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EMPOWERMENT**

**TOPIC: FAMILY PLANNING AND REPRODUCTIVE  
RIGHTS IN TANZANIA**

**BY**

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## 1. ABSTRACT:

In the wake of the 1994 United Nation's International Conference on Population and Development (ICPD), the issue of reproductive rights has received new standing as part of the development and implementation of population policies around the world. While many countries have spoken out against family planning programmes set up to achieve only demographic goals, key questions still linger on how to ensure reproductive health to the general public, particularly women. For instance, do governments, particularly those in Africa, actually ensure people's reproductive rights, what are the socio-economic and cultural constraints that hinder provision of reproductive health and how can reproductive rights become an integral part of a sustainable health programme in these countries?

This paper examines the above questions within the context of reproductive health in Tanzania. The paper examines the provision of family planning services in Tanzania and the challenge that the country faces to ensure that reproductive rights are part and parcel of a comprehensive health programme. For instance, to what extent is the government providing men and women - particularly young people - with access to the information, education and means which will enable them to exert the basic right to decide freely and responsibly the number and spacing of their children. How can family planning programmes and providers ensure that reproductive rights become a realistic reality to the average woman across the country? Indeed what is the role of the general public, particularly women, in the promotion of reproductive health and what must be done to advance reproductive rights in the twenty first century. These questions are the central focus of our paper.

The paper indicates that Tanzania has in the past twenty years trying to promote family planning in all parts of the country. An increasing number of people are now aware of family planning, particularly contraceptive use. However, awareness and increased knowledge about family planning has not led to increased use of contraception. There is now a growing realization that reproductive rights in Tanzania have to be advanced as part of an overall strategy to improve reproductive health and development in the country. As such the government is now confronted with the necessity of adopting need-oriented national policies and implementing them to enhance family planning and contraceptive use.

The quality of care provided by family planning services is often seen as an essential pre-requisite for reproductive rights to be met (Hardon, 1997). In this paper we argue that it is also essential that the well being of expecting mothers and children are included in any set of reproductive rights. In other words we must explore how we can move from family planning and reproductive rights to overall social and economic well - being of the Tanzanian society.

## **2. INTRODUCTION:**

### ***Family Planning, Reproductive Rights and Reproductive Health:***

**Family planning:** is often defined as a voluntary decision and action taken by a couple or individual to delay, space or limit child bearing (Bureau of statistics 1994). Although family planning is today considered as a right and responsibility of anyone who can cause pregnancy or become pregnant, the reality in Tanzania and other developing countries show that this right remains out of reach of many women.

In many parts of the world, family planning services are at present an essential element of reproductive health care and have saved the lives and protected the health of millions of women and children. However, almost 600,000 women still die each year as a consequence of pregnancy and children, including those who die as a result of abortions performed under unsafe conditions. All but a small percentage of these deaths occur in developing countries, where pregnancy and childbirth remain among the leading causes of mortality for women of childbearing age, and where the risk of maternal death is 50 to 100 times greater than in developed countries (WHO,1997).

The above situation calls for intensified efforts to promote family planning as part of a comprehensive reproductive health strategy in Tanzania and other developing countries.

**Reproductive Rights:** All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. They also have the right to attain the highest standard of sexual and reproductive health. While the right to health is recognized almost universally, women in Tanzania carry a heavy and largely avoidable burden of poor health and related to reproduction and sexuality. Reproductive rights were first recognized as human rights in 1968, and have been endorsed and strengthened in successive international forums, particularly at the 1994 International Conference on Population and Development (ICPD) in Cairo. Others include the Fourth World Conference on Women (Beijing, 1995), the World Summit for Social Development (Copenhagen, 1995) and the World Conference on Human Settlements (Istanbul, 1996).

The right to health, the right to the benefits of scientific progress and the right to determine the number and spacing of one's children, among other, imply a right to reproductive health, and hence to reproductive health services that respect and promote the rights of clients. This means that that services must respond to clients' needs and desires, and facilitate individual choice and informed consent. The Tanzanian experience indicates that existing family planning programmes and services are yet to respond to clients' needs and this is the major challenge that family planning programmes will face in the twenty first century.

Over the past three decades, the development of acceptable, safer methods of modern contraception has given women and men greater individual freedom and enhanced their ability to exercise choice in childbearing. However, these family planning methods remain unavailable to many who need them, both women and men. This is particularly the case for sub-Saharan Africa. It is estimated that at least 350 million couples do not have access to the full range of safe and effective modern methods of family planning. In many countries this includes women and men who face economic, cultural and institutional barriers to the free exercise of reproductive rights.

**Reproductive Health:** Reproductive health is a state of complete physical, mental and social well-being-and not merely the absence of disease or infirmity-in all matters relating to the reproductive system and to its functions and processes, according to the Programme of Action adopted by the delegates to the ICPD. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

In order to exercise that freedom, reproductive health requires access to both family planning and related health care services. Beyond family planning, services to enable women to go safely through pregnancy and childbirth are of particular importance, as are programmes emphasizing prevention of sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV), the virus that cases AIDS.

In Tanzania many people are unable to attain optimal reproductive health because of incomplete knowledge about health and human sexuality as well as high-risk sexual behaviour. Other reasons include the unavailability or poor quality of reproductive health care services;

existing gender bias; and the limited power of many women and girls over their sexual and reproductive lives. The growing incidence of STDs and AIDS and the continuation of practices such as female genital mutilation also negatively affect reproductive health. Adolescents are particularly at risk, because of high levels of social discomfort about sexual activity among young unmarried people and their lack of information and access to relevant services in most countries. Older women and men also have distinct reproductive and sexual health needs that are often inadequately addressed.

