CARE - UGANDA
COMMUNITY REPRODUCTIVE HEALTH PROJECT - (CREHP)
SOUTH-WESTERN UGANDA.

PROJECT EVALUATION COMMUNITY SURVEY -DECEMBER 1995

FINAL DRAFT REPORT

Dr. F.M. Kaharuza, and Dr. N. Nshakira

Child Health and Development Centre,
Makerere University,
P.O. Box 6717,
Kampala.

CARE-Uganda,
P. O. Box 7280,
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TABLE OF CONTENTS

List of Figures

List of Tables

List of Abbreviations

CBDA	Community-Based Distribution Agent
CHDC	Child Health and Development Centre
CPR	Contraceptive Prevalence Rate
CREHP	Community Reproductive Health Project
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DMO	District Medical Office(r)
FPAU	Family Planning Association of Uganda
HMIS	Health Management Information System
IEC	Information Education and Communication
IUD	Intra-Uterine Contraceptive Device
LC	Local Council
NGO	Non-Government Organization
OPD	Out Patient Department
QOC	Quality of Care
SDP	Service Delivery Point
SOMARC	Social Marketing for change
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception

Acknowledgements

This rapid follow-up survey would not have been successful without the efforts of those whom we now acknowledge. We are grateful to CARE - Uganda for commissioning the Child Health and Development Centre (CHDC) to participate in the evaluation of CREHP, from where we were detailed to implement the community survey component. We wish to acknowledge the support received from the members of Staff of CARE Kampala, CARE Kabale and CREHP in particular. The cooperation and logistical support of the DMOs in all three districts - Kabale, Kisoro and Rukungiri is also sincerely appreciated.

We wish to acknowledge the tremendous work done by the team of interviewers, supervisors and drivers that were called at such a short notice but worked with joy and determination till the end. We would also like to thank Mssers Jesse Busuulwa and Raymond Wamalwa for the excellent data management job they did in the field and in the office and Mrs Betty Okumu for typing parts of this manuscript.

Finally, we acknowledge the support received from the community leaders in the sampled areas, particularly the LCs, Health Unit Staff and CBDA Leaders; who worked together to make all practical arrangements for smooth work in their areas. The welcome, openness and willingness to help we found in the communities visited was overwhelming. To the respondents in the study, we can only say that what constitutes this report is primarily your information and we are grateful for the opportunity you gave us to share your knowledge and experiences.

Executive Summary

CARE International in Uganda has since April 1992 implemented the Community Reproductive Health Project (CREHP) in a defined geographic area covering Kabale, Kisoro and Rukungiri Districts. The project is aimed at strengthening family planning education and contraceptive service delivery, and to fully integrate this service into all established health units in the three districts of the project area.

The study was a descriptive cross-sectional survey, assessing knowledge, attitudes and practices of modern contraception among men and women of reproductive age was carried out in December 1995 to determine to what extent the project meet its goals.

The 30 clusters (parishes) that had previously been sampled in the baseline survey were revisited and at least 60 households visited in each cluster. Over 1700 men and women of reproductive age were interviewed. Semi-structured follow-up interviews were carried out with a sub-sample of 394 respondents (177 males and 217 females) from among those interviewed in the main sample above. Those interviewed at follow-up included all main sample respondents who had ever used some modern family planning method, and a random sample of 10 non users from each cluster. The focus of these follow-up interviews was on an in depth verification of the quality of contraceptive knowledge and practice, and fertility attitudes. Quality of care interviews were carried out with community based distribution agents that had been trained by the project. Health staff at clinics serving the parishes that were sampled were assessed for the quality of care offered at the unit. The CREHP Management Information System was analyzed to obtain current levels of training and service provision in the project.

In all ,914 women and 860 men were interviewed. The majority of the respondents were between 20-40 years of age. The estimated total fertility rate is 6.6. There is are significant change in the opinions on the ideal number of children with those wanting large family sizes reduced by half. There is an unmet demand for limiting family size is 28.5% and that for spacing is 58.5%. There is increased geographical and physical access for family planning services. All the 74 health units had a trained family planning provider. About 20% of the parishes in the project area have CBDA services. On cognitive accessibility , more than 80% of the non users knew an appropriate source of family planning service if they so wished. One in every three respondents could not mention any benefit of family planning while about a quarter could mention two or more benefits.

There has been an improvement in the level of knowledge of family planning. More than half of the respondents discussed family planning with their spouses. The respondents in the follow up survey were more knowledgeable about methods of family planning than the baseline respondents . More than a third of the respondents had accurate knowledge (defined as knowing how a method works and at least one side effect and 81% for knowing how one method works and mentioning at least two benefits). The level of misinformation about various methods ranged from 23% for pills

to about 9% for permanent methods of contraception. The key sources of information were the health workers, and the cadre of providers- the CBDA and friends.

The contraceptive prevalence rate is 9.6. The CYP was about 30% of the projected CYP The method mix in the project area shows that clients prefer long acting methods of family planning. The method mix is not similar to that suggested in the original project plan. The source of family planning methods were government health units, NGO health units and CBDAs. Only 12% used the market, friends or relatives as main sources of services.

The quality of care was adequate in more than a third of the CBDAs. The quality of care at the health units was adequate at 72% of the clinics .

There is significant progress in the CREHP programme towards the goals and objectives. The CBDA have an important role to play in the provision of services

1.0 Background

CARE International in Uganda has since April 1992 implemented the Community Reproductive Health Project (CREHP) in a defined geographic area covering Kabale, Kisoro and Rukungiri Districts. The project is aimed at strengthening family planning education and contraceptive service delivery, and to fully integrate this service into all established health units in the three districts of the project area.

In this geographic area, population pressure is a factor leading to decline in soil fertility and encroachment on national reserves. The area is much more densely populated (density of 201 persons per square kilometre) than Uganda's overall 79 per square kilometre according to the Uganda Population Census of 1991. There is virtually no unused land. The total fertility rate in the area was 7.8 children per woman in 1991 census.

Prior to the full implementation of the CREHP project, a baseline assessment was conducted to establish the level of knowledge and use patterns of modern contraceptives, as well as the structural and other barriers to effective family planning service delivery in the project area.

A Mid-Term Evaluation of the project was conducted in July 1994, and an external evaluation was done in February 1995 by USAID, the Project donor. As the life cycle of the project comes to an end, a final project evaluation is necessary; to assess the progress and achievements of the project. This evaluation will also serve as a baseline measure for the next project cycle.

The key question in this evaluation was: **To what extent did the project meet its goals?** The information gathered was aimed at demonstrating the project progress based on the following
project goals and indicators:

- Behavioural goals and indicators;
  Increase in use of contraceptives, increase in knowledge of family planning: contraceptive prevalence rate, couple years of protection, number of contraceptive acceptors or users, contraceptive method mix, knowledge of modern method of family planning, knowledge of source, accurate knowledge of methods.

- System goals and indicators
  Increased access to and availability of family planning services, improved quality of care, promoted sustainability of services: number of fixed service sites of family planning, number of family planning CBD agents, number of trained family planning providers, cost recovery.

2.0 Methodology

The study was a descriptive cross-sectional survey, assessing knowledge, attitudes and practices of modern contraception among men and women of reproductive age. The language for interview was mostly Runyankole/Rukiga in Kabale and Rukungiri districts and Urufumbira in Kisoro district.

Sampling of respondents was done on a randomized quota basis, from among 30 clusters (parishes) previously sampled during the baseline study (see baseline study report 1992). These parishes were revisited at evaluation to assess changes in access to and utilization of family planning services. It was assumed that minimal migration has taken place over the project period, therefore the population sampled would be fairly similar.

