SOCIO- ECONOMIC DETERMINANTS OF CONTRACEPTIVE USE AMONG WOMEN IN GEITA DISTRICT

BY

JENITHA DAMASSEN BYAGALAMA

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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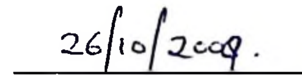
ABSTRACT

This study identified socio-economic factors influencing contraceptives use among women in Geita district; Specifically it determined the level of awareness about contraceptives, identified the types of contraceptives used, source of information about contraceptives as well as social economic factors which influence women use of contraceptives. A cross sectional study design was employed where by a multistage sampling technique was used in combination with simple and purposive sampling methods to obtain a representative sample. A total of 100 respondents were sampled. Questionnaires and a checklist was used to gather information from individuals, Focus Group Discussion (FGD) and Key informants. Statistical package for social science (SPSS) was employed for data entry and analysis. The study revealed that there was high awareness of contraceptives rampant, unavailability of contraceptives, inadequate knowledge of various contraceptives and limited access and use of contraceptives. This situation was mainly caused by a number of factors which include physical features, poor infrastructure, remoteness, inconsistent availability of contraceptives, ignorance and traditional practices. Furthermore, the study found that rural communities access contraceptives information through radio and MCH staff. The study findings further showed also that the use of contraceptives was influenced by socio-economic characteristics such as age, marital status, sex preference and household size. The recommendation made include the establishment of more health centers and hospitals in rural areas, training should be provided to contraceptives providers, raising awareness on different types of contraceptives methods, ensuring constant availability of all contraceptive methods, the provision of contraceptives education in schools for both sexes and provision of all necessary materials like flyers, brochures, posters and magazines which are needed for

effective provision of information in different areas. There is a need for more development specialist in relevant Ministry, NGO's, and development planners to establish more programmes on contraceptives issues.

DECLARATION

I, Jenitha Damassen Byagalama, do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my own original work and has never been submitted nor concurrently being submitted for a higher degree award in any other University.



Jenitha Damassen Byagalama, Date

MA Candidate

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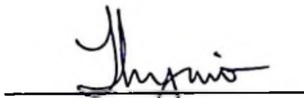

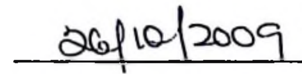

Dr. J.G. Lyimo-Macha Date

(Supervisor)

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DEDICATION

This work is dedicated to my almighty God who guided and lighted up my way during my studies, (Psalm: 119:105).

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
CPS	Contraceptive Prevalence Surveys
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
GDHS	Ghana Demographic Health Survey
GDP	Gross Domestic Product
HIV	Human Immuno-Defficiency Virus
IMF	International Monetary Fund
IUD	Inter-Uterine Device
MDG	Millennium Development Goal
MOH	Ministry of Health
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic Health Survey
NGOs	Non-Governmental Organization
NPC	National Population Commission
NPP	National Population Policy
NSGRP	National Strategy for Growth and Reduction of Poverty
SACCOS	Savings and Credit Cooperations
TDHS	Tanzania Demographic Health Survey
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nation Fund for Population Activities
UNICEF	United Nations Children's Fund

URT	United Republic of Tanzania
WB	World Bank
WFS	World Fertility Survey
WHO	World Health Organization
SPSS	Statistical Package for Social Science

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Family planning implies the ability of individuals and couples to anticipate and attain their desired number of children, the spacing and timing of their births; it is achieved through use of family planning methods (Kessy, 2001). Also, it is the way of regulating the number and spacing of children in the family through the use of contraceptives or other methods of birth control. Africa is a region with the highest population growth rates in the world. The growth rates in the region ranges from 2.2 percent to 2.8 percent compared to 1.4 percent and 1.7 percent for the world as a whole. But Africa is also the poorest region of the world (UNFPA, 2000). The Human Development Report of 2001 indicates that out of 36 nations in the world with low development, 29 are in Africa and the rest are in Asia. Therefore, Africa which has the most serious social economic problems in the world is also the continent with the most challenging population problems.

Available literature shows that high levels of fertility still observed in Africa especially Sub–Saharan Africa is a combination of cultural and social economic factors which determine the attitudes and behavior of people towards procreation. The high incidence of fertility at least reflects that reproduction starts at young ages, first marriage is 12 years and contraceptives are not being used in a wide spread and effective manner (WHO, 1997). In many parts of the world, family planning services are at present an essential element of reproductive health care and have saved lives and protected the health of million of people especially women and children. Also, the adverse impact of

population growth has led developed countries to be involved in family planning as means of slowing population growth (WHO, 1995). In the late 1960s family planning service were introduced and became a worldwide social movement. In Tanzania family planning service were introduced in 1959 by the Family Planning Association of Tanzania (UMATI) which was registered as a welfare Institution (TDHS, 2005).

Efforts of UMATI to introduce family planning in early post independent period were not well received by many people. The attitudes of many, including some party, government and religious leaders, were negative. As in most parts of Africa, family planning service in Tanzania were seen by many as aiming at population control. During the early post independence period, the majority of African countries, including Tanzania, did not consider population growth as a problem. This was partly due to the feeling that there were few people while resources were plenty. In addition the economies of many countries by then could cope well with the small population size.

However, as the population growth slowly begun to put pressure on resources changes began to be implemented in many of Africa countries. In the case of Tanzania in 1974 family planning (FP) service began to be provided officially in all government health facilities. UMATI was officially recognized and given the responsibility of procuring and distributing contraceptives in all Maternal and Child Health (MCH) clinics established almost in all health institutions. Following these developments the Ministry of Health began to involve itself in expanding and improving the quality of FP services in the country. In 1989 the Ministry of Health developed and launched the National Family Planning Programme for the year 1989-1993.

The programme set out national goals, targets and strategies for achieving FP services in Tanzania. The broad objective of the programme was to raise the contraceptives acceptance rate in the country from 7 to 25 percent by 1993 (TDHS, 2005). Other specific objectives included: improvement of quality and accessibility to FP services; improvement in the general health of mothers and children; and raising awareness and demand of FP service in the country (TDHS, 2005). Although family planning activities in Tanzania began as far back as the late 1950s, by mid 1980s only between 5 and 10 percent of women of child bearing age were using contraceptives in the country.

Contraceptives behaviour in developing countries is characterized by a regional pattern. The data from World Fertility Survey (WFS), prevalence survey contraceptives (CPS) and Demographic Health Survey (DHS) indicate that knowledge and use is high in Latin America and the Caribbean, followed by South- East Asia and lastly South Asia and Africa (Mwageni, 1999). Analysis of the trends in contraceptives prevalence shows that there has been a considerable increase in some countries between the major surveys.

The indicators mentioned previously have been used to estimate contraceptives levels in different parts of the world through different sources of data. In most developing countries data on contraceptives use can be obtained from three main sources all based on national representative samples WFS, CPS and DHS. There are also data from micro level studies conducted at sub-sample level. While WFS and CPS were limited to women and to a few countries, DHS which is the latest of the three main sources has included men and has a wider coverage. For example while WFS covered about 21 countries in developing countries, DHS by the end of 1993 had covered about 33 countries.

1.2 Problem Statement

Despite government and non government organizations efforts on emphasizing women in Geita District on the use of contraceptives; it has achieved little. This is due to the use of contraceptive which varies significantly by region from high as 50 percent in Kilimanjaro to as low of 7 percent in Pemba North. In 2005 in Geita District 89 percent of women were not users current of contraceptives (TDHS, 2005). The District is the third highly populated district after Kinondoni and Temeke Districts in Dar es Salaam, with the total of population 709 078 (URT, 2002). It has a population growth rate of 3.4% this include in migration of people and also, the growth rate is higher when compared to the economic growth of 5.1%. This is due to the fact that its economy cannot absorb the population, of the district although the District is highly endowered with mineral resource particularly gold (URT, 2003). The district remains poor, ranking the third poorest among 119 districts of Tanzania after Bunda and Musoma rural (URT, 2005).

However, family planning services, promotion and education information which are available among women in Geita are not enough to guarantee the adaptation of contraceptive use which eventually will reduce population growth. Therefore empirical information generated by this research might be useful for development planners, policy makers, development specialist in the relevant Ministry, NGOs and Geita District Council. The findings from this study will fill the information gap and determine the socio-economic contraceptive behavior among women in Geita District.

1.3 Justification of the Study

This study is important because it will contribute in providing education on contraceptives methods and helping existing national strategies cluster I which is growth and reduction of income poverty among rural people and cluster II on improvement of the quality of life and socio well being of the people (URT, 2004). Many socio-economic studies have shown that essential factors of agriculture production such as land, labour, access to credit facilities and extension service favour men rather than women (Due and Magayane, 1990; Mgina, 1992; Milter, 1994). Thus make many women face unfavorable circumstances such as low income, limited access to productive resourccs, and lack of right in family decision making.

A previous study which was done in Tanzania focused on accessibility and use of family planning information among rural people in Kilombero District (Emanuel, 2005). There is information gap on social economic determinants of contraceptive behaviour among women. This study will add knowledge on the existing body of knowledge and help in formulation of policies to contraceptives use. This research is related remains in line with Millennium Development Goals 4 and 5 which emphasize on the reduction of child mortality improvement in maternal health and finally will assist in designing new or improving life of women in Tanzania specifically rural areas.