### ***3. Family Planning in Africa: An Overview***

Family planning service provision is a complicated process, entangled in social, political, moral and cultural debate in Tanzania and many African countries (Howson et. al., 1996:109). As we shall illustrate in this paper, family planning services to teenagers, who would benefit with significant mortality reduction, are often tightly restricted. The male population is yet to become a dynamic force in the formulation and implementation of family planning programmes. In many rural areas in Tanzania immediate child bearing is expected after marriage, and often after an infant death to replace the lost child. Where marriage comes early and infant mortality rates are high, family planning may not be the desired option for many women. Even if the social and political debates were resolved, there remain many reasons for non-use: side-effects are a significant concern; method failure is not uncommon and refusal on religious grounds remain salient. It will be argued in this paper that to be successful, family planning programmes must be sensitive to the reservations and to the community being served, and services must be delivered in a manner that meets users' needs. This has often resulted in an improvement in the quality of their lives. Twenty years ago, the world's population experts were divided on the question of how to bring down fertility. Some believed that socio-economic development alone could reduce family size, others thought that vigorous promotion of contraception would be effective regardless of levels of development (Ersheng, 1997). Many African countries including Tanzania acted on this second view.

The 1994 ICPD Conference ushered in a new era of thinking that fertility decline will best be achieved by providing for people's needs in the area of reproductive health, education and income generation, especially for women. The Conference further emphasized that reproductive health services that are comprehensive, high quality and voluntary are likely to improve the timing and spacing of births, reducing sickness and death among mothers and children. They also contribute to more consistent use of contraception and fewer unnecessary abortions.

While the 1994 *Program of Action* is now setting the stage for international discussions on how family planning can be expanded to cover the whole area of reproductive health and sexuality, the time has come for critical examination and evaluation of family planning programmes in Tanzania and other African countries. This includes examination of the impact of rapid socio, economic and political changes and challenges that Africa faces and must overcome if it's population policies, particularly family planning programmes are to go beyond concern about mere numbers of people and demographic targets.

We emphasize the observation that new and dynamic family planning programmes for Africa must be those that explicitly places human beings at the center of all population and development activities. Investments in people, in their health, education and in the quality of their lives are seen as the key to change of family planning programmes and sustained development in Africa.

This paper calls for family planning in Africa to be integrated into the broader context of reproductive health and sustainable development. If this is accomplished, family planning can become a potent tool to spearhead Africa's development efforts, particularly against the spread of mass poverty and human destitution.

#### **4. Family Planning and Reproductive Health in Tanzania**

The family planning Association of Tanzania (UMATI) has been playing a big role in family programmes. The Family Planning Association of Tanzania (UMATI) introduced family planning services to Tanzania in 1959. During the early years the services were mostly provided in few urban areas with little support from the government. With the expansion of UMATI in the early 70's, services were extended

to cover more areas in the country. The government became actively involved in providing family planning services following the launching of the integrated Maternal and Child Health (MCH) programme in 1974. From 1974 up to the present, UMATI has the responsibilities of providing information, education and communication (IEC) to the general public. UMATI is also responsible for training of services providers and procurement of contraceptives and supplies. Currently, family planning services are provided by both governmental and non-governmental organisations under the coordination of the Family Planning Unit (FPU) in the Ministry of Health.

A lot of efforts have been done in the last twenty years in Tanzania to promote family planning use to all sections of society. The 1996 TDHS shows that over 24 per cent of currently married women have unmet need for family planning services - 15 per cent for spacing and 9 per cent for limiting births. According to the 1996 TDHS study the unmet need for family planning among currently married women in Tanzania has declined from 30 per cent in 1991-92 to 24 percent in 1996 and the total demand satisfied has increased from 63 per cent to 44 per cent during the same period. Despite these achievements, the wider population - the majority of whom are youths, has achieved little in regard to adoption and use of family planning methods. We have now reached a juncture where we need to take stock and make a critical assessment of family planning services and to formulate a dynamic agenda to include family planning as an essential catalyst for change and development in the twenty-first century.

The issue of reproductive rights in Tanzania remains an unrealized dream. Women are in general denied access to proper health care and are excluded from many decisions that affect their welfare and that of the society in which they live in. In order to enhance reproductive rights there is need to confront problems of increasing domestic and sexual violence, elevations in teen pregnancies, alarming growth in the number of persons affected with STDs and AIDS, unsafe abortions with their deadly consequences and the culmination of unacceptably high maternal and infant death rates.

## **5. The Right to Access and Use of Essential Reproductive Health**

### ***Knowledge and Information.***

One of the basic reproductive rights that is not being adequately provided to women and other family planning users in Tanzania is the right to proper, adequate information about family planning methods that are being provided.

At first glance available information and data from area specific studies indicate that there is a much higher level of contraceptive awareness which is not matched with a similar level of practice. For example, the 1996 TDHS study indicates that while more than 80 percent of women and men know of at least one modern method for family planning, only 16 percent of all women are currently using a contraceptive method of which 12% are using modern contraceptive methods. Twenty-two percent of men in Tanzania are currently using contraception; 14% using modern and 8% using traditional methods (TDHS, 1996).

A plausible explanation is that family planning users are not being provided with adequate information about contraceptives to motivate them to use the available contraceptives. A study carried out by Kopoka (1998) in Kibaha district on contraceptive use in the district shows that over 50% of the one hundred respondents interviewed did not have adequate information to identify the expiry dates of the contraceptives that they were using or planning to use. They did not know the manufacturer or country of origin. More disturbing is that many did not have adequate information on the possible side effects of the various contraceptives. The little information they had came from practical experience or from fellow users who are or were using contraceptives.

The above findings more or less support The 1996 TDHS Survey also indicates that at least a third of women in Tanzania need contraceptive services. Some of these women do not know about modern methods, are unable to obtain or afford them, or distrust or dislike the methods that are available. Some are single women or teenagers who are barred by policy or practice from obtaining contraceptive services. Other women may not be using a method because they are ambivalent about whether they want a child or are unsure about their ability to become

pregnant; still others live with a partner who does not approve of contraception or who wants them to become pregnant.

