforts to ensure integrated family planning services at primary healthcare and improvement of the infrastructure to allow for privacy, and skills to manage clients appropriately can considerably help boost adoption. The potential of community health workers in delivering services like injectable contraceptives should also be tapped.*

Keywords: Access, quality of care, family planning, unmet need, supply and demand side

1. Introduction

As a way of confronting the rapid population growth and promoting child and maternal health in Tanzania, the government has increasingly emphasized the provision of reproductive health services within primary healthcare facilities, and instituted policies and strategies to that effect. The country's core services include reproductive health in which the policy underscores interventions to improve maternal health conditions, family planning and addressing the needs of the child and vulnerable groups including people with disability and the elderly. The policy focus on reproductive health dates back in 1989 when the country became the first among countries in Sub-Saharan Africa to adopt the Safe Motherhood Initiative (Magoma et al., 2013). Access to reproductive health services and family planning in particular has been underscored in various subsequent policies and strategies including the child and reproductive health strategy (1997); the national package of essential health interventions (2000); the health sector strategic plan (2009); the national strategy for growth and reduction of poverty (2010), among others. Reproductive health interventions have been further emphasized in Tanzania in the framework of the sharpened one plan, which accentuates access and quality of family planning, care at birth, and community health to maximize health outcomes for women and children (United Republic of Tanzania (URT), 2014).

Despite these policy developments, maternal health in Tanzania is still a challenge. The government's target of reducing maternal mortality by half from 529 per 100,000 live births in 1996 to 265 per 100,000 by 2010 has not been realized. Indicators of Maternal Mortality Ratio (MMR) suggest improvement with Tanzania Demographic and Health Survey (TDHS) 1996 reporting 529 deaths per 100,000 live births which increased to 578 in 2004, improving to 454 in 2010 and 432 in 2012 (from the National Census), yet worsening again in 2015/16 up to 556 as reported in TDHS (MoHCDGEC et al., 2016; NBS and ICF Macro, 2011; URT, 2012). The 2013 "State of the World's Mothers Report" ranks Tanzania as the 135th worst

country for mothers globally, and ranks it among the top ten countries with the highest newborn deaths and the country with most first-day deaths (Save the Children, 2013).

The extent of unmet need for modern family planning, defined as the proportion of married women who want to space their next birth or stop childbearing entirely but are not using contraception is remarkably high in Tanzania. The unmet need for family planning has remained between 22% and 24% since 1999 while the percentage of women satisfied with modern methods is only 53% (MoHCDGEC et al., 2016). As a result, unwanted and mistimed pregnancies remain high in the country. The TDHS 2015-16 survey show that while most births (69%) are wanted at the time of pregnancy, as much as 27% are mistimed and 4% are unwanted. The proportion of mistimed births increased from 23% in 2004-05, while the proportion of unwanted births has not changed (Ibid).

Of particular interest is why a large fraction of women in Tanzania wish to avoid untimed and unwanted pregnancies, but do not practice family planning. Existence of unmet need for contraception presumes the existence of multiple obstacles to contraceptive use. Ensuring low monetary costs and high knowledge of family planning services are not enough to guarantee adoption of family planning methods (family planning services are provided free of charge in public health facilities and knowledge of contraception is almost universal in Tanzania). Expanding the quality of family planning services is one approach to achieve greater use of modern contraceptive methods (Mroz et al., 1999; Veney et al., 1993). One important policy question underscored in the National Family Planning Research Agenda is whether quality of contraceptive services in the country is hindering adoption, and if increasing quality might encourage more women to use modern contraceptives thereby accelerating the process of fertility decline (URT, 2013a).

This paper presents an analysis of how quality issues in delivering family planning services (supply side), and

attitudinal and behavioural issues of the potential users (demand side) merge together to influence adoption of family planning methods. The subject was explored by blending Bruce's quality of care of family planning services framework with an access framework with five determinants of decisions to use and sustain family planning services (availability, accessibility, affordability, adequacy, and acceptability of services).

2. Literature and Theoretical Framework

The crucial factor for attaining Sustainable Development Goal (SDG) 3 (reducing the global maternal mortality ratio to less than 70 per 100,000 live births and ending preventable deaths of newborns and children under 5 years of age in particular) is access to family planning with its impact on Total Fertility Rate (TFR) and population growth. It has been observed that with population doubling in the next decades, the attained development achievements can be seriously jeopardized and therefore pose risk for attaining SDGs by 2030. Bringing down the population growth rates (mainly through substantially reducing the fertility rates) appears to be crucial for the achievement of the SDGs (Zinkina and Korotayev, 2014).

