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# Access is not Enough: Family Planning in Dar Es Salaam

Claire Burrus  
*SIT Study Abroad*

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# Access is not Enough: Family Planning in Dar Es Salaam



(image: Sanitas Hospital website)

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Tanzania: Wildlife Conservation & Political Ecology  
Fall 2016

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## **Abstract**

Population growth is a large problem, both globally and at local levels. The global population is growing at an unsustainable rate, particularly in developing nations. Tanzania, as a developing nation, is one of the fastest growing countries in the world, and as a result, faces many hardships related to high population. The Tanzanian government, non-governmental organizations, and private institutions have made attempts to address these concerns by encouraging family planning. Even so, the national population continues to rise. Many social and cultural factors have contributed to this phenomenon. This study was performed in the Women's Clinic at Sanitas Hospital in the Mikocheni district of Dar Es Salaam, Tanzania. Results have shown that the usage rate of proven effective family planning methods is alarmingly low, even when women have full access to family planning information and resources. Family planning access and education was not proven to have an effect on the usage rate of proven effective family planning methods. This study has revealed the key contributors to family planning education and the spread of family planning information, as well as the key social and cultural concerns that women have regarding family planning use. Family planning initiatives could be improved by taking women's opinions into account, using information from studies such as this.

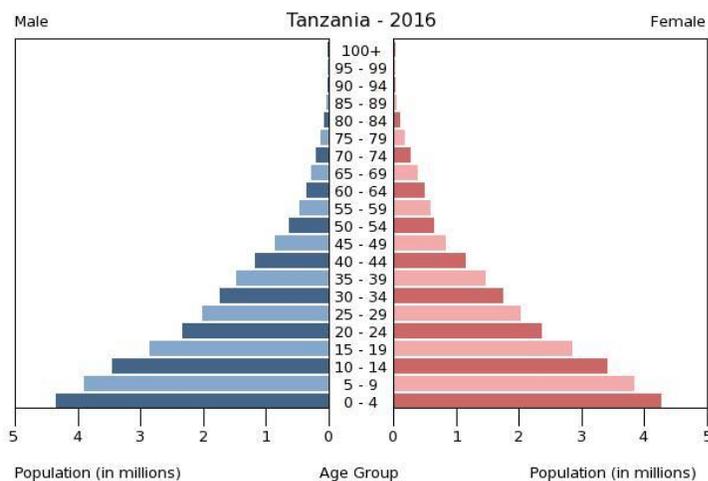
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## Introduction

The global population is growing at an unsustainable rate. If humans were to continue to consume resources and create a global ecological footprint at the same rate as today, we would need 1.5 earths to support our current population, and would need 3 earths to support our projected population by the year 2050 (Population Connection, 2016). Currently, the global population is over seven billion, with projected continuous exponential growth, especially in certain, concentrated areas of the world. Most of this growth is occurring in developing countries, many of which are found in Africa (United Nations Secretariat, 2003). Tanzania, with a GDP of 945 US dollars in 2015, a population of over 45 million, a fertility rate around 5.4, and a projected population doubling time of 26.1 years, serves as an excellent example of countries such as these (Agwanda & Amani, 2014).

The population of Tanzania has more than tripled between the years of 1967 to 2012 (CIA, 2016). Every year, more children are born than the year before. This growth is outlined by the Tanzanian 2016 population pyramid (Figure 1). This pyramid shows that the population is in a period of rapid growth. The younger the age category, the more people it contains, both male and female.



*Figure 1. Population pyramid displaying the age structure of Tanzania in 2016 (CIA World Factbook, 2016).*

The United Republic of Tanzania (URT), along with many other African nations, has implemented a number of programs within the past 50 years that support family planning, in an effort to decrease national population growth, and in turn global population growth (United Nations Secretariat, 2003). The Tanzanian national government has supported numerous mass media campaigns to encourage family planning use and has

been involved with NGO efforts to provide contraceptive access and education to its people since 1976 (Brosche, 2016).

The national government of the URT has been promoting family planning and population growth control for decades. However, the national population continues to rise, further exacerbating the country's pervasive poverty. Tanzania has a poverty rate of 28.2%, a GDP of 44.9 US dollars, and has been classified as a developing nation by the World Bank. The demographic transition model (Figure 2), established by Warren Thompson, demonstrates the relationship between the

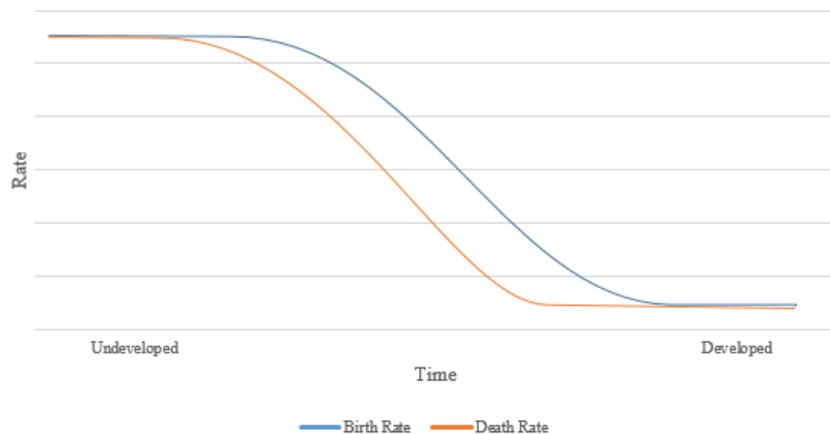
population growth and the development of a nation (Dudley, 1996). The more stable the population size, the more stable the economy of a nation will be, the higher its development status and in turn the better the standard of living.

Because of this connection, the

national government has a strong incentive to work on this issue for the welfare of the nation.

The URT established the Reproductive and Child Health Section in 1997 through the Ministry of Health. Today, the section consists of nine programs, including one entitled "Family Planning" and one entitled "Management Information System and Research" (Reproductive and Child Health Section, 2016). The Tanzanian government's current family planning goal, set by former President Jakaya Kikwete at the 2012 London Summit on Family Planning, is to double the number of family planning users in the country from 2.1 million to 4.2 million by the year 2020 (Family Planning 2020 Commitment, 2012). This effort is being promoted by an increase of government funds being allocated to existing family planning programs, such as the National Family Planning Costed Implementation Program and the National Costed One Plan II for Reproductive Maternal Newborn Child and Adolescent Health.

The government of Tanzania has reportedly allocated 1.186 billion TSH in the 2015-2016 time period, and anticipating to allocate 5 billion TSH to these efforts in 2017 (Family Planning



*Figure 2. Simplified visual representation of the Demographic Transition Model.*

2020 Annual Commitment Update, 2016). The efforts have included family planning services, campaigns for girls and youth, the construction of new plans for family planning, and public-private partnerships established with existing family planning organizations and contraceptive providers. In its partnership with PSI, the URT has spearheaded an ad campaign with posters reading lines like “accomplish your goals” with contraceptives, describing them as “easy”, “sure”, and “safe”, and encouraging readers to learn more by visiting their health care center (PSI, 2016). Local media sources are also being influenced by the national push toward family planning and population control education. Newspapers such as Daily News have highlighted the dangers of overpopulation and have shed light on the cultural factors that are causing high birth rates and national population growth (Domasa, 2016). These campaigns have provided information and awareness to the widespread public, but the effects on the behavior of the population are unknown.

Many studies have been performed in order to ascertain the uptake of family planning and the factors that play into family planning choices. In fact, the national government has contributed to this research by forming an agenda to organize future efforts, the Tanzania National Family Planning Research Agenda (Ministry of Health and Social Welfare, 2013). These studies assist the government and its partner organizations in making the right choices as to where to allocate funds to encourage an increase in family planning use, and meet the goals of the FP2020 Plan.