One conclusion that can be arrived at from the above is the absence of adequate information about family planning and contraceptive use in Tanzania. It can also explain the failure to turn awareness of family planning and contraception to actual use.

The overall picture in Tanzania is one that shows increasing levels of awareness about family planning and contraception among the general public while actual use still remains low. This is clearly indicated in tables 1,2& 3 below:

<b>Table 1: Knowledge of contraceptive methods</b>							
Percentage of all women, of currently married women, and of sexually active unmarried women and of women with no sexual experience, and the percentage of all men 15-59, of currently married men, and of sexual active unmarried men who know specific contraceptive methods, Tanzania 1996							
Contraceptive Method	Women who know method				Men who know method		
	All women	Currently married women	Sexually active unmarried women	No sexual experience	All men	Currently married men	Sexually active unmarried men
<b>Any method</b>	84.2	88.5	85.5	55.1	89.2	93.4	90.8
<b>Any modern method</b>	83.6	87.7	85.2	55.1	88.8	92.8	66.6
Pill	78.4	84.0	79.5	41.4	71.1	82.2	66.6
IUD	48.8	52.8	55.7	17.8	34.9	43.8	32.1
Injectables	70.8	76.8	72.1	31.0	55.6	67.1	52.2
Diaphragm/foam/jelly	30.7	34.2	32.0	8.5	35.3	42.5	33.8
Condom	72.2	75.2	78.9	45.6	85.8	89.8	89.8
Female sterilization	60.7	66.2	63.8	25.8	63.3	74.7	58.9
Male sterilization	24.8	27.6	24.8	8.0	35.1	42.9	32.7
Implant	23.5	25.4	29.5	7.7	17.0	21.4	17.6
<b>Any traditional/folk method</b>	47.0	51.8	50.3	14.4	56.1	69.1	55.0
Calendar/mucus	30.7	32.1	35.9	12.1	45.2	56.4	42.4
Withdrawal	31.6	36.3	29.2	6.2	42.5	52.6	43.9
Abstinence	0.3	0.3	0.0	0.1	0.4	0.5	0.2
Other	12.6	14.8	12.1	1.4	6.2	9.3	2.8
Number of respondents	8,120	5,411	671	1,048	2,256	1,288	355
Men number of methods							
Known	5.0	5.4	5.3	2.1	5.1	6.1	4.9
Percent knowing three or more							
Modern method	70.9	76.6	73.5	31.9	66.8	78.2	64.3
Mean number of							
Modern methods known	4.1	4.4	4.4	1.9	4.0	4.6	3.8

Source: Bureau of Statistics (1997), **Tanzania Demographic and Health Survey 1996**, Bureau of Statistics Planning Commission: Dar-Es-Salaam.

Table 4.1 shows the percentage of all women and men, currently married women and men, and sexually active unmarried women and men, and women with no sexual experience who know specific contraceptive methods. Almost all of the women who have heard of any method have heard of a modern method, while about half of the women have heard of a traditional or folk method. Results show that 84 percent of women age 15-49 have heard of at least one method of family planning. The level is higher among currently married women (88percent). The most commonly recognized methods in Tanzania are the pills (78 percent), condoms (72 percent), injectables (71 percent), female sterilization (61 percent), and IUD (49 percent). Only 31 percent of all women know of diaphragm/foam/jelly, and about one-fourth know of male sterilization and implants (Norplant). Of the traditional methods, similar proportions of women have knowledge of withdrawal and calendar or mucus methods (recognized by 31 to 32 percent of women, respectively).

Knowledge of family planning methods is higher among men than women. Almost 90 percent of all men interviewed know of at least one method. The difference in knowledge between men and women is especially notable for male sterilization and condom: 35 percent of men compared with 25 percent of women know of male sterilization and 86 percent of men compared with 72 percent of women know about condoms. While women are generally more likely than men to know the methods used by women, it is surprising to note that the proportion of men who know of the calendar or mucus method is higher than among women (45 vs. 31 percent). Overall, knowledge of contraceptive methods is higher among married respondents. Seventy-one percent of women and 67 percent of men know of at least these modern methods (Table 4.1). On average, women and men know of five methods, four of which are modern methods.