The sampled parishes had been selected at baseline by proportionate stratified random sampling design. A total of 60 households were randomly selected from the household list at LC 1 level or from a random zoning scatter for the whole cluster where lists were not present or could not be generated. Eligible respondents (30 males and 30 females) were sought and interviewed from the sampled households, and households where no eligible respondents could be traced were replaced with the nearest household.

The sampling frame included all the parishes in the project area. The names and populations of these parishes were obtained from the Uganda population and housing census district summaries. Cumulative population for each listed parish was computed and the total cumulative population for the region obtained. The sampling interval was obtained by dividing the total cumulative population by 30 (the required number of parishes). Three parishes - Kashasha, Kifunjo and Kyeshero - were weighted for during the baseline survey from the DTC area and they were again sampled for the same reason.

A random number that is less or equal to the sampling interval was selected from a table of random numbers. Parish number one to be studied was identified from the table of random numbers. the second and subsequent parishes were obtained by adding the sampling interval to the random number. A listed parish whose cumulative population was equal to or exceeded that number became the subsequent selected parish.

At parish level, an LC 1 was randomly selected and visited. Sixty households were selected at random from the LC 1 lists that were available. An eligible male or female was interviewed at each household. Usually one LC1 was selected and visited in each parish. In places where an LC 1 had less than the required number of households, other neighbouring LC1s had to be selected to obtain at least one hundred household to be visited.

2.1 Data collection methods

1. Rapid reproductive health survey.

A Survey of reproductive health events was conducted on 1774 (860 males and 914 females of reproductive age) randomly selected respondents in the project area. Major contents of this segment included;

Personal demographic characteristics,
Reproductive health knowledge,
Knowledge of modern methods of contraception,
Contraceptive usage patterns,
Patterns of service provider choices.

(See Appendix III for details of instrument)

2. Follow-up interviews.

Semi-structured follow-up interviews were carried out with a sub-sample of 394 respondents (177 males and 217 females) from among those interviewed in the main sample above. Those interviewed at follow-up included all main sample respondents who had ever used some modern family planning method, and a random sample of 10 non users from each cluster. The focus of these follow-up interviews was on an indepth verification of the quality of contraceptive knowledge and practice, and fertility attitudes. (See appendix IV for details of instrument)

3. CBDAs Interviews.

CBDAs located in the Sub-counties sampled were met at the local health units and interviewed through a modified version of the quality of Care Instrument used in the project for monitoring their services. (See Appendix V for details of instrument)

4. Staff interviews on Quality of Care.

The health staff providing family planning services in the health units serving the sampled areas were interviewed to get first hand information on the family planning service delivery in their units, including an inventory of the method range and amounts as well as service facilities available. A modified version of the instrument regularly used in the project for clinic Quality of Care monitoring was used for these interviews. (See Appendix VI for details of instrument)

5. Service statistics review.

The CREHP Management Information System was analyzed to obtain current levels of training and service provision.

2.2 Personnel

1. Two Principal Investigators (PI) were the key personnel who developed the study protocol, designed the study instruments and undertook the overall leadership of the study team.

2. Seven Field Supervisors, two for each district team and one who functioned as a Team leader for the third district (in addition to the two PIs who covered the other two districts)

3. Two Data Entrants did the data entry alongside the actual collection of the data in the field. This was aimed at reducing the turn around time for data entry.

4. Three teams of interviewers, each consisting of 10 interviewers, with an equal representation of males and females.

The data collection teams are shown in Appendix II.

2.3 Quality Control

To ensure rapport and reliability, questions on sexual behaviour which are usually personal and sensitive were preceded by a number of questions of a more general nature. All interviewers were in the same age range as the respondents. Male interviewers interviewed male respondents while female respondents were handled by the female interviewers.

The interviewers were especially selected/recruited from the project area, through public advertisement, shortlist and interview. Only those who could speak English and Urufumbira or Runyankole/Rukiga were used. Persons with previous survey experience, particularly those who had been involved in the baseline survey, were given priority. All the interviewers were intensively trained for five days. A training manual had been developed and was used during the training.

Standard questions were used, pre-translated by the research team into Urufumbira and Runyankole/Rukiga. The questionnaires were pretested to determine the clarity and suitability of the questions, and the length of time required to do each interview. Translations and final modifications on questions were discussed in detail and agreed upon by the whole study team during the training period.

The interviewers and supervisors kept field diaries to enable them keep track of any observations about the process of the survey that could affect the interpretation of the results. Guidelines on how to keep the diaries were given during the training.

2.4 Limitations of the study

Geographic

Due to the terrain of the region, i.e., very hilly and served by few roads, some households were reached with difficulty. It required well motivated and very cooperative field workers to obtain the required data.

Instrument bias

In order to keep the original meaning of the questions, the questionnaires were translated from English to Urufumbira and Runyankole/Rukiga during the training, and the translated versions were availed to all interviewers for reference in the field. There was input from all participants in the training, and the most appropriate translation were selected by consensus. Interviewers came from the very communities where the survey was to be done and therefore knew the current dialects and terminologies. This proved to be an asset to the study.

Due to time constraint, pretesting of the questionnaires was only done as part of the training of interviewers, and the debriefing thereafter filled the gaps. Final production of the questionnaires was done after readjustments resulting from the pretesting.

2.5 Ethical considerations

All study clusters were pre-visited by CREHP Field Officers to establish contact and appointment with community leaders and health administrators of the area. District Leaders and all LC 3 Chairmen for sampled areas were informed in writing about the purpose and process of the evaluation exercise.

A simple explanation of the purpose of the survey was given to individual respondents and permission obtained from them at the start of the interview. Respondents were informed of their rights to decline to take part or to drop out of the interview at any stage. Information obtained in the course of the survey will not be used for any other purpose other than achieving the objectives set for the study. To maintain confidentiality, individual persons interviewed are not referred to by name in this report.

Family planning service deliverly points existing in the region were identified and this information was availled to all study personnel. Any persons that requested information or services related to contraceptives in the course of the survey were directed to these facilities. Contraceptives were not distributed by the survey team despite some respondents asking for supply.

Persons found in poor health were assisted as far as possible, including provision of health advice, First Aid treatment where possible and referral to the close by health facilities.

2.6 Data Management

All final questionnaires were produced after the questionnaire had been pretested. All interviewers were given translated versions of the questions so that they could standardize their questions.

In addition to spot checks by supervisors and investigators during the survey, the questionnaires were edited in the field at the end of each day. Call-backs were made for incomplete, poorly filled, or incorrectly filled forms. Repeat interviews were made by supervisors on some households to ensure good quality work by the interviewers. Further editing of the completed questionnaires was done by the investigators to remove any errors that escaped their attention during field editing.

Programming of the questionnaires and actual data entry were done using EpiInfo 6.0 software. Open ended questions were coded during data editing and entered as codes. Analysis was done using Epi Info 6.0 and occasionally DBase IV. Harvard Graphics Version 3.0 was used for the Graphics. Maps were created using DesignWorks software.

3.0 Results

3.1 Socio - demographic characteristics

a) Sampled Community

About 1900 household were visited by 30 interviewers in ten days. From these households, 1774 eligible respondents were interviewed. The households where respondents were interviewed had a total population of 9678 people, whose demographic characteristics are summarized in Figure 1.

