FAMILY PLANNING AMONG CATHOLICS AND ANGLICANS IN DODOMA MUNICIPALITY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN RURAL DEVELOPMENT OF SOKOINE UNIVERSITY OF AGRICULTURE. MOROGORO, TANZANIA.

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ABSTRACT

The major objective of this study was to examine the influence of religious beliefs on family planning among Catholics and Anglicans in Dodoma municipality. Four wards were selected. From each ward 25 respondents were randomly selected making a total of 100. Specific objectives of the study were to; (1) identify the contraceptives mostly used in the study area, (2) assess the practices of family planning among Catholics and Anglicans in the study area, and (3) examine the perception of followers of Catholic and Anglican churches in regard with family planning practices. Data collection was done using structured questionnaire to obtain quantitative and qualitative data. Focus Group Discussions (FGDs) and in-depth discussions were conducted with people with information on family planning issues to obtain detailed information. Interviews were undertaken with key informants guided by checklist questions. Data analysis was based on descriptive statistics, crosstabs, frequency analysis and percentages. Data were presented using texts, Tables and Figures to illustrate findings. Results from the analysis show that there was association between family planning practices and respondents' religion. From the results it was concluded that religious beliefs had influence on their followers on the family planning practices. It was recommended that churches should organize seminars on family issues that involve both husbands and wives; churches should put clear their stand and teachings on family planning to their followers; and education on traditional methods should be given by involving specialists and experts on family planning in order to eliminate difficulties that people face.

DECLARATION

I, **Denis Muhamba,** do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my original work done within the period of registration and that it has neither been submitted nor being concurrently submitted in any other institution.

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Denis Muhamba Date
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The above declaration is confirmed

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Prof. Z.S.K. Mvena (Supervisor) Date

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DEDICATION

I dedicate this work to my beloved mom Ms. Bertha Kamaliza Mutalemwa; my uncle Mr. Byabato Wincheslaus; my sisters Dativa, Merriness and Dorah Byabato; and my brothers Erasto and Delfinus Byabato whose contributions laid down the foundation of my education.

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ACT	Anglican Church of Tanzania
AIDS	Acquired Immuno-Deficiency Syndrome
AMECEA	Association of Member Episcopal Conference in East Africa
AU	African Union
CCC	Catechism of the Catholic Church
CPR	Contraceptive Prevalence Rate
FGD	Focus Group Discussion
FP	Family Planning
FPA	Family Planning Association
FPAD	Family Planning Association of Dar es Salaam
HIV	Human Immunodeficiency Virus
IDRC	International Development Research Centre
IPI	International Peace Institute
IUD	Intrauterine Device
LAM	Lactational Ammenorrhea Method
MCH	Maternal and Child Health
MGDs	Millennium Development Goals
n.d	not dated
NBS	National Bureau of Statistics
NFP	Natural Family Planning
NSGRP/ MKUKUTA	National Strategy for Growth and Reduction of Poverty/ Mkakati wa Kukuza na Kuinua Uchumi Tanzania
SCCs	Small Christian Communities
SPSS	Statistical Package for Social Sciences

TFR	Total Fertility Rate
TV	Television
UMATI	Chama cha Malezi Bora Tanzania
UNFPA	United Nations Fund for Population Activities
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Family planning is a development phenomenon. It improves health, reduces poverty and empowers women (Okech *et al.*, 2011). More than 200 million women in the world fail to plan their families (Bongaarts *et al.*, 2012). They face many obstacles, including lack of access to information and health care services, opposition from their husbands and communities, misperceptions about side effects and cost (URT, 2010; Bongaarts *et al.*, 2012). If these obstacles could be overcome and the demand for family planning met, 54 million unintended pregnancies, more than 79,000 maternal deaths and more than a million infant deaths could be averted each year (Bongaarts *et al.*, 2012). Families could save more and begin to break the grip of poverty and communities could make greater investments in education, health care, and infrastructure (Bongaarts *et al.*, 2012; Okech *et al.*, 2011: URT, 2010; USAID, 2009b).

According to USAID (2009a, 2009b; Okech *et al.*, 2011) family planning achieves the principal objective to have only the desired number of children in order to reduce child mortality, improve maternal health as the important step to meet the Millennium Development Goals (MGDs) and to reduce the fast growing population of the world. Fadhala (2012) presents that the world witnesses today that every minute there are 266 births, 108 deaths which leads to the natural increase of 158 people. World population grows to about 83 million annually (UN, 2012). Okech *et al.* (2011) stipulates that Sub-Saharan Africa (SSA) is one of the regions with the highest population growth (2.8 percent).

Many developing economies are characterized by rapid population growth that is partly attributed to high fertility rate, high birth rates accompanied by steady declines in death rates, low contraceptive prevalence rate and high but declining mortality rate (Oyedokun, 2007; Okech *et al.*, 2011). Igwegbe (2009) presents that in Sub-Saharan Africa the level of unmet needs among married women ranges from 10 percent in Chad to 35percent in Senegal.

Demographers have historically been interested in the relationship between fertility and religion in sub-Saharan Africa because of the region's high fertility and dynamic and influential religious environment (Yeatman and Trinitapoli, 2008). Sub-Saharan Africa may well offer greater resistance to fertility decline than any other world region. The reasons are cultural and have much to do with a religious belief system that operates directly to sustain high fertility but that also has molded a society in such a way as to bring rewards for high fertility (Caldwell and Caldwell 1987). Religion is still a barrier to fertility decline and to family planning adoption in the region. According to Bourne *et al*. (2010) the use of contraceptives and family planning among women is mostly determined by religious beliefs. However, Bunce *et al.* (2007) highlights that religions differ on their dictates about contraception. This is to say that religious influences on family planning basing on contraceptive attitudes and behavior is conceptualized as being denominationally-driven according to Yeatman & Trinitapoli (2008). Whereas conservative churches like the Catholic Church advocate natural family planning and strictly prohibit the use of contraceptives, liberal churches, on the other hand, such as the Anglican Church followers are free to use or not to use contraceptives.

Family planning in Tanzania as argued by Mavanza and Grossman (2007) is not a new phenomenon; our ancestors used various traditional methods to space children. In Kigoma

district for example, local methods that are recorded include wearing the "*hirizi"* (a charm to be worn all the time around the waist) provided by traditional healers. Upon weaning their children, women then take off the "*hirizi"* and conceive. Modern methods of family planning in Tanzania can be traced as far back as 1959 when the Family Planning Association of Tanzania (UMATI), the first family planning program in Tanzania was founded and recognized by the Government (URT, 2010, Pile and Simbakalia, 2006). Expansion of the program and growth in the contraceptive prevalence rate (CPR) were accelerated after a speech by the late first President Julius Kambarage Nyerere in 1989 that recognized the importance of FP to Tanzania's development. In 1989, the Tanzanian government assumed responsibility for integrating FP into government Maternal and Child Health (MCH) services from UMATI. During the next few years—the 'golden age' of FP in Tanzania—the prevalence of modern FP method use doubled, increasing from 6.6 percent in 1992 to 13.3 percent in 1996, growing at an average of 1.5 percentage points per year. Beginning in 2000, however, the increase in prevalence dropped to 0.6 percentage points per year, with contraceptive prevalence for all methods among married women of reproductive age reaching only 26.4 percent by the time of the last Demographic and Health Survey (DHS) in 2004–2005 (URT, 2010).

Research by Bunce *et al.* (2007) specifies that the Roman Catholic Church in Tanzania actively discourages the use of modern methods. The church emphasizes on using the calendar method or/and other natural methods (not modern methods). However, Handout (2009) shows that on the other hand Protestant Churches have been less harsh on birth control, and the use of condoms, but condemn premarital sex. Bunce *et al*. (2009) argues that in Tanzania the Seventh Day Adventist Church is a strong advocate of contraception.

The role of religion in development arena according to Mhina *et al.* (2007) has been always viewed as both important and non-problematic. The contribution of religions can be seen in the framework of poverty reduction strategies. Holestein (2005) argues that religion and spirituality are sources of world view and views of life that they are forces for cohesion as well as polarization and they serve as instruments for political reference legitimacy. In Tanzania since independence, the government has seen religions as development partners that silently provide services to citizens especially in the areas the state is unable to reach. In addition, Green *et al.* (2010) argues that religious organization notably Christian churches have retained an engagement in development activities through continuation of services delivery functions established under previous regime of contracted service provision (Malya, 2001). The study by Mercer (2002) stipulates that Christian churches are also involved in longer established development sectors with local level projects in areas such as environment or micro-enterprise particularly for women, micro-finance banks and other projects to support children and combat AIDS. Less is known on how religious organizations notably Christian churches influence their followers in family planning.

1.2 Statement of the Problem

The current annual rate of population growth of Tanzania according to URT (2010) is 2.9 percent. The population is projected to reach 65 million by 2025, putting increased strain on already overstretched health and education services, infrastructure, food supply, and the environment (URT, 2005; 2010). The government has put in place various strategies and policies to facilitate the use of family planning services as a step towards reducing the fertility rates, increasing contraceptive prevalence rate (CPR) and reducing the unmet family planning needs (URT, 2010). Despite these policy measures, Total Fertility Rate (TFR) still remains high at 5.6 percent (Bongaarts *et al.*, 2012) while Contraceptive

Prevalence Rate (CPR) for modern methods is at 20 percent (URT, 2005) and the unmet needs for family planning services average at 21.8 percent (URT, 2010). The high TFR together with low CPR, unmet needs for family planning services and great number of pregnant women or with live births by age 19 could be contributing towards high population growth. Standards of living tend to worsen when the rate of population growth exceeds the rate of economic growth (Feyisetan and Bamiwuye, 1998). At the household level, the high fertility rate may be contributing towards depletion of productive resources in the society, rising cost of living, ill health, poor nutrition and limited educational opportunities, ultimately trapping women in a poverty cycle. According to Green (2010) religious organizations have been in partnership with the government to establish social and economic services for the well-being of the people since independence. Up to 2006 traditional Christian churches (Catholic, Lutheran and Anglican) had established 13 percent of dispensaries, 22 percent of health centres and 40 percent of hospitals and other organizations or projects for development purposes. Although, Mhina (2007) and Green (2010) present religious organizations as the state development partners that have been providing services to citizens especially in areas where the state has been unable to reach, the influence of religious beliefs on family planning in the Dodoma municipality is inadequately documented. This study therefore, seeks to examine the influence of religious beliefs among Catholic and Anglican churches on the use of family planning in Dodoma municipality. The study findings will help to fill the knowledge gap on the role of religious practice on family planning.

1.3 Justification of the Study

The study will help to find out the probable factors contributing to low or high use of contraceptives and other appropriate methods among Catholics and Anglicans. This will be of importance in facilitating the practices of family planning among people especially

those who need to plan their families but in one way or another it is difficult. The study will give measurable quantities for the evaluation of the ministry of the Christian churches in real lives of the people.

Basically, the study will contribute to the national goal of reducing poverty for improving peoples livelihoods within the framework of the National Strategy for Growth and Reduction of Poverty - Phase II (NSGRP II), Tanzania Development Vision 2025 and the fourth and fifth Millennium Development Goal (MDGs 4& 5).

1.4 Objectives

1.4.1 Overall objective

The general objective is to examine the influence of religious beliefs on Family Planning in Dodoma Municipality, Tanzania.

1.4.2 Specific objectives

i. To identify types of contraceptives used among the followers of catholic and Anglican churches.
ii. To examine the practices of family planning among Catholics and Anglicans in the study area.
iii. To determine the perceptions of Catholic and Anglican followers on family planning in the study area.

1.5 Research Questions

i. What types of contraceptives are used among the followers of catholic and Anglican churches?

ii. Which are the common practices of family planning among Catholics and Anglicans churches?

iii. How do followers of Catholic and Anglican churches perceive family planning?

1.6 Conceptual Framework

The conceptual framework of this study was based on religious relational ethics theories that regulate sexuality. Geissler *et al*. (2008); Kleinman & Benson (2006) state that principle-based ethics can be contrasted with a second broad type of ethical reasoning that is relational, culturally embedded, and a matter of personal morality. *Agent-relative* ethics allows that relationships and proximity may properly influence ethical judgments; that we should, for example, treat people to whom we are personally committed better than strangers. More generally, it is observed that norms of ethical behaviour vary locally and cross-culturally as well as responding to institutional and contextual change. Transactions respond to concrete and relational ethics and practice (Geisman *et al*., 2008).

Many religions of the world bring diverse and occasionally divergent attitudes to bioethical issues. These beliefs may guide followers and health care professionals as they seek or provide health care. Evangelical religious groups have commonly been conservative in their approach to sexual behaviour and have sought to control the manner and process by which sexual rights could be exercised, although a few religious groups have broken away from the traditional norm (Ojo, 2005). Based on ethical/ moral theories and according to other literature it was assumed that Catholicism is based on conservatism and hierarchy while Protestantism (Anglicanism) is based on liberalism and individualism.