<b>Table 2 Ever use of contraception: women</b>																	
Percentage of all women, of currently married women, and of sexually active unmarried women who have ever used any contraceptive method, by specific method and age, Tanzania 1996																	
Age	Modern method							Traditional/folk method							Number of women		
	Any Method	Any modern method	Pill	IUD	In-ject-able	Dia-phragm/foam/jelly	Con-dom	Female sterili-zation	Male sterili-zation	Implant	Any tradi-tional/folk method	Cal-endar/ mucus	With-draw- al	Absti-nence		Other	
<b>ALL WOMEN</b>																	
15-19	8.7	5.9	2.7	0.4	0.7	0.1	3.5	0.0	0.0	0.0	3.8	2.6	1.6	0.0	0.2	1,732	
20-24	35.6	25.5	15.3	1.1	5.4	0.2	10.7	0.1	0.0	0.1	17.8	9.0	11.0	0.1	1.5	1,676	
25-29	40.3	29.3	21.1	1.6	7.9	0.2	8.9	0.2	0.1	0.0	19.4	8.8	12.0	0.1	2.4	1,440	
30-34	40.2	29.4	21.8	2.5	9.2	0.8	8.3	0.8	0.0	0.1	20.0	10.3	12.3	0.0	1.8	1,118	
35-39	38.1	30.4	21.6	3.2	10.1	0.4	6.7	3.0	0.0	0.2	20.1	9.0	12.4	0.2	3.2	888	
40-44	35.3	26.7	17.2	2.7	9.9	0.8	5.0	6.7	0.1	0.0	16.8	7.5	10.8	0.1	2.7	680	
45-49	26.9	17.0	9.9	1.5	5.0	0.3	1.9	5.2	0.0	0.0	15.9	6.5	9.5	0.2	3.1	585	
Total	30.9	22.5	15.0	1.6	6.2	0.3	7.0	1.4	0.0	0.0	15.4	7.5	9.4	0.1	1.8	8,120	
<b>CURRENTLY MARRIED WOMEN</b>																	
15-19	15.9	9.9	5.7	1.2	1.1	0.2	5.0	0.2	0.0	0.0	8.1	4.9	3.7	0.0	0.6	401	
20-24	36.2	25.6	15.9	1.3	6.0	0.2	8.8	0.1	0.0	0.1	18.9	8.7	12.3	0.1	1.7	1,131	
25-29	41.8	30.1	21.8	1.7	8.8	0.2	8.7	0.2	0.0	0.0	20.6	8.9	13.0	0.1	2.5	1,184	
30-34	38.3	28.3	21.4	2.7	8.5	0.9	6.4	1.0	0.0	0.1	19.1	9.1	12.0	0.0	2.0	947	
35-39	38.3	30.2	20.4	3.3	10.1	0.5	5.8	3.3	0.0	0.1	19.9	7.8	12.7	0.2	3.6	740	
40-44	34.7	25.5	15.3	2.8	10.2	0.8	4.3	7.1	0.2	0.0	17.7	7.9	11.3	0.2	2.8	561	
45-49	26.0	15.2	9.0	1.4	5.0	0.3	0.3	5.2	0.0	0.0	16.2	6.8	9.9	0.2	2.9	447	
Total	35.6	25.6	17.4	2.1	7.6	0.4	6.5	1.9	0.0	0.1	18.3	8.2	11.5	0.1	2.3	5,411	
<b>SEXUALLY ACTIVE UNMARRIED WOMEN</b>																	
Total	40.1	34.1	21.6	1.9	6.4	0.5	18.4	0.6	0.1	0.1	14.3	8.9	8.1	0.0	1.2	671	

Source: Bureau of **Statistics Tanzania Demographic and Health Survey 1996**, op.cit p.46

All women and men interviewed in the 1996 TDHS who said that they had heard of a method of family planning were asked if they had ever used that method. Ever use of family planning methods thus refers to use of a method at any time with no distinction between past and current use. Table 4.4.1 shows the percentage of women who have ever used family planning, according to method and age. Modern methods have been more frequently used (23 percent) than traditional/folk methods (15

percent). The modern methods commonly used by women are pills (15 percent), condoms (7 percent), and injectables (6 percent); while traditional methods frequently used are withdrawal (9 percent) and calendar/mucus (8 percent). Ever use of contraception is higher for sexually active unmarried women than currently married women.

**Table 3. Current use of contraception by background characteristics: men**

Percent distribution of all men by contraceptive method currently used, according to selected background characteristics, Tanzania 1996.