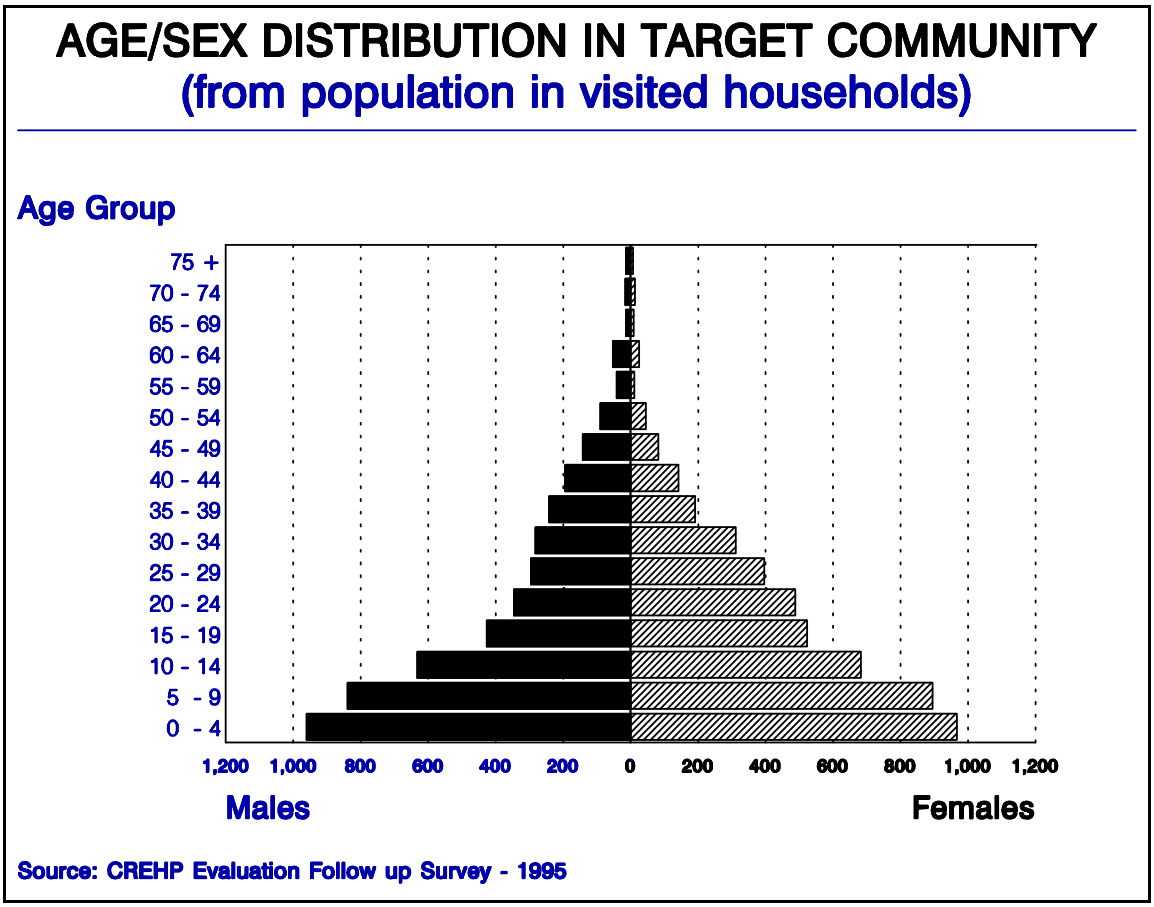


Figure 1:

The size of households visited ranged from one to 17 people in a household with a mean household size of 5.5 $\pm$ 2.4. This is slightly higher than the national average of 4.8, but close to the average for the western region at 5.2.

b) Respondents Characteristics

Only people in reproductive age(females 15-49 and males 15-60) were eligible for interview There were 2141 eligible females and 2069 eligible males in the visited households. Of these, 1774 were interviewed, including 914 females and 860 males. Selected socio-demographic characteristics of the respondents are compared with the corresponding values for the baseline survey in Table 1 below.

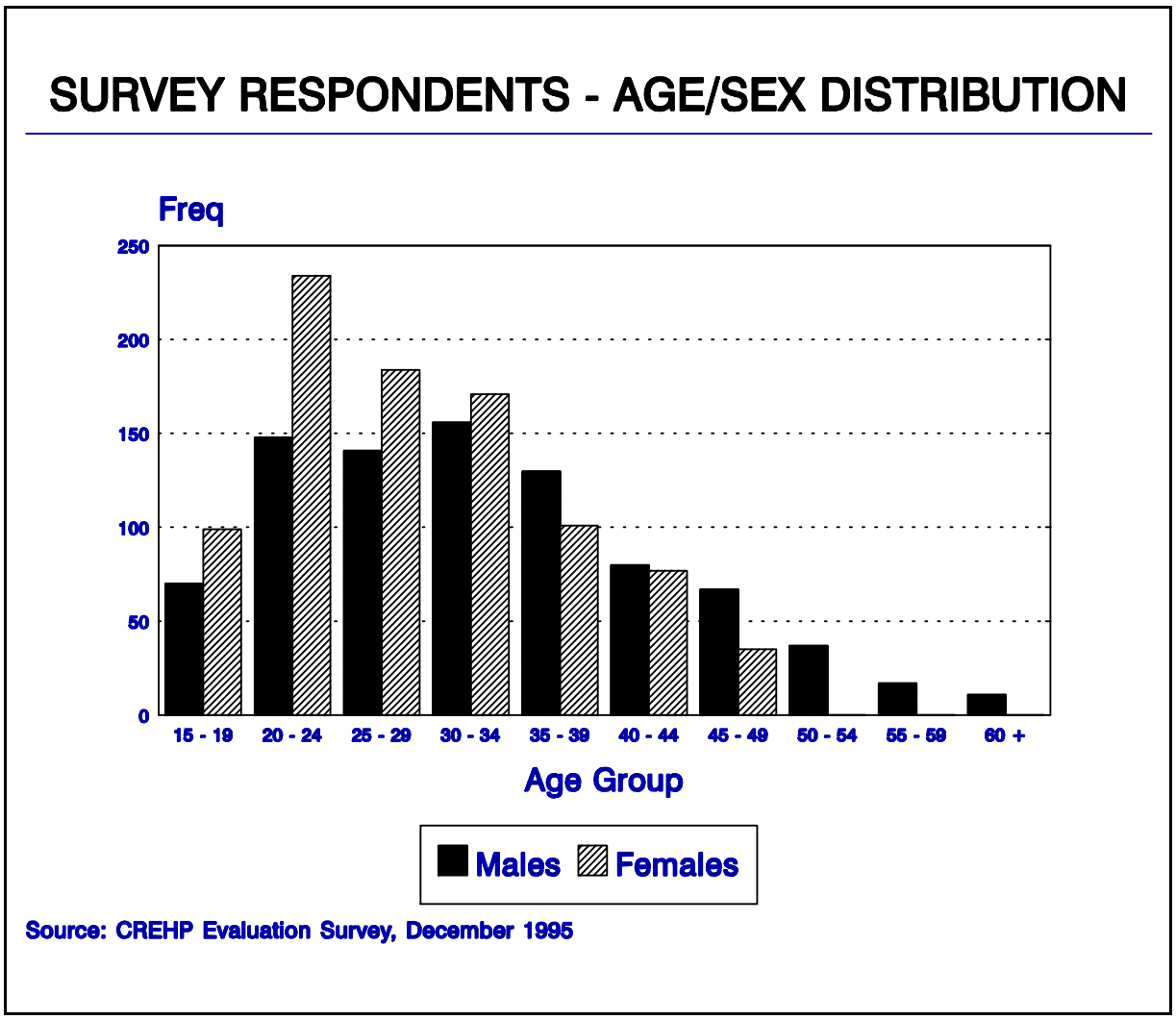
Table 1: Respondent characteristics - Evaluation and Baseline compared (Expressed as percentage of N)