Basing on these perspectives, there are varied interpretations of the scriptures between the two parts, each trying to suit its teachings in its respective philosophy. Being conservative and hierarchical, Catholic Church follows the traditional styles while liberal Anglican Church on the other hand follows the autonomy of the followers to choose between the traditional, modern or both. According to Sachs (1993) in Anglican Church it is believed that modern techniques must reconstruct Christian dogmas and institutions to suit present experience. Catholic Church on the other hand embraces conservatism when the question of modernity comes. The Catholic Church remains traditional and hierarchical in all its actions. Religious conservatism and/or liberalism leads to use or non-use of contraceptives. The conservative church will strictly prohibit its followers not to use contraceptives but only use the traditional (Natural) methods while the liberal churches will observe autonomy of the followers to use or not to use contraceptives. The outcome of this is family planning.

The study also assumed that social economic statuses of the people such as income, education and health facilities can directly affect the people to use or not to use contraceptives. It was assumed that people with low income, low education and inaccessible to health care will face problems with contraceptive use and family planning. These people will not be able to afford to buy contraceptives because of low income. They will also lack knowledge on how to use contraceptives and family planning because of low levels of education. NBS and Macro (2000) enlightens that education attainment has a strong effect on reproductive behaviour and contraceptive use. It is strongly related to awareness, knowledge, attitude and behaviour towards family planning methods. The people will fail to acquire contraceptives and family planning if these services will not be accessible to them. In contrast, the people with high income, high levels of education and

accessibility to health care will have greater chance to use contraceptives and plan their families.

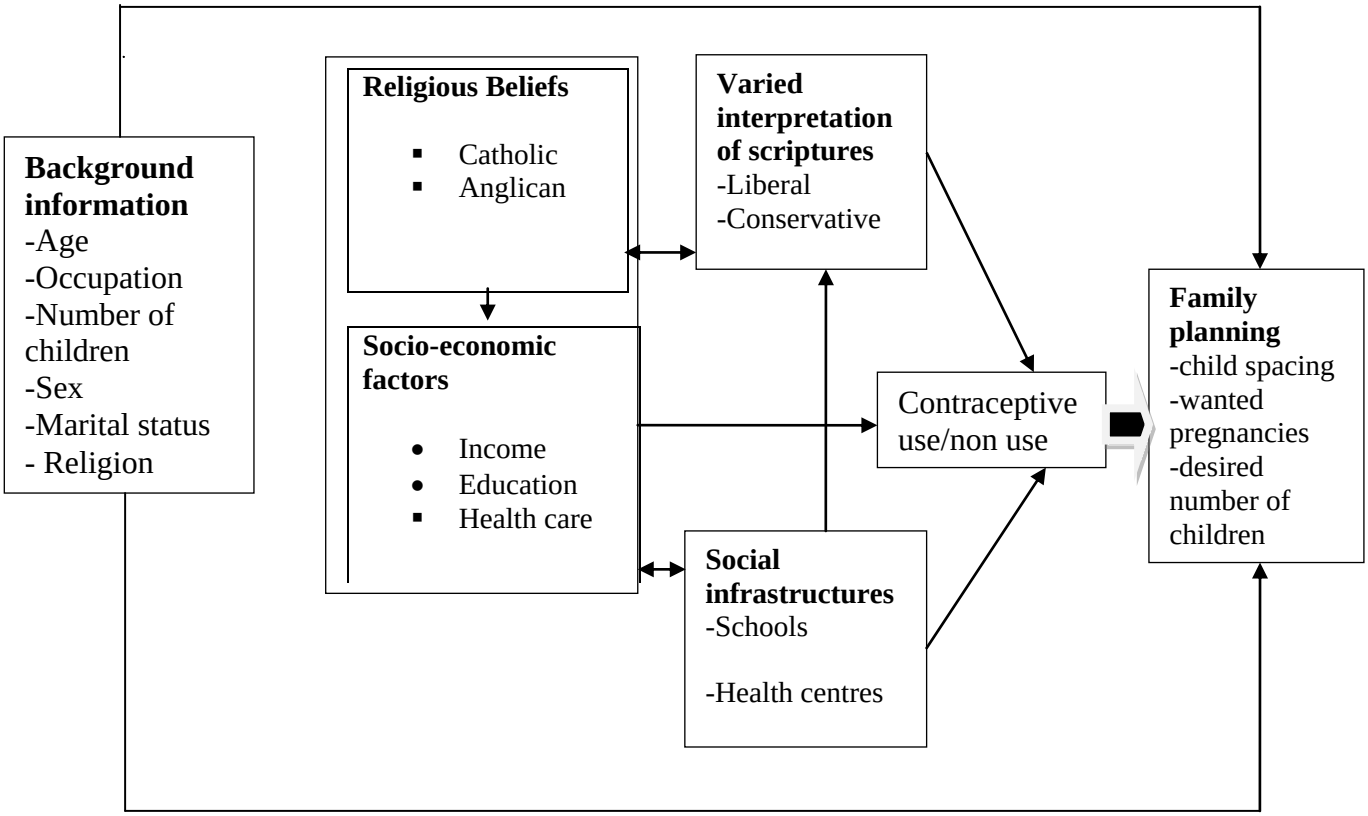

Figure 1: Conceptual framework; the influence of religious beliefs on family planning

Further, social infrastructures in a given area will be influenced by the developed socio-economic aspects of the people. High income, high level of education and accessibility to health care will lead to the construction of social services infrastructures such as schools and health centres. Social services infrastructures will influence adoption of family planning and/or contraceptive use in the area.

In the conceptual framework shown in Fig. 1, socio-demographic factors such as age, sex, occupation, number of children, marital status and religion were assumed to affect an individual's perception and thus influence his/her reproductive behaviour. Thus, it is not

surprising that individuals in a certain age group are more likely to use more contraceptives and family planning practices than other age groups. Likewise people with certain occupation status are more contraceptive users and more active in family planning issues than other occupation status. Also marital status of individuals affects family planning practices and contraceptive use. Mbwilo (2008) discloses that marriage provides an important role in regulating sexual behavior and child bearing in most societies of the world.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Religion and Religiosity

Religion and religiosity are not interchangeable terms. In simple term as stipulated by Salleh (2012) religiosity may be referred to as the state of one's belief in God, characterized by his piety and religious zeal. The higher his piety and religious zeal are, hence the stronger his belief in God, the higher his religiosity is. Religion on the other hand according to Denton *et al.* (2002) is a person's belief of a purpose in life, and person's actions in pursuit of that purpose.

Myers (1996) cited by Zhang (2008) stresses that religiosity is an important aspect of religion which often is viewed as the intensity of religious beliefs and participation. Religious beliefs are, notably, beliefs in hell, heaven, and an afterlife. Strong religiosity usually is marked by strong daily influence of religious beliefs on individual decisions and frequent participation in religious activities (Barro and McCleary 2003; Corijn 2001; Myers 1996).

2.2 Family Planning

According to Kinemo (1998) family planning (FP) refers to practices consciously and intentionally adopted by a family (husband and wife) to determine the number of children through child spacing for the interest of the welfare of the members of the family. UNFPA (2006) argues that parents have a right to make their own decision about how many children to have, and when to have them. Bill and Melinda Foundation (2009) argues that family planning is a cost-effective way to save the lives of women and children, and it empowers families to determine the optimal timing and spacing of births. Having too

many pregnancies or pregnancies too closely spaced can negatively impact the health of the mother and her infant (USAID, 2005). Women and couples with access to family planning methods can more easily space pregnancies and reach their desired family size, which reduce the risk of maternal and neonatal morbidity and mortality (Bongaarts, *et al.*, 2012; USAID, 2005). Beyond the health and survival implications of high levels of closely spaced and unintended births, high fertility rates accelerate population growth, undermining development efforts across all sectors. Unintended pregnancies and births have a potentially devastating impact on both the individual and society (Bongaarts, *et al.*, 2012; Rosenzweig and Zhang 2009). The pattern of low literacy, high rates of school dropouts, low income-earning potential, and low participation in civil society is all too common among women and girls in countries with high unmet need for family planning (USAID, 2005).

2.3 Family Planning Methods

There are various kinds of family Planning methods (Yakobson *et al.*, 2012). Mesce *et al.* (2009) identifies only two methods namely traditional and modern methods. Traditional is sometimes referred to as natural family planning. Traditional methods include periodic abstinence (also known as the calendar or rhythm method), breastfeeding and withdrawal. Modern methods include hormonal methods such as injectables like Depo-Provera, birth control pills, and implants; female and male sterilization; intrauterine device (IUD); barrier methods such as the male or female condom, diaphragm, and cervical cap; and chemical spermicides in the form of jelly or foam.

2.3.1 Natural family planning (Traditional Methods)

Natural family planning is the family planning method that does not employ contraceptives but natural way whereby the couples employ periodic abstinence as a part

of fertility awareness during the ovulation period of the woman (Hotonu, 2008). It includes the first observation or sensation of cervical mucus and /or some type of calendar based formula (CCIH, 2010). Natural family planning does not involve the use of medicines, mechanical devices or chemicals.

All methods of natural family planning are based on the concept that, while men are always fertile, women are most times infertile. The couple's combined fertility, there is dependent primarily upon the identification of fertile and infertile phases of women's cycle (CCIH, 2010). But since the couple's combined fertility is never activated by the isolation one from the other, the methods require the co-operation of both man and woman when implemented. Its implementation may be either to achieve or to avoid pregnancy. The primary differences between the different natural methods lie in the means by which they define the fertile and infertile phases of the woman's menstrual cycle. These differences also account for their different efficacies and ease of use (Yakobson *et al.*, 2012).

a) The Calendar Method

This method is traditionally called the rhythm method. It defines the fertile and infertile phases based upon the following assumptions (WHO, 2011). Ovulation occurs for 14 ± 2 days before the onset of the next menstrual period; sperm survival is 3 days and ovum survival 2 days. In addition to these assumptions, the exact lengths of the previous 6 to 12 menstrual cycles must be known. By subtracting 19 (16 + 3) from the length of the shortest previous cycle, one obtains the first day of fertility (Billings, *et al.*, 1972; Yakobson *et al.,* 2012). By subtracting 10 (12-2) from the longest previous cycle, the last day of the fertile phase is determined. The remaining days are infertile. This method is the original natural method but, since it is not very effective, it is no longer recommended for

use. It is not highly effective because it does not clearly distinguish the true biological periods of fertility and infertility (Flynn and Lynch, 1990).

b) The Temperature Method

It has long been known that a woman's basal body temperature rises following ovulation. This shift in the temperature is due to the thermo-genic action of the hormone progesterone which is produced by the *corpus luteum* following ovulation (WHO, 2011). If one defines the infertile phase to begin on the evening of the third day of the temperature shift, one has a natural method which is based on sound scientific principle and is highly effective (Gleeson, 2012). While this method is currently serving many people quite well, its main disadvantage is that it is strictly a postovulatory method and thereby somewhat restrictive.

c) The Ovulation Method

This is the newest of the natural methods; it relies upon the identification of a characteristic mid-cycle vaginal discharge of cervical mucus to determine the fertile phase of the cycle. This discharge is apparent to women at the opening of the vagina and requires no internal examinations. In this method the menstrual period is considered fertile (Yakobson *et al.,* 2012). Following menstruation, a woman will experience a positive absence of mucus discharge (dryness) and these days are infertile. The dry days are succeeded by the development of the mucus symptom (WHO, 2011). The discharge begins as sticky, cloudy, tacky mucus and progresses to become clear, slippery, stretchy and lubricative. The last day of the latter mucus is called the Peak. Ovulation occurs, on the average, one day after the Peak. The fertile period extends from the beginning of the mucus discharge through three full days past the Peak. From the evening of the fourth day

past Peak until the beginning of the next period is infertile. This method, too, is very effective and its existence has created a renewed interest in natural family planning.

All methods of natural family planning are best learned from well-trained teachers. Success in their use depends upon the co-operation of the couple combined with a good understanding of the method in use.

2.3.2 Modern methods

More than half of all couples in the developing world now use a modern method of contraception for healthy timing, spacing, and limiting of births to achieve their desired family size (Yakobson *et al.*, 2012). Modern methods of family planning include mechanical, chemical and surgery. Family planning counselors should provide accurate information about modern family planning methods in order to help couples decide what method suits them. Couples can choose from many reversible contraceptive methods to delay their next pregnancy. If couples have had all the children they want they may choose a permanent, non-reversible family planning method (WHO, 2011).

a) Mechanical Family Planning

Merce *et al*. (2009) state that mechanical family planning are barrier methods such as the male or female condom which prevent sperm from entering the vagina, diaphragm, and cervical cap which prevent sperm from entering the uterus. The most common barrier family planning method is the male condom. According to Yakobson *et al*. (2012) male and female condoms are the only contraceptive methods that provide protection from STIs, including HIV, in addition to pregnancy. Less common barrier methods are diaphragms and cervical caps; they are not readily available in many countries. All of these devices form a mechanical barrier between the sperm and an egg. Barrier methods

should be used every time a couple has sex. The effectiveness of barrier methods depends greatly on people's ability to use them consistently and correctly. If a woman is fertile and does not use the method consistently and correctly, she can become pregnant.

b) Chemical Family Planning

Chemical family planning involves using chemical substances (spermicides) that are inserted deep into the vagina shortly before sex to kill or disable sperm. They can be used alone as well as with diaphragms, cervical caps, and condoms. Spermicides are available as foaming tablets, vaginal suppositories, foam, melting film, jelly, and cream (Yakobson *et al*, 2012). It involves the use of pills or drugs that stop the release of eggs or block ovulation. Vemer (n.d) shows that it includes vaginal ring that releases an estrogen and a progesterone which stops ovulation; combined oral contraceptive pill which contains an estrogen and a progesterone, which stop ovulation; progesterone only pill, or estrogen free pill which contains a progesterone, which makes the mucus of the cervix impenetrable to sperm cells and in a number of women also blocks ovulation; and Intrauterine Device (IUD) with hormone which makes mucus of the cervix impenetrable to sperm and prevents implantation of an egg

c) Surgical Family Planning

Gardner (n.d) contends that surgical family planning is the method whereby one (either man or woman) undergoes surgeries that prevent pregnancies. If a couple is certain that they will want no more children, a permanent contraceptive method may be their most convenient option. The permanent methods are female sterilization, also called tubal ligation, and male sterilization, also called vasectomy. Both are relatively simple surgical procedures. Both are very safe and effective. A woman or man who chooses sterilization will be protected from pregnancy for the rest of their lives, although an extremely small

risk of pregnancy still exists, if the fallopian tube or vas deferens partially reconnects (WHO, 2011).

