



Modern or Traditional: Factors Influencing the Adoption of Family Planning Methods among Women in Urban District Zanzibar

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Abstract— The world is moving towards ensuring healthy lives and promoting well-being for all. In practice, there are several dynamics requiring attention at the international, regional, national and local scales persist. The paper examined the practice of modern and traditional methods of family planning among women in the Urban District of Zanzibar Tanzania. A sample size of 40 generated data through cross-sectional design and mixed approach whereby it used systematic random sampling procedures of health facility women users. It was found that the majority of women were reproductively aged between 19 to 32 years (77.5%) being literate (97.5%), married (62.5%), and with income (70%). It was also found that women had a moderate level (level 2.9) of motivation from using traditional family planning methods (TFPM) in the area indicating the influence of both modern and TFPM among women. The paper found that modern family planning methods (MFPM) had a low level of influence (level 2) among women. It was concluded that women had been influenced by both MFPM and TFPM of which the adoption of MFPM is still low. It was recommended that efforts to promote strategies for poverty ending and livelihoods should be promoted to help the use of human and natural resources that is underutilized in the area.

Keywords— Influence, Modern, Motivation, Traditional, and Women

1. INTRODUCTION

The adoption of family planning had been agreed and practical in all policy levels at international, regional, national, and societal arenas since many decades. However, there has been an experience of variations that characterise the use of modern and traditional family planning methods in developed and developing countries respectively. This call for the continuous search for the progress of the influential factors that shape the existing dynamics of use of modern methods (contraceptives) and traditional ones. Normally, contraceptive methods are often categorized as either modern (barrier methods such as male and female condoms, diaphragm, cervical cap, and the sponge; hormonal contraceptives that include oral, injectable, transdermal, vaginal ring, and implants; intrauterine device (IUD)) or traditional (rhythm method (periodic abstinence), withdrawal (coitus interruptus), fertility awareness-based methods, the lactational amenorrhoea method, and folk methods) [1].

According to [2] some contraceptive methods like male condoms, withdrawal, and rhythm methods have been used for a long time while methods like the pill and intrauterine device started to be used in the 1960s. Some decades later, the vaginal ring, emergency contraception, subcutaneous injections or implants became available. Given the changing tastes, needs, and levels of attitudes by users of

the methods, the available contraceptive methods have both strengths and weaknesses. The cited [2] argues that women who are only sometimes sexually active and who want to delay pregnancy for some time or several years may prefer a short-acting method, one that they can start and stop on their own, over an IUD or an implant, both of which usually require a visit to a service provider to obtain and remove the device, or a permanent method such as sterilisation. Also, it is put forward that factors such as the experience, or awareness, of side effects and inconveniences of using specific contraceptive methods and their effectiveness at preventing pregnancy, are influential in the choice of the method used. Again the range of choices available to women and their partners depends on the local availability and accessibility of different methods [2]. That being the case, the prevalence of specific contraceptive methods varies widely across the world. Currently, method mix has shifted over time due to changes in related policies, changes in the healthcare system, development of new technologies, and changes in access to the various methods [2].

While there are diverse methods of family planning that provide room for diverse needs, appetite and values of users in time, economy and space, the world is still experiencing a low level of adoption that does not control deterministically the rate of reproduction, resources and population increase. This is particularly more problematic

in the developing world like Africa where the level of development despite resource endowment is not compatible with the rate of births and population growth. Developing world is characterised by a young population with majority of children and youths who are economically less productive therefore not able to contribute to the exploitation of the abundant natural resources in their communities. On the other hand, the young population of developing world would be imperative in bringing about growth and social development if there could be technological advancement that could enable effective use of resources, therefore, promoting the Boserupian thinking of population growth as a resource to promoting development in economic sectors such as agriculture. However, this has not been the case, leading to continuous querying of the effectiveness and efficacy of strategies adopted on population control. This paper use a local lens to explore the factors that influence women on use of modern and traditional family planning methods in Zanzibar.

2. RELATED WORKS

The practice indicates that among the 1.9 billion women of reproductive age (15-49 years) living in the world in 2019, 1.1 billion needed family planning, that is, they were either current users of contraceptives whereby 842 million use modern methods of contraception and 80 million use traditional methods or have an unmet need for family planning. About 190 million women want to avoid pregnancy and do not use any contraceptive method [2]. Female sterilisation is the most common contraceptive method used worldwide. In 2019, 23.7 percent of women who were using contraception that is 219 million women relied on female sterilisation. Three other methods had more than 100 million users worldwide. Male condom with (189 million), IUD (159 million), and the pill (151 million). Overall, 45.2 percent of contraceptive users rely on permanent or long-acting methods (female and male sterilisation, IUD, implant), 46.1 percent on a short-acting method (such as a male condom, the pill, injectable, and other modern methods). About 8.7 percent reliance on traditional methods (withdrawal, rhythm methods, and other traditional methods) [2].

In Eastern and South-Eastern Asia, IUD is the most common contraceptive method used (18.6 percent of women rely on this method), followed closely by male condoms (17.0 percent). In Europe and Northern America, the pill and male condom are the most commonly used methods (17.8 and 14.6 percent of women, respectively), while in Latin America and the Caribbean it is female sterilisation and the pill (16.0 and 14.9 percent, respectively). In Oceania, the dominant method is the pill (16.9 percent) and in Central and Southern Asia it is female sterilisation (21.8 percent of women rely on this method). In Northern Africa and Western Asia, the two most common methods are the pill (10.5 percent) and IUD (9.5 percent). Sub-Saharan Africa is the only region in which injectables are the dominant method with a

prevalence of 9.6 percent among women of reproductive age [2]. Globally, as well as in most regions, the prevalence of male condoms has more than doubled worldwide from 4.5 percent in 1994 to 10.0 percent in 2019, with the largest increase in Eastern and South-Eastern Asia from 5.0 to 17.0 percent. As contraceptive use has taken off in sub-Saharan African countries, the prevalence of implants, injectables, and male condoms has increased. In Latin America and the Caribbean, the continued increase in contraceptive prevalence is due to the rapid increase in the use of injectables, the pill, and male condoms. The prevalence of rhythm methods and withdrawal has been declining since 1994 with the sharpest declines in Europe and Northern America [2]. Although their popularity declined after the introduction of more effective methods, traditional methods of family planning are still used by 6% of the world's women. Methods like periodic abstinence (rhythm or calendar method), withdrawal (coitus interruptus), and country-specific traditional methods of proven effectiveness have been among the practical traditional methods [3].

