Freedom to choose

Women’s possibility to take reproductive decisions in Babati, Tanzania

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“If you have too many children it means that you have to cook a big pot and that doesn’t taste so good.”

Iraqw woman in Dareda, Tanzania 2009
Abstract

This thesis study women’s possibility to take reproductive decisions in Babati, Tanzania. Tanzania has one of the highest total fertility rates in Sub-Saharan Africa and hence a high child- and maternal mortality rate. Family planning service can help individuals to reach their reproductive goals but it is not always available or accessible. The purpose is to see what socioeconomic factors affect women’s ability to influence family planning, make a comparison between urban and rural settings, and see if women perceive themselves to have the freedom to choose. A field work in Babati was conducted during three weeks in the spring of 2009. The research questions were answered through a qualitative study with semi structured group interviews, mainly done with women but also with health personnel. The result was analysed through the concepts of gender, power and education. The respondents expressed that the husband is the main obstacle for their possibility to decide over their own fertility. Urban women generally felt free to take reproductive decisions, but rural women did not. The difference between the two settings is explained by women’s negotiating skills that depend on their status within the family and the society. Urban women are more often educated and therefore have more status and more power to influence decision-making, including reproductive decisions. Other problems in rural areas are that family planning services are less accessible and facilities sometimes lack resources. Rural health workers do not always keep statistics which makes it difficult for health planners to know what needs to be improved. The Ministry of Health and other actors need to promote women’s access to the facilities. Further recommendations suggest programs that empower women and educate men in family planning issues.

Keywords: family planning, fertility, socioeconomic, influence, urban, rural
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>FP</td>
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<td>FPS</td>
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<td>HIV</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>International Planned Parenthood Federation</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Right</td>
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<td>TDHS</td>
<td>Tanzania Demographic Health Survey</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UMATI</td>
<td>National Family Planning Association of Tanzania</td>
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<td>UNFPA</td>
<td>United Nation Population Fund</td>
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<td>USAID</td>
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1. Introduction

Fifty years ago concerns about population growth started to increase the interest for international family planning (FP) efforts (Lindstrand et al., 2006). Population control and birth control has been a controversial issue throughout the years. A question frequently debated is; in whose interest does fertility needs to be controlled and why not control poverty, instead of the number of poor people. National policies have many times negatively interfered with people’s most private areas of life. By aiming for improved welfare for the society, governments have often overlooked the welfare of individuals. Earlier population growth was mainly seen as putting negative pressure on national societies, hindering economical development and stressing the global environment (Sedgh et al., 2007). At the International Conference on Population and Development (ICPD) in Cairo in 1994, focus shifted toward the right and need of individuals. 179 countries signed the agreement; that every man and woman should have the right to decide over their own fertility. The new human right perspective has changed the attitude and approach towards sexual and reproductive health and rights (SRHR) throughout the world. Efforts to improve reproductive health and investing in family planning services (FPS) has increased contraception use considerably in developing countries since the 1960s, and reduced fertility by half (UNFPA, 2008). However still every six married woman cannot stop or space her births for various reasons. The unmet need for family planning leads to 76 million unwanted pregnancies every year. This contributes to unsafe abortions, maternal deaths, high risk births and injuries, and puts negative pressure on the social and economical well-being of individual’s.

Family planning was recently included in the fifth Millennium Development Goal (MDG) on improving maternal health as an indicator to follow the progress (UNFPA, 2008). Family planning is an inexpensive intervention that can save lives and improve the health and well-being for millions of women, men and children. Studies show that it also have added benefits that can help reaching the other MDGs. Family planning can promote socioeconomic development, reduce population growth and poverty, promote children’s school attendance and gender equality, reduce child and maternity mortality, slow the spread of HIV/aids and help protect the environment. People’s preference in family size differs and it is important to understand everyone’s specific situation in order to meet their needs. Studies show that globally women’s most prominent reason for not using contraceptives is because services and methods are not available to them (Sedgh et al., 2007). Even if FPS is available, women who wish to control their fertility might not have access because of low status, limited knowledge
about FP, beliefs that they are not at risk of getting pregnant, religious constraints, costs or worry about side effects. Differences between rural and urban areas, between poor and non-poor, educated and less educated women is becoming smaller but still the most marginalized are in urgent need for improvements. Today global trends show that governments, NGOs and donors invest less in promoting reproductive health because of needs for targeting HIV/aids and poverty instead.

Studies show that high fertility rates can be associated to the fact that people want to have many children due to various reasons (Mturi & Hinde, 2001). Large families are tradition in some societies and give status, especially for men. Many children can secure the household economy by working on the family’s agriculture production. If they take jobs within the non-agricultural sector they are expected to give money to their parents. Some women leave it to God to decide how many children she has, which means that she can have as many as her body allows her to. Others might want to control their fertility, but are hindered because of religious reasons since contraception may be prohibited in the area. The unmet need for family planning is largest in sub-Saharan Africa (UNFPA, 2008). Family planning facilities might not be available because of poor health infrastructure and governments unwillingness to prioritize reproductive health. Even if there is availability people might not have access to FP because of social or economic reasons. In poor societies women often have low status, which means that few girls attend school, social norms stagnate, and fertility patterns are difficult to change.

1.1 Background
Tanzania has one of the highest total fertility rates (TFR) in sub-Saharan Africa, and consequently one of the highest maternal mortality rates. Even though the TFR has decreased from 6.3 (1991-1992) to 5.7 births per woman (2004-05), it is still relatively high (TDHS, 2004-05). Fertility patterns vary within the country. Rural women have on average 6.5 children while urban women have 3.6 children. Women that have completed secondary school or higher, and also women of the highest economical quintile have 3.3 children. Non educated women have on average 6.9 children and women of the lowest economical quintile have 7.3.

Tanzania Ministry of Health and Social Welfare play a key role in improving the availability and access to FPS and other health facilities in the country. They fund the National Family Planning Association of Tanzania (UMATI) and also work together with, and get support from international organizations. UNFPA offers Tanzania extended FP support in order to
reduce unwanted pregnancies and thus save lives of mothers and children. The British organization Marie Stopes provides health facilities in Tanzania, and works as a supplement to existing clinics and dispensaries (2009). The United States Agency for International Development supports health programs to combat HIV/AIDS, malaria and mothers and children’s ill-health (USAID, 2009). There is a large need for targeting youths since they are vulnerable to sexual and reproductive health problems and this is something that UMATI focuses on. Young people learn about their sexual and reproductive health and rights (SRHR) so they can avoid diseases and early pregnancies which can hold back their individual development. Also the involvement of men in family planning is believed to be the key to success by many. The problem is that interventions and organizations not yet reach out to remote areas and all individuals. It will take a long time to involve men in FP issues due to gender inequalities, power imbalance, tradition, religion and social taboos, but it is nevertheless crucial. Reproductive health and family planning is a recognized issue in Tanzania, and is frequently addressed in daily newspapers (Ajwang; Andrew; Kabendera; Maro, 2009).