2.4 Theories on Human Sexual Behaviour

While the mating habits of other species are guided by strong biological instincts, humans have evolved to become more flexible in how we can be trained to behave, and we can be very resourceful at exploiting opportunities (Thinker, 2006).

2.4.1 Cultural evolution

Different populations often developed different customs depending on their unique tribal histories and the survival strategies that best suited their particular environment (Chandra, *et al*., 2011). Whenever different groups came into contact, whichever culture facilitated the survival of more healthy young was more likely to dominate and spread. Marriages were usually arranged by families. Sons or daughters were often sold into marriage for a price. Multiple wives were common in communities that were ravaged by war, where men were often killed and women taken away as slaves (Rothbaum, *et al*., 2002). In places where women were rare, marriages were sometimes arranged with multiple husbands. Dominant male behavior still occasionally happened, like in the case of ancient kings and medieval sultans who took hundreds of wives and concubines. Men driven by power and desire could do as they pleased as long as no rival force could stop them (Dawkins, 2006).

2.4.2 Religion and sexual morality

With refinements to the art of writing, strict rules governing sexual behavior became enshrined in religious scriptures (IPI, 2013). Strict laws condemning sex outside of marriage, and even laws against divorce and abortion, were enforced by powerful religious institutions for thousands of years (Zgouride and Zgouride, 2000). The old Church of

England matrimonial ceremony describes the tradition of marriage as a mystical union, instituted in the time of man's innocence, not to satisfy men's carnal lusts and appetites, like brute beasts that have no understanding, but rather to be taken soberly duly considering the causes for which matrimony was ordained, which are for the procreation of children, and so that men and women may satisfy their lusts without harmful consequence, and so that families may aid and comfort one another in times of adversity and prosperity (Thinker, 2006).

According to the Catechism of the Catholic Church (1997) Chastity means the successful integration of sexuality within the person and thus the inner unity of man in his bodily and spiritual being. Sexuality, in which man's belonging to the bodily and biological world is expressed, becomes personal and truly human when it is integrated into the relationship of one person to another, in the complete and lifelong mutual gift of a man and a woman. Sexuality is ordered to the conjugal love of man and woman. In marriage the physical intimacy of the spouses becomes a sign and pledge of spiritual communion. Marriage bonds the baptized persons who are sanctified by the sacrament. In marriage God unites them in such a way that, by forming *one flesh* they can transmit human life: *Be fruitful and multiply, and fill the earth*. By transmitting human life to their descendants, man and woman as spouses and parents cooperate in a unique way in the Creator's work.

The laws and values of Islam reflect the harsh desert conditions from which it arose. At the time, tribesmen regularly battled each other for control of scarce desert resources. Men were often killed and women enslaved (Ojo, 2005). As Muhammad fought to unite the desert tribes under Islam, his followers were permitted to marry up to four wives, and his warriors were allowed to keep any number of captured slave girls (Zhang, 2008).

Generally, regulation of sexual behaviour has been an important concern for many religious groups at various times and in various cultural settings. The extent to which any religious group will legislate to control sexual behavior and even marriage and marital unions depends largely on whether the religious group is sectarian and consequently world-rejecting in its response to the prevalent societal values or whether the religious group has become established and therefore has become world-affirming. This polar distinction determines not only the perspectives on sexuality but also the response of the religious group to the society in which it finds itself (Ojo, 2005).

2.4.3 Modern relationships

The spread of modern democracy and the invention of modern technologies like television have resulted in the formation of a distinct modern global culture (Turner, 2011). This modern global culture is rapidly replacing traditional cultures all over the world except in those places where it clashes with beliefs that are enshrined in traditional religious scriptures (Weber, 1992). The availability of reliable birth control in the modern world has broken the connection between sex and pregnancy, and now sex can be pursued for pleasure while having children has become a matter of choice (Ojo, 2005).

It is now common for people to have more than one sexual relationship before they choose to have children (Strong *et al.,* 1996; Thinker, 2006). Couples often live together for years before they marry. Some men and women avoid lasting relationships as long as they can continue to attract desirable partners (Ojo, 2005). The result has been the formation of an unregulated social reproductive system, sometimes called ‘the meat market’ (Thinker, 2006). This system is particularly noticeable in the big cities in both developed and developing world, where people continue to “try before they buy”, often in the hope of

finding a compatible partner before they consider settling down to start a family (Kirway, 2009).

2.4.4 The meat market

Almost everyone would like a partner who is physically attractive, smart, funny, and possibly even wealthy. But it is usually very difficult to find all of these qualities in the same person (Thinker, 2006). Most people are forced to compromise and lower their expectations in order to find a compatible partner. The degree to which we compromise depends on what we ourselves have to offer and how desirable we are to others, in other words, our own value on the meat market (Kirway, 2009; Thinker, 2006). Those who understand the rules of the mating game are usually the most successful players. Those who think that there are no rules and who try to cheat usually end up suffering penalties they never knew existed. And those who hold out for too long, waiting for something better, are often the ones who end up with less, or end up with nothing (Kirway, 2009).

2.4.5 Conservative forces

One potential problem with the deregulated social reproductive system is that without government assistance for single parents, children born outside of marriage or children whose parents get divorced may end up being seriously disadvantaged. Allowing premarital sex and easy divorce can result in more children becoming a financial burden on their extended family or on the wider taxpaying society (Kirway, 2009). The deregulation of reproduction often becomes a political power struggle between liberal forces concerned with the freedoms of the individual, and conservative forces concerned about the costs to society (Ojo, 2005). The prevailing balance will depend largely on the wealth of the nation to afford a generous welfare system, or the ability of governments to hold biological fathers responsible for the costs of their offspring (Weber, 1992).

The most common strategy employed by conservatives is to try to uphold traditional religious moral values (Kirway, 2009). However, because of the historical peculiarities of most traditional religions and their inability to adapt to changing conditions, their ancient rules for regulating sexual behavior often work against the interests of both the individual and the wider taxpaying society (Weber, 1992; Thinker, 2006).

2.5 Religious Beliefs and Family Planning

The perceived goal of a religious organization and the manner it wants to achieve such goals also influences how the group will control sexual expressions among its members. A religious group may use the societal values as its reference point or may resort to internal dynamics or an agenda of renewal in deciding how to regulate sexual behaviour (Ojo, 2005). Notwithstanding the issues that determine regulations of sexual behaviour, the social functions of most regulations are to test members' fidelity to church doctrines and practices, verifying the depth of spiritual maturity of their members, specifying the manner of inter-personal relationships particularly across the gender division, and as a means of subordinating members to the leaders (Ojo, 2005).

2.5.1 Family planning in the catholic church

The Catholic Church according to Shivanandan (2003) has been opposed to contraception as far back as one can historically trace. Many early Catholic Church fathers made statements condemning the use of contraception including John Chrysostom, Jerome, Clement of Alexandria, Hippolytus of Rome, Augustine of Hippo and many others. The Catechism of the Catholic Church specifies that all sex acts must be both unitive and procreative (CCC, 1997). Pope Paul VI's Humanae Vitae (1968) cited by Shivanandan (2003) contends that artificial contraception is a mortal sin, but methods of natural family

planning are morally permissible in some circumstances, as they do not usurp the natural way of conception.

John Paul II (1990) cited by Shivanandan (2003) clarifies the Church's position claims that in begetting life the spouses fulfill one of the highest dimensions of their calling: they are God's co-workers who must have an extremely responsible attitude. In deciding whether or not to have a child, they must not be motivated by selfishness or carelessness, but by a prudent, conscious generosity that weighs the possibilities and circumstances, and especially gives priority to the welfare of the unborn child.

According to AMECEA (1986) every local Catholic Church within AMECEA should inform Christians of the grave dangers, both moral and medical, contained in the artificial methods of family planning and their means. This would be met when every diocese of AMECEA, natural family planning was to be strongly promoted; all clergies and other pastoral workers had to form courageously the consciences of their Christian in accordance with the magisterial teaching of the Catholic Church. Handout (2009); Bunce *et al.* (2007) presents that even the new school syllabus incorporating teaching about condoms and other contraceptives has been described by Roman Catholic bishops in Tanzania as unacceptable in Catholic schools.

2.4.2 Family planning in the protestant churches

According to Handout (2009) Protestant Churches have been less harsh on family planning. They condemn premarital sex, birth control and condoms. Research by Bunce *et al.* (2009) show that in Tanzania, the Seventh Day Adventist Church is a strong advocate of contraception and most other denominations, including Islam, Anglican, Lutheran and

Pentecost churches were seen as falling somewhere between the stances of the Seventh Day Adventist Church and the Roman Catholic Church.

Protestant churches often teach that it is acceptable to use birth control as long as it is not used to encourage or permit promiscuous behaviour (Schenker and Rabenou, 1993). Historically, Christians have not always shared today's generally positive ethical attitude to contraceptives. Their use was almost universally rejected until 1930 when the Anglican Church eased its sanction in limited circumstances (Hotonu, 2008). Over subsequent decades much of the Protestant Church has followed its lead. Nowadays the ethics of contraception are rarely considered in protestant churches and most protestant couples enter marriage without reservation about their use. The Anglicans were the first church to issue a statement in favour of contraception, which they did at the Lambeth Conference in 1930 by majority of 193 to 67. A group of American Protestants followed in 1931. Nowadays most Protestant denominations permit artificial birth control (Schenker and Rabenou, 1993).

2.4.2 Family planning in islam

Whilst pre-marital sex is prohibited, a sexual relationship is seen as part of married life, both for the purposes of having children and to ensure that the sexual needs of the couple are satisfied within a legitimate relationship. Whether a Muslim is liberal or conservative, their core values come from the Koran and religious teaching. Islam supports the health of the mother. If it can be shown that the mother's health is improved by timing and spacing (of pregnancies) then family planning is important. Procreation among Muslims is expected in marriage to maintain the human race; sexual relations in marriage need not always be for the purpose of having children. Within Islam, healthy spacing of

pregnancies is explicitly described in the Koran, particularly to maintain the health of the mother (IRH, 2011).

Contraception has been judged permissible in certain circumstances: to space child-bearing, thus promoting the health of all children in the family. For example, to protect the health of an existing child who may not yet be weaned; where there is fear for the physical and mental well-being of the mother; and for personal reasons dictated by conscience (Johnson-Hanks, 2006). However, *Coitus-interruptus*, the withdrawal method, was practiced by early Muslims with the tacit approval of Prophet Muhammad. Some Muslim jurists have inferred from this that other non-permanent methods such as condoms, cap, IUD and oral contraceptives are also permissible(Caldwell and Barkat-e-Khuda 2000; Casterline *et al*. 2001). Vasectomy is strictly forbidden. Although female sterilization may be permissible, this is only when there is a medical opinion that the woman's life would be endangered or her mental health seriously affected by a pregnancy, which could not be prevented by other legitimate means.

2.5 The Role of Religion in Development in Tanzania

The contribution of religion to development in the form of enabling Tanzanian society to achieve and maintain high levels of material and social wellbeing has been concrete over the years. At independence, the country inherited glaring educational disparities between Christians and Muslims (Mhina, 2007). During the early days of independence (1961–1966), religious institutions continued to play an active role in social and economic activities. The adoption of socialist (*Ujamaa*) policies from 1967 to the mid-1980s, however, sidelined religious institutions from political activities and from social and economic development (Green *et al.*, 2010; Mhina, 2007).

Religious institutions that engaged in service provision, for example in education and health, were obstructed in different ways and had their properties nationalized. With the introduction of liberalization policies in the mid-1980s, however, the state began to recognize the role of religious institutions in economic and social development. Since then, religious institutions have been playing an increasingly crucial role in national development in various sectors, such as education, health, civic education and caring for orphans (Mhina, 2007). Following the withdrawal of the Tanzanian state from some of its former areas of responsibility, non-governmental organizations, including religious institutions, have been striving to provide the services previously provided by the state (AU, 2005). Christian organizations are, however, relatively better equipped than their counterparts to deliver a range of services. For example, in 1999 the churches were running 83 hospitals, 30 health centres and 450 dispensaries. About 19 of those hospitals were designated as district hospitals (Mhina, 2002). Bakari and Mussa (2004) document the range of services that Islamic philanthropic institutions have provided since the mid-1980s.