Background Characteristic	Modern method						Traditional/folk method						Total	Number of men
	Any method	Any modern Method	Pill	IUD	Injec ables	Con dom	Female steri lisa or Tion	Any trad or folk method	Cal endar mucus	With drawl	Other method	Not cur rently using		
<b>Residence</b>														
Mainland	22.6	14.2	3.9	0.3	1.7	7.5	0.7	8.4	5.6	2.4	0.3	77.4	100.0	2,187
Total urban	29.6	32.9	5.2	0.6	1.6	15.2	1.0	5.7	4.2	1.3	0.1	70.4	100.0	509
D'eslaam city	32.0	27.2	5.1	1.1	2.2	16.9	1.5	4.8	3.3	1.1	0.4	68.0	100.0	171
Other urban	28.4	22.2	5.2	0.4	1.3	14.4	0.7	6.2	4.7	1.3	0.0	71.6	100.0	338
Total rural	20.5	11.3	3.4	0.1	1.8	5.2	0.6	9.3	6.0	2.8	0.4	79.5	100.0	1,678
Zanzibar	14.0	7.0	4.1	0.0	1.9	1.1	0.0	7.0	4.8	2.2	0.0	86.0	100.0	69
Pemba	7.4	3.7	1.9	0.0	1.9	0.0	0.0	3.7	3.7	0.0	0.0	92.6	100.0	28
Unguja	18.5	9.3	5.6	0.0	1.9	1.9	0.0	9.3	5.6	3.7	0.0	81.5	100.0	41
<b>Region</b>														
Dodoma	16.4	13.6	2.9	0.0	1.4	9.3	0.0	2.9	1.4	0.7	0.0	83.6	100.0	96
Arusha	20.2	10.6	3.2	0.0	1.1	4.3	2.1	9.6	4.3	5.3	0.0	79.8	100.0	156
Kilimanjaro	26.7	15.4	3.1	1.5	1.5	8.2	1.0	11.3	4.6	5.6	0.0	73.3	100.0	119
Tanga	28.0	17.3	4.0	0.0	1.3	12.0	0.0	10.7	4.0	6.7	0.0	72.0	100.0	108
Morogoro	17.5	13.3	4.9	0.7	1.4	5.6	0.0	4.2	0.7	2.1	1.4	82.5	100.0	95
Coast	30.6	25.8	9.7	0.0	4.8	11.3	0.0	4.8	1.6	3.2	0.0	69.4	100.0	45
Dar es Islam	31.9	27.0	5.3	1.0	2.3	16.4	1.6	4.9	3.3	1.0	0.7	68.1	100.0	191
Lindi	22.5	16.9	5.6	0.0	4.2	7.0	0.0	5.6	2.8	0.0	1.4	77.5	100.0	54
Mtwara	14.9	12.9	10.9	0.0	1.0	1.0	0.0	2.0	0.0	2.0	0.0	85.1	100.0	96
Ruvuma	29.4	19.6	12.7	0.0	2.9	2.9	1.0	9.8	6.9	2.0	1.0	70.6	100.0	82
Iringa	16.8	10.9	2.2	0.0	0.7	5.8	2.2	5.8	1.5	3.6	0.0	83.2	100.0	100
Mbeya	38.9	30.6	1.4	0.0	4.2	25.0	0.0	8.3	2.8	4.2	1.4	61.1	100.0	137
Singida	36.9	29.8	4.8	0.0	4.8	19.0	1.2	7.1	4.8	1.2	1.2	63.1	100.0	80
Tabora	16.7	5.6	1.9	0.0	1.9	1.9	0.0	11.1	11.1	0.0	0.0	83.3	100.0	82
Rukwa	52.6	17.9	5.1	0.0	3.8	7.7	1.3	34.6	23.1	11.5	0.0	47.4	100.0	71
Kigoma	32.9	10.0	5.7	0.0	2.9	1.4	0.0	22.9	22.9	0.0	0.0	67.1	100.0	95
Shinyanga	6.1	4.9	0.6	0.6	0.0	3.0	0.6	1.2	0.6	0.6	0.0	93.9	100.0	202
Kagera	27.5	7.2	4.3	0.0	0.0	1.4	1.4	20.3	20.3	0.0	0.0	72.5	100.0	139
Mwanza	1.3	1.3	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	98.7	100.0	176
Mara	14.5	7.3	0.0	0.0	1.8	5.5	0.0	7.3	5.5	1.8	0.0	85.5	100.0	64
<b>Education</b>														
No education	12.5	4.4	1.0	0.0	0.5	2.4	0.5	8.1	6.3	1.8	0.0	87.5	100.0	304
PR. in complete	11.8	6.8	1.7	0.1	0.9	3.5	0.6	5.1	3.4	1.2	0.2	88.2	100.0	664
Primary complete	28.5	18.4	5.8	0.2	2.7	9.3	0.3	10.1	6.4	3.0	0.5	71.5	100.0	1,066
Secondary+	38.3	27.6	5.3	1.1	1.8	16.0	3.2	10.7	6.8	3.9	0.0	61.7	100.0	222
<b>No. of living Children</b>														
0	10.9	9.2	0.4	0.0	0.1	8.7	0.0	1.7	1.0	0.6	0.1	89.1	100.0	974
1	27.0	16.8	3.9	0.3	1.3	11.1	0.3	10.2	6.9	2.3	0.6	73.0	100.0	228
2	27.6	15.2	5.9	1.5	1.1	6.7	0.0	12.4	7.7	4.7	0.0	72.4	100.0	206
3	42.8	26.0	11.6	0.0	3.2	10.4	0.7	16.8	13.4	3.4	0.0	57.2	100.0	188
4+	30.2	16.2	6.1	0.3	4.2	3.4	2.1	14.1	8.8	4.1	0.7	69.8	100.0	661
<b>Total</b>	22.4	14.0	3.9	0.2	1.8	7.3	0.7	8.4	5.5	2.4	0.3	77.6	100.0	2,256

Source: Bureau of Statistics (1997) **Tanzania Demographic and Health Survey**, op. Cit P.49

Table 3. above shows the percent distribution of all men age 15-59 by the contraceptive method currently used, according to background characteristics. The differentials in contraceptive use by men resemble those among women. Men in urban areas are more likely to use contraception, especially modern methods, than their counterparts in rural areas on the mainland. There are quite large differences in the use of contraceptives among men in the various regions on the mainland. For example, 26 to 30 percent of men in the Mbeya, Singida, Dar es Salaam, and Coast regions are using modern family planning methods, compared with only 1 to 5 percent in the Mwanza and Shinyanga regions. Greater contraceptive use was found to be associated with increasing level of education. Use of modern contraceptive methods increases from 4 percent among men with no formal education to 28 percent among those with at least some secondary education

## **1. POPULATION GROWTH AND FAMILY PLANNING IN TANZANIA.**

According to the 1988 national census, the population of Tanzania is growing at 2.8% per annum, though the World Bank estimates the same to be 3.2%. The total fertility rate is approximately seven, with no indication that this has changed significantly over the past three decades. The population is basically a young one with 45% under 15 years of age. This high fertility rate should be seen against a very low contraceptive prevalence rate estimated to be 5-7% only nationally. Maternal mortality rates are very high and analysis of available statistics shows that areas of highest maternal mortality rates are the same ones with lowest recorded use of modern contraceptives.

### **FROM FAMILY PLANNING TO SUSTAINABLE DEVELOPMENT IN TANZANIA.**

**Poverty and Inequality limit Success of Family Planning:**

Women's success in achieving their reproductive goals has important implications for the social and economic well being of the country.

The success of family planning programmes will depend on the extent to which extreme poverty and profound inequalities between men and women and between members of society is addressed. Poverty and discrimination undermine women's ability to contribute to and take full advantage of social and economic progress - in the workplace and within the family.

**Closing the Gap between Hopes and Realities:**

Making high quality contraceptive services more accessible is, obviously, a key to closing the gap between women's childbearing hopes and their realities, but more is required. To eliminate barriers that reflect women's second-class position within the family and their neglected status within the larger society, substantial improvements will also be necessary in their personal lives and in the legal, economic and social conditions in which they live.

**Problems that Limit success of Family Planning Programmes:**

Family planning programmes fail to offer a wide selection of contraception methods.

Lack of high standards of medical practice

Insensitivity to cultural conditions

Insufficient information about proper use or possible side effects.

Neglect of women's other reproductive health needs.

Integrating men into family planning programmes.

