Factors that Influence Attitudes towards Utilization of Modern Family-Planning Methods in Tanzania and Lessons Learned from Application of Participatory Action Research.

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Introduction

Currently in the field of family planning (FP), implementation research is ranked at utmost priority in the global research agenda (Moazzam et al. 2014). The demand for implementation research is in-effect due to the small progress made in reducing unmet need. Researchers are interested to understand why uptake and use of modern FP continues to be low despite knowledge of these methods. The experience in Tanzania is no different. Statistics show that knowledge of at least one method of family planning is almost universal. However, utilization is still very low because only 34% of married women use any method of contraception (TDHS 2010). Also high in the research agenda is integration of FP services and outreach to vulnerable groups such as adolescents.

Family planning (FP) not only plays part in bringing about socio-economic development but it also saves lives of women, children and adolescents. While Tanzania has made huge strides in reducing infant and under-5-child mortality, maternal mortality rates remain persistently high. Compared to the US that has a maternal mortality ratio of 21 deaths per 100000 live births, in Tanzania this ratio is 460 deaths per 1000,000 (World Bank, 2010). Family planning plays a huge part in preventing maternal mortality and is projected that it can help reduce maternal deaths by 32% (Cleland et al. 2006). According to the 2010 Tanzania Demographic Health Survey (TDHS), the total fertility rate (TFR) in Tanzania (2010) is 5.4 births woman. In mainland Tanzania the TFR among all age-groups is significantly higher for rural women (6.1 births) compared to urban women (3.7 births). The rate of national population growth is 2.9 percent, ranking Tanzania 7th in the world (UNDP 2010). Given the high TFR and if this population growth rate does not decline, Tanzania's population is projected to reach 65 million by 2025, increasing the strain on already overstretched resources (MoHSW, 2010).

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Knowledge of at least one method of family planning is almost universal in Tanzania regardless of gender, marital status or sexual experience even though men are more likely to have heard of modern FP methods than women (TDHS, 2010). Knowledge however does not translate into practice as evident from the low contraceptive uptake in Tanzania. Tanzania's national target for contraceptive prevalence rate (CPR) is 60%, however the CPR is currently only at 27% (TDHS, 2010). Moreover, the unmet need for FP among currently married women in Tanzania is representative of sub-Saharan Africa's region which at 25% (TDHS 2010 and Gribble 2012). This unmet need is higher for spacing (16%) children than for limiting (10%) number of children.

In the 1990's studies of unmet need had indicated that main reasons for non-use of contraceptives in sub-Saharan Africa include lack knowledge, fear of health or side effects and familiar or spousal disapproval (Bongaart et al, 1995). Knowledge of modern FP methods is no longer a huge concern in Tanzania, the predominant demand side factors to non-use include fears of side effects and health concerns of specific methods (44.3%), spousal disapproval (12.1%), women opposition (11.5%) and infrequent sex (17.8%) (Sedgh and Hussain 2014). Currently public-sector facilities in Tanzania do not charge for FP methods and services, however, there are several supply-side driven obstacles. The most urgent issue facing FP services is maintaining an adequate supply of contraceptive commodities to meet clients' needs in-order to prevent stock-outs. Tanzania needs to strengthen its procurement and logistical systems so that there are better forecasting, budgeting and tracking methods for contraceptives, to meet the needs of FP clients (MoHSW, 2010).

In order to develop and strengthen FP demand generation activities it is important to design programs that are culturally appropriate, encourage community participation and that also have political support (Mwaikambo et al 2011). However, very few policy or scientific studies offer practical guidance to managers and policymakers on how this can be achieved (Nazzer et al). Participatory Action Research (PAR) is a reflective approach that empowers communities to share their experiences, opinions and expectations providing data that is useful for not only strong program design and planning but also successful implementation (Fenenga et al, 2015). In this paper we discuss findings from a formative evaluation on demand-side factors that shape attitudes towards modern FP methods and the lessons learned from application of PAR to tackle these barriers.