Characteristics	**Baseline Survey (1992)**			**Follow-up Survey (1995)**		
	F	M	**Total**	F	M	**Total**
N	787	672	**1459**	914	860	**1774**
Education						
Nil	31.3	11.3	**22.1**	37.6	17.3	**27.8**
Primary	57.8	63.8	**60.6**	53.3	62.7	**57.8**
Post-Prim Institution	0.4	0.3	**0.3**	1.3	4.1	**2.6**
Secondary	10.4	24.4	**16.9**	6.2	11.8	**9.0**
Tertiary	0.1	0.2	**0.1**	1.2	3.6	**2.4**
Religion						
Protestant	57.7	57.3	**57.5**	54.3	55.3	**54.8**
Catholic	39	39.3	**39.1**	41.9	40.9	**41.4**
Muslim	2.2	2.7	**2.5**	2.4	1.6	**2.1**
*Others	1	0.8	**0.9**	1.4	2.0	**1.7**
Marital Status						
Married	71.2	64.6	**68.1**	80.4	81.8	**81.1**
Separated	8.6	2.8	**6.0**	10.6	2.2	**6.5**
Single	20.2	32.6	**25.9**	9.0	15.9	**12.4**

*Others include Seventh Day Adventists and Pentecostals

(Source: CREHP Baseline Survey May 1992 , CREHP Evaluation Survey Dec 1995)

Figure 2:



Nearly 10% (169/1774) of the respondents are teenagers, while the majority 71% (1265/1774) are between 20 and 40 years old. The female respondents are generally younger than the males, with 10.8% of the female respondents teenagers, 75.5% aged 20-39 and 13.7% above 40 years of age. On the other hand, it is only 75% of the males that are below 40 years old.

2.2. Demand

Questions were asked relating to the current demand for children as well as for Family Planning services in the community. Measurements used for this demand was based on the respondents' opinions on ideal family size and spacing between children.

2.2.1. Demand for Children (Fertility Demand)

Of the 914 female respondents, only 70 (7.6%) had never had sexual intercourse, while 62 of the 860 male respondents (7.2%) had not. Of the females who had had sex, 98.1% (828/844) had ever been pregnant and 4.7% (40/844) were currently pregnant.

A total of 4120 pregnancies were reported to have occurred among the fecund respondents; including 3489(84.7%) live births and 623 (15.1%) foetal losses (abortion, and still births). Only one in every ten (9.9%, 346/3489) of the children born alive to the interviewed mothers had died by the time of interview. Further analysis was carried out to determine whether there was any relationship between foetal loss and use of family planning. The was no significant relationship between fetal loss and use of modern contraceptive methods [p value=0.14 RR 1.17 (0.89-1.55)].

Of the 1642 respondents who have ever had sex, 757 (46.1%) had it before marriage; including 62 who are currently single(Table 2).

Table 2: Percentage distribution of sexual experience (Comparison of Baseline and Evaluation Values)

	Baseline			**Evaluation**		
	Females	Males	**Total**	Females	Males	**Total**
N	787	672	**1459**	914	860	**1774**
Ever had sex	89.0	93.0	**90.8**	92.4	92.7	**92.6**
Age at first sex						
<15	12.0	27.3	**19.1**	15.0	22.2	**18.5**
15 - 16	30.3	26.3	**29.2**	29.6	20.4	**25.1**
17 - 18	31.8	25.0	**28.6**	33.6	23.4	**28.6**
19 - 20	17.2	11.2	**14.4**	16.0	17.2	**16.6**
21 +	8.5	10.5	**9.5**	5.3	17.0	**10.9**

The effect of education on the age at first sexual intercourse was analyzed and shown to be statistically significant (Table 3).

Table 3. Effect of Education on age at first intercourse.

Education	**Nil**	**Prim**	**PP Inst.**	**Sec**	**Post Sec**	**Total**
Age						
< 15	68	194	5	29	8	**304**
15 - 18	260	514	25	66	15	**880**
19 +	117	251	18	57	23	**466**
Total	**445**	**959**	**48**	**152**	**18**	**1650**

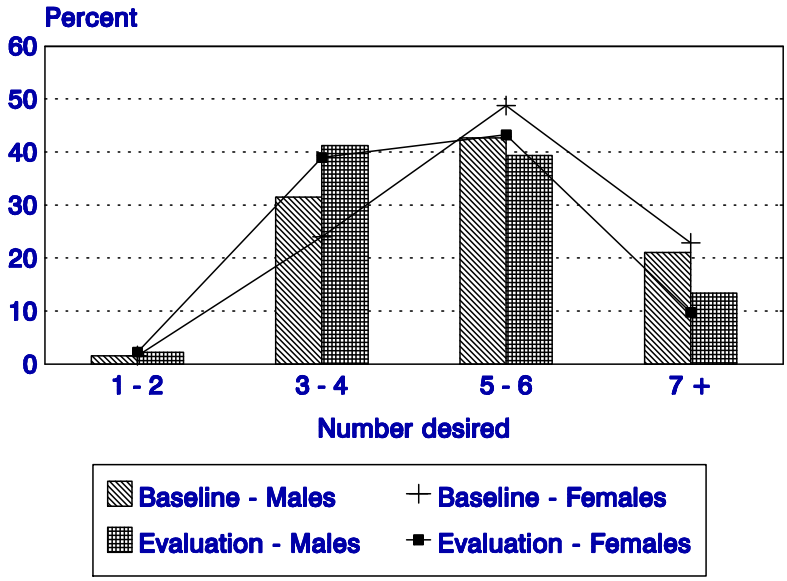
(Source: CREHP Evaluation Survey, Dec 1995) Chi-square = 7.05 2df (p = 0.02)

The ideal number of children a couple should have as expressed by the respondents was compared to the baseline finding as in Figure 3.

Figure 3:

DESIRED NUMBER OF CHILDREN

EXPRESSED AS NUMBER MOST IDEAL



Source: CREHP Evaluation Survey, December 1995

There is a significant change in the opinions on ideal number of children as compared to the baseline(figure 3). The proportion of respondents who wanted seven or more chilren were almost halved while those wanting less than four children were nearly doubled.

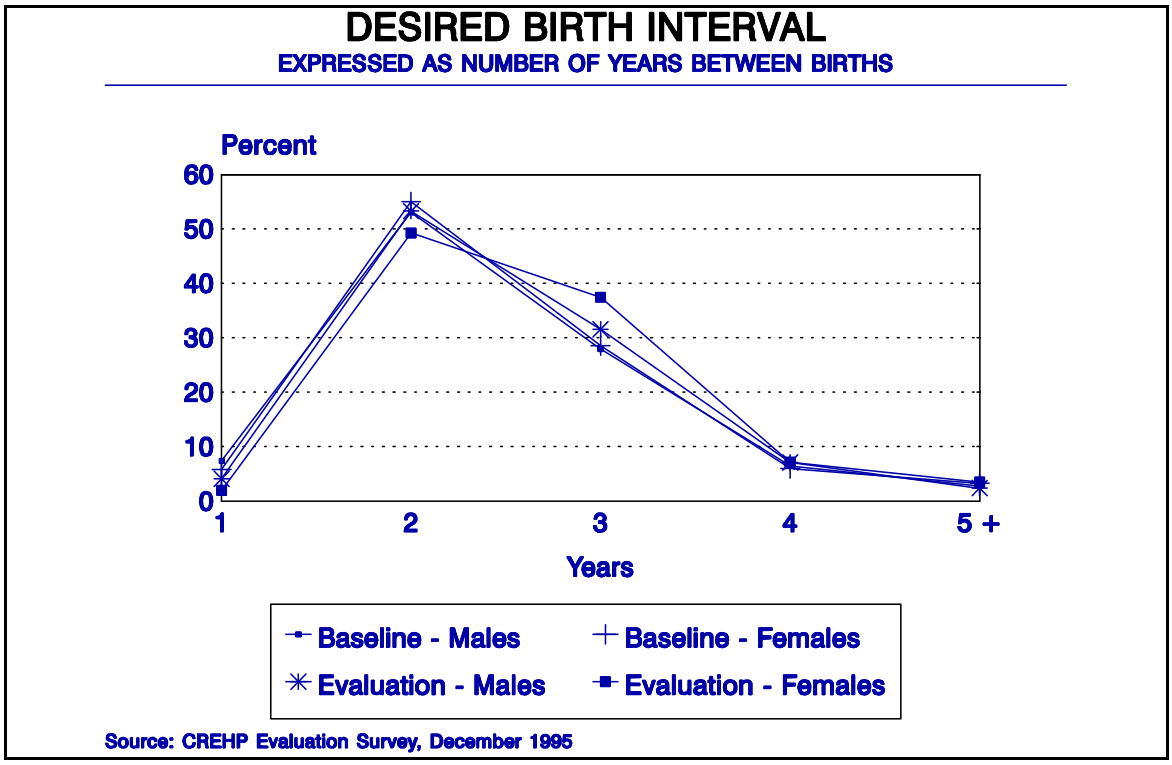
Table 4. Variation of ideal family size with education status.