Family planning is considered a highly cost-effective public health intervention and one of the most cost-effective ways to reduce maternal and child mortality (Cleland et al., 2006; World Bank, 1993). Ensuring basic access to family planning could reduce maternal deaths by a third and child deaths by as much as 20% (Cleland et al., 2006; Stover and Ross, 2010; UNFPA, 2008). Family planning helps ensure that pregnancies occur at the healthiest time of a woman's life and that the pregnancies are wanted and planned. When pregnancies occur during healthy times, women and their newborns are more likely to survive (Norton, 2013). Yet the benefits of family planning remain out of reach for many, especially those who often have the hardest means of accessing right family planning information and services they need to plan their families. In most cases, the rural poor, marginalized, and young people fall in this category.

Voluntary family planning is an effective way of controlling fertility as it gives couples the ability to have their desired family size (Prata, 2007), thus allowing women to have fewer exposures to risky pregnancies and risky healthcare environments which may lead to maternal deaths. Modern contraception can help mothers avoid pregnancies that may be too early, too frequent, too many, and too late (USAID et al., (2012). Evidence shows that if couples can space their pregnancies by at least two years apart through the use of family planning, up to 35% of maternal deaths and up to 13% of child mortalities could be averted, while 25% of under-five mortalities could be averted if birth intervals were at least three years (Stover and Ross, 2010).

A complex set of factors contributes to Tanzania's high MMR. First is extensive poverty in the country. At least 28% of the population lives below the basic needs poverty line (URT, 2012b). Second is persistent underfunding of the health sector (Ministry of Health and Social Welfare, 2013) along with systemic difficulties arising from shortfalls in structures and processes set up for healthcare delivery.

While there are various hindrances at the health facility level, reasons for an uneven distribution of maternal morbidity and mortality in Tanzania are also reinforced by socio-cultural beliefs and practices of different societies in the country (Mbaruku, 2005; Mbuyita and Mayombana, 2006; MoHSW, 2013; NBS and ICF Macro, 2011).

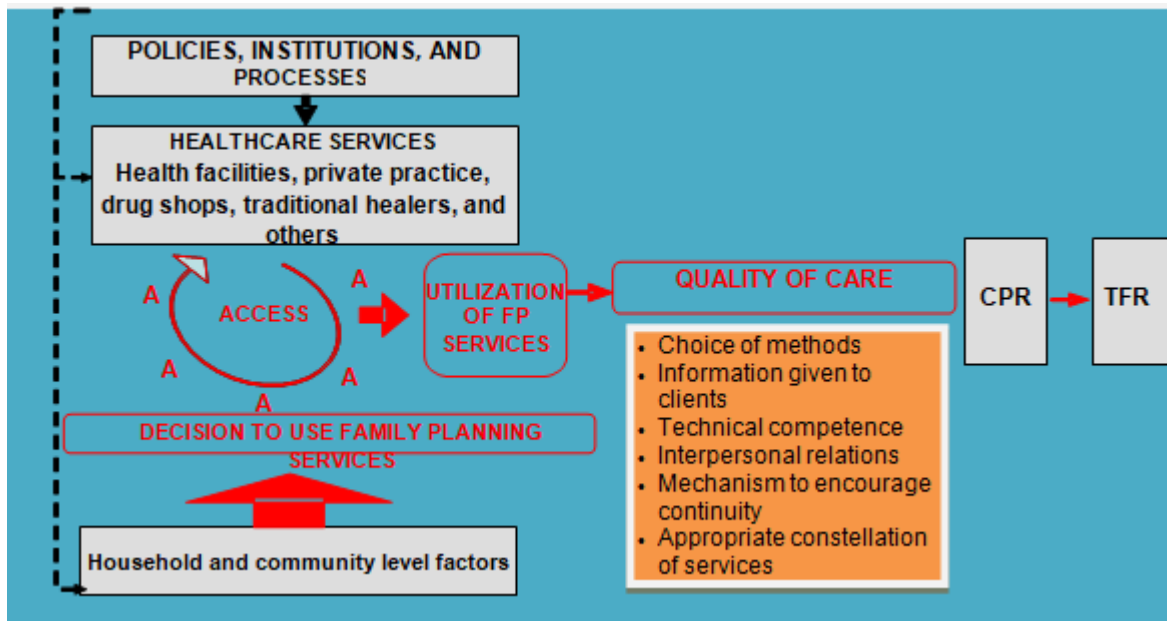
Studies are replete on the household socio-economic and community-level determinants of contraceptive use in Africa and in Tanzania in particular. Factors found to be positively associated with contraceptive use include education level, woman's occupation, support from husbands/partners, husband's education, and access to information (Alene and Worku, 2009; Arends-Kuenning and Kessy, 2007; Aziem et al., 2013; Michael, 2012; Stephenson et al., 2007; Stephenson, Beke and Tshibangu, 2008). For example, Arends-Kuenning and Kessy (2007) show that transforming rural women from illiterate to literate would increase the predicted probability of using modern contraceptives by 52%. Husband's education was also shown to have a large impact on women's contraceptive use in rural areas. Increasing husband's education from "no schooling" to "13 years of schooling" increases the probability that a rural woman will use contraceptives by 228%.