According to the Tanzania Demographic Health Survey (TDHS) women on average want to have 5 children, and men want to have 5.3 children (2004-05). People’s knowledge of contraception is very high, and few lack access to FPS or cannot afford contraceptives. However usage of contraceptives differs between regions, living area, educational level, economical situation and the number of children people already has. Abortions are illegal but most health facilities provide short-term and long-term contraceptives, some even provide permanent solutions. Family planning and fertility rates have not changed much since the last survey in 1999. More than 25% of young women aged 15-19 are already pregnant or have received their first child. Among married women 42% use contraceptives in urban areas, and 22% use it in rural areas. In Manyara region the average of total contraception use is 26.5 percent.

Women’s status in the household and her perception of her own power and control over her life is related to her possibility to plan births. The Tanzania DHS (2004-05) shows that there is an association between use of contraceptives and status of women. The more final say a woman have in decisions the more likely she is to use contraceptives. Reasons why women do not use contraceptives mostly has to do with fertility related aspects, because they want many children, worry about bad side effects, or because they, or their husband oppose to contraceptives.
1.2 Formulation of problem

In Tanzania the man is the head of the house; he takes most decisions and therefore he also has reproductive rights (Mturi & Hinde, 2001). A large family gives him more status and power because he decides over many people. Women are usually responsible for taking care of the children, the household economy and the agricultural production. Many children can act as work force on the farm; they can contribute to the household economy, and secure their parents pension. On the other hand many children can become a socioeconomic burden for poor households that cannot afford to take care of them properly, feed them and give them an education. Poorly educated people, especially women have difficulties taking control over their lives. Bearing many children, often from a young age, puts the woman’s physical health at risk and can hold back her development and future life options. An educated, empowered woman that participates in activities outside the home is more likely to have influence over her own life and well-being (Lindstrand et al., 2006). An empowered woman can also positively impact the life of her husband and children. Babati works as a particular case in order to examine women’s perception about their situation. The study sets out to answer the following purpose and research questions.

1.3 Purpose

This thesis study married women’s self perceived view on their possibilities to influence family planning in urban and rural settings in Babati. The purpose is to examine whether they can choose if and when they want to have children, and identify potential restraining socioeconomic factors.

1.3.1 Research questions

- What socioeconomic factors affect women’s possibility to influence family planning?
- Are there differences between urban and rural settings?
- Do women feel free to take reproductive decisions?
2. Theory

First terms that are frequently used in the study are explained under definitions. Secondly the theories will give the case study a framework and set it in a wider and more general applicable perspective. The theories that are essential for this case study are the concepts of gender, power and education. Finally other studies are presented that have investigated similar issues.

2.1 Definitions

**Access** and availability are frequently mentioned in this study, and it does not imply the same. Even if family planning service and contraceptives exists, everyone might not have access to it due socioeconomic (see below) or geographical factors.

**Availability** of FPS means that facilities exist relatively close enough for everyone to use it. It is available because it has resources, medicine and staff to attend those who seek help.

**Family planning** can assist people to reach their reproductive goals (WHO, 2009a). This includes infertility treatment for those who cannot become pregnant naturally, as well as fertility control for those who wishes to limit or space their births. Short-term contraceptives include the pill, condoms and hormone injections; long-term contraceptives are implanons, IUCD (intrauterine contraceptive device) and the permanent methods are min laps (uterine tubes ligation) and sterilization. Natural methods refer to the calendar method, prolonged breastfeeding, withdrawal and abstinence.

**Reproductive health** is complete physical, mental and social well-being that includes the reproductive function and process at all stages of life for women and men (WHO, 2009b). According to the WHO everyone should be able to have responsible, safe sex and decide when they want to have children. Everyone has the right to information, to good, safe, affordable fertility regulation methods, and to good health care that can promote safe pregnancies and deliveries.

**Socio economic factors** include income, poverty, equity, gender, social support, education, culture, ethnicity and security (Lindstrand et al., 2006). These factors are some of the most important determinants for people’s health and well-being (FHI, 2009). Social and economical security, as well as equal opportunities for individuals promotes good public health. A reverse situation can lead to ill-health and larger health inequalities between women and men, and between groups of people. Women and men often have uneven access to health facilities and to resources, and therefore have uneven opportunity to participate in the
economical and political arena. Women are often disfavoured which negatively affect their life options (Lindstrand et al., 2006).

2.2 Gender theory

Gender is the social construction of what identifies femininity and masculinity (Lindstrand et al., 2006). The meaning of gender differs between cultural and social settings, and depends on how the society is organized. Many societies are patriarchal, that is male dominated, both within the family and institutions (Momsen, 2004). Friedrich Engels (1820-1895) saw reproduction as the main factor that explains women’s subordination by men. Since reproduction is linked to the man’s private property the woman’s sexuality needs to be controlled so the man can ensure he has children to pass on his belongings to. Engels on the other hand thought that women could become more free and independent if they participated in productive work outside the home. Today women in low income countries are far more involved in activities outside the household, but they are still subordinated men. The social structures are reproduced where patriarchal manners rule; within the family and on most levels of the society. Development does not always include women and hence do not make them freer. Many times women have to bear the double burden of both reproductive and productive work, within and outside the household.

Lately much has been done to improve women’s physical and mental health, by recognizing the unequal access to factors that improves health (Momsen, 2004). There is no universal solution for changing the power structures between women and men. Gender equity differs due to religion, class, beliefs and education, and especially in strongly patriarchal societies women have difficulties to gain power. National policies and interventions that increase the access to health facilities can affect fertility rates (Momsen, 2004). Still social, religious and cultural views on family size strongly influence the number of children people decide to have. Momsen means that there is a difference between women’s practical needs and strategic needs (1991). Practical needs are basic needs such as shelter and food, which often uphold the uneven division of labour between women and men. Strategic needs can empower women and change the gender inequality. But since poor women often need to address their practical needs they do not have time to reflect on how they can fulfil their strategic needs. Targeting empowerment of women is crucial in programs though often neglected by governments because the effects are not immediately visible. Ignoring gender issues in development programs will have negative effects on population growth, national production, the economy, child and maternal mortality and the environment if neglected. The society will keep on being
divided, unequal and poor, and women and girls will stay subordinated. Women must be seen
as agents of change and their needs, rights and wishes must be addressed on all levels of
development work. At the same time including men in programs concerning women’s and
children’s health, has shown good results in changing gender roles and social attitudes
(Momsen, 2004).