Education	Nil	Prim	PP Inst.	Sec	Post Sec	Total
Ideal Num						
1 - 3	27	91	3	17	9	**147**
4 - 6	343	789	39	128	30	**1329**
7 - 9	47	70	3	8	0	**128**
10 +	35	39	1	3	0	**78**
Total	**452**	**989**	**46**	**156**	**39**	**1682**

(Source: CREHP Evaluation Survey Dec 1995) Chi-square = 25.35 3df (p = 0.00001) RR 3:1

Respondents were asked about the ideal time interval between births, and their responses are compared with those at baseline in figure 4.

Figure 4:



The only noticeable difference between baseline and evaluation opinions about birth interval is the slight shift of females towards longer spacing.

2.2.2. Demand for Family Planning Services

Female respondents who had ever been pregnant were asked to indicate the number of surviving children they had. They also expressed the ideal number of children one ought to have. Of these, 20.5% (170/828) have the number of surviving children greater than the number they recommended. Interestingly only 40 of the 170 women (28.2%) are using a method of family planning. Another 107 of the females ever pregnant had living children equal to the number they recommended as ideal; and 12 (11.2%) of these were using some modern family planning method.

If the number of children they recommend is assumed to be the number they would have desired for themselves, the proportion above (170 + 107/828, 33.5%) can be taken as the level of demand for limiting family size, of which only 6.3% (52/828) is met. The unmet demand for limiting is therefore 28.5%.

On the other hand, women who have children aged less than the ideal birth interval they recommended can be taken as representative of demand for spacing births. This figure is 495 among all those ever pregnant, 425 among those who had resumed sexual intercourse (708). Sixty two of these have ever used a modern family planning method. The level of demand for spacing among the females currently having sexual intercourse is therefore 51.3% (363/708) unmet demand and 8.8% (62/708) met demand.

3.3. **Access to Family Planning Services**

Three aspects of access to family planning were evaluated. Physical access was determined based on actual service delivery points established within the project area, as well as the perceptions of respondents about their own access to family planning services. The ability of respondents to mention an appropriate source of service where they are able to go for service was used as an indicator of cognitive accessibility. Psycho-social accessibility was measured by the level of constraint to family planning use attributable to psychological, attitudinal or social factors which affect demand or use of services.

3.3.1. **Geographical Accessibility** (See Map 1)

The project area is served by six hospitals (three government and three missionary hospitals, nine health centres and 71 dispensaries and sub-dispensaries. At the time of the baseline survey only five health unit were offering family planning services. To date, CREHP has trained health workers currently providing family planning services in 74 health units. All these units submit regular returns of their family planning services to CREHP office and their respective DMOs.

MAP 1 - DISTRIBUTION OF FP CLINIC SERVICES

MAP 2 - DISTRIBUTION OF CBDA SERVICES

CREHP also initiated a CBDA training program. To date, the CBDA training program has trained 320 CBDA's that are offering services in 52 parishes. The project area has a total of 273 parishes. This implies a 19.8% coverage of the project area parishes, including the two parishes covered by CBDAs trained by the FPAU. All the above strategies have improved the geographical access for a large number of people in the project area.

Respondents who were not using any modern family planning method at the time of survey were asked for the reasons why. Three in every one hundred (53/1544, 3.4%) of those who had never used gave "lack of service" or "services were too far away" as the reason for not using, while 14 said that the methods are too expensive. Of 65 who stopped using, seven, (10.8%) discontinued because of lack of access to methods.

3.3.2 **Cognitive Accessibility**

Respondents who had never used any modern family planning method were asked about where they would go for service if they wished to use family planning. Sources mentioned by respondents were categorised as appropriate or inappropriate as follows:

Appropriate	Inappropriate
Government Health Unit	Relatives/Friends
NGO Health Unit	Market/Shop
CBDA	
Private Clinic	

Of the 1544 non users, 1267 (82.1%) chose an appropriate source of family planning service while 9.5% (146/1544) didn't know where to get a method. Another 3.7% (57/1544) mentioned sources categorized above as inappropriate. The rest (74/1544, 4.8%) did not mention any specific source, saying that they do not want to use the service or do not need it having stopped producing.

3.3.3. **Psychosocial Accessibility**

Factors noted that may limit demand for FP service include:

- Inadequate awareness about benefits of family planning - one or no family planning benefit known,
- Low unprompted knowledge of modern family planning method - one or none,
- Low recognition of a method among those shown- one or none,
- Confessed opposition to family planning.

More than one in every three respondents (660/1774, 37.2%) could not mention any benefit of family planning, while less than one-quarter (408/1774, 23%) were able to mention two or more benefits. Nearly one in every ten of the non-users (119/1544, 7.7%) gave personal opposition to family planning use as their reason for not using it. Of those opposed to family planning, nearly two thirds (64%, 74/119) are males.

Factors mentioned as limiting the use of family planning for respondents who would otherwise have demand for services include: fear of side effects (117/1544, 7.6%) and partner refusal (125/1544, 8.1%).

Fear of side effects may be attributed to the level of misinformation about methods, particularly the effects attributed to family planning methods that are not true. Respondents who recognized samples of methods that were shown were also asked about any side effects of the methods they knew. The level of false side effects mentioned is summarized in Table 5

Table 5: Level of "Rumours" about contraceptive methods

Method	**Number**	**%**
Pills	71/307	23
Injectables	51/256	19.9
Tubal Ligation	41/227	18.1
IUD	20/162	12.3
Condom	30/311	9.6
Foams/Spermicides	10/112	8.9
Vasectomy	14/161	8.7

(Source: CREHP Evaluation Survey, Dec 1995)

It is interesting to note that nearly one third (38/125 30.4%) of the respondents reporting "partner refusal" are males; whose female partners are not willing to allow use of family planning. About half (49.9%, 715/1433) of the married respondents said they have discussed family planning with their spouses.

Table 6: Discussion of FP between spouses (N = 1433)

Status	**Female**	**Male**	**Total**
Discussed	358 (48.8%)	357 (51.0%)	715 (49.9%)
Not discussed	375 (51.2%)	343 (49.0%)	718 (50.1%)
Total	**733**	**700**	**1433**

(Source: CREHP Evaluation Survey, Dec 1995)

Further analysis shows that (higher) education and younger age tend to favour discussion of

family planning. There is also a positive relationship between discussion of family planning and knowledge of benefits of family planning.