1.4 General Objective

To determine socio-economic factors influencing contraceptive use among women in Geita District.

1.4.1 Specific objectives

(i) To assess the level of awareness about contraceptives among women

(ii) To examine the types of contraceptives used by women in Geita district

(iii) To examine source of information about contraceptives

(iv) To examine socio-economic factors which influence women to engage in contraceptives

1.5 Research Questions

1. What is the level of awareness on contraceptives use among women ?
2. What types of contraceptives are used by women in Geita District?
3. What are the sources of information about contraceptives?
4. What socio-economic factors influence women contraceptives use?

1.6 Conceptual FrameWork

In order to meet the information needs of the study objectives and identify the variables for data collection a conceptual frame work was developed (Fig. 1). The independent variables were social and economic factors and on the other hand was the use of contraceptives will be dependent variables (modern and traditional methods). The frame work reflects that background variables such as age, sex, family size, marital status directly the influence determinants of contraceptive use. Furthermore, the framework shows that social, economic factors, level of knowledge and limitation/accessibility in interact with of use of contraceptive. It is assumed each of these factors contribute differently to the use of contraceptives.

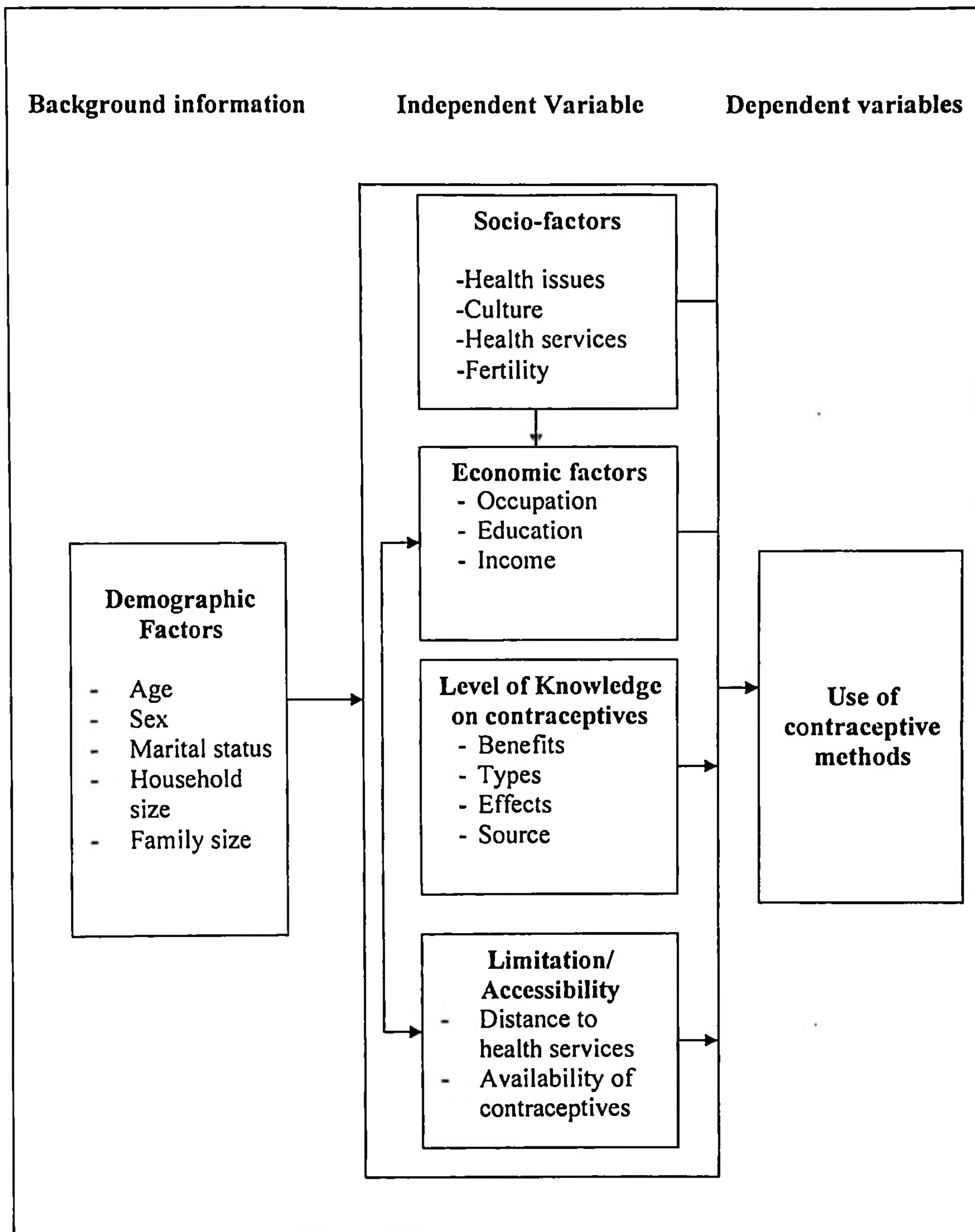

Figure 1: Conceptual Frame Work.

Table 1: Variables and definition

Variables	Operational Definition	Indicators
Income	Assets own by women	- Asset owned –high value, low value.
	Money earned per month	- Individual (women) cash income
Education	Highest level of education attained	Ability to read and write Number of years of schooling
Level of knowledge on contraceptives	State of being informed about contraceptives and attitude towards it.	By scores from agree, undecided and disagree
Fertility	Number of live children per women	Number of live children (girls/boys)
Household size	A group of people who eat from a common pot, share dwelling house and has the unit command from the head of the household who is the decision maker	Number of members in each household
Utilization	Ability of individual to use different type of contraceptives	Distance from MCH/Dispensary and hospital
Accessibility	Situation /factors hindering easy accessibility or passability of women to the dispensary, hospital, health center, and MCH	Remoteness (distant village) - Number health services available.
Information source	Ability of individual to access information through radios magazine MCH, friends, TV	Availability of TV, radio magazine, brochure books flipchart poster about contraceptives

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Definition of Contraceptive

Contraceptives are devises or drugs used to prevent women from becoming pregnant as a result of having sexual intercourse, also helps to determine the number and spacing of ones children through effective method of birth control (WHO, 2000).

2.2 Types of Contraceptives Used by Women in Tanzania

There are two types of contraceptives that is modern and natural methods. Modern methods include the condom (male and female), Depo provera, IUD, Norplant, pills, sperm codes, diaphragm and withdraw as traditional. While the natural (permanent) methods include menstrual cycle, mucus, basal body temperature and abstinence, other are nursing or Lactation Amenorrhea Methods (LAM) (Ngalinda, 1998).The contraceptives use varies by the place of residence, level of education, number of living children, and economic status of the household. The use of contraceptives varies significantly by region, from as high as 50 percent in Kilimanjaro to a low of 7 percent in Pemba North. The use of specific methods also varies by region. For example, women in Mbeya are most likely to rely on withdrawal while in Kilimanjaro, injectables and sterilization are most common. In Lindi, almost one –fifth of currently married women use the pill (TDHS, 2005).

2.3 Knowledge and Level of Awareness about Contraceptives Methods

Knowledge about fertility control is an important step towards gaining access to and then using a suitable contraceptive method in a timely and effectively manner. Contraception

knowledge is high among women in some methods but other methods were not clearly known. The average currently married and unmarried women who have never had sex know about four methods. Modern methods are more widely known than traditional methods. Nine out of every ten women have heard about the pill, injectable and the male condom (WB, 2000).

Knowledge was the major reason for different respondents who never used contraceptives, it is important, for them to get teaching sessions, seminars, campaigns as well as encouraging them about the different methods available (Emanuel, 2005). This could increase contraceptive knowledge as well as increase the use of contraceptives. Most women who visited MCH Clinics were not taught about contraceptives rather than asked to mention which method they need without being informed on the advantages and disadvantages of their choices. One of the basic reproductive rights that is not being adequately provided to contraceptive users in Tanzania is the right to proper, adequate information about contraceptives methods that are being provided (Kopoka, 1999).

2.4 Population Growth and Contraceptives

According to the 2002 Population and Housing the population of Tanzania was growing from 0.7 up 2.9 percent though the World Bank estimates the same to be 3.2 percent. The total fertility rate is approximately seven percent, with no indication that this has changed significantly over the past three decades (UNFPA, 1997). The population is basically a young one with 45% being under 15 years of age. This high fertility rate reflect very low use of family planning methods with a prevalence rate estimated to be 5-7 percent (TDHS, 2005). Maternal mortality rates are very high and available statistics show that areas of

highest maternal mortality rates are the same as those with lowest recorded use of modern contraceptive (WB, 1996)

2.5 Need for Contraceptive

Although fertility rate is high in Tanzania, there still exists a substantial need for family planning. Women who are potentially in need of contraceptive are those who either want to wait two or more years before their next pregnancy (need for spacing) or want to stop child bearing altogether (need for limiting). However married women who want to space or limit their child bearing, but are not using contraceptive.