Goal 3 of the 2030 Agenda, which seeks to ensure healthy lives and promote well-being at all ages, includes a target specifically related to reproductive health and family planning. Target 3.7 aims to ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes [4]. According to [3], in almost all regions of the world, 63 percent of women use contraceptives making the majority of women in the reproductive age ranging from 15-49 years who are married or in a union. It is emphasised that contraceptive use was above 70 percent in Europe, Latin America and the Caribbean, and Northern America while being below 25 percent in Middle and Western Africa. Across regions in 2017, this proportion was lowest in Africa, at 56 percent, and above 75 percent in all other regions. In some countries, the use of modern contraceptive methods by couples who want to prevent pregnancy remains low. In 2017, less than half of the total demand for family planning was being met with modern methods in 45 countries (including 32 in Africa). In an additional 64 countries, more than half but less than 75 percent of the total demand was being met by the use of modern methods [3]. Recently [4], it is indicated that in all regions of the world, the majority of women who use contraception are using modern methods. In 2020, the percentage of contraceptive users who used modern methods was near or above 90 percent, except in Northern Africa and Western Asia, and Oceania excluding Australia and New Zealand. According to [5], many regions in Sub-Saharan Africa have experienced a substantial increase in rural population densities in the last decade. Yet, few regions can increase food production through expanding arable land [6]. This calls for the new approach or new methods of controlling population growth versus sustaining the use of resources in these regions.

Family planning is argued to be a major approach to population growth control and enhances the economic dividends of the country. In the past decades, Nigeria one of the fastest-growing populations in the world has got a low level of contraceptive use [7]. The estimated population was over 170 million while more than 40,000 women in Nigeria die annually from childbirth and related complications from unplanned pregnancies [8, 9]. A recent report confirmed the majority of people living below the poverty line in Nigeria [10]; and this brings to limelight the benefits of family planning and the need to provide the opportunity to decide freely the number, timing, and spacing of childbirth. It is argued that notably, more children survive and thrive when their parents can efficiently plan for their future and cater for them. Family planning is the nexus to the development of any nation and has been observed to be the gateway intervention to achieving the third Sustainable Development Goal (SDG-3) [11, 12]. However African countries despite the low levels of socio-economic progress less attention is invested in family planning methods for diverse reasons. This puts a low level of adoption of modern methods aiming at limited population growth. According to [13], evidence is clear that the use of modern contraception increases when more methods become available, which supports the often undermined fact that no single method serves the needs of every subgroup in a population. However, for several decades, contraceptive choice in many Sub-Saharan African countries has remained limited to condoms, pills, and injectables, leaving long-acting and permanent methods (LAPMs) less accessible and under-utilized despite their high effectiveness in preventing unwanted pregnancies. In practice, contraceptive choice means: [14] Individuals and couples can decide freely on the number and timing of their births; [15], have access to a choice of contraceptive options with which to realize their reproductive intentions and [16], they experience neither barriers nor coercion in putting their decisions and intentions into practice [14]. Access to a wide range of contraceptive options is a human right, yet it is still a dream for most women in Sub-Saharan countries.

The right to informed choice in contraceptive use was first asserted at the International Conference on Human Rights in Teheran in 1968, and again by the 1994 International Conference on Population and Development (ICPD) [16]. The 1994 ICPD reaffirmed as human rights involving the right to voluntarily choose whether or not to marry and whether or not to establish a family, the right to decide on the number, timing, and spacing of children, the right to have access to the information and means needed to exercise voluntary choices, and the right to the highest attainable standard of health [16]. These are rights that women and young girls, in particular, are unable to access in most Sub-Saharan countries, including Tanzania, due to many policies and programs implementation barriers [13]. Zanzibar's population has grown by 32.8 percent over 10 years since 2002. The population is currently estimated to be growing at a rate of 2.8 percent per year and is expected to double by 2036. Urban West is the fastest-growing

region of Zanzibar at 4.2 percent per year, followed by Zanzibar North at 3.2 percent per year [4]. The rapid population growth, coupled with the small size of the islands, makes the population density to be high at 530 people per square kilometers [17]. With exception of Dar-es-salaam which has the highest concentration of people per square kilometre in Tanzania, 4 of the 5 Zanzibar regions have the highest population densities in the entire country [17]. In Zanzibar, ever since the inception of family planning services in 1959, the modern contraceptive use rate (mCPR) among currently married women progressively rose to a peak of 15 percent in 1999 [17]. However, a dramatic decrease in mCPR was subsequently observed in 2004/5, when the mCPR reached 9 percent [17]. Thereafter, the mCPR began to rise again, and after 10 years since the loss was registered, Zanzibar is finally close to regaining its 1999 mCPR rates. As of 2016, the modern contraceptive prevalence among currently married women reached 14 percent with an annual percentage point of 0.3. Despite these gains, modern contraceptive use remains to be more than twice lower than the national level rate of 32 percent [17]. According to [18], the Zanzibar Family Planning Project was launched in 1985 to reduce maternal morbidity and mortality by 1995, 104 family planning clinics had been established at maternal-child health family centers, yet contraceptive prevalence remained low (6.6% in 1992).

