

1) FACTORS INFLUENCING MODERN FAMILY PLANNING  
ACCEPTANCE IN A FAMILY HEALTH PROGRAMME  
AREA, BAGAMOYO DISTRICT, TANZANIA. 11

Submitted in Partial Fulfilment of the  
Requirements of the Degree of Masters of  
Science in Applied Human Nutrition of the  
University of Nairobi - Kenya

by

*Kaaya Pulcheria W.*

Kaaya Pulcheria W.

Date: 30/9/1994

THIS THESIS HAS BEEN ACCEPTED FOR  
THE DEGREE OF MSc 1994  
AND A COPY MAY BE PLACED IN THE  
UNIVERSITY LIBRARY.

**DECLARATION**

I **Pulcheria W. Kaaya** hereby declare that this thesis is my original work and has not been presented for a degree in any other University.

*Pulcheria W. Kaaya*

**Pulcheria W. Kaaya**

Date:

30 / 9 / 1994.

The thesis has been submitted with our approval as  
University Supervisors:

**Jane W. Muita**

(Lecturer)

*J. W. Muita*  
30/9/94

**Nelson M. Muroki**

(Senior Lecturer)

*N. M. Muroki*  
30.9.94.

Department of Food Technology and Nutrition,  
Unit of Applied Nutrition.

## DEDICATION

	Page
DECLARATION	v
DEDICATION	vi
TABLE OF CONTENTS	vii
LIST OF TABLES	x
LIST OF FIGURES	xi
LIST OF SYMBOLS	xii
LIST OF REFERENCES	xiii

To my sweet daughters **Lili-Pendo, Lulu-Tunu** and **Noela-Nuru**. Your love, patience and understanding have always been the guiding light to my success.

CHAPTER ONE	
1.0 INTRODUCTION	1
1.1 World wide electronic systems	2
1.2 International reference to industry	3
1.3 Electronic industry in Nigeria	4
1.4 Electronic industry in Africa	5
1.5 Electronic industry in Europe	6
1.6 Electronic industry in Asia	7
1.7 Electronic industry in Latin America	8
1.8 Electronic industry in the Middle East	9
1.9 Electronic industry in Australia	10
1.10 Electronic industry in New Zealand	11
1.11 Electronic industry in South Africa	12
1.12 Electronic industry in the Caribbean	13
1.13 Electronic industry in the Pacific	14
1.14 Electronic industry in the Balkans	15
1.15 Electronic industry in the Mediterranean	16
1.16 Electronic industry in the North Atlantic	17
1.17 Electronic industry in the South Atlantic	18
1.18 Electronic industry in the Indian Ocean	19
1.19 Electronic industry in the Arctic	20
1.20 Electronic industry in the Antarctic	21

## TABLE OF CONTENTS

	Page
DECLARATION .....	i
DEDICATION .....	ii
TABLE OF CONTENTS .....	iii
LIST OF TABLES .....	x
LIST OF FIGURES .....	xii
LIST OF APPENDICES .....	xii
LIST OF ANNEXES .....	xiii
DEFINITIONS AND ABBREVIATIONS .....	xiii
ACKNOWLEDGEMENTS .....	xvi
ABSTRACT .....	xix
<b>CHAPTER ONE</b>	
<b>1.0 INTRODUCTION</b> .....	1
1.1 World Population Issues .....	1
1.2 International Efforts to Reduce Population Problems .....	2
1.3 Tanzanian Population Issues .....	4
1.4 Efforts to Solve Population Problems in Tanzania .....	6
1.5 Achievements in Population Control in Tanzania .....	9
1.6 Impact of the Pilot NFHP in Bagamoyo District .....	10

1.7	Conception of the Present Study .....	10
1.8	Objectives .....	11
<b>CHAPTER TWO:</b>		
2.0	LITERATURE REVIEW .....	12
2.1	Socio-demographic Factors and Modern Contraception .....	13
2.1.1	Age .....	13
2.1.2	Marital status .....	14
2.1.3	Parity .....	15
2.1.4	Child spacing .....	18
2.1.5	Sex preference .....	18
2.1.6	Offspring mortality .....	19
2.2	Socio-cultural Factors and Modern Contraception .....	20
2.3	Socio-economic Factors and Modern Contraception .....	23
2.4	Religion and Modern Contraception ....	24
2.5	Education and Modern Contraception ...	25
2.6	Problems Related to Modern FP and Modern Contraception .....	27
2.6.1	Family planning programmes ....	27
2.6.2	Attitudes side effects and modern contraception.....	29

**CHAPTER THREE:**

<b>3.0</b>	<b>BACKGROUND INFORMATION ON BAGAMOYO DISTRICT</b> .....	33
<b>3.1</b>	<b>Geography</b> .....	33
<b>3.2</b>	<b>Climate and Agriculture</b> .....	33
<b>3.3</b>	<b>Tribes</b> .....	35
<b>3.4</b>	<b>Education</b> .....	36
<b>3.5</b>	<b>Health/family Planning Services</b> ....	36

**CHAPTER FOUR:**

<b>4.0</b>	<b>RESEARCH DESIGN AND METHODOLOGY</b> ....	37
<b>4.1</b>	<b>Sample selection</b> .....	37
4.1.1.	Sample size .....	38
4.1.2	Sampling procedure .....	39
<b>4.2</b>	<b>Type and Description of the Data Collected</b> .....	40
4.2.1	Socio-demographic characteristics .....	40
4.2.2	Socio-cultural characteristics .....	41
4.2.3	Socio-economic characteristics .....	41
4.2.4	Knowledge of modern FP .....	42

<b>4.3</b>	<b>Research Activities .....</b>	<b>43</b>
4.3.1	Preliminary phase .....	43
4.3.2	Pilot study .....	44
4.3.3	Definitive study .....	44
<b>4.4</b>	<b>Theoretical Framework and Methods of Analysis .....</b>	<b>45</b>
 <b>CHAPTER FIVE:</b>		
<b>5.0</b>	<b>RESULTS .....</b>	<b>46</b>
<b>5.1</b>	<b>Socio-demographic characteristics...</b>	<b>46</b>
5.1.1.	Age .....	47
5.1.2	Age and school attendance....	48
5.1.3	Marital status .....	49
5.1.4	Child bearing and preferred age at first pregnancy .....	51
5.1.5	Breastfeeding .....	54
5.1.6	Age at first pregnancy .....	55
5.1.7	Age and off spring mortalities .....	56
<b>5.2</b>	<b>Socio-cultural Characteristics .....</b>	<b>58</b>
5.2.1	Ethnicity .....	58
5.2.2	Socio-cultural practices ....	59
5.2.3	Traditional education and child spacing .....	60

5.2.4	Traditional methods familiar to the respondents .....	61
5.2.5	Traditional FP practice .....	62
5.2.6	Non-practice of TFPM .....	63
<b>5.3</b>	<b>Socio-economic Characteristics .....</b>	<b>64</b>
5.3.1	Husbands' occupations .....	64
5.1.2	Respondents' occupations, incomes and expenditures ....	64
<b>5.4</b>	<b>Religion .....</b>	<b>66</b>
<b>5.5</b>	<b>Education .....</b>	<b>67</b>
5.5.1	Formal education .....	67
5.5.2	Education level and age .....	68
5.5.3	education level and age at first pregnancy .....	69
5.5.4	Education level and total pregnancies .....	70
5.5.5	Adult education .....	70
<b>5.6</b>	<b>Problems related to Modern FP .....</b>	<b>70</b>
5.6.1	Ever used and discontinued modern FP methods .....	73
5.6.2	Reasons for not having ever used modern FP methods .....	74
5.6.3	Current use of MFPM in Bagamoyo district .....	74

5.6.4	Reasons for the current non-	
	use of modern FP methods ..	75
5.6.5	Characteristics of modern	
	FP users .....	76
5.6.6	Family Planning situation	
	in Bagamoyo District .....	79
5.6.7	Preference for FP .....	80
5.6.8	Preference for future use of	
	specific MFPM .....	81
5.6.9	Reasons for preference of	
	specific MFPM .....	85
<b>5.7</b>	<b>Comparative Results.....</b>	<b>87</b>
5.7.1	Demographic Variables .....	87
5.7.2	Socio-cultural Variables .....	89
5.7.3	Formal Education .....	91
 <b>CHAPTER SIX</b>		
<b>6.0</b>	<b>DISCUSSION .....</b>	<b>93</b>
<b>6.1</b>	<b>Socio-demography and Modern</b>	
	<b>Contraception .....</b>	<b>93</b>
6.1.1	Age .....	93
6.1.2	Marital status .....	94
6.1.3	Child bearing period .....	95
6.1.4	Child spacing .....	96

6.1.5	Sex preference .....	96
6.1.6	Offspring mortalities .....	97
6.2	Socio-culture and Modern Contraception .....	99
6.3	Socio-economy and Modern Contraception .....	100
5.4	Religion and Modern contraception ...	101
6.5	Education and Modern Contraception .....	102
6.6	Problems Related to Modern FP and Modern Contraception .....	103
6.6.1	FP Programmes .....	103
6.6.2	Attitudes towards MFP .....	105
 <b>CHAPTER SEVEN:</b>		
7.0	CONCLUSIONS AND RECOMMENDATIONS.....	108
7.1	Conclusions .....	108
7.2	Recommendations .....	110
<b>REFERENCES .....</b>		<b>111</b>

## LIST OF TABLES

1.	Projected Population Growth Trends .....	2
2.	Demographic Profile of Tanzania .....	5
3.	Distribution of Respondents by Age and School Attendance .....	48
4.	Distribution of Respondents by Age and Marital Status .....	50
5.	Distribution of Respondents by Actual and Preferred Age at First Pregnancy .....	52
6.	Distribution of Older Mothers and Total Pregnancies .....	53
7.	Distribution of Respondents by Preferred Breastfeeding Period .....	54
8.	Distribution of Mothers by Age at First Pregnancy and Offspring Mortality .....	55
9.	Distribution of Respondents by Age and Offspring Mortalities .....	56
10.	Distribution of Respondents by Tribes ...	58
11.	Distribution of Respondents by Tribes and Age at First Pregnancy .....	59
12.	Distribution of Subjects by Child Spacing Intervals .....	60
13.	Distribution of Respondents by Type of Recall on TFPM .....	61

14.	Traditional Family Planning Methods Practised at the Time of Survey .....	63
15.	Distribution of Subjects by Education Level .....	67
16.	Distribution of Respondents Education Level and Age .....	68
17.	Distribution of Respondents by Education and Age at First Pregnancy .....	69
18.	Distribution of Respondents by MFP Recall and Knowledge.....	72
19.	Distribution of Subjects by Current Use of Modern FP Methods .....	75
20.	Characteristics of Modern FP Users .....	78
21.	Distribution of Subjects by Preference for Type of Family Planning .....	80
22.	Characteristics of Women Who Prefer to Use MFPM .....	84
23.	Distribution of Respondents by Reasons for Choice of Specific MFPM .....	86
24.	Relationship Between Demographic Variables and Selected Dependent Variables .....	88
25.	Relationship Between Cultural and Economic Variables and Selected Dependent variables .....	90
26.	Relationship Betweenm Eduction and Selected Dependent Variables .....	92

## LIST OF FIGURES

1.	Summary of Sampling Procedure within the Study Area .....	39
2.	Distribution of Respondents by Age .....	47
3.	Respondents' Marital Status .....	49
4.	Distribution of Subjects by Monthly Income and Expenditure .....	65
5.	Distribution of Subjects by Religion ....	66
6.	Current Family Planning Situation in Bagamoyo District .....	79
7.	Preference for Specific Modern Contraceptives .....	82

## List of Appendices

1.	Map of Bagamoyo District .....	121
2.	Women's Questionnaire .....	122

## List of Annexes

1.	A guide to Methods Used in Modern Family Planning .....	143
2.	Educational Material: "Matatizo ya Uzazi Katika Umri Mdogo" .....	144
3.	Reading Material: Kwa Maisha Bora ya Kesho, Panga Uzazi Sasa" .....	145
4.	A Calendar of Selected Events in Tanzania .....	146

## DEFINITIONS AND ABBREVIATIONS

### Definitions

**"Unyago"** Traditional initiation ceremonies given to adolescent girls at onset of menstrual cycle in preparation for motherhood

**Formal education:** Conventional classroom schooling

**Informal education:** Casual instructions given out side the classroom

**Traditional education:** Customary instructions given by societal communities

**Ten cell leader (TCL):** A grassroot leader (in Tanzania) for an area containing at least 10 households (HH) whose HH leader

is a member of the ruling party (CCM).

### Abbreviations

<b>BF:</b>	Breastfeeding
<b>CCM:</b>	Chama cha Mapinduzi
<b>CDC:</b>	Centre for Disease Control
<b>DANIDA:</b>	Danish International Development Agency
<b>FAO:</b>	Food and Agriculture Organisation of the United Nations
<b>FP:</b>	Family planning
<b>FPP:</b>	Family Planning Programme(s)
<b>GTZ:</b>	Deutsche Gesellschaft fur Technische (German Technical Cooperation Agency)
<b>HH:</b>	Household
<b>IUCD:</b>	Intra-Uterine Contraceptive Device
<b>MCH:</b>	Maternal and Child Health
<b>MFP:</b>	Modern Family Planning
<b>MFPM:</b>	Modern Family Planning Methods
<b>NFP:</b>	Natural Family Planning
<b>NCSP:</b>	National Child Spacing Programme
<b>NFHP:</b>	National Primary Health Project
<b>TANU:</b>	Tanganyika African National Union
<b>TAPA:</b>	Tanzania Parents Association
<b>TFP:</b>	Traditional family planning
<b>TFPM:</b>	Traditional Family Planning Methods
<b>UN:</b>	United Nations

- UNFPA:** United Nations Funds for Population  
Activities
- UNICEF:** United Nations Children's Fund
- UNESCO:** United Nations Educational Scientific and  
Cultural Organization
- UPE:** Universal Primary Education
- VHW:** Village Health Workers

by the various groups in the various regions  
and provinces. It is hoped that these groups  
during the initial years of this study, they  
through the various groups of the various University  
of Agriculture who participated in the applied  
extension program and encourage the extension of  
agricultural education.

The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.  
The study is intended to be completed in the year 2000.

## ACKNOWLEDGEMENTS

I am indebted to my government and employer for granting permission to pursue this study.

I am most grateful to the Danish International Development Agency (DANIDA) and the International Research Centre of Canada (IDRC) who provided funds for my study and research. Without their financial assistance this study would not have been undertaken.

My most sincere thanks to Ms. Nandita Kielmann and Professor A. Kielmann for their encouragement during the initial stage of this study. Many thanks to Dr. James Bangu of the Sokoine University of Agriculture who introduced me to the Applied Nutrition Programme and encouraged me to pursue the Applied Human Nutrition course.

I am highly indebted to my supervisors Drs. Jane W. Muita, Gabriel K. Maritim and Nelson M. Muroki for their guidance during the whole research period. I wish to thank Dr. Abihud Omwega for the encouraging support he gave during his supervisory trip to Tanzania. My sincere gratitude to the Applied Nutrition staff for their comments and

support they gave from the development of this study to its completion.

I owe Dr. Neuvians and Mrs. A. Mlay of GTZ (Tanzania) my most sincere thanks for allowing me to conduct the research in their programme. I wish to thank them for the assistance they gave me during my preliminary visit to the study area and also for the transport they provided during the main research period. The motorbike was ideal in the many places which could not be reached by car.

I will not forget Rev. Fr. H. M. Kessi of Kihonda Parish, Morogoro for his encouragement and support during this study. I am most grateful for the assistance he provided particularly in accommodation and transport during the pilot study.

I express my sincere gratitude to Professor Alfeo M. Nikundiwe of the University of Dar-es-Salaam for availing to me computer facilities without which the data analysis and Thesis write up would not have been possible. I owe many thanks to Mr. Gregory Wagner who readily availed his services for statistical consultancy.

Many thanks to my field assistants, Mr. Benjamin and Miss Ernesta Njuu who worked with me tirelessly to the end of the field work.

Last but never least I give my heart felt and sincere gratitude to my dear husband William A. Kaaya who patiently and tirelessly supported me during the whole study and in particular during the field survey. To my beloved daughters, Lili, Lulu and Noela be assured of my heart felt gratitude for your love and patience and understanding during the whole study. Many thanks to my sisters Martha and Mary and my sister in law Mrs. Martha Mlumba for their loving care and support to my family while I was away for this study.

## ABSTRACT

The survey culminating in this thesis was carried out in a National Family Health Project (NFHP) area, Bagamoyo district where a total of 240 randomly selected women of reproductive age, 15-49 years were studied. The low acceptance of the modern contraceptives in the district where modern family planning was a component of the project (NFHP) prompted the study. A cross-sectional survey was therefore conducted with the aim of finding out the reasons for the low acceptance and so advice the bodies concerned accordingly.

The study findings revealed that there were underlying, intermediate and immediate problems that accounted for the low acceptance of the modern methods of contraception. These problems were socio-demographic and socio-cultural in nature. Education and some of the modern planning aspects also contributed to the low acceptance of the methods.

Offspring mortalities constituted the major socio-demographic characteristic which greatly affected modern contraception. Women with higher

numbers of offspring life losses tended to avoid the modern contraceptives which were feared to threaten fertility. Subsistence farming and low incomes were the major socio-economic aspects which accounted for the low acceptance of the MFP methods. Large families were necessary for farm work and hence modern contraception was not called for.

The study findings also showed a great adherence to traditional family planning practice which discouraged the use of the modern methods. The traditional methods were considered non-hazardous to the users and did not threaten fertility in women. The traditional methods therefore, have been used for years and with time have become part and parcel of the community's culture. The modern methods however, were feared to cause infertility and so were avoided.

Nonetheless, the study showed that with education and reduced offspring mortality modern family planning was likely to be accepted at higher rates

## CHAPTER ONE

### 1.0

### INTRODUCTION

#### 1.1 WORLD POPULATION ISSUES

The population growth rates in the developing countries, despite the interventions by family planning programmes (FPP) have been on the increase, bringing the population size from one billion a century ago, to four billion in 1990 (Bongaarts et al, 1990). Assuming the same growth trends, the world Bank estimated the population size in these countries would reach ten billion by the end of the next century (Bulatao et al, 1983). However, in the absence of effective strategies in FPP Bongaarts et al (1990) estimated that the population size in the developing countries would reach fourteen billion by the end of the next century.

A demographic profile featuring the past, present and the projected population growth trends in the developing countries was drawn by Bongaarts et al. The data is presented in Table 1.

**Table 1. Projected Population Growth Trends In Developing Countries**

<b>Time</b>	<b>Population size</b>
A century ago -----	1 billion
Late 1950s -----	2 billion
1975 -----	3 billion
1990 -----	4 billion
By 2000 -----	5 billion
End of next century --	10 billion (World Bank estimates)
End of next century --	14 billion

Source: Bongaarts J., et al, 1990

High fertility (6.1 live births) and low contraception practice (9%) in the 1960s, were identified as the immediate causative factors for the increased population growth rates.

## **1.2 INTERNATIONAL EFFORTS TO REDUCE POPULATION GROWTH**

To decrease population growth, family planning programmes (FPP) were initiated in different countries in collaboration with a number of international organizations. These programmes were aimed at increasing the contraception practice. The aims of these efforts were to reduce the

fertility rates, and in the long run stabilize the population growth to socio-economically sustainable rates.