UMATI is about 95% dependent on foreign donors with the result that often the Association cannot implement all its activities as it wishes. The International Planned Parenthood Fund (IPPF) is by far the major donor providing over 80% of financial assistance to UMATI. Contributions from local resources have so far been poor.

The success and prospects of family planning programmes remain in doubt

unless efforts are made to integrate population policies/family planning with wider issues of reproductive health and sustainable economic and social development. Sustainable Development and improving the quality of life of the people will strengthen family planning programmes and other measures designed to hasten the pace of demographic change.

In other words, health planning has to be linked to development in order to contribute effectively to the problem of population growth. This is particularly so for the case of the rural sector in Tanzania.

In order to manage the family planning program successfully, a comprehensive evaluation system is necessary for the evaluation of on-going programmes.

## **2. Introduction:**

Over the last ten years family planning services in Tanzania have increased and family planning is now available to almost 40 percent of the population in both rural and urban areas. By 1992 there were 3733 health facilities (hospitals, health centers and dispensaries) of which 67.6 per cent were offering family planning services. The results from the 1991/1992 Demographic and Health Survey (TDHS) revealed that one fourth of women live within 1 Km of a facility that provide family planning while another two third (2/3) live within 5 km of a family planning service. In 1994, 90% of maternal and child health clinics provided family planning services, an increase of 22% to from 1992. These efforts have yet to succeed in reducing fertility rates.

This has however not been accompanied by a corresponding rise in contraceptive use. It is becoming increasingly clear that providing access to family planning services is only one of the requirements for an effective family planning programme. Other factors have also to be considered. For instance, people also need to have complete and accurate information about the various family planning methods, including both the benefits and the risks of each method. They also need access to follow-up services, and they may also need information about and help with other elements of reproductive health. Few studies have made detailed and critical assessment of the kinds of information, knowledge and perceptions that the general public has on family planning/ contraceptive use and whether this information or knowledge is sufficient for people to have confidence in modern family planning methods. They must also have the ability to make effective use of the available range of contraceptives. There are also few studies that examine the impact of factors such as rapid social and economic changes - particularly the growing state of poverty on family planning programmes, especially the use of contraceptives. This paper is aimed to bridge some of these gaps.

Knowing about contraceptives is an important step needed before one can actually use contraceptives. According to TKAP (1994) the knowledge of at least one contraceptive method is high and has increased for both men and women in Tanzania. It has increased from 85.8 per cent for men and 74.4 per cent for women in 1992 to 88 per cent and 79.5 per cent respectively in 1994. Despite this apparent high level of knowledge or awareness, the use of family planning is still low. This low prevalence of contraceptive use calls for an in-depth examination to highlight factors hindering use of contraceptives and to find means and ways to bridge the gap between awareness and practice. This is particularly important as the same studies indicating high levels of awareness of contraceptive use also indicate that about half of women in Tanzania live within 5 km of a facility that offers some form of medical services and have access to a medical facility.

An article by the Nichters (1989) is one of the few studies which could throw some light on the issue of acceptability of family planning programmes by focusing user-views of family planning services and contraceptive technologies in Asia. This research shows how people in Sri Lanka view their own fertility, and how the contraceptive technologies that are provided are believed to affect the 'flow of bodily fluids'. The article discusses the importance of cultural perceptions of fertility in the South Asian context. The Nichters argue that lay notions of fertility will not disappear with mere education. This appears to be the case for Tanzania and other African countries that are trying to improve contraceptive use through increased education and awareness campaigns. There is a growing need to examine other factors that affect fertility.

There is also need to explore various ways and means to translate awareness and knowledge about contraceptives that the public has into actual use of contraceptives. For instance, what is the basis for a decision to use or not to use contraceptives? Is the decision based on experience of contraceptive use or a person's sexual practices, or is the decision based on other factors?

A number of studies in Tanzania, including UNICEF, 1990; TDHS, 1992; TKAPS, 1994; UNFPA, 1996; TDHS, 1996 and others have emphasized the need for improved family planning programmes in order to enhance contraception use. For instance, according to TKAP (1994), the use of family planning is still low because the quality of family planning is below standard, many couples still want more children and there is misconceptions on various family planning methods. The 1996 TDHS data show that unplanned pregnancies are still common. About one-fourth of the births in the three years prior to the survey were reported to be unplanned; 15 per cent were mistimed (wanted later) and 9 per cent were unwanted. If unwanted births could be eliminated altogether, the total fertility rate in Tanzania would be 5.1 births per woman instead of the actual level of 5.8 (TDHS, 1996). The problem of lack of access and availability of family planning services is also underscored and is advanced as a probable cause for low contraceptive use. Other factors mentioned in these studies include illiteracy, lack of properly trained staff and poor services particularly in rural areas. The problems of

inadequate information, communication and education efforts for men have also been highlighted.

There has however been very little work on examining in greater detail why the majority of the population are still hesitant to use modern family planning methods and how to translate the apparent high level of awareness of the population on contraceptives to actual use of family planning methods. In other words there are few studies which give attention of how to motivate the population that is aware of the benefits of family planning methods to actually use family planning. There is need to get a better understanding of user's views and the dynamics that affect their behavior towards contraceptive use. It is important to elucidate the social, economic and cultural context that people live in and how this affects their decisions regarding family planning.

Many nations have endorsed international declarations, which address the choice of contraceptives provided, and the information and the environment in which women and men should receive family planning services. However, the reality is often a far cry from such international standards. Many countries in the developing world, particularly in sub-saharan Africa are still struggling to provide basic family planning services. For instance, an assessment carried out in South Africa (Progress, 1996), found out that many South African women have limited contraceptive choice. The study observes that about half of South African couples use contraceptives but few have adequate access to a choice of contraceptive methods, especially in rural areas. The problem in Tanzania is even greater as less than 18% of couples use contraceptives with more limited choices. There is thus need for a study to examine users needs and access to contraceptive methods of their choice. However, for people to have real options it is necessary to ensure that the methods being introduced are needed in the country and that the service delivery system can provide them with appropriate quality of care. This in turn will create an enabling environment for contraceptive use.