From the supply side of healthcare, erratic supplies, limited range of choices, gaps in provider knowledge and skills (along with provider bias), and insufficient counselling to determine and meet clients' needs are some of the major factors influencing family planning use (Wanjiru et al., 2007; Pathfinder International, 2008). Providing a choice of methods to meet the changing needs of clients throughout their reproductive lives increases contraceptive usage levels and enables individuals and couples to meet their reproductive goals. In a recently released Service Availability and Readiness Assessment (SARA), family planning services were offered in more than 80% of the sampled health facilities, and more than 70% of the facilities were ready to offer these services (URT, 2013b). Given this evidence, a possible cause of high levels of unmet demand is the lack of high-quality family planning services, that is, services are offered in a significant number of health facilities, but these are not of a desired quality.

Bruce (1990) proposed a framework to define quality of services, using six specific elements of the service delivery process. These are choice of methods, which measures the range of family planning methods available at each facility; information given to clients, which is captured by variables that show if the clients are given any/enough information concerning family planning; technical competence, which measures how competent the providers are in clinical techniques and the condition of the facility in general; interpersonal relations, which measures how clients perceive interaction with providers, including issues such as the degree of empathy in the provider's manner and the amount of time spent with the clients; mechanism to encourage continuity, such as community media, forward appointment, and home visits; and lastly appropriate constellation of services, which is defined as situating family planning services within the existing health services.

Family planning access framework presented in Figure 1 has been used to examine the influence of supply side factors (as defined by Bruce) and demand side factors on the usage of family planning (Bruce, 1990; Obrist et al., 2007). By placing access to healthcare in a wider context of poverty and development, the framework moves beyond the

conventional biomedical or public health approaches. The framework is based on the assumption that before a decision to use family planning services is made, several access dimensions have to be considered.



Note: CPR = Contraceptive Prevalence Rate; TFR = Total Fertility Rate

Figure 1: Framework of access to family planning services

Five dimensions referred to as the “5 As” influence the course of the decision a woman is going to make: *Availability, Accessibility, Affordability, Adequacy, and Acceptability* (Table 1). What degree of access is reached along the five dimensions depends essentially on the interplay between:

- (a) The healthcare services and the broader policies, institutions, organizations, and processes that govern the services; and
- (b) The households and community-level context influencing the norms of a particular society.

Table 1: Dimensions of family planning decision making

Availability	What types of family planning services exist (choice of methods)? Is there enough equipment, supplies and skilled personnel (technical competence)? What information is given to clients? What mechanisms are in place to encourage continuity? Are the services appropriately constellated?
Accessibility	What is the geographical distance between the services and the homes of the intended users? What means of transport exist? How long does it take to reach the service delivery point?
Affordability	What are the direct costs of the services/products delivered? What are the indirect costs (transportation, lost time and income, bribes)?
Adequacy	Does the organizational set up meet the patients' expectations and needs? E.g. do opening hours match farmers' work schedules? Are services offered in an environment that considers the privacy of the clients? Do the providers handle clients empathetically (interpersonal relations)?
Acceptability	Do the services take local concepts into account?