The initiation of the FPP was coincidentally timely because by then and particularly after the Bucharest United Nations World Population Conference in 1974, the developing countries had realized the importance of population growth rates that were compatible with desired economic growth and social development goals (Heckel, 1986). Thus after the 1984 United Nations conference held in Arusha Tanzania, many of the Sub-Saharan countries amended their legislation related to population issues. Some countries which included Kenya, Zambia and Uganda, adopted explicit policies while others like Chad and Gabon adopted implicit policies. Other countries like Tanzania and Togo, invariably supported family planning, while Mali and Senegal opted for legal reforms that encouraged FP (Heckel, 1986).

On the average, the fertility and contraceptive use trends reported by the United Nations estimates in 1988, were encouraging. Fertility dropped to 4.2 during the 1980-85 period and contraceptive use increased to 45% by the same time. However, the regional differences were

dramatically wide. In Africa, the fertility decline was negligible (i.e. from 6.6 in 1960-65 to 6.3 in 1980-85). Contraception practice was still low although it doubled from 5% to 14% in the same years. According to Bongaarts et al (1990), Africa had the highest fertility and the lowest contraception rate, as per the UN report on fertility and contraception trends in 1988-89. East Asia on the other hand, during the same time had its fertility drop from 6.1 to 2.4 and contraception prevalence increased from 13% to 74% (Bongaarts et al,1990)

### **1.3. TANZANIAN POPULATION ISSUES**

In Tanzania, population issues started to be of concern to the government during the post independence times (after 1961) and particularly so after the first national census conducted in 1967. The high population sizes and growth rates became evident after the two subsequent national census conducted in 1978 and 1988, as shown by a demographic profile (Table 2) containing selected information relevant to this study.

**Table 2. Demographic Profile of Tanzania (1988)**

---

Total population 1967	-----	12,313,469.
Total population 1978	-----	17,512,610.
Total population 1988	-----	23,174,336
Population growth rate 1967-1978	----	3.3%
Population growth rate 1978-1988	----	2.8%
Crude birth rate 1988	-----	47/1000
Total fertility 1988	-----	6.9 live births
Infant mortality rate 1957	-----	190/1000
Infant mortality rate 1967	-----	160/1000
Infant mortality rate 1978	-----	137/1000
Infant mortality rate 1988	-----	115/1000

---

Adopted from Tanzania National Census, 1988.

It is evident from the profile above that the population size increases could be attributed to:

- High crude birth and population growth rates both of which stem from the high fertility rate.
- Drop in mortality rates with no parallel reduction in fertility rate.

After the 1967, 1978 and 1988 census surveys it became evident that the large population sizes as shown by the demographic profile (Table 2), could hardly be sustained by the low economic growth rate. Prospects of improving the standard of living above that of the colonial times appeared remote.

#### 1.4 EFFORTS TO SOLVE POPULATION PROBLEMS IN TANZANIA

Before 1974, Tanzania was among the many Sub-Saharan countries that strongly argued against population policies and fertility reduction as means of developing their countries. She stressed that the actual need was to improve the economic and social development of the people. After 1974, however, Tanzania under the Ministry of Health, launched Maternal and Child Health (MCH) with family planning programmes. These programmes emphasized child spacing. To date there are over 2000 MCH centres all over the country, and 71% of them provide FP services.

In 1983, the government launched another project, the National Family Health Project (NFHP), jointly financed by the World Health Organization (WHO), Food and Agricultural Organization (FAO) and the German Technical Cooperation Agency (GTZ). Bagamoyo, a district in the Coast region, became a pilot area for the implementation of the NFHP project. The project had four main components which included:

- Control of malaria
- Control of acute respiratory infections

- Immunization and Control of diarrhoeal diseases.
- Family planning (FP).

The family planning component was started in 1987. According to GTZ (Tanzania) authority, the baseline prevalence for modern contraceptive use was 5-6%. The family planning programme (FPP) within the NFHP was community based in that trained village health workers (VHW) provided family planning education and distributed contraceptives in their own villages. The VHWs were also required to monitor the progress of the acceptors in order to detect side effects or any other complaints and give advice as may be necessary.

A network of supervision operated from the headquarters to the district, ward, and village levels. Motor vehicles/ bikes were provided at the supervisory level and bicycles at the implementation levels. The FPP was also equipped with a mobile unit which showed FP related films as a mass medium and an audio-visual aid. Seminars were conducted from time to time and frequent meetings convened to give and discuss the progress reports of the periodically assigned duties. These strategies were designed to encourage acceptance and minimize defaulting. In-process evaluations

were done to measure the impact of the project on the targeted population.

In 1985, the National Child Spacing Programme (NCSP) was launched. NCSP is financed by the United Nation Funds for Population Activities (UNFPA). The direction of implementation, like in all prior programmes, was child spacing with the aim of improving the health of both the mother and child.

The latest efforts were the development of a Population Policy draft which contains the same element of emphasis on child spacing as a priority and strategy to solve the now erratic population growth.

Other policy components implemented by the government in line with the 1984 declaration that Tanzania had signed, include:

- Recognition of the importance of education and information services in the implementation of the MCH-FP programmes.  
(education is provided mainly through seminars).
- Encouragement of research on infant and child mortalities.
- Provision of contraceptive supplies, clinic and hospital facilities for MCH-FP services.

- Taking measures to improve the social status of women, that is equal education and job opportunities irrespective of gender, and/or biased opportunities to favour women where necessary.

### **1.5 ACHIEVEMENTS IN POPULATION CONTROL IN TANZANIA**

In 1984, during the United Nations conference held in Arusha, (Tanzania), the host country was one of the Sub-Saharan countries which had to admit that, directed population sizes were necessary for the socio-development and growth of a nation. Like many of the other countries, Tanzania signed a declaration affirming the importance of achieving population growth rates that are compatible with desired economic growth and social development goals (Berelson, 1990). However, evidence from the 1988 census results with annual economic growth rate of about 2%, the population growth rate of 2.8% and the population size of 23,174,336 shows that not much has been achieved. The fertility rates of 6.9 live births were still high. In addition, the infant mortality rate that dropped from 137/1000 in 1978 to 115/1000 ten years later (1988) contributed to population growth.

## **1.6. IMPACT OF THE PILOT NATIONAL FAMILY HEALTH PROGRAMME IN BAGAMOYO DISTRICT**

From Personal communication (1990) with GTZ it was noted that after the FP programme evaluation in 1989, in Bagamoyo district where extra inputs were added contraceptive use remained low, (i.e 5 to 6%) practically equal to that of the Africa region in the 1960s.

The NFHP expected to realize a higher modern contraception acceptance and raise the prevalence to a figure higher than 10% in two years time. However, an in-process evaluation of the FP component done two years after its initiation (1989), revealed that contraception level remained about where it was that is 5-6%, which is surprising after all the efforts and inputs cited earlier.

## **1.7 CONCEPTION OF THE PRESENT STUDY**

To identify the factors which lead to the low performance of efforts in the pilot study area, i.e. Bagamoyo district the present study was conceived. The findings were expected to help assess the alternatives that may be relevant/-suitable for Tanzania and Bagamoyo in particular and hence advise policy makers and the FHP organizers accordingly.

## **1.8. OBJECTIVES**

### **1.8.1. Main Objectives**

The study had two main objectives.

1. To determine the prevalence of modern contraception in the study area.
2. To determine the effects of selected factors on modern contraception practice in the study area.

### **1.8.2. Sub-objectives**

- 2.1 To determine the effects of demographic, cultural and economic factors on modern contraception acceptance.
- 2.2. To determine if religion and education influence modern contraception acceptance.
- 2.3 To determine the effects of problems related to modern family planning on modern contraception acceptance.

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

World wide, modern family planning prevalence has been reported by a number of researchers. Caldwell (1975) reported 1% modern contraceptive use by women of the Sub-Saharan Africa. This was confirmed by the findings of the World Population Report (1985) which revealed that contraceptive prevalence is highest in Europe (>40%) and lowest in the sub-Saharan Africa (0% to <40%). Parker and Segal (1986) made similar observations with most of Africa. They observed that the prevalence varied from 40% in Zimbabwe to 5% in Tanzania).

A number of review articles provide useful background on the various socio-demographic, socio-economic, and socio-cultural factors which influence modern contraception. Other reported factors which also affect modern family planning practice include government support efforts in population issues and the strength of family planning programs.

## 2.1 SOCIO-DEMOGRAPHIC FACTORS AND MODERN CONTRACEPTION

Earlier studies in socio-demographic characteristics have shown that age, marital status, parity, offspring mortality, number of surviving children and the children's gender influences modern contraception practice.

### 2.1.1 Age.

Contraceptive use patterns differ substantially by age in both the developed and developing countries. Carrasco (1981) and Nortman (1982) argued that contraceptive use increases with age until 35 to 40 years then declines due to infecundity among older age groups for whom contraceptive is unnecessary. In Kenya; Muia (1985) found out that, women of age group 15 to 19 years contribute least while those of age group 20 to 39 years contribute most to modern contraceptive use. Trussel (1986) found out that age at first pregnancy could have a profound effect not only in the health of child and mother but also on the ultimate fertility and population growth.

In the United States of America, 77% of the women aged 15-19 years, are both fecund and

contraceptive users (World Fertility Survey 1982). The prevalence is five times higher than the same age group in the developing countries. In the developing countries, according to this report, modern contraceptive use among women aged less than 30 years is low, but rises substantially after that. In the USA, however, contraceptive use is relatively even among women aged 15-44 years. Nyange (1990) found out that in Kilima-njaro, (Tanzania), modern contraception was slightly higher among women aged 25-29 years and lower among women of age groups 15-19 and 40-49 years.

#### **2.1.2 Marital Status.**

Bongaarts (1978) showed that marital status is an important intermediate fertility variable. He noted a higher proportion of contraception among married women compared to the unmarried ones. Muia (1985) showed that contraceptive use in Kenya was higher among married women aged above 20 years. These findings were supported by the National Demographic Survey report, (1989) which showed higher contraceptive use among married women and reported that their efforts were supported by their husbands. In Iran, husband support was further shown to be a prerequisite for modern contraception

among married women and that female sterilization is legalized on condition that women obtain permission from their husbands (Moreno and Goldman, 1991).

In Metropolitan Indonesia, Joesoef (1988) found out that husband's approval was a must for contraceptive use. In Sudan, in the same year, Khalifa (1988) used the 1985 Male Attitude Survey data and found out that the decision to use or not use contraceptives was male dominated. He also revealed that husbands were responsible for providing contraceptives where family planning was practised.

### **2.1.3 Parity.**

Third World men and women are pronatalists and their traditions encourage women to bear as many children as possible (Betrand 1989). The author observed that a large number of children added the prestige in the community, strengthened the clan, provided labour for household tasks and agricultural work, provides security for parents at old age and offset the effect of infant and child mortalities. The need to have a certain number of children before embarking on modern contraception practice was shown by the Iranian government when

female sterilization was legalized. The clients had to have at least three children (Moreno and Goldman, 1991).

According to Jejeebhoy and Sumati (1989) in Maharashtra, Indian women seem to need more children for security at old age, while men in addition to security, want to preserve the family's continuity and carry out ritual obligations. In Kenya, Oniango and Rogo (1985) found out that the traditional status of women in the community was strongly tied to their fertility and that the higher the fertility, the higher the status in the community. Modern contraception is, therefore, reluctantly accepted because it is believed to negate the traditional family values.

Oyemade and Ogunmuyiwa (1981) found out that in rural Nigeria with extensive agricultural practices, children were viewed as indispensable assets in cultivation. Women with few children or widely spaced births were pitied and ridiculed. In Nepal, couples have at least four children before they adopted modern FP methods (Gubhaju, 1985). Again Gubhaju (1985) and Westoff (1990), examining data in 134 surveys from 84 countries and evaluating whether the stated desire to terminate child bearing was a valid predictor of fertility

found out that there was a strong relationship between the total fertility rate and the number of women who wanted no more children. More women who did not want more children were on contraception than those who wanted more children.

Jejeebhoy (1984), however, revealed that couples usually have a desired number of surviving children. Further, he noted that in the developing countries, at household level, once the number of children a couple has exceeded the desired, there is a latent demand for terminating child bearing. According to him, at this juncture the role of family planning became critical.

A vivid change of the desired number of children and its effect on FP practice and fertility reduction was shown by the National Demographic Surveys in Kenya, in 1984 and 1989. According to the 1984 survey report the desired family size was 5.8, contraceptive use was 17% and fertility was 7.7. The 1989 report showed a reduced desired family size (4.4), an increased FP practice (27%) and reduced fertility (6.7).

#### **2.1.4 Child spacing**

Birth spacing and child survival was studied by Pebley and Millman (1986). The authors found that there was a strong relationship between birth spacing and child survival. They also observed that children throughout the developing world were more likely to die if they were born less than two years after their mother's previous births than when the birth interval was longer.

The impact of birth spacing on fertility was also studied by Trussel (1986) who found out that the interval between births has a profound effect on the health of the mother and child and the ultimate fertility and population growth.

#### **2.1.5 Sex preference**

It has been reported in many cases that the sex of children has a great effect on child bearing and ultimately on contraceptive use. According to Elrich and Elrich (1970) many families have additional children in an attempt to have a son or a daughter if they have only one or none of them. Bulatao and Fawcett (1983), showed that the low status of women in the society induces preference for sons over daughters and contributes to higher fertility rates.

Karki (1988) found that the preferred sex composition by Nepalese women was two sons and one daughter. The author also found that the women had at least a son and an average of four children before embarking on modern contraception. Oyeka (1989) found that in Nigeria, women with no sons and daughters were less likely to have ever used contraception than those with one son and one daughter.

Muna (1987) revealed that in an urban district of Tanzania, the need to have male children prevented couples from using contraceptives especially where previous births were dominated by female children. In Kilimanjaro (Tanzania) couples had a strong preference for sons which contributed to high fertility and low contraceptive use (Nyange, 1990).

#### **2.1.6. Offspring mortality**

According to Casteline (1989) mortalities are a possible reason for disapproval of modern contraception.

Family environment and competing effects for food, love and other family services among siblings may cause infant mortality. Gubhaju (1985) used the data from the 1976 Nepal Fertility Survey to

explore the relationships of sibling mortalities. He found that even when the demographic variables were considered, due to family environment effect, the risk of infant and child death was considerably higher among children of mothers whose child died than among those who had a surviving child. The author found that whether the previous child survived or died, the effect of birth interval on infant mortality were present due to the competing child effect.

## **2.2. SOCIO-CULTURAL FACTORS AND MODERN CONTRACEPTION.**

Traditional family planning in Africa has been practised from time immemorial to date. The methods used range from use of plant substances (herbal contraceptives) to cultural reproductive behaviour patterns (CDC, 1983).

Cultural behaviour patterns related to reproduction and sexuality practised in Africa which affect fertility include strict observance of virginity until marriage, sexual abstinence during breast feeding (BF), polygynous marriages and coitus interruptus.

Presence of virginity is highly valued in

Africa, particularly in Zaire where sexual activity is prohibited before the girl is married (CDC, 1983). In this country, according to the same author, a woman is not supposed to bear children once she becomes a grand mother and has to abstain from sexual contact indefinitely.

Sheon and Stanton (1989) observed that temporary abstinence which involves the use of calendar or rhythm technique to determine the fertility period is more commonly used because total abstinence has been reported to be difficult in practice. The calendar and rhythm methods, however, have been associated with ineffectiveness and according to these authors their discontinuity are due to their high failure rates. The failure of the methods had been attributed to the users inability to identify their fertile period correctly.

Postpartum sexual abstinence prevents conception and so facilitates lengthy breastfeeding (BF) periods. Widely spaced births by practising lengthy abstinence of more than three years after birth and six months after weaning have been reported (Caldwell and Caldwell 1988). Lengthy breastfeeding was successful because it was believed that coitus during breastfeeding was

harmful and that semen could enter the blood of the mother and poison the milk. Diseases such as kwashiorkor and marasmus which are caused by protein and energy deficiencies respectively, are believed to be a result of coitus during breastfeeding period, (Walle and Walle, 1988). In Kenya, the 1984 and 1989 National Demographic Surveys and the work of Ferguson (1990) showed that most non- users of modern contraceptives depend on breastfeeding for spacing their births.

Abstinence, total or temporary is, however, practised by women while men enter in polygynous marriage or extramarital relations (Walle and Walle, 1988). The authors observed that men cannot abstain for long periods and so during breast-feeding strain and fighting among couples is common.

Bongaarts (1978) found out that due to uncertainty of return of ovulation, prolonged breastfeeding discouraged modern contraception. His findings are supported by Jain et al (1979) who reported that it is not possible to ascertain the order of menses and ovulation, although they found out that women who were no longer ammeno- rrheic, but continue to breastfeed are of lower fecundity compared to those who are no longer breastfeeding.

Eslami et al (1990) found out that although breastfeeding mothers are of low fecundity, menses is not always a reliable indicator of postpartum ovulation. According to these authors, menses before six months postpartum are anovular while after this period, menses can be preceded by ovulation, making it highly probable to conceive

Interpreting findings made here leads to a conclusion that breastfeeding alone was not reliable as a contraceptive.

According to the findings by Walle and Walle (1988), the underlying rationale for traditional FP despite the pronatalist values, is mainly to space births for the health of both mother and child. Therefore, attempts to introduce modern contraception to promote child spacing are not successful.

### **2.3 SOCIO-ECONOMIC FACTORS AND MODERN CONTRACEPTION**

A number of findings have shown that socio-economic factors influence modern contraceptive use. Gulhati (1983) has observed that women continue to depend on children for farm and domestic work if their incomes are not increased by

technology. According to this author dependency on children for labour accounts for increased fertility and negation to modern contraception.

Baulier (1983) observed that favourable socio-economic factors increased modern contraception practice and accounted for 27% in total fertility rate decline. Mbugua (1984) also reported that contraception practice by women increases as their incomes and access to agricultural resources increase.

#### **2.4. RELIGION AND MODERN CONTRACEPTION.**

Contradicting findings have been observed on effect of religion on modern contraception practice. The 1984 and 1989 National Demographic Survey reports in Kenya, showed that religion does not have any influence on modern contraceptive use among the Kenyan women of reproductive age. These results were supported by Ferguson (1989 and 1990) who carried a research in Etionono and Nyamira, Kisii District of Kenya. Elsewhere, religion has been found to affect modern contraceptive use (Bongaarts et al, 1990). Haile (1990) found out that in Gondar, Northwest Ethiopia, strongly religious women have a higher number of births and offspring mortalities and furthermore, these women strongly

disapprove of modern contraception.

The Catholic church has been about the only religion against modern contraception practice and has been recommending the practice of abstinence (total or periodic), the Billing method and the symptothermal method or their combination.

On the other hand, Islam which has been said to be against modern contraceptive use appears not to be against it as is evident from legalization of female sterilization by the Iranian government in 1990 (Moreno and Goldman 1991).

## **2.5. EDUCATION AND MODERN CONTRACEPTION**

Education was shown by the World Fertility Report (1982) to influence modern contraception use. According to the report, wide spread contraceptive use is difficult to achieve where literacy is low. The same report revealed that in Bangladesh, women who attend school for seven or more years, are five times more likely to use modern contraceptives than those who attend for shorter periods.

Muia (1985) showed that the prevalence of contraceptive use in Kenya was lower (18%) among non educated women than among those with secondary

education who showed a prevalence of 40%. Better educated women in urban areas in Bas, Zaire were reported to be more likely to adopt modern contraceptive use than the less educated (Betrand et al, 1989). In Nkole, Uganda, Ntonzi (1991) found that low use of modern family planning methods is due to low education among women.