Methodology

Background

Data for the formative research is derived from qualitative research conducted in Kilombero district, Morogoro Region, as a sub-study of the *Connect Project* (Ramsey et al., 2013). Connect is a randomized controlled trial designed to test whether the introduction of trained and paid community health agents (CHA) into the current Tanzania health care system will reduce infant, child and maternal mortality; thereby accelerating progress towards Millennium Development Goals 4 and 5. The family planning services performed by the *Connect* CHW, known as WAJA

(*Wawezeshaji wa Afya ya Jamii* – Community Health Agents) include distribution of condoms, re-filling oral contraceptives to users and providing FP education at village and household levels. This research was conducted in 2013 to contextualize midline findings that WAJA had no effect on contraceptive utilization after two years of deployment. It employed in-depth interviews (IDI) and focus group discussions (FGD) with key informants from the community-level and also WAJA, providers at facilities and members of Council Health Management Team (CHMT) in Kilombero. This paper reflects feedback from various stakeholders of Connect intervention communities. The research employed two types of methodologies for data collection, focus group discussions (FGD) and in-depth interviews (IDI) with key informants. Interviewers modified the content and sequence of questions so that the lines of questioning were relevant vis-à-vis the roles and experiences of the different participants; therefore not all topics are addressed in a similar matter across the FGDs and IDI. Formative evaluation was conducted for the following objectives (1) To provide accounts on various stakeholders' prevalent views, experiences, and concerns on FP methods (2) To provide knowledge on motivational factors that influence pregnancy intentions and ability achieve reproductive goals.

A broad representative sample of stakeholders was used and in total, 8 FGD's and 20 IDI's were conducted (see Table 1 below).

Table 1: Participants in qualitative formative research for Connect-FP

Village	**Respondent Type**	**Number**	**Inclusion criteria**	**Data collection exercise**
Igima. Iragua, Kisawasawa, Lumemo	Women of reproductive age	48 (Lumemo and Kisawasawa)	Ages 15-49, segmented by age (15-24 and 25-49)	FGD (4, segmented by age, two amongst women 15-24 and 25-49 respectively)
	Influential woman	4	Village leadership opinion based on service to community	IDI (4)
	Influential man	4	Village leadership opinion based on service to community	IDI (4)
	WAJA	8	Appointment as Connect *WAJA*	IDI (8)
	Village Executive Officer (VEO)	4	Appointment by local government as VEO	IDI (4)
	Men of reproductive and or heads of household	48 (Igima and Iragua)	Ages 15-49, segmented by age (15-24 and 25-49)	FGD (4, segmented by age, two amongst women 15-24 and 25-49 respectively)
		116 respondents		**8 FGD and 20 IDI**

Methods

Scientists conducted qualitative analysis of transcripts obtained from the FGD and IDI implemented amongst community respondents listed in Table 1. Purposive sampling was used. A total of three health facilities (two dispensaries from Kilombero district and one health center from Ulanga district) were involved in the study. Each IDI or FGD was operated by two research assistants (one moderator and one note taker). Each pair of research assistants was required to summarize key findings and observations from interviews at the end of each day. Special rolling analysis forms were designed and utilized for these summaries. The FP research scientists also met with the research assistants to review the major findings from the day based on field notes and rolling analysis forms. This process helped to identify topics requiring further probing and questions that were not clear to participants. Additionally, the evening reviews helped to address emerging field challenges while continuously summarizing the key findings from the formative research. Interviews lasted an average of sixty minutes, while focus group discussions were approximately one and half to two hours each.

Four social scientists reviewed all transcripts guided by the framework used for designing the data collection tools which give emphasis to four themes: pregnancy intentions, contraceptive utilization, and perceptions of family planning service delivery. Each scientist wrote extensive memos for each theme in conjunction with conducting a literature review on these topics. Iterative discussions ensued and resulted in the derivation of a code book which mirrored the language and nuance which emerged from the text vis-à-vis each theme. During the initial phase of 'open coding' periodic inter-coder reliability checks were conducted to ensure agreement on reliability. To manage and analyze data, coders and scientists used QSR International's NVivo 10 qualitative software package.

Starting in the second phase of 'axial coding', social scientists re-organized the text according to code. Different dimensions of coded themes, how sub-groups enrolled differed or were similar, and hypotheses about each theme in question and its relation to others were examined. Based on this, data reduction ensued to distil information, generate theories for each theme and inter-relationships. Analysis of matrices which resulted from this comprised the final step of 'selective coding' where by explanations for the thematic ideas were finalized into an integrated theory for how fertility desires and contraceptive behaviors form, respectively, and converge to articulate an unmet need for family planning.