Efforts to promote modern family planning are continuous in Tanzania. By 2020, in Tanzania, it was asserted that the country would increase the availability of modern contraceptive methods at all levels of its health system particularly the allocation for family planning commodities from Tanzanian Shillings (TZS) 14 billion in 2017 to TZS 17 billion by 2020, expand the availability of at least three modern contraceptive methods at primary-level facilities and at least five modern contraceptive methods at secondary- and tertiary-level facilities from 40 percent to 70%, and scale up the number of health facilities providing youth-friendly reproductive health services from 30 percent to 80% [19]. Tanzania has an annual fertility rate of 15.4 children per 100 women, with an estimated 1.6 million babies born in 2017 [20]. It is estimated that 20% of pregnancies in Tanzania are unintended or unplanned, with a high unmet need for contraception, and limited access to safe abortion. There is a high maternal mortality ratio (MMR) in Tanzania with an estimated 524 deaths per 100,000 live births [21]. As per [22] study on "Knowledge, Attitude and Practice of Family Planning among the women of rural Karachi", found out that 80% of the respondent have a positive attitude towards family planning 7.4% of the respondent are not clear in their thinking so they don't decide yet that family planning is good or bad for them 7.4 % have a negative attitude towards family planning. It was also found that 80% know about family planning while 20% were unaware of spacing or control over birth, also 74.5% source of knowledge about family planning was the health visitors or doctors, 10.5% said they get information from family planning centers 8.25% of the respondents said their husband gave

them knowledge about family planning while 6.75% said they get such. This paper is supported by both Malthusian and Boserupian perspectives on understanding the practices of modern and traditional family planning methods. According to [23] (1766–1834), the rate of population growth has double impacts on resources. Applying this perspective to the developed and developing countries has a contending influence. On the side of developed societies attempt to promote population reduction measures have been successful due to either the condition of having limited resource endowment or scarcity in those societies. In developing countries, the practice of family planning is not adequately influential because of potential resource availability though not taped into the use-value. Such resources involve land, forest, minerals, marine, and wind, sunshine, and human resources. Developed societies have evidence of a relatively high rate of adoption of modern family planning methods whereas the developing societies are more adoptive to the traditional family planning methods. For that matter, both Malthusian and Boserupian perspectives are relevant to inform and justify variably the practice of family planning over space. On the other, Maslow's hierarchy of needs model also attempts to guide the understanding of the practice of modern and traditional family planning methods among women.

This paper is organised as follows. Section one discusses the introduction of the paper. Section two is about the related literature to the topic. The methodological orientation of the paper is described in the third section. The fourth section presents the results and discussion of the paper. The fifth section profiles the synthesis of the discussion linking to the results with the discussion on the theoretical and empirical understanding of the topic. The sixth section states the conclusion and future scope of the paper. The acknowledgment section is provided in section seven. The references section and authors' profiles are presented in section eight and nine respectively.

3. METHODOLOGY

The paper is based on the study conducted in Urban District Zanzibar. Specifically, the study was done in the wards of Fuoni, Magogoni, and Mwembeladu. It was done in this area because; in Zanzibar, there is a large discrepancy in the use of modern family planning methods compared to mainland Tanzania. Thus, calling the attention to select conveniently this area because it had the same characteristics as other urban areas in Zanzibar for examination. According to [24], contraceptive use is much lower in Zanzibar compared to mainland Tanzania. The study was a cross-section in design. This enabled the detailed comparative examination of the factors motivating the adoption of FPM to be adequately done. The cross-sectional design was important because of the need to collect data once across respondents and to be able to describe the current situation of the study area sufficiently. The study employed a mixed approach. This is because of the need to have comparative and complementation of

results. According to the [25] Tanzania national census, the population of the Zanzibar Urban west region was 593, 678. The sample size was 40 all women at the reproductive age of 18-49, and health Facility Officers of the selected wards, health officers as key informant participants. The choice of this population was due to the nature of the study that required a reproductive age and health managers as reproductive service providers. Women were selected systematically using simple random sampling with 2 intervals but at the start, the purposive selection was implemented. The health managers who formed the key informants were selected purposively because of their crucial roles in health services delivery including FPM in the respective health facilities. The study involved a total of 4 wards selected systematically out of 29 wards. Ten households were selected from each ward. The Focus Group discussion used a guide to aid the collection of data by involving 6 participants. Since the study was mixed in nature data were analysed by both descriptive statistics and thematic analysis. Likert scale was used. Coding was done through the assistance of a Statistical package for social Sciences software. These were then presented in tables and explanation building. The research obtained a permit from the relevant authorities including The Mwalimu Nyerere Memorial Academy and The Revolutionary Government of Zanzibar.

4. RESULTS AND DISCUSSION

This section includes the presentation of the results on demographic variables. These include age, marital status and occupation. Others are education level, and religion. This demographic information was very important in addressing knowledge about the features of the respondents in the study.

Table 1: Respondents Features (N=40)

| Variables | Percentage |
|------------------------|-------------------|
| Age | |
| 19-26 | 42.5 |
| 27-32 | 35 |
| 33-45 | 22.5 |
| Marital status | |
| Single | 25 |
| Married | 62.5 |
| Divorced | 12.5 |
| Occupation | |
| Government Employee | 10 |
| Business person | 22.5 |
| Private sector | 20 |
| NGO Employee | 17.5 |
| Student | 27.5 |
| Others | 2.5 |
| Education Level | Percentage |
| None | 2.5 |
| Adult education | 2.5 |
| Primary | 2.5 |
| Secondary | 20 |
| Certificate | 7.5 |
| Diploma | 25 |
| Advance Diploma | 30 |
| Bachelor degree | 10 |
| Religion | |
| Islam | 100 |

4.1 Age

The study examined the attributes of age among study participants using contraceptives as presented in Table 1. The study found that the majority of the respondents, who participated in this study were aged between 19 and 26 years old 17 (42.5%). The second majority were those aged between 27 and 32 years of 14 (35%) whereas the last category was composed of age group between 33 to 45 years old 9 (22.5%). These results indicate that the majority of respondents who participated in the study and users of contraceptives were young indicating their high level of fertility. According to Maslow's hierarchy of needs theory, love need constitutes needs for all humanity. The desire for childbearing according to the theory is likely to discourage the use of any type of contraceptives. On another hand, the missing need for childbearing among partners attracts the use of any type of contraceptives. Again the decision to use either modern or traditional contraceptives depends upon the rationality of influential factors of importance to partners. In all the rationalities on the use of contraceptives among actors, level of age is among important parameters of consideration influencing the type and use of contraceptives with young ages being preferring modern and old age groups having a mix of both traditional and modern methods.