Caldwell (1975) showed that in Nigeria education level influenced modern contraceptive use. He found out that 6% of the non educated women, 16% of women with some education, 38% of those with secondary education and 64% of those with tertiary education practised modern contraception. However, findings by Ferguson (1989) in rural Kenya, contradicted those by Caldwell and Nyange. According to the author, user rate was 34.2% among educated women and 30.4% for those without education. He also found that there was no significant difference in contraceptive use among women of varying degrees of education once age is taken into account.

Finally, that both the wives' and husbands' education can increase contraceptive use has been reported by Bulatao (1984). However, the author noted that the wives' education has a larger effect than the husbands'.

## 2.6 PROBLEMS RELATED TO MODERN FAMILY PLANNING AND MODERN CONTRACEPTION PRACTICE

### 2.6.1 Family planning programmes

Bongaarts (1978) observed that family planning programs are a powerful tool for depressing fertility levels. The author emphasized that well organized FPPs supported by government policies motivate contraception practice. He noted that strength of FPPs depends on resources such as funds, educators and service related activities for easier outreach both at programme and government levels. Giving the Africa region as an example, he showed that the development level of a country and strength of FPPs has effect on fertility reduction. In this region where the level of development was low (2.1%-1.4%), family planning programmes were weak and fertility was high (6.3). In the developed countries such as Europe contraceptive use is high ie. above 40% (World Population Report, 1985).

Fertility reduction and quality of family planning services were studied by Jain (1989). The author equated FPP quality to the way individual couples are treated by the system providing the services. According to the author the success of

the programmes depends on the quality of the system. Quality elements according to her includes the six components incorporated by Bruce (1988).

These are:

- Choice of contraceptive methods which serve sub-groupings i.e. beginners, spacers and or stoppers, males/females, tolerant and non-tolerant so as to allow switch over.
- Information given to users to make them aware of the contraindications, risks and benefits of the methods and their applications, potential side effects and how to manage them, and what to be expected of the provider in terms of advice, support, supply and referrals to other services.
- Provider competence which includes skills and experience of the provider, doctors or paramedics particularly in use of sterile instruments e.g. in intrauterine devices (IUCDs) and sterilization.
- Client/provider relations which allow effective contact between them and allow couples to feel positive about the personnel with whom they interacted while

trusting their capacity and have good will

- Recontact and follow up mechanism to promote continuity
- Appropriate grouping of services to make them acceptable and convenient to couples.

### **2.6.2 Attitudes, side effects and modern contraception practice**

Although studies in attitudes towards modern contraception in the sub-Saharan countries are still at pilot and infancy levels, failure rates, side effects and convenience of application have been reported to have contributed much to the negative attitude towards the use of contraceptives and hence account for the discontinuity of their use.

According to Moreno and Goldman (1986), in the developing world overall failure rates varied across countries from low values of 2% in Thailand and 3% in Indonesia to high values of 16% in Peru and 29% in Bolivia. The pill failure was 5.4% in Brazil and 11.8% in Dominicus.

Philliber and Philliber (1985) have reported that tubal ligation (TL) acceptance in Zaire was very low for moral reasons while others fear

operations and their consequences. The consequences include side effects such as too heavy bleeding and/or irregular menses. TL is further feared because husbands demand continued child bearing and frequent offspring losses that demand replacement.

The few who accept TL do so either for health purposes or want to avoid pregnancy because they are already grandmothers. Widows in Zaire were reported to prefer TL for economic purposes.

The impact of attitude on condom use as a contraceptive was studied in Mexico and Jamaica by Staver and Bravo (1990). The authors found that due to emphasis of condom use for prevention of sexually transmitted diseases during the AIDS information campaigns, potential users fear they can be suspected of having AIDS or sex with people who are likely to be infected.

Personal experience of the author of this work in her village with women who say that modern contraceptives cause health problems and that they can reduce breast milk yield have been supported by research findings. The use of oral contraceptives has been observed to affect lactation (Hull, 1981). According to this author oral contraceptives containing oestrogen and progesteron, adversely

affect lactation by reducing the milk volume and changing its constituents. WHO (1988) report supported these findings from the study on the effect of hormonal contraceptives on breast milk and infant growth. WHO also found that there was a significant decrease in milk output and total energy content in addition to widespread changes in milk constituents.

Side effects such as discomfort attributed to intra uterine devices (IUCD), and nausea attributed to pills have been reported by Stephen and Chamrathirong (1988). The authors also noted that side effects among contraceptive users were high among those using injectable and oral pills reported by 40 and 39% respectively, followed by 9, 7 and 5% of users of IUCDs, condoms and other methods respectively.

According to Lianda (1989), error in pill contraceptive use contributes to its ineffectiveness and side effects. The author reported that in Colombia, new contraceptive users make error in pill use. Errors are high both in the daily use (43%) and incorrect transition from one cycle to another (47%). The report further noted that most errors were purposive because the subjects wanted to reduce side effects and some women used the

gills during sexual intercourse only.

## 3.0 BACKGROUND INFORMATION ON BAGAMOYO DISTRICT

### 3.1. GEOGRAPHY

The study was conducted in Bagamoyo district, Coast Region, Tanzania. The district is situated north west of Dar-es-Salaam region, east Tanzania. It borders the Indian ocean coastline on the east, Tanga region on the north, and Morogoro region to the west. The southern part of the district is partly bordered by Dar-es-Salaam region and partly by Kibaha, a sister district of the Coast region. It covers an area of 5000 square km.

Bagamoyo district lies between latitudes 6° S and 7° S, and longitudes 38° E and 39° E. (Appendix 1). Bagamoyo town, the district's administrative headquarters, historically was a slave trade centre which served as a port receiving slaves from the mainland (Tanganyika), for shipment to the Arab countries across the Indian ocean. It was during the slave trade that the Arabs started to settle in the coast of Bagamoyo and eventually Bagamoyo town was born and subsequently, the Moslem religion was introduced. The cultural values of the indigenous

## CHAPTER THREE

### 3.0 BACKGROUND INFORMATION ON BAGAMOYO DISTRICT

#### 3.1. GEOGRAPHY

The study was conducted in Bagamoyo district, Coast Region, Tanzania. The district is situated north west of Dar-es-Salaam region, east Tanzania. It borders the Indian ocean coastline on the east, Tanga region on the north and Morogoro region to the west. The southern part of the district is partly bordered by Dar-es-Salaam region and partly by Kibaha, a sister district of the Coast region. It covers an area of 5000 square km.

Bagamoyo district lies between latitudes  $6^{\circ}$  S and  $7^{\circ}$  S, and longitudes  $38^{\circ}$  E and  $39^{\circ}$  E. (Appendix 1). Bagamoyo town, the district's administrative headquarters, historically was a slave trade centre which served as a port receiving slaves from the mainland (Tanganyika), for shipment to the Arab countries across the Indian ocean. It was during the slave trade that the Arabs started to settle in the coast of Bagamoyo and eventually Bagamoyo town was born and subsequently, the Moslem religion was introduced. The cultural values of the indigenous

population became mixed with Islam as a result of the Arab settlement in the coast and today the two are practically inseparable.

### **3.2 THE CLIMATE AND AGRICULTURE**

Bagamoyo district has a bimodal rainfall pattern with the short rains from October to December and long rains from about mid-March to June. The soils vary from sandy in the coastal parts to sandy loams and loams further inland. The climatic conditions are fairly suitable for the subsistence farming practised in the district. Food crops grown include maize, cassava, rice and millet. Millet is sparsely grown further inland. These crops serve as a main source of energy for the community. Legumes grown, include pigeon peas, cow peas and greengrams and form a good and cheap source of proteins. The district is endowed with a variety of seasonal fruits. Major fruits include oranges, pineapples and mangoes. Pawpaws are available throughout the year. The fruits are a cheap source of vitamins to the community.

Cash crops grown which include cotton, sim-sim, cashewnuts and coconuts form a varied and major source of cash income to the community.

Extra income is generated from sale of fresh water fish from rivers which flow across the district. Fish in the district is an important source of cash income as well as a good source of animal protein to those close to the rivers and the coastline. Unfortunately, the staples are also sold to get some extra cash as an effort to make ends meet at this time of economic crisis and inflation. Sale of food crops more often than not, creates food scarcity between harvests. Animal keeping is not common in the community, except by the Masai who are strictly pastoralists. The Masai's large herds of cattle provide a source of rich first class proteins and cash income from the sale of live animals, milk, meat and hides.

### 3.3 TRIBES

The major tribes which inhabit the district include the Zigua, Kwere, Doe, Matumbi, Zaramo and the Masai. Except for the Masai who are exclusively pastoralists the community depends on subsistence farming for living.

### **3.4 EDUCATION**

The country basically, and indiscriminately, offers free and equal education opportunities to all citizens. Universal Primary Education (UPE) is part of the education policy, which also explicitly spells out that, every Tanzanian child has the right to get into school and complete primary education. At secondary and college levels education opportunities get limited, and are narrowest at the university level. At these levels academic excellence is the criterion for selection.

### **3.5. HEALTH/FAMILY PLANNING SERVICES**

The government provides free health services through out the country. In Bagamoyo district, the services are provided in one referral district hospital a few rural health centres at ward level and over thirty dispensaries at the village level. Among the services given in the health centres at all levels, is mother and child health service with child spacing and family planning as integral components.

## CHAPTER FOUR

### 4.0 RESEARCH DESIGN AND METHODOLOGY

#### RESEARCH DESIGN

A cross-sectional survey was conducted in a randomly selected population of women of reproductive age, 15-49 years in Bagamoyo district using a structured questionnaire.

#### 4.1. SAMPLE SELECTION

Two hundred and forty households (HH) were included in the study. By using Random Table Numbers, only one respondent was selected from each household. The probability proportional sampling procedure was applied to select the sub-samples from the division and ward levels using the 1988 census. Random Table Numbers were also used to select the study villages and Ten Cell Leaders (TCL). This sampling is clarified in figure 1, in the sampling procedure

#### 4.1.1 Sample size

According to GTZ (Tanzania) authority, the baseline modern family planning methods prevalence was 5% (GTZ Tanzania, 1989). The prevalence during the programme's first evaluation was 6% (GTZ Tanzania, 1989). Taking into consideration the low modern contraception acceptance, a prevalence of 7% at the time of study was expected.

The sample size was then calculated from the formula:

$$n = \frac{z^2 pq}{d^2}$$

Where: n = the desired sample size, ( the female adult population in the district was more than 10,000).

z = standard normal deviate, set at 1.96 and corresponds to 95% confidence level.

p = the proportion in the target population estimated to be practising modern FP.

q = 1 - p

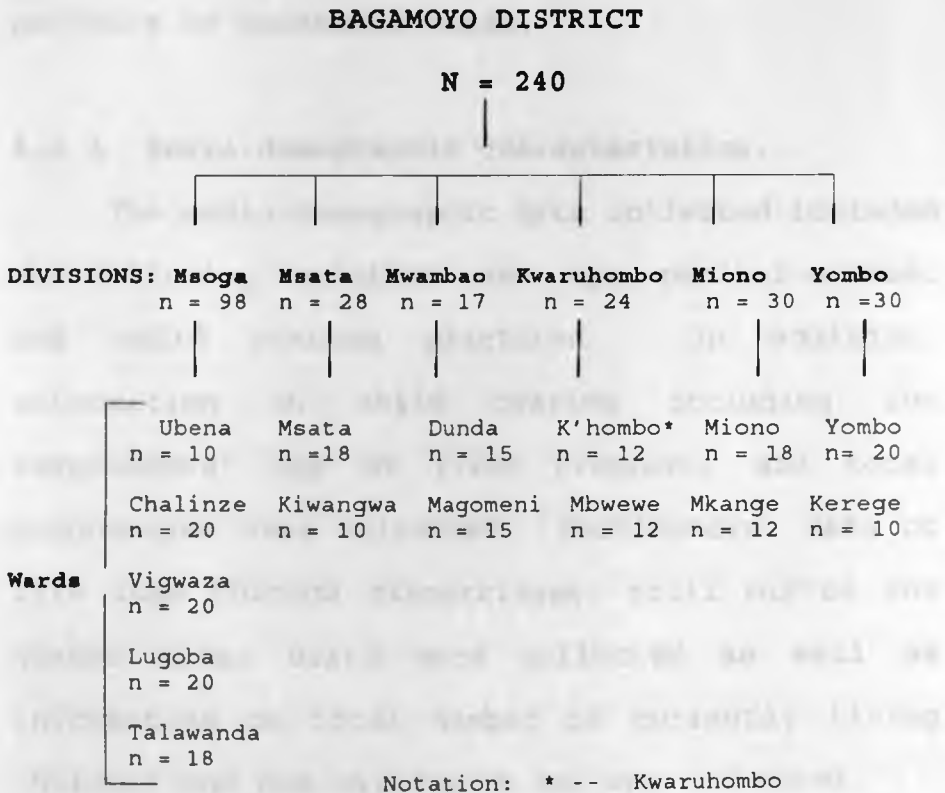
d = desired degree of accuracy at 0.05 level.

The sample size obtained was 208 subjects. To increase reliability in analysis and provide for the desired level of accuracy a larger study sample size 240 was taken.

#### 4.1.2 Sampling Procedure

The study was designed to include respondents representing the whole district. For this reason the sampling frame included all the eligible respondents (women of reproductive age 15-49 years) within the entire study district. Figure 1 represents the sampling procedure employed.

Figure 1. Summary of sampling procedure within the study area



## **4.2 TYPE AND DESCRIPTION OF THE DATA COLLECTED**

The data collected were grouped into socio-demographic, socio-cultural and socio-economic characteristics, religion, education and modern family planning aspects. The major study tool used was a pretested and adjusted structured questionnaire. Before conducting the interviews ethical considerations were observed, i.e. verbal consent was obtained from the respective husbands, partners or household heads.

### **4.2.1 Socio-demographic characteristics:**

The socio-demographic data collected included the following variables: sex, age, marital status, and child bearing practices. In addition, information on child bearing including the respondents' age at first pregnancy and total pregnancies were collected. Furthermore, data on life loss through miscarriages, still births and deaths after birth were collected as well as information on total number of currently living children and the children's sex was collected.

To make sure that correct data were obtained, child bearing information obtained was counter-checked by comparing it with that recorded in Table

(i) in the questionnaire (Appendix 2). Age was counter checked with birth certificates where possible. In older respondents, age was further verified by comparing with peer groups. A calendar of events (Annex 4) was also used to verify data on age. Other information collected included the respondents' preferences for family size and gender of children, age at first pregnancy and duration of breast feeding. Information on literacy was counter-checked by subjecting the respondents to a literacy test (Annex 3).

#### **4.2.2 Socio-cultural characteristics**

Information collected was mainly on ethnicity, traditional child bearing and family planning practices.

#### **4.2.3 Socio-economic characteristics**

In the present study, socio-economic data collected included the type of occupation of the respondents, their total earnings as well as their expenditure. Probing was used to obtain information on the total earnings. Total crop harvested was compared with the information given on crop consumed, sold, stored or given away as gifts. This was transformed to monetary value. Total

expenditure accrued from the different earnings was used to get accurate income data.

Sale of live animals and their products was collected from the pastoralists and converted to monthly income using current prices.

Data on religion and education were also collected. Each respondent was asked to which religion she belonged and whether or not she practiced modern family planning. In addition each was asked the education level she had attained.

#### **4.2.4. Knowledge of modern family planning**

Finally data on modern family planning was collected. As regards the measure of knowledge and preference for future use of the modern methods, each respondent was shown some of the modern methods which are used or shown the diagrams of the methods from a FP handbook. They were asked what they knew about the methods and marks were awarded as per Annex 1 column 2. The respondents were then informed of the use, reliability, side effects and management of the methods. They were also allowed to ask questions related to modern family planning. After the demonstration each of the interviewees was asked whether she preferred to use modern or

traditional family planning methods and what specific MFPM they preferred to use in the near future.

#### **4.3. RESEARCH ACTIVITIES**

The field exercise was carried out in three phases, the preliminary phase, the pilot phase and the actual research phase.

##### **4.3.1 Preliminary phase**

A preliminary visit to the study area was undertaken in April 1990. The main aim was to obtain background information related to the study, and to assess the magnitude of the problem. Authorities in the FP programme were visited, and the research problem discussed. For the same purpose, some of the National Family Health Programme (NFHP) workers, village health workers (VHW) and members of the community were visited. The background information obtained and the local literature review ascertained the existence of the problem and the need for research.

#### **4.3.2 Pilot study**

Prior to the pilot study, the English questionnaire was translated into Kiswahili and edited. This phase of the study was conducted in Msoga village, a village within Msoga division. This was done in February and March 1991. The main aim of the pilot study was to test the questionnaire and to make sure that the questions were not ambiguous and were easily understood. This study also enabled the researcher to establish a comfortable interview time that would not tire the interviewees and yield the required information.

At the end of the pilot study, necessary corrections and adjustments were made and the questionnaire reformatted and finalized for the actual study.

#### **4.3.3 The Definitive study**

The actual study was conducted from mid-June to mid-October 1991. Since family planning is a sensitive topic and also to minimize error the principal investigator conducted all the interviews.

The survey forms were screened and checked at the end of each interviewing day. Errors were

corrected and whenever necessary check backs were made immediately.

Finalized forms were taken to the University of Dar-es-Salaam for data entry. Data cleaning was done by counter checking the outliers with the survey forms.

#### **4.4 THEORETICAL FRAMEWORK AND METHODS OF ANALYSIS**

In order to gain information on the studied community, descriptive statistical analysis was done and presented in tabular and graphic forms.

Because all the data in this study was based on counts (of individuals for characteristics) Chi-Square ( $X^2$ ) tests were employed to test for associations between selected variables.

## CHAPTER FIVE

### 5.0 RESULTS

#### INTRODUCTION

This chapter presents both the descriptive and analytical results of the study. The descriptive results are presented in tables and graphs and analytical results and levels of significance are indicated at ( $p = 0.05$ ).

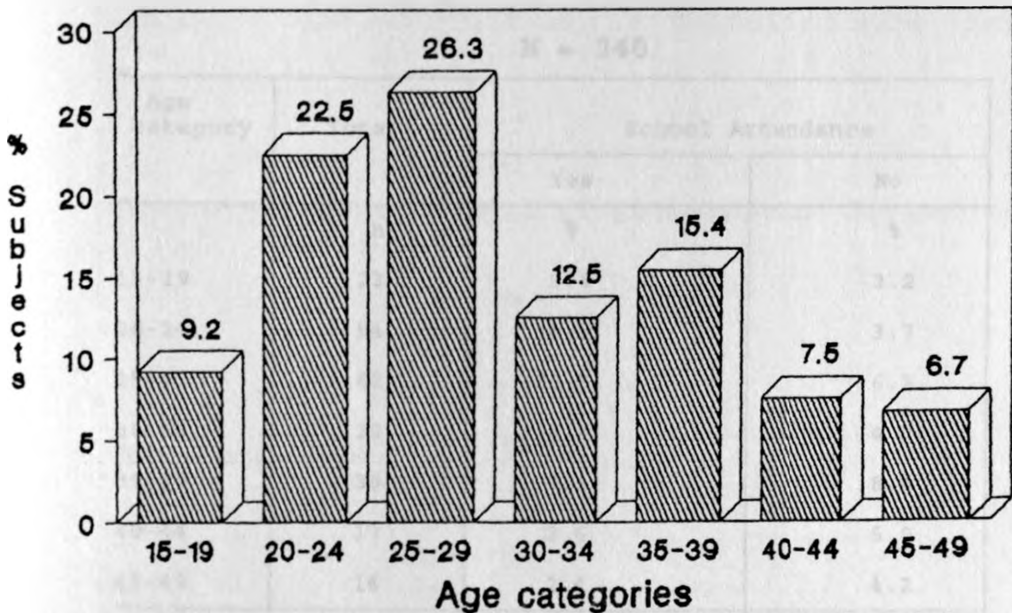
#### 5.1. SOCIO-DEMOGRAPHIC CHARACTERISTICS

A total of 240 women respondents of reproductive age ranging from 15 to 49 years were included in the study. Their mean age was 32.3 years.