3.4. Contraceptive Knowledge

For purposes of this evaluation, a number of indicators for level of knowledge of family planning were suggested. These related to the operational definitions used by the project.

Adequate awareness:
A person who could spontaneously mention at least two benefits of family planning.
A person who could spontaneously mention at least two modern methods of family planning
A person who could spontaneously state an appropriate source of family planning service.

Accurate knowledge:
A respondent who could recognize a modern FP method, and was able to state correctly how it works and mention at least 1 correct side effect of that method was categorized as having accurate knowledge.
A respondent who could state correctly how at least one family planning method works, and was able to mention at least 2 benefits of family planning.

3.4.1. General awareness

The level of knowledge of the benefits of family planning is summarized in Figure 5a and 5b below.

Figure 5a:

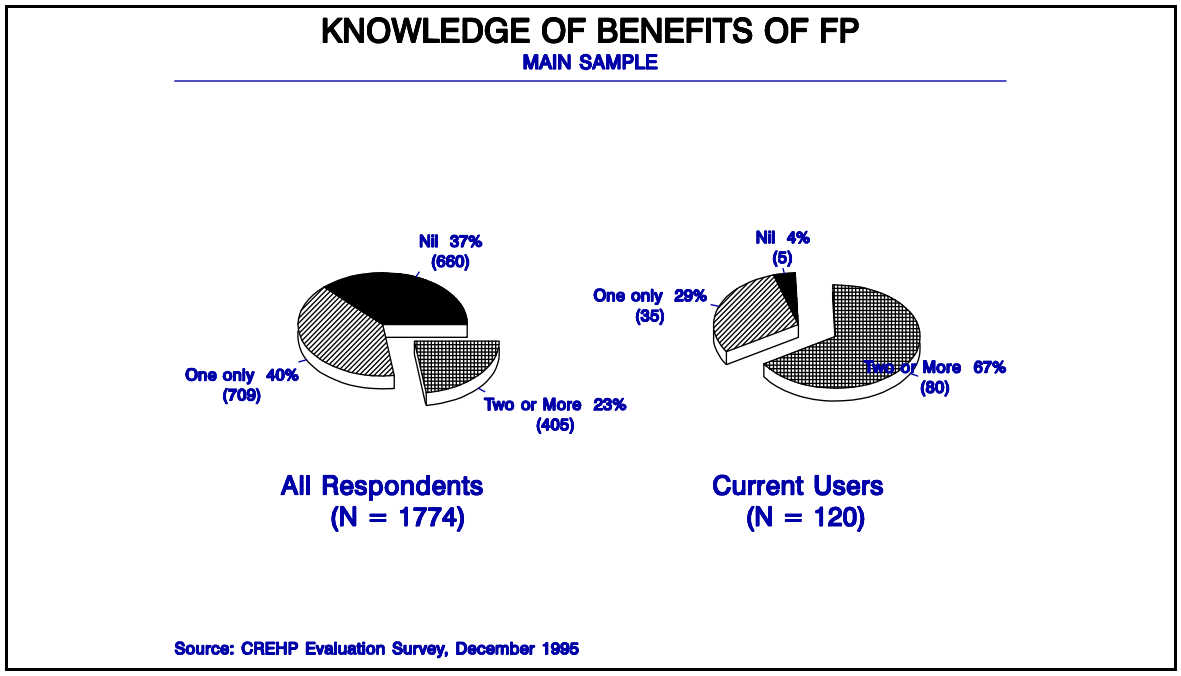
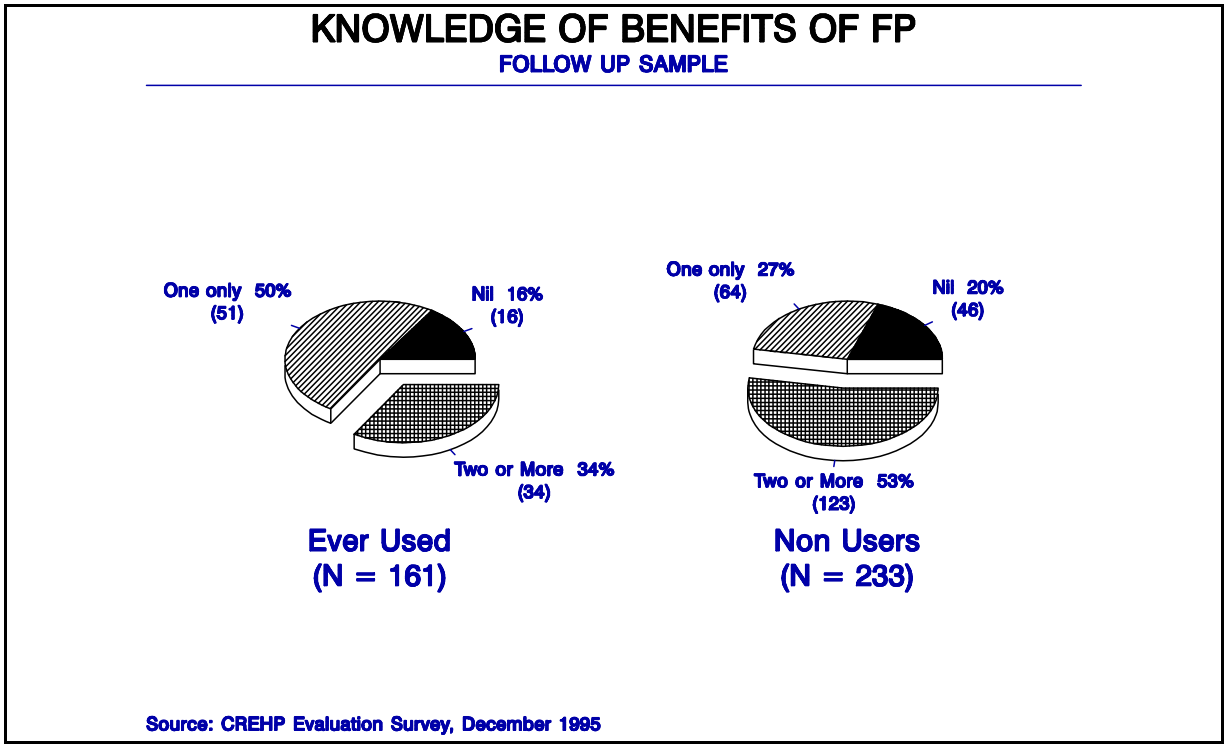

KNOWLEDGE OF BENEFITS OF FP
MAIN SAMPLE
Nil 37%
(660)
One only 40%
(709)
Two or More 23%
(405)
All Respondents
(N = 1774)
Nil 4%
(5)
One only 29%
(35)
Two or More 67%
(80)
Current Users
(N = 120)
Source: CREHP Evaluation Survey, December 1995

Figure 5b:



The benefits of family planning mentioned by respondents in both the main interview and at follow up include:

	Total Freq.		Freq from Females		% from females	
Better child care		689		461		66.9
Better maternal health	485		462		95.3	
Better child nutrition	394		121		30.7	
Child education is eased		356		140		39.3
Child spacing	334		241		72.2	
Land adequate for the children		140		19		13.4
Improved family social status	109		52		51.0	
Improved family economy		84		41		48.8
Improved child health	147		77		52.4	
Control of STDs		7		0		

The level of unprompted knowledge of modern methods is compared with the baseline finding in

Figure 6 below.
Figure 6:

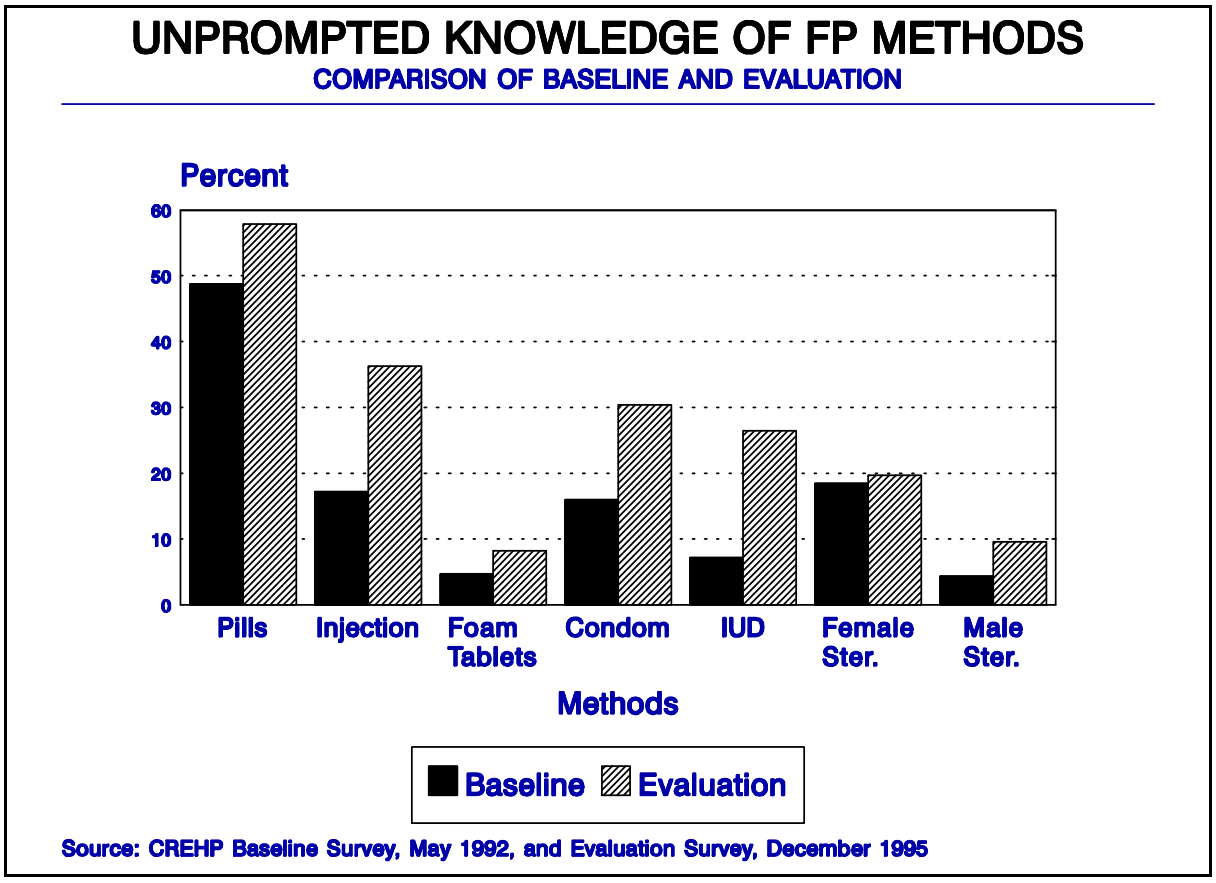


Table 7 shows the change in knowledge for males and females from baseline to evaluation.

Table 7: Gender differential for Knowledge of FP methods (Comparison between baseline and evaluation)

Method	Baseline		Evaluation	
	Males (N = 669)	Females (N = 785)	Males (N = 860)	Females (N = 914)
Unprompted Knowledge				
Pills	46.6	51.0	55.2	60.5
Injection	12.9	21.5	26.4	46.1
Foam	3.3	6.1	5.2	11.1
Condom	22.4	9.6	37.3	23.5
IUD	5.4	8.9	13.6	19.5
Female Ster.	22.9	15.0	21.6	17.8
Male Ster.	5.2	3.6	11.9	7.3
Total Knowledge - Prompted and Unprompted				
Pills	66.9	69.5	86.0	85.2
Injection	45.1	54.5	63.5	78.4
Foam	14.2	18.5	25.7	32.9
Condom	84.2	67.2	88.5	77.6
IUD	23.0	28.5	39.2	54.7
Female Ster.	70.2	71.0	66.5	61.5
Male Ster.	27.4	24.0	40.7	37.4

Respondents interviewed at follow up were shown samples of modern family planning methods and asked whether they could identify them. The results are summarized in Figure 7 (by use status) and Table 8 (by sex of respondent).

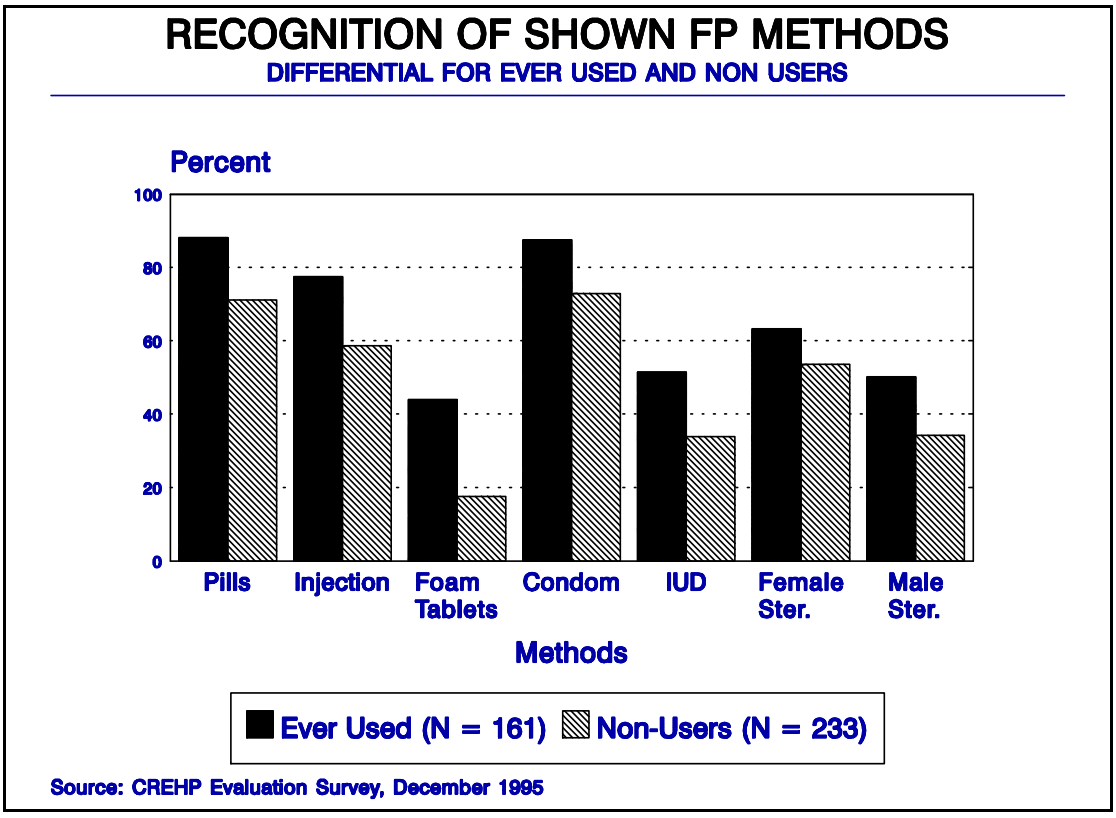

RECOGNITION OF SHOWN FP METHODS
DIFFERENTIAL FOR EVER USED AND NON USERS
Percent
100
80
60
40
20
0
Pills
Injection
Foam Tablets
Condom
IUD
Female Ster.
Male Ster.
Methods
Ever Used (N = 161)
Non-Users (N = 233)
Source: CREHP Evaluation Survey, December 1995