4.2. Marital Status

Table 1 presents results on the marital status of respondents. The results indicate that the married women were 25 (62.5%). The single women constituted 10 (25%) and the divorced women were 9 (12.5%). This indicated that the majority of respondents using family planning methods were married making the use of contraceptive methods limited across time due to desire for a new child and the need for childbearing at some period in time. According to Maslow's hierarchy of needs theory, the need for a child is among partners' needs that are justifiable for acquisition. But this depends on the factor of marital status among women whereby married women as per this results have a more limited desire for use of family planning methods than the single and divorced women at various levels.

4.3 Occupation

In examining the respondents' occupational features the results are presented in Table 1. It was found that 4 (10%) of respondents were government employees. The others constituted 9 (22.5%) were employed in business sector. Others 8 (20%) were employed in the private sector. Those who were working in the non-governmental organisations were 7 (17.5%) while 11 (27.5%) were students and 1 (2.5%) was working on other occupations. The results indicate that majority of participants were employed in business occupations implying that the majority of respondents are employed in business relating to the urbanite nature of population. Occupation has a direct link to family planning methods as it offers economic power among individuals and the desire for having or not having a child. These results related to the determinants of health services that people's demand on health services is

correlated to other variant determinants, which are called social determinants. They are a set of determinants and structural circumstances of daily lifestyle that is responsible for a main branch of health contrasts. These include: income level, goods, services, people living standards and conditions such as providing health services and health insurance, schools and education, work conditions among others [26].

4.4 Education

The respondents were asked to provide the educational qualifications which are important in capturing data from appropriate respondents who use family planning. This is presented in Table 1 results of results on education. The results indicated that among 40 respondents 30% had advanced diploma, 25% were diploma holders, 20% were secondary school leavers, 10% were Bachelor degree holders, 7.5% were certificate holders, 2.5% were primary school leavers, 2.5% were adult education receivers and 2.5% were None educated. This means that among the interviewees most of them were educated as shown by majority who were (30%) with advanced diploma level of education.

4.5 Religion

It was found that 100% of participants were Islam. This holds the feature of TFPM in contention with MFPM due to external influence of modernity and urbanism among women in the study area. Hence the adoption of either of the methods found root sources from the religion on TFPM as well as from external factors of modernity, education and urbanism.

Table 2: Influence of TFPM and MFPM

| Motivation for TFPM and MFPM | Mean | Mode |
|-------------------------------------|------------|----------|
| Attitude on use of TFPM | 3.3 | 3,4 |
| TFPM affordability | 1.3 | 3,4 |
| TFPM safe for mothers' health | 2.9 | 3 |
| Ownership and use of TFPM | 2.9 | 2,4 |
| Cultural influence on use of TFPM | 2.7 | 2 |
| Religious influence on TFPM use | 2.9 | 3 |
| Good feeling on TFPM use | 3.5 | 3 |
| Bad perception on TFPM use | 3.3 | 4 |
| Mean (TFPM) | 2.9 | 3 |
| Cultural influence on MFPM | 3.5 | 5 |
| Religious influence on use of MFPM | 3.4 | 4 |
| Government support on MFPM | 2.5 | 1 |
| Information on benefits of MFPM | 2.9 | 3 |
| Husband support on use of MFPM | 2.9 | 3 |
| Community orientation on MFPM | 3 | 2,5 |
| Reliability influence on MFPM | 3 | 4 |
| Cost influence on use of MFPM | 2.8 | 2, 5 |
| Awareness influence on MFPM | 2.6 | 1 |
| Health influence on use of MFPM | 2.9 | 1 |
| Family health influence on MFPM | 2.7 | 2 |
| Education influence on MFPM | 3 | 3 |
| Husband influence on MFPM | 2.8 | 3 |
| Effective family management on MFPM | 2.7 | 2 |
| Sexual reason influence on MFPM | 2.9 | 2, 4 |
| Need for few children on MFPM | 2.8 | 2 |
| Need for many children on MFPM | 2.8 | 1 |
| Mean (MFPM) | 2.4 | 2 |
| Grand Mean (TFPM+MFPM) | 2.9 | 3 |

Note: 1 indicates very low influence, 2 low influence, 3 moderate influence, 4 high influence and 5 very high influence

4.6 TFPM Safety for Mother's Health

Table 2 presents results on the use of TFPM due to health reasons. The researcher thought it necessary to establish the contraceptive prevalence of the respondents. This analysis was important in understanding the factors which influence the uptake of traditional contraceptive methods by women. It was found that 14 (35%) were neutral, 11 (27%) agreed, 8 (20%) disagreed, 5 (12.5%) strongly disagreed and 2 (5%) strongly agreed on the use of TFPM for promoting mother's health. The findings indicated that the majority of respondents were neutral on the fact that TFPM is safer for mothers' health. This is a moderate level (2.9 mean) of attitude towards TFPM in the study area. Generally, the results indicate the moderate influence of health reasons by women using TFPM.