### 5.1.1.1. Age.

Figure 2 depicts the age distribution of the respondents where about 50% were in the 20-24 and 25-29 years of age. Few women fell in the lower and upper age categories of 15-19 and 40-49 years respectively.

Figure 2. Distribution of Respondents by Age



### 5.1.2 Age and school attendance

Table 3 shows the distribution of respondents by age and school attendance. The Results show that in age categories 15-34 years there were more women who had attended school than those who had not. On the other hand, in age categories 35-49 years, there were fewer women who attended school than those who had not.

**Table 3. Distribution of Respondents by Age and School Attendance**

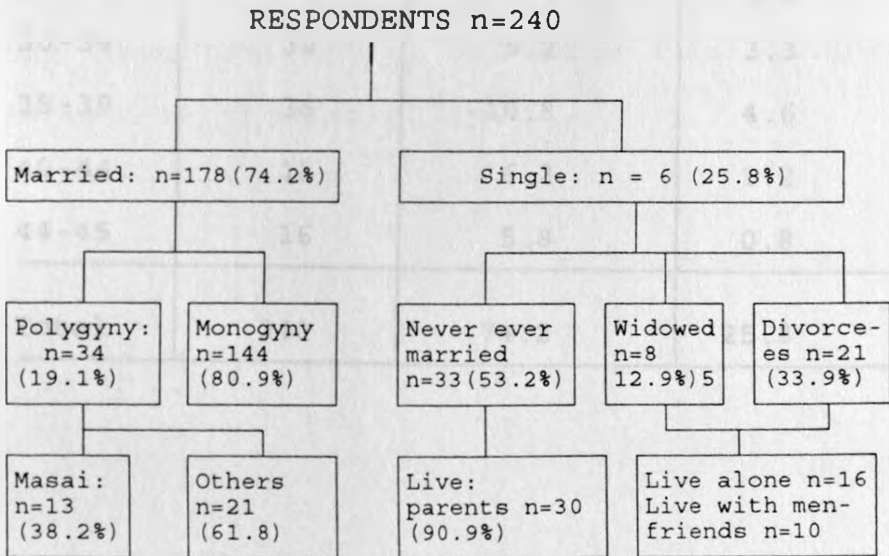
**N = 240**

Age category	Total	School Attendance	
		Yes	No
	n	%	%
15-19	23	5.8	3.2
20-24	54	18.8	3.7
25-29	62	20.8	6.3
30-34	30	8.3	4.2
35-39	38	7.1	8.4
40-44	17	2.6	5.0
45-49	16	2.4	4.2
<b>Total</b>	<b>240</b>	<b>65.0</b>	<b>35.0</b>

### 5.1.3 Marital status.

About three quarters (74%) of the subjects were married at the time of survey with the majority (80.9%) being in monogamous marriages (Fig. 3). It is interesting to note here that the majority (59%) of the Masai are polygynous constituting about 38% of all the reported polygynous cases. It is also shown here that a large proportion of about 91% of the single women live with their parents. The divorcees and the widowed lived on their own or cohabited with their men friends.

**Figure 3. Distribution of Respondents' by Marital Status**



Through out the age categories, more women were married than not with an overall proportion of 25.8% of the respondents being single as shown in Table 4.

**Table 4. Distribution of Respondents by Age and Marital Status.**

**N = 240**

Age	Total	Marital Status	
		Married	Not married
	n	%	%
15-19	23	6.7	2.7
20-24	54	15.0	7.5
25-29	62	20.4	5.8
30-34	30	9.2	3.3
35-39	38	10.8	4.6
40-44	18	6.2	1.2
44-45	16	5.8	0.8
Total	240	74.2	25.8

#### 5.1.4 Child bearing and preferred age at first pregnancy

Table 5 shows an appreciable proportion (about 39%), of very young mothers aged <15-16 years, this is an indicator of high vulnerability and exposure to early pregnancy risks. On the other hand a small proportion (about 21%) preferred to have their first pregnancy below 17 years of age while the majority (about 80%) preferred to be pregnant at a later stage i.e 17 years and above. There was a highly significant difference of the actual age at which mothers got their first pregnancy and the preferred age at first pregnancy ( $p < 0.005$ ). Actually most mothers got pregnant earlier than they would have preferred. The majority (69.5%) of the women preferred to have their first pregnancy between 17-20 years of age.

**Table 5. Distribution of Respondents by Actual and Preferred Age at First Pregnancy.**

n =240

Age	Actual		Preferred	
	n	%	n	%
<15-16	94	(39.2)	50	(20.7)
17-20	118	(49.1)	<b>167</b>	<b>(69.5)</b>
21+	28	(11.5)	23	(9.8)
<b>Total</b>	<b>240</b>	<b>(100.0)</b>	<b>240</b>	<b>(100.0)</b>

p <0.005

Age	Total	Total respondents			
		Actual	Preferred	Diff	%
<15-16	94	94	50	44	46.7
17-20	118	118	167	49	41.5
21+	28	28	23	5	17.9
<b>Total</b>	<b>240</b>	<b>240</b>	<b>240</b>	<b>100</b>	<b>100</b>

The present study showed that older mothers aged 35-49 years constituted 29.7% (71). Table 6 shows that of these mothers, more than 70% continued to bear children and had large numbers of pregnancies (5-11+). As expected there was a statistically significant increase in the number of pregnancies with increasing age of mothers ( $p=0.05$ ).

**Table 6. Distribution of Older Mothers by Age and Total Pregnancies**

**n = 71 (29.7% of total subjects)**

Age	Total	Total pregnancies			
		None	1-4	5-8	11+
	n	%	%	%	%
35-39	37	2.8	15.5	28.2	5.6
40-44	18	0.0	4.2	1.4	19.7
45-49	16	2.8	4.2	5.6	9.8
Total	71	5.6	23.9	35.2	35.2
				70.4	

**p < 0.05**

### 5.1.5 Breastfeeding

Table 7 below presents results on duration of breastfeeding preference. It is shown that the majority (about 83%) of the women preferred to breastfeed for 1-2 years. Few preferred to breastfeed for more than two years while none preferred to breastfeed for less than one year. It is noted that significantly more mothers preferred to breastfeed for 1-2 years than longer than 2 years ( $p < 0.005$ ).

**Table 7. Distribution of Respondents by Preferred Breastfeeding Period**

**N = 240**

BF Period (years)	Respondents	
	n	%
< 1	0	0.0
1 - 2	199	82.9
> 2-3	15	6.3
> 3	26	10.8
Total	240	100.0

$p < 0.005$

**5.1.6 Age at first pregnancy and offspring mortalities**

A total of 71 (29.5%) respondents reported having lost a first pregnancy offspring. Table 8 shows that of the mothers who lost their offsprings more than half (56.4%) were aged <15-16 years at the time of first pregnancy, while slightly more than a third (33.8%) were in the age group 17-20 years when they had their first pregnancy. Statistical analysis results also showed that the difference in offspring mortality among women aged <15-16 and those aged 17-21= was very highly significant ( $p < 0.005$ ).

**Table 8. Distribution of Mothers by Age at First Pregnancy and Offspring Mortality**

**N = 71 (29.5% of all subjects)**

Age at first pregnancy	Mothers who lost offsprings	
	n	%
<15-16	40	56.4
17-20	24	33.8
21+	7	9.8
Total	71	100.0

$p < 0.005$

### 5.1.7 Age and Offspring mortalities

Results presented in Table 9 show that the number of dead offsprings increased with the age of the mothers. High loss of offsprings that is 5 and above was observed from age groups 35-49 years. The mean loss per mother was 2 with a range of 0-9 offsprings.

**Table 9. Distribution of Mothers by Age and Offspring Mortalities**

**n=118** (50.6% of all the mothers)

Age category	Total	Number of dead offsprings			
		1-2	3-4	5-6	7+
	n	%	%	%	%
15-19	7	100.0	0.0	0.0	0.0
20-24	9	88.9	11.1	0.0	0.0
25-29	17	94.1	5.9	0.0	0.0
30-34	23	82.6	17.4	0.0	0.0
35-39	29	72.5	17.2	10.3	0.0
40-49	33	42.5	42.4	12.1	3.0



## 5.2 SOCIO-CULTURAL CHARACTERISTICS

The socio-cultural characteristics studied included ethnicity and traditional practices on family planning and child bearing.

### 5.2.1 Ethnicity

Tribes encountered in the study area were as shown in Table 10. The Zigua and the Kwere were the majority making a proportion of 47.5%. The Doe, Zaramo, Masai and Matumbi made up about 37%. A proportion of about 15% was made up of the other tribes with 1 or 2 respondents.

**Table 10. Distribution of the Respondents by Tribes**

N = 240

Tribe	n	%	
Zigua	67	27.9	} 47.5
Kwere	47	19.6	
Doe	31	12.9	} 37.1
Zaramo	29	12.1	
Masai	22	9.2	
Matumbi	7	2.9	
Others	37	15.4	
total	240	100.0	

### 5.2.2 Socio-cultural practices

The culture of the different tribes in the studied community seems to accept pregnancies at early ages as can be seen in Table 11. In all the tribes the proportion of women who had their first pregnancy at <15-16 years was high.

**Table 11. Distribution of Respondents by Tribe and Age at First Pregnancy.**

Age	Tribes					
	Zigua n=67	Kwere n=47	Doe n=31	Zaramo n=29	Masai n=22	Matumbi n=7
	%	%	%	%	%	%
<15-16	43.3	35.5	50.0	35.7	61.9	57.1
17-18	32.8	31.1	25.0	28.6	19.0	14.4
19-20	14.9	26.7	21.4	14.7	14.3	14.3
21+	9.0	6.7	14.3	10.3	4.9	14.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

### 5.2.3 Traditional education and child spacing

Traditional instructions for motherhood and child rearing start early at adolescence that is at the onset of the first menstrual cycle. This was reported by 92.5% of the respondents who gave the elderly as the source of traditional FP methods. In reference to "unyago" defined in page xiv, as well as the health authority of the nation recommend a child spacing of 2 years.

Results in Table 12 show that slightly more than half of the mothers (about 53%) space their births for more than two years. In this study about 8.9% of the mothers spaced their births for less than a year.

**Table 12. Distribution of Subjects by Child Spacing Intervals (in years)**

N = 210

Birth spacing (years)	Subjects		
	n	%	%
>3	40	19.1	52.8
>2-3	71	33.7	
1-2	80	38.3	
< 1	19	8.9	
Total	210	100.0	

#### 5.2.4 Traditional family planning methods

##### familiar to the respondents

The withdrawal method was the most commonly recalled traditional family planning method (Table 13). Other methods recalled are also shown in the table. It is interesting to note that women mentioned breastfeeding as a method for family planning. In general, total recall on traditional methods was high (above 75%).

**Table 13. Distribution of Respondents by Type of Recall on Traditional FP methods**

N =240

TFPM	Type of Recall		Total
	Spontaneous	Probed	
	%	%	%
Calendar	12.5	63.7	76.2
Abstinence	36.7	53.7	90.4
Breastfeeding	15.8	67.1	82.9
Traditional herb	60.4	27.1	87.5
Observing virginity	23.7	55.0	78.7
Coitus interruptus	22.9	75.0	<b>97.9</b>
Polygyny	3.3	80.8	84.1

### 5.2.5 Traditional family planning practice

About three-quarters (75.1%) of the respondents reported that the major reason for traditional family planning practice was to facilitate child spacing. Other reasons were to delay first pregnancy and to terminate child bearing as reported by 19.1% and 2.4% respectively.

Results in Table 14 show that traditional family planning is achieved mainly by practice of abstinence and withdrawal which were reported by about 45%, and 32% respectively. Breastfeeding polygyny and herbal medicine were practised but to a less extent. The safe period method was not practised at all.

It was reported by 98.9% of the women that practice of abstinence and the withdrawal demands a very high degree of self control and discipline particularly on the part of men. Disharmony between couples caused by stress of over abstaining was reported by 37% of those who ever practised the method.

**Table 14. Traditional Family Planning Methods Practised at the Time of survey.**

**N = 146**

Traditional FP methods	Subjects	
	n	%
Safe period	0	0
Sexual abstinence	65	44.5
Prolonged breastfeeding	25	17.1
Herbal medicine	1	0.7
Withdrawal	46	31.5
Polygyny	9	6.2
Total	146	100.0

#### **5.2.6 Non-practice of traditional FP methods**

At the time of survey 39.2% of the 240 women interviewed were not practising traditional FP. Reasons given for the non-practice were desire to have another pregnancy and using modern methods as reported by 56.4% and 23.4% respectively. Use of herbal medicine was abandoned by all those who ever used it because it has become a commercial commodity sold by persons other than the traditional herbalists. Some young respondents (41%) said that the herbs never work because they have no contraceptive effect.

### **5.3 SOCIO-ECONOMIC CHARACTERISTICS**

The socio-economic characteristics which were studied included the respondents' and their husbands occupations, incomes and expenditures.

#### **5.3.1 Husbands' occupations**

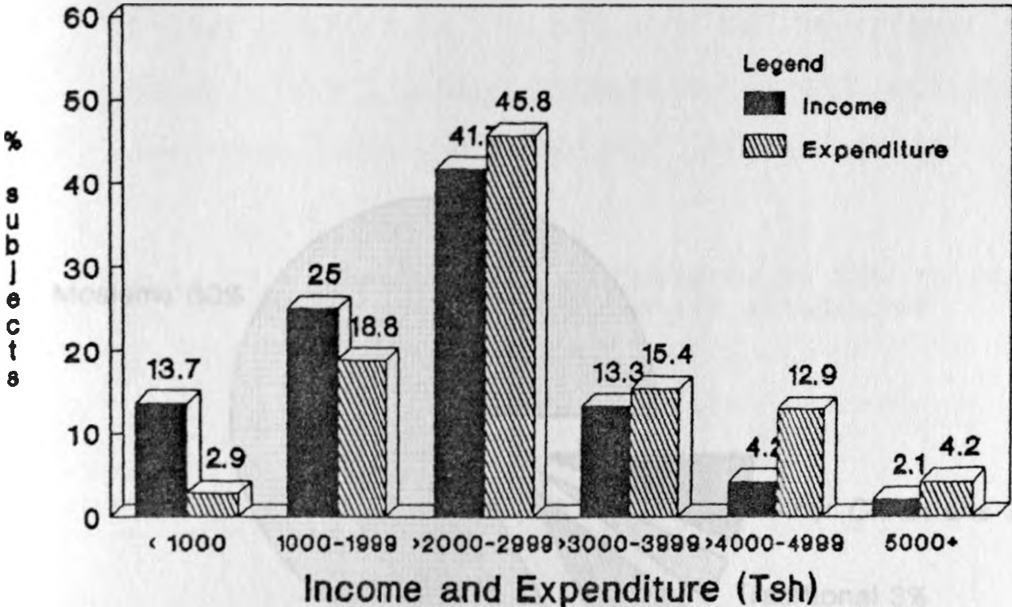
Information on occupation of most husbands was reported by the wives. Slightly more than half (57.3%) of the interviewed husbands were subsistence farmers, 11.2% were pastoralists and the rest were either fisher men, (8.4%) business men (6.4%) or employed in the government 10.1% or private sectors 6.2%.

#### **5.3.2 Respondents' occupations, incomes and expenditures**

The information obtained on the respondents' incomes and expenditures represented those of the respective households. The major occupation of the respondents was subsistence farming reported by 90.4%. About 8% kept animals, a few operated small businesses or were purely housewives. The modal incomes and expenditures were Tsh 2,000 - 2,999/= per month. Figure 4 shows that households (HH) below the modal figures were about 39% and 22% for

income and expenditure respectively. Those above the mode were 19.6% for income and 32.5% for expenditure.

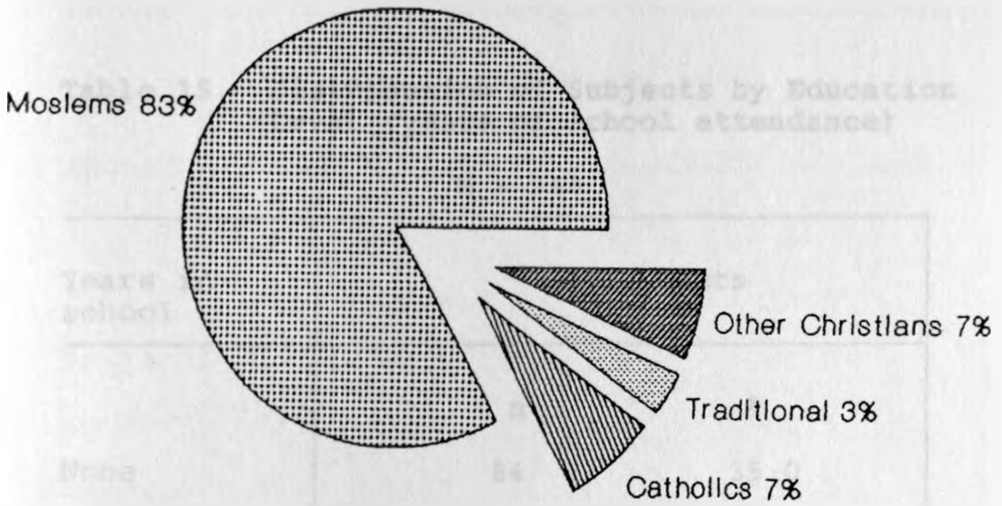
Figure 4. Distribution of Respondents by Monthly Income and Expenditure. N = 240



5.4 RELIGION

Figure 5 shows that Islam was the major religion in the studied community. A minority of the respondents (17%) were either Christians or non-believers.

Figure 5. Distribution of Respondents by Religion



## 5.5 EDUCATION

### 5.5.1 Formal education

Results in Table 15 show that the observed general education level was low among the women. School attendance above the primary level was almost negligible, (below 1%). The total primary school attendance was two thirds while a proportion of over a third of the subjects had never been to school. The school attendance of 65% was much lower than the normal national average of 85%

**Table 15. Distribution of Subjects by Education Level (years of school attendance)**

N = 240

Years in school	Respondents	
	n	%
None	84	35.0
1-4	27	11.3
5-8	127	52.9
9+	2	0.8
Total	240	100.0

### 5.5.2 Education level and age

Education level by number of years in school is depicted in Table 16. It is noted that the younger population had completed more years in school than the older age group. For example those aged 15-19 years (63.6%) had attained 5-8 years of schooling whereas only 12.5% of those aged 44-49 years had completed a similar level.

**Table 16. Distribution of Respondents by Education Level and Age**  
N = 240

Age	Total	Education level		
		None	1-4	5-8+
	n	%	%	%
15-19	23	36.4	0.0	<b>63.6</b>
20-24	54	16.7	1.8	81.5
25-29	62	22.2	12.7	63.5
30-34	30	33.3	6.7	60.0
35-39	38	56.8	18.9	24.3
40-44	17	66.7	27.8	5.5
45-49	16	62.5	25.0	12.5
Total	240			

### 5.5.3 Education level and age at first pregnancy

Results in Table 17 show that more than half (58.3) of those who had no education got pregnant at an early age (<15 years). Those with education e.g 5-8 years delayed their first pregnancy to later ages as shown by more than two thirds who had their first pregnancy after age 15- 20 years. At age 21 years and above, the level of education was no longer important for first pregnancy since there was already a pregnancy even for those who had been to school for 9 years and above.