The use of contraceptive is not solely to limit the number of birth but also to control the pattern of births. However, the cost of child production and care to asses older is very high. The cost include women's opportunity cost of time and other purchased child needs like clothing, education, health and food. Children are costly in terms of time and money to the household, they may also be valued as productive in security and assist in the family for their labour while young and as an investment that yield return to the parents for the future life. If the cost of children out weigh their benefits, then it is advisable to invest in family planning in order to limit the number of children (Ngalinda and Chuwa, 2006).

2.6 Importance of Contraceptive in the Society

Slowing population growth buys time for a country to invest in development aimed at raising living standards of people (Thang and Anh, 2002). As more people choose to use family planning, fertility falls and population growth slows. Slower population growth helps to protect the environment. It conserves resources, preserves clean air and water,

improves health, eases pressure on cities and helps to avoid conflicts. Slower population growth aids development. It buys time and provides a demographic bonus that can be invested in education, job creation, healthcare and other effort to raise living standards. The sooner fertility falls to low levels, the better most countries will be able to achieve sustainable development. Even small declines in fertility today will make a substantial difference in helping to meet peoples needs today and improves prospects for future (Upadhyay and Robey, 1999).

2.7 Success of Contraceptive Use Methods in Tanzania

The percentage of married women using one or more method of contraception has changed little since 1999. However, there has been a small shift from traditional to modern methods. Modern methods like depo-provera, pill, IUD, and condom methods use has increased from 17 percent in 1999 to 20 percent in 2004-05. The most notable change is in the mixing of modern methods used by married women has been a slight increase in the proportion using injectables (TDHS, 2005).

2.8 Factors Affecting Access and Use of Contraceptive

UNFPA (1997) has estimated that over 350 million couples worldwide (more than one third of all couples) do not have access to a full range of modern contraceptive and services. The reasons why family planning needs are often not met may include poor access to quality services, a limited choice of methods, lack of information, concerns about safety or side effects and partner disapproval (WHO, 2001). For instance, women and men often worry about side effect of family planning use. Others include lack of accurate information about reproductive health or access to appropriate services.

2.9 Source of Information about Contraceptives

In Nigeria it shows that the access to radio was in general, higher than access to television. Rural males had more access to radio than females (NDHS, 2004). A major source of awareness about contraceptives increased up to 69% compared to those listened on mother and child health, women's rights and development issues. Also, rural people have less access to television compared to radio and MCH. Males have more access of radio than females . Nigeria television mostly provide development information, such as child rights, vaccination, iodine deficiency, child rights to education and birth registration. (NPC, 2004) Newspaper and magazines are small and not significant to review the effectiveness of contraceptives promotion.

In sub-Saharan countries specifically Ghana has fallen in population sharply in recent years, with the rate of decline being one of the most rapid in sub –Saharan Africa. One of the most marked changes coinciding with Ghana's fertility decline has been the increase in the exposure to contraceptives message via the media. The use of radio increased from 35% in 1993 to 51% in 1998. The 1998 GDHS found that 11 percent of women had read a family planning message in a newspaper or magazine. Women who have heard or seen contraceptives via the radio, television, newspaper, magazines, posters, brochures or leaflets are considerably more likely to be using modern contraception than women who have not heard or seen such message at hospitals, clinics, pharmacies drug stores and along the road.

Jato *et al.* (1999) described the impact of multimedia family planning promotion on the contraceptive use of women Tanzania being high and varied and concluded that multiple

media sources of information reinforce one another and extend the reach of contraceptives messages. Other women in Tanzania argued that "complimentary messages may help to create an environment nature; contraceptives are perceived as a social norm. Therefore, contraceptives media should continue to be used to promote contraceptives" because the more types of media that people are exposed to, the more likely would use contraceptives. For example Kirangu *et al.* (1996) explained that promoting FP (modern and traditional) through mass media in Nigeria increased family planning use from 25% to 32% within six months.

2.10 Socio factors and Contraceptives use in East Africa

Socio- economic factors in East Africa differ specifically in Kenya. Age, marital status, education and level of income were factors which influenced use of contraceptives. These may be mitigated by behavioral and biological factors such as sexual activity, the desire for children and fecundity (Ntozi, 1991). In Tanzania women who had attended secondary education were ten times more likely to use contraceptives than those with no education. This is because of the knowledge and benefits they get on using contraceptives (Emanuel, 2005). Also, lack of knowledge of contraceptives is clearly a key reason for non-use (Bongaarts and Bruce, 1995). However, the relationship between education and fertility is much more complex than suggested. Though the underlying pattern most commonly known shows a negative relationship, there are instance where positive relationships at very low and very high levels of schooling have been found (Zlidar, 2003). Other determinants such as occupation were by the out of school youth who are more likely to use contraceptives than the in school youth girls basing on their age maturity and economic capacity.

2.11 Socio factors Influencing Use of Contraceptives

Socio and economic factors depend on sexually active youth who are more likely to adopt contraceptives practice as a wise precaution against STI and pregnancy and their associated implication than her married counterpart (TDHS, 2005). The level of education showed that the higher the level of education one attains the greater the probability of using a contraceptive method. The education system exposes one to more interactions and other source of information that enables one to make wise decisions such as using contraception when sexually active (Ntozi, 1991). Social activity also is a determining factor where by the youth interacting in social activities were more likely to acquire varied information and attitude regarding contraception from peers and others such as media idols. The right or wrong information they get often consciously or unconsciously influence their attitude and desire to adopt contraceptive practice (TDHS, 2005).

Cultural factors such as religious, of the society morals and values are often embedded through socio-cultural experiences like religion that promote chastity and mould attitudes towards contraception for the youth, married and society (Mwageni, 1999). Service factors, range of services; availability of a wide range of service gives greater room for choice. Thus the myths and misconceptions on contraceptive, effectiveness and effects of influence choice and access to a point accentuated by the popularity of the much publicized and easily accessed male condom (Mwageni, 1999). Women attitudes, beliefs or religious can also influence her on contraceptive use directly or indirectly through her desire for children. Moreover, traditional belief can support the demand for large families and limit the uptake of contraception, particularly non traditional methods (Sasu, 2007).

2.12 Religion and religiosity

Religion is among the socio-cultural factors influencing reproduction. Religion refers to a system of beliefs, attitudes and practices which individuals share where the main orientation is towards life and death. As a component of culture, religion has an influence on human sexuality and reproduction as it promotes or discourages certain types of behaviour. The relationship between religion and contraceptives behaviour is explained in terms of specific attitudes in religion as well as the doctrine in a particular religion towards reproduction (Mwageni, 1999).

Generally, all the religious groups are pro-natalist, however the resistance to human fertility interference largely depends on the presence of a central authority. In Tanzania there is no clear-cut policy on birth control. The religion of Islam allows the non-permanent methods of contraception and rejects the permanent like sterilization. The objection of sterilization is mainly based on the irreversibility of the method. The view of some Muslim scholars maintains that sterilization is an attempt to change what God created (Mwageni, 1999) Christianity, particularly Roman Catholicism (RC), has a negative attitude towards non-natural methods of birth control other than rhythm and withdrawal. According to RC the ultimate aim of sexual intercourse in marriage is the procreation of children. Thus any artificial interference with the process of conception is contrary to the laws of God.

2.13 Religion and Use of Contraceptives

The extent of use of contraceptives for currently married women does not vary much between Moslems and Protestants. In the category of Moslem never married Moslem

women have the highest contraceptives use followed by Catholics. Protestant women who are currently married are more likely to use contraceptives than other currently married women, while Protestants who never married women are less likely to use contraceptives than Moslem and Catholic never married women (Sasu, 2007). Whether married or not, women who declared themselves not to belong to one of these three religions are less likely to use contraceptives than other women. In traditional African societies, people believe that God has control over the human reproductive system or that children are a gift from God. Therefore, no one should prevent a child from coming into the world (MOH, 2005).

2.14 Health Related Factors and Contraceptive Use

The relationship between health related factors and contraceptives use has received less attention. Focus has been made on the safety of the methods as a determinant for use. Methods that have been to have perceived side effects are more likely to be used than others. It is reported that some men dislike vasectomy since they associate it with importance, loss of virility or physical weaknesses (TDHS, 2005).

In some societies in Sub Saharan Africa health concerns have been reported to be associated with women contraceptives use. URT (2004) reported that among women the main reason for using contraceptives was the preservation of the health of the mother and children. In a study of men attitudes towards family planning in Sudan, Mwageni (1999) noted that about 91 percent of the respondents were ready to approve contraceptive use if the wife's health was to be jeopardized by another pregnancy.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Description of the Study Area

The study was conducted in Geita which is one of administrative districts of Mwanza Region; it has got 7 divisions namely Geita, Kasamwa, Bugando, Butundu, Msalala, Nyangh'wale and Busanda. Also it has 33 wards and 187 registered villages. It covers 7825 km2 of which, 6775 km2 is landmasses and 1050 km2 constitute water bodies largely covered by Lake Victoria (URT, 2002). Geita District is located North East of Sengerema District, North West of Kagera Region, South East of Kwimba District and South of Shinyanga Region. The District is located on shore of the Lake Victoria lying between $2^{0}28'$-$3^{0}28'$ South to 32^{0} -32^{0} 45' East. Geita district is linked by all weather roads from Mwanza city via Sengerema District (URT, 2002).