Figure 7:

Table 8. Recognition of a shown Contraceptive method

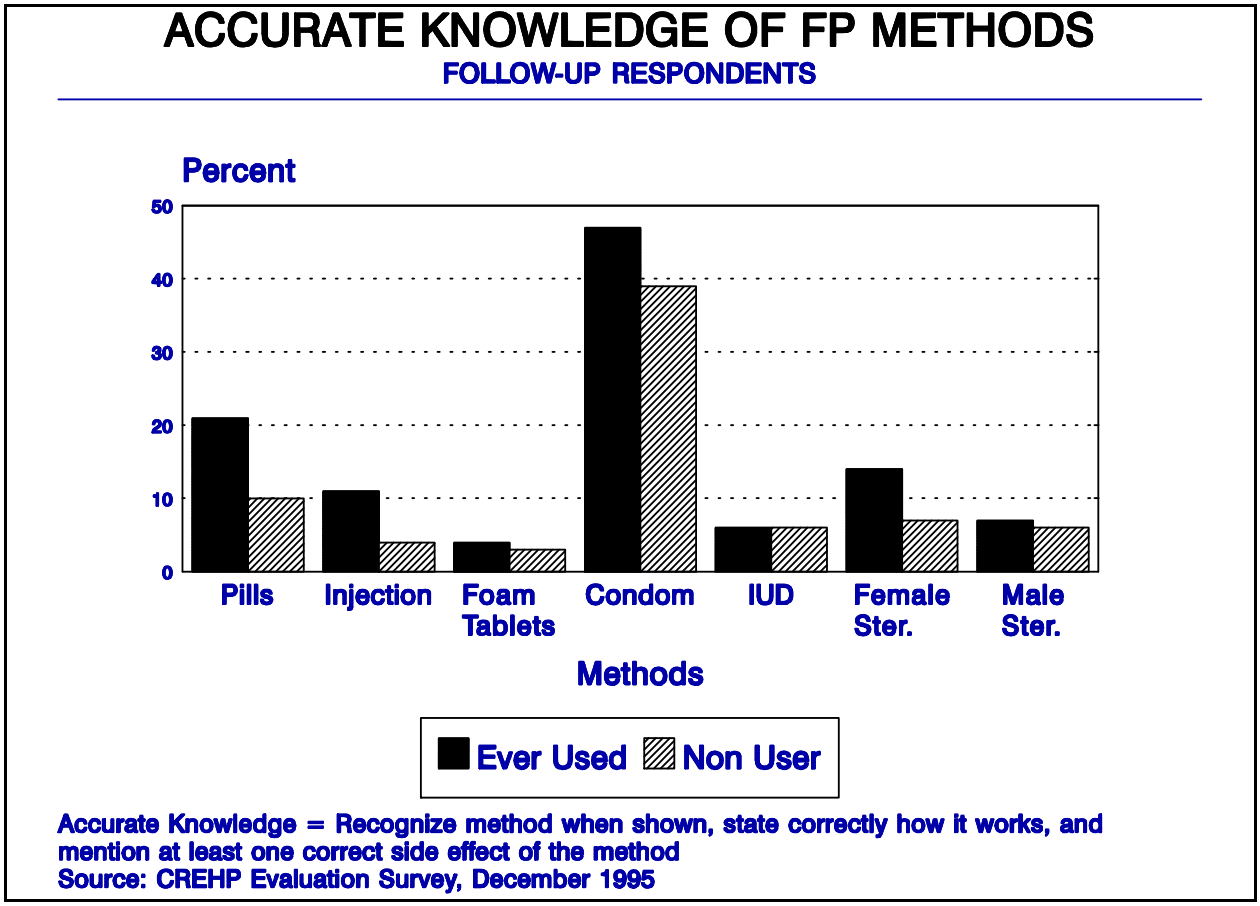
Method	Males		Females		Total	
N	177	%	217	%	394	%
Pills	115	65	193	88.9	308	78.2
Injection	77	43.5	180	82.9	257	65.2
Foam	37	20.9	75	34.6	112	28.4
Condom	143	80.8	168	77.4	311	78.9
IUD	44	24.9	118	54.4	162	41.1
Female Sterilization	99	55.9	128	59	227	57.6
Male Sterilization	77	43.5	84	28.7	161	40.9

(Source: CREHP Evaluation Survey Dec 1995)

Accurate knowledge

Using the first definition of accurate knowledge (how a method works and one side effect), it was found that 120 of the 394 follow up respondents (30.5%) had accurate knowledge of at least 1 method of FP. Of these, 48 were non user, and 72 had ever used some modern FP method. Statistical testing on the findings show that users are 3 times more knowledgeable than non-users ($p = 0.0000003$, OR = 3.12 [1.95 - 4.99]). This level of accurate knowledge for different methods is summarized in Figure 8.

Figure 8:



Knowledge of the benefits of family planning may be an important predictor of its use, and it was used as a component of accurate knowledge in the second definition (how method works and two benefits of family planning). This definition gave a level of accurate knowledge of 81.2% (320/394), including 147 users (91.3% of the users) and 173 non-users (61.45 0f all non-users). This is statistically significant [p = 0.0000363] but there is minimal relative advantange for the users compared to the non-users [RR = 1.23 ± 0.11].

The only component in accurate knowledge that was measured at baseline is knowledge about how a family planning method works. Table 9 is a comparison of this variable at baseline and evaluation.

Table 9. Knowledge on how method works.
(Comparison of Baseline and Evaluation Values)

Method	Baseline (N = 205)		Evaluation (N = 394)	
	Freq	%	Freq	%
Pills	6	2.9	75	19.0
Injection	3	1.5	72	18.3
IUD	1	0.5	32	8.1
Condom	71	34.6	191	48.4
Foam	3	1.5	51	12.3
Female Sterilization	11	5.4	88	22.3
Male Sterilization	0	0	68	17.3

(Source: CREHP Evaluation Survey Dec, 1995 and Baseline Survey May, 1992)

3.4.3. Source of Information

The key source of information for every method known was inquired after. The top three sources mentioned for each method are shown in Table 10 below.

Table 10 Percentage distribution for top three sources of information

Method	Main	Second	Third
Pills	Health Worker (34.7%)	Friends (26.0%)	CBDA (17.5%)
Injection	Health Worker (40.1)	Friends (23.5%)	CBDA (20.0%)
Foam Tablets	Health Worker (43.2%)	CBDA (27.3%)	Friends (15.8%)
Condoms	Friends (32.7%)	Health Worker (31.0%)	CBDA (18.8%)
IUD	H/Worker (40.6%)	CBDA (23.7%)	Friends (20.9%)
Female Sterilization	H/Worker (38.9%)	Friends (24.6%)	CBDA (18.6%)
Male Sterilization	H/Worker (38.6%)	CBDA (24.6%)	Friends (22.3)

(Source: CREHP Evaluation Survey Dec 1995)

Health workers are the key source of information for nearly all modern methods. CBDAs are being utilized by many in the community as sources of information, but seem to be recognized for information on methods other than those they provide (Pills and condoms). Other potential sources of information, e.g., the media, sexual partners and parents were mentioned by less than 55 of the respondents.