While the acceptability is mainly influenced by community socio-economic and cultural issues, the availability and adequacy (reflecting the quality of services) is affected by policies and institutions around healthcare delivery. Affordability and accessibility is affected by both health policies and community socio-economic variables such as income and education. Bruce (1990) proposed a quality of care of family planning services with six elements: choice of methods, information given to clients, technical competence, interpersonal relations, and mechanisms to encourage continuity, and appropriate constellation of services. When all these elements are addressed, clients' satisfaction and positive health outcomes, in terms of CPR and TFR, will be achieved.

Data and Methods

The study was conducted in Misungwi (high performance in use of family planning) and Ukerewe (low performance) districts in Mwanza region, Tanzania. Mwanza region was sampled because it is of the regions with low CPR in the country (15% for use of all methods) and second worst region in the country in terms of satisfying the demand for family planning services (29%). The study's target population comprised of all women and men of reproductive age, health services providers, council health management team members responsible for reproductive and child health (RCH), and employees of non-governmental organizations implementing family planning interventions in the study areas.

A total of 14 and 11 public health facilities (30% and 33% of total health facilities in the districts) were randomly sampled from Misungwi and Ukerewe districts, respectively. From

these facilities, a total of 118 clients of family planning services (women) were purposively selected (75 from Misungwi and 43 from Ukerewe). The average age of sampled women was 29 years (range 17–34 years). Most of these women were married (77%) and a few were single (7%). The rest were either divorced or separated (5% each) and cohabiting (4%). The majority had a primary education (73%), and 14% had secondary education. Only 4% had no formal education. The average number of children per woman was 4 (with the range of 0–9 children).

One provider was purposively sampled from the RCH unit of each health facility for key informant interview. Further, a total of four key informant interviews were conducted with district reproductive and child health coordinators from both districts and service providers from Population Services International (PSI) - a non-governmental organization providing family planning services in the study areas. Convenient sampling was used to reach a total of 117 other study participants who participated in Focus Groups Discussions (FGDs) conducted in 4 villages (33 women users, 35 women non-users, and 49 men). Two villages were sampled from each district – one located far from the district headquarters and another one located nearby.

Descriptive statistics were used as the main framework for presenting results from the quantitative data gathered in the study. Indices of quality of care were constructed for all relevant indicators, with values ranging between 0.00–0.19 (indicating very poor), 0.20–0.39 (poor), 0.40–0.59 (average), 0.60–0.79 (good), and 0.80–1.00 (indicating excellent quality of care), as proposed by Arends-Kuenning and Kessy (2007). Analysis of Variance (ANOVA) was performed to confirm statistical differences among variables. The ANOVA was also used to check for statistical differences on the performance of quality indicators among the three types of facilities. In addition, t-test was used to confirm any statistical difference on the average performance of quality indicators (the choice of family planning methods, information given to clients, and technical competence) per district.

Moreover, thematic analysis was performed to interpret qualitative data collected from FGDs and key informants. This technique makes it possible to make inferences by objectively and systematically identifying and classifying patterns of meanings and key themes/messages emerging from the data. A mixed methods approach was used in presenting the findings (Steckler et al., 1992). The quantitative data from the closed-ended questions were triangulated with qualitative evidence from the FGDs and key informant interviews to explain the patterns in the results.

Given the sensitive nature of the study theme, care was taken in making sure that the study participants' rights are not violated. Measures to ensure this included seeking verbal consent from the respondents before interviewing them; organizing separate focus groups for men and women; and ensuring that male focus group discussions (FGDs) are handled by male data collectors, while female FGDs are handled by female data collectors. Interviews with clients at the health facilities were handled by female data collectors. It was made clear to the clients that if they were

uncomfortable with the observation method (observing the interactions between the provider and the client), only exit interviews would be used. However, no client indicated being uncomfortable with observations.

3. Results

Quality of care of family planning services

Composite indicators of quality of care were developed based on six thematic areas described in Bruce's framework: Choice of methods of family planning services, information given to clients, technical competence, interpersonal relations, mechanisms to encourage continuity, and appropriate constellation of services.

Choice of methods of family planning services

The range of methods available, based on women's accounts of available family planning services, was found to be of average in the three types of health facilities and in both districts. This may be interpreted as no combination of methods is offered at these facilities. Most promoted methods, and those of which the women were most aware of are pills and injectables (depo-provera) (>90%), intra-uterine contraceptive devices (IUCDs), and implants (>75%). The lesser known methods include diaphragms, foaming agents/spermicides, female and male sterilization, and natural family planning (<15% knowledge). Observational data from health facilities show the same with pills and depo-provera, available in >95% of the facilities. Condoms (mainly male condoms) were only available in 50% of the surveyed health facilities. Diaphragms and foaming agents were not available in any of the sampled facilities.