The population of Geita district according to the 2002 Tanzania Population and Housing census was 709 078 where by females were 355 013 and males were 354 065. The major economic activities in Geita district are farming, livestock keeping, trading, fishing and mining. Most people have an income which is very low. Gold mining which is done in Geita District is of two types small scale artisanal mining which is conducted in 250 small scale mining sites and large scale mining which include sub-components of research, actual mining and master gold dealer. The major activities for women in villages were food vending, selling vegetable in small markets, saloons, tailoring and few in mining activities. Agricultural activities are done by both women and men.

3.2 Research Design

The study was carried out using a cross sectional survey approach where data were collected once at single point in descriptive study as recommended by Bobbie (1992) and Babbie (1990). The cross sectional research design was considered to be favorable because of resource limitations and time for data collection. The design has grater degree of accuracy and precision in social science studies than other designs (Casley and Kumar, 1998).

3.3 Sample Size and Sampling Method

A total of 100 respondents were selected from 10 villages to represent all women aged between (15-49). The sample size was large enough to make scientific conclusion and thus is well above the minimum cases recommended which is 30 cases (Bailey, 1998).

A multistage sampling technique was used to obtain the desired population, purposive and randomly sampling technique was also used. Geita District was purposively selected because it is highly populated compared to other districts in Mwanza Region. At district level, five wards were randomly selected. From each ward two villages were randomly selected by using lottery method. In each village ten respondents were selected randomly from the village register where all families have been registered. Also, purposive sampling was used to select respondent for (Focus Group Discussions) FGDs from clinics registers and those attending clinics to get in formations as well as contraceptives and also having age group ranging between 15 – 49 years.

3.4 Data Collection

3.4.1 Primary data

A structured interview schedule containing both open - close ended and likert 1-5 scale questions was used. The questionnaire was formulated in English and translated into Kiswahili to facilitate easy communication during data collection. However pre-testing of the study instrument was done to test clarity, sequence of the questions and the information obtained were helpful to modify the questionnaire in order to fit in the objectives of the study.

3.4.2 Qualitative data collection

(a) Focus group discussion

This method was used to collect information from the community. During FGDs, women were grouped into age categories from 15-30 years and from 31-49 years each group was comprised of 6-12 people. All participants were seated in chairs which were arranged in a circle to help maximum participation and allow freedom of expressing their views, feelings and opinions. The principle researcher and one research assistant conducted the discussion. The principle Researcher was a moderator while the assistant researcher was a recorder of the discussions and observer. The principle researcher introduced herself and then introduced the recorder. Kiswahili language was used during discussion. The moderator introduced the topic and allowed the group to discuss. All the discussions were held for about two hours in each session. The advantages of FGDs discussion are that they are flexible and can give more information by providing the researcher an opportunity to probe and ask follow up questions.

(b) Non participant observation

During the data collection the researcher observed how discussion went on, and also collected information before, during and after provision of services like filling cards, measuring weight of women, checking B.P which was very important before providing contraceptives. That method helped to eliminate subjective bias, also was relatively less demanding of active cooperation and it is daily routine services so it helped to get reliable information concerning the study (Kothari, 2004).

(c) Key informants

The researcher interviewed key informants. A checklist was used to guide the interviews. Key informants in this study include birth attendants, nurses, clinical officers and doctors. Five nurses and two doctors were interviewed from each health centers and two birth attendants from each village. The interviews with the key informants provided information regarding the availability of health services and contraceptive use. Like wise the checklist gathered information on services between birth attendant agents and women.

3.4.3 Secondary data

Secondary data particularly on social and economic determinants of contraceptive behaviour were gathered from various sources, including using available information from both published and unpublished reports from various sources such as Sokoine National Agriculture Library (SNAL), NGO's, hospitals, health centers, MCH. Electronic materials and other available source of relevant information.

3.5 Data Processing and Analysis

The data gathered from field survey were edited, coded, verified and cleaned before analysis. A Statistical Package for Social Science (SPSS) version 11.5 was used to analyse the data. In this package descriptive statistics namely mean, frequency and percentage were analysed. Chi-square was used to measure the correlation/relationship between variables. Finally content analysis was used to analyse responses from qualitative data including FGDs, key informant, and likert 1-5 scale result (Kothari, 2004). Likert scale was constructed by collecting many statements relevant to the alternative, retesting the statements to ascertain which ones were not ambiguous to retain, while ambiguous ones were discarded (Bernard, 1994). Also, the Index scale was constructed by formulating statements about a phenomenon being scaled by assigning them points.

In the analysis of qualitative data the recorded and the summaries written by note taker have been used. The analysis has employed ethnographic approach that is relying on the direct information given by respondents according to the theme used during the discussion (Kothari, 2004). Although in most cases the analysis has used the summaries occasionally original statement have been included to obtain insight of the respondents to a certain issue (Stemler, 2001).

3.6 Limitations of the Study

a) Respondents could not remember how much income they earned per month. This information was very important as information on social-economic status of respondents could be established. To get information, the researcher probed through and income categories to get estimated amount of income.

b) Lack of fund was also a problem because the researcher had to pay for transport for the data collection assistants. To get information the researcher requested the village leader who educated them that, this information was for academic not for project purpose then they agreed and assisted me.

c) In some cases, country, community events such as funerals and public meeting interrupted the survey exercise. More time was used to cover the interruption.

d) It was difficult to get information on which type of child needed from respondents. Majority said that they cannot choose the sex of a child because it is only God who decides on what sex of a child to give them. But after detailed explanations, they responded.

e) Finally, the logistics to specific areas or group of people in particular place was a problem due to the fact that it was a rainy season hence created transport problems.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Overview

The first section in this chapter describes briefly the socio economic characteristics influencing the use of contraceptives, the second section identifies describes the types of contraceptives used by women. The third section explains the source of information about contraceptives and fourth explained attitude of women toward contraceptives use.

4.2 Characteristic of Respondents

Characteristic of respondents are presented in Table 2. The characteristics were age, level of education, marital status and occupation.

4.2.1 Age

The results of the study show that the minimum age of respondent was 15 years and maximum age was 60 years. The majority (47%) of respondents had an age ranging between 16 and 25 years, other respondents were between 26 and 34 years and only few (2%) of respondents who fell between 45 and 60 years. The study noted that the use of contraceptives, first sexual intercourse, marriage and giving birth differ with age, region, religion and place of residence of a woman. Similarly TDHS (2005) indicated that Tanzanian women have a low age at first birth. More than half of the interviewed population of women (50.8%) became mothers before they reach the age 20 of years, with a high proportion of them reported their first birth between ages 15 and 17. Ngalinda and Chuwa (2006) noted that unmarried sexually active women under 35 years of age seem to

be the ones interested in delaying the first birth, while older women aged 35 years and over do not do any thing to delay their first births. This might lead to the conclusion that women aged 35 and over do not delay their first births. The ultimate conclusion is that women over 35 years are no longer hoping to get married and might not care any longer about premarital births as men in Tanzania prefer to marry young ones.

4.2.2 Level of education

Education was considered as one of the factors that can influence the use of contraceptives by women, although it is difficult to contribute the changes of attitudes and knowledge to a single factor. Carnoy (2000) provided three key dimensions of education that have implications on reproductive behaviour. These are education as a source of knowledge, vehicle of social economic development and transformer of attitudes.

The findings of this study were. That the majority (62%) of the respondents attended primary school. Meanwhile 11% of the respondents attended technical education and only few (1%) of the respondents attended adult education. About a quarter (24%) of the respondents had no formal education. These findings are similar to those observed by Mwageni (1999) that both males and females in developing countries indicate that the use of contraceptives increases with educational levels of the respondent. Respondents with primary education are more likely to use contraceptives method than those with no education but are not as likely to those with a secondary education or more. For example, according to the 1990-91 DHS of Pakistan eight percent of women with no education used contraceptives methods compared to 18 percent of women with primary education and 35 percent of women with education above primary level.

Low level of education did not affect the women use of contraceptives due to the fact that most of respondents who use contraceptives, were not provided a place to sign and there were not much work to fill the form. But for the staff at hospital and health centers who provide contraceptives, education is important because they should know expiring date of drugs, how to check blood pressure, keeping information of every women using contraceptives and to read brochures, flyers and magazines which were not regularly supplied ,rather depend on availability of contraceptives from UMATI.

4.2.3 Marital status of the respondents

Marital status has been used as an important factor that may influence women to use contraceptives. In this study marital status was taken to include formal and informal unions. The study findings show that the majority (74%) of respondents were married, only (15%) were single and the rest (7%) were separated (Table 2). Married women had effects in contraceptives use because they were restricted by their husbands (TDHS, 2005).The result of this section are supported by Ngalinda and Chuwa (2006) that many men do not want their sexual partners to use any contraceptive methods especially in rural areas. Men would like to have as possible as many children as future labour force for future social security. The other hidden reason for men to dislike modern contraceptives might be due to culture that permits men to have sexual activities outside their marriage as long as their wives are either pregnant or breast-feeding. During that time, and only then they can engage in sexual relationship with other women.