Ethics

Permission for this study was accorded by the ethical review boards of the Ifakara Health Institute (IHI/IRB/No. 16-2010), the National Institute for Medical Research's Medical Research Coordinating Committee (NIMR-CC) (NIMR/HQ/R.8a/Vol.IX/1203) and the Internal Review Board (IRB) of Columbia University Medical Center (Protocol AAAF3452). Research assistants administered formal informed consent procedures and obtained the signature or thumb print of subjects to confirm willingness to participate.

Phase One

Qualitative findings from formative research: Demand-side barriers to uptake of FP services

Experienced or feared side effects and health concerns of contraceptives

FP clients complain of side effects from using different contraceptives. For example many women who use injectable contraceptives get irregular menses or don't see their menses for a while, others complain of stomach pains from using pills and they believe that these FP methods can cause cancer. All these side effects whether feared or experienced, act as barriers for use of modern contraceptives. The question of return to fertility for certain contraceptives also dissuades some from using contraceptives.

The first challenge understands, there is some people think they will get side effect after using it, but there is others who are very few means they already used it and they affected with it, for-example increases in weight, BP, for those who got complication they will end-up with negative attitude *on using this methods. (DMO, Ulanga)*

Those who stop using family planning maybe it's because they don't feel good when they use them. So these family planning methods depend with the way people feel when taking them because not all who cope with these family planning methods. ***Some they become fat and others they menstruate for many days some few days so these are the reasons which will make a person stop using family planning****. (DHO, Kilombero)*

They are also saying that some people are delaying to get pregnant. (CHA, Kisawasawa)

Religious Barriers

Some religions are in opposition of using modern family planning methods and so there is a sense of guilt for those that are using or are considering using. Due to religious oppositions some may not seek FP services at health facilities because of fear that other people find out that they are using FP while it is forbidden in their congregation.

Some can start using then after they have attended churches and Mosque and hear some words from pastors and Mashehe (Muslim priest) concerning giving birth then they are convinced and stop using*. You know everyone has his/her belief and we have a different way of perceiving things. (CHA , Kisawasawa)*

Honestly because of fear of God during that time I had never used anything*, I have been giving birth and I have never using injection or anything. (FGD Adult Female, Lumemo)*

Opposition from men

Men view family planning as a woman's concern and many prefer their wives to use natural methods of family planning and so they discourage their wives from using contraceptives. Some men complain that some contraceptives have side effects that interfere with sexual intercourse.

I think a woman is the one who can plan because she knows when she can get pregnant and when she is safe depending on her menstruation cycle. But some are prohibited by their husband to use any kind of family planning methods ***so they sometimes hide to their friends. (CHA, Kisawasawa)***

The fear of side effects on the health of the woman also makes some men hesitant to support their spouses in using contraceptives.

As mentioned before ***pills brings swelling to their stomach, previous they have been using pills much but after observing these problems once you see women with obesity and you think she is working in a bank but these are effects of pills, myself my wife have good figure like number eight but now she has obesity.*** *(FDG Adult Male, Igima)*

Stigma associated with adolescents and youth to use family planning

There is still a general stigma especially among adolescents on the use of FP. Stigma limits access because many young people fear seeking FP services in health facilities where the providers may recognize them and so they go to facilities that are further or they use drug stores where they are unlikely to see a trained professional or access.

So they are afraid to go for injection because a certain nurse might know that she is using the methods and for vitanzi (Intrauterine Device) they are going to do the process far from here because they don't want to be noticed, *they need it to be more confidential.(VEO, Kisawasawa)*

Phase Two

Use of Participatory Action Research to empower stakeholders to take ownership of the reproductive challenges in the community

This section provides a summary of the PAR implementation milestones adopted to disseminate findings from the formative research to key stakeholders at the district level. The district stakeholders using a 'learning by doing' approach work with community stakeholders to tackle some of the existing demand side barriers to FP.