Information given to clients

The family planning information given to clients was rated good in all sampled facilities, except for hospitals in Ukerewe, where the facilities attained an average score. The t-test values showed borderline significant variation between Ukerewe and Misungwi districts in mean scores for information given to clients ($p < 0.063$), meaning that compared to Ukerewe, Misungwi district offers slightly higher quality services as defined by the variables for measuring this indicator. Most variables under this theme performed well (>70%), e.g. given a chance to select preferred method, informed of difference between permanent and reversible methods, and discussion on reproductive goals and dual protection of condom use (77%). The surveyed women were very conversant on the mode of action of depo-provera and implants – that is, they know they have to go to the facility for injection after every three months, and they understand that implants can last for 3–5 years. They were also conversant on the side effects of some of the methods, e.g. headaches, abdominal pain, nausea, dizziness, unusual body-swelling, swelling of the veins, loss of body weight, pains in the part of the arm where implants are placed, increase in blood pressure/abnormal blood circulation, and prolonged menstrual cycles. Prolonged menstrual cycle was mentioned as a common symptom among women using depo-provera.

Nevertheless, most women had no knowledge on symptoms that would require them to return to the health facilities for additional assistance and check-up. Women users also

pointed out that providers often do not provide adequate information on the side effects of contraceptives, and on how to cope with them. Lack of proper knowledge about these side effects can result in discontinuation of use and also deters women from seeking family planning services.

On the other hand, some male FGD members pointed out that some women had experienced family planning side effects caused by the users themselves when they fail to follow instructions from the health service providers. Some women misuse family planning methods such as taking more pills than the prescribed amount with the intention of abortion:

"...like other medicines, family planning pills become poisonous in the body if excessively swallowed," (FGD with men, Misungwi A Street, Misungwi).

The major weakness in delivering family planning information is that it is confined to women who have presented themselves to the health facility for various reasons. Community-wide modes of delivering family planning information are rarely used, and those that do occur are usually from intermittent interventions by non-governmental organizations. While users have adequate information on some aspects of family planning methods, the FGD findings point out inadequacy of the information provided to the community. This was echoed in the men FGDs:

"Family planning materials should be provided to ALL and not only to those few people that go to the clinics; why will I go to the health facility if I don't have a sick child or my wife is not pregnant? I recommend family planning materials to be provided at the village assembly," (FGD with men, Iteja village, Misungwi).

"We have never seen road shows in this village! Family planning stakeholders can use road shows, organize meetings with councillors, organize village meetings with both men and women, to provide family planning education; people will ask questions when they get answers they will understand," (FGD with men, Hamkoko village, Ukerewe).

Technical Competence

The technical competence aspect of quality is divided into visible technical competence in terms of staff training and clients' management, and privacy. Overall, the technical competence was found to be excellent in hospitals, good in health centres, and average in dispensaries in both districts. The average for all health facilities was pulled down by failure to manage clients appropriately in terms of taking necessary diagnostic tests before providing family planning services. For the dispensaries, apart from managing the clients well, the average was also pulled down by lack of privacy and unavailability of electricity and running water. Specific components of technical competence are discussed below.

Visible technical competence was measured by availability of electricity and water supply in the facility. The index for this indicator was excellent for hospitals in both districts and good for health centres in Ukerewe. The index was poor for dispensaries located in both districts. The t-test values showed significant variation in mean scores for visible technical competence between Ukerewe and Misungwi

districts ($p < 0.006$), meaning that Ukerewe district offers services of higher quality compared to Misungwi. Furthermore, only visible technical competence was significantly different among the three types of health facilities ($p < 0.0001$). Although most dispensaries in rural areas do provide a wide range of RCH services, including ante-natal and postnatal care and delivery services, about a third of dispensaries do not have running water (MoHSW et al., 2015). In some rural facilities it is still common that a woman showing up for delivery services must come with a bucket of water or have a relative around who can fetch water for her. Likewise, some rural health centres lack piped water and electricity. Nevertheless, the invention of solar technology has been very helpful for rural-based health facilities.