In January 2016, a family planning study was published by a Swedish medical student named Linn Brosche, in which she investigated the rates of Tanzanian women’s family planning use and uncovered the family planning methods chosen by the women at a women’s health clinic in Dar Es Salaam. These women are not only urban, living in the largest city in the country, but they were also already educated enough in women’s health to be visiting a gynecology clinic. She concluded that there is a relationship between the women in her study’s access to family planning information and their choice of which contraceptive methods to use, thus demonstrating that family planning has an effect. However, despite having a sample of relatively educated, urban women, all visiting a women’s health clinic in which the doctors consistently recommended family planning methods, the data showed no higher rates of use among this sample of women than the national average, which includes women with no access or education in family planning at all. This result was surprising, and it indicated that there must be other

underlying reasons why Tanzanian women choose not to use family planning methods, other than socioeconomic factors. In addition, Brosche's study failed to include any investigation into the reasons why women may not favor family planning methods or may choose not to use family planning methods, despite their access to these resources. In fact, there is a lack of data in the field that reflects the cultural and social factors that influence Tanzanian women's low use of family planning.

High birth rates have been linked to a lack of information about family planning methods, economic or geographic barriers to purchasing contraceptives, and cultural values that encourage large families, discouraging contraceptive use (World Atlas). There is a large discrepancy in contraceptive access and education between rural and urban areas in Tanzania. In rural areas, birth rates are higher, at 6.1 per woman, with a perceived necessity for larger families in agricultural communities (World Bank). In addition, rural areas tend to have less access to contraceptives or information about their use, so family planning is left to local doctors and traditional healers, with often ineffective results, leading to large families, and in turn, growing populations. In urban settings, women often are more educated, rely less on agriculture for their incomes, and have far greater access to contraceptives and family planning information than do their rural counterparts.

However, despite the reduced geographic, economic and informational constraints to the uptake of family planning methods and the increased initiatives to provide contraceptives to Tanzanians, women in urban areas continue to give birth at an unsustainable rate, although it is significantly lower, at a national average of 3.9 births per woman (World Bank). There is plenty of access to family planning products and information on use in many of these communities, and yet women are making the active choice not to use contraceptive methods enough to decrease the birth rate to a sustainable level. If geographic and economic factors are less significant in these urban communities, there must be deeply engrained social and cultural influences causing this phenomenon. Uncovering these influences could be beneficial for more effective and accurately directed implementation of government family planning programs in the future.

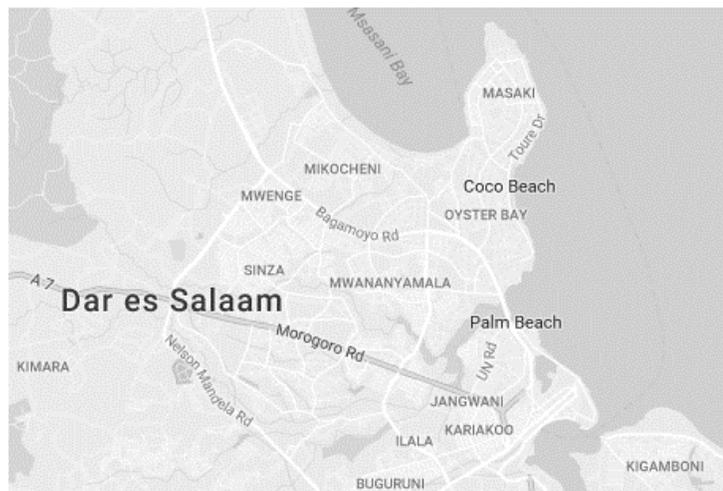
It seems to be assumed, based on where the aforementioned family planning efforts are being focused, that access to contraceptives and education about them are the primary barriers to the use of these methods. The government and its international and local partners are bringing resources to communities that demonstrate low family planning method use, in order to

encourage greater use of these methods, reduce unintentional pregnancies, and in turn, stabilize the national population. However, as Brosche's study shows, even many women with access to the methods and the information at their fingertips are choosing not to use family planning. It is likely, therefore that there are other, social and cultural factors that are causing this effect. In this case, access to family planning resources would not be sufficient alone to encourage a rise in contraceptive and family planning use. My study aims to uncover what some of these factors may be, in an effort to contribute to the growing body of research from which the national government is basing its family planning projects and goals.

## Study Site

In order to explore the social and cultural factors that influence Tanzanian women's family planning choices, a population of women with ready access to family planning education and with contraceptive resources available to them was chosen for this study. In doing this, the study was controlled for any socioeconomic or geographic barriers women may face in their use of family planning. By narrowing the survey sample to a population of urban women with access to women's health facilities and with access to plentiful pharmacies and facilities providing family planning options, this study focuses on exposing exclusively social, cultural, or other various underlying factors that may affect women's family planning choices. This study site was selected specifically to provide a sample that was most likely to fit this description, for these reasons.

The sample was taken from a population of women visiting the Women's Clinic at Sanitas Hospital in the Mikocheni district of Dar Es Salaam, Tanzania. Dar Es Salaam (Figure 3) is the largest city in Tanzania, with a population of over 5 million, composing nearly 10% of the

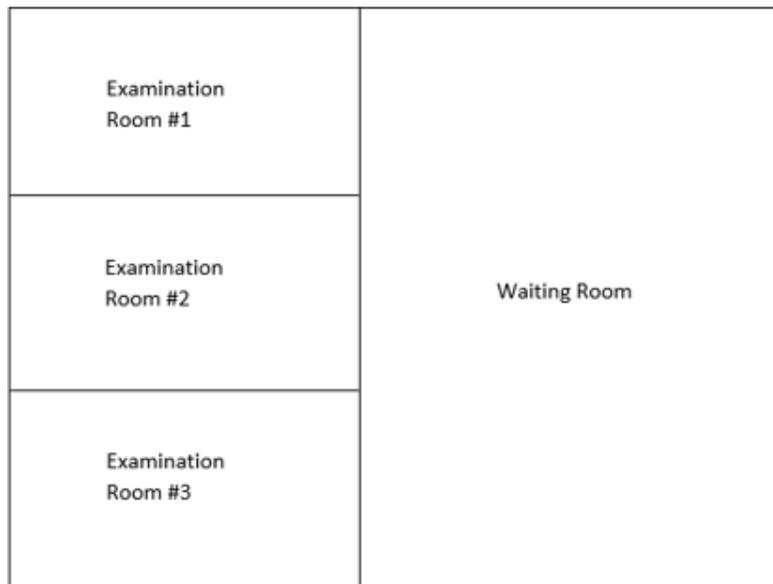


*Figure 3. Map of Dar Es Salaam, showing the location of the study site, Mikocheni district*

national population (CIA, 2016) and also functions as the city’s economic capital. Home to a majority of the nation’s government buildings, various industry centers, and massive markets and office buildings, Dar Es Salaam is easily the most urbanized and developed city in the country (Tanzania Tourist Board). Urban areas provide many different family planning services and options to women, from non-governmental organizations to hospitals to pharmacies at nearly every street corner. Mikocheni is a relatively gentrified, middle to upper class area of the city, and Sanitas Hospital is a privately owned hospital found in the Baraka Plaza shopping center of Mikocheni.

Sanitas Hospital is contained within two floors of Baraka Plaza, with a third floor designated for the administrative office of the hospital. The hospital is composed of a minor emergency room, a children’s clinic, a dental clinic, dialysis center, physiotherapy center, a modern medical laboratory, and a pharmacy, in addition to the women’s clinic in which this study was performed. There are four gynecologists on staff in the women’s clinic, and several doctors are always present during the working hours of the clinic, from 8am to 8pm from

Monday to Saturday. The doctors take their patients on a first-come, first-serve basis as the patients check in at the front desk in the waiting room. There are three examination rooms in which patients can be seen (Figure 4). The system is efficient, and women move in and out of the clinic for their appointments quickly. The



*Figure 4. Sanitas Hospital Women’s Clinic layout.*

standard rate for a gynecology consultation at Sanitas is 40,000

TSH. The cool, clean waiting room contains seating for around 15-20 people to sit together comfortably, and is plastered in women’s health posters and images of smiling mothers and babies.