Nationally, secondary education provision has changed substantially over the last decade as a result of government expansion drive, in which every ward has a community secondary school (Sichalawe, 2006).. The majority formal education services are provided by Christian churches, although there is no national data available that disaggregates provision by denomination. Madrasas which provide Quran education are also widespread (Becker, 2008). Christian churches are also involved in longer established development sectors, with local level projects in areas such as micro-enterprise particularly for women (Mercer, 2002). Newer evangelical and Pentecostal churches are becoming engaged in local services provision, most frequently concerned with children or water. In Dar es Salaam for example, the Efatha Pentecostal church runs a micro-finance bank.

Some other churches have focused on HIV/AIDS to be their areas to support (Dilger, 2007).

The Catholic Church's activities include not only charitable works to help the poor, orphans and handicapped, but also services to promote education, health, vocational training and other forms of economic facilitation. In addition to its traditional church activities in favour of the poor, it is pursuing an advocacy approach to poverty alleviation. The advocacy role includes raising awareness among Christian communities about the importance of helping the poor. It has also created Christian Professionals of Tanzania (CPT), a think-tank for commenting on policy making and for providing open forums on public issues. The Catholic Church's main argument is that economic growth is important but that government policies must balance the market's liberal economic orientation with social policy that can cater to the needs of lower income groups, who are the majority (Sichalawe, 2006). The contribution of religions to family planning as the indicator of development is not disclosed. This study therefore, sought to establish the influence of religious beliefs on family planning more particularly among Catholic and Anglican churches.

2.8 Summary of the Chapter

Basing on the theoretical review and literature from earlier studies, this chapter connects the ideas of various authors and theories adopted in this study. The chapter begins with introducing concepts of religion, religiosity and family planning. Then the chapter introduces family methods namely traditional methods and modern methods. It also introduces theories that guide the study. These theories are moral/ethical theories that cover the Catholic's conservativeness and Anglican's liberalism. Further, it gives some details on the notions of family planning and contraception in various religions. It explains

family planning in the Catholic Church, in Protestant churches and among Muslims. Finally, the chapter tries to narrate the role of religions in socio-economic development in Tanzania since independence. Religions have been playing an important role to side the government to bring about development and reduce poverty since independence. They have built education institutions; they have established and run health organizations; and they have established and undertaken economic projects. This study therefore, longs to know the influence of religious beliefs on family planning more particularly among Catholics and Anglicans in Dodoma municipality.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Description of the Study Area

This study was conducted in Dodoma Municipality. The municipality is located in the central part of Tanzania about 500 km west of Dar es Salaam. The municipality has an area of 2,576 Km^2 and a total population of 324,347 (URT, 2003). The main occupational activities include agriculture, business, wine processing and arts/crafts. The population of Dodoma Municipality was 324,347 in 2002 whereby males were 157,469 (48.5 per cent) and female were 166,878 (51.5) (Muro, 2006). The population of Dodoma Municipality was projected to reach 507,141 by 2011 according to URT (2006). Dodoma Municipality has a greater number of Catholic and Anglican followers than any other Christian denomination. It is also the headquarters of Anglican Church of Tanzania. Religions have played a great role in terms of development issues in Dodoma municipality in the areas of education, health and housing. However, Dodoma municipality has higher yearly population growth rate of 3.4 percent (higher than the target of MKUKUTA II of 2.7 percent) (URT, 2010).

3.2 Research Design

Research design according to Milanzi (2009) is a blue print that enables the investigator to come up with solutions to those problems. It guides the researcher in various stages of the research. It is about organizing of research activity, including the collection of data, in ways that are most likely to achieve the research aims. This study employed cross-sectional research design. This design according to Bryman (2004) involves collection of data on more than one case, at a single point in time. It is a design which is typically associated with quantitative research, also often employed in qualitative research,

evidenced by the use of semi-structured or unstructured interviews. The method can be used also for descriptive study as well as for determination of relationships between variables (IDRC, 2003).

3.3 The Study Population

The study population is a sampling frame from where the sample was drawn. The study collected data regarding variables identified in the objectives of the study about the influence of religious beliefs on family planning. The targeted population was the entire population of men and women aged 15 and above (who belong to Catholic or Anglican Churches). The age of 15 and above is appropriate as it is reported by Fadhalla (2012) that most men and women aged 15-49, married or in union, are currently using contraceptives and more exposed to family various planning methods than any other age group. Information was also sought from key informants who were in position to provide relevant information, ideas and insights on the relationship between religious beliefs and family planning. Key informants included priests, pastors, family planning experts, district health officers, contraceptive suppliers etc.

3.4 Sampling Procedures

Sampling is a process of learning about the population on a basis of a sample drawn from it. A sample is a subset of population units (Milanzi, 2009). The sampling techniques in this study were both the probability and non- probability sampling.

For probability sampling, systematic random sampling technique was used to obtain Small Christian Communities. The lists of small Christian communities were given to the researcher from the parishes, numbered and every third community was selected. Simple random technique was used to obtain respondents in the Small Christian Communities

(SCCs). Questionnaires were distributed to respondents randomly whereby every member in a SCC had an equal opportunity of being selected to become a respondent.

Non- probability, purposive sampling technique was used to get the wards and to get data from the key informants. To obtain the required information, four wards were purposively selected, one with the highest population (Chamwino); one with lowest population (Kilimani), one with more religious health organizations (Miyuji) and one with most committed religious followers (K/ndege) (Muro, 2010 The key informants included eight Priests (from parishes within or near the wards), one municipal health officer, one municipal birth and death registrar, one family planning specialist and one contraceptive distributor. The total number of the key informants was twelve (12). Anglican and Catholic churches were also purposively selected. Anglican Church is the initiator to approve the use of contraceptives among married followers and Catholic strictly prohibits the use of contraceptives and embraces natural family planning. Also the two denominations are similar in some areas.

3.5 Sample Size

The sample size for the study was calculated according to the formula recommended by Yamane (1973) as cited by Jigme (2007) which is as below.

$n= N/ 1+N (e)^2$

Whereas, n= size of the sample, N = population of sample, and

e= is probability of error of (0.1).

Sample size was therefore 100 respondents. From Catholic Church, 50 respondents were taken and other 50 respondents were taken from Anglican Church. Then, four small Christian communities were taken from each church. In the areas were Small Christian

Communities (SCCs) were not practiced church choir groups were used. Each SCC or choir group provided 12 or 13 respondents.

3.6 Data Collection

Data collection is the process that enables the researcher to systematically gather relevant answers to research questions (Milanzi, 2009). This study used structured questionnaires, interviews, Focus Group Discussion and documentary reviews to collect primary and secondary data to facilitate revealing the facts on the influence of religious beliefs on family planning among Catholics and Anglicans.

3.6.1 Primary data

Primary data were collected by using questionnaire survey, in-depth interviews to key informants, selected respondents and focus group discussions (FGDs). Questionnaires were formulated of both open and closed-ended questions. The in depth-person approach was adopted during the questionnaire administration to obtain data from respondents of childbearing age who belonged to either Catholic or Anglican Churches. Key informants were interviewed using a well-structured checklist to guide the discussion with family planning specialists, contraceptive suppliers, Priests and Pastors. Furthermore, Focus Group Discussions were employed under the supervision of the researcher. Some respondents were randomly selected and they had to remain back after the gatherings for discussion. Checklists were used as the guidelines in conducting the discussion.

3.6.1.1 Quantitative data collection

Quantitative data were collected by using questionnaires administered to prospective users of identified family planning practices. The questionnaires of open and closed ended questions were formulated. The in-depth personal interview approach was adopted during

the questionnaire administration. The formulated questionnaires were pre-tested before using them to ensure their logical flow, relevance to the topic, and completeness. Enumerators, who had to administer the questionnaires, were trained before they went to the field.

3.6.1.2 Qualitative data collection

According to Odhiambo *et al.* (2005) qualitative techniques of data collection act as complementary or even alternatives, to conventional quantitative approaches. Qualitative data collection enables a researcher to gain empathic understanding of social phenomena, to facilitate recognition of subjective aspects of human behaviour and experiences, and to develop insights into group's lifestyles and experiences that are meaningful, reasonable and normal to those concerned (e.g. hospital inmates when a researcher gets close to them through qualitative approaches). Below is a presentation of selected key qualitative approaches. In this study qualitative data were collected through interviews and discussions. All the preparations were arranged to visit the wards so as to carry out the case studies.

3.6.1.2.1 Focus group discussion (FGD)

This approach begins with selection of social groups, with specific social category delineation. Participants' composition is guided by homogeneity, cohesiveness and knowledge of the issues involved (Odhiambo *et al.,* 2005). Examples, of these groups include: groups of women only; groups of men only; groups of youth (girls or boys only); groups of female elders; and, groups of male elders, among others (Mango *et al*., 2004). In this study Focus Group Discussion involved members of small Christian communities or choir groups of both churches to get the detailed information. FGD for men was separated from that of women. Checklists were the guidelines in conducting the discussion.

3.6.1.2.2 Key informant interviews

Key informants are knowledgeable and other persons strategically positioned to provide specific types of information on particular situations, depending on their status in society or organizational hierarchies, with respect to the purpose of the assessment (Milanzi, 2009). They could be experts, with required knowledge on particular issues and situations (Odhiambo *et al.,* 2005). Thus, the researcher used a well-structured checklist to guide the interviews with parish Priests, Pastors, Municipal Health Officers, Municipal birth and death registrars, ward health officers, family planning specialists and contraceptive distributors.

3.6.2. Secondary data

Secondary data refer to information that is gathered from other people's findings, statistical reports and other documents (Kothari, 2004). In this study secondary data were obtained from various sources such as ward health reports (on family planning), district health report (on family planning), district population Reports, encyclicals, journals, files from municipal health officers, municipal birth and death registrars, Pope's and Bishop's pastoral letters, University library, published and unpublished papers and websites.

3.7 Data processing, analysis and presentation

This refers to the process of editing, coding, classification and tabulation of the collected data in order to find solution to the problem under study (Kothari, 2004). The study employed largely the quantitative data analysis procedures. However, qualitative techniques were used too in analyzing some qualitative data. Questionnaires were checked and edited for completeness and internal consistency. Questionnaires were then sorted, numbered and data coded before entry into access software.

3.7.1 Quantitative data analysis

Quantitative data processing involved categorization, reorganization, editing, coding and entered in a computer by using Statistical Package for Social Sciences (SPSS) program. A substantial part of the analysis in this study was based on t-test and descriptive statistics analysis by using SPSS computer software based on crosstabs, frequency analysis and percentages. Data were presented using texts, graphs, tables and charts to illustrate findings.

3.7.2 Qualitative data analysis

According to Creswell (1994), the process of data analysis is eclectic; there is no right way. Data analysis requires that the researcher be comfortable with developing categories and making comparisons and contrasts. It also requires that a researcher be open to possibilities and see contrary or alternative explanations for the findings. The researcher used some suggestions made by Creswell (1994) to analyze the qualitative data. The process of qualitative data analysis was based on data interpretation. The volume of the data that was collected from the transcribed interviews and documents was reduced as the researcher used a coding procedure to reduce the information to contents, sub-contents and categories. These categories and codes systematically formed the basis for the emerging story that was revealed by the researcher. The researcher marked quotes that were useful in generating the contents and carefully considered information that was contrary to the emerging contents.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.2 Demographic and Socio-Economic Background of the Respondents

The socio-economic background of the respondents of this study included sex, age, marital status, education level, occupation, and number of children as indicated in Table 1. The target of the study was to interview 100 respondents whereby 50 respondents were Catholics and 50 respondents were Anglicans. The findings in Table 1 show that among Catholics 21 (42%) were males and 29 (58%) were females while among Anglicans 24 (48%) were males and 26 (52%) were females. Female respondents were favored since they are the ones who frequently deal with the issues concerning family planning more than men. They are also likely to access to more family planning methods and information than men. Majority of respondents (62%) and (68%) among Catholics and Anglicans respectively had their age ranging between 20 and 49. The age between 20 and 49 is the bearing age especially for women before their menopause according to Nestel (2000). Further, the findings show that majority of respondents (54%) and (56%) among Catholics and Anglicans respectively were married. Marriage provides an important role in regulating sexual behavior and child bearing in most societies of the world (Binkerhof and White, 1998).

Table 1: Socio-economic characteristics of respondents

Variable	Category	Catholics (Freq.) n=50	Percent (%)	Anglicans (Freq.) n=50	Percent (%)
Sex	Male	21	42	24	48
	Female	29	58	26	52
Age (Years)	Below 20	3	6	2	4
	20-29	18	36	20	40
	30-39	13	26	14	28
	40-49	8	16	9	18
	50-59	6	12	5	10
	60 and Above	2	4	0	0
Marital Status	Single	19	38	16	32
	Married	27	54	28	56
	Separate/Divorced	0	0	1	2
	Widowed	4	8	5	10
Education Level	Primary	18	36	13	26
	Secondary	25	50	19	38
	Post-Secondary	7	14	18	36
Occupation	Employed	20	40	17	34
	Self employed	16	32	9	18
	Unemployed	14	28	24	48
Number of children	0-2	32	64	32	64
	3-5	12	24	14	28
	Above 5	6	12	4	8

N=100

In regard with education level, data in Table 1 show that majority of respondents (50%) and (38%) among Catholics and Anglicans respectively, had secondary education. It was found that all respondents (100%) had formal education which enabled them to give their analytical views on family planning issues. This is supported by Ngalinda (1998); Bongaarts *et al.* (2009) that respondents' education is the strongest predictor of the use of contraceptives and family planning in Tanzania. Higher education provides women with status or opportunities that reduce the importance of early child bearing. Desired family size is highly responsive to improvement in human development, in particular in female education and child survival. In regard with occupation data in Table 1 show that more

than one third of respondents (40%) among Catholics were employed while nearly a half of respondents (48%) among Anglicans were unemployed. According to Alene (2010) occupation of women and that of their partner are the most important factors that influence the practice of FP by couples at national level. The study findings found that there was a significant relationship between the occupation of the respondents and the desired methods to space their children. In the FGD it was revealed that people who were employed were likely to be more educated than those who were not employed and thus, those who were employed seemed to be aware of the methods of family planning. Also the employed respondents witnessed to face some limitations in their maternity leaves which were so limited at their work place.