4.7 Decision on Ownership and Use of TFPM

Table 2 presents results on the use of TFPM due to decisions owned by women themselves. It was found that 11 (27.5%) of the respondents agreed in using traditional family planning methods influenced by their own decision. The study found that 11 (27.5%) disagreed, 10 (25%) were neutral, 5 (12.5%) strongly disagreed, and 3 (7.5%) strongly agreed. This indicates the relatively moderate level (2.7 mean) of influence of own decision by the majority of women who use TFPM influenced by their decisions. These results indicate that majority of women have a low level of influence on holding an independent decision on using TFPM in the area.

4.8 Cultural Influence

Table 2 presents results based on the use of TFPM due to cultural influence. The study required the understanding of influence culture on TFPM adoption. It was found that that 11 (27.5%) disagreed on the influence of culture on the use of TFPM. Others 9 (22.5%) were neutral on the influence of culture on the use of TFPM by women. Another group of 9 (22%) agreed on the statement. Also, it was found that 8 (20%) strongly disagreed with the statement. The last respondents 3 (7.5%) strongly agreed on the influence of culture on the use of TFPM. The results indicate a relatively moderate level of influence of the factor (2.7 mean). This findings show that the majority of respondents disagreed with the use of TFPM because of cultural influence, hence arguing against the dependence theory and promoting the modernization theoretical perspective.

4.9 Religious Belief

Table 2 presents results on the use of TFPM due to religious belief. It was found that 17 (45.5%) of the respondents were neutral on the influence of religion on the use of traditional family planning methods. Another group of women 7 (17.5%) strongly disagreed with the statement. The study found that 6 (15%) disagreed on the influence of religion on the use of TFPM. Also regarding religion 6 (15%) strongly agreed on its influence on the use of TFPM. Lastly, it was found that 4 (10%) agreed on the influence of religion on the use of TFPM. So these results indicated that religious belief has a moderate influence (2.9 mean) on the use of TFPM by women. The results mean

that there is the persistence of modernising practices that influence negatively the use of TFPM in the study area according to the modernisation theory.

4.10 Good Attitude on Use of TFPM

Table 2 presents results on the attitude on the use of TFPM among women. The results indicated that 14 (35%) women were neutral on having a good attitude on the use of TFPM. Others 10 (25%) agreed on having a good attitude towards the use of TFPM. A group of 10 (25%) respondents strongly agreed on having a good attitude on the use of TFPM. On the other hand, 3 (7.5%) respondents strongly disagreed indicating a negative attitude on the use of TFPM. Lastly, 3 (7.5 %) respondents disagreed indicating a bad attitude on the use of TFPM. So these results mean that women have a moderate level of attitude in the use of TFPM indicated by the mean of 3. This indicates a slight wearing away of the traditions that keep TFPM among women in the area due to external influence as a result of modernizing practices in family planning methods.

4.11 Motivations for Use of MFPM among Women

This section presents and discusses results on the use of modern family planning methods among women in the study area. These involve results on cultural, social-economic, and institutional factors that influence women in the adoption of modern family planning methods.

4.12 Cultural and Ancestral Background

Table 2 presents results on the use of MFPM due to cultural influence. It was found that 14 (35%) of the respondents strongly agreed with using modern family planning methods due to cultural influence. A group of 9 (22.5%) respondents were neutral on the influence of culture on the use of MFPMs. A group of 7 (17.5 %) respondents agreed on the use of MFPMs due to cultural influence. A group of 6 (15%) respondents disagreed on the use of MFPM due to cultural influence. Lastly, 4 (10%) respondents strongly disagreed on the use of MFPMs due to culture. The results indicate a mean of 4 which is the high level of influence of culture over the use of MFPM in the area. Generally, the majority of women are influenced by culture on the use of MFPM meaning that still traditions of women are great factors influencing the use of modern family planning methods. The results relate to those by [27], who found that most of the women (84.94%) reported that they were using non-modern contraceptive methods due to low influence of partner or husband or other in Nigeria.

4.13 Use of MFPM on Religious Belief

Table 2 presents results on the use of MFPM due to religious belief. It was found that 12 (30%) of the respondents agreed on use family planning due to religious reasons. A group of 10 (25%) strongly disagreed on the use of MFPMs due to religious reasons. A group of 8 (20%) respondents disagreed on the use of MFPMs due to religious reasons. On the other hand, it was found that 5 (12.5%) respondents strongly agreed on the use of MFPM

due to religious reasons. Lastly, 5 (12.5%) respondents agreed on the use of MFPMs due to religious reasons. The results indicate a mean of 4 which is a high level of influence of religion on the use of MFPMs. These results mean that majority of women use MFPMs having been highly influenced by religious reasons.

4.14 The Government Support on MFPM

Table 2 presents results on the use of MFPM due to government support. It was found that 14 (35%) of the respondents strongly disagreed with government support on the use of modern family planning methods. A group of 13 (32.5%) were neutral on the statement. A group of, 6 (15 %) agreed on having government support on the use of MFPMs. A group of 4 (10%) disagreed with the statement. Lastly 3 (10%) respondents strongly agreed on being supported by the government on the use of MFPMs. The results indicate a relatively moderate level of influence (2.5 mean) of government support in MFPM in the area. This means that the government has little support or motivation for the use of MFPM among women in the area. The results signify little practices by government institutions on promoting MFPM in the area denying the modernizing practices of development and promoting the traditional practices of development of health as per modernization and dependency theories of development.

4.15 Information on Benefits of MFPM

Table 2 presents results on information on the benefits of MFPM. It was found that 12 (30%) of respondents were neutral on receiving information on the benefits of MFPM. A group of 9 (2.5%) respondents strongly disagreed on having information on the benefits of MFPM. A group of 7 (17%) respondents agreed on being informed about the benefits of MFPM. A group of 6 (15%) respondents disagreed on having information on the benefits of MFPM. Lastly, 6 (15%) respondents strongly agreed on being informed of the benefits of MFPM. These results indicate a mean of 2.9 signifying a moderate level of information on the benefits of MFPM in the area. The results imply that little is done to promote the understanding and practices of modern family planning methods by development actors in the area. This leads to sustaining the traditional practices as informed from the dependency theory of development.