In many of the cultures in Tanzania, men have an interest in keeping their wives either pregnant or breast feeding since they want to keep their privilege of having sexual partners

outside their marriage. Mwageni (1999) observed that, communication between partners is considered instrumental in marital relationships because it entails egalitarian and conjugal relations within the family. Communication is also considered as essential for individuals to arrive at a consensus regarding several family matters. Interpartner communication is considered as an important variable in studies of reproductive behaviour.

4.2.4 Occupation

The relationship between occupational status and contraceptives behaviour is based on the general hypothesis that modern work is incompatible with high fertility. It is assumed that the work status particularly of women influences their fertility aspirations and behaviour. The study findings showed that the majority (62%) of the respondents were farmers they mainly producing maize, beans, millet, cassava, very few respondent produce bananas, sugarcane and sunflower in addition to food products. Slightly less than one quarter (24%) were self employed engaged in tailoring, brick making, local brewing, retail shop, selling firewood and water. Only few (8%) of the respondent were unemployed, (6%) of the respondents were civil servants employed as teachers or health assistant (Table 2).

The link between occupation status and contraceptives behaviour can be illustrated in four ways. First, as a woman become employed in an occupation outside the home, she is provided with an alternative satisfaction to children such as companionship, creative activity as well as social and economic reward. These alternative activities may compete with raising children.

Secondly every additional child may increase what the economists refer to as opportunity cost of a working woman. Thus individuals may consider whether for sometime during pregnancy and afterwards, they should abandon their income by staying at home and not participating in the labour force. The opportunity cost is likely to affect the decision of working couples to allow the partner to have additional children. Third, the occupational status of a woman can increase her status in the family and community as well. In this way she way improve her participation in reproductive decision making, through mechanism such as inter-partner communication.

Lastly, individual occupation status may lead to improvement in income. The income obtained can reduce the dependence on children as old age security. The literature shows that there is no clear pattern between individuals occupational status and contraceptives use. Moreover Emannuel (2005) showed that there is little variation, for example among women who were employed and those who were not. In another study Ngalinda and Chuwa (2006) found that a wife's employment was not significantly related either to current, or intention to use contraceptives.

Table 2: Distribution of respondents by socio-economic characteristics (n=100)

Category	Frequency	Percentage
Age (years)		
1-15	4	4.0
16-25	47	47.0
26-34	33	33.0
35-44	14	14.0
45-60	2	2.0
Total	**100**	**100.0**
Education level		
No formal education	24	24.0
Primary	62	62.0
Secondary	11	11.0
Adult education	1	1.0
Technical education	2	2.0
Total	**100**	**100.0**
Marital status		
Married	74	74.0
Single	15	15.0
Divorced	7	7.0
Widowed	3	3.0
Separated	1	1.0
Total	**100**	**100.0**
Occupation		
Farmer	62	62.0
Unemployed	8	8.0
Civil servant	6	6.0
Self employed	24	24.0
Total	**100**	**100.0**

4.2.5 Income level

Majority (38%) of respondents said that they earned less than 100 000 Tshs per annum. Slightly more than a quarter (29%) earned between 100 001-200 000 Tanzania shillings per annum and only few (12%) of the respondents earned between 300 001 and 400 000.The rest (11%) of respondents earn more than 400 000 Tshs (Table 3). Respondents level of income differed because they sold products like rice, cotton and maize as a main source of income, since they mainly depend on agricultural activities. Some depend on small businesses like selling water, bricks, and formal employment like nurses, teaching, small mining.

4.2.6 Number of children

Respondents were asked to mention the number of children they have. The study findings (Table 3) indicate that the majority (66%) of the respondents had between 5-8 children followed by 23% of the respondents with 1-4 children and the rest (11%) of the respondents had no children. Child bearing in rural and urban areas was perceived differently. Children were very important in urban areas than in rural areas. Rural people attached more importance to child bearing as a source of farm labour and for assisting the parents during the old age while it was only important for the security in urban areas. For females children were considered more important in urban areas than in rural areas as they were perceived useful for parents. Female children were found to have more commitment in taking care of parents when they were old than male children. Male children were considered important for inheritance of the parent's properties when they get very old and incapable for managing the properties like farms (land) and houses in rural areas. Children in rural areas were useful in providing farm labour and parents spent little time in social

services like education, clothing and health care. The traditional system of kinship and land ownership in rural areas give more value to sons than daughters (Sasu, 2007).

4.2.7 Sex preference

In this study the preference of couples to have a child of particular desired sex is called sex preference. Male child (son) preference in Tanzania is among the underlying factors on sex preference and normally contributing towards high fertility (Mwageni, 1999). The study results show that the majority (70%) of respondents said that sons were preferred most. Where as 18.3% of respondent said girls were preferred and only few (11.7%) of respondents said both girls and boys are preferred (Table 3). Such results imply that in many African societies sons are preferred more than daughters because of cultural identity that sons in the family increase the clan as well as the expansion of the properties like cows and farms (Campbell, 1991). In this study, most parents preferred boys and children of both sexes. In the focus group discussion held at Katoro village at Katoro Ward one female member of the group said in Sukuma language that "*Ng'wana ni ng'wana abize nkima ninga ngosha bose bana duhu*". Means a child is a child whether female or male, all are equal. This cause high population because women would continue to produce many children and hence no contraceptives are used.

4.2.8 Household size

The result from sampled respondents shows that majority (66%) of respondents had between 5-8 people whereas 11% of respondents had 9-12 members and the remaining 23% of the respondents had 1-4 members respectively (Table 3). According to this study there is no household with more than 13 members. Most rural dwellers accepted the risk of having more members in the household where the critical and immediate problem to solve

was food which was obtained from own farms, contrary to urban dwellers who had to purchase food as well as other amenities which were costly. Sasu (2007) furthermore noted that families in the rural areas were more nucleated compared to those in urban areas. Bigger households' sizes in rural areas were related to dependence on on-farm income generation, early marriages and less awareness on contraception.

Table 3: Distribution of respondents by other socio-economic characteristics (n=100)

Category	Frequency	Percentege
Number of children		
No children	11	11.0
1-4 children	23	23.0
5-8 children	66	66.0
9- above	0	0.0
Total	**100**	**100.0**
Sex preference		
Boys	70	70.0
Girls	18	18.3
Boys and Gilrs	17	17.7
Total	**100**	**100.0**
Household Size		
1-4	23	23.0
5-8	66	66.0
9-12	11	11.0
Over 12	0	0.0
Total	**100**	**100.0**
Income level		
Less than 100 000	38	38.0
100 001 – 200 000	29	29.0
200 001 – 300 000	10	10.0
300 001 – 400 000	12	12.0
More than 400 000	11	11.0
Total	**100**	**100.0**

4.2.9 Asset control and ownership by women

Assets which are owned by women were categorized as household assets, livestock, transport assets and farm equipments. These assets were used by women in different activities. The majority (70%) of respondents said that they had access to some of the listed assets and few (30%) of respondents they had no assets. The result of this study shows that (90%) of male respondents owned land /plots, houses, car, television, livestock like cows, goats, sheep and pigs. Also furniture like beds, tables, chairs, sewing machines, bicycles were mentioned. About 90% of women respondents owned small assets like charcoal/stove, saucepans and animals such as chickens, and ducks (Table 4). This result is supported by Ngalinda and Chuwa (2006) that access to and control of resources and income indeed show inequality in access to both resources and income. Land, labour and capital resources are equally accessible to men and women, but men have an upper hand in their control. Income earned from crops, livestock and farm activities is equally accessible to men and women.

On top of that Due and Magayane (1990) argued that women have access to means of production including land and cattle implements. However, the majority do not own those means as they are vested in the hands of men as husbands, fathers, brother and sons. Both the policy and Land Acts of 1999 have access to and ownership of land. Furthermore, section 3 (2) of both Land Act 1999 and Village Land Act 1999 emphasizes that the right of every woman to acquire, hold, use and deal with land should be to the same extent and subject to the same restrictions as the right of every man. At the same time, the new Land Act 2002 allow for the traditional ways of holding land to be regarded and supported fully not with standing the patriarchal nature of the customary laws. This is a controversy that

needs to be addressed. The existing statutory laws such as the Marriage Act of 1971 have tended to reinforce further gender inequalities as far as land ownership is concerned.

Table 4: Distribution of respondents by ownership and control of assets (n=100)

Types of assets	Owned	
	Male (%)	Female (%)
Houses	90.0	10.0
Car	80.0	20.0
Bicycle	80.0	20.0
TVs	90.0	10.0
Land/Plot	10.0	90.0
Radio	90.0	10.0
Livestock		
-Cows	70.0	30.0
-Sheep	75.0	25.0
-Goats	80.0	20.0
-Chicken	10.0	90.0
-Pigs	10.0	90.0
Furniture		
-Beds	80.0	20.0
-Chairs	90.0	90.0
-Tables	10.0	90.0
Utensils		
-charcoal/stove	10.0	90.0
-Sauce pans	20.0	80.0
Sewing machines	10.0	90.0

Experience shows that in many societies women ownership of resources were lower than males. Moreover, the result is supported by Makombe (1999) that women's unequal access to resources is generally common to many poor women in Tanzania who most of

them are still affected by social-economic constraints prevailing in their societies. The study result on ownership and control of assets show that the imbalance of power between women and men affects women's status in the community, and also access and control of transport assets furniture, communication assets, land, large animals which were tools to effective production resources (Mahendeka, 2007). In this case access and lack of control over most productive resources affect women use of contraceptives.