Of all respondents, majority of respondents (64%) for both Catholic and Anglican Churches had number of their children ranging from 0 to 2. The findings suggest that the people especially in the urban areas in Tanzania are awakened on family planning. Most of them know various methods to prevent unwanted pregnancies. The researcher learned that most of them prefer to have fewer children nowadays than in the past. This may be due to the economic difficulties that people might be facing in urban areas. The interviewed respondents claimed that they are afraid to have many children because of the difficult and terrifying life. Most of them put it clear that they tend to bear a few children that they can take care of in terms of schooling, nutrition, health facilities and housing.

4.2 Types of Contraceptives Used in the Area

The first objective of this research intended to identify the types of contraceptives used among the followers of Catholic and Anglican churches. In order to understand the contraceptives used in the study area the researcher first needed to know the contraceptives known by the respondents. Then contraceptives used by respondents were

identified. To do this, the researcher distributed questionnaires and interviewed priests and specialists of family planning. Reports on family planning were also reviewed.

4.2.1 Types of contraceptives known by respondents

The respondents were asked to mention contraceptives they knew. The respondents were given a room to mention more than one contraceptives that they knew. Data in Figure 2 indicate that of all respondents, majority of respondents 81 (81%) knew pills, 80 (80%) knew calendar, 71 (71%) knew male condoms, 66 (66%) knew Depo-Provera, 60 (60%) knew Loop (IUD), 57 (57%) knew sterilization, 47 (47%) knew Norplant, 31 (31%) knew female condoms, 24 (24%) knew LAM, 15 (15%) knew foam/jelly, 12 (12%) knew emergency pills and 11 (11%) knew diaphragm.

It was revealed that pills were mostly known by respondents. The reason to why pills were so popular as compared to other methods their response was that pills were mostly available and accessible in their streets. This was in line with Mbwilo (2008) that because pills are greatly known as they are one of the earliest methods that were introduced in Tanzania. The other studies by WHO (2011); Yakobson *et al.* (2012) argue that in many developing countries today the Pills are usually readily available at pharmacies as well as clinics and from community-based providers. Therefore, the researcher also learned that pills were simple to use as simple directions were given by providers.

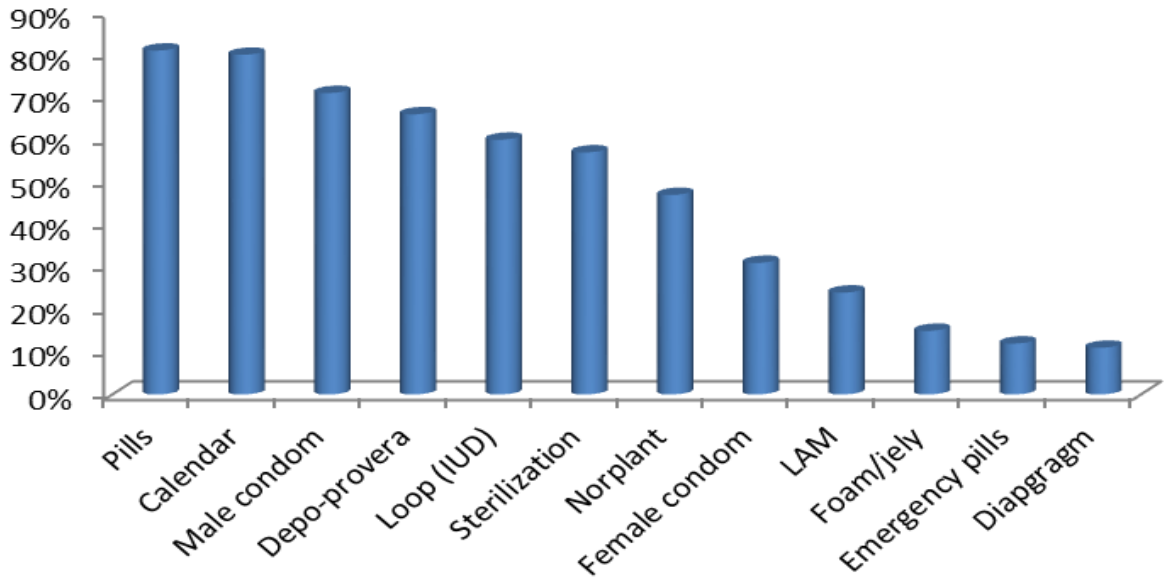

Figure 2: Types of contraceptives known to respondents

Pills were followed by Calendar in popularity among respondents. When the respondents were asked why calendar method was famous it was found that it was because calendar and traditional methods in general were strongly emphasized by religious leaders especially the Catholics. The Catholic Church teaches that in marriage God unites them in such a way that, by forming "one flesh", they can transmit human life: "*Be fruitful and multiply, and fill the earth*". By transmitting human life to their descendants, man and woman as spouses and parents cooperate in a unique way in the Creator's work (CCC, 1997). Under this perspective the Catholic Church prohibits its followers to use artificial means to plan their families as the church believes such actions undermines human sexuality (FPA, 2004). Some respondents also added that the calendar method was the method that the ancestors used and taught to their young generations before the introduction of modern methods. Respondents in FGD contended that male condoms were also mostly known because they are widespread in people's street, even in small shops- they are available for anyone who needs them at any time. They are also available for both, married and unmarried people. The researcher could learn that condoms are not only

for family planning but also for preventing sexually transmitted diseases like HIV/AIDS. This is in line with WHO (2011) that Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections.

4.2.2 Types of contraceptives used by respondents

The respondents were asked to mention the types of contraceptives they were using or had ever used for family planning/child spacing. The findings in Figure 3 show that 41 (41%) respondents used pills, calendar 36 (36%), male condoms 33 (33%), Depo-Provera 24 (24%), 7 (7%) Lactational Amenorrhea Method (LAM) or Breastfeeding, 6 (6%) Loop (IUD), 4 (4%) Norplant, 3 (3%) Emergency pills, 2 (2%) female condoms, 2 (2%) Foam/jelly, 2 (2%) sterilization and 0 (0%) diaphragms.

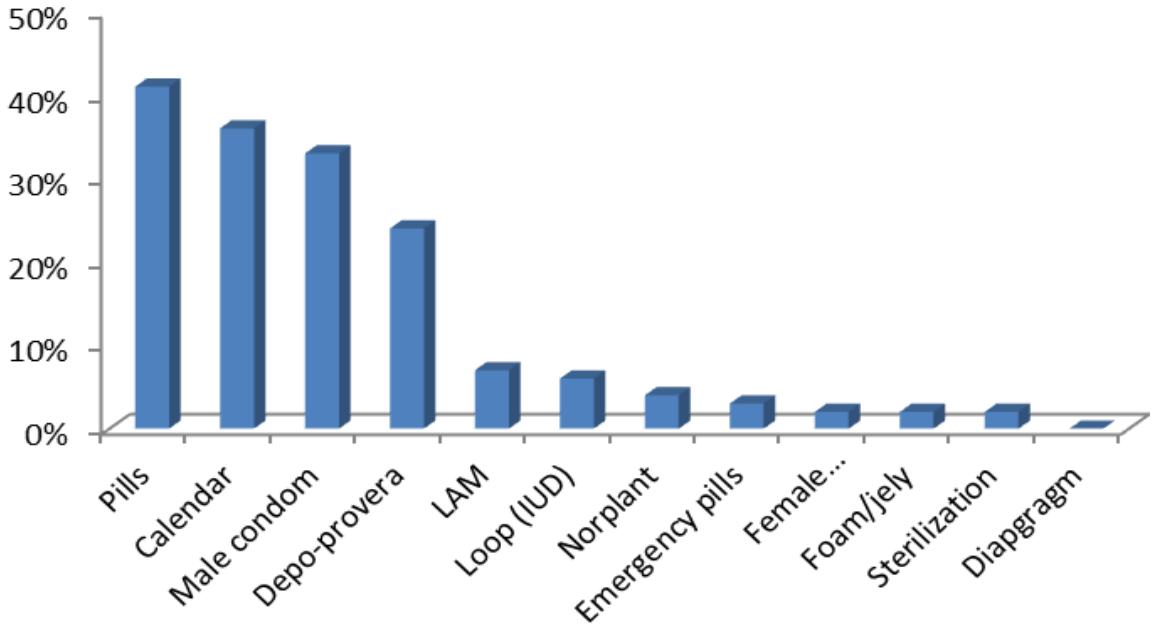

Figure 3: Types of contraceptives used by respondents

a) Pills

The study found Pills were leading to be the most used by respondents. Reasons given by respondents why they like to use pills most were that pills are more known than any other

method; pills are also available and accessible to users as they are easily found in clinics and private pharmacies/chemists in their areas of residence. Moreover, most respondents claimed that the pills were cheaper and simple to use as instructions given to them were simple to follow. The studies by Yakobson *et al*. (2012) and Hotonu (2008) present that pills are mostly used because they are most effective especially when no pills are missed. In addition, the study by WHO (2011) stipulates that most women like to use pills because pills are under the control of women, they can be stopped at any time without provider's help and they do not interfere with sex.

b) Calendar

Data in figure 2 display that calendar method to be more used after pills in the study area. It was revealed that most respondents used it with other methods (contraceptives). Many respondents claimed that they first used calendar method but it was difficult for them. So when they see calendar is not effective they employ other method. Most of respondents 70 (70%) from both Anglican and Catholic churches witnessed to use more than one methods. The reasons they mentioned to make traditional methods to be difficult for them were the question of education and poor involvement of men in the family planning practices. According to respondents, most women had low education on how to undertake traditional methods. Also most men were reported not to be responsible in family planning matters. For calendar to be effective men must become full partners in the decision to use them, men should be willing to abstain from sex or to use condoms on fertile days (Yakobson *et al*., 2012)

c) Male Condoms

Male condoms were also found to be more used in the area. This was possibly because they are available for all, married and unmarried people. In the interview with doctor in a

hospital under Anglicans contended that over 80% of condom users are youth. This is supported by Kinemo (1998) that many young men used male condoms because most of them use them not only for unwanted pregnancies but also for preventing sexual transmitted diseases such as HIV/AIDS especially in extra-marital affairs. Further, many people tend to use condoms as stipulated by WHO (2011) that when condoms are used correctly at every sexual act, they are 98% effective in preventing pregnancy that is why they are more liked. However, as commonly used, when men sometimes forget or refuse to put a condom on, condoms are only 85% effective. This means that each year out of 100 women who rely on condoms, 15 may become pregnant. The other study by Yakobson *et al.* (2012) states that many men and women like to use male condoms because they have no hormonal side effects, they can be used as a temporary or backup method, they can be used without seeing a health care provider, they are sold in many places and generally easy to obtain and they help protect against both pregnancy and STIs, including HIV. Generally, condoms are common used because they are inexpensive, easy to find and simple to use (Yakobson *et al.*, 2012).

d) Depo-Provera

It was found by the study that Depo-Provera (injectable) was used by more than 24% of all respondents. The reasons most respondents gave to why they preferred Depo-Provera were their reliability and effectiveness. This is in line with WHO (2011) that as commonly used, about 3 pregnancies per 100 women using progestin-only injectable over the first year. This means that 97 of every 100 women using injectable will not become pregnant. Moreover, the study found that they do not require daily action. They can be taken once and last for long (three months) so, many users did not like the high frequencies of taking drugs as it is done when taking pills. It was also found that Depo-Provera was used by people who did not like to be known that they planned their families. These people were

those prohibited to use the modern ways to space their children either by their churches or partners because they are private and no one can tell that a woman is using contraceptives. It was also found that injectables were more used by women who wanted to increase their wait. Some respondents in addition contended that injectables made them avoid monthly bleeding for their conformability. In interview with family planning specialist it was contended;

> "*Having no bleeding pleases many women, but some may worry that something is wrong or that they are pregnant. They should know that having no bleedings is harmless and does not cause permanent damage to a woman's fertility. It can even be good for some women's health because the absence of monthly bleedings reduces the risk of anemia (low iron level in the blood). Women need to be aware of these side effects in advance so they know what to expect and do not worry".*

e) Lactational Amenorrhea Method or LAM

This is also known as breastfeeding that provides contraceptive protection for the first 6 months after delivery if certain conditions are met (Yakobson *et al.*, 2012). It was expected by the study this method would be used by majority of respondents because it is 98% effective when practiced correctly and it has no side effects. However, minority of respondents (7%) used LAM. When respondents were asked why most of them did not like to use LAM, responses were that the method was good but it was delicate as it required some conditions to be fulfilled. These conditions included feeding the baby only the mother's milk and not anything else. The interviewed family planning specialist in the area emphasized that during Lactational Amenorrhea Method (LAM) no other foods or liquids should be given for six months, except for vitamins, medicines, and vaccines. This

is not a simple task especially in today's world when mothers have to join men in economic and social responsibilities far from home whereby newborn babies are to be left behind at home with their house-maids. In addition to that, many people according to WHO (2011) fear to use LAM because of the spread of its misunderstanding that it does not function for the fat women, it requires special nutritious food for the users and that mothers are worried that the woman will run out of milk. The interviewed doctor in the areas crushed these misconceptions and emphasizes that LAM works well regardless the body size of the user and no special and supplementary nutritional foods are required. Also milk continues to be produced through 6 months and longer in response to the baby's suckling or the mother's expression of her milk.

f) Trends of Contraceptive Use in Dodoma Municipality (2006-2009)

In accordance with secondary data in Table 2 condoms seemed to be most used varying from 22,156 in 2006 to 113,562 users in 2009. Data in Table 2 show that condoms were followed by pills varying from 6,280 in 2007 to 25,116 in 2009, Depo-Provera increasing from 9,229 in 2007 to 13,237 in 2009. Natural family planning (observing calendar, mucus, body temperature etc.) was difficult to measure because not even single person attended any health centre for advice or to be educated. This was due to the fact that no campaigns were made for traditional family planning methods. All campaigns and movements were made for only modern methods by government and non-government agencies.