Assembling and orienting district level facilitation team

Six staff members from the district comprised the district facilitation team (DFT). The DFT consisted of Reproductive and Child Health Coordinator; District Community Development Officer, Community Health Agent Focal person, the Family Planning Unit in-charge, District Nursing Officer and District Social Welfare Officer. The objective of forming a district facilitation team was to empower the district to have ownership and take a lead role in the implementation of the PAR. The Connect Family planning researchers, held PAR training to the DFT in Kilombero district. The purpose of the training was to reflect and discuss on the findings from the formative research and to build their capacity in implementing PAR in three pilot villages in the district that were Kisawasawa, Lumemo and Igima. The training program gave a background of Connect-FP, discussed the family planning issues in the district and PAR skills.

The team was taught on how to conduct district social mapping, seasonal calendar of the district, to do institutional analysis and to identify family planning challenges with in the districts.

Community Entry

After orienting the DFT to participatory approaches, the DFT along with the Connect-FP researchers visited the three pilot villages. On the first day in each village the team made initial contact with the village leadership, oriented them to the family planning agenda and the use of PAR as an approach for eliciting community support and participation in development efforts.

Sensitization meetings at village level

On the second day the DFT conducted the sensitization meeting with support from the researchers. Twenty (20) participants in each village were selected based on DFT opinion on which village actors hold strong influence over reproductive health norms and decisions and were invited to the sensitization meetings. Participants included village leaders, religious leaders, traditional birth attendants, traditional doctors, facility health in-charges, primary teacher, influential people and CHA. In the sensitization meetings, the DFT disseminated findings from the formative research to invited community members. Efforts were taken to select relevant information and present findings in a manner amenable to participants' understanding. Members of the DFT facilitated intensive discussion to elicit participants' reactions to the findings and learn if they corresponded well with their views and perceived realities. The family planning focal person from the DFT took the lead on facilitating a discussion on the meaning of family planning and its importance. Out of discussions some of the demand-side factors

Formation of village facilitation teams (VFT)

The twenty community participants in each village selected 10 representatives among themselves to form the village facilitation teams (VFT) in Lumemo, Kisawasawa and Igima. These village facilitation teams consisted of the CHA's as well as recognized representatives from the community such as religious leaders, the village government representative, traditional healer midwife, influential persons, and primary school teachers.

Conducting Community Reflective Activities.

In each village, VFT, with support from the DFT and researchers, conducted social mapping, seasonal calendar and institutional analysis. The aim of the activities was to not only understand the setting of the village, but, moreover, to build the capacity of the VFT to lead different PAR activities and take ownership of FP challenges within their community.

I. Community set up

a. Social Mapping: VFT were asked to work in groups and draw on blank sheets of paper maps that give an actual depiction of their villages and of social and economic activities including social clubs, shops, health facilities, churches, mosques, source of income for the village, source of water, market places, etc. Then the VFT, DFT and researchers together discussed on how **social mapping** can be used to identify existing places that can influence the utilization of FP.

b. Seasonal Calendar: VFT's are asked to create a year calendar identifying when most of the social and economic activities happen throughout the year. The seasonal calendars were used to identify the different seasons that affect or encourage the provision of Family Planning services. By using the seasonal calendar the VFT was able to know which period of the year the community has enough money which leads them to engage in the negligent sexual acts. It also helped to know in which period the community has a time to partake in Family Planning activities.

c. Institutional Analysis: Third, in each village all groups recognized all the institutions which provide the FP services, the methods provided there, and then brainstormed the problems and solutions with each institution, ranked and prioritized how these issues should be addressed by community action.

II. Family Planning problems

*a. Focus Group Discussions and Problem Tree***:** It was important for the VFT to identify health and FP challenges in their own community therefore FGD's was used to come up with top ten FP health needs, and afterwards, the team divided the participants into three groups. The Connect-FP and DFT used the problem tree tools of posing the "BUT WHY" question to every FP-problem to support each small group to come up with root cause and challenge to each FP problem. For an example, the facilitator encouraged the participant to think where does the problem of unwanted pregnancy lay explaining that the branches represents a symptom and the roots, represents the cause.

b. Scoring & Ranking: After each team identified their respective problems, the DFT provided them beans. Following the PAR 'scoring and ranking' methodology, VFT members were asked to allocate their beans for the priorities which they individuals felt represent the most challenge to the community with regards to family planning. After this, physical demonstration of prioritization, scoring and ranking was done by counting the number of beans allocated to each challenge. After this, the DFT facilitated a group discussion about the results of this activity.