**Table 17. Distribution of Respondents by Education and Age at First Pregnancy**

Age at first pregnancy	Education level				Total
	None	1-4	5-8	9+	
	%	%	%	%	%
<15	58.3	16.5	25.2	0.0	100.0
15-16	9.2	25.4	<b>65.4</b>	0.0	100.0
17-18	19.2	10.8	<b>70.0</b>	0.0	100.0
19-20	30.3	4.3	<b>65.4</b>	0.0	100.0
21-22	45.4	10.4	39.0	5.2	100.0
23+	46.0	21.6	26.8	5.2	100.0

#### **5.5.4 Education level and total pregnancies**

About 18% (42) of all the 233 mothers had 7 or more pregnancies. The proportion being 10.4% who had never been to school, 4.2% who had attended school for 1-4 years and 3.4% who had been to school for 5-8 years. Statistical testing indicated that the level of education significantly affects the total number of pregnancies a mother has ( $p < 0.05$ ).

#### **5.5.5 Adult education.**

Only two (2.3%) of the 85 women who had never been to school had attended adult education classes and they were able to read as shown by results when they were subjected to read the material in Annex 3.

### **5.6 PROBLEMS RELATED TO MODERN FAMILY PLANNING**

Problems related to modern family planning were studied in order to find out whether or not they influence modern contraceptive use. These included knowledge of methods ever or currently used and preference for future use. Methods which were of interest in this study included all the modern contraceptives that had been introduced in

the country by the time of survey. These are listed below.

Rank	Type of Method	Total
1.	Oral pills	62%
2.	Injectables	29%
3.	Intra-uterine devices (IUD).	24%
4.	Condoms	21%
5.	Tube ligation (TL)	10%
6.	Foaming tablets	8%
7.	Diaphragm	7%
8.	Vasectomy	5%

Table 18 shows that the most widely known modern method to the community was the oral pill followed by condoms, the loop and the injectables which were recalled spontaneously by about 62%, 29%, 24.% and 21% respectively. Spontaneous recall, was low for vasectomy, tubal ligation, foaming tablets and diaphragm. After probing the recall rates increased for tubal ligation, injectables and condoms. Except for the oral contraceptives, the knowledge of the modern methods was low.

**Table 18. Distribution of Respondents by Modern FP Recall and Knowledge**

MFPM	Type of recall			Knowl- edge
	spontan- neous	after probing	Total Recall	
	%	%	%	%
OC*	62.5	7.9	70.4	55.6
INJ*	20.8	42.1	62.9	12.4
IUCD*	24.2	32.9	57.1	8.7
CND*	29.2	41.7	73.3	17.4
TL*	6.3	48.8	50.0	3.4
FT*	7.1	33.8	40.9	6.5
DPG*	8.3	35.4	43.7	7.6
VST*	5.0	39.2	44.2	0.0

Notation: \* OC ----- Oral contraceptives  
 INJ ----- Injectables  
 IUCD ----- Intra uterine  
 contraceptive  
 device  
 CND ----- Condoms  
 TL ----- Tube Ligation  
 FT ----- Foaming tablets  
 DPG ----- Diaphragm  
 VST ----- Vasectomy

### 5.6.1 Ever used and discontinued modern FP

#### Methods

About 22% (52) of the studied women had used modern FP methods before this survey. There were only three types of methods that were ever used and these were, "the pills", condoms and loops at rates of 75.0% (39), 23.1% (12) and 1.9% (1) respectively. There was a 100% drop out rate for each of the ever practised methods.

The single Lippes loop user needed a child and so had the loop removed. Reasons given for abandoning "the pill" use was non-reliability as reported by about 51% of those who used and became pregnant. The second reason was need for a child which was reported by 17.9%. Side effects such as over bleeding, irregular menses and painful menses were given as a reasons by (15.4%) of the respondents, while (12.8%) reported that they wanted another pregnancy to replace their lost offspring(s). A small proportion of only (5.1%) discontinued the use because they were breastfeeding.

### **5.6.2 Reasons for not having ever used MFPM**

About 69% of the respondents had not used any of the modern FP methods before the survey. Asked why they had not done so, about two thirds (63.8%) said they had not understood the methods. A proportion of about 52% feared health hazards and side effects while about 20% feared their husbands' or partners. A proportion of about 18% said that they had no reason for use while a small proportion of 5.4% said that they had not yet decided on the use.

### **5.6.3. Current use of modern contraceptives in Bagamoyo district**

Modern family planning was studied with the objective of determining the prevalence of modern contraceptive use in the community. The current prevalence is 9.2% as shown in Table 19. Most of the current users 7.5% were on "the pill". The least in use were the injectables, condoms and tube ligation which were used by 0.8%, 0.4% and 0.4% respectively.

About 91% users obtained the contraceptives from the MCH clinics and the rest from the village health workers.

**Table 19. Distribution of Subjects by Current Use of Modern FP methods**

n = 22

Modern FP methods	Subjects	
	n	%
Oral pills	18	7.5
Injectables	2	0.8
Condoms	1	0.4
Tube Ligation	1	0.4
Non-users	218	90.8
Total	240	100.0

#### **5.6.4 Reasons for the current non-use of MFPM**

Major reasons given for the non-use included fear that side effects of the contraceptives would threaten fertility of the mother and/or life of the child as reported by 84.8% of the respondents. Other reasons were lack of understanding and breastfeeding as reported by 68.8% and 38.9% of the respondents respectively. Practically all the users reported that they understood the schedule or regimen of use and have no problems except for three (11.1%) who had irregular menses and were suspected to be pregnant. These were advised to report to their respective health centres for further advice.

### 5.6.5 Characteristics of modern FP users

Results in Table 20. show that at the time of survey:

- Modern family planning was mostly practised by women at 20-34 and 35-49 years of age.
- Those aged 15-19 years did not practice. Married women were the main users of modern family planning methods.
- Half of the subjects who were on current modern FP practice had 3-6 pregnancies and about a third of them had more than 6 pregnancies. A smaller proportion of subjects on contraceptive use had 1-2 pregnancies. None of the subjects who had no pregnancy was practising modern family planning.
- About 50% of those who were on MFPM had not experienced offspring mortality.
- There was no contraceptive use among women who had no living children. The prevalence among women with 1-2 and 3-4 children was slightly lower than among those with more than 4 living children.
- About three quarters of the subjects who were on modern contraception had both male

and female children while a few of those who had either boys or girls only were not using any of contraceptives.

- The MFPM prevalence was very high among the Moslem subjects and very low among the non-moslems.

- About three quarters of the modern contraceptive users had attended school.

**Table 20. Characteristics of the Current Modern Family Planning Users**

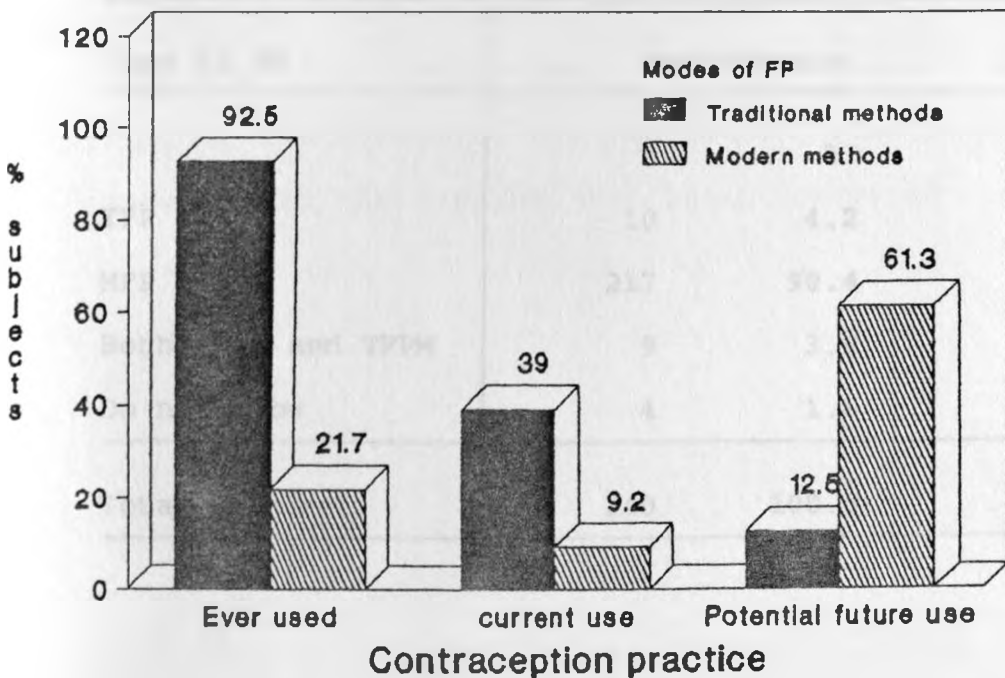
n = 22

Characteristics	Modern FP methods users	
	n	%
<b>Age</b>		
15-19	0	0.0
20-34	12	54.5
35-49	10	45.5
<b>Marital Status</b>		
Married	15	68.9
Not married	7	31.1
<b>Total pregnancies</b>		
None	0	0.0
1-2	4	18.2
3-6	11	50.0
7+	7	31.8
<b>Offspring mortalities</b>		
None	11	50.0
1-2	8	36.4
3+	3	13.7
<b>Number of living children</b>		
None	0	0.0
1-2	7	31.8
3-4	7	31.8
5+	8	36.4
<b>Gender of Living children</b>		
Girl(s) only	3	13.6
Boy(s) only	3	13.6
Both sexes	16	72.8
<b>Religion</b>		
Moslems	20	90.9
Others	2	9.1
<b>Education</b>		
Educated	6	27.3
Not educated	16	72.7

### 5.6.6 Family planning situation in Bagamoyo District

At the time of survey, both traditional and modern family planning methods were being practiced as shown in Figure 6. Results show that the past and present use of traditional methods was higher (about 93% and 39% respectively) than the past and present use of modern methods which was 21.7% and 9.2% respectively. However, preference for future use of modern methods was higher (about 61%) than for the traditional methods (about 12.5%).

Figure 6. Current FP Situation in the District



### 5.6.7. Preference for family planning methods.

Over 90% of the respondents preferred modern FP methods (Table 21). However, 79.7% stressed that one should have at least 2-3 living children before they can attempt to use "the pill", the injectables or the IUCD. They nevertheless expressed fear that the pills, injectables and TL could harm both the mother and the offspring.

A small proportion preferred traditional family planning. Similarly only a few preferred both methods.

**Table 21. Distribution of Subjects by Preference for Type of Family Planning.**

**N = 240**

Type of FP	Respondents	
	n	%
TFP	10	4.2
MFP	217	90.4
Both MFPM and TFPM	9	3.8
Do not know	4	1.6
Total	240	100.0

#### 5.6.8 Preference for future use of specific MFP methods.

Overall preference for future use of specific modern methods dropped dramatically when the respondents were asked to mention the specific methods they preferred to use in the future. The decline was from 217 (90.4%) subjects who generally preferred MFPM to 147 (61.3%) who opted to use specific MFPM in the near future

Results presented in Figure 7 show that the pill was the most preferred modern contraceptive. Slightly less than half preferred to use oral pills while about a third preferred injectable contraceptives and quite a number were for the loops and tubal ligation. Foaming tablets, diaphragms and vasectomy, were not opted for despite the additional information afforded by the researcher. The condoms were least preferred.

**Figure 7. Preference for specific Modern Contraceptives**

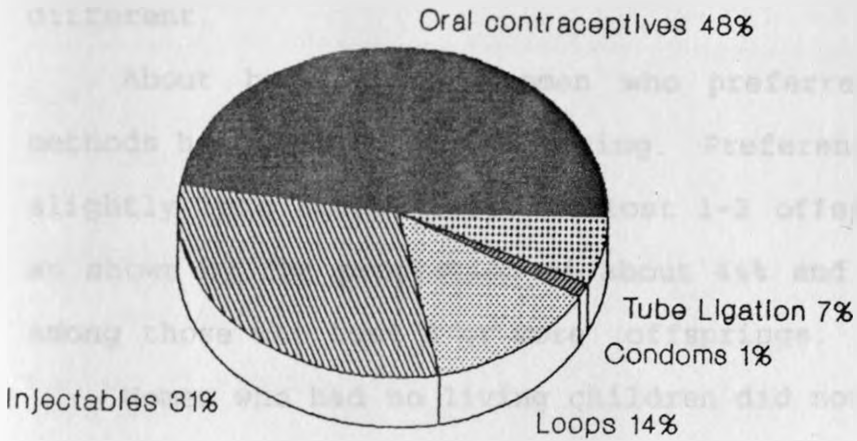


Table 22 shows the characteristics of the subjects who preferred to use MFPM in the near future.

Preference for use of MFPM in the future was highest among women aged 20-34 years where the proportion was about 2 thirds and lowest among those aged 15-19 years, this was about one eighth. About a quarter of the women aged 35-49 years preferred the use.

About three quarters of the women who preferred to use modern methods were married while

about a quarter were single.

The proportions of those who had 3-4, 5-6 and 7 or more pregnancies were practically not different.

About half of the women who preferred the methods had not lost any offspring. Preference was slightly less among those who lost 1-2 offsprings as shown by the proportion of about 44% and least among those who lost 3 or more offsprings.

Women who had no living children did not wish to use modern methods. Preference for the method among women with at least a child was about one third.

Preference for the methods was higher among women with children of both sexes (as shown by more than half) than among those with children of one sex only.

More than three quarters of those who preferred modern methods were Moslems while a few were from other religions.

Over two thirds of the women who preferred to use the methods had attended school and slightly less than a third had not attended school.

**Table 22. Characteristics of Women Who Prefer to Use Modern Family Planning Methods:**

**n = 147**

Characteristics	Subjects	
	n	%
<b>Age</b>		
15-19	18	12.2
20-34	92	62.7
35-49	37	25.2
<b>Marital status</b>		
Married	112	76.2
Not married	35	23.8
<b>Number of pregnancies</b>		
None	0	0.0
1-2	59	40.1
3-4	28	19.3
5-6	32	21.7
7+	28	19.3
<b>Offspring mortalities</b>		
None	71	50.4
1-2	62	40.0
3+	14	9.6
<b>Number of living children</b>		
None	0	0.0
1-2	47	32.0
3-4	49	33.3
5+	51	34.7
<b>Gender of living children</b>		
No girls	30	20.4
No boys	32	21.8
Both sexes present	85	57.8
<b>Religion</b>		
Moslems	139	94.6
Others	8	5.4
<b>Education</b>		
Did not attend school	44	29.9
Attended school	103	70.1

### 5.6.9 Reasons for preference of specific MFPM.

When the respondents were asked why they preferred the particular methods they gave different answers (Table 23). Slightly over a half (about 54%) gave ease of use as the most important reason for adopting the method. The next important reason for the use was long action followed by familiarity and keeping the use secret (hidden from children and/or husband) reported by few respondents. Other reasons which included prevention of sexually transmitted diseases, terminating child bearing and fear of pills were given by a minority of the respondents.

1. - Easy to use
2. - Long action
3. - Keeping secret (not hidden) not  
all used
4. - Familiarity
5. - Mean to terminate child bearing
6. - Fear of pills
7. - To prevent sexually transmitted  
diseases

**Table 23. Distribution of Respondents by Reasons for Choice of Specific MPPM**

N = 190

Methods	Reasons for preference *						
	1	2	3	4	5	6	7
	%	%	%	%	%	%	%
OC	36.8	9.5	-	-	-	-	-
INJ	15.8	2.6	8.4	5.3	-	-	4.2
LP	-	-	-	7.9	-	4.7	3.7
CND	1.1	-	-	-	-	-	-
TL	-	-	-	-	5.3	-	-
Total	53.7	12.1	8.4	13.2	5.3	4.7	7.9

**Notations for reasons:**

1. - Easy to use
2. - Used to it (Familiarity)
3. - Keeping secret from husband and children
4. - Long acting
5. - Wish to terminate child bearing
6. - Fear of pills
7. - To prevent sexually transmitted diseases.

## 5.7 COMPARATIVE RESULTS

After a descriptive presentation of the various parameters influencing acceptance of modern contraception, Analysis by Chi-square was performed on selected characteristics thought important in modern family planning endeavors. Results are shown in Tables 24, 25 and 26.

### 5.7.1 Demographic Variables

Significant relationships were noted between demographic variables; age, marital status, total pregnancies, offspring life losses, living children, and modern family planning practice as shown in Tables 24.

The present modern contraceptive use was significantly higher among women who were married, had many pregnancies, had lost fewer offsprings or had at least a son than among those who were single, had few pregnancies, lost many offsprings or had girls only, ( $p < 0.05$ ). Preference for specific modern family planning methods was also significantly higher among the younger respondents than among the older ones ( $P < 0.01$ ). Likewise, preference for the pill among the respondents with fewer pregnancies (1-4) was significantly higher

than among those with very high numbers of pregnancies (9+) who preferred tubal ligation ( $P < 0.001$ ). It was also shown that significantly more women who had lost fewer offsprings preferred to use the modern methods than those who lost many offsprings ( $p < 0.01$ ).

Table 24. Relationship Between Demographic Variables and Selected Dependent Variables

Demographic variables	Dependent variables	p. values
Age	- Education level	$0.081 \times 10^{-6}$ ****
	- Present FP practice	0.4689
	- Preferred specific MFPM	$2.248 \times 10^{-7}$ ****
Marital status	- Present modern FP practice	0.0401
	- Preferred specific MFPM	0.7896
Offspring mortalities	- Present FP practice	$2.218 \times 10^{-3}$ ***
Total Pregnancies	- Present FP practice	0.0302**
	- Preferred specific MFPM	$2.332 \times 10^{-5}$ ****
Living children	- Present FP practice	0.4201
	- Preferred specific MFPM	0.0125 **

Notations for p-values

\*\* ---- significant

\*\*\* ---- highly significant

\*\*\*\* --- very highly significant

### 5.7.2 Socio-cultural and socio-economic variables

The differences in breastfeeding period, preferred number of children and education level among the different tribes was statistically significant ( $p < 0.01$ ) as presented in Table 25.

Preference for shorter breastfeeding periods of less than two years was significantly higher among the Zaramo than among other tribes ( $p < 0.025$ ). Likewise preference for number of surviving children was different among the tribes. It was statistically significant that the Masai preferred to have more living children (7 and above) than other tribes who preferred to have 4-5 children ( $0.01 < p < 0.025$ ).

Education level also differed significantly among the different tribes. The Masai were the least educated compared to other tribes ( $p < 0.001$ ).

There was no statistical significant difference between socioeconomic variables and the selected dependent variables (Table 25).

**Table 25. Relationships Between Cultural and Economic Variables and Selected Dependent Variables**

Cultural variables	Dependent variables	p-values
Tribes	- Education level	7.648x10 <sup>-6****</sup>
	- Age at first pregnancy	0.6310
	- Preferred age at first pregnancy	0.9836
	- Total pregnancies	0.3370
	- Breastfeeding period	1.974x10 <sup>-3***</sup>
	- Number of living children	6.479x10 <sup>-3***</sup>
	- Preferred number of living children	1.920x10 <sup>-3***</sup>
	- Preferred sex of children	0.1365
	- Present family planning practice	0.3873
Socio-economic variables	Dependent variables	p-values
Income	- Age at first pregnancy	0.7627
	- Offspring mortalities	0.3253
	- Preferred number of children	0.5230
	- Present family planning practice	0.2395
	- Preference for specific MFPM	0.2995

Notations for p-values:

\*\*\* ----- Highly significant

\*\*\*\* ---- Very highly significant

### 5.7.3. Formal education

Table 26 shows the statistical relationship between the education level of the respondents and selected dependent variables.