4.3 Types of Contraceptives Used by Women

A woman's desire and ability to control her fertility and her choice of contraceptives method are in part affected by her status in the household and her own sense of empowerment. The percentage of currently married women age 15-49 that are using any method of family planning is known as the contraceptives prevalence rate CPR (TDHS, 2005). The results of this study show that the majority (30%) of respondents use Depo-Provera, and only few (7%) of the respondents use pills, whereas 4% of the respondents use IUD and condoms. Among all respondents, a half of them (52%) knew different types of contraceptives but they were not using them. Other methods like jell or foam, tubal ligation, withdrawal, mucus, vasectomy and calendar rhythm also were not used (Table 5).

These results were contrary to Koc (2000) who observed that a married woman usually does not have sexual intercourse with other men for the fear of having a child that is not her husbands. This could lead to divorce. In this sense, men believe that contraceptives use is a warrant for women to commit adultery, and are therefore against it. For these reasons injections are now popular to countercheck these cultural factors as a husband would not know if women were using contraceptives.

Table 5: Distribution of types of contraceptives used by women in Geita district (n=100)

Types of contraceptive	Frequency	Percentage
Depo-provera	30	30.0
Pills	7	7.0
Intra-uterine Device (IUB)	4	4.0
Female sterilization	1	1.0
Condom	4	4.0
Calendar Rhythm	2	2.0
Not use any method	52	52.0
Total	**100**	**100.0**

4.3.2 Traditional methods

The researcher asked the respondents to mention the types of traditional methods used by women to prevent pregnancy. The findings show that the major methods used include wearing of small pieces of traditional trees around the waist" Mphigi" in Sukuma language many women believe that through wearing Mphigi they can prevent pregnancy. Whereas 8% of respondents reported that women take traditional medicine and only few (6%) of respondents said that women use roots from traditional shrubs and mix them with menstrual blood, and tie in a string and wear around the waist (Table 6).

Table 6: Distribution of respondents by types of traditional methods used by women (n =100)

Traditional type	Frequency	Percentage
Mphigi (wearing around waist)	60	60.0
Roots mixing with menstrual blood	6	6.0
Drinking traditional medicines	8	8.0
I don't know	26	26.0
Total	**100.0**	**100.0**

4.4 Source of Information about Contraceptives

Study respondents who were aware of the various contraceptives in their locality were requested to say where they got such an information. The study results showed that the majority (51%) of the respondents obtained information from clinics, whereas 19% of the respondents got information from the radio. The few (18%) of the respondents got information from friends. The remaining 4% of the respondents obtained information from magazines (Table 7). This result disagrees with those of Kirangu *et al.* (1996) who found that rural women were harder to reach than their counterparts, the use of broadcasting media is an excellent way to reach rural audience. The radio played greater role in advertising information about contraceptives provider, supplier and how contraceptives should be used to women in different urban areas, because there was limited access of other media such as television and print materials.

Table 7: Distribution of respondents by types of information about contraceptives (n=100)

Type	Frequency	Percentage
Friends	18	18.0
Clinics	51	51.0
Radio	19	19.0
Magazine's	4	4.0
Posters	8	8.0
Total	**100**	**100.0**

4.4.1 Source of information which is preferred most

The respondents were able to mention different sources of information which they preferred most. The study results showed that 34% of the respondents preferred the radio,

16% preferred the information from the television, whereas 25% preferred the information from MCH Clinics and only a few (3%) of the respondents preferred the information from neighbors and this is because other women trust information from informal meetings (Table 8). Most (34%) of respondents preferred the information from radio because there are announcements, advertisements and drama which was broadcasted and presented the contraceptive campaign in Tanzania by Mama Ushauri radio program on Radio Tanzania.

Table 8: Distribution of respondents by source of information which they preferred most (n=100)

Preferred source of information	Frequency	Percentage
Radio	34	34.0
Posters	15	15.0
Friend	7	7.0
Neighbours	3	3.0
Television	16	16.0
MCH clinics	25	25.0
Total	**100**	**100.0**

4.4.3 Source of information appropriate at community level

When asked about the appropriate source of information at community level the respondents were able to mention different appropriate sources of information. The findings showed that 30% of respondents mentioned the radio, 13% mentioned friends whereas (28%) mentioned MCH Clinics and only few (5%) mentioned the newspapers (Table 9). Most (30%) of the respondents mentioned appropriate source of information at community level was the radio because radios are affordable and can be accessed by the majority of rural women. Furthermore, it can be operated in many rural areas unlike the

television which needs electricity. These findings are supported by Zijp (1994) who observed that the radio makes information available at low cost in remote areas, and it can reach large numbers of people despite the fact that radios are owned by men in rural areas like Geita district than women.

Table 9: Distribution of respondents by source of information appropriate at community level (n=100)

Appropriate source	Frequency	Percentage
Radio	30	30.0
Posters	8	8.0
Friends	13	13.0
Newspapers	5	5.0
Television	1	1.0
Community Health Worker	15	15.0
MCH Climes	28	28.0
Total	**100**	**100.0**

4.5 Effects of Decision-Making of Women's Use of Contraceptives

The result showed that 26% of the respondents reported that women have the power on the use of contraceptives while 22% of the respondents reported that in decision making affect the use of contraceptives. On the other hand, more than a the limitation half (52%) of women did not use contraceptives (Table 10). For women who decided themselves to use contraceptives they faced problems such as husbands not trusting them. They are however, in an advantage that they can choose the methods of contraceptives they wanted to use, to avoid unwanted pregnancy and hence income level of their family increased. As for those whose decision making was done by their husbands they faced effects like having

many children. Moreover they were unwilling to choose the methods they wanted and the methods which were chosen by their husband caused side effects in their bodies. In focus group discussion held at Kasamwa village in Kasamwa Ward, it was noted that there were some other reasons like lack of confidence, low capability, lack of control on resources, patriarchy system, traditional beliefs, reproductive and reproduction role and low level of education affect women power in making decisions about the use of contraceptives. This result is supported by Ngalinda and Chuwa (2006) that more couples used contraceptives methods for birth spacing than for stopping childbearing and the family planning decision making the role was mostly influenced by both couples where the role of men could be very high. Men's desire for more children was in all age groups. However, the desire was more apparent among those above the age of 34 years and those who already had 4-6 or more children. The desire for more children among men particularly in rural areas is explained by the fact that men culturally consider children as an asset and think that they socially and economically gain from having a large number of children.

Table 10: The distribution of respondent on decision making about use of contraceptives (n=100)

Decision making effect on women's use of contraceptives	Frequency	Percentage
Yes	22	22.0
No	26	26.0
Don't use	52	52.0
Total	**100.0**	**100.0**

4.6 Attitude towards the Use of Contraceptives

The respondents were given 10 statements to ascertain their attitude toward use of contraceptives. Their responses were recorded in a Likert type scale where they were asked to indicate whether they agree, disagree, and undecided, with the given statements. Statements administered to respondents are presented in (Table 11).

Table 11: Index of attitude toward use of contraceptives

Category	1	2	3
		Percentage	
Having many children increase women status in the family	70	1	29
Using contraceptives is a sin	85	1	14
Using contraceptives cause total sterilization	50	5	45
Healthy providers increases discourage women to use contraceptives	69	1	30
Level of education affects the use of contraceptives	19	8	73
Contraceptive limit the number of children in the family	39	4	56
Knowledge on contraceptive is good enough to influence the use of contraceptives	2	6	92
There is need of emphasing women to use contraceptive also should decide themselves	45	5	50
Contraceptives have benefit to the use children and husband	19	1	80
Television, newspaper, health worker and radio are good source of information on contraceptive use	18	3	79

Key: 1. Disagree 2. Undecided 3. Agree

4.6.1 Attitude towards use of contraceptives

To develop the index of attitude towards use of contraceptive respondent were given new value for easy comparison, the response have been grouped into three categories namely, agree, undecided and disagree. In positive statement i.e. those in favour of the use of contraceptives responses score 3 while "undecided" score 2 and "disagree" score 1. For negative statements i.e. do not favour use of contraceptive for agree response score 1 while "undecided" score 2 and disagree score 3.

To find the levels of attitudes toward the use of contraceptives the first step was to obtain the total score for each respondent for all 10 statements. The favorable attitude ranges 1-24 low attitude, 25 undecided and 26-50 high attitude. After running the frequency table, the following percentage indicates attitude toward the use of contraceptives The finding from the study indicate that the majority (62%) of respondents had positive attitude toward the use of contraceptives (Table 12).

Table 12: Levels of attitude toward use of contraceptives (n=100)

Levels	Respondents (%)	
Low attitude	1-24 score	35
Undecided	3 score	3
High attitude	26-50 score	62

Also the intention is one of the indicators of continuation of contraceptives use. In addition, it can be used as a measure of attitude of individuals towards contraception. Since attitudes are difficult to measure precisely, the intention to use is sometimes used in

surveys as an indicator of attitudes. Individuals who respond that they are willing to use contraceptives in future are considered to have positive opinion to contraception. However, this measure is not necessary reliable, as there is no guarantee that those who say that they are willing to use, will actually practice in the future.