Table 2: Trends of contraceptive use in Dodoma municipality (2006-2009)

Method	Total number of family planning users			
	2006	**2007**	**2008**	**2009**
Pills	18,312	6,280	12,177	25,116
Loop	100	381	409	786
Depo-Provera	10,121	9,229	10,408	13,237
Norplant	170	698	1,800	3,000
Condoms	22,156	92,387	21,515	113,562
Tubal-ligation	0	0	56	158
Vasectomy	0	0	0	0
Natural	0	0	0	0

Source: Dodoma Municipal Council report (2010)

4.3 Practices of Family Planning among Catholics and Anglicans

This section addresses the second objective and second research question for this study. The researcher thought that it was important to assess the practices of family planning among the Catholics and Anglicans in the area. Questionnaires, interviews, discussion and reviews of documentaries were used to obtain the appropriate information.

4.3.1 Method of family planning desired by respondents

Data in figure 4 indicate that majority of respondents (68%) and (60%) from Catholics and Anglicans respectively desired to use traditional methods of family planning. Findings in figure 4 indicate that minority of respondents (32%) and (40%) among Catholics and Anglicans respectively desired to use modern methods in family planning. It is implied by data in figure 4 that more Catholics desire to use traditional family planning than Anglicans and Anglicans desire more to use modern family planning methods than Catholics. This can be attributed to the teachings of the respective churches that Catholics are strictly prohibited to use modern methods and they are taught to use only traditional methods. On the other hand, ethics of contraception are rarely considered in Anglican Church and most Anglican couples enter marriage without reservation about their use (Hotonu, 2008).

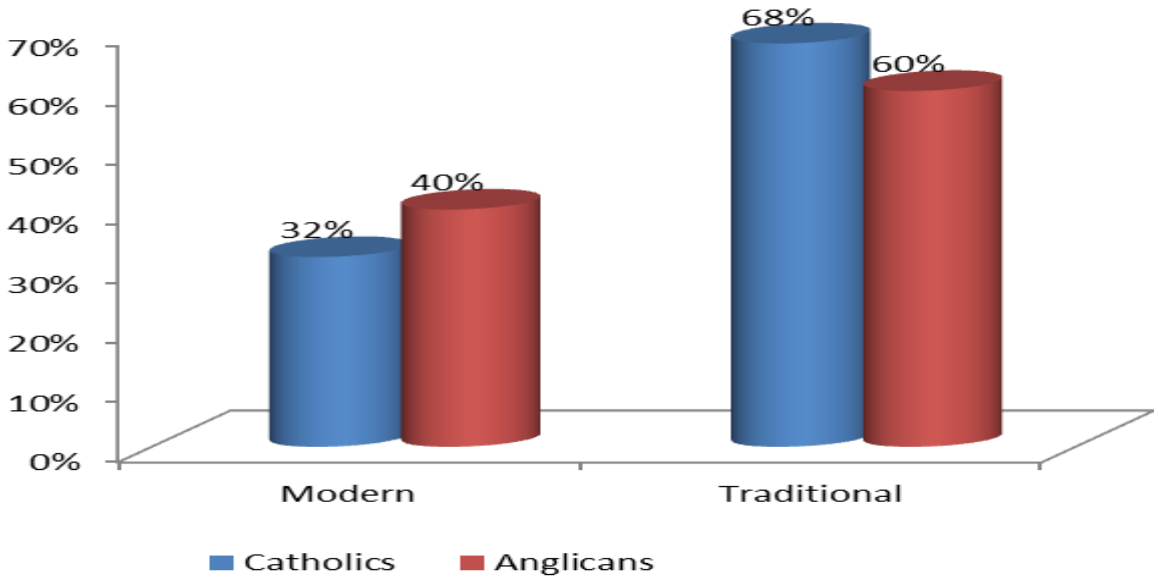

Figure 4: Methods of family planning desired by Respondents

In discussion with respondents they were asked why they preferred traditional method. Respondents' responses to the question were that traditional methods have no side effects upon their health; they are methods that their ancestors used and taught them, they are emphasized by their religious leaders and they are safe. The respondents condemned the modern methods to have fatal side effects such as cancer, irregular menstruation and high blood pressure for those who use them. According to them, traditional methods were better than modern methods but the problem was the lack of education on how to use them. It was reported that education on the better use of traditional family planning was rarely provided to the people by both the religious institutions and public health organizations. In their churches especially the Catholics were told to plan their families by traditional methods but they were not taught how to practice them. Due to this, most of the Catholics were using modern methods but secretly. Many hospitals and clinics provided education on modern methods but not on the traditional methods. This was verified by the specialists in family planning at Makole health centre that they had not provided traditional family planning services to the people since 2006 to 2009 as indicated in Table 2 above.

4.3.2 Source of knowledge of the known family planning methods

The study was interested to know if religions have influence on the knowledge of family planning methods known to their followers. Respondents were asked how they came to know the methods they knew. Data in Table 3 shows that majority of respondents 28 (56%) Catholics and 29 (58%) knew the methods from health centres (clinics, hospitals, dispensaries and pharmacies). The other respondents 5 (10%) Catholics and (20%) Anglicans had knowledge from media (TV/Radio), 8(16%) Catholics and no (0%) Anglicans had their knowledge from their churches, 5 (10%) Catholics and 7 (14%) Anglicans had their knowledge from books and 4 (8%) Catholics and 4 (8%) Anglicans had their knowledge from peer friends.

Table 3: Source of respondent's knowledge of family planning methods

	Health Centre	Radio/TV	Church	Books	Peer
Catholics (%)	56	10	16	10	8
Anglicans (%)	58	20	0	14	8

From the data in Table 3 it is revealed that majority of respondents at the average of 57% had information of family planning methods form health centres. This is due to the reason that there are efforts made worldwide by governmental, non-governmental agencies and International health organizations to sponsor and encourage hospitals, clinics and health centres to host the campaigns and seminars on family planning today than the past decades (Bunce, 2007). Ngalinda (1998) adds the other reason that it is because in Tanzania family planning services are provided free of charge in public and private clinics (except for selected methods in some private clinics).

In regard with religious influence, data in Table 3 show clearly that Catholic Church influences its followers more than Anglican Church. This is because of the fact that the Catholic Church remains the most powerful opponent of birth control. According to Thinker (2006) through political influences Catholic Church has succeeded in slowing down by decades the worldwide acceptance and availability of birth control. The Anglican Church, on the other hand, rarely observes the ethics of family planning and contraceptive use. When one of the Anglican priests was asked if the church organizes seminars on family planning for the follower his response was that family planning is a part and parcel of humanity and thus there is no need to teach. He added that what the Anglican Church follows is the Bible which says nothing on the method to be used. On the other hand the Catholic priest said that the church strictly emphasizes on the natural family planning because even the human body is natural. In line with this, Markwell and Brown (2001) argue that the question of family planning and reproductive technologies for Catholics rests in bioethics. Catholic's bioethics is a belief in the sanctity of life: the value of a human life, as a creation of God and a gift in trust, is beyond human evaluation and authority. God maintains dominion over it. In this view, we are stewards, not owners, of our own bodies and are accountable to God for the life that has been given to us.

In discussion with some respondents from Catholic Church it was revealed that most of the respondents thought that the issues of family planning are not in the Bible. Most of them could even utter it plainly that the Holy Bible does not say anything about family planning more than one verse in Genesis 1:28 that states "*Be fruitful and multiply; fill the earth and subdue it; have dominion over the fish of the sea, over the birds of the air, and over every living thing that moves on the earth*". In addition, respondents from Anglican Church claimed that religious leaders ignored the issues concerning family planning because they had no standing point in their holy book, the Bible. Furthermore, all the

interviewed family planning experts/specialists 4 (100%) said that they had never been called in their respective or other churches to give seminars on family planning.

4.2.4 Reasons why respondents stopped using contraceptives

Data in Figure 5 shows that majority of respondents (46%) and (39%) from Anglican and Catholic Churches respectively were using contraceptives. Some respondents had stopped using contraceptives due to various reasons. Data in Figure 5 demonstrate that some Catholic respondents had stopped using contraceptives due to religious prohibition (27%), side effects (27%), to get children (2%) and inaccessibility (5%). On the other hand, some Anglican respondents had stopped using contraceptives due to religious prohibition (5%), side effects (31%), to get children (15%) and inaccessibility (3%).

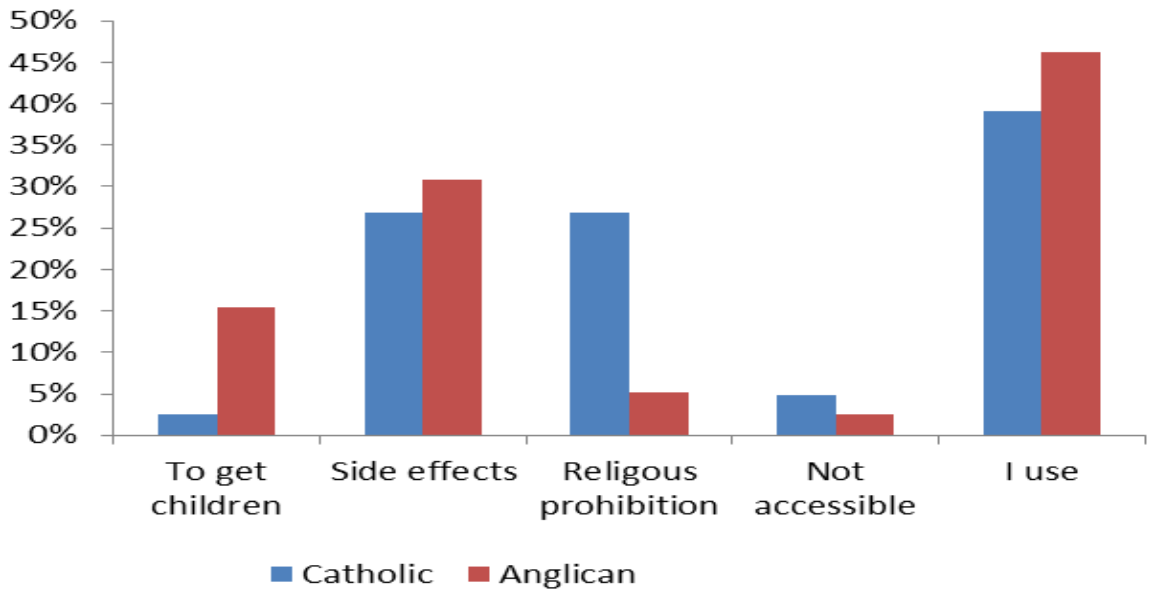

Figure 5: Reasons why respondents stopped using contraceptives

Through discussion, most respondents from both churches were afraid of the side effects which are caused by the modern contraceptives. The common side effects mentioned included irregular menstruation cycles (irregular bleeding), higher blood pressure (BP), cancer, infertility (when a child is needed), headache and nausea. Further, according to

WHO (2011); Yakobson *et al.* (2012) side effect depend on the type of contraceptive used but the common ones include changes in bleeding patterns (including: Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding and no monthly bleeding); Headaches; Dizziness; Nausea; Breast tenderness; Weight change; Mood changes and Acne (can improve or worsen, but usually improves).

In the interview with health specialist and contraceptives distributors, they agreed that contraceptives have negative impacts on the users' health but contended that these were only small side effects like other types of medicines and drugs. It was emphasized that not each person could use any contraceptives but there should be pre-test before one takes and uses contraceptives. The user is first examined and then given contraceptives that suit to one's health.