2.3 Power theory

The concept of power can be explained in many different ways and the discussion is divided.
Foucault said that people are shaped by power that exists in the society, culture and social
groups (Lukes, 2004). People are socialized and adjusted to their surroundings, and they
reproduce these structures by the way they live and react. He agrees with Durkheim when he
says that people might think they can choose freely, while in fact they are only free to decide
within certain frames of discipline and control. Lukes somewhat radically explain his basic
power concept by saying that “A exercises power over B when A affect’s B in a manner
contrary to B’s interest” (2004, p. 39). Lukes defines power as a capacity were A can
exercise power over B but he does not have to. Power is used over someone which puts A and
B in a relationship to each other. Power is also used over someone when their interests are
being ignored, and even when they are unaware of it. Power is a wide concept and it can also
be called influence, encouragement, and persuasion, manipulation, having authority over, or
forcing someone. From this perspective there are different levels of power. Power has been
used if A leads B to act upon something that B would not have done otherwise, but from
another perspective power has not been used since B has accepted A:s advice. As well as
there are different levels of power practice, there are different levels of interests. The concept
of interest also has to be valued and put in perspective. Some interests are more or less
important, more or less essential for people’s lives.

Amartya Sen (1999) argues that women’s well-being is best improved by recognizing women
as active agents rather than passive recipients of help. To have agency means to be in action
and have power. People are responsible individuals that by acting (or not acting) can change
their own lives as well as others. People can make changes by the way they act, and their
success should be valued from their perspective and aims, not from someone else’s external
views. People are however part of the society and hence will affect their surrounding
environment by the way they act. The freedom of individual’s agencies can be limited
depending on the political, economical, and social opportunity that exists within the society.
Sen (1999) argue that development best comes from beneath, from grass-root level, where
individuals can act freely and make changes. When the well-fare of people are changed to the
better this will also benefit the society in the end. However the system needs to remove all
types of unfreedoms so that people can become liberated agents. Different freedoms interact
with each other, for example the social freedom to get education and health care can enlarge
the chances to participate in the political or economical arena.

Empowerment is work that aim to strengthen individuals or groups possibility to influence
their own lives (Janlert, 2000). The agency of women has outcome on their life options (Sen,
1999). Women’s well-being is often neglected due to gender bias within societal and cultural
structures. Women’s lives are not only affected by access to healthcare and other
requirements, but also by socioeconomic factors. Empowerment of women come with the
possibility to earn own money, have an employment outside the house, have the right to own
things, have education and have the ability to take everyday decisions. Working outside the
household improves the status of women on all levels of the society. Empowerment and
independence makes women more able to take decisions which can positively influence their
own well-being, and also their husbands and children’s. There is a strong association between
reduced child mortality and women’s empowerment, literacy and labour force participation.
Freedom in one area can lead to freedom in another area. For example education enhances the
opportunity to get a job. Participation within the society gives women more status, more
independence and more negotiating skills, including in fertility related matters.

2.4 Education theory
Knowledge is said to be power, and power to decide over your own life can determine the
quality of it (Abbott, 1998). Education is one of the most important foundations for good
health and well-being (Lindstrand et al., 2006). There is a strong association especially
between female education and child survival. Studies show that children are more likely to
survive if both parents are illiterate, rather than if only the mother is illiterate. This is due to
the power imbalance between the husband and wife that follows the disparity in educational
level. If both spouses are illiterate they are less likely to be unequal and the woman has more
power to negotiate. The adult literacy rate has increased globally in the last couple of decades,
but due to population growth the absolute number of illiteracy is still about the same. In Sub-
Saharan Africa there are large gender differences in school attendance, much fewer girls than
boys go to school.
There are several reasons why educated mothers gain better health for themselves, and their children (Lindstrand et al., 2006). Studies suggest that the association between educated mothers and child survival is due to the empowerment that comes from education, rather than education itself. An educated mother has more knowledge and understanding, and is more likely to use different methods to improve her and her children’s well-being. She is more open to modern health care, nutrition recommendations, hygiene, and preventable care. An educated woman has greater confidence, more status and power, and is more likely to have a stronger social position. This allows her to more freely move around, interact socially, seek health care or consultation, and take decisions within the family. An educated woman has more power over her body and fertility.

Studies in low-income countries show that public policy investments in female literacy can have positive outcomes for women’s health and fertility decline, even if the country is strongly traditional or patriarchal, and even if women have limited rights. An educated woman is more likely to put her own children in school, which positively reproduces the trend. Poor families also often strive to give their children education so they can improve their chances to break the vicious circle of poverty and limited control (Momsen, 2004). On the other hand children, especially girls are taken out of school in order to help with household work. A deprived family might not be able to buy school uniforms and supply, and pay school fees at the same time as they lose labour force at home.

2.5 Previous similar studies

Larsen and Hollos’ (2003) qualitative study among rural women in Pare, Kilimanjaro in Tanzania investigates the association between empowerment and fertility decline. Empowerment and gender equity is used synonymously in the article and refers to socioeconomic status, employment outside the house, educational level, equity within the relation and ability to take everyday decisions. This correlation is suggested especially by large secondary data based surveys. The region has had a fertility decline in the last couple of decades, and the study set out to see if this is due to women’s enhanced empowerment. Larsen and Hollos’ (2003) compare two ethnic groups and find a difference. The result show that one group have on average delayed their first births and limited pregnancies today compared to a couple of decades ago. This is explained by the higher level of education, ability to choose their husband, larger participation in paid jobs, better economical situation, and higher status and more to say within the family. The other group had lower education; more often only worked with household chores, had lower status and less ability to take everyday decisions.
Even if these women had good contraception availability they could not freely use it because of bad communication with their husbands. The concluding remark of the study is that women’s status explains fertility patterns.

Another study on maternal referrals in Tanzania indicates that women have little decision-making power, even when it comes to life depending issues (Pembe et al., 2008). When a woman has got a suggested medical appointment from health workers due to complications at pregnancy or delivery, the husband needs to approve before she is allowed to seek further help. The study shows that the husband and his mother have a high social status and play an important role in taking decisions. Women do not intentionally stand outside the process of deciding. Pembe et al. (2008) says that other studies show that women do not participate in similar discussions, but a possible reason is that they are socially subordinated and know that they are not expected to discuss such matters. Women’s low status gives her little decision-making power. At the same time men’s ignorance and lack of understanding for possible dangers that comes with pregnancies and child birth can be devastating. The study recommends local interventions that involve men in maternal and reproductive health. Educating men and involving them in campaigns and workshops has shown positive effects on women health outcomes in other African countries.
3. Method
The empirical data was collected through a fieldwork in Babati district during three weeks in the spring of 2009, with the help of a field assistant. Babati is situated in Manyara Region in Northern Tanzania. Research was carried out in Babati town and in the villages of Dareda and Bonga. Health facilities in each area were visited, together with two organisations.