Preferred breastfeeding period and age at first pregnancy was significantly higher among women who had attended school than among those who had not ( $p < 0.01$ ). It was also observed that high present practice and preference for future use of modern contraceptives was significantly higher among women who had attended school than among those who had not ( $p < 0.05$ ). There was also a statistical significant difference between the education level of the respondents and offspring mortality events ( $p < 0.03$ ).

There was a statistically significant difference between education and preference for breastfeeding period among the women. Women with education preferred to breastfeed for longer periods (2+ years) than those with no education who preferred to breastfeed for shorter periods (1-2 years) ( $p < 0.001$ ). There was also a statistically significant difference between education of the women and age at first pregnancy preference. Women with education preferred older ages at first

pregnancy (17 years and above) while non-educated women preferred younger ages at first pregnancy (17 years) ( $p < 0.001$ ).

**Table 26. Relationship Between Education Level and Selected Dependent Variables**

Level of education	Dependent variables	p-values
	- Age at first pregnancy	0.0997
	- Total pregnancies	0.2578
	- Preferred breastfeeding period	$2.86 \times 10^{-3}$ ***
	- Preferred age at first pregnancy	$1.044 \times 10^{-3}$ ***
	- Offspring mortalities	0.5937
	- Number of living children	$7.340 \times 10^{-7}$ *****
	- Present MFPM practice	0.0799

Notations for p-values:

\*\*\* ----- Highly significant  
 \*\*\*\*\* ----- very highly significant

## CHAPTER SIX

### 6.0 DISCUSSION

Results from this study have shown a low prevalence of modern contraceptive use (9.2%). This supports observations of other researchers (Caldwell 1975, World Population Report 1985, Parker and Segal 1986). The findings also confirm those of earlier reports by Carrasco (1981), Nortman (1982) and others referenced in respective sections that a diversity of factors directly or indirectly influence modern contraception practice.

#### 6.1. SOCIO-DEMOGRAPHY AND MODERN CONTRACEPTION.

##### 6.1.1 Age

In the present study age has been found to affect modern family planning practice as also reported by Muia (1985) and Trussel (1986). The distribution of the prevalence of modern contraceptive use by age is comparable to that observed by the World Fertility Survey (1982) and Nyange (1990). However, the factors leading to this distribution were much different. While in Bagamoyo the reasons for the differential

contraceptive use among age groups were related to contraceptive aspects, Carrasco (1981) and Nortman (1982) gave low fecundity among the young and old ages and high fecundity among the middle ages as a reason for the differential contraception practice.

### **6.1.2 Marital status**

The high prevalence observed for present and future contraceptive use among the married women than among the non-married is not unique in Bagamoyo. Bongaarts (1978), Joesoef (1988), Khalifa (1988), The National Demographic Survey Report of Kenya (1989) and Moreno and Goldman (1991) made the same observations. According to them the main reasons for more use among the married women were husband support or male domination for decision to use or not use modern contraceptives. This study, however, was not able to identify the type of husband support or disapproval of use, as this was beyond the scope of this work.

### 6.1.3 Child bearing period and parity

A number of factors and child bearing practices affect the length of child bearing period. Trussel (1986) observed that the mother's health and child survival are the most important factors influencing child spacing. The factors were also observed in Bagamoyo and these included early onset and lengthy child bearing periods, desired breastfeeding and child spacing intervals. These factors have a bearing on the length of child bearing period given that a certain number is desired. For this study, child bearing period was increased by early pregnancies and late births.

Tendency to bear as many children as possible observed in the present study, may be explained by a number of reasons. These include provision of labour for household tasks and agricultural/-pastoral work and offsetting of the effect of offspring mortality as also shown by Bertrand (1989), and Oyemade and Ogunmuyiwa (1989). Apart from these reasons, couples and individuals have in mind a desired number of children and balancing of the sexes. In the present study the number was 4-5 children. The desire to have a given number of children has also been made by Jejeebhoy (1984)

#### **6.1.4 Child spacing**

In Bagamoyo, breastfeeding and pregnancy intervals of at least two years are desired so as to enhance the health of both mother and child. However, intervals shorter than two years that occurred were most likely intended to replace the lost offsprings. Short intervals of child spacing were also reported in Nigeria by Oyamade and Ogunmuyiwa (1981) where women with widely spaced children were ridiculed because they could end up with few children. The community in Bagamoyo feared that modern contraceptives threaten fertility and for this reason they were discouraged while abstinence from sex was strictly observed.

#### **6.1.5 Sex preference**

In rural communities both sexes are required to fulfil different roles as the division of labour is strict. Most of the respondents in the present study expressed this view. Each of the sexes had an important role in land cultivation or livestock keeping. The implication then is that child bearing would continue in an attempt to have both sexes of the children. In this study the present practice of modern contraception and preference for future use of specific modern contraceptives was

lower among women who did not have either a son or a daughter and higher practice among those with both sexes of living children. These results expressed need for a sex that a couple did not have and support those by Elrich and Elrich (1970) and Oyeka (1989), who reported that modern contraceptives were less likely to be used by women with no sons nor daughters in attempt to have a child of a sex they did not have. These results however, differ from those by Bulatao and Fawcett (1983) and Muna (1990) who reported stronger need for sons than daughters and non-use of MFPM in attempt to get a son. Although mothers stressed the need to have at least 2 or 3 children before embarking on modern contraception, preferred sex composition noted by Karki (1988) was not detected in this study.

#### **6.1.6 Offspring mortalities**

Ideally, there should not be high infant mortality when health and family planning services are adequate. However, in many societies offspring mortalities reportedly have effect on contraceptive use. In the Bagamoyo community infant mortalities were observed at all ages and increased with age of

mothers. This possibly was one of the major causes of low practice and preference for modern contraception practice.

The report by Bertrand (1989) that high parity in the developing countries offsets offspring life losses has been supported by the findings of this study. Spacing intervals were shorter where miscarriage or death of a child occurred at any period before and during breastfeeding. In this case Conception was immediate in attempt to replace the dead offsprings.

The observed low prevalence and preference for future use of modern methods (13.7% and 9.6% respectively) for mothers who had lost more offsprings (3+) compared to those who had lost 1 or 2 offsprings shown by the present study suggests resistance to practice and adoption of MFPM with high mortalities. These findings are supported by those of Casteline (1989).

It is clear that demographic factors which either prevent/limit offspring life losses or encourage/ensure child survival favour traditional family planning methods. Modern family planning methods which are perceived, suspected or believed to threaten life of a child are strongly discredited and avoided. This is noted in the

current study where 84.8% of the respondents gave threat to fertility and health by modern contraceptives as a reason for the current non-practice of modern contraception.

## 6.2. SOCIAL-CULTURE AND MODERN CONTRACEPTION

Demographic factors discussed above and their effect on modern contraception do to a great extent reinforce socio-cultural practices. The observation that breast-feeding is not adequate for family planning is not confined to this study and neither are the supplementary methods of abstinence and withdrawal (coitus interruptus). Bongaarts (1978), Jain et al (1981) and Eslami (1990) made the same observations.

Important to be noted in this study is that traditional family planning methods were practised in order to aid child spacing rather than to delay first pregnancies. A similar observation has been made by Walle and Walle (1988). With this in mind, low contraceptive use may be explained by the fact that the community does not appreciate the need for modern contraception at earlier and older ages. Since in the earlier ages they still need to achieve the desired family size and in the later

ages fecundity is low.

Higher use of traditional family planning methods than the modern methods reported by Ntonzi and Kabera (1988) has been revealed in this study. This was possible because the traditional methods besides being widely and well known are also considered safe to the health of both mother and child. On the contrary the modern methods are less known and feared to threaten health and life.

Polygynous marriages in the community have contributed not only to low modern contraception practice but also may discourage husband support since it is accepted that sexual abstinence is for women and not for men as also reported by Walle and Walle (1988).

### 6.3. SOCIO-ECONOMY AND MODERN CONTRACEPTION

The economic activities in Bagamoyo are subsistence farming, cattle rearing in the case of the Masai and fishing along the coastal areas. Most of the women (90%) were subsistence farmers. The subsistence economy requires human labour which over time has lead to dependency on family labour for the activities. With this dependency, pronatalism has become inevitable and part of the

culture of the society. The culture is not likely to change unless better and technological economy replaces it. Increased modern contraceptive use with improvement in economic status has been observed (Baulier 1984, World Fertility Survey Report 984). On the other hand, Gubhaju (1984) and Mbugua (1986) found that women were more likely to continue to depend on children for farm and domestic work if technology did not increase their incomes, an observation which may explain the persistent resistance to modern family planning practice.

#### **6.4. RELIGION AND MODERN CONTRACEPTION**

In this study both the Moslem and Christian groups practiced modern contraception. The observation agrees with that made in the National Demographic Survey (1989) in Kenya and those by Ferguson (1990) which showed that religion did not affect contraception practice.

In this same study, the high prevalence of contraceptive use among the Moslems (95%) confirm findings of Moreno and Goldman (1990) who observed that contrary to what is commonly believed, Islam is not of necessity against modern contraceptives.

## 6.5 EDUCATION AND MODERN CONTRACEPTION

Traditional type of education was common in the past and in some places still is in African societies. It is expected to be particularly common among rural communities and pastoralist nomads as was observed in this present study where among the indigenous people the proportion getting traditional education was high. Close adherence to "unyago" was evidence given that a higher proportion about (40%) practised traditional family planning than those practising modern family planning which was 9.2%. Great adherence to practice of traditional family planning compared to the modern methods has also been reported in Uganda by Ntonzi and Kabera, (1989). The "unyago" greatly prepares adolescents for motherhood by inculcating in them the expected sexual behaviour although in the case of child spacing the expected intervals are not achieved due to high offspring mortalities which require immediate replacement.

Formal education is reported to influence age at first pregnancy and by extension contraception practices. However, since in Bagamoyo education level is practically up to 8 years only, the effect was not very obvious. Nonetheless a higher

proportion of those who had schooled for up to 8 years preferred to adopt modern contraceptive use.

## **6.6. PROBLEMS RELATED TO MODERN FAMILY PLANNING AND MODERN CONTRACEPTION PRACTICE**

### **6.6.1 Family Planning Programmes**

GTZ had from its inception introduced most of the contraceptives found in most FPP elsewhere and for easier outreach government support has integrated family planning with MCH services. It was also highly strategic that FP services were community based.

Surprising, however, contraceptive use was very low (9.2%). The knowledge of the methods was also low. The observed drop of number of surviving children from 4.3 to 3.3 was contributed by mortalities and practically not by contraceptive use meaning that in Bagamoyo modern contraception practice may not be a priority for the community. A number of findings explain the set back of the programme efforts.

Although the FPP in the studied community had set strategies to attract clients, findings show that the basic needs of the community were overlooked and as a result unmet. This may have

contributed to the unchanged attitude and low acceptance of the contraceptives.

Obvious also in the community was the low knowledge of modern contraceptives. In addition, the seminars conducted and intended to educate the population on issues related to modern family planning did not reach the target population at grassroot level. This was shown by the small number of respondents who ever attended the seminars from the programme. The selected representatives also did not take the acquired knowledge to those whom they represented.

It is highly likely that the MCH personnel are overworked and would be least motivated to have additional work with no additional pay. Under this set up, there are follow up problems.

Numerous other problems which may contribute to the low acceptance/practice were observed by the researcher. The village health workers for example were not motivated. They did not have transport and they claimed that they could not reach the clients easily especially considering that the villages cover a large area. One needed at least a bicycle to have a wide coverage. The VHW also indicated that they were not paid by their respective villages as was the agreement. To the

community modern contraception is in no way a priority.

Further, the researcher observed that some of the VHW were too young to deal with sensitive child bearing issues among the elderly. There could be a high possibility that they shied away from playing their role.

#### **6.6.2 Attitudes towards modern contraceptives and their side effects**

In the present study little knowledge and the fear for the modern contraceptives were remarkably high. This may also help to explain the low acceptance of the modern contraceptives. It is highly possible that the reported accidental pregnancies and side effects while on contraceptives were caused by mismanagement during practice. These in turn may have created distrust of the contraceptives resulting in high defaulting and low acceptance. Side effects from ICUD and pills have been reported by Stephen and Chamratrithirong (1988). Lianda (1989) also reported that errors in use (sometimes purposive) of the contraceptives contributed to their ineffectiveness and side effects. This study, however, could neither discern the type of error

nor could it establish whether the errors were purposive or not.

Other reasons which may explain the low acceptance include the perceived danger of modern contraceptives on breast milk and the risk the milk may have on the breastfeeding children. Mothers feared to use modern contraceptives during breastfeeding as was also observed by Hull (1981) and WHO (1988). Naturally this is a sufficient cause for negative attitude and non acceptance of the modern methods.

Future use of the methods depended on better knowledge as was shown by mothers who stressed the need to understand these methods better before they could start using them. More interesting, however, was the basis of preference. Convenience of application was the criterion for choice. The pills and the injectables were considered convenient for use. The most inconvenient methods reported were the loops and tubal ligation. Loop application was described to involve too much and unnecessary exposure to the personnel. Tube ligation was feared because it involved anaesthesia and operations. These findings agree with those by Philliber and Philliber (1985) who found out that tubal ligation was feared for the same reasons.

Despite the many obstacles sited which disfavour modern contraception acceptance in Bagamoyo, there are high chances of succes of the programme given that after explanation and demonstration of the modern contraceptives there was a higher preference for future use than for the traditional methods.

## CHAPTER SEVEN

### 7.0 CONCLUSIONS AND RECOMMENDATIONS

#### 7.1 Conclusions:

Modern contraceptive prevalence of 9.2% in Bagamoyo district is still low even after two years of FPP. There are underlying, intermediate and immediate problems causing the low modern FP acceptance.

The underlying causes are mainly the effects of socio-economic and socio-cultural factors. The prevailing subsistence economy works against social development efforts. The low incomes make the use of improved agricultural techniques impossible. The community, therefore, continues to depend on family labour for all the agricultural activities and hence the need for many children. Modern contraceptive use is therefore, discouraged for fear of reduction of fertility.

About 40% of the study community accept pregnancy at early ages (<15-16 years) and the Masai's practice of polygyny remove the need for modern family planning. Introduction of sexual

education at adolescence ("unyago"), observance of virginity to marriage, the practice of sexual abstinence during BF period and prolonged breast-feeding, are traditional practices considered safe, not threatening fertility and are preferred to modern family planning contraceptives.

The low level of education is also a major intermediate factor which causes the low modern family planning acceptance in the area. The high non-school attendance (35%), the low formal education level and the negligible adult education hinder the acquiring of knowledge of modern family planning techniques and appreciation of benefits of contraception.

Offspring mortality is an immediate problem leading to low acceptance of MFPM. High offspring mortalities have encouraged strong adherence to the traditional FP practices.

## 7.2 RECOMMENDATIONS

1. Efforts should be made to increase the level of education of women.
2. Education packages should be modeled with the educational background of participants in mind so as to be understood.
3. Methods to improve the economic conditions of the community need to be identified and implemented.
4. Strategy to reduce infant mortality through improvement of health services and continued immunization and therefore increase child survival should be sought.
5. More family planning options e.g. natural family planning (NFP), which may be more suited to and easily accepted by groups of people with varied religious and cultural beliefs and practices and those who for medical reasons do not wish to use the modern methods should be supported, encouraged and incorporated in existing family planning programmes.

## REFERENCES

- Baulier, B. 1984.** "The Effect of Organized Family Planning on Fertility". A Cross Country Analysis: *World Bank Staff Working Paper*, Washington.
- Berelson, B. 1990.** "The Great Debate on Population Policy: An Instructive Entertainment". *International Family Planning Perspectives* 16, 4: 126-138.
- Betrand, J. T., Mathu, N. Dawyer, J., Thuo, M., Wambwa, G. 1989.** "Attitudes Towards Voluntary Surgical Contraception in Four Districts of Kenya". *Studies in Family Planning* 20, 5: 281-288.
- Bhatia, S. 1989.** "Patterns and Causes of Neonatal Mortality in Rural Bangladesh". *Studies in Family Planning* 20, 3: 136-146
- Bongaarts, J. 1978.** A Framework for Analyzing the Proximate Determinants of Fertility". *Population and Development Review* 4,1.
- Bongaarts, J., Maulidin, W. P., Philips J. F. 1990.** "The Demographic Impact of Family Planning Programmes". *Studies in Family Planning* 21, 6: 299-310.

- Bulatao, R., Fawcett, T. 1983.** "Influence on Child Bearing Intentions Across the Fertility Career: Demographic and Socio-economic Factors and the Value of Children". *Papers of The East-West Population Institute Honolulu.*
- C. D. C. 1987.** *Family Planning Methods and Practice: Africa Special Section; Family Health Benefits and Fertility: vii.*
- Caldwell, C. J. 1975.** "Fertility Control in Population Growth and Socio-Economic Change in West Africa". Columbia University New York.
- Caldwell, C. J., Caldwell P. 1988.** "Is the Asian Family Planning Model Suited in Africa"? *Studies in Family Planning* 19, 1: 19-286.
- Casteline J. B. 1989.** "Collecting Data on Pregnancy Loss: A Review of Evidence from the World Fertility Survey". *Studies in Family planning* 20, 2: 81-95.
- Carrasco, E. 1981.** "Contraceptive Practices". World Fertility Survey. *Comparative Studies* No. 9, London.
- Ehrlich, P., Ehrlich, H. 1970.** "Population Resources Environment". *Issues in Human Ecology.* Freeman and Company, San Francisco.

- Eslami, S. R., Ronald, H. G., Ruben, A., Rebecca, R.** 1990. "The Reliability of Menses to Indicate the Return of Ovulation of Breast-feeding Women in Manila, the Phillipines". *Studies in Family Planning* 21, 5: 242-250.
- Etto, S., Chamrarithirong, A.** 1988. "Contraceptive Side Effects Among Current Users in Thailand". *International Family Planning Perspectives* 14, 1: 9-14.
- Ferguson, A.** 1989. "Etono Fertility Survey. GTZ Family Planning Project; Ministry of Health, Kenya.
- 1990. "Nyamira Baseline Survey: Fertility, Maternal and Child health and Family Planning in Nyamira District, Kenya".
- Haile, A.** 1990. "Fertility Conditions in Gondar North-western Ethiopia: An Appraisal of Current Status". *Studies in Family Planning* 21, 2: 110-118.
- Gubhaju, B. B.** 1985. "The Effect of Previous Child Death on Infant and Child Mortality in Rural Nepal". *Studies in Family Planning* 16, 4: 84-89.

- Gulhati, R. 1983.** "Rapid Population Growth in Sub-Saharan Africa: Issues and Policies". *World Bank Staff Working Paper No. 559*, Washington.
- Heckel, N. J. 1986.** "Population Laws and Policies in Sub-Saharan Africa, 1975-1985". *Intrnational Family Planning Perspectives* 12, 4: 132
- Hull V. 1981.** The effect of Hormonal Contraceptives on Lactation: Current Findings, Methodological Considerations and Future Priorities". *Studies in Family Planning* 12, 4: 134-155
- Jain, A. K. 1989.** "Fertility Reduction and Quality of Family Planning Services". *Studies in Family Planning* 20, 2: 1-16.
- Jain, A. K., Bongaarts J. 1981.** "Breastfeeding Patterns, Correlates and Fertility Effects". *Studies in Family Planning* 12, 3: 79-99.
- Jejeebhoy, S., Sumati, K. 1989.** "Reproductive Motivation: A Comparison of Wives and Husbands in Mahrashra, India". *Studies in Family Planning* 20: S: 264-272.