4.6.2 Factors influencing the choice of contraceptives methods

The respondents who were aware and were using contraceptives were requested to give the reasons which influenced their choice of contraceptives that they were using. The results revealed that 18% of the respondents used Depo-Provera because they were convenient in privacy compared to Pills. About 12% of the respondents mentioned knowledge on the methods used and only few (8%) of the respondents were influenced by friends (Table 13).

Table 13: Distribution of respondents by factors influencing the choice of contraceptives (n=100)

Reasons	Frequency	Percentage
Availability of methods	10	10.0
Convenience of the methods	18	18.0
Influence from a friend	8	8.0
Knowledge on the method	12	12.0
I don't use	52	52.0
Total	**100**	**100.0**

Other reasons stated by respondents was availability of contraceptives at a particular time and place. The study was supported by Virginia Department of Health (2002) that contraceptives use has benefited to health of women, children, families and communities

and is a key component of sexual and reproductive health services. The study further showed that contraceptives use play an important role in economic and social development. This is also supported by Koc (2000) who observed that population growth buys time for a country to invest in development aimed at raising living standard of the people.

4.7 Factors that Hinder Women's using Contraceptives

The findings showed that 31% of the respondents said that the major reasons that made women not to use contraceptives was due to the restrictions from their husband and that they did not trust their wives who are involved in family planning. About (23%) of the respondents said that it is due to long distance (more than ten kilometer) from their residents to the hospital or heath centers. In order to see a provider, a prospective client has to travel long distance and postponed their activities for the day. Very few (17%) reported that their major reason was due to unavailability of specific contraceptives. Further, the findings showed that (14%) of respondents reported that the reason made them not to use contraceptives was due to poor rural roads from where they stayed to the main road where they expected to get transport to hospitals (Table14).

This is supported by Ali (2001) that problems which hinder the use of contraceptives are associated with three factors smaller numbers of health personnel trained in contraceptives, limited access to facilities and limited range of available contraceptives methods. Mwageni (1999) found that discontinuation of use of contraceptives methods can be considered as an indicator of stability of motivation to continue using methods for a prolonged length of time. Avery general picture of discontinuation of contraceptives can be provided by the

differentials between ever-use and current use of methods. However, such information is not specific. It is also possible to obtain such information in programme based data. These sources make a follow-up of the clients registered in their programme. However, this source has many limitations in some developing countries due to loss of follow-up and poor storage of records.

Table 14: Distribution of respondents by factors that hinder women's use of contraceptives n =100

Factors that hinders women's use of contraceptives	Frequency	Percentage
Long distance	23	23.0
Husband not trusting their wives	31	31.0
Un availability of contraceptives	17	17.0
Poor infrastructure	14	14.0
Geographical features	10	10.0
Remoteness	5	5.0
Total	**100**	**100.0**

4.8 Contraceptives Awareness among Women

Information on knowledge about contraceptives methods aims to establish the level of awareness among the individuals to different types of contraceptives methods and their source. The assumption is that awareness of the fertility limiting options and their sources is central to their subsequent use. The study was also interested to know different strategies which should be taken in order to raise the consciousness on the use of contraceptives. The findings show that the majority (41%) of respondents reported

education on contraceptives to couples should be introduced from primary level up to secondary level. This is supported by Emanuel (2005) who observed that young adults need to have appropriate information on reproductive health and family planning and access to services and this can be done through family life education.

Table 15: Distribution of respondents by contraceptives awareness among women (n=100)

Strategies	Frequency	Percentage
Education to women and their husband	41	41.0
Advice to women	18	18.0
Seminar	30	30.0
Create awareness through promotion	11	11.0
Total	**100.0**	**100.0**

The result from the study indicates that the majority (30%) of the respondents said that contraceptives seminars for couples should be done before marriage so that men might feel comfortable to attend clinics. This is supported by Green *at al.* (2002) that using men as contraceptive providers may encourage men to share responsibility for family planning equally with women and may increase the acceptability and use of contraceptives methods. Only few (18%) of the respondents said that the advice on contraceptives should be recommended for both sexes especially at different levels from villages to district level and at different places like MCH clinics, hospitals and meeting where both sexes attended is equally important. This is supported by Emanuel (2005) that involving men can increase contraceptive adoption, client satisfaction contraceptives use effectiveness and continuation. The rest (11%) of respondents supported that the creation of awareness

through the promotion of different types of contraceptives through poster advertisements in different media like radios and televisions.

4.9 Benefits of Respondents Got in using Contraceptives

The study findings show that 90% of the respondents knew the benefits of using contraceptives only few (10%) of the respondents did not know the benefits. The finding from the study show that, the majority (45%) of the respondents reported that contraceptives leads to child spacing, whereas (30%) reported that using contraceptives improve their standard living for women and their partners. Only few (14%) said that contraceptives limit family size and the rest (11%) of the respondents said contraceptives prevent transmission of diseases especially sexually transmitted infections and HIV /AIDS in case of consistent use of condoms (WHO, 2001) (Table 16). This result disagree with those of TDHS (2005) that many people in Tanzania dislike "barrier methods" especially condoms, because they are considered to reduce sexual pressure. However, as an HIV preventive measure condoms are highly used now days.

Table 16: Distribution of respondents by benefits they get in using contraceptives (n=100)

Reasons	Frequency	Percentage
Child spacing	45	45.0
Improve their living standard	30	30.0
Limit family size	14	14.0
Prevent transmission of diseases	11	11.0
Total	**100**	**100.0**

4.11 Women, Community Workers and Birth Attendants on Reasons for Use of Contraceptives

Focus Group Discussion was used to obtain information from birth attendants, community workers, key informants based on reasons which made men to be involved in contraceptives use. This was relevant for this study because using contraceptives need both couples. The findings from focus group discussion show that, involving men in contraceptives use programs has benefits to both men and women. It has, also been found to have a positive impact on women health and providing contraceptives use effectiveness and continuation. This is supported by Raju and Leonard (2000) that there could be only very small improvement in women's access and use of family planning without men's support and active involvement. Another study reported that contraceptive use was improved by effective communication between couples on sexual and fertility related matters. This is also supported by Ali (2001) that even in areas in which the prevailing patriarchy system (traditional belief) many couples report discussing matters related to family size and contraceptives use.

4.12 Summary of Findings

The study found that there was limited use of contraceptives methods. The situation was mainly caused by a number of factors including ignorance of respondence on existence of some methods like vasectomy and tubaligation, moreover withdrawal is not known compared with pills, IUD, Depo-Provera, condom and tradition methods of using "mphigi". Others include, inadequate contraceptives knowledge, inaccessibility of contraceptives services, few staff with limited training. Several problems which hinder accessibility and use of contraceptives were identified. The problems were limited of

access, illiteracy or low level of education causing people to believe on rumorus about contraceptives side effects, long distance, unavailability of contraceptives, poor infrastructure, geographical features, remoteness and ignorant men who did not want their wives to use contraceptives. These factors could, however, be reduced or eliminated if all important factors like promoting contraceptives services would increase awareness and demand for contraceptives services, educating both for women and men would reduce ignorance and impart contraceptives knowledge, building more health centers and hospitals and employing more trained staff would improve the accessibility of contraceptives service.

Furthermore, the study found that rural communities access information through the radio and MCH Clinics staff, television, friends, newspapers and neighbors. The radio was the most popular, most preferred and very appropriate source. Also the use study found that there were socio economic factors which influence use of contraceptives like age, number of birth, education and availability of methods, marital status, and occupation.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 An Overview

This chapter presents the conclusion from the research findings and recommendations for socio- economic determinants of contraceptives use. The overall goal of the study was to determine socio economic factors influencing contraceptives use among women. The specific objectives of the study were; to determine the level of awareness about contraceptives among women, to examine the types of contraceptives used by women, to examine source of information about contraceptives and finally to determine social economic factors which influenced women to engage in contraceptives.

5.2 Conclusion

This study concludes that the awareness as well as the use of contraceptives tends to increase with increasing age of person. It was found that contraceptives used mainly were pills, IUD, Depo-Provera, condom, calendar rhythms and tradition method known as "Mphighi". Other methods like jelly or foam, tubal ligation, withdrawal method, mucus methods, vasectomy were not known as well as not used. The source of information on contraceptives were clinics, friends, radio, magazines posters. Among these the source of information which preferred was like radio, television, MCH Clinics and neighbors. The appropriate source of information at community level were friends, MCH Clinics and newspapers. Radios were appropriate because they are affordable and can be operated by many in rural people unlike the television which need electricity.

The access and control over resource, level of education, traditional beliefs, level of income and occupation did not show much relationship to use of contraceptives, rather it was through age, number of birth, accessibility and availability of contraceptives methods and influence from doctors and nurses.