c. Transend walk: This activity complemented those implemented earlier, by providing an opportunity for participants to guide DFT and Connect-FP members through their village, to impart information on the physical, geographical influences on reproductive health behavior and outcomes. Examples of this are the bars, trading centers, clubs ('kilabuni'), places where local alcohol is sold, and places where adolescents meet ('kijiweni'). This activity can be thought of both as rapid triangulation exercise verifying information already mentioned in methods such as social mapping but also as an opportunity add more fine details about these sites such as their proximity to residential areas, their size, hours of operation, and the gender composition of their workforce. This level of detail was not available from the social maps produced.

Documentation and Monitoring

There was thorough documentation of the process. The team had note books and pen to take all the notes and interesting quotes out of discussion. A voice recorder was used to record all

discussion for the PAR activities as a backup .Also all the flip chart were collected after the sessions and kept safe to guide on the reporting processes. We had a camera which took all the important events /scenes with consents from participants.

The VFT work-plans were monitored to ensure fidelity to work-plans and also ascertain any short-term attitudinal changes among beneficiaries of the VFT activities. VFT provided reports of each activity completed and number of men and women that attended as well as key messages and main issues or questions that were raised by participants. Short-interviews were also conducted to VFT's to understand implementation success and challenges of the work-plans.

Phase 3

Implementation strategies used to address attitudinal constraints to FP identified in the formative research

Village Facilitation Teams Work Plans

After use of participatory methods to enable the VFT's take ownership of the reproductive challenges in their community each VFT received a three-day workshop on family planning led by the DFT. The first day of the workshop VFT received basic FP education on what it is, its importance especially in reducing maternal mortality and the different methods available and facts about myths and rumors concerning FP. On the second day of the workshop, the VFT in each village were asked to work in groups and create 3-month action plans on how they as key champions to FP in their community would help to deal with some of the attitudinal barriers to uptake of modern contraceptive use. Table one below summaries the main action-plan activities of the VFT in the three pilot villages. Some of the activities organized in the action plans were community-wide events such as the football matches and the performance art groups in the hamlet divisions of the villages while others were FP outreach targeting specific key stakeholders in the community. On the third day of the workshops, the VFT were trained on monitoring skills for their own work-plans and good documentation practices.

Table 2: Village Facilitation Teams work-plans in the three pilot villages

LUMEMO	KISAWASAWA	IGIMA
FP sensitization meeting with the village government and key religious leaders	FP sensitization meeting with the village government	FP sensitization meeting with the village government
FP mobilization to traditional healers and traditional birth attendants	To provide FP education to art group that will be used in some of the FP community-wide outreach activities	To provide FP education to art group that will be used in some of the FP community-wide outreach activities
FP mobilization to fisherman	FP mobilization in the	To mobilize people on

in their fishing camping sites	hamlets using art groups	family planning through art groups in their 6 sub village
To conduct FP education to participants of outreach programs organized by health facilities	To conduct FP education to participants of outreach programs organized by health facilities	To conduct FP education to participants of outreach programs organized by health facilities
Mobilizing youth groups in sub villages about FP	Provide FP education to religious leaders	To organize a football matches amongst the hamlet football teams and provide FP health at the beginning of every match
FP mobilization to primary school students in Lumemo and Kigamboni	To organize a football matches amongst the hamlet football teams and provide FP health at the beginning of every match	FP mobilization to religious leaders and the village elders about family planning
	To provide education to students of primary schools, secondary and also youth groups	FP health talk to primary school and secondary school students as well as youth in their groups in the streets.

The VFT action plans were used to develop implementation strategies that can be used to address community attitudes towards contraceptive use and uptake. Table 3 below presents the attitudinal barriers to FP identified from the formative research, the related operational contractions and the implementation strategy adopted from VFT work plans.

Table 3: Attitudinal barriers to FP, related operational constraints and implementation strategy adopted in the VFT action plans.