## **Methods**

This study was conducted over the course of two weeks in the waiting room of the Women's Clinic at Sanitas Hospital in November of 2016. Women were asked to participate in a written survey (see appendix, p.25) after checking in at the registration desk, and to fill out the questionnaire while they waited to be seen by their doctor. The researcher briefly explained the study in Kiswahili to women seated in the waiting room and asked the women if they would be willing to fill out a questionnaire on family planning. Women were first ensured to be of 18 years of age or above after agreeing to participate, and all data was collected exclusively from adults. The surveyed population was taken as a convenience sample, and the selection technique was voluntary response. Exactly 100 surveys were collected over the course of the research period, and the responses were documented electronically in spreadsheets by the researcher. Trends in the data were analyzed, compiled, and expressed graphically in order to reveal the key factors influencing urban Tanzanian women's family planning choices. Variables were cross-tested using chi-squared analysis for statistical significance.

## Results

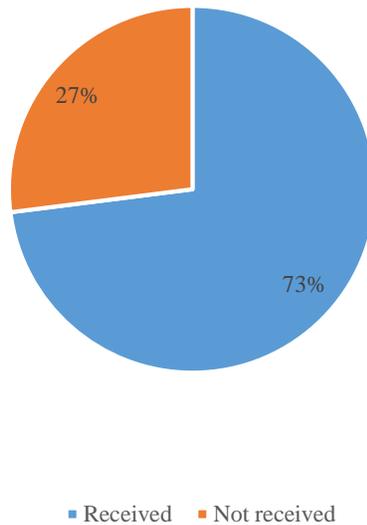
Age:	<u>18-24</u>	<u>25-34</u>	<u>35-50</u>	<u>&gt; 50</u>	
	21%	57%	21%	1%	
Religion:	<u>Christian</u>	<u>Muslim</u>			
	78.6%	27.3%			
Marital Status:	<u>Married</u>	<u>Single</u>			
	72.3%	27.7%			
Education:	<u>University</u>	<u>College</u>	<u>Secondary</u>	<u>Primary</u>	
	64.3%	18.4%	13.2%	4.1%	
Employment:	<u>Employed</u>	<u>Unemployed</u>			
	88.2%	11.8%			
Income (TSH):	<u>&lt; 500,000</u>	<u>500,000 – 1m</u>	<u>1m – 1.5m</u>	<u>1.5m – 2m</u>	<u>&gt; 2m</u>
	19%	49%	14%	7%	12%
# Children:	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>6+</u>	
	30%	57%	13%	0%	
Future children:	<u>Want more</u>	<u>Content</u>	<u>Wish fewer</u>		
	70%	26%	4%		

*Figure 5. Summary of responses from survey questions regarding demographic information.*

A majority of respondents were aged in their late 20s or early 30s, and few were older than 50 years old. Most of the women were Christian, 27.3% of which self-identified as Catholic. A majority of respondents reported being married. The education level of the sample was, in general, highly educated. A majority of surveyed women had completed university, followed by having completed college, then secondary, and a small minority having completed only primary school. Zero of surveyed women reported having received no education. A large majority of surveyed women reported being employed, 25.4% of which identified as self-employed. A large majority of women experienced monthly household incomes of less than 1m TSH/month. Most of the women surveyed reported having few children, however, a large majority reported desiring more children in the future. Of women who specified how many children they want to have in total, the average of the numbers reported was 2.95 (n=21). No statistically significant

relationship was found between age, religion, marital status, education, employment, or income on the use of family planning methods by any individual respondent.

### Received Family Planning?



*Figure 6. Response to survey question regarding family planning education or information about family planning.*

A majority of women (73%) reported having received education on or information about family planning. No statistically significant relationship was found between reception of family planning education and the use of family planning methods or between the reception of family planning education and the number of children an individual respondent had.

### Sources of FP Education

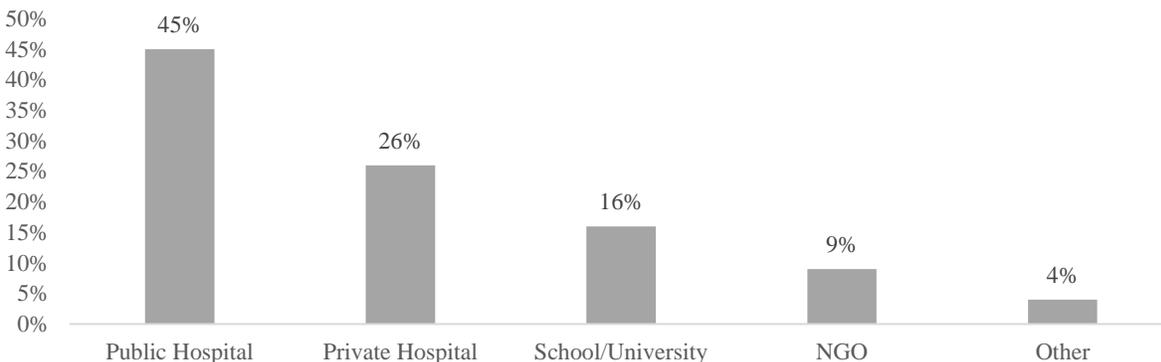


Figure 7. Rates of respondents' sources of family planning information, if received.

Public hospitals were the leading institutional source of information and education about family planning (45%), followed by private hospitals (26%), schools or universities (16%), and non-governmental organizations (9%). A small minority of respondents reported having received this information from other, unspecified sources (4%). No statistically significant relationship was found between the source of family planning education and the use of family planning methods.

### FP Information Sources

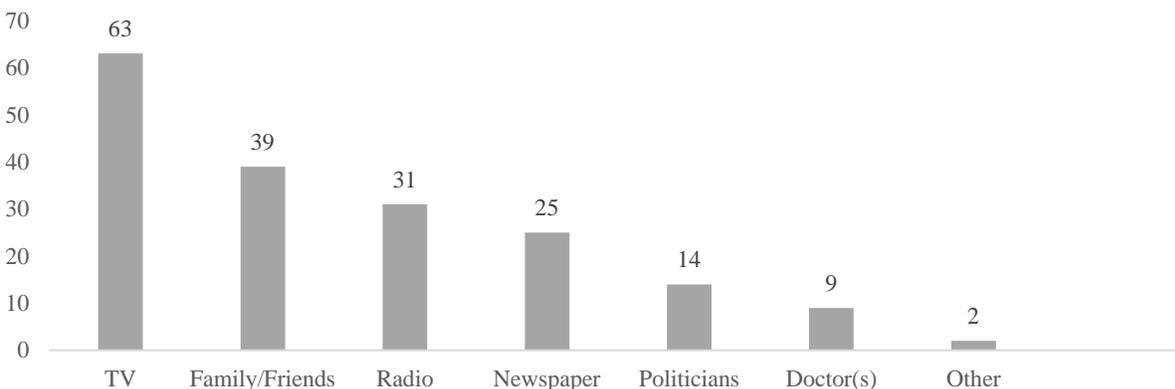


Figure 8. Reports of exposure to media and human sources of family planning information.

Television was reported as the leading source of family planning information (63) by a large margin, when compared with other media sources or individuals. Family and friends (39), radio (31), and newspapers (25) were also widely reported to be sources of information about family planning. Politicians (14) and doctors (9) were also cited, but in much fewer numbers.