Religious influence was greater to Catholics more that to Anglicans as it is revealed in Figure 5. In FGDs most of respondents (most of whom were Catholics) who had attended the seminar on marriage and family issues contended that they had committed sin by adopting contraceptives before they knew the truth that God did not like them and now they had confessed and started using natural methods that is advocated by the church. Most of them complained against their husbands who did not even want to hear about such issues.

> "*Our husbands do not think if these seminars are important. They undermine them, and when we had been called to attend the seminar at our parish we attended only women and not even a single man was there. You know, these issues concerning family planning seem to be our business and men do not care. The church should seek the way to convince our men because if the husband does*

not understand the calendar procedures natural family planning is so difficult"

(a Catholic woman aged 40-49 from Miyuji, Dodoma Municipality).

The study found that accessibility of contraceptives was not to be a problem, contrary to what was reported by URT (2010) that Dodoma municipality faced the problem of inaccessibility of contraceptives. The study found that contraceptive services (mostly condoms and pills) were widespread in the people's areas of residence even in small shops. Health centres, pharmacies and shops were found widespread in almost all streets of the municipal and most of them were used to provide and/or sell various types of contraceptives especially those which are simple to use like condoms and pills.

4.4 Perceptions of Respondents towards Family Planning and Contraceptive Use

In objective three the study was interested to determine the perceptions of Catholic and Anglican followers on family planning and contraceptive use in the area. Perception of respondents towards the whole process of family planning and contraceptive use varied from person to person in accordance with personal beliefs. The status and sex were also determinants of one's perception on family planning and contraceptive use. For example, the perception of religious leaders, contraceptive providers and lay people were not the same to some extent.

4.3.1 Respondent's knowledge of the teaching of the church

The findings in Table 5 show that the respondents (74%) and (54%) from Catholic and Anglican respectively reported to know the teachings of their respective churches on family planning and contraceptive use. Some respondents (26%) and (46%) from Catholic and Anglican churches reported that they did not know the teachings of their respective churches on family planning and contraceptive use.

Table 4: Knowledge of the teachings of the churches on family planning and contraceptive use

Religion	Yes	No
Catholic (%)	74	26
Anglican (%)	54	46

The implication of the data is that Catholic Church has greater chance to influence its followers than the Anglican Church. In interview with the Catholic priest it was revealed that Catholic Church has it system to conduct seminar on marriage and family issues for the people who are in preparation to get into marriage. It was also revealed that the Catholic Church in its dioceses there are departments under CARITAS dealing with health issues including family planning. In the Catholic Church only natural family planning is to be taught as the church considers the human person to be a free being that needs to control himself/herself under the drive of rationality. In the interview with the Anglican priest it was reported that there are no specific teachings of the Anglican Church on family planning though the church has department dealing with health affairs. In FGD most Anglican followers claimed that the issues of family planning and contraceptive use need not to be taught by experts but they were known naturally, spontaneously. On the other hand most catholic followers had the conception that family planning especially using modern methods was a sin that could separate one form sharing the sacrament of Eucharist. When they were asked if they had their knowledge from their religious leaders, others said that religious leaders had not taught them but they knew that family planning is a good thing from other sources. One respondent claimed;

> "*.....and I tell you, those times they (church leaders) slept and found Luther had taken followers, slept found Muhammad had taken other Christians and today our priests and bishops are sleeping. We do not know what will happen. They are not teaching important and basic issues but they preach about money! Do you think people are not using condoms and pills? They are using them and still they are sharing Eucharist. No one cares."* (a Catholic woman aged 40-49 from Kiwanja cha Ndege).

4.3.2 Personal belief of respondent on family planning practices

Data in Table 6 indicate that majority of the respondents 31 (63%) and 25 (51%) from Anglican and Catholic churches respectively considered family planning to be a good thing. Other respondents 21 (43%) and 11 (22%) from Catholic and Anglican churches respectively perceived family planning practices as bad practices which do not please God while other respondents 7 (14%) and 3 (6%) from Anglican and Catholic churches respectively did not care.

Table 5: Personal beliefs on family planning practices

Religion	Good thing	Does not please God	I do not care
Catholic (%)	51	43	6
Anglican (%)	63	22	14

In discussion with respondents it was claimed that family planning practices are good practices. They tried to connect their own economic situations, economic situation of the world and the world increasing population. Most of them had the ideas that God gave man rationality, power to know what is good and bad so that he could control whatever man could control. They contended that people should bring forth to the earth the children they

are capable of taking care of, in terms of education, health facilities, food and all other required facilities to human beings. For them, if someone is not able to take care of the children and bears them in big numbers, that person is against God's will, and that is a sin in the eyes of God. Supporting this, Gleeson (2012) argues that the ethics of family planning should be situated within the wider context of Christian marriage and the mutual self-giving of spouses. Responsible parenthood is not a technical problem to be solved, but a sacred responsibility to be lived out in the complexities of the human condition. Biblical themes relevant to a theology of human procreation include the goodness of creation as male and female in the image of God, the dignity of the human person, the value of marriage and family, fertility and fruitfulness, and divine providence. For the Church, good sex is always marital – the expression of a life-long faithful love that is open to new life.

However, some respondents perceived family planning activities to be bad practices that do not please God. Most of these respondents believed that there is nowhere in their Bible where family planning is written, instead, it is written and directing the followers to multiply and fill the earth. So, for them to plan family would be termed to go against God's will since every child is a gift from God (the only creator).

Almost all religious leaders (more than 90%), except one in the study area who were interviewed said that family planning was a good thing. The only difference was that the catholic priests supported the family planning practices if and only if the natural methods are followed. For them, the use of modern (artificial) methods is a sin because it interferes to God's creation by killing the created organism and most of them considered it to be abortion. The Anglican pastors on the other hand did not only support family planning practices but also all the methods that can be used to space children among their followers.

For the Anglicans, the followers were free either to plan or not to plan their family. They were also free to use any methods of their choice.

One religious leader who was against family planning practices contended that they do not fit African societies. For him, family planning is only propaganda from the western countries which want to control the African countries the way they like, neo-colonialism.

4.3.4 Respondent's perception on what is taught by the church about family planning

Data in Figure 6 show that the majority of respondents (61%) and (65%) from Catholic and Anglican Churches respectively considered the teachings to be good. Other respondents (16%) and (8%) from Catholic and Anglican churches respectively were not happy with the teachings of their respective churches while some other respondents (27%) and (22%) from Anglican and Catholic churches respectively did not know the teachings of their respective churches.

The findings in Figure 6 show that greater percentages of Catholics than Anglicans were not happy with the teachings of their church. This could imply that the Catholic Church was so strict on the prohibition of the use of modern methods of family planning. The Anglicans on the other hand were happy to enjoy the freedom that they had to choose to use any methods they liked.

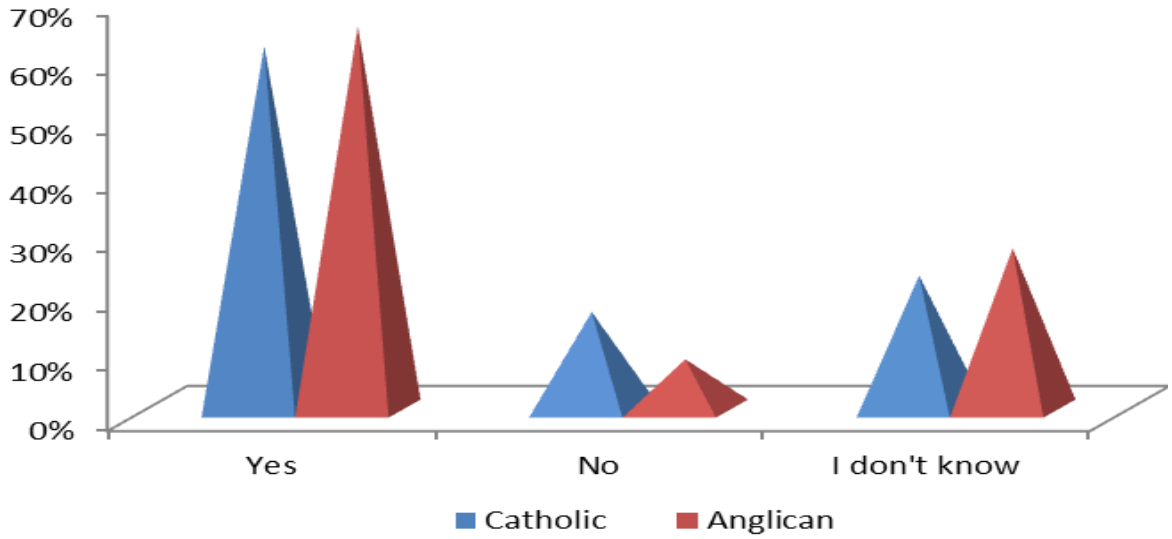

Figure 6: Perception on the teachings of the churches

Through FGD respondents could express their ideas on the teachings of their respective churches. Some catholic respondents would say that the teachings of their church were good but the ministers of the church were not teaching what they were required to teach. One of the respondents could say;

> "*Do you think our priests have time to teach us family planning? The priest of today is in need of money. They do not preach important things but preach offerings (sadaka). So we know that family planning does not please God because God created us to multiply and fill the earth. But who is to teach this young generation? The priests of those times were committed but today priests have their own businesses."* (a Catholic layman aged 50-60 in Miyuji, Dodoma Municipality).

Another woman said;

> "*We know that using contraceptives is a sin but for we who do not have enough education, calendar is so difficult. These things (contraceptives) help us to space our children or we will be giving birth every year and you can see how life has changed. It is not the way our forefathers and foremothers lived. Nature provided everything to them. Today you have to struggle, to buy even water and grass (vegetables) which our ancestors got freely."* (An Anglican woman aged 30-39 from Chamwino, Dodoma municipality).

4.3.5 Respondent's perception on the church to write books and articles on family planning and contraceptives use

Data in Table 7 show that majority of respondents from both Catholics and Anglicans (64%) and (67%) respectively had positive perceptions with the statement that the church should write books, articles and other sources in order to teach its followers. The other respondents (30%) and (27%) from Catholic and Anglican churches respectively had negative perceptions with the statement that their respective churches should write books, articles and other sources to teach on family planning and contraceptive use. A few respondents (6%) and (6%) from Catholic and Anglican churches respective had no opinion.

Table 6: Respondent's perception on the church to write books and articles on family planning and contraceptives

Response	Religious Affiliation			
	Catholic		Anglican	
	Frequency	Percentage	Frequency	Percentage
Positive perception	30	64	32	67
Negative perception	14	30	13	27
No opinion	3	6	3	6
Total	47	100	48	100

From the findings in Table 6 researcher could learn from the study that majority (most of whom are Anglicans) of respondents longed to know about religious teachings on family planning and contraceptive use. The religious leaders have responsibility to teach their followers because most of respondents and interviewees longed for much information. Ojo (2005) argues that the Christian churches have the responsibility to teach their followers on sexuality as part of the creation and that it is fundamental to the human experience and Christian identity. Genesis 1:26 introduces gender distinction, biological differences and the responsibility of procreation and productivity. Despite the sexual deviancy and latitude of sexual freedom in some groups and the acceptance of these lifestyles by members of the groups, orthodox Christianity is responsible to regulate and control sexual expressions among their members along what have been perceived as biblical standards. Ojo (2005) argue that the control of sexual behaviour by Christian groups is an institutional way and the most ubiquitous modalities through which religious groups demonstrate power and exercise social control over their members. In other passages of the Bible, procreation rather than pleasure is the aim of any sexual intercourse. Consequently the churches should teach through relevant means to the followers that the body and all its organs, and especially the sex organs, have taken on symbolic meaning of obedience or rebellion, fidelity or unfaithfulness, and the sacred or the profane. Secondly, the central notion that Christians are called to a personal morality is grounded in the biblical norm of virginity

before marriage and mutual love and understanding within marriage (Kumunyi, 1988). Following from Apostle Paul's injunction in I Corinthians 7:1-11, the evangelical position is that every Christian is charged with a personal responsibility to chastity and to maintain the sanctity of human sexuality within a controlled space from the understanding that the body is "the temple of Holy Spirit". Overall, there is little room for personal choice in sexual expression that departs from the biblical standard.

4.3.5 Respondent's perception on whether the church should teach how to use contraceptives

Data in Table 7 indicates that respondents (48%) and (53%) form Catholics and Anglican respectively had positive perception that their respective churches should teach on how to use contraceptives while others (42%) and (27%) Catholic and Anglicans respectively had negative perception that their respective churches should not teach on the use of contraceptives and the some respondents (10%) and (20%) from Catholic and Anglican churches respectively had no opinion.