A.K. Jain, a leading expert on family planning, has said: "without significant attention to quality, we will neither see a sustained increase in the contraceptive prevalence rate nor succeed in lowering birth rates through voluntary means"(Jain, 1992). The quality that is being stressed here and which is indeed very significant is

better care of the users. All the above indicate the need for relevant, clear and detailed information and knowledge about family planning and contraceptive use. Evidence suggests that care of family planning users can greatly be improved by provision of accurate, unbiased and essential information about each of the various contraceptive methods to the user. This is the real challenge that faces the government and other family planning providers in the Country.

The dangers (real and imagined) and fear of the unknown - modern contraceptives- are also often cited as reasons for nonuse of contraceptives. Studies including WHO (1995), have consistently pointed out that women are concerned about how fertility regulation methods affect their overall health, including their interest in sex, physical stamina and emotional well-being. Over and above that, the effects of contraceptives on their ability to have children and effects on their offsprings concern many men and women. This makes it imperative for people to have sufficient information and knowledge about each contraceptive method to offset these concerns.

In discussions of safety of contraceptive methods and how this influences use, scientists often tend to argue that the health risks of a method should be measured against the health risks of an abortion or a full-term pregnancy. In this regard, scientists have often overlooked preferences and needs of users in their pursuit of developing better and more effective contraception methods. The priority of contraceptive researchers is to develop the most effective methods that will avert the need for women to have high-risk pregnancies or to resort to dangerous abortions. Women health advocates, on the other hand, often feel that such a comparison is an insufficient basis for declaring a method safe. Contraceptive methods, they may say, should have minimal side effects and should not simply be less risky than abortion (Progress, 1995). More often than not, the poor use is left out of the discussion and is provided with little or no information to decide what type of contraception is best for her/him. What is becoming increasingly clear is that there is a lot more to know about contraceptives and their safety and why some people are still reluctant to use modern contraceptive methods. This is reflected by the fact that many users and potential users are still not

certain about the safety of modern contraceptives and require more information about them before using them. There is hence need to listen to the users/potential users of family planning to find out their concerns and views regarding contraceptives and how they can make effective use of existing family planning methods.

Other limitations hindering use of family planning methods include social barriers, such as requirements for spousal permission or proof of a given number of living children, and encounters with the medical establishment can be intimidating for women. There is also significant unmet need among adolescents and rural populations, and limited technical ability in the area of family planning. There is also the problem of integrating family planning to become an integral part of reproductive health endeavors in Tanzania. It is consistently being argued that if family planning is not integrated into other services that have some logical affinity (MCH, STD screening, infertility management, and activities for enhancing women's skills) it is marginated, theoretically and practically, in ways that constrain both access and effectiveness (Herz and Measham, 1987; Raikes, 1989; Royston and Armstrong, 1989). This limitation also affects women's ability to gain sufficient knowledge about family planning, as well as an adequate understanding of their options, to make informed decisions (Howson, et al, 1996).

The success of family planning programmes will to a large extent depend to a large extent on improving the general well being of the society. Poverty, unemployment, deterioration of basic services such as education, health, housing and clean water which in recent years have become part and parcel of the socio-economic landscape of Tanzania are likely to have a negative impact on family planning programmes. For instance, the increasing state of poverty in both rural and urban areas makes it increasingly difficult to put into effect measures for adoption of modern family planning methods. It is difficult to influence or encourage people who are unemployed, hungry, sick, homeless, and in despair to take into serious consideration or to participate effectively in measures designed to promote and improve use of family planning methods.

Evidence suggests that there is great discrepancy between the

level of awareness/knowledge on contraceptives and actual use of contraceptives. (TDHS, 1992, 1996 amongst others) also indicate that knowledge and use of contraception also varies from one region to the other and by urban rural residence, region and educational attainment. In rural areas, contraceptive knowledge and use is lower than in urban areas (73 versus 94 percent for women and 80 versus 99 percent for men). Contraceptive use is lowest among respondents with no education (69 percent). There are also differences in the level of current use of contraceptives between the mainland and Zanzibar and more notably by regions, levels, and number of living children. Use of modern family planning methods is lower in Zanzibar (8 percent) than on the mainland (12 percent). Between the two islands, use of modern family planning methods is slightly higher in Unguja (9 percent) than Pemba (6 percent). In the mainland, urban women are much Kagera more likely to be using modern contraceptive methods (24 percent) than rural women (8 percent). Levels of current use of modern family planning methods are highest in the Kilimanjaro, Coast, and Dar es Salaam regions (23 - 24 percent) and lowest in the Shyinyanga, and Mara regions (4 - 5 percent). Current use of modern family planning methods is less than 10 percent in six (6) regions and more than 10 percent in 14 regions.

Access to family planning services in Tanzania as demonstrated by our study of Kibaha district is restricted for many of the same reasons that affect access to health care services overall: insufficient government commitment, lack of knowledge about services, distance, and logistics. There are also social barriers, such as requirements for spousal permission or proof of a given number of living children, and encounters with the medical establishment can be intimidating for women.

This study will therefore examine the nature and extent of awareness and knowledge, and perceptions of the public about contraceptives and the factors for the dichotomy between high awareness of family planning methods and low prevalence of contraceptive use in Tanzania. The study will revolve around the question of why it is that despite over 80% of women and men having some form of knowledge of contraceptive use, it is only about 16% of all women and 22% of all men who are using a contraceptive method? The study will also investigate reasons for the variation in contraceptive use among four regions of

mainland Tanzania and within these individual regions.