- Jejeebhoy, S. J. 1984.** "The Shift from Natural to Controlled Fertility: A Cross-sectional Analysis of Ten Indian States". *Studies in Family Planning* 15, 4: 191-198.
- Joesoef, R. M., Bangman, L. A., Otomo, B. 1988.** "Husbands Approval of Contraceptives Use in Metropolitan Indonesia: Programme Implications". *Studies in Family Planning* 19, 3: 162-168.
- Karki, Y. B. 1988.** "Sex Preference and Value of Sons and Daughters in Nepal". *Studies in Family Planning* 19, 3: 169-178.
- Kenya. 1984.** "Demographic and Health Survey". National Council for Population Development, Ministry of Home Affairs and National Heritage, Nairobi.
- 1989.** "Demographic and Health Survey". National Council for Population Development, Ministry of Home Affairs and National Heritage, Nairobi.
- Khalifa, M. A. 1988.** "Attitudes of Urban Sudanese Men Towards Family Planning". *Studies in Family Planning* 19, 4: 236-243.

- Kitula, M. D. 1987.** "The Effects of Some Socio-demographic Factors on infant and Child Deaths". *M. A. Thesis, University of Dar-es-Salaam, Tanzania.*
- Lianda, P. S. 1988.** "Oral Contraceptive Compliance in Rural Colombia: Knowledge of Users and Providers". *International Family Planning Perspectives* 15, 1: 27-31.
- Mbugua, J. 1984.** "Family Planning Adoption in Kiambu District Hospital, Kenya". *B. A. Dissertation. University of Nairobi, Kenya.*
- Moreno, L., Goldman, N. 1991.** "Contraceptive Failure Rates in Developing Countries: Evidence From Demographic Health Survey". *International Family Planning Perspectives* 17, 2: 44-49.
- Muia, E. G. 1985.** "The Impact of Community Based Distribution of Contraceptives in Rural Kenya". *M. Sc. Thesis. University of Nairobi, Kenya.*
- Muna, D. S. R. M. 1987.** Factors Affecting Contraceptive Prevalence in Morogoro Urban District. *M. A. Thesis. University of Dar-es-Salaam, Tanzania.*

- Neuvians, D., Mtango, F. D. E. 1985.** "Reduction in Child Mortality from Pneumonia and Malaria in Rural Tanzania". *Trop. Med. Parasit.* 36:1-23
- Nortman, M. 1982.** "Fertility and Family Planning Survey". *An Update Series*". No. 1M-8: 298.
- Ntozi, J. P. M., Kabera, J. 1989.** "Family Planning in Rural Uganda: Knowledge and use of Modern and Traditional Methods in Ankole". *Studies in Family Planning* 22, 2: 116-123.
- Nyange, F. K. 1990.** "Some Demographic and Socio-economic Determinants of Contraceptive Use in Kilimanjaro Region of Tanzania". *M. A. Thesis.*
- Oniango, R., Rogo, K. 1985.** "Factors contributing to Use of Contraceptives by Women in their Fifth Subsequent Pregnancy". *Family Planning Acceptability in Kenya and Zambia, a Qualitative Perspective* 36-39.
- Oyamade, A., Taiwo. A. O. 1981.** "Socio-cultural Factors and Fertility in a Rural Nigerian Community". *Studies in Family Planning* 12, 3: 109-111

- Oyeka, I. C. A. 1989. "Influence of Number of Living Sons on Contraceptive Use Among Female Teachers in Nigeria". *Studies in Family Planning* 20, 3: 169-178.
- Parker, W., Segal, J. 1986. Prevalence of Contraceptive Use in Developing Countries. Rockefeller Foundation.
- Pebley, A. R., Millman, S. 1986. "Birth Spacing and Child Survival". *International Family Planning Perspectives* 12, 3: 71-79.
- Philliber, S. G., Philliber, W. W. 1985. Social and Psychological Perspectives on Voluntary Sterilization: A Review". *Studies in Family Planning* 16, 1: 1-29.
- Population Reports*. 1985. "Fertility and Family Planning Surveys: An Update Series". Nos.1-8.
- Sheon, A. R., Stanton C. 1989. "Use of Periodic Abstinence and Knowledge of the Fertile Period in Twelve Developing Countries". *International Family Planning Perspectives* 15, 1: 29-33.

- Staver, J., Bravo M. 1991. The Impact of Knowledge and Attitudes About Condoms as a Contraceptive Method in Urban Mexico". *International Family Planning Perspectives* 17,2.
- Stephen, E., Chamrathrithong, A. 1988. Contraceptive Side Effects Among Current Users in Thailand". *International Family Planning Perspectives* 14, 1: 9-14.
- Trussel, J. 1986. "The Impact of Child Spacing on Fertility". *International Family Planning Perspectives* 121, 3: 80-82.
- United Republic of Tanzania. 1989. "National Socio-economic Profile of Tanzania". Bureau of Statistics, Planning Commission, President's Office, Dar-es-Salaam.
- Walle, E., Walle, F. 1988. "Birth Spacing and Abstinence in Sub-Saharan Africa". *International Family Planning Perspectives* 14, 1: 25-26.
- Westof, C. F. 1990. "Reproductive Intentions and Fertility Rates". *International Family Planning Perspectives* 16, 3: 84-89.

World Fertility Survey Report. 1982. World

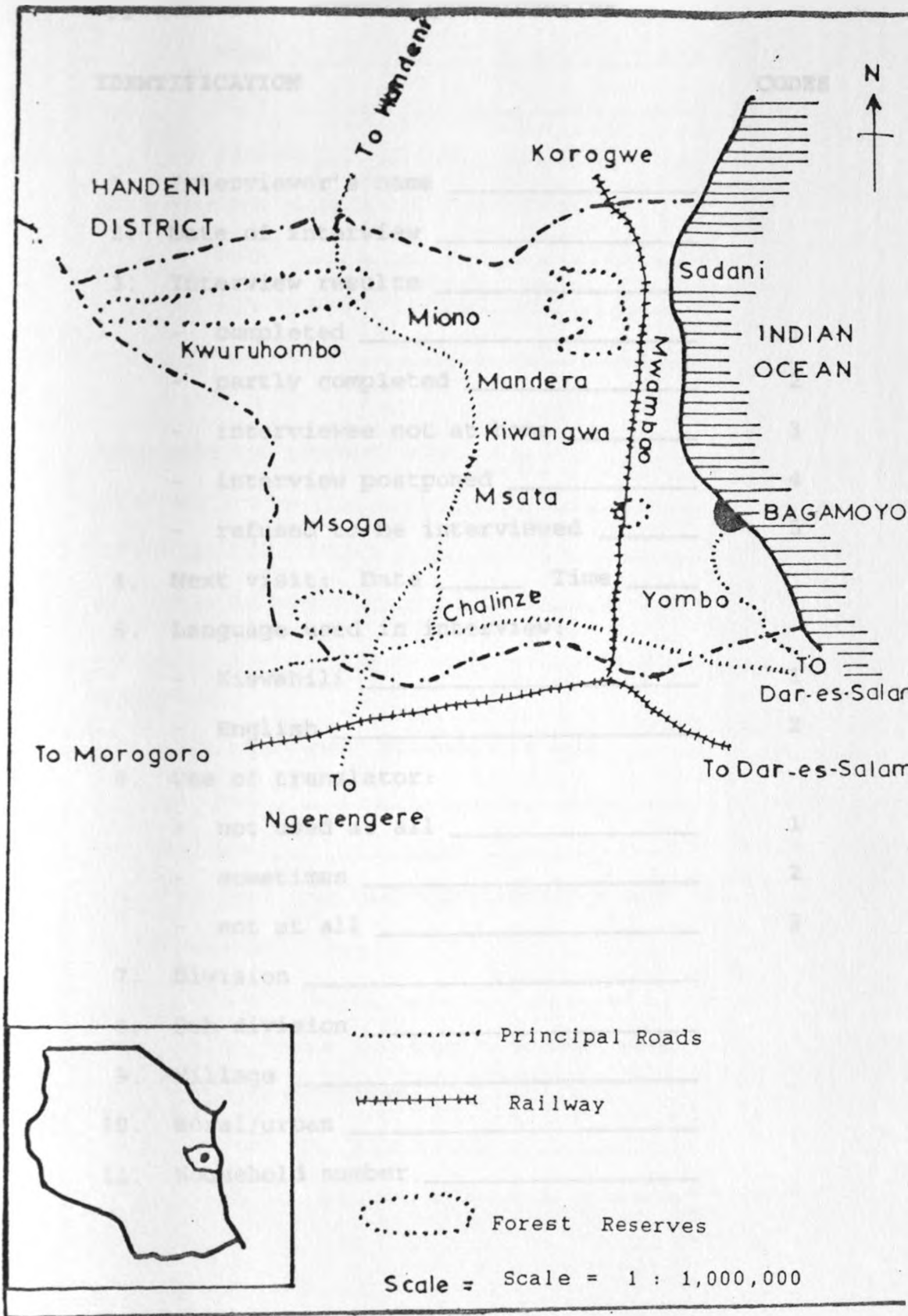
Health Organization Task Force on Oral  
Contraceptives on Breast Milk Composition and  
Infant Growth". *International Family Planning  
Perspectives* 19, 6: 361-369.



Legend:  
----- District boundary  
----- National boundary  
----- Major road  
----- Railway  
----- Water body  
----- Forest area  
Scale: 1:1,000,000

Source: U.S.A.I.D. - Myanmar Development and Demographic  
Research, National Institute of Statistics, 1982

# Appendix 1: A Map of Bagamoyo District



Source: Ishumi, A. G. M., Community Education and Development  
 Nairobi, Kenya Literature Bureau, 1981.

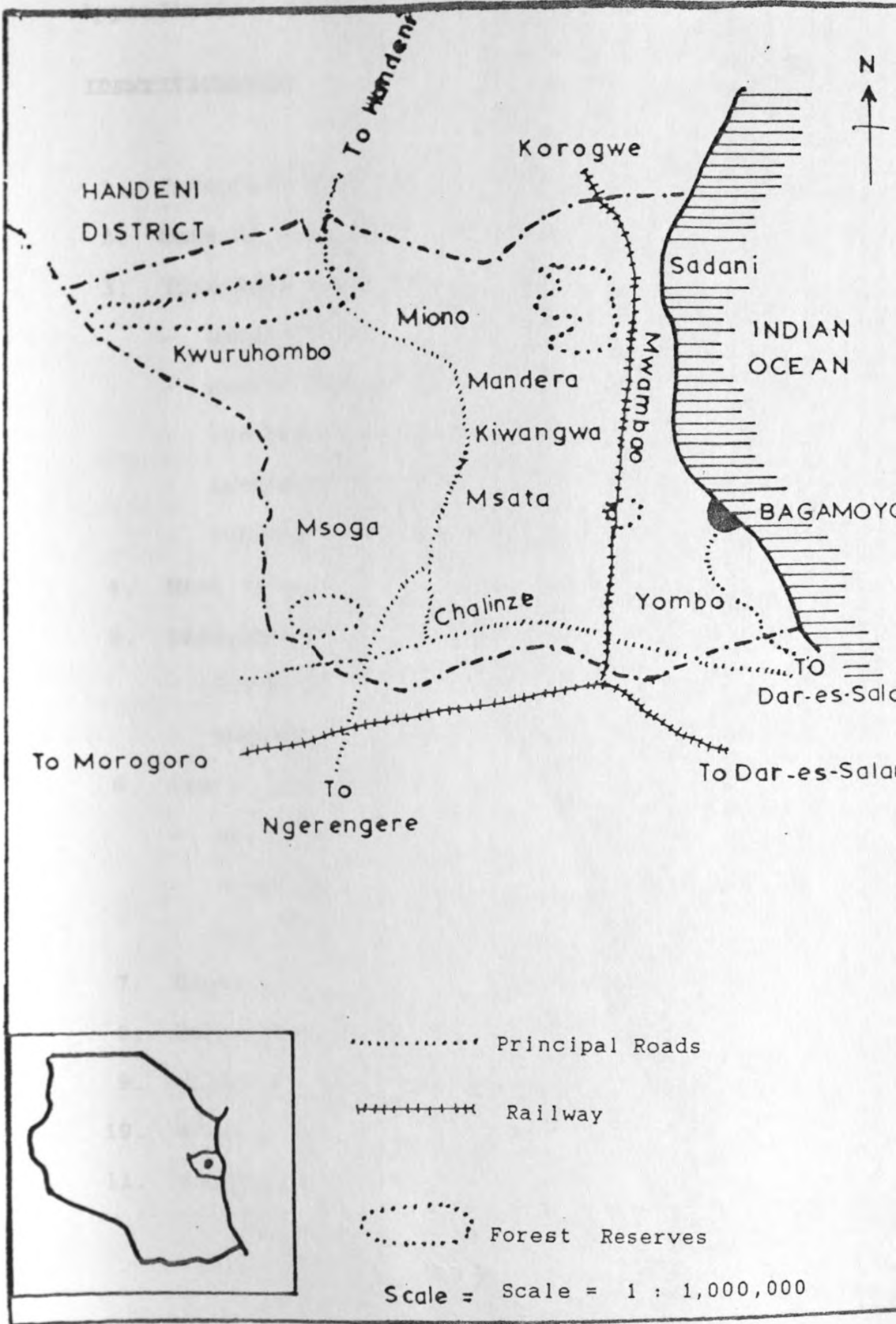
Appendix 2: WOMEN'S QUESTIONNAIRE

IDENTIFICATION

CODES

1. Interviewer's name \_\_\_\_\_
2. Date of interview \_\_\_\_\_
3. Interview results \_\_\_\_\_
  - completed \_\_\_\_\_ 1
  - partly completed \_\_\_\_\_ 2
  - interviewee not at home \_\_\_\_\_ 3
  - interview postponed \_\_\_\_\_ 4
  - refused to be interviewed \_\_\_\_\_ 5
4. Next visit: Date \_\_\_\_\_ Time \_\_\_\_\_
5. Language used in interview:
  - Kiswahili \_\_\_\_\_ 1
  - English \_\_\_\_\_ 2
6. Use of translator:
  - not used at all \_\_\_\_\_ 1
  - sometimes \_\_\_\_\_ 2
  - not at all \_\_\_\_\_ 3
7. Division \_\_\_\_\_
8. Sub-division \_\_\_\_\_
9. Village \_\_\_\_\_
10. Rural/urban \_\_\_\_\_
11. Household number \_\_\_\_\_

# Appendix 1: A Map of Bagamoyo District



Source: Ishumi, A. G. M., Community Education and Development  
Nairobi, Kenya Literature Bureau, 1981.

Appendix 2: WOMEN'S QUESTIONNAIRE

IDENTIFICATION

CODES

1. Interviewer's name \_\_\_\_\_
2. Date of interview \_\_\_\_\_
3. Interview results \_\_\_\_\_
  - completed \_\_\_\_\_ 1
  - partly completed \_\_\_\_\_ 2
  - interviewee not at home \_\_\_\_\_ 3
  - interview postponed \_\_\_\_\_ 4
  - refused to be interviewed \_\_\_\_\_ 5
4. Next visit: Date \_\_\_\_\_ Time \_\_\_\_\_
5. Language used in interview:
  - Kiswahili \_\_\_\_\_ 1
  - English \_\_\_\_\_ 2
6. Use of translator:
  - not used at all \_\_\_\_\_ 1
  - sometimes \_\_\_\_\_ 2
  - not at all \_\_\_\_\_ 3
7. Division \_\_\_\_\_
8. Sub-division \_\_\_\_\_
9. Village \_\_\_\_\_
10. Rural/urban \_\_\_\_\_
11. Household number \_\_\_\_\_

12. Household head

- Name \_\_\_\_\_
- Male \_\_\_\_\_
- Female \_\_\_\_\_

13. Husband's/partner's information:

- Name \_\_\_\_\_
- Age (years) \_\_\_\_\_
- Occupation \_\_\_\_\_

**Respondent's particulars**

- 14. Full name \_\_\_\_\_
- 15. Date of birth \_\_\_\_\_
- 16. Age in years \_\_\_\_\_

**Education**

17. Have you ever attended school?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

18. If yes, what was the highest class reached?

- Class \_\_\_\_\_

19. If no, have you ever attended adult education classes?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

20. Can you read posters/news papers?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2

21. In which language can you read?
- Kiswahili \_\_\_\_\_ 1
  - English \_\_\_\_\_ 2
  - Other language(s) (specify) \_\_\_\_\_ 3

**Ethnicity**

22. What is your tribe?
- Kwere \_\_\_\_\_ 1
  - Zaramo \_\_\_\_\_ 2
  - Zigua \_\_\_\_\_ 3
  - Doe \_\_\_\_\_ 4
  - Masai \_\_\_\_\_ 5
  - Others (specify) \_\_\_\_\_ 6

**Religion**

23. What is your religion?
- Islam \_\_\_\_\_ 1
  - Catholic \_\_\_\_\_ 2
  - Lutheran \_\_\_\_\_ 3
  - Anglican \_\_\_\_\_ 4
  - Traditional \_\_\_\_\_ 5
  - Others (specify) \_\_\_\_\_ 6

**Economy**

24. Are you employed?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2
25. If yes, what is your employment?
- Mention \_\_\_\_\_
26. If no, what is your occupation?
- Crop farming \_\_\_\_\_ 1
  - Animal farming \_\_\_\_\_ 2
  - Fishing \_\_\_\_\_ 3
  - Business (specify) \_\_\_\_\_ 4
  - Others (specify) \_\_\_\_\_ 5
27. Estimate your monthly income  
(monetary) from all sources in Tsh.
- Less than 1000/= \_\_\_\_\_ 1
  - 1000/= to 1999/= \_\_\_\_\_ 2
  - 2,000/= to 2,999/= \_\_\_\_\_ 3
  - 3,000/= to 3,999/= \_\_\_\_\_ 4
  - 4,000/= to 4,999+ \_\_\_\_\_ 5
28. Estimate your monthly expenditure  
(monetary)
- Less than 1000/= \_\_\_\_\_ 1
  - 1000/= to 1999/= \_\_\_\_\_ 2
  - 2,000/= to 2,999/= \_\_\_\_\_ 3
  - 3,000/= to 3,999/= \_\_\_\_\_ 4
  - 4,000/= to 4,999+ \_\_\_\_\_ 5

29. Which and how many of the following do you possess?

Item	Number	Value in sh.
Radio	_____	_____ 1
Bicycle	_____	_____ 2
Sewing machine	_____	_____ 3
Cooker:		
- Gas	_____	_____ 4
- Electric	_____	_____ 5
- Kerosine	_____	_____ 6
- Charcoal	_____	_____ 7
- Fridge	_____	_____ 8
- M/cycle	_____	_____ 9
- Boat	_____	_____ 10
- Others	_____	_____ 11
(specify)	_____	_____ 11

**Marital status**

30. Are you married?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

31. If no go to question 34.

32. If yes, what type of marriage?

- Monogamous \_\_\_\_\_ 1
- Polygamous \_\_\_\_\_ 2

33. How many times have you married?

Mention \_\_\_\_\_

34. If not married, have you ever  
married before?

- Yes \_\_\_\_\_ 1

- No \_\_\_\_\_ 2

35. If yes, what happened to your  
earlier marriage?

- We separated \_\_\_\_\_ 1

- I was divorced \_\_\_\_\_ 2

- My husband died \_\_\_\_\_ 3

36. If not married, with whom do you  
live?

- With parents \_\_\_\_\_ 1

- With my fiance \_\_\_\_\_ 2

- With my friend \_\_\_\_\_ 3

- With my sister \_\_\_\_\_ 4

- With my brother \_\_\_\_\_ 5

- Others (specify) \_\_\_\_\_ 6

**Information on child bearing**

37. Total pregnancies \_\_\_\_\_

38. Age at first pregnancy \_\_\_\_\_

39. Total Pregnancy losses \_\_\_\_\_

40. Total deliveries \_\_\_\_\_

41. Total still births \_\_\_\_\_



**Information on the respondent's family planning**

47. Do you listen to family planning (FP) radio programmes?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

48. Do you attend seminars organized for women affairs?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

49. Who organizes these seminars?

- Village Health Workers \_\_\_\_\_ 1
- UMATI \_\_\_\_\_ 2
- MCH leaders \_\_\_\_\_ 3
- UWT \_\_\_\_\_ 4
- Others (specify) \_\_\_\_\_ 5

50. Do you discuss FP in the seminars?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

51. Do you like to participate in seminars and discuss matters on FP?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

52. Have ever heard anything about FP from sources other than the radio and seminars?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2
53. If yes mention the sources.
- Government hospital \_\_\_\_\_ 1
  - MCH clinic \_\_\_\_\_ 2
  - UMATI \_\_\_\_\_ 3
  - VHW \_\_\_\_\_ 4
  - Friend \_\_\_\_\_ 5
  - Traditional healer \_\_\_\_\_ 6
  - Traditional birth attendant \_\_\_\_\_ 7
  - Husband \_\_\_\_\_ 8
  - Others (specify) \_\_\_\_\_ 9
54. Have you ever taken any measure to avoid pregnancy?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2
55. If yes, why?
- To delay the first pregnancy \_\_\_\_\_ 1
  - To space births \_\_\_\_\_ 2
  - To end child bearing \_\_\_\_\_ 3
  - Health problems \_\_\_\_\_ 4
  - Others (specify) \_\_\_\_\_ 5

56. If no why?

- I take what God gives \_\_\_\_\_ 1
- Every child has its own blessings \_\_\_\_\_ 2
- It is against my religion's teachings \_\_\_\_\_ 3
- It is against the traditional norms \_\_\_\_\_ 4
- My husband/partner disapproves \_ 5
- I need more children \_\_\_\_\_ 6
- I need a son \_\_\_\_\_ 7
- I need a daughter \_\_\_\_\_ 8
- I fear health problems \_\_\_\_\_ 9
- I see no reason for doing so \_ 10
- Other reasons (specify) \_\_\_\_\_ 11

57. - What is family planning?  
Explain as you understand \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Traditional Family Planning

There are various traditional FP methods, refer to Table (ii).