Table 7: Respondent's perceptions on whether church should teach on how to use contraceptives

Response	Religious Affiliation			
	Catholic		Anglican	
	Frequency	Percentage	Frequency	Percentage
Positive perception	24	48	26	53
Negative perception	20	42	13	27
No opinion	5	10	10	20
Total	50	100	48	100

In FGD most Catholics were against the statement that the church should teach on the use of contraceptives. They had their ideas that the use of contraceptives was the sin against

God. This is supported by CCC (1997) that in marriage there is a union of man and woman. The use of contraceptives distorts the union by mutual recriminations, the union becomes subject to tensions and relations henceforth are marked by lust and domination. Harmony with creation is broken: visible creation becomes alien and hostile to man. The use of contraceptives implies that someone seeks pleasure. The Sexual pleasure is morally disordered when sought for itself, isolated from its procreative and unitive purposes. This could imply to the respondents that the church should not involve itself in evil activities. Most of the interviewed respondents said that it was not good for the Christian to use contraceptive methods though most of them were using them. Most of the Anglicans had their opinion that the people should be educated on health issues. It was found that Anglicans had no negative perception with contraceptives as it was for Catholics. For Anglicans and some other protestant churches contraceptives are used only in the God-given context for sexual intercourse - that of marriage. It can be argued that the availability of contraception has promoted fornication and adultery. There is the false expectation of sexual activity without the consequence of pregnancy. The widespread availability of the condoms has led to the illusion of freedom from sexually transmitted infections. The result has been untold emotional damage, a breakdown in marriage, rising levels of unwanted pregnancies often resulting in abortions, and epidemic levels of sexually transmitted infections (STIs) (Hotonu, 2008). Even when reserved for marriage, the use of contraceptives raises several important ethical issues, which the Protestant Church is only beginning to recognize. Since the development of the oral contraceptive in the 1950s we now know more about how the Pill interacts with fertilization and early life, although there is still more to discover. However, it has become clear that the separation of sexual union from procreation by the use of medicines is difficult to do effectively and precisely (Hotonu, 2008; Bongaarts *et al.* 2012). This fact raises an important ethical issue.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of the Major Findings

The study was guided by ethical/moral theories. The ethical/moral theories cover the aspects of liberal and conservative perspectives of religions. The main objective of this study was to determine the influence of religious beliefs on family planning more particularly among the Catholics and Anglicans. Specific objectives were to; (1) identify the main contraceptives used in the study area, (2) assess the practices of family planning among Catholics and Anglicans in the study area; and (3) examine the perception of followers of Catholic and Anglican churches in regard with family planning practices. The study assumed that the Catholic Church was conservative and Anglican Church was liberal.

The study findings show that the majority of respondents (62%) and (68%) among Catholics and Anglicans respectively were aged between 20 and 39. Big number of these respondents (54%) and (58%) among Catholics and Anglicans respectively were married; all respondents (100%) had formal education and were all Christians (Catholics and Anglicans). Also the results show that more than two third of respondents (64%) had 0-2 living children. Major findings of the study show that more than one third of the respondents used pills, calendar and male condoms. Contraceptives that were less used are diaphragms, sterilization, foam/jelly, female condoms and Norplant.

Further, it was found that more than a half of all respondents (68%) among Catholics and (60%) among Anglicans desired to use traditional methods in family planning. The major source of knowledge of family planning methods was health centres (hospitals, clinics and

pharmacies) (56%) and (58%) among Catholics and Anglicans respectively. Few respondents (16%) among Catholics and no respondents from Anglican Church had their knowledge of family planning from their churches. It was further, found that more than one third of respondents (39%) and (46%) among Catholics and Anglicans respectively were using contraceptives. Of all respondents, more than a quarter (27%) of Catholics and a few respondents (5%) among Anglicans had stopped using contraceptives due to prohibition from their church.

Moreover, majority of respondents (74%) Catholics and (54%) Anglicans knew teachings of their respective churches on family planning and contraceptive use. It was also found that more than a half of all respondents (63%) Catholics and (51%) Anglicans perceived family planning activities to be good practices. In addition, majority of respondents (65%) and (61%) among Catholics and Anglicans respectively had the perception that what is taught by their respective churches to be good. It was also found that more than two third of all respondents (64%) and (67%) among Catholics and Anglicans respectively agreed with the statement that their respective churches should write books and articles on family planning and contraceptive use. Also, it was found that less than a half of all respondents (48%) form Catholic Church and more than a half (53%) from Anglican Church supported the statement that the church should teach on how to use contraceptives.

5.2 Conclusions

The conclusions under this section are based on the objectives of the study and on the analysis of the variables conceptualized in the framework. Basing on the views of Catholic and Anglican respondents, priests, family planning specialists and contraceptives providers, several conclusions can be drawn. The study concludes that contraceptives mostly used in the area are pills, calendar and male condoms. The reasons why the

mentioned contraceptives were widely used were that they are the ones mostly known; they are accessible/available and simple to use. Contraceptives less used in the area included diaphragms, breast feeding, emergency pills, female condoms, sterilization, foam/jelly, loop and Norplant. These contraceptives were less used because they are less known and they are less available and accessible to the users.

Further, the study concludes that the Catholic Church has been able to influence its followers on family planning methods despite institutional challenges such as unaccountability of some of its ministers, competition from other organizations, unwillingness of some of its followers specially men/husbands to attend seminars and talks on family issues and lack of experts in family planning issues. The Anglican Church on the other hand has been indifferent regarding family planning issues especially when it comes to methods to be used.

Furthermore, the study concludes that majority of respondents from both Catholic and Anglican churches have positive perception on family planning as a good thing that is acceptable in the Holy Bible. Therefore, majority of respondents demanded their respective churches to write books and articles to teach their followers on the better involvement of family planning practices.

5.4 Recommendations

The following recommendations might be useful to development planners, religious leaders, governmental policy makers and development partners towards improvement of family planning services as one strategy to control population growth in Dodoma municipality and the country at large.

Firstly, this study found that calendar method was used besides other contraceptives because it was difficult to follow as many respondents had insufficient knowledge on how to adopt it. Therefore, there is a need for both churches to establish appropriate ways to teach their followers by involving specialists and experts to adopt calendar methods as it can be effective, less costly and safe to user's health if clearly understood.

Secondly, it was revealed by the study that seminars organized by the churches on family planning and marriage issues were rarely attended by men. Thus, it is recommended that campaigns to involve men in seminars concerning family planning and marriage issues should be done so that to make sure that both men/husbands and women/wives are involved and responsible in family planning issues.

Thirdly, it was found that many respondents did not know the difference between family planning and contraceptive use. Therefore, there is a need for the churches to make their followers aware of the difference that exists between family planning and contraceptive use by conducting seminars and writing books and articles on family planning and contraceptives.

Fourthly, a number of respondents did not know exactly what their churches teach in regard with family planning and contraceptive use. The churches, therefore, need to publish their teachings so that they may be known by everyone so that the stand of the church becomes clear.

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APPENDICES

Appendix 1: Questionnaires

Name…….

Ward……QUESTIONNAIRE No……

Parish……

Sub-parish……

SECTION A. BACKGROUND INFORMATION

1. What is the category of your age? (Years)

a) 15-19 [ ] b) 20-29 [ ] c) 30-39 [ ]

d) 40-49 [ ] e) 50-59 [ ] f) Above 60 [ ]

2. Your gender/sex is…….

a) Female [ ] b) Male [ ]

3. Your marital status is ……..

a) Single [ ] b) Married [ ]

c) Separated [ ] d) Widow/widower [ ]

e) Divorced [ ]

4. Your highest level of education is……

a) Non formal [ ] b) Primary [ ]

c) Secondary [ ] d) VETA/certificate/diploma [ ]

e) University [ ] f) Others (specify……)

5. Your occupation status…….

a) Employed [ ] b) Self-employed [ ] c) Unemployed [ ]

d) Others (specify……..)

6. Your religious affiliation……

a) Catholic [ ] b) Anglican [ ]

7. Your number of children…..

a) 0-2 [ ] b) 3-5 [ ] c) Above 5 [ ]

SECTION B. FERTILITY AND METHODS

8. How many more children would you like to have?

a) I do not need [ ] b) 1 [ ] c) 2 [ ] d) 3 [ ]

e) More than 5 [ ]

f) Others (Specify…….)

9. How would you like to space your children?

a) By using of modern FP method (Pills, condoms, IUDS etc.)

b) By using of traditional FP method (calendar etc.)

c) Others (specify)……

10. At what interval would you like to space your children?

a) 1 year [ ] b) 2 years [ ] c) 3 years [ ]

d) I cannot decide [ ] e) others (specify…….)

11. How do you postpone your childbearing?

a) Use of modern FP method (Pills, Condom, IUD etc.) [ ]

b) Use traditional FP method (periodic abstinence) [ ]

c) Not just getting pregnant naturally [ ]

d) Others (specify)…….

12. What family planning choice(s) do you know? (Please tick those you know)

a) Pills [ ]

b) Injectables (Depo-Provera) [[ ]

c) Intrauterine Device (IUD) [ ]

d) Implant (Norplant) [ ]

e) Male Condom [ ]

f) Female Condom [ ]

g) Diaphragm [ ]

i) Foam/Jelly [ ]

j) Sterilization [ ]

k) Lactational Amenorrhea Method (LAM) [ ]

l) Emergency contraception [ ]

m) Periodical Abstinence (Calendar) [ ]

n) Others (specify)……

13. How did you get to know about the family planning choice(s)?

a) Health education by health care workers [ ]

b) Radio or/and TV [ ]

c) Preaching at the church [ ]

d) Books [ ]

e) Friends/Peers [ ]

f) Others (specify)……..

14. What family planning choice(s) do you use or you have ever used? (Please tick those used)

a) Pills [ ]

b) Injectables (Depo-Provera) [[ ]

c) Intrauterine Device (IUD) [ ]

d) Implant (Norplant) [ ]

e) Male Condom [ ]

f) Female Condom [ ]

g) Diaphragm [ ]

i) Foam/Jelly [ ]

j) Sterilization [ ]

k) Lactational Amenorrhea Method (LAM) [ ]

l) Emergency contraception [ ]

m) Periodical Abstinence (Calendar) [ ]

n) Others (specify)……

15. Why did you choose to use that contraceptives/fp method (s)?

a) Safe [ ]

b) Effective (works well) [ ]

c) Encouraged by the religious leaders [ ]

d) Low side effects [ ]

e) Only method known to me [ ]

f) Only method available [ ]

g) Affordable [ ]

h) Others (specify)……

16. For how long did you use the FP contraceptives?

a) 0-2 years [ ]

b) 3-5 years [ ]

c) 6-10 years [ ]

d) I do not plan [ ]

e) Others (specify)……..

17. Why did you stop using it? (If discontinued)

a) To have a child [ ]

b) Side effects [ ]

c) Religious Prohibition [ ]

e) Costly [ ]

f) Non availability [ ]

h) I use contraceptives [ ]

i) Others (specify)……

SECTION C. PERCEPTION AND ATTITUDE

18. Do you know what your church teaches about family planning?

a) Yes [ ]

b) No [ ]

19. What do you believe in family planning?

a) It is a good thing [ ]

b) God does not like it [ ]

c) I do not care [ ]

d) Others (specify)…….

20. Do you think what the church teaches about family planning is right?

a) Yes [ ]

b) No [ ]

c) I do not know [ ]

21. The church should publish many books and articles emphasizing family planning and contraceptives use.

a) Yes [ ]

b) No [ ]

c) Others (specify)……

22. Do you think it is right for the church to teach the best use of contraceptives?

a) Yes [ ] b) No [ ] c) I do not know [ ]

d) Others (specify……)

23. Does the Bible support family planning and use of contraceptives?

a) Yes [ ]

b) No [ ]

c) I do not know [ ]

d) Others (Specify)…….

24. What could you say if you were given an opportunity to give your opinions for Christians to plan their families?

……

……

……

25. Being a Christian, what could you personally advise the church if it were ready to change its position regarding the family planning methods?

……

……

……

26. Do you know of any verses in the Bible that should be followed by the church with regard to family planning? Yes _____ No _____. If yes, which of these verses?

……

……

27. Are you allowed to discuss the issues of family planning and contraceptives in your small Christian community?

……

Appendix 2: Interview Guide for contraceptive distributors

1. When did you start distributing contraceptives? (Since …….)

2. Can you mention the types of contraceptives you know of?

3. Which types of contraceptives do you have here?

4. What types of contraceptives are mostly used in these areas? Why?

5. Do you distribute them to Christians? Yes, of which denominations who come most?

6. What are the side effects of contraceptives?

7. Do you think religions have influence on contraceptive use? How?

6. What do you say about religious beliefs and contraceptives?

8. What obstacles do you meet in this activity as far as religious denominations are concerned?

9. Do you think these contraceptives are safer than the traditional ways?

10. If yes can you demonstrate?

Appendix 3: Interview Guide for Priests and pastors

1. For how long have you been a priest/pastor here? (……..years)
2. Do you believe family planning is a good thing? Why?
3. What does the church say about family planning?
4. Do you like the way it teaches?
5. Does the church have any specialized department/unit dealing with family issues?
6. Are there any alternatives for those who fail to follow?
7. If yes, can you mention them?
8. What are ways used by the church to teach the followers?
9. Are you comfortable with these ways? Why?
10. What verses in the Bible the church uses to interpret family planning?
11. Which verses do you think are more right than the used ones?
12. What is to be done if the Christians do not follow the teachings?

Appendix 4: Focused group discussion guide

1. People nowadays do plan their families more than in the past years. Why this?
2. Methods to plan family are many. What methods are normally used in this area?
3. Which method (s) do you use?
4. Bible and other religious books have been saying much on this issue. Is family planning a right thing? Why?
5. You attend masses almost every week. Do priests/pastors tell you anything about family planning and contraceptive use?
6. Does your church conduct seminars on family planning?
7. Do you think your church's teachings have influence to the people? How?
8. Moral and ethical families are crucial for the church and national development. What do you think is to be done to have good families as far as family planning is concerned?