Interpersonal relations

The interpersonal relations index was excellent for all the sampled health facilities. The scores were constructed from variables showing how comfortable the providers were in discussing sexual behaviour related to sexually transmitted infection/HIV, with women attending RCH clinics. Women users noted that in most cases, they were treated with empathy and were encouraged to ask questions during their visits. Bad language by providers was perceived to be common when women visited for delivery services, compared to when they visited for family planning.

Mechanisms to encourage continuity

The score for mechanisms to encourage continuity ranged from good to excellent in the sampled facilities. The index was measured by three proxy variables: whether the facility makes referral (for health centres and dispensaries); whether the providers discussed return visits and follow ups with the clients; and, whether clients are asked to return to clinic at any time if they have a question, or concern or a problem.

Fewer referrals were expected from hospitals (referrals could be made to the non-governmental organizations) but dispensaries were expected to be making more referrals, followed by health centres. Dispensaries, particularly in rural areas might not have been making referrals even where they were needed because there are no nearby facilities that they could refer the women to. Adequate management of clients who consistently experience side effects from using various contraceptive methods is important in encouraging continuity:

"The issue is not only about how to encourage continuity. If a woman has started with pills and is affected and switches over to implants and still experiences serious side effects, the woman is told to just tolerate and the problems persist for so long. If this happens, the use of family planning services becomes another disease to her; she will despair and end up at the traditional healers and sometimes if God wishes, she is cured. Such a client cannot believe in family planning services and cannot use it again," Key Informant, PSI.

Appropriate constellation of services

The constellation of services index was good for all facilities. Most of the sampled health facilities had child immunization services, intermittent presumptive treatment for pregnant women, tetanus toxoid for pregnant women,

and antenatal care services. Maternity/delivery care was also provided even at dispensaries (although most dispensaries do not have the capacity to offer even basic emergency obstetric care. This is because in the rural areas, often times that is the only available option. Constellation of services is important because some of the symptoms of sexually transmitted infections e.g. bleeding, are quite similar to side effects experienced from use of contraceptives. It is as such important that women are encouraged to return to facilities for investigation, advice, and care whenever they experience complications or unusual symptoms. This might help reduce the prevalence of misconceptions about side effects of the family planning options.

Accessibility and affordability of family planning services

This study finds out that the services are mostly accessible and affordable to the majority of community members at the point of service delivery. Nevertheless, there is a problem of limited choice, especially at dispensaries, which, given their nearness, are the first place of contact for most community members. Although the choice of methods is broad at hospitals and partly at health centres, few women live within the vicinity of these facilities. Most hospitals are located in urban areas/district headquarters, while the majority of women live in rural areas. This means that the services offered at hospitals and health centres might not be accessible to a lot of women. Occasionally, providers from hospitals (e.g. Nansio district hospital) and non-government organizations such as PSI conduct community outreach programmes. IUCDs, implants, and condoms have been made available through these kinds of community outreach programmes as well.

Family planning services in public health facilities are provided for free, as are the services offered by some non-governmental organizations such as PSI Tanzania. However, payment of unofficial fees, especially for inserting and removing implants, was reported during the FGDs with women users. Given the competing demands on the limited incomes for rural dwellers, and low acceptability of the services, attaching a fee to family planning use could deter women from accessing the services. One member in women users FGD noted:

"... Mhhh! Family planning services are available in our dispensary. If we were asked to pay anything, it wouldn't have been possible for us to access these services because the economic situation wouldn't allow us. If you ask your husband for TZS 500 (USD 0.25) for the service, he would say, 'get out of here (...), I have no money to waste,'...." (FGD with women users, Buzegwe village, Ukerewe).

Acceptability of family planning services

Acceptability of family planning services is affected by both demand and supply side factors. As presented above, if major issues on availability (methods selection and information given to clients), accessibility (bringing the services closer to people), and adequacy (privacy) are not addressed, women would be discouraged from seeking family planning services. At the community level, low awareness of and misconceptions on the efficacy and side effects of family planning options were echoed in this study.

Communities do not have adequate knowledge and understanding of family planning methods and use. The reasons behind this, as raised in the FGDs, include lack of inclusive and sustainable strategies for community sensitization and engagement. In various family planning campaigns, men have not been involved as equal partners. Furthermore, some community members believe that family planning may cause cervical and uterine cancer and fibroids; women might give birth to abnormal children with mental retardation or other forms of disability (e.g. cleft lips and cleft palate); and women believe that devices like IUCDs and implants can continuously move along with blood circulating inside the body.