Table: (ii) Traditional Family Planning Methods

METHODS	201	202	203	204	205	206
Safe period	1	1	1	1	1	1
Total abstinence	2	2	2	2	2	2
Breastfeeding	3	3	3	3	3	3
Herbal medicine	4	4	4	4	4	4
Chastity before marriage	5	5	5	5	5	5
Withdrawal	6	6	6	6	6	6
Polygyny	7	7	7	7	7	7
Others (specify)	8	8	8	8	8	8

**CODES:** 201 Methods known spontaneously  
202 Methods recognized after probing  
203 Ever used methods  
204 Discontinued methods  
205 Presently used methods  
206 Preferred methods

58. Do you know any of them? \_\_\_\_\_
- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2
59. If yes, mention them (Interviewer circle code(s) for the mentioned methods in 201 Table (ii)).
60. If no, have you ever heard of any of the following methods? (Interviewer mention and explain each method in Table (ii), then circle codes for any of the methods that are recognized in 202).
61. Have you ever used any of the methods to avoid pregnancy?
- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2
62. If yes, mention all the methods you have ever used. (Interviewer circle the code(s) for the mentioned methods in 203).
63. Have you ever dropped any of the ever used method(s)?
- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

64. If yes, mention them. (Interviewer circle codes of the methods that are mentioned in 204).
65. Why did you did you discontinue the use?
- Methods were not reliable \_\_\_\_\_ 1
  - I needed a child \_\_\_\_\_ 2
  - I was breastfeeding \_\_\_\_\_ 3
  - It/they caused health problems \_ 4
  - Method(s) not easily available  
all the time \_\_\_\_\_ 5
66. Do you at present practice any of the traditional methods?
- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2
67. If yes, mention the methods.  
(Interviewer circle the code(s) of the mentioned methods in 205).
68. How often do you use these methods?
- Once in a while (specify method)  
\_\_\_\_\_ 1
  - Often (specify method) \_\_\_\_\_ 2
  - All the time \_\_\_\_\_ 3

69. Do the methods work as expected?

- Yes \_\_\_\_\_ 4

- No \_\_\_\_\_ 5

70. Where from do you get the TFP

services?

- From the TBA \_\_\_\_\_ 1

- From the traditional healer \_\_\_\_\_ 2

- From my mother \_\_\_\_\_ 3

- My own self discipline \_\_\_\_\_ 4

- Other sources (specify) \_\_\_\_\_ 5

71. If at present you do not use the traditional methods what are your reasons?

- The methods are not reliable \_\_\_\_\_ 1

- Husband/partner/parents dis-approve \_\_\_\_\_ 2

- I am pregnant \_\_\_\_\_ 3

- I am breastfeeding \_\_\_\_\_ 4

- I am on MFPM \_\_\_\_\_ 5

- I am trying to get pregnant \_\_\_\_\_ 6

- Other reasons (specify) \_\_\_\_\_ 7

72. Which traditional family planning methods do you prefer?

Mention them. (Interviewer circle the code(s) of the mentioned methods in 206.

## Modern Family Planning

There are also modern methods used to avoid pregnancy, refer to Table (iii).

Table (iii). Modern family planning methods

METHODS	301	302	303	304	305	306
Oral pills	1	1	1	1	1	1
Injectables	2	2	2	2	2	2
Intra-uterine device (IUD)	3	3	3	3	3	3
Condoms	4	4	4	4	4	4
Foaming tablets	5	5	5	5	5	5
Tube ligation (TL)	6	6	6	6	6	6
Diaphragm	7	7	7	7	7	7
Vasectomy	8	8	8	8	8	8
Others (specify)	9	9	9	9	9	9

CODES:

- 301 Methods known spontaneously
- 302 Methods known after probing
- 303 Ever used methods
- 304 Discontinued methods
- 305 Presently used methods
- 306 Preferred methods

73. Do you know any of the methods?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

74. If yes, mention them. (Interviewer circle the codes of the mentioned methods in 301 Table (iii)).
75. If no, have you ever heard any of the following methods? (Interviewer mention and explain each of the listed methods, then circle the codes of the methods that are recognized in 302).
76. Have you ever used any of the MFPM?
- |       |       |   |
|-------|-------|---|
| - Yes | _____ | 1 |
| - No  | _____ | 2 |
77. - If yes, mention them.  
(Interviewer circle the codes of the methods that are mentioned in 303).
78. Have you ever discontinued any of the methods that you ever used? Mention the methods that you ever discontinued (Interviewer circle the code(s) that are mentioned in 304).

79. Why did you drop the methods?
- They caused health problems \_\_\_\_\_ 1
  - The methods were not reliable \_\_\_ 2
  - The service outlet was too far  
from home \_\_\_\_\_ 3
  - I wanted to try other TFPM \_\_\_\_\_ 4
  - I was pregnant \_\_\_\_\_ 5
  - I was breastfeeding \_\_\_\_\_ 6
  - I needed a child \_\_\_\_\_ 7
  - Other reasons (specify) \_\_\_\_\_ 8
80. Are you at present using MFPM?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2
81. If yes, mention them. (Interviewer circle the codes of the mentioned methods in 305).
82. How often do you use the methods?
- Sometimes \_\_\_\_\_ 1
  - Often \_\_\_\_\_ 2
  - Continuously \_\_\_\_\_ 3
83. Are the methods working as expected?
- Yes \_\_\_\_\_ 1
  - No \_\_\_\_\_ 2

84. If using any modern methods, what is the outlet of the method(s)?

- Government hospital \_\_\_\_\_ 1
- MCH clinic \_\_\_\_\_ 2
- Government dispensary \_\_\_\_\_ 3
- UMATI \_\_\_\_\_ 4
- VHW \_\_\_\_\_ 5
- Private pharmacy \_\_\_\_\_ 6
- Other sources (specify) \_\_\_\_\_ 7

85. Why do you use this outlet?

- It is the only one available \_\_\_\_ 1
- The services are good \_\_\_\_\_ 2
- The method(S) is/are always available \_\_\_\_\_ 3
- It is close home \_\_\_\_\_ 4
- The contraceptives are provided free of charge \_\_\_\_\_ 5
- Other reasons (specify) \_\_\_\_\_ 6

86. How long does it take you to reach the source?

- Time: Hours \_\_\_\_ Minutes \_\_\_\_

87. Was/Were the method(s) of your own choice?

- Yes \_\_\_\_\_ 1
- No \_\_\_\_\_ 2

88. If yes, why did you prefer it to others?
- The method(s) is/are always available \_\_\_\_\_ 1
  - Method(s) does/do not cause health problems \_\_\_\_\_ 2
  - Method(s) is/are easy to use \_\_\_\_\_ 3
  - Method(s) is/are reliable \_\_\_\_\_ 4
  - Other reasons (specify) \_\_\_\_\_ 5
89. Which MFPM do you prefer? Mention them. (Interviewer circle the codes of the mentioned methods in 306).
90. Why the preference? Reason(s) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
91. What is your opinion about family planning?
- It is time wasting \_\_\_\_\_ 1
  - It is against God's will \_\_\_\_\_ 2
  - It is against my religion \_\_\_\_\_ 3
  - It is against the traditional norms \_\_\_\_\_ 4
  - Others (specify) \_\_\_\_\_ 5

92. Which of the following do you prefer?
- Traditional FP \_\_\_\_\_ 1
  - Modern FP \_\_\_\_\_ 2
  - Both traditional and modern FP \_\_\_ 3
93. Why this preference?
- The methods are safe \_\_\_\_\_ 1
  - The methods are reliable \_\_\_\_\_ 2
  - The methods convenient in use \_\_\_ 3
  - Other reasons (specify) \_\_\_\_\_ 4
94. what in particular would you like to know about modern family planning?
95. In your opinion, which age do you think is best for first pregnancy?
- Mention \_\_\_\_\_
96. Why this age?
- Reasons \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
97. For how long do you a baby should BF before it is completely weaned.
- Period in years \_\_\_\_\_
- 98 Why this period?
- Reasons \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

99. How many children would you prefer to have?

Number \_\_\_\_\_

100. Why this number?

Reason \_\_\_\_\_

101. What is your sex preference for your children?

Girls only \_\_\_\_\_ 1

Boys only \_\_\_\_\_ 2

Both sexes \_\_\_\_\_ 3

Any sex \_\_\_\_\_ 4

102. Why this preference?

Reasons \_\_\_\_\_

\_\_\_\_\_

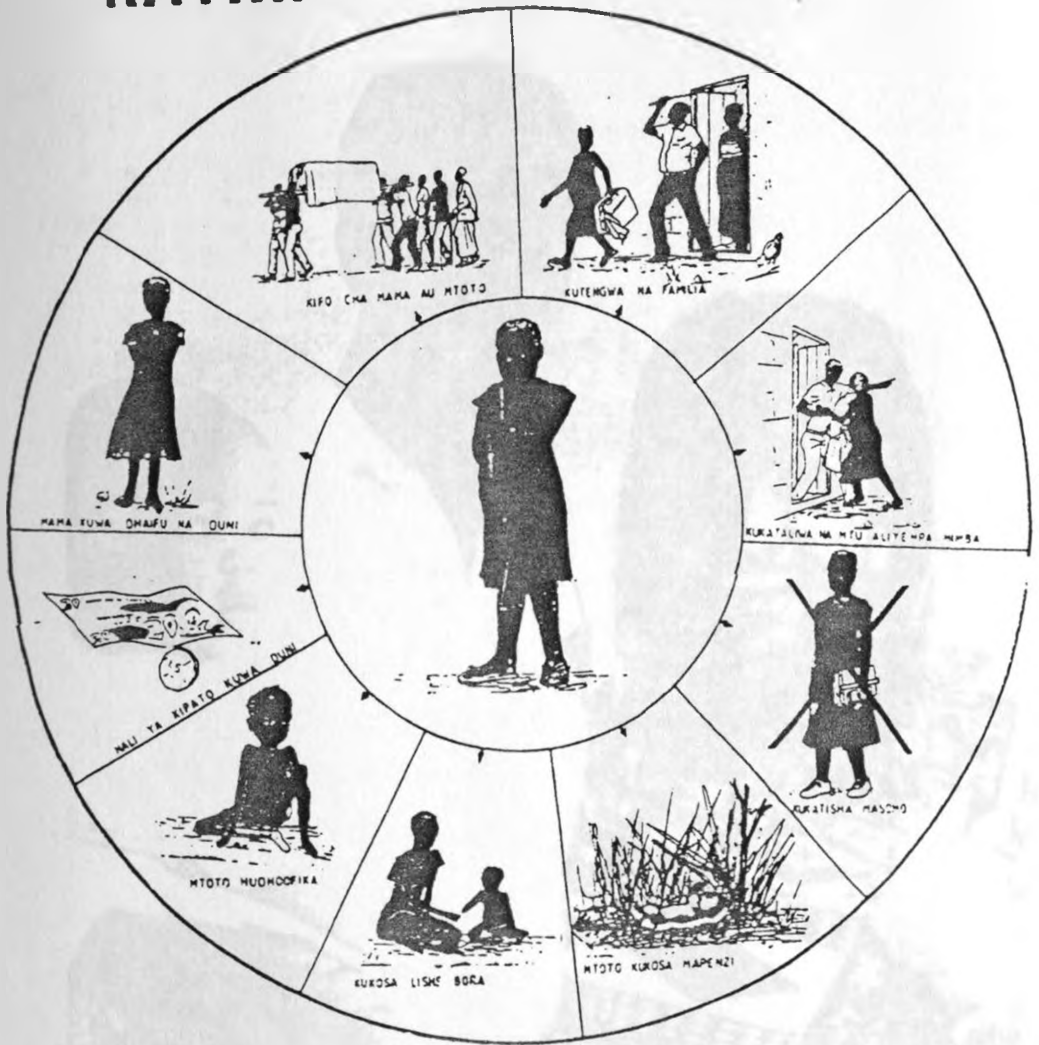
\_\_\_\_\_

Annex 1. A Guide to Methods Used in Modern Family Planning

Method	MECHANISM OF USE	FAILURE RATE (%)	ADVANTAGES	DISADVANTAGES
Oral pills	<ul style="list-style-type: none"> <li>- swallowing</li> <li>- Suppress ovulation</li> </ul>	1-8	<ul style="list-style-type: none"> <li>- Highly effective</li> <li>- Easy to use</li> <li>- Easily reversible</li> <li>- Independent of intercourse</li> </ul>	<ul style="list-style-type: none"> <li>- Need strict daily use</li> <li>- Causes side effects (nausea fatigue and depression)</li> </ul>
Injectables	<ul style="list-style-type: none"> <li>- Injected</li> <li>- Inhibits ovulation</li> </ul>	< 1	<ul style="list-style-type: none"> <li>- Highly effective</li> <li>- Long acting</li> <li>- Easy to use</li> <li>- Independent of intercourse</li> </ul>	<ul style="list-style-type: none"> <li>- May cause side effects</li> <li>- Requires timely injections</li> <li>- Delay return of fertility</li> </ul>
Loops (IUDs)	<ul style="list-style-type: none"> <li>- Placed in the uterus</li> <li>- Immobilizes sperms</li> </ul>	< 1	<ul style="list-style-type: none"> <li>- Highly effective</li> <li>- Long term acting</li> <li>- Highly reversible</li> <li>- Independent of intercourse</li> </ul>	<ul style="list-style-type: none"> <li>- Insertion and removal by trained personnel</li> <li>- May be painful during insertion</li> <li>- May cause irregular or heavy bleeding</li> </ul>
Tube ligation (TL) (Female Sterilization)	<ul style="list-style-type: none"> <li>- tube cut tied and clipped</li> <li>- Staple surgery</li> </ul>	0.2-1	<ul style="list-style-type: none"> <li>- Highly effective</li> <li>- Permanent and non-reversible</li> </ul>	<ul style="list-style-type: none"> <li>- Permanent and irreversible</li> <li>- May cause pain, discomfort bleeding and infection</li> </ul>
Vasectomy (male sterilization)	<ul style="list-style-type: none"> <li>- Tubes cut, tied and clipped</li> <li>- staple surgery</li> </ul>	0.15-1	<ul style="list-style-type: none"> <li>- Highly effective and safe</li> <li>- No side effects</li> </ul>	<ul style="list-style-type: none"> <li>- May be Permanent and irreversible</li> <li>- May be painful</li> <li>- May cause bleeding, swelling and infection</li> </ul>
Condoms	<ul style="list-style-type: none"> <li>- Placed over erect penis before intercourse</li> <li>- Prevents sperms from reaching the vagina</li> </ul>	15-20	<ul style="list-style-type: none"> <li>- Entirely user-controlled</li> <li>- Protects against sexually transmitted diseases</li> </ul>	<ul style="list-style-type: none"> <li>- May disrupt activity and reduce pleasure</li> </ul>
Condoms	<ul style="list-style-type: none"> <li>- Placed over erect penis before intercourse</li> <li>- Prevents sperms from reaching the vagina</li> </ul>	15-20	<ul style="list-style-type: none"> <li>- Entirely user-controlled</li> <li>- Protects against sexually transmitted diseases</li> </ul>	<ul style="list-style-type: none"> <li>- May disrupt activity and reduce pleasure</li> </ul>
Diaphragm (Cervical caps)	<ul style="list-style-type: none"> <li>- Rubber devices inserted in vagina</li> <li>- Prevent sperms from reaching the uterus</li> </ul>	5-25	<ul style="list-style-type: none"> <li>- User controlled</li> </ul>	<ul style="list-style-type: none"> <li>- May cause infection</li> </ul>
Foaming tablets and jellies	<ul style="list-style-type: none"> <li>- Inserted deep in vagina before intercourse</li> <li>- Inactivate sperms</li> <li>- Block sperms from entering uterus</li> </ul>	10-30	<ul style="list-style-type: none"> <li>- User controlled</li> </ul>	<ul style="list-style-type: none"> <li>- May cause irritation</li> </ul>

Source: Population Crisis Committee  
Washington D. C. USA

# MATATIZO YA UZAZI KATIKA UMRI MDOGO



**ANZA KUZAA WATOTO UFIKIAPO  
MIAKA 20**



INATUMBAKANA NA UMATI NI ENCHAFISHANE ENA HAKUNA NA FOMU LETAKA ENAP NA C.T.1.

# KWA MAISHA BORA YA KESHO PANGA UZAZI SASA



**Annex 4: A Calender of Selected Events in  
Tanzania**

- 1945: End of Second World War
- 1961: Independence year of Tanganyika
- 1962: Republic year of Tanganyika
- 1964: Union Year of Tanganyika and Zanzibar
- 1967: Year of the Arusha Declaration
- 1984: Death of the Prime Minister Edward Moringe Sokoine
- 1985: Mwalimu Julius K. Nyerere resigned from the Presidential post