4.16 Husband Support on MFPM

Table 2 presents results on the influence of husband support on the use of modern family planning methods. It was found that 16 (40%) of respondents were neutral on the influence of husband support on the use of MFPM. A group of 7 (17.5%) respondents agreed on the influence of husbands on the use of MFPM. A group of 7 (17.5%) respondents disagreed on husband support on the use of MFPM. A group of 6 (15%) respondents strongly disagreed on husband support's influence on the use of MFPM. The last one 4 (10%) respondents strongly agreed on the influence of husbands on the use of MFPM in the area. The results indicate a moderate influence by husbands in promoting MFPM among women with 2.9

mean. This means that there are both elements of TFPM and MFPM that preoccupy partners in the study area.

4.17 Community Orientation on MFPM

Table 2 present results on this factor. The study examined the influence of the orientation of community on the use of MFPM in the area. It was found that 9 (22.5%) respondents disagreed on having an orientation towards the use of MFPM. group of 9 (22.5%) respondents strongly agreed on the influence of orientation on the use of MFPM. A group of 7 (17.5%) respondents strongly disagreed on the influence of orientation on the use of MFPM. A group of 7 (17.5%) respondents agreed on the influence of orientation on the use of MFPM. Lastly, 8 (20%) respondents were neutral on the influence of orientation on the use of MFPM. The results indicate a mean of 3 which is a moderate level of influence of the orientation of women in using MFPM. Generally, the findings revealed that the majority of respondents have a moderate orientation on MFPM. Hence the community of women possesses moderate practices of using MFPM informed by the promotion of social, and religious norms which are traditional as opposed to modernizing practices of family planning.

4.18 Reliability of MFPM

The researchers thought it necessary to examine the reliability factor in influencing the use of MFPM among women respondents as presented in Table 2. It was found that 13 (32.5%) respondents agreed on MFPM being reliable. A group of 11 (27.5%) respondents disagreed on the reliability of MFPM. A group of, 7 (17.5%) respondents were neutral on whether MFPM is reliable or not. A group of 5 (12.5%) respondents strongly agreed on MFPM being reliable. about the last group of 4 (10%) respondents disagreed on the fact that MFPM is reliable. These results indicate a mean of 3 which signifies a moderate level of influence of reliability on the use of MFPM among women. The findings mean that to a moderate extent women are influenced by the reliability factor on the use of MFPM in practice. It shows that the majority of respondents were moderately motivated by the reliability of MFPM.

4.19 Influence of Cost on Use of MFPM

The paper examined the influence of cost on the use of MFPM among women as presented in Table 2. It was found that 9 (22.5%) respondents strongly agreed on the influence of cost. A group of, 9 (22.5%) respondents disagreed on the influence of cost on the use of MFPM. Others 8 (20%) respondents were neutral on the influence of cost on the use of MFPM. A group of 7 (17.5%) respondents strongly disagreed on the influence of cost on the use of MFPM. Also, it was found that 7 (17.5%) respondents agreed on the influence of cost on the use of MFPM. The results show a mean of 2.8 which is a relatively a moderate level of influence. The findings show that the majority of women are moderately motivated by the cost of using MFPM. Hence, the cost for MFPM is one

of the negative motivations among women's use of the methods.

4.20 Motivation of Awareness on Use of MFPM

The study examined the influence of awareness on the use of MFPM in the area as presented in Table 2. It was found that 12 (30%) respondents strongly disagreed on the influence of awareness by women on the use of MFPM. A group of 9 (22.5%) respondents was neutral on the influence of awareness on the use of MFPM. A group of 8 (20%) respondents agreed on the influence of awareness on the use of MFPM among women. A group of 7 (17.5%) respondents disagreed on the influence of MFPM among women. The last respondents were 4 (10%) who strongly agreed on the influence of MFPM among women. These results indicate a mean of 2.6 which signifies a relatively moderate level of influence of awareness on the use of MFPM among women in the area.

4.21 Health Motivation on Use of MFPM

Table 2 presents results on the influence of health on the need for good health on use of MFPM. It was found that 10 (25%) respondents strongly disagreed on health influence on the use of MFPM. A group of 9 (22.5%) respondents was neutral on the influence of MFPM due to health. A group of 7 (17%) respondents agreed on the use of MFPM influenced by health. A group of seven 7 (17.5%) respondents disagreed on using MFPM due to health. Another group of 7 (17.5%) respondents strongly agreed on the use of MFPM due to the influence of health issues. This is a mean of 2.9 which signifies a moderate level of influence of health on the need of good health on use of MFPM among women in the area.

4.22 Family Health on Use of MFPM

Table 2 presents results on the use of MFPM due to family health reasons. This was important to know if women have consideration of their family wellbeing regarding family planning. It was found that 14 (35%) of respondents disagreed on the use of MFPM because of family health promotion rationale. A group of 11 (27.5%) respondents agreed on the influence of family health reason in using MFPM. A group of 5 (12.5%) respondents were neutral on the influence of family health rationale in using MFPM. Another group of 5 (12.5%) respondents strongly disagreed on the influence of family health rationale for using MFPM. The last group was of 2 (12.5%) respondents who strongly agreed on the influence of the need for family health in using MFPM. These results indicate a mean of 2.7 signifying a relatively moderate level of influence of the family health promotion factor in using MFPM in the study area.

4.23 Education Purpose

Table 2 presents results on the use of MFPM due to educational reason. It was found that 14 (35%) of respondents were neutral on the influence of education on the use of MFPM. A group of 12 (30%) respondents agreed on the influence of education on the use of MFPM. A group of 7 (17.5%) respondents disagreed on the

influence of education on the use of MFPM in the area. A group of 4 (10%) respondents strongly agreed on the influence of education by women on the use of MFPM. Lastly, 3 (7.5%) respondents strongly agreed that education influences the use of MFPM among women. These results indicate a mean of 3 which is a moderate level of influence of the factor on the use of MFPM in the area.