### Pop. Control Information Sources

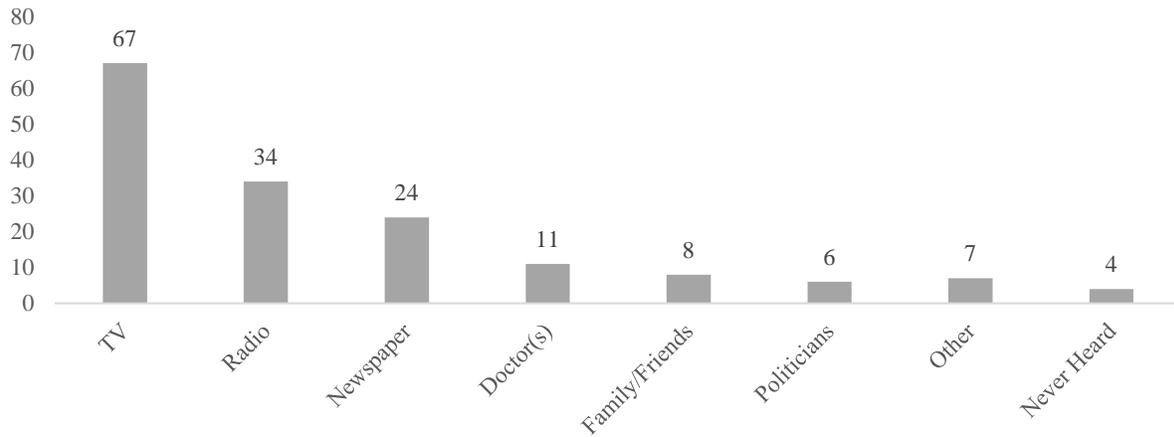


Figure 9. Reports of exposure to media and human sources of information about population control in Tanzania.

Television was reported as the leading source of population control information in the media and from individuals (67). Radio followed (34), then newspapers (24), doctors (11), hearing from family and friends (8), from politicians (6), and from other sources (7). Some of the surveyed population said that they had never heard of the population control issue in Tanzania (4).

### Information from Sources

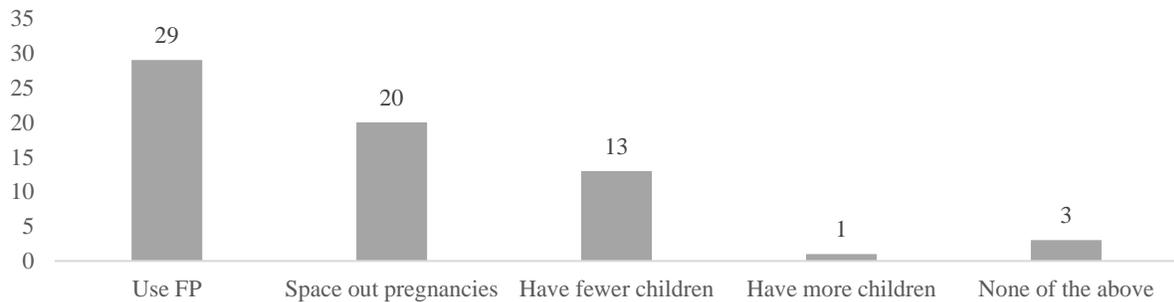
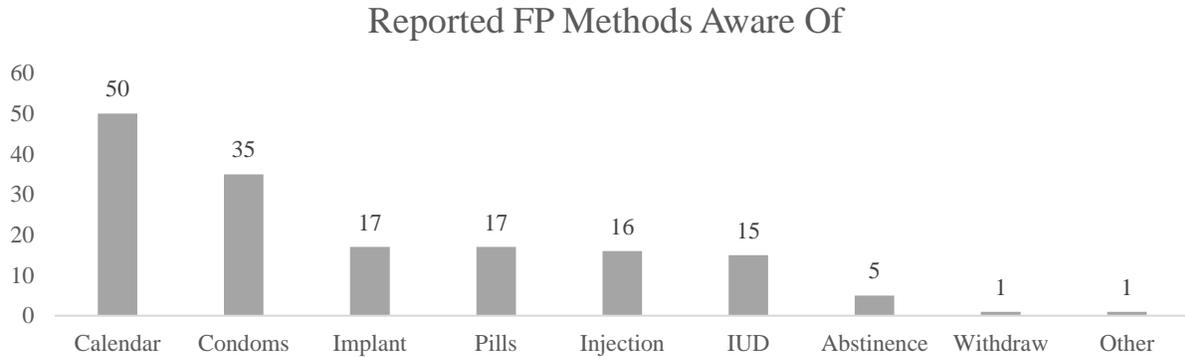


Figure 10. Reported general sentiments communicated to the surveyed women from family planning sources and/or from population control sources, by category.

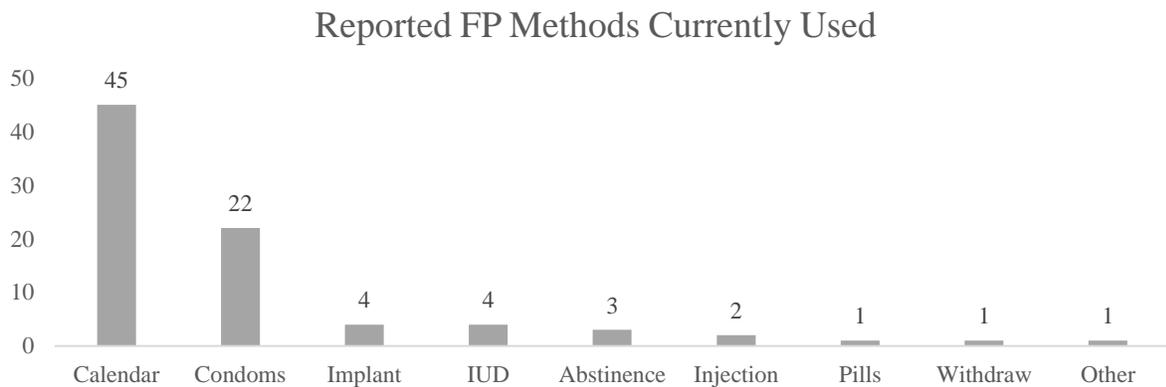
Surveyed women reported having heard messages that encourage the use of family planning more than any other of the messages reported (29). Many also reported having heard to space out their pregnancies (20). This message was followed by a sentiment of encouraging the public to have fewer children overall (13). One respondent reported having heard to have more children

from family planning and/or population control sources. Three respondents had heard none of the above messages from these sources.



*Figure 11. Reports of individual respondent awareness of various popular contraceptive methods.*

The calendar method was the most commonly known contraceptive method (50), followed by condoms (15), contraceptive implants (17), contraceptive pills (17), contraceptive injections (16), intrauterine devices (15), and abstaining from sexual activity (5). The withdrawal method was listed as an “other” method by one respondent.



*Figure 12. Reports of individual respondents’ use of various popular contraceptive methods at the present time.*

The calendar method was reported as the most commonly currently used contraceptive method (45), followed by condoms (22). A wide margin behind, use of contraceptive implants was reported (4), as well as intrauterine devices (4), followed by abstinence (3), then contraceptive

injections (2). One respondent reported currently using contraceptive pills. The withdrawal method was listed as an “other” method by one respondent.

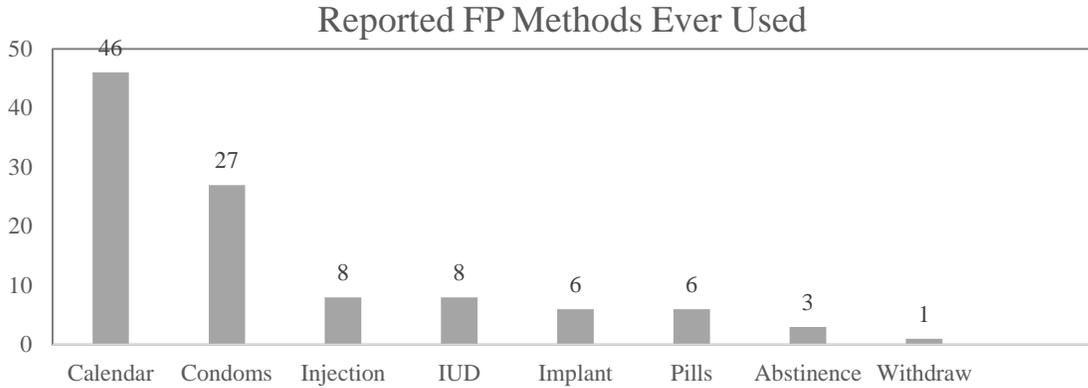


Figure 13. Reports of individual respondents’ use of various popular contraceptive methods at any point in their lives.