3.1 Possible methods and choice of method
Quantitative research is based on the approach to gather information from a large representative population, and to test a hypothesis or theory (Bryman, 1997). The information can be collected through surveys in order to reveal differences between two groups, so called correlation studies. The quantitative method is structured because the researcher looks for certain patterns or answers in the aim to generalise.

Qualitative research is based on the will to illustrate the perspective from the people that are being studied (Bryman, 1997). Qualitative research can give an understanding of the subject’s reality, their values, norms and reactions to their surroundings. This research has different kinds of standpoints; one is the “verstehen-perspective”, an understanding perspective that was coined by Max Weber. To gain understanding for social events and explain the effects of these actions, the researcher can either use participatory observations or interviews. Bryman (1997) says that qualitative studies do not have the same need to generalize as quantitative studies, but still they often try to. This is where the division between the two methods lay, but also their resemblance. Sociological studies are inductive which means that they study the empirics first and then choose a theoretical frame. In this way the researcher is more open to the reality and not hindered by presumptions. This open method increases the possibility to find unexpected answers and results, and decreases the difference in perspective between the researcher and the respondents.

Since this study aims to describe women’s self perceived view on their ability to take reproductive decisions, the method best suited is the inductive qualitative approach. Due to limited time and the character of the study semi structured interviews is preferred rather than observations, though the respondents behaviour will be observed during the interviews.

3.2 Sources of data and study questions
Primary data was collected through semi structured interviews. Health personnel were interviewed to gain a public perspective on the issue, some statistics, and to see if there could be any societal or institutional obstacles that inhibit women from controlling their fertility.
The public views are represented by one midwife from Mrara Hospital in Babati, one from Dareda Missionary Hospital and one from Bonga Dispensary, one representative from UMATI, and one Coordinating Nursing Officer for Reproductive and Child Health at the Bible School/Church of God in Babati. They were asked about their kind of work, what service they provide, if they have enough resources, if they believe that women are free to take reproductive decisions and what the possible socioeconomic obstacles are (see appendix 8.2).

Main focus was put on group interviews with married women from different socioeconomic settings. In Babati 12 women were interviewed, in Dareda 12 women, and in Bonga two women. The women were first asked about their age, their number of children, their education and occupation (see appendix 8.1). More specific questions were then asked about; why they prefer many or few children, decision making within the family, responsibility for economy and for taking care of the children, access to FPS, perception about their freedom to take reproductive choices, and possible socioeconomic obstacles (see appendix 8.3). The interview lasted for about 20 minutes, in someone’s home or on a private spot where discussions could go on without others interfering or listening. All respondents were told that they would remain anonymous. No tape recorder was used, but notes were taken. Secondary data was collected through literature reviews of articles, reports, books and websites.

3.3 Motivation of method

A subject can be studied through different methods, and different techniques are suitable depending on the types of questions that are asked (Bryman, 1997). Quantitative surveys are appropriate when the researcher has a lot of knowledge about the area of interest, when the information is easy for the respondents to answer, and when the study needs a large sample size. Qualitative interviews are suitable when the investigator wants primary information about social relations and processes, or convey a picture of a specific situation. The chosen method does not necessarily have to do with the type of social phenomenon that is studied, but more with what type of questions needs to be answered.

Group interviews can promote interaction between the respondents, be creative and flexible. Bryman (1997) means that a case study done through semi structured interviews can be fairly generalized beyond the particular case, if the respondents are sampled from different geographical and social settings. Semi structured group interviews was the best suitable method for this study because of these reasons. The possibility to discuss gave room for
follow up questions, and confirmations of statements when answers were unclear or not sufficient. A survey would not have been suitable because the character of the questions, because the need to translate to both Swahili and Iraqw (see 3.5), and because some of the women were illiterate.

3.4 Previous research on the subject
Many previous studies are partly based on the Tanzania Demographic Health Survey. The TDHS (2004-05) is created by the National Bureau of Statistics; it is a quantitative large survey with a sample size that intends to represent the entire Tanzanian population. The Guttmacher Institute is an independent organization that provides public education, research and policy analysis on sexual and reproductive health issues (Sedgh et al., 2007). Their study about contraception use is based on 53 worldwide national Demographic Health Surveys. The DHS material has through a qualitative approach been reviewed and deeply analysed. The findings are presented by groups of people, by nations or regions in order to reveal different patterns on the subject. The UN-report by Mturi and Hinde (2001) rely on the TDHS and the Tanzania Population Censuses. The Population Censuses in turn is a quantitative survey that has counted and gathered information from the whole population (The Government of Tanzania, 2003). Mturi and Hinde’s study (2001) is a qualitative literature review that investigates fertility levels and trends in Tanzania. Larsen and Hollos’ study (2003) has both a quantitative and a qualitative approach. Their hypothesis is that there is a correlation between empowerment of women and fertility decline. This is tested through an ethnographic qualitative study with observations and interviews. A supplementary demographic survey with a large sample size gave answers about fertility levels and trends. The findings were further examined through in-depth interviews. Pembe et al. study (2008) on maternal referrals is a qualitative study with focus group discussion as a main tool for gathering data.

3.5 Critical approach, reliability and validity
Especially three aspects of the qualitative method can be criticized (Bryman, 1997). Even if the researcher obviously has an interest to convey the studied person’s views, he or in this case she, must stay objective and be aware of her own role. She may influence the interview simply by her presence, the answers by the way the questions are asked, and the result because of her earlier knowledge and presumptions. The theoretical frame might affect the result, which is the interviewed people’s perception. This is however inevitable because the researcher has to use a theory in order to be able to generalize to a larger perspective.
Possible biases might have influenced the reliability and validity of this study. The public workers represented a facility or organization which may have affected their answers and therefore the reliability. The field assistant worked as a gate keeper and picked the women for the study, which makes them not randomly selected as many researchers prefer (Bryman, 1997). Though randomly selected respondents is more important in quantitative studies, when the researcher wants the study to represent a larger population. The interviews with the women were all translated from English to Swahili which gives a risk for misinterpretations, misunderstandings and information-loss. During both group interviews in Dareda the conversation was even further translated from Swahili to Iraqw and back. The women were not asked about their social class (middle and lower) and their religion during the interviews but the field assistant categorized that information afterwards. The area of investigation is somewhat sensitive which may have influenced the answers. Many women were observed to be shy, and they often gave short answers. Some of the women were old and might not have answered the same if they had been of fertile age today. Due to limited time for field work the sample size could not be larger, and no follow-up interviews could be done in order to get a deeper understanding for the socio economical factors that influence their decision making.