4.24 Effective Management of Family

Table 2 presents results on the use of MFPM due to the need to realize effective family management. This was important in so far as resources are concerned. It was found that 11 (27.5%) of respondents disagreed on the fact that there is a need to maintain effective family management among women. A group of 8 (20%) respondents agreed on the factor. A group of 9 (22.5%) respondents strongly disagreed on the factor. A group of 7 (17.5%) respondents were neutral on the factor. The last group of 5 (12.5%) respondents strongly agreed on the rationale to have an effectively managed family among women. These results indicate a mean of 2.7 which ranks as a relatively moderate level of influence of the factor towards the use of MFPM among women in the area for effective family management.

4.25 Sexual Reason

Table 2 presents results on the use of MFPM because of sexual reason among women. It was found that 10 (25%) respondents disagreed on the influence of sex on the use of MFPM among women. A group of 8 (25%) respondents agreed on the factor. A group of 8 (20%) respondents was neutral about the sex rationale for using MFPM. A group of 7 (17.5%) respondents strongly disagreed on the factor. Also, 5 (12%) respondents strongly agreed on the factor. Another group of 5 (12.5%) respondents disagreed on the factor. These results indicate a moderate (2.9 mean) level of influence of sexual reason as a factor influencing the use of MFPM among women in the area.

4.26 Need to Have Few Children

This section presents and discusses results on the use of MFPM because of the need to have few children by respondents as per Table 2. It was found that the majority of respondents 11 (27.5%) disagreed on the influence of the factor on the use of MFPM. A group (22.5%) of respondents strongly disagreed on the influence of the factor on the use of MFPM. Another group of 9 (22.5%) respondents agreed on the influence of the factor on the use of MFPM. A group of 6 (15%) respondents strongly agreed on the influence of the factor on the use of MFPM. The last respondents were 5 (12.5%) who agreed on the influence of the need to have few children to use MFPM. These results have a mean of 2.8 which is a moderate level of influence of the factor on using MFPM among women in the area.

4.27 The Need to Have Many Children Reason

Table 2 presents results on the influence of the need to have many children among women ability to use MFPM.

It was found that 10 (25%) respondents strongly disagreed on the influence of the factor. A group of 9 (22.5%) respondents disagreed on the influence of the factor. A group of 8 (20%) respondents strongly agreed on the influence of the factor. A group of 6 (15%) respondents agreed on the influence of the factor on the use of MFPM. The other 7 (7.5%) respondents were neutral on the influence of the factor on the use of MFPM. These results indicated a moderate level (mean of 2.8) of influence of the factor on the use of MFPM among women in the area.

5. SYNTHESIS

The findings indicate that majority of respondents of the study were literate, which means that they are aware of the philosophy regarding modern and traditional family planning methods. They were also young aged with a reproduction potential being married in majority. The respondents of the study also were economically live because of having jobs in diverse categories, therefore they can earn income for various needs as per Maslow's hierarchy of needs model. These were culturally religious respondents in the form of Islamic religion meaning that there are religious attachments related to the understanding, and practice of either modern or traditional family planning methods. With these features, it is typically important to understanding the cornerstone towards the use of MFPM and TFPM among actors that underscore the dynamics within the use of the two methods.

Regarding the use of TFPM, the findings indicate a moderate level of usage in various elements measured including attitude, affordability, health need, cultural influence, feeling, and bad perception. Hence the prevalence of both Malthusian and Boserupian perspectives in the use of FPM among women. On the other hand, the findings revealed a low level of influence on the use of modern family planning methods. This is an indication that to some extent the society has got a low level of adoption of modern family planning methods among women. This is related to the empirical literature as well as the relevance to the Boserupian perspective on promoting population growth that is embedded in the religious and cultural orientation among women of the area. This also to large extent opposes the Malthusian perspective on reduction of population growth and the western practice informing the modern family planning methods adoption.

5. CONCLUSION AND FUTURE SCOPE

The study concludes that women have a mixed motivation for the use of traditional family planning methods indicated by 2.9 mean informing the moderate level of adoption among women in the area. The TFPM acquire a relatively moderate level of influence among women with a mean of 2.9. Culture, religion, and the need for many children by women are among the positive motivations that promote the use of TFPM. The MFPM have a low level

(mean of 2.4) of influence among women in the study area. Education, the need for a few children, health, and manageability of the family are among the positive motivation that promotes the adoption of MFPM among women. Again, culture, religion, and limited of awareness comprise negative motivations among women on the adoption of MFPM. Respondents' features including age, marital status, occupation, education and religion have influence of adopting either TFPM or MFPM. Majority of women were youths being aged 19 to 26 (42.5%). The second category were aged 27 to 32 (35%) informing a high capacity of fertility and reproduction roles. In terms of marital status majority of women participants were married (62.5%) informing the use of either of the methods of family planning. The occupation of respondents was diverse with majority being employed in various sectors (20% in the private sector, 22.5% doing own business, 17.5% employed in non-governmental organizations, and 10% employed in the public sector. Therefore have the capacity to make decision over the use of either TFPM or MFPM in their area. Educationally, the majority of women participants indicated the evidence of various levels of education. These involved holders of advanced diploma (30%), diploma (25%), secondary (20%), and degree levels of education qualifications. Therefore they are knowledgeable on matters regarding both TFPM and MFPM. Lastly, it was evidenced that all participants are believers of the Islamic religion, therefore they possess knowledge of the religion regarding the essence of family planning.