The calendar method was reported as the most commonly used contraceptive method (46), followed by condoms (27). Following behind, contraceptive injections (8) and intrauterine devices (8) were reported. Contraceptive implants (6) and contraceptive pills (6) were also reported as ever having been used by respondents to the survey. The withdrawal method was listed as an “other” method by one respondent.

### Contraceptive Methods Ever Used

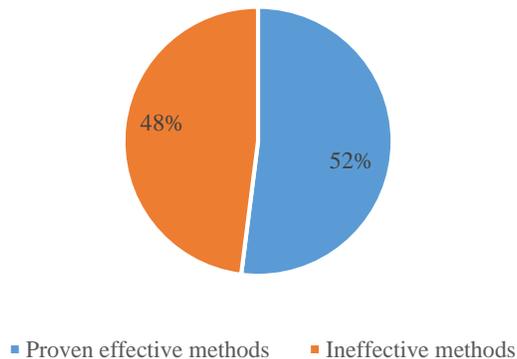
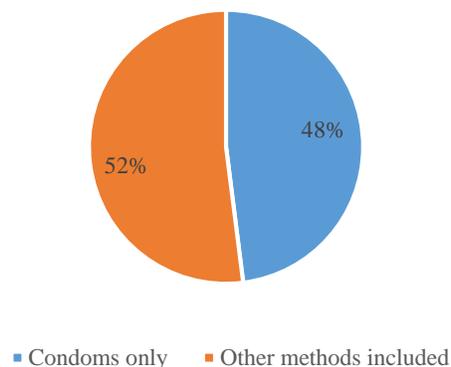


Figure 14. Reports of individual respondents’ use at any point in time of one or more proven effective contraceptive methods, versus the use of exclusively ineffective contraceptive methods.

Just over half of respondents reported having used any of the proven effective contraceptive methods included in this study at any point in their life (52%). Just under half of respondents reported never having used any of the proven effective family planning methods included in this study at any point in their life, using either zero methods, or only ineffective methods (48%). “Proven effective” family planning methods, for the context of this study, are defined as methods with a less than 20% failure rate, as specified by the Center for Disease Control and Prevention. The “proven effective” methods included in this study are the following: abstinence, condoms, contraceptive pills, contraceptive injections, IUDs, and contraceptive implants. In his study, “ineffective” methods, with a failure rate of greater than 20% (CDC, 2011), include the “calendar” method, frequently referred to as the “rhythm” method, and the withdrawal method. No statistically significant relationship was found between the use of proven effective contraceptive methods and the number of children and individual respondent had.

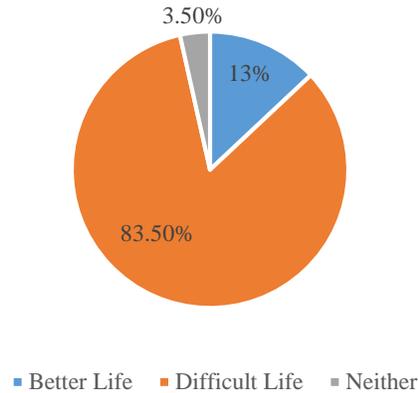
### Proven Effective Methods Ever Used



*Figure 15. Reports of proven effective contraceptive methods ever used by individual respondents, comparing the use of condoms to the use of other proven effective contraceptive methods.*

Just under half of respondents who reported having used proven effective contraceptive methods reported only ever having used condoms (48%), of all proven effective contraceptives included in this study. The other proportion reported having used proven effective methods other than condoms, in addition to or in substitution of condoms (52%).

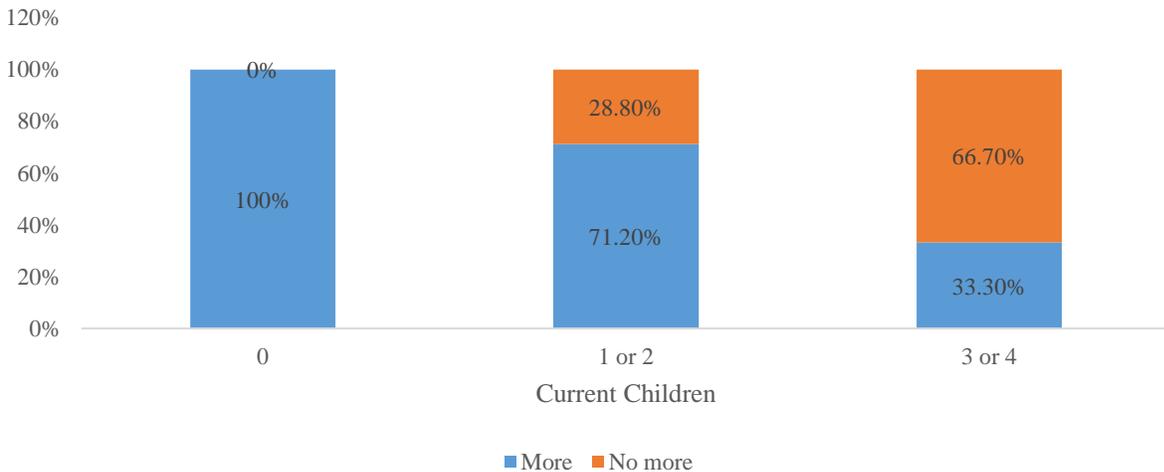
## Children and Quality of Life



*Figure 16. Survey responses to the statement, “Having a large number of children leads to...”*

A large majority of the surveyed population indicated the belief that having a large number of children leads to a more difficult life (83.5%). A minority reported that having a large number of children leads to a better life (13%). A few respondents selected that there is no effect. No statistically significant relationship was found between the perceived effects of having many children and the use of family planning by the women surveyed in this study.

## Number Current Children & Future Children Desired

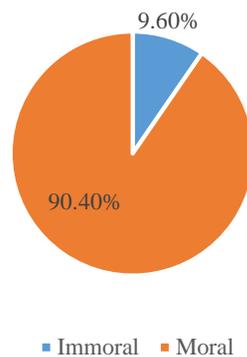


*Figure 17. Correlation between the number of children an individual respondent has and her desire to have more children in the future.*

Chi-squared analysis indicates a statistically significant relationship between the number of children a respondent currently has and her desire to have more children in the future ( $p < 0.05$ ,

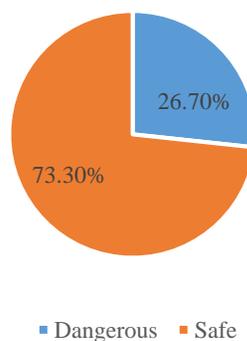
n=78). According to this study, as the number of children a woman has increases, her desire to have more children in the future decreases. Overall, a large majority of respondents reported desiring more children. No statistically significant relationship was found between the number of children a woman currently had and her use of family planning methods, or between whether she desired more children and her use of family planning methods.

### Morality of Family Planning



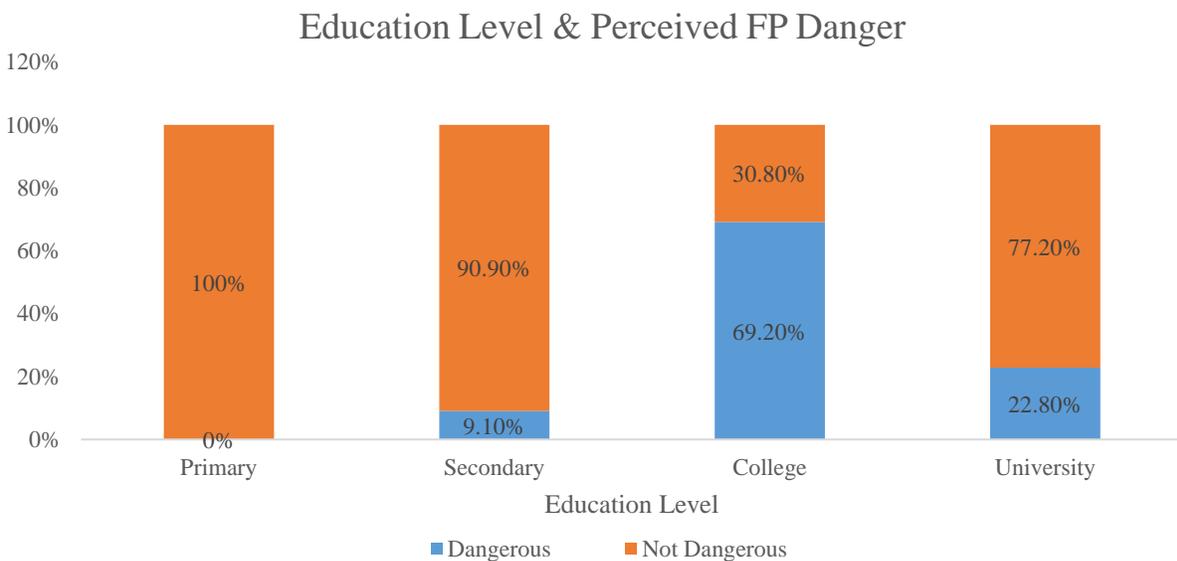
*Figure 18. Survey responses to the question, "Do you think family planning is morally wrong?"* A large majority of respondents indicated the belief that family planning is not morally wrong. No statistically significant correlation was found between the perceived morality of family planning and the use of family planning. No statistically significant relationship was found between religion and the perceived morality of family planning.