Other people were not present at the time of the interviews. Though on two occasions the women’s teenaged children were in the same house and could have overheard the conversation, which means that the respondents might have adjusted their answers. The role of the researcher, the presence of the field assistant, and the presence of the other women in the group needs consideration when valuing the results. Even if group interviews can promote interaction between the respondents and be creative, it can also hinder people from expressing their views (Bryman, 1997). This study is valid to this particular case, time for research, and to these women. The data has been carefully analysed with an aim for objectivity. For ethical reasons the respondents are anonymous, therefore it is difficult to repeat the exact same study.

Secondary data such as books and web pages have been carefully reviewed and analysed, but there is always a risk for misinterpretations and unreliable sources. The scientific articles are peer reviewed and can be considered reliable. The Tanzania Demographic Health Survey is created by the National Bureau of Statistics. Governmental information might be partly selective due to interests to show certain information, and hide other information.
4. Result

The empirics are presented in two main parts, but first a short summary give a picture of the fertility levels among the studied women. The public perspective is demonstrated by the midwives, the UMATI-representative and the Nursing officer. The women’s perspectives are divided in urban and rural women. Finally the result is summed up in concluding remarks.

From the basic information about the women (see appendix 8.1) the urban respondents have on average 3 children, while the rural have 5.6. Women that have completed secondary school have 2.6 children and those who have no education, or only completed primary school have 5.1 children. Middle class women have 2.5 children and lower class women have 5.3. Women that have an occupation outside the household have 2.6 children, while housewives and farmers have on average 6 children.

4.1 Public perspective on women’s freedom to take reproductive decisions

A midwife\(^1\) at Mrara Hospital in Babati said that they provide long term; short term and permanent contraceptives. Family planning service and contraceptives is free for everyone. They also reach out to people through mobile clinics, mass services, and health education. Normally they have sufficient resources, but for the last couple of months they have lacked implants and injections because the Ministry of Health are out of stock. The midwife estimated that couples in town have on average four to six children, while rural families have about ten. She considered women to be free to decide over family planning, because when they get pregnant they get registered at the hospital and automatically get FPS if they want to.

A midwife\(^2\) at Dareda Missionary Hospital informed that they do not provide family planning service due to catholic reasons. They only suggest natural methods to women that seek consultation.

A midwife\(^3\) at Bonga Dispensary said that they provide free short term and long term FP methods depending on the couple’s reproductive goals. They always put the woman’s need first and sometimes help them in secrecy, without their husband’s approval. The Ministry of Health and Social Welfare supply good projects, education and funds, though Bonga cannot tend all women due to lack of some instruments, not enough staff, and no resources to do min

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\(^1\) Interview on March 3, 2009. Note that hereafter all responses from this midwife refer to this date of interview.

\(^2\) Interview on February 28, 2009. Note that since Dareda did not provide FPS, they did not answer the following questions.

\(^3\) Interview on March 7, 2009. Note that hereafter all responses from this midwife refer to this date of interview.
laps and sterilizations. Permanent methods are instead provided by Mrara Hospital, their mobile clinics, and several NGOs, for example Maria Stops. The midwife estimated that women in Bonga have between six and eight children, but usually wants to have less. An interval of three years, and not more than four children all together would promote women’s health and save lives. The midwife thinks that few women are free to decide over their fertility. Even if they want to use FPS the husband is often an obstacle, since many men and Muslims in general prefer natural ways.

The Nursing Officer\(^4\) of Reproductive and Child Health at the Bible School/Church of God in Babati said that they work as a complement to governmental hospitals and dispensaries in the area. They are supported by national NGOs and funded by USAID; they have three family planning centres in town and seven mobile clinics that attend villages and schools. They announce their arrival by loud speaker and provide FPS and also gender projects that involve men in family planning. The Nursing Officer said that they normally have enough resources, but at the moment the clinics lack implanons and injections because the Medical Department is out of stock. However they would like to have more cars (they only have one today) so they can provide more mobile clinics in rural areas. Since statistics is not enough registered by village health workers it is difficult to know what the exact problems are and hence what needs to be targeted. Still the government could take more responsibility and supply more interventions in the villages in order to improve reproductive health and women’s access to FPS. The Nursing Officer said that FPS is generally available for every woman but she might not have access because of the husbands’ disapproval.

Babati’s UMATI representative\(^5\) said that the organization has successful programs throughout Tanzania but they have not yet started in this region. They are waiting for funds from the government and the International Planned Parenthood Federation (IPPF) who is the initiative taker and the main donor. UMATI collaborate together with the Ministry of Health in projects, clinics, community education, and youth clubs. They tackle family planning, sexual and reproductive health and rights, and HIV/aids issues. The UMATI representative expressed that it is important to target children already in primary school since they become sexually active in young age. Even if youths have free access to condoms they do not use it enough because they are not educated on the subject, or because of taboos, shame, or

\(^4\) Interview on March 4, 2009. Note that hereafter all responses from this Nursing Officer refer to this date of interview.

\(^5\) Interview on February 27, 2009. Note that hereafter all responses from this UMATI representative refer to this date of interview.
ignorance. She said that FPS is available in Babati, but women usually do not have the access due to low educational level or because their husbands oppose. Educated parents have fewer children than non-educated. The problem in rural areas is that the educational level is low, which means that women often have more children than they want.

4.2 Women’s perspective on their freedom to take reproductive decisions

4.2.1 Socioeconomic reasons for having many or few children

The urban women\(^6\) generally preferred to have few children, not more than four, because of economical reasons. They expressed that few children are easier to take care of, feed well, take to the hospital if they get sick, and give a proper education. Too many children can be difficult to tend, they can become problem kids that rob, or end up as street children. Three catholic women responded that it is good to have many children if you can afford to take care of them. However they left it to God to decide how many children they had. Some thought that many children can be time consuming and exhausting. One woman did not want to risk her health by becoming pregnant again because she had already had three circumcisions. She said that women that are unhealthy, underweight or malnourished should avoid becoming pregnant because it can be dangerous. The women in Babati did not think that many children represent status, but they claimed that this is the case for some tribes throughout the country.

The rural women\(^7\) generally wanted to have few children, about four, for the same economical reasons as the urban women. Most of the older women had on average between six and ten children, but they confessed that they would prefer to have less. They lacked education in family planning and access to contraceptives at the time of their childbearing, but today younger women that are pregnant have better options. Older women revealed that having many daughters can be status for men, because fathers get a bride price for them when they marry. Having many sons is not status because they can rather become a burden since they depend economically on their fathers. A man can be seen as powerful if he has many children (both boys and girls) because he decides over many people. This gives him more respect in the community, and others might look up to him, and come to him for advice. The younger women claimed that some people in the society think that many children can benefit the household economy, because children can act as work force on the farm, and help their

\(^6\) Group interviews on February 24 & 25; March 4 & 5, 2009. Note that hereafter all responses from urban women refer to these dates of interviews.