The paper has revealed the areas of concern on the motivation for the adoption of family planning methods among the women in Zanzibar. The paper revealed that the majority of women have a moderate level of adoption of TFPM and a low level of adoption of MFPM. This status has implications on population growth related to resource use and development at various levels. In order to promote the commitment for adoption of modern family planning methods sensitisation on the importance of having small families should be done at all levels of governance by various stakeholders concerned with matters of reproductive health. National and local governments should strive to improve the awareness creation from primary to secondary schools to get better understanding of reproductive rights and the benefits of modern family planning methods by women and girls as well as other stakeholders. The government should endlessly support women economic empowerment programmes in order to enhance their capacity to earnings for their families. There is also a need to adopt a sustainable strategy to empower communities. For that matter the government should invest in vocational education and make it universal to all youths in the primary and secondary education in Zanzibar and Tanzania as well. This will add value to knowledge and skills acquisition among youths to enable them be self-reliant after graduating. This will mitigate the economic vulnerability of the population of Zanzibar and Tanzania that is characterized by youths' dominance as the second majority population category after children, preparing them

fit for the adult and reproductive roles by using resources equitably and beneficially.

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REFERENCES

- [1] M. Almalik, S. Mosleh and I. Almasarweh, Are users of modern and traditional contraceptive methods in Jordan different?. *EMHJ* – Vol. 24 No. 4 – 2018
- [2] United Nations, Department of Economic and Social Affairs, Population Division, *Contraceptive Use by Method: Data Booklet (ST/ESA/SER.A/435)*. 2019
- [3] T. Gebreselassie, K. Bietsch, S. Staveteig, and T. Pullum. Trends, Determinants, and Dynamics of Traditional Contraceptive Method Use. DHS. Analytical Studies No. 63. Rockville, Maryland, USA: ICF. 2017.
- [4] United Nations Department of Economic and Social Affairs, Population Division. (2020). *World Family Planning Highlights: Accelerating action to ensure universal access to family planning (ST/ESA/SER.A/450)* 2020.
- [5] S. Sesiere and M. D’Haese. Boserup versus Malthus: Does population pressure drive agricultural intensification? Evidence from Burundi. *Contributed Paper prepared for presentation at the 89th Annual Conference of the Agricultural Economics Society*, University of Warwick, England 13 - 15 April 2015.
- [6] D. Headey, and, T.S. Jayne, Adaptation to land constraints: Is Africa different? *Food Policy*. Vol. 48. pp.1-16 2014.
- [7] K.E.Osinowo, O; Ojomo; A Hassan & O.A. Ladipo. Patterns of triggers, ideation and motivational factors of contraceptive utilization among women and gate-keepers in Nigeria: a scoping study on the resilient and accelerated scale-up of DMPA-SC in Nigeria (RASUDIN). *Contraception and Reproductive Medicine*, Vol.5:38, 2020.
- [8] United Nations, Department of Economic and Social Affairs, Population Division. *Trends in contraceptive use worldwide*, 2015.
- [9] World Health Organisation, Trends in maternal mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division, ISBN 978 92 4 156514 1 (NLM classification: WQ 16) 2015.
- [10] World Bank. Poverty Reduction in Nigeria in the Last Decade: *World Bank*; 2016.
- [11] C.L.Ejembi, T. Dahiru, A.A.Aliyu. Contextual factors influencing modern contraceptive use in Nigeria. *DHS Working Papers* NO. 120. Rockville, Maryland, USA, ICF International. 2015.
- [12] W. Rosa, Ed. Transforming Our World: The 2030 Agenda for Sustainable Development. In: A New Era in Global Health. New York: *Springer Publishing Company*; 2017.
- [13] C. Kahabuka, Barriers and Opportunities for Accelerating Contraceptive Choice in Tanzania *Background Paper for a Working Meeting on “Expanding Options through Country Leadership in Sub-Saharan Africa”*. Boma Hotel, Nairobi, Kenya 2-4 April 2014..
- [14] J. Ross, J. Stover: Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009 *John Ross, a John Stover*
- [15] R.Jacobstein, and H.Stanley, Contraceptive implants: Providing better choice to meet growing family planning demand. *Glob Health Sci Pract*. 1(1):11-17. 2013.
- [16].Earth Negotiations Bulletin: *International Conference on Population and Development (ICPD)*:1994.
- [17] Revolutionary Government of Zanzibar. The Zanzibar Family Planning Costed Implementation Plan Zanzibar. 2018 – 2022.
- [18].*Revolutionary Government of Zanzibar. Zanzibar Family Planning Project, Zanzibar, 2015.*
- [19] United Republic of Tanzania. National Family Planning Costed Implementation Plan 2019-2023,2019.
- [20]. Central Intelligence Agency, The CIA World Factbook 2018-2019 *Paperback* – May 8, 2018.
- [21]. WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 2000 to 2017. Geneva, *World Health Organization, 2019*
- [22]. K. Kazi, A study of Knowledge, Attitude, and Practice of Family Planning among the women of rural Karachi Department of the social works University of Karachi. 2008.
- [23]. L. Tim, The principle of population vs. the Malthusian trap: A classical retrospective and resuscitation, *Darmstadt Discussion Papers in Economics*, No. 232, Technische Universität Darmstadt, Department of Law and Economics, Darmstadt, 2018.
- [24] Africa Women Development Fund, Advocacy in Zanzibar Leads to Reduction in Family Planning Commodity Stock-outs, Case Study, *Bill & Melinda Gates Institute for Population and Reproductive Health Johns Hopkins Bloomberg School of Public Health, 2015.*
- [25].United Republic of Tanzania. National Household and Population Census, Dar es Salaam. 2012.
- [26] Bassel Anwar Asaad. The Impact of Covid-19 (Coronavirus Pandemic) on the Demand of Health Services in Syria (Analytical Study in Lattakia). Research Paper *World Academics Journal of Management* Vol.8, Issue.2, pp.06-11, June 2020
- [27]. E. Odjesa, C.A. Ighodaro & P.I. Sede, The Effect of Women’s Empowerment on the Use of Modern Contraceptives: A Case Study of Nigerian Married or In-union Women Aged 20 to 34 Years. *Amity Journal of Healthcare Management* 4 (1), (42–61), 2019.

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