### Perceptions of Danger Using Contraceptives



*Figure 19. Survey responses to the question, "Do you think family planning is dangerous?"*

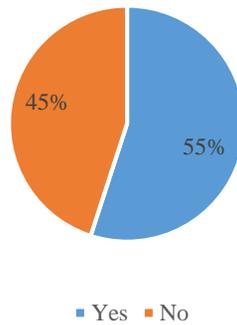
A majority of respondents indicated the belief that family planning is not dangerous. No statistically significant correlation was found between the perceived danger of the use of contraceptives and the use of family planning methods. When asked why they believe that family planning is dangerous, respondents who answered that they found it dangerous cited a wide variety of reasons. The reported reasons for finding family planning dangerous were the belief that it causes permanent infertility, the belief that it causes diseases such as cancer, that it leads to uterine swelling and pain, and that it leads to unfavorable side effects such as body weight changes, changes in monthly cycle, and hormonal effects. Respondents also reported concerns of mistakes in the application of intrauterine devices that could result in long-term negative health effects and the need for surgery. In general, women who answered this question reported that the “calendar” method was the only safe method of family planning, and a general unspecified sentiment of common negative effects of the use of contraceptives.



*Figure 20. Correlation between highest education level an individual respondent has completed and her perceived danger of family planning use.*

Chi-squared analysis indicates a statistically significant relationship between the highest education level a given respondent has completed and her perceived danger of the use of family planning methods ( $p < 0.05$ ,  $n = 83$ ). From primary school to college level education, perceived danger of family planning increases as education increases. From college to university level education, perceived danger of family planning drops with increased education.

## Desire for more FP



*Figure 21. Survey responses to the question “Would you like to receive more family planning?”* Just over half of survey respondents reported a desire to receive more information and education about family planning or a desire to use more family planning in the future. Their reported reasoning, when indicated, included wanting to assert control over the number of children they have and when they have them, avoiding unplanned pregnancies, allowing for better parental care and allowing more time for women to participate in community activities beyond the responsibilities of motherhood. Some women who answered yes to this survey question also reported believing that family planning is healthy, and wanting to learn which methods are safe and effective. No statistically significant relationship was found between a desire for more family planning and individual family planning use.

## Discussion

The goal of the URT's FP2020 plan is to double national Tanzanian family planning use, with a target of a 60% national use rate by the year 2020 (Family Planning 2020 Commitment, 2012). The surveyed population of this study reported a current use rate of proven effective family planning methods of 36/100, or 36% of the sample (Figure 12). This sample is not representative of the population of Tanzania, but rather is a limited sample that reflects a higher level of opportunity for family planning access. Even so, the sample has reported low rates of family planning usage, both currently and at any point in time (Figure 12, Figure 14). There is much progress to be made in order to bridge this usage gap. Clearly, access to family planning alone is not enough to effectively encourage its usage.

Despite the low level of proven effective family planning usage by the sample, survey responses indicated substantial reach of family planning programs. More than half of surveyed women reported having received family planning education (Figure 6). Family planning education was reported to have been provided primarily through public hospitals (Figure 7), indicating that government sources of family planning resources had a widespread influence in the surveyed population. The leading source of both family planning information and national population control information was television. Radio and newspapers also ranked highly as sources of information for both types of information (Figure 8, Figure 9). A large majority of respondents reported having been told to use more family planning from these sources. Respondents reported having received family planning education and information at a much higher rate (73%, Figure 6) than they reported ever having used proven effective contraceptive methods (52%, Figure 14). There was no statistically significant relationship shown between the reception of family planning and the use of proven effective contraceptives. The low rate of use is especially concerning considering the heightened access that the women surveyed in the study sample have to the resources needed to learn about, purchase, and use contraceptives.

Gynecologists at Sanitas actively encourage family planning use and provide information to their patients about various methods (Mkono, pers. comm.) Survey respondents had access not only to this information from their doctors simply by being patients at Sanitas, but also to the pharmacy on site at Sanitas, just down the hall. The women's clinic does not provide contraceptive methods directly, but the gynecologists will provide any procedures necessary for

the application of contraceptive products, such as injections, implants, and intrauterine devices (Mkono, pers. comm.) The only obvious barriers to the patients' use of family planning, considering how readily available family planning is to them, besides the social and cultural factors focused on by this study, are economic considerations.

Consultations with a gynecologist in the Women's Clinic at Sanitas Hospital cost 40,000 TSH per visit. This is not an insignificant cost, especially to the 68% of surveyed women who experience a monthly household income of less than 1,000,000 TSH (Figure 5). For these women, a single consultation at Sanitas would cost at least 4% of their household's entire income for a month. This could prevent some women from coming back for more information or for family planning consultations. That being said, the cost of consultations can be covered by health insurance, of which a majority of Sanitas patients have, usually provided by their employers (Mkono, pers. comm.) Health insurance eliminates this economic barrier, although not all women have it. However, the consultation does not include the cost of contraceptives themselves. Contraceptives and any family planning products must be purchased at a pharmacy, which cannot be covered by insurance. The hormonal contraceptives included in this study – pills, injections, IUDs, and implants – cost around 65,000 TSH (Mkono, pers. comm.) Injections, IUDs and implants last a year at the very least, though, while pills must be purchased monthly. All of these methods were reported as being used at much lower rates than were condoms, with nearly half of women ever having used proven effective family planning methods using condoms exclusively and no other methods (Figure 15). Condoms cost around 1,000-1,500 each at a pharmacy (Mkono, pers. comm.) Costs such as these may be unachievable for some. Of course, however, the cost of contraceptives is negligible when compared to the cost of a pregnancy or of raising a child.

The women surveyed in this study seem to understand that having many children can lead to hardship for the parent(s). A large majority of women reported that they believe that having a large number of children leads to a difficult life (Figure 16). In addition, a statistically significant relationship was shown between the number of children a woman already has and her desire to have more children in the future (Figure 17). As the number of children a woman has increases, her desire to have more decreases. These responses reflect a rejection of the traditional large family culture of Tanzania, in which having many children is celebrated and encouraged (Domasa, 2016). The survey responses also indicated a general sentiment that the women did not

believe that using contraceptives was immoral and also that they largely did not believe that using contraceptives was dangerous (Figure 18, Figure 19). These responses are signs of a healthy and positive general understanding of family planning and how it can be used to improve one's life. This sentiment was confirmed by respondents' responses to their reasoning for wanting to use family planning more. However, none of these variables displayed a statistically significant relationship with the use of family planning, and the rates of these positive responses highly outnumber the rates of response about the use of proven effective family planning methods. This indicates that although women are receiving family planning education and are learning important information about it, there remains a general mental disconnect between this information and women's use. It is evident, considering these results, that sources of family planning education and information are not adequately addressing the concerns of women, leading to a continuation of low rates of usage rather than convincing more women to begin using contraceptives.