\(^7\) Group interviews on February 26 & 28 & March 7, 2009. Note that hereafter all responses from rural women refer to these dates of interviews.
parents when they are old. These younger women did not agree with this view, but upheld the importance of children’s education instead.

4.2.2 Power, decision-making and household responsibilities

The urban women expressed that men generally take everyday decisions within the family. All women felt free to wish and discuss together with their husbands, but they did not have the final say. Few women took joint decisions together with their husbands, but some had more influence in family planning issues. In most families both spouses brought in money to the household. Since women have the main responsibility for the home and for taking care of the children they usually had to work harder. The urban women said that they spend money on good things, on the house and on the children, while the man often spends it on himself and on drinking.

Most rural women answered that men took all the decisions within the family, the woman could have wishes and sometimes discuss with her husband but she could not take final decisions. Some issues she was not allowed to discuss with her husband at all. Some of the younger women took everyday decisions together with their husbands. Principally women were responsible for bringing in money to the household but the husband controlled it, and made economical decisions. Some of the younger spouses both contributed to the household economy, but the woman spent it on the family. Almost all women were responsible for taking care of the children.

4.2.3 Access to FPS and contraceptives

All urban women considered themselves to have access to family planning service and modern contraceptives. They knew that they could get it for free at Mrara Hospital and dispensaries if they had the need for it. However some gave social and medical reasons for not using contraceptives on occasion. For example women could not tell the man to use a condom, and they sometimes did not use the pill because of possible bad side effects. Infections from implanons were relatively common which could be a reason for not using it. Women did not use traditional medicine as contraceptives, but older women had tried to limit their births by calendar method when they were pregnant. Catholic women did not use contraceptives even if they knew that they could get it for free. These women usually prayed between births instead, and put their faith in God for answering their wishes.

All rural women perceived that they had access to FPS if they wanted it. There were no economical restrains since contraceptives are free at the hospital, in dispensaries and
pharmacies. Although most of them got it from family and friends, that had bought it in town. The older women could not get birth control at the time of their pregnancies. No women used traditional medicine as contraceptives.

4.2.4 Freedom to make reproductive choices

The urban women mostly felt free to decide if and when they wanted to have children. They took that decision together with the husband, thought they could not decide that by themselves. Catholic women normally did not think in terms of freedom to choose, because God decides how many children they have.

The rural women on average did not feel free to decide over family planning matters, and the main obstacle was the husband. He might think that his wife has an affair and that she wants to control her fertility therefore. The younger women were more likely to have the ability to influence family planning discussions, but they could not decide on their own. If the woman made her own choice, or went against her husband’s decision her family might take his side and push her away.

4.3 Concluding remarks

4.3.1 Public perspective

- Mrara Hospital in Babati and Bonga Dispensary provide family planning service, but Dareda Hospital does not. The Bible School/Church of God also provides FPS and gender projects through centers and mobile clinics. UMATI is not yet operative in Babati, but works well in other regions of Tanzania.
- Mrara Hospital and the Bible School/Church of God usually have enough resources, but lack medicine at the moment. Bonga Dispensary lack some resources, instruments and staff. UMATI are waiting for funds so they can start operating.
- The public perspective is that women are generally not free to take reproductive decisions because of the husbands. Only the midwife in Babati considered women to have the freedom to decide, since FPS is available and free for everyone.

4.3.2 Women’s perspective

- Both urban and rural women preferred to have not more than about four children, for economical reasons.
- In urban settings men took most decisions, both spouses brought in money to the household, and women were responsible for household chores and taking care of the children. In rural settings men took all decisions, mostly women brought in money to
the household, and all women were responsible for the household and taking care of the children.

- All urban women perceived that they had access to family planning service and modern contraceptives, but some gave social and medical reasons for not using it. All rural women felt that they had access to FPS if they wanted it, but they mostly got it from family and friends instead.
- Most urban women felt free to take reproductive decisions, while most rural women did not feel free. The women that felt unfree were hindered by their husbands and their poor negotiating skills within the relationship.

4.4 Analysis

The public perspective is that urban women are freer to take reproductive decisions than rural women. Urban women’s status is supported by the power she has within the family, her educational level, participation outside the house and the fact that she contributes to the household economy. Urban women are more independent than rural women; they often have a higher education and a public employment. At Mrara Hospital in Babati FPS is available for everyone and from that perspective that midwife thinks everyone is free to decide over their fertility. However a distinction between availability and accessibility is needed, because even if there is availability women might not have access because of a long distance to the health facility or an opposing husband. It is difficult to say whether the catholic women are free to take reproductive choices or not, since their perception is not based on those terms.

The women’s perspective is that the husband is the main obstacle for their freedom to choose if and when they want to have children. Even if FPS is relatively available to everyone, women’s access can be limited due to her status within her marriage, and because her husband might oppose. Access to family planning service can be limited because of geographical reasons as for the women in Dareda, where the nearest hospital did not provide FPS. This means that these women have to go to Babati for advice or contraceptives which can be time consuming, expensive both trip wise and because women lose a day worth of income, or work at the farm. If the facility was closely accessible the women could have gotten help without their husband’s approval, as the women in Bonga. In Bonga the dispensary is geographically accessible so women can get contraceptives, even in secrecy without their husband’s knowledge. However the facility is situated in the centre of the village which makes is visible for everyone to see who enters it. Women’s access here, as on other locations, is rather hindered by low status, tradition and religion. The midwife in Bonga expressed that even if
women want to limit their pregnancies the husband is often an obstacle. Men and Muslims in general prefer natural ways of not controlling fertility.

**From a gender perspective** women can be seen as subordinated men because of biological reasons (Abott, 1998; Momsen, 2004). Because they give birth to children they are expected to take care of them and other household associated chores. Household activities done by women have less status than paid jobs more often done by men. Religion, class, traditional beliefs and education are factors that affect the level of gender equality. In reality women often have many children even if they do not always want to, and this is explained by several reasons. The empirics illustrate that traditional family structures in Dareda give men more status if he has a large family because that means that he decides over many people. This is confirmed by Mturi and Hinde (2001). Especially many daughters can be positive due to the bride price fathers get when she marries. Given that men are the decision-makers in the family they also decide over their wife’s fertility. Empirics show that rural women are more bound to the household because they are responsible for tending the children, the house and the farm work. Since they are at home, and do not achieve money from a paid job their status is considered low both within the society and the relationship. Even if women have an official employment, as urban women in Babati, they carry he double burden of also being responsible for household associated chores (Momsen, 2004). However urban women perceive that they are fairly free to take reproductive decisions, but this can be questioned through the concept of power.