While knowledge and awareness of family planning and contraceptives has risen amongst the majority of the public, actual use of contraceptives remains low. There is thus need for a study, which will shade some light on this problem. A study which will provide detailed information on the extent and nature of awareness/knowledge and perceptions that the public has on family planning and why the apparent high level of awareness about family planning and contraceptives has not yet been accompanied by equivalent use of contraceptives among the general public. The thrust of this study is towards meeting this objective.

#### ***THE CASE FOR FAMILY PLANNING IN TANZANIA.***

These are tormentors times in Tanzania with increase of poverty and the spread of sexually transmitted diseases (STDs) and HIV/AIDS. This study is significant because it will investigate factors affecting contraceptive use and will provide indicators of how the country can promote reproductive health to young people and reduce the growing rate of unsafe sex and abortions. For instance, between 20% and 30% mothers die in abortion every year, the majority of them being adolescents. An estimated 7% of all Tanzanian births are to mothers under the age of 18. This highlights the need for encouraging family planning and use of contraceptives and the overall situation of women in society. The study will contribute to new and urgently required knowledge to address the above situation and may improve reproductive health for girls and young adults.

This study will provide more knowledge about the factors that are affecting contraceptive use and why the great majority of the population is still hesitant to use modern contraceptives. The study will also enable us to evaluate and take stock of the impact of the on-going socio-economic changes that are going on in the country. The

introduction of a free market economy, privatization and reforms of the health sector are having a profound impact on the lives of people and on the scope of options for provision of health services. Family planning programmes are also being affected by these changes and there is thus a need to examine the impact of these factors so as to try to determine how best Tanzania can proceed to provide reliable and effective family planning programmes, particularly information about family planning methods and how this knowledge/awareness can then lead to acceptance and increased use of contraceptives by a public that is increasingly becoming pessimistic and overburdened by the drudgery of life.

Overall, this study is significant because it will provide not only essential knowledge and information that will contribute to the set up of a health-care infrastructure which enables fertility-regulating methods to be accepted and used by the general public, but also provide significant information on the problems that are hindering self sustaining development in Tanzania.

- The conduct of family planning services is usually based upon health and population policies. Therefore secondary sources of data will include important government documents and other relevant literature will be examined. These include documents, records and evaluative reports of UMATI on family planning from various ministries e.g. Ministry of Health, Ministry of Community Development, Women Affairs and Children, etc., also from the Bureau of Statistics and Planning Commission.

## **The Road Ahead:**

### ***Community Involvement in Family Planning Programmes***

Tanzania needs to integrate community involvement in the execution of family planning programmes. This can be achieved through the training

of local family planning field workers and traditional birth attendants for community-based distribution (CRD) of family planning information and services. These efforts are necessary especially in rural areas whereby the local population has little or no time to visit family planning clinics. For instance our study of Kibaha district demonstrate that rural women are engaged in a struggle to make ends meet and are therefore fully engaged in agricultural production and small scale businesses as well as looking after the family. The husband has also little motivation to visit a family planning clinic on his own. Family planning field workers must therefore move to the family household to deliver their services.

Community involvement will mean little if the male population is not fully integrated in family planning programmes. It is without doubt that men wield considerable power and influence in the household and their acceptance and involvement in family planning programmes will provide a big push for use of family planning methods. The youth population also has to get fully involved in the planning and execution of family planning programmes in Tanzania. This is primarily due to the fact that the youth population in Tanzania now makes up almost half of the country's population and the most active sexually/

Finally, the enhancement of private sector and non-governmental organization family planning and reproductive health activities has to be promoted at all levels. This will be instrumental in spreading family planning IEC and services, particularly at the local level. Although most contraceptives are provided free or at minimal cost by many government-based sources, private outlets are crucial for women or couples who place a premium on confidentiality. With the ongoing process of health reforms and privatization, the government needs to encourage private investment in the promotion of family planning programmes.

It is not unreasonable to argue that because of the clear relationship between childbearing and female health, women will be able to improve their health status significantly when they have made significant gains in reproductive freedom, and family planning programmes are conceptually and practically integrated into health programmes and overall development of the Tanzanian society.

Family planning programmes for present day Tanzania should be designed to serve the needs of women and adolescent females. These needs must move from the mere need for contraceptives to include basic need that are linked to the general well being of women and their families. These include the need for economic empowerment, education, shelter and food. Also the right to land ownership and inclusion in political leadership. Family planning programmes must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Although there at present family planning clinics in most parts of the country, local women at the grass roots level are yet to be involved in the planning, management or evaluation of family planning programmes in the country. The most outstanding aspect of this is that the choice of contraceptives available in family planning clinics is not dependent on the choices of local women or men. They are only advised on what is considered the best from the viewpoint of the providers. The government and other organizations providing family planning services should take positive steps to include women at all levels of the health-care system.

Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning, domestic and child-raising responsibilities and to accept the major responsibility for the prevention of sexually transmitted diseases.

Family planning must reach men in their workplaces, at home and where they gather for recreation. Boys and adolescents, with the support and guidance of their parents, and in line with Convention on the Rights of the Child, should also be reached through schools, youth organizations and wherever they congregate.

Our case study of Kibaha district underscored the growing realization that men influence women's contraceptive experiences. In this regard family planning providers in the country may also want to consider the following questions. How can policy-makers and program managers, particularly in rural areas, educate men that they too have reproductive health needs? How can providers make more services and methods available to men? What types of programmes are needed to train

health workers to provide comprehensive reproductive health care for men? How can programmes help women and men improve their communication skills? Domestic violence in the home affects many women in the country and is sometimes associated with the use or non-use of contraception. How can family planning programmes and policies improve women's safety - which is a basic human right? Dynamic family planning programmes for Tanzania in the new millenium have therefore to ensure that gender issues are addressed and to make them more "gender-sensitive".





















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