The information provided by this study could contribute to the growing body of research surrounding family planning use in Tanzania and encourage further studies on this subject. Both governmental and non-governmental family planning programs and initiatives can incorporate this information and the information provided by potential future studies into their systems in order to provide the public with a deeper and more holistic understanding of family planning. A majority of respondents to this study reported wanting to learn more about family planning (Figure 21), and many reasons indicated a current state of uncertainty regarding the safety and effectivity of contraceptives. Although a majority of respondents reported feeling that family planning is safe, over a quarter responded that it is not, and specifically indicated hormonal methods as being unsafe. Many of these women believe that learning more could assuage these concerns. The responses to this study also indicate which platforms are reaching the widest audiences with regards to family planning and population control, and to what extent. Both hospitals and television have proven to be widespread platforms for spreading this information. If the messages spread were altered to include more information targeted at the factors that most influence women's family planning choices, it is possible that these initiatives would become much more effective in altering the behavior of women. Current access to family planning information and resources is not enough to reach the goal of a 60% usage rate, as proven by this

study. These sources must take into account the opinions and concerns of the public in order to effectively increase rates of use and address the population concerns of the nation.

## **Limitations & Recommendations**

There are many ways in which this study could have been improved in order to reduce bias and further control the sample for variation that could potentially have skewed the results. The most significant limitations to this study included a limited sample size and a language barrier. An expanded study including a larger number of respondents could have resulted in an improved potential for statistical analysis of the variables. Many of the tests run on the data could have produced flawed results due to a small body of data with which to analyze trends. Additionally, the surveyor's limited knowledge of Swahili led to an inability to respond to inquiries from potential respondents before their agreement or declination to participate. This could have caused some women to feel uncomfortable, even choosing not to participate because they were not clear on the premises of the survey.

There is a large potential for a response bias in this study, as answers were only collected from women who agreed to participate, and respondents were permitted to omit any questions that they did not wish to answer. This decreased the sample size from which variables could be analyzed for trends and relationships. Women could have been unintentionally excluded from this study due to illiteracy or not knowing Swahili, due to their physical illness, or due to their time limitations in rushing to see the doctor, causing them to choose not to participate. A large portion of the potential respondents were visibly pregnant, which could have led them to feel unwell. This also could have influenced their current use of family planning, as preventing pregnancy would be unnecessary if a woman is already pregnant. Other possible biases include power dynamics between myself and the respondents I surveyed, discomfort with the subject material, and the interference of men in the survey process. These factors could have resulted in further response bias, or could have affected the way that respondents answered the questions.

More research is needed investigating the social and cultural factors that influence the use of family planning in Tanzania. This growing body of knowledge could make essential contributions to the success of institutional family planning initiatives. An expansion of this

study with a greater sample size and with the inclusion of men could lead to a better basis for statistical analysis of the relationships between variables that may affect Tanzanian family planning use. A comparative study between rural and urban areas could reveal differences between the social and cultural factors that affect family planning between the two groups. Further investigation of Tanzanian family planning initiatives could indicate any general failures to address the social and cultural concerns that women have regarding family planning, as outlined by this study. This could lead to significant improvements in these initiatives, and in turn, higher rates of the use of family planning methods.

## **Conclusion**

The usage rate of proven effective family planning methods is alarmingly low, even in Tanzanian communities with increased access to family planning resources. Family planning access and education does not necessarily have a direct positive effect on the usage rate of proven effective family planning methods. In these cases, there is likely room for improvement in the information provided by family planning education and information sources. Family planning education and information sources have widespread reach, particularly television media campaigns and resources provided through both government and private hospitals. These sources have provided the public with important information with regards to family planning, yet women have reported still having safety concerns about contraceptives and have reported wanting to know more about family planning.

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**This survey is optional and completely confidential. Your responses cannot and will not be traced back to you. It is not necessary to participate in the survey if you do not want to. If there are any questions that you do not want to answer, you may leave them blank. If you choose to participate, please answer the questions truthfully and return the survey to the student when you have finished. The survey will take less than five minutes to complete. Thank you again and have a good day!**

<i>Age:</i>	18-24	25-34	34-50	50+	
<i>Nationality:</i>	Tanzania	Which country: _____			
<i>Tribe:</i>	_____				
<i>Religious Affiliation:</i>	Muslim	Christian	Catholic	Hindu	Another: _____
<i>Married?</i>	Married	Single			
<i>Education completed:</i>	None	Primary	Secondary	College	University
<i>Employment</i>	Employed	Self-employed	Unemployed		
<i>Household monthly income:</i>	Less than 500,000 TSH	500,000-1,000,000	1,000,000 – 1,500,000	1,500,000 – 2,000,000	More than 2,000,000 TSH
<i>Number of children</i>	0	1-2	3-5	6+	
<i>Have you been given family planning?</i>	Yes	No	DK		
<i>How many children do you want to have?</i>	More than I have		Fewer than I have		The number I have
<i>Have you had trouble giving birth to children?</i>	Yes	No		DK	

• Select all of the below sources from which you have received family planning:

- Public hospital
- Private hospital
- NGO
- School/university
- Other: \_\_\_\_\_
- I have not been given FP.

• Do you or your partner use one or more family planning methods?

- Yes
- No
- DK

• Where do you or your partner get access to family planning methods?

- Shop/pharmacy
- Public hospital
- Private hospital
- Other: \_\_\_\_\_
- I do not use FP
- DK

• Estimated monthly expenditures on family planning TSH \_\_\_\_\_

• Select all of the below methods which you are aware of:

- Abstinence
- Condoms/physical barriers
- Oral contraceptives
- Contraceptive injection
- Contraceptive implant
- IUD
- Calendar method
- Other: \_\_\_\_\_

• Select all of the below methods which you have ever used:

- Abstinence
- Condoms/physical barriers
- Oral contraceptives
- Contraceptive injection
- Contraceptive implant
- IUD
- Calendar method
- Other: \_\_\_\_\_

• Select all of the below methods which you currently use:

- Abstinence
- Condoms/physical barriers
- Oral contraceptives
- Contraceptive injection
- Contraceptive implant
- IUD
- Calendar method
- Other: \_\_\_\_\_

• Would you like to have more access to family planning methods?

- Yes  
-- Why? \_\_\_\_\_
- No

• Select all of the sources below from which you have heard about FP:

- TV
- Radio
- Newspaper
- Politicians
- Family/friends
- Doctors
- Other: \_\_\_\_\_
- I have not heard about FP

• Select all of the sources below from which you have heard about population growth control in TZ:

- TV
- Radio
- Newspaper
- Politicians
- Family/friends
- Doctors
- Other: \_\_\_\_\_
- I have not heard about FP

• Select all of the statements below which you have been advised from the above sources:

- Have more children
- Have fewer children
- Space out your pregnancies
- Use FP methods
- None of the above

• You think giving birth to a large number of children leads to:

- Happy life
- Difficult life
- does not matter

• Do you believe that FP is morally wrong?

- Yes
- No

• Do you believe that FP is dangerous?

- Yes  
-- Why? \_\_\_\_\_
- No

• How do you feel about family planning?

- Support
- Do not support
- No opinion

• How does your partner feel about FP?

- Supports
- Does not support
- DK
- I don't have a partner

• How does your community feel about FP?