**From a power perspective** Lukes (2004) would argue that the husband exercises power over his wife if he decides over her fertility contrary to her interests, needs and wishes. Foucault said that people are also shaped by the existing power structures that are both visible and invisible in the society and culture (Lukes, 2004). This means that women can be powered over even if they do not consider themselves to be manipulated or forced to act against their will. Women make decisions within certain frames, more or less freely depending on their social status. The power relationship between the spouses can be promoted by structural power within the society, where women in fact allow her husband to exercise power over her because she is expected to. One question is if power has been used over her if she has been persuaded not to take contraceptives; Lukes might have said both yes and no (2004). When men prohibit women from controlling their fertility power is used over her, if she otherwise would have used contraceptives. At the same time power has not been used over her because she has accepted the advice, and by herself acted upon that decision. The women in this study
that felt free to take reproductive decisions can according to Lukes theory (2004) still be 
unfree because their needs are being neglected, even if women might not be aware of this. On 
the other hand individual’s perception counts rather than external views, says Sen (1999) 
which means that if women feel free to decide they are in fact free because they make that 
evaluation. According to Sen’s (1999) theory women’s ability to choose is limited not only by 
the husband but by societal power structures that inhibit women from being free agents. Foucault also said that people are shaped by the power that exists in the society and culture, 
and when they live and react to their surroundings they reproduce these structures (Lukes, 
2004). In order to prevent these structures from being socially reproduced, women have to 
become free agents that can take control over their lives and fertility. The system needs to 
remove the unfreedoms that lie within the societal, cultural, and traditional construction that 
subordinate women today (Sen, 1999). These unfreedoms, or restraining socio-economic 
factors, inhibit women’s access to FPS even if it is often physically available to them.

The empirics show a clear difference in freedom to choose between urban and rural settings. 
This can best be explained through the concept of power. Men have more power over women 
in traditional, rural sites. In Dareda family planning is not available at the nearest hospital 
because this catholic institution does not promote fertility control due to religious beliefs. This 
can be seen as a structural unfreedom (Sen, 1999) that inhibit women’s access to FPS. However women did not mention this as a constraining factor, but said that they can get 
contraceptives from family and friends if they want to. Again, according to Sen (1999) 
individual’s views counts rather than external views, so if women feel that this is not an 
obstacle that must be accepted. Even if women only perceive that the husband is an obstacle, 
one question is if more accessible family planning facilities perhaps could promote their 
awareness and improve their possibility to control their fertility. As Sen (1999) states women 
have to become agents over their own lives, as long as there are structural unfreedoms this 
negatively affect their well-being.

The women in Bonga felt free to take reproductive decisions, but the midwife perceived that 
women on average are not free. In Bonga FPS is fairly available but not accessible because of 
the husband who often objects women’s wish to control her fertility. Men’s preference for 
natural ways is a structural obstacle which means that women might have as many children as 
her body allows her to. Women generally do not want more than around four children, but 
they often have because they are not free agents (Sen, 1999) that can control their own lives 
and fertility. Empowerment is work that aims to strengthen people’s possibilities to influence
their life options (Janlert, 2000). The public perspective in Babati is that gender projects that involve men in FP can promote not only equality between sexes and improve women’s power to influence reproductive decisions, but also improve all individual’s sexual and reproductive health.

From an education perspective literacy empowers women and promotes their status within the household and within society (Lindstrand et al., 2006). The empirics showed that low educated women belong to the lower class and are housewives, farmers or have a small business. Women with lower education or no education have on average more children than women that have completed secondary school. Women that have completed secondary school belong to the middle class, and most often have a public employment. Lindstrand et al. (2006) argue that education is one of the most important foundations for good health and well-being. Education promotes knowledge and understanding, confidence, and gives more status and power. Educated women become more independent, can interact socially, and have more possibility to influence everyday decisions.

Studies show that female literacy have positive outcome on women’s health and fertility decline even in strongly patriarchal societies (Lindstrand et al., 2006). Even if educated women are more likely to put their children in school, poor families also strive to give their children education so they can improve their life options (Momsen, 2004). This was confirmed in this study when all women responded that they prefer few children because they want to ensure that they can give all their children an education. The public perspective in Babati was that educated parents have fewer children than non-educated parents. The problem in rural areas is that the educational level is low, which means that women often have more children then they want. All women despite their residence, status, educational level, or religion responded that children’s education is important. Most women in this study had only primary education, but urban women with primary education often had a small business. These women had much fewer children than rural women with the same level of education, who exclusively worked on the family farm and had many more children. This implies that in this case participation outside the household might explain women’s ability to influence family planning, more than education does.

Previous similar studies in Tanzania show that there is an association between empowerment and fertility decline (Larsen & Hollos, 2003). They show that the higher education a woman has, the more public participation, the better economical situation, the
higher status and more negotiating skills she has. Larsen and Hollos’ study illustrate the same trends as the findings of this study. In Babati, even if there is FPS and contraceptives available, women’s access is often hindered by their husbands. Pembe et al. (2008) show that women have little decision-making power, even when their lives are in danger. This is because she has a low status, and men are unaware and ignorant of the dangers that might come with pregnancies and child birth. Pembe et al. (2008) uphold the importance to involve men in education, interventions and workshops on maternal and reproductive issues in order to improve women’s health. The public perspective in Babati implied the same; that it is important to educate men in gender projects, and also target youths in SRHR issues.
5. Discussion and further recommendations

The empirics showed that the husband is the main obstacle that interferes with women’s possibility to influence FP matters. The economical aspect of FPS or contraceptives is not a problem since this is free at hospitals and dispensaries. There are large differences between urban and rural settings, where women in town mostly feel free, but women in the villages on average do not feel free to take reproductive choices.

From a public perspective the health facilities aimed to help women, even without the husband’s approval if they could. The availability of FP facilities is generally not a problem, but rather women’s access to it. The women in Dareda could not seek FPS at the nearest hospital, because they did not provide assistance due to catholic reasons. These women’s access is therefore both hindered by their husbands and by geographical, societal and religious factors. In Manyara Region 26.5 percent of all married women use contraceptives, which is about the same as the Tanzania average in total. According to the Tanzania DHS contraception use is higher among women with higher status, higher education and among urban women. The empirics reveal that this is the case in Babati as well. The midwife at Bonga Dispensary said that the Ministry of Health and Social Welfare fulfil their assignment. At the same time she said that they cannot tend all women due to lack of resources. This is a contradictory statement but should be interpreted as the Ministry of Health does not enough targets reproductive health and people’s access to FPS. The Nursing Officer expressed that one problem is that there is no information documented by rural health workers and therefore it is difficult to know what needs to be improved.