Attitudinal barrier to FP	Operational Constraint	Implementation Strategy
• Experienced or feared side effect	• The fear of side effects is heighted by rumors and myths concerning side effects that often perpetrated by elders and religious leaders in the community	• Select influential elders in the community who have power and voice to influence social norms and ideals to be part of the VFT • To conduct FP mobilization activities to influential elders in the community
• Religious opposition	• Religious leaders oppose use of contraceptive methods	• Have Christian and Muslim leaders and representatives as part

	creating fear and stigma for uptake of FP methods	of the VFT • Conduct FP mobilization and outreach targeting religious leaders
• Opposition from men	• Men view contraceptives and FP as a women concern • Lack of FP education and services targeting men	• Organize football matches with the aim of providing FP education to men • FP outreach to specific key groups such as fishermen and motorcycle drivers etc
• Stigma towards youth and adolescents using FP	• Lack of youth friendly family planning services	• FP mobilization organized to primary and secondary school students • FP outreach organized for youth groups and campsites • FP outreach to key youth stakeholders such as motorcycle drivers

Phase 4: Lessons learned from the use of Participatory approaches

The power of community elders in tiring community norms and enabling easier community entry.

In each village there are some opinion elders chosen to be part of the VFT. These opinion elders or influential persons are common in many rural communities in Tanzania. They don't necessarily hold any leadership positions but some come to popularity because they were leaders in the past while many others are respected because they are long-term residents of the community and know the history of that community. They are often called upon to solve family quarrels and community disputes. In many communities they have a lot of convincing power in shaping community ideals and are therefore usually invited to comment in community meeting or events such as funerals and weddings. They are revered by the community for their wisdom. During the PAR activities these opinion elders often had the last say in the VFT groups had the power to make others in the VFT group comply with team decisions. Having these influential elders as part of the VFT, made it easier for the VFT to assemble people and get their attention when they were conducting FP mobilization activities in the hamlets, because people respect and

want to come and listen to these respected elders. As seen in the findings from the formative research, many of the myths and fears concerning modern FP methods are perpetrated by elders and influential people. Therefore during implementation of work-plans these elders acted as champions of FP especially in the community-wide activities where there were mass gatherings of people from the community. These influential elders were helpful also in trying to re-shape the narrative of FP within the community because during the FP work-plan activities these respected elders were able to give deeper historical context of FP. They spoke of older methods of FP such as use of herbs and strings tied to the stomach and how those no longer work and why FP is very important given the socio-economic changes in the current generation.

Having different stakeholders in the VFT gave strength to the community mobilization activities

Within the DFT's there were various staff from the district community health management team (CHMT) who played a strong role to empower the VFT to be able to conduct community mobilization activities. For instance two members of the DFT are family planning nurses and they so they provided health education on what FP is and the different methods of FP and how to deal with questions on side effects and myths on modern contraceptives. Other members of the DFT were social welfare personnel who provided recommendations to VFT on how to deal with special groups for example on youth and adolescents and what FP messages were relevant to these groups. On the other hand each VFT comprised of a member who represented a different stakeholder in the community. By having representatives from the various community stakeholders as part of the VFT, enabled the VFT to be more confident in approaching different targeted audience because there was already a representative in the VFT who had accepted FP. Participants were more receptive of the FP message once they saw that one of their own was a member of the VFT and had already accepted FP. This was more evident For example there were leaders from the Muslim community and there was also a Christian priests in one of the VFT groups who spoke of the opposing views from their religions and how they now feel empowered to be able to advocate for FP within their community. For example a Christian preacher was one a VFT member in Kiswasawa gave this feedback *"As a priest, before I used to think of myself only responsible for the spiritual growth of people. However, after receiving this FP education and learning its importance for the father, mother and child I will counsel my congregation on how to take-care of their families by using FP because at the end of the day man is both spirit and body I can't just focus on the soul."* Therefore having these different stakeholders in the DFT and VFT help to increase acceptability of FP mobilization among targeted audience because once they saw that one of their own is part of the VFT and has already accepted FP then they were more likely to listen and be open concerning FP.