Trust issues between couples were also associated with low usage of family planning services. In the FGDs, it was noted that due to mistrust issues among couples, husbands tend to be suspicious when wives express a desire to use family planning services. This is especially so for men who equate family planning with marriage betrayal, i.e. the desire to have sex out of wedlock. Women also fear that using family planning may push their husbands to other women in order to get more children. This is particularly the case in communities where demand for children is high.

4. Discussion

The Sustainable Development Goal (SDG) 3 aims at "ensuring healthy lives and promoting well-being for all at all ages by improving reproductive, maternal and child health" (UN, 2016). Attaining this SDG is a function of multiple factors including improved access and use of modern family planning services. The theory of change which explains "why we think certain actions will produce desired change in a given context (Parsons et al., 2013) informs us that, increasing access to family planning services will contribute to meeting the family planning needs and therefore the achievement of SDG 3 through improved maternal and child health. The study found rather low rate for choice of methods at rural dispensaries, which is a reflection of the inability of dispensaries to offer some types of family planning methods, e.g. IUCDs and sterilization. Dispensaries are expected to offer oral contraceptives and condoms, while health centres and hospitals, in addition to offering oral contraceptives and condoms, can offer surgical methods and IUCDs, depending on the available infrastructure and expertise. Surgical/permanent contraception is largely restricted to hospitals (URT, 2012c). This level of protection/restriction affects rural women's access to the desired services. Rural women in many parts of Africa receive services from dispensaries and Community-Based Distributors (CBDs), but dispensaries may not have the desired method, and CBDs are only allowed to distribute pills and condoms. Yet it is exactly in rural Sub-Saharan Africa where women prefer injectable contraceptives. Depo-provera provision by CBDs has been used in many parts of Asia and Latin America, and it has been tried in pilot projects in Uganda, Madagascar, and Ethiopia (Prata, 2009). However, in most Sub-Saharan Africa, depo-provera can only be provided by skilled personnel, despite the evidence showing its safety, feasibility, and acceptability at community level (Stanback et al., 2007). Similarly, the satisfactory provision of IUCD insertion by non-physicians

has been established since 1970s (Prata, 2009), but restrictions are still rampant.

Incorrect information education and communication (IEC) on efficacy of family planning services also deters women from accessing the needed family planning methods. A study of eight developing countries showed that 50%–70% of women thought the use of oral contraceptive pills was a considerable health risk, even though having a baby in a low-resource setting can be up to 1,000 times as dangerous as taking oral contraception (Prata, 2009). Effective communication with clients and communities on the benefits, efficacy, and effectiveness, as well as side effects of family planning is thus very important.

Bringing services to the doorstep in rural areas through health extension workers and CBDs has resulted in tremendous achievements in contraceptive use in Ethiopia (USAID et al., 2012) and in hard to reach areas in Tanzania (Kibuga, 2005; Simba et al., 2011). Madagascar also records an informative success story in increasing CPR through training of community health workers to provide family planning services with injectable contraceptives (WHO and UNICEF, 2010).

5. Conclusion

In making family planning more accessible, efforts should be made to facilitate provision of all family planning methods (except those requiring surgical procedures, such as tubal-ligation and vasectomy) at the primary health facility level. To compensate for the lack of trained personnel to provide family planning services at the outreach level, efforts need to be made to tap the potential of community health workers (and CBDs where available) who operate outside the health facility and whom potential users trust in delivering services like injectable contraceptives. This will help expand the range of services communities will have access to, and help ameliorate gaps caused by staffing and competence constraints in primary public health facilities.

To control fertility effectively, women, couples, and the community at large need to have access to correct information about contraceptive methods and be able to afford the method of their choice. It is important that people attain correct knowledge about the benefits of family planning, how the various methods work, and their safety and possible side effects. To sustain continuity and expand usage, it is equally important to address misinformation and misconceptions about family planning.

Proper management of clients, including protection of clients' privacy, and ensuring that necessary tests and counselling are done before any method is prescribed is of essence. Constellation of services is another important step in promoting family planning use. Family planning services should be integrated and provided alongside other routine reproductive and child health services to improve access and reduce missed opportunities, especially during postpartum periods. The services can be integrated into immunization, growth monitoring, post-abortion care, in-patient paediatrics or gynaecological consultations, and in care and treatment centres for HIV and AIDS.

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