The women did not state any economical reasons for not seeking FPS or using contraceptives, but economical reasons for not wanting too many children. No women in this study wanted more than four children, which is one less than the latest TDHS revealed. All women wanted to assure that they would be able to take well care of their children and give them an education. However they thought that many children was not a problem for others who could afford it. The fact that the poorest had the most children is therefore a contradiction, because it stresses their social and economical situation even further. Reasons why women did not use contraceptives even if they wanted to were mostly because of their low status in the relationship. If husbands did not want them to seek FPS, because he worried about bad side effects or suspected that their wife might have an affair women did not have much to say in that discussion. Some women worried about side effects and infections from implanons which is a reason for them not using it sometimes. Only one woman revealed that she did not want to
become pregnant due to concerns about her health, and a couple of women said that many children can be exhausting. All women answered from the perspective of their children, with focus on their well-being rather than their own well-being. Lindstrand et al. says that other studies and theories confirm that women tend to secure the health and well-being of their children and husbands before taking care of themselves.

One problem is that young women become pregnant early which can hinder their individual development. The Tanzania DHS reveal that more than 25 percent of young women aged 15-29 are pregnant or have received their first child. According to the health survey the probability to become an adolescent parent is more likely in rural settings, and among those with no education or only primary education. There is no difference between the lower and middle social class, but the highest economical quintile have much fewer children at young age. In Tanzania UMATI target young people’s SRHR issues, but they have not yet started in Babati district. The public perspective in this study was that UMATI can have a positive effect on youth’s awareness and sexual behaviour which can delay women’s first pregnancy, and allow them to complete their education. This will have a positive outcome on their status, ability to participate in the society, give them decision-making power and better life options. The fact that young boys are included in UMATIs sexual and reproductive education can break traditional negative patterns, social stagnation, and the subordination of women.

Parts of Tanzania as well as parts of Babati district have a high total fertility rate, but it seems to have little to do with the availability of FPS. The public perspective was that the Tanzania Ministry of Health and Social Welfare together with NGOs address reproductive health and family planning issues fairly well in the region. However they need to target remote areas because today they have poor access to FPS. One problem is that they lack information and statistics from village health workers which makes it difficult to know what needs improvements. More gender projects were recommended by the respondents to involve men in fertility related issues. As other studies have concluded, for example Larsen and Hollos, and Pembe et al. educating men in SRHR issues together with empowering women in Babati can break the vicious circle and thus make women freer.

Even if there is an unmet need for family planning in Tanzania, and other Sub-Saharan African countries it is important to see to the right and need of the individual as stated at the ICPD in Cairo 1994. Mturi & Hinde’s study show that some people want to have many children because of tradition, status, or religious reasons. The catholic women in this study
did not think in terms of freedom to choose, but left it to God to decide, and for some women in Dareda many children meant status. It is a human right to decide over ones fertility, but if FPS is accessible and available individuals will have more freedom to decide. This study confirms that there is an unmet need for FP which means that governments and organizations have to promote especially women’s access to these facilities. Enhancing people’s ability to reach their reproductive goals will not only benefit the well-being of women, but also their families and the society in whole. In the end this might promote socioeconomic development, children’s school attendance and gender equality, reduce poverty and population growth, reduce child and maternal mortality, slow the spread of HIV/aids and help protect the environment. Family planning can perhaps help Tanzania to aim towards the other Millennium Development Goals.

This study has only touched the surface among a small group of women in Babati, in the aim to investigate their possibility to take reproductive decisions. Considering the sensitive subject women might not have revealed the whole picture. Other underlying factors may contribute to their situation, beliefs and power to decide. Follow up interviews could have given them time to reflect over the questions, and deeper interviews with one woman at the time could also have given a better understanding. Questions about women’s solutions to their problems could have been recommendations for future interventions, and analysis through other theories could have given different perspectives. Nevertheless this study is a small first step in reflecting women’s reproductive situation in Babati district. During this process answers from the respondents together with literature reviews has given thoughts about recommendations for the future:

- Further investigations, with a larger sample size can gain a deeper understanding for the family planning related problems and needs of women and families.
- Including men’s perceptions in such research is necessary since they seem to be the main obstacle for women’s possibility to control their fertility.
- Rural health workers need to gather more statistics, so the Ministry of Health and other actors can get a better understanding of what problems needs to be targeted.
- UMATI needs funding so they can start educating children and adolescents in sexual and reproductive health and rights.
- Men need education in family planning issues to gain more awareness and knowledge on the subject.
- Women need information about the side effects of contraceptives, and assistance with possible alternatives.
- Programs that empower women are necessary so they can take more control over their lives.
- Better access to health facilities will promote women’s ability to control their fertility and thus improve their and their family’s well-being.
6. Conclusions

This study set out to investigate what socioeconomic factors affect women’s possibility to influence family planning, if there are differences between urban and rural settings, and if women feel free to take reproductive decisions. The empirics have been explained through the concepts of gender, power and education. The findings are that women have different status depending on where they live, how much education they have, their occupation and class. Both the public perspective and women’s perspective is that urban women are relatively free to take reproductive decisions, but rural women are not. This can best be explained through the concept of power and by the fact that gender roles are less traditional in urban settings than in rural settings. Urban women are more independent, have more education, often have an employment outside the house, contribute to the household economy, and therefore have a higher status. These factors give women more power to negotiate, including in fertility related discussions. A reverse situation among rural women gives them less decision-making power. Rural women often have more children than they want to have, which means that there is an unmet need for family planning. Other problems in rural areas is that FPS is less accessible, facilities sometimes lack resources and they do not always keep statistics which makes it difficult for health planners to know what needs to be improved.

The Ministry of Health and other actors need to promote women’s access to FP facilities. Further recommendations include programs that empower women and educate men in family planning issues. When UMATI get funding from the government they can start addressing youth’s awareness on sexual and reproductive health and rights, which in the long run can help change gender roles. If women’s possibility to decide over their fertility continues to be limited a probable outcome is that these trends will be socially reproduced. More public interventions are essential in order to meet the need for family planning; this will contribute to improved health and well-being for women, men and children.
7. References


8. Appendix

8.1 Basic information about the interviewed women

Table 1

<table>
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<tr>
<th>Resp. no.</th>
<th>Residence</th>
<th>Age</th>
<th>No. of children</th>
<th>Education</th>
<th>Occupation</th>
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</table>

All urban respondents live in Babati. *All rural respondents live in Dareda, except no. 25 and 26 that live in Bonga.
8.2 Public perspective - interview questions

- How do you work and reach out to women and what FPS do you provide?
- Is FPS available for everyone?
- Do you have enough resources to attend everyone that needs help?
- How many children do women here have on average, and how many do they want?
- For which socioeconomic reasons do women prefer many or few children?
- Do you think women are free to take reproductive decisions, if not – why?

8.3 Women's perspective - interview questions

- Do you want to have many or few children, and for what socioeconomic reasons?
- Who takes everyday decisions within the family?
- Who is responsible for the household economy, bringing in money and spending it?
- Who is responsible for taking care of the children?
- Do you have access to family planning services and contraceptives if you want it?
- Do you feel free to decide over family planning issues, if not - why?