Mobilization activities targeting specific groups such as youth, market women, and traditional healers had a positive effect on group dynamics

In the VFT work-plans many of the organized activities targeted particular groups of people for example traditional healers, men, religious leaders and healers who are known to be resistant to FP. These FP mobilization activities that targeted specific groups were very successful because the audience felt that if VFT were providing FP education specifically to them then FP matters to them as well. The discussions were more lively and engaging within the target groups than in

large community meetings with a large mix of people. For example there were sessions organized to target youth working as motorcycle drivers (Bodaboda) drivers. The young men showed a lot of interest in the topic and they openly discussed some of their concerns and myths concerning different contraceptive methods. They were particularly interested to learn of ways to effectively use condoms as a family planning method because it is normally only used for prevention of transmission of HIV and sexually transmitted diseases. Within target groups people were more open to ask questions and interrogate the facilitators on FP concerns that relate to their reproductive needs and goals.

Community-wide organized activities such as football matches built a sense of community ownership to their problems.

Community-wide activities such as football matches and performance festivities brought in a large audience and were one of the very successful events. Many women came to cheer in the play-offs and the village government leaders were also very engaged in the planning and organizing of the matches. For example in the FP football matches that were organized by the VFT in Kisawasawa, a team jersey was to be awarded to the winning team; however, community members decided the team jersey will remain with the village government and will be used by the community football team for matches within and outside their village. Involving community members in such decision making greatly influenced community ownership for the whole activity. Findings from the evaluation reveal that such activities had strong impact in attracting youth and adolescents in the community and this also helped to create sustainability because many of the football teams are still functioning.

Other community-wide mobilization activities such as the use of performance groups to attract groups of people from the community and then provide FP health talk were successful in bringing in a lot of people however they were mostly women. Men were not as interested in such activities and it was mostly the women who gathered around. Also because village leaders were sometimes used to call in for these community-wide meetings in some communities it was viewed as a political stunt, that the leaders were calling in meeting so that they can be re-elected.

Recommendations and next steps

According to the findings from the formative research, it is evident that demand-side attitudes towards modern FP methods are not only influenced by individual factors or experiences but also external factors. Even though fear of side effects and health concerns can stem from actual experience of the side effects but potential FP users attitudes are also influenced by rumors and myths concerning contraceptives that affect uptake of contraceptive use from new users but also discontinuity of methods from current users. As seen from the formative research many of these rumors and myths on health effects and oppositions to FP are perpetrated by three opinion groups which included elders within the community, men and also religious leaders. Therefore when designing programs it is important to make sure that not only potential FP clients are mobilized but also stakeholders from these opposition groups so are mobilized. This is why in the PAR, religious leaders and influential leaders were included in the

VFT. Once key religious leaders and influential elders of the VFT were mobilized, community entry and mobilization to stakeholders who are generally known to oppose FP was easier. In programming FP mobilization events it is important to create champions of FP within the different stakeholders are known to oppose FP so that they can continue to mobilize within their circle of influence.

In Tanzania there is still a great need for design of FP programs and intervention that are more adolescents and youth friendly. Qualitative findings reveal that stigma towards young FP deters many from seeking FP services in the health facilities. Many fear being recognized or being judged by providers in health facilities and so discussions, during the PAR revealed that many young people, specifically students commonly opt to get their FP services from local drug stores. However, since they do not get FP counselling in drug stores there is high discontinuity especially once they start experiencing side effects. Through PAR activities such as the football matches and outreach to different youth groups such as motorcycle drivers and visiting secondary schools it was evident that there is a demand for FP services from young people. Young people do not find it conducive to visit health facilities for the sole purpose of receiving FP services and many do not return due to sub-par quality of care found not only in health facilities but also drug stores. There is a need to have more youth friendly centers either within health facilities or within the community that target meeting the reproductive health needs of youth.

Community-wide mobilization activities were able to gather a large number of people of all ages and gender and were generally low cost activities because programs like dance performances hired local artists who were cheap labor. These activities are helpful when there is a need to conduct mass mobilization and create community wide awareness. The limitation with the community-wide FP activities is that because of the diversity of the participants it is sometimes hard to provide intensive mobilization to the intended audience. However, these are usually when there FP outreach services within the community.

Conclusion

People's attitudes concerning family planning can be rooted in individual experiences; however several societal factors have a strong impact in shaping one's decision to use modern contraceptive methods. Even though participatory action research is costly and time-consuming it provides invaluable knowledge for the development and implementation of effective approaches to improve uptake and utilization of modern family planning methods.

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