5.3 Recommendations

The study recommends that.

a) The government and different NGOs should provide education on contraceptives use to community so as to impart knowledge to clear out dated beliefs which have effects on the use of contraceptives.

b) The government and other health centers, and clinics staff should take all influences on the use of contraceptive information into consideration when promoting contraceptives use.

c) At the health centers responsible personnel should ensure adequate availability of different types of contraceptives.

d) NGOs i.e. UMATI should be encouraged to open new offices, hospitals, health centers in rural areas rather than towns to supply contraceptives.

e) Seminars, workshops long and short term training on contraceptive providers should be conducted.

f) Family planning programmes should emphasize the exchange of ideas or information between husband and wife (or partners).This means FP programme should encourage partners to communicate or discuss about family planning, use of specific contraceptives methods and child bearing. Promoting frequent communication between partners will not only lead to more contraceptives use but also improve the status of women.

g) Publicity of family planning services, products and messages to areas of special interest to women is another strategy. This can be done using materials such as T-shirts, polythene bags, and khangas. These can display pictures, logos and messages designed to raise male consciousness in family planning. Male should raise male consciousness in family planning, Male oriented magazines (sports magazine or sports page) sports like football, and the pop music industry (in Geita the industry is largely dominated by male artists) can be used to convey family planning messages that appeal to the needs and desires of men.

h) Government should use traditional media channels such as radio messages, posters and television to provide knowledge on methods of contraceptives which is not known like vasectomy and tubaligation.

i) Community should be advised by government staff like nurses, doctors, to continue using the traditional contraceptives methods which have been proved to be effective.

j) NACP and NFPP may need to coordinate their activities jointly in areas of common interest to ensure condoms are located not only in convenient or strategic positions but also in respectable and acceptable areas such as pharmacies, retail sops and village offices.

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APPENDICES

Appendix 1: Questionnaire for women in Geita

Your participation is completely voluntary but your experience could be very helpful to others.

Location

Date of Interview..................................

Name of interviewer..............................

Village................................ Ward........................ Hamlet....................

Division.............................. District......................

Back ground information

1. Questionnaire number...
2. Age of the respondent years..................................
   1. = 1<15
   2. = 15-19
   3. = 20-24
   4. = 29-29
   5. = 30 -34
   6. = 35-39
   7. = > 45

3. Marital status
   1 = Married
   2 = Single
   3 = Divorced
   4 = Widowed
   5 = Separated

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Location

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   3. = 20-24
   4. = 29-29
   5. = 30 -34
   6. = 35-39
   7. = > 45

3. Marital status

   1 = Married

   2 = Single

   3 = Divorced

   4 = Widowed

   5 = Separated

If the above answer is 1= married what was your age at first marriage..........years

4. Level of education

   1 = None

   2 = Primary

   3 = Secondary

   4 = Adult education

   5 = Technical education

   Others (Specify)...

5. Occupation of respondents

   1 = Farmer

   2 = Unemployed

   3 = Civil servant

   4 = Self employed (explain)..

6. Do you have children?

   1 = Yes

   2 = No

7. If the answer is yes, how many children

   1 = Live children.......................Boy (s).........Girl(s)........

   2 = Dead children......................

8. House hold size

   1. = 1-4

   2. = 5-8

   3. = 9-12

   4. = over 12

9. Which child sex do you prefer?

   1. = Boys

2. = Girls

3. = Boys and Girls

Level of awareness

10. Do you know about contraceptive methods

1 = Yes

2 = No

If yes tell me methods you know……………………..

11. What contraceptive methods are you aware of (tick which is appropriate)

1 = Depo-provera

2 = Pills

3 = Intra-uterine device (I UD)

4 = Jell or foam

5 = The injectable

6 = Condoms

7 = Tubal ligation

8 = Withdrawal

9 = Calendar rhythim

10 = Mucus method

11 = Vasectomy

12 = Female sterilization

13 = Other (Please specify)…………………………………………………………..

12. Do you use contraceptive?

1 = Yes

2 = No

13. If yes, what kind of methods do you use (specify)…………………… …………..If answer is no go to question 14

14. Have you experienced problems with your contraceptive you use

1 = Yes

2 = No

15. If yes what problems have you experience

1...

2...

3...

16. Why you do not use contraceptive. please tick reasons

1=women status will decrease

2= it is sin, it acts against religion.

3= it causes side effects.

4= my husband does not like it.

5= an availability of MCH clinic

6= wanted to have more children.

17. What do you think are benefits you get when decide to use contraceptive

1= Child spacing

2 = improve their living standards through reducing un intended pregnancy.

3= Limiting family size.

4= prevent transmission of sexually transmitted infections including HIV/ AID

18. Do you think there are traditional methods of contraceptive?

1 = Yes

2 = No

19. Have you ever heard women using them

1 = Yes

2 = No

20. Please mention those methods

1..
2..
3..

Source of information

21. Where have you got information of contraceptive

1 = Friend
2 = Clinics
3 = Radio
4 = Magazines
5 = Posters

22. Which of the following contraceptive source information do you prefer most?

1. = Radio
2. = Posters
3. = Friend
4. = Neighbors
5. = Television
6. = MCH clinics

23. At community level which source of information are appropriate

1. = Radio
2. = Posters
3. = Friends
4. = Newspapers
5. = Television
6. = Community health workers

Social Economic information

24. What is your main source of income

1 = Salary/wage
2 = Farming

3 = Livestock keeping.
4= charcoaling
5= Petty business
6= Water selling
7= Food vendors
8= Mining

23. What is or income level per annum? Tsh
1 = Less than 100,000
2 = 100,000 – 200,000
3 = 200,001 -300,000
4 = 300,001 – 400,000
5 = More than 400,000

24 Who control your income
1 = Myself
2 = My husband
3 = A member of the family (specify)..

25 Do you own any assets
1= Yes
2= No

26 If yes mention them

S/NO	Types of assets	Owned	
		Yes	No
1	Houses		
2	Car		
3	Bicycle		
4	TVs/Radio		
5	Land/Plot		
6	Livestock -Cows -Sheep -Goats -Chicken -Pigs		
7	Furniture -Beds -Chairs -Tables		
8	Utensils -Charcoal/stove -Sauce pans -Electrical cooker		
9	Sewing machines		
10	Others		

27 What influenced your choice of contraceptive methods?

1 = Availability of the method

2 = Convenience of the method

3 = Influence from a friend

4 = Knowledge on the method

5 = Others please specify…………………………………………………

28 If you have not influence with the above reasons. What are other reasons ....

29 Is their any .... Around here

1= Dispensary

2= Health centers

3= Hospital

4= MCH

31 Do you encounter any problems in getting contraceptive methods?

1 = Yes

2 = No

32 If yes, what are the problems

1 = Long distance (more than ten kilometers) to the health facilities

2 = Husband not trusting their wives.

3 = Un availability of contraceptives in the health facility.

4 = Poor rural roads.

5 = Geographical features (valley, hills, mountains)

6 = Remoteness (long distance from the main roads)

33. Do you discuss contraceptive issues with your partner

1 = Yes

2 = No

34. Do you think there are women who do not know contraceptive?

1 = Yes

2 = No

35. What should be done so that contraceptive to be known? Give reasons

1..

2..

3..

Tick one number based on whether you are strongly agree (SA), Agree (A), Undecided (UD), Disagree (DA), or Strongly Disagree (SD) with the statement.

Statement	Strongly disagree	Disagree	Undecided	Agree	Strong agree
	1	2	3	4	5
Having many children increase women status in the family					
Using contraceptives is a sin					
Using contraceptives cause total sterilization					
Healthy providers increases discourage women to use contraceptives					
Level of education affects the use of contraceptives					
Contraceptive limit the number of children in the family					
Knowledge on contraceptive is good enough to influence the use of contraceptives					
There is need of emphasing women to use contraceptive also should decide themselves					
Contraceptives have benefit to the use children and husband					
Television, newspaper, health worker and radio are good source of information on contraceptive use					

THANK YOU FOR YOUR COOPERATION

Appendix 2: Checklist for focus group discussion

1. Do you know what is contraceptive
2. What are source of information about contraceptives.
3. For those using family planning what do you think are reasons which influenced them to use contraceptive
4. Can you please tell me type of contraceptive you know and which kind do you use?
5. What influence the women to use kind of contraceptive chosen?
6. Which method do you prefer most..

Social economic factors affects use of F.P

1. Mention social factors affects the use of contraceptive
2. Mention economic factor affects the use of contraceptive
3. Do you think men are affected on the use of contraceptive
4. Do you think there are factors which hinder access of contraceptive
5. Mention factors hinder utilization of contraceptive
6. What should be done so that contraceptive accessed and utilized full
7. Is there any organization outside your community that help in distribute and utilization of contraceptive (mention them)...

Appendix 3: Questionnaire for key informants/staff

The purpose of this study is to find out the view and opinion on the status of social economic factors affecting the use of contraceptive methods. Interviews intends to find out the staff views of the topic study.

1. Do you have any programme for provision of contraceptive methods?
2. Are there any hospital health centers or MCH around here?
3. What are source of information about contraceptives?
4. Mention difficulties which encounter in provision/teaching on contraceptive methods. Please mention solution for difficult you know.
5. What factors hinder effective use of contraceptive services and how do you go about it?
6. Mention types of contraceptive methods available around and which methods women like most?
7. What factors do you think influence women to choose the method the liked/use more?

THANK YOU FOR YOUR COOPERATION