- Supports
- Does not support
- DK

**Mafunzo haya ni chaguo la mtu kufanya na ni siri. Majibu yako ya maswali hayatarudi kwako au kuhojiwa kwa chochote. Siyo kushiriki katika mafunzo haya kama hukati kufanya hivyo. Kama kuna maswali ambayo kupendi kuyajibu, unaweza kuyaacha tu. Kama umechaagua kushiriki, tafadhali jibu kwa ukweli na urudishe karatasi hii kwa mwanafunzi utakapokuwa umemaliza kujaza. Maswali haya yatachukua chini ya dakika kumi kujaza. Asante tena na siku njema!**

<i>Umri:</i>	18-24	25-34	34-50	50+	
<i>Utaiifa:</i>	Tanzania	Nchi gani: _____			
<i>Kabila:</i>	_____				
<i>Dini:</i>	Mwiislamu	Mkristo	Katoliki	Mhindu	Dini nyingine: _____
<i>Umeolewa?</i>	Umeolewa	Uko mwenyewe			
<i>Kiwango cha elimu:</i>	Hamna	Shule ya msingi	Shule ya sekondari	Chuo	Chuo kikuu
<i>Ajira</i>	Nimeajiriwa	Nimejajiri	Sijaajiriwa		
<i>Kipato cha familia kwa mwezi:</i>	Chini ya 500,000 TSH	500,000 – 1,000,000	1,000,000 – 1,500,000	1,500,000 - 2,000,000	Zaidi ya 2,000,000 TSH
<i>Idadi ya watoto ulionao</i>	0	1-2	3-5	6+	
<i>Je, umeshawahi kupewa elimu ya mpango wa uzazi?</i>	Ndiyo		Hapana	Sijui	
<i>Ungependa kuwa na watoto wangapi?</i>	Watoto zaidi ya hawa nilionao		Watoto wachache kuliko nilionao	Idadi ya watoto nilionao kwa sasa	
<i>Je, unapata shida yoyote wakati wa kujifungua watoto?</i>	Ndiyo		Hapana	Sijui	

• Chagua chanzo chochote hapo chini ambocho/ambavyo umewahi kupata uzazi wa mpango:

- Hospitali ya serikali
- Hospitali ya mtu binafsi
- Shirika lisilo la kiserikali
- Shula au chuo
- Chanzo kingine: \_\_\_\_\_
- Sijawi kupata elimu yoyote ya mpango wa uzazi.

• Je, wewe au mwenza wako mnatumia njia moja au zaidi ya mpango wa uzazi?

- Ndiyo
- Hapana
- Sijui

• Je, wewe au mwenza wako mananunua au mnapata wapi aina za uzazi wa mpango?

- Duka la dawa
- Hospitali ya serikali
- Hospitali ya mtu binafsi
- Sehemu nyingine: \_\_\_\_\_
- Situmi njia yoyote ya uzazi wa mpango
- Sijui

• Unatumia kiasi gani cha pesa katika uzazi wa mpango? TSH \_\_\_\_\_

• Chagua kati ya njia hizo hapo chini ambazo unazijua:

- Sifanyi ngono au tendo la ndoa
- Kondomu au vizuri vingine
- Vidonge vya uzazi wa mpango
- Sindano za mpango wa uzazi
- Njiti
- Lupu
- Kalenda
- Njia nyingine: \_\_\_\_\_

• Chagua kati ya njia hizo hapo chini ulizowahi kutumia:

- Sifanyi ngono au tendo la ndoa
- Kondomu au vizuri vingine
- Vidonge vya uzazi wa mpango
- Sindano za mpango wa uzazi
- Njiti
- Lupu
- Kalenda
- Njia nyingine: \_\_\_\_\_

• Chagua kati ya njia hizo chini ambazo unatumia kwa sasa:

- Sifanyi ngono au tendo la ndoa
- Kondomu au vizuri vingine
- Vidonge vya uzazi wa mpango
- Sindano za mpango wa uzazi
- Njiti
- Lupu
- Kalenda
- Njia nyingine: \_\_\_\_\_

• Je, ungependa kutumia zaidi njia za uzazi wa mpango?

- Ndiyo
- Kwanini? \_\_\_\_\_
- Hapana

• Chagua chanzo chochote cha kupata habari ambacho umewahi kusikia kuhusu mpango wa uzazi:

- Televisheni (TV)
- Radio
- Magazeti
- Wanasiasa
- Rafiki wa familia
- Madaktari
- Vyanzo vingine vya habari: \_\_\_\_\_

• Siawahi kusikia kuhusu mpango wa uzazi.

• Chagua chanzo chochote hapo chini ambacho umewahi kusikia kuhusu mpango wa idadi ya watu hapa Tanzania:

- Televisheni (TV)
- Radio
- Magazeti
- Wanasiasa
- Rafiki wa familia
- Madaktari
- Vyanzo vingine vya mpango wa idadi ya watu.
- Sijawahi kusikia kuhusu wa idadi ya watu hapa Tanzania.

• Chagua ushauri ambo umeshawahi kupewa kutoka katika vyanzo hivyo hapo juu:

- Zaa watoto zaidi
- Kuwa na namba ya watoto wachache
- Pishanisha/achanisha watoto kwa muda wa kutosha
- Tumia njia za uzazi wa mpango
- Hakuna jibu kati ya yote

• Unafikiri kuwa idadi kubwa ya watoto inakusaidia kuwa na:

- Maisha mazuri
- Maisha magumu
- Haijalishi

• Je, unafikiri kuwa njia za mpango wa uzazi ni kinyume na maadili?

- Ndiyo
- Hapana

• Je, unafikiri kuwa njia za mpango wa uzazi ni hatari?

- Ndiyo
- Kwanini? \_\_\_\_\_
- Hapana

• Je, unaonaje kuhusu njia za uzazi wa mpango?

- Ninaunga mkono
- Siungi mkono
- Sina chaguo

• Je, mwenza wako anaonaje kuhusu njia za uzazi wa mpango?

- Anaunga mkono
- Haungi mkono
- Sijui
- Sina mwenza

• Je, jamii yako inaonaje uzazi wa mpango?

- Wanaunga mkono
- Hawaungi mkono
- Sijui

## **Nuts & Bolts**

I loved the subject matter and research process of my project, and I had a great time in the big city while working on my study! I encourage future SIT students to continue research on these issues, which will only become more and more important as time goes on and the national population becomes increasingly problematic.

No matter what subject you choose, there are some important considerations to take into account if you are performing your ISP in Dar Es Salaam. You may feel discouraged at first by the response from SIT after you propose Dar as your study site. There have been many students in the past that have endured troubles during their stays there, and because of this, the program administration has many safety and logistical concerns about sending students to the city. However, if you wish to perform your study in an urban environment, Dar Es Salaam is by far the most fitting study site in all of Tanzania, and it is worth it to go there for the sake of your study. Make sure to visit your site during ISP prep week to make sure that you have worked out the logistics of your study before ISP period begins. Some communication is much easier in person, and it would be very unfortunate to have to change your study, rewrite another whole proposal and get it approved again all during ISP period.

If you do go to Dar, and you are going to be working in the western or northern areas of town, I highly recommend On the Way Hostel. You can book your stay in advance on Hostelworld, the rate is \$15/night, and it is beyond worth it. The hostel is very nice and clean, with air conditioned rooms, hot showers, and full access to a kitchen. The cost does not include meals, but there are many restaurants on Mwai Kibaki Rd, as well as mamas selling traditional food and produce vendors selling fruits and vegetables along the side of the road. If you stay at On the Way, contact John Hu, the manager before you go and ask him to set up a cab to pick you up at the bus stop and bring you to the hostel. John is very cool and funny, and would be more than happy to set that up for you. The best bus line to take between Arusha and Dar is Kilimajaro Express. Tickets cost 33,000 TSH, the bus is comfortable, and makes a stop for lunch. The ride is about 11 hours, and spending all day on a bus is a lot better if it's a nice one. There are tons of cab drivers at the Dar bus station that will try to give you rides, but On the Way is very difficult to find, even for cab drivers, as many streets are unmarked and you will likely be traveling there in the dark. It is better to have one of John's guys come, as they already know where the place is.

No matter where your study or what the topic, if you plan to do your research in a hospital, you must be prepared to face some adversity when you first approach the institution. Hospitals are obligated to take certain measures to protect their patients and create a safe environment within their walls. The administration may not be keen on having a random American student tromping around and bothering their patients. Be prepared to have your proposal denied by a hospital, although of course this is not guaranteed to happen. If you approach the administration humbly and calmly and express your intentions as clearly as possible, your chances of getting access will be much higher. Be sure to have a draft of your methods and the letter of purpose from SIT with you when you go.

Good luck with your ISP, and remember to have fun and use this opportunity to get to know the place you're studying in!