

GENDER NORMS AND FAMILY PLANNING DECISION-MAKING IN TANZANIA: A QUALITATIVE STUDY

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TABLE OF CONTENTS

SUMMARY	1
INTRODUCTION	1
METHODS	2
FINDINGS	3
GENDER NORMS	3
DEMAND FOR FP	6
PERCEPTIONS OF MODERN FP METHODS	7
COUPLE COMMUNICATION AND DECISION-MAKING	7
DISCUSSION AND CONCLUSIONS	10
RECOMMENDATIONS FOR COMMUNICATORS	11
REFERENCES	12

SUMMARY

Experience suggests that the incorporation of gender approaches into family planning (FP) and reproductive health (RH) programs could increase their impact and sustainability, but further work is needed to examine the interactions between gender norms and FP and to incorporate this understanding into social and behavior change communication (SBCC) in specific social contexts.

The purpose of this qualitative study was to examine the role of gender norms in reproductive decision-making and contraceptive use among young married men and women in Tanzania. Study methods consisted of open-ended, in-depth interviews with 30 young currently married men, 30 young married women, and 12 older people who influenced FP decisions. Six focus group interviews were also conducted.

The findings suggest that gender factors, such as men's dominance in decision-making, do function as barriers to the use of modern contraceptives, but that fear of side effects among both men and women might be an even more important deterrent. Results from this research will inform the development of SBCC interventions to be tested in a subsequent intervention study in which gender factors and poor information about contraceptive methods will be addressed.

INTRODUCTION

Gender norms often support high fertility, influencing the timing of marriage and childbearing, and aspirations regarding family size and sex composition. FP programs and services have often selectively accommodated rather than challenged prevailing gender norms by targeting FP toward women and have reinforced the idea that reproduction and family welfare are women's responsibilities. Beyond limiting the reach of FP services, gender inequality and the norms surrounding masculinity, femininity, and male-female relationships can impede the healthy timing and spacing of pregnancies. For example, men might be willing to accept women's contraceptive use but unwilling to bear the costs and perceived risks of FP, as has been documented in Bangladesh (Schuler et al. 1998). In many African settings, fathering children is a sign of virility and status (Isiugo-Abanihe 1994). In many parts of the world, dominating women by pushing them to have unprotected sex is considered an acceptable way of asserting male power and demonstrating manhood and male rights over women (Pulerwitz et al. 2006). In some settings, women have reported that bringing up the issue of condom use can result in violence (George & Jaswal 1995; Jenkins & National Sex & Reproduction Research Team 1995; Wyatt et al. 1992). A synthesis of case studies supported by WHO (Brown et al. 2001) points to a number of gender-related constraints that female youth, in particular, face in exercising choice regarding sexual relationships, accessing sexual and reproductive health information, and using contraceptive methods. These include gender-based double standards, fear of losing a partner, and fear of disclosure.

Gender norms can have a positive influence on RH as well. For example, programs have emphasized the norm of men as providers for their families, encouraging them to consider the economic costs of children in the context of rising aspirations for education and consumer goods. Operations research studies have shown success in involving men in maternity care (Varkey et al. 2004) and increasing spousal communication about family size and FP (Lundgren et al.

2005). A study in Tanzania found gender equity to be associated with lower fertility (Larsen and Hollos 2003).

Among 12 sub-Saharan countries for which Demographic and Health Survey (DHS) data exist, Tanzania has the fourth-highest fertility rate, at 5.7 children per woman. Throughout Tanzania, a quarter of young women ages 15-19 have begun childbearing, with the highest rates found in the Lake (35%) and Southern (36%) zones. Sixteen percent of births have spacing periods of less than two years, and 5% have a spacing period of less than 18 months (NBS 2005). Unsafe abortion is a significant problem (Plummer et al. 2008). Nearly a quarter (24%) of sexually active married and unmarried women has an unmet need for FP, according to the most recent DHS (Khan and Mishra 2008). Promotion of condoms for disease prevention might be contributing to this unmet need by associating the method with infection and promiscuity (Plummer et al. 2006).

This qualitative study explored the role of gender norms in supporting high fertility, unplanned pregnancies, and unhealthy timing and spacing of births in Tanzania. Its objectives were to 1) collect and analyze new data on the role of gender norms in reproductive decision-making and contraceptive use among young married men and women; and 2) develop recommendations for behavior change interventions that address gender-related barriers to effective FP choices. Results from this research are intended to inform the development of SBCC interventions to be tested in a subsequent operations research study.

METHODS

The study was conducted among ethnically mixed populations in one urban/peri-urban and two rural sites: Temeke District in Dar es Salaam Region; Mbeya Region; and Mwanza Region.

Table 1. Data collection plan

	Site one	Site two	Site three	Total
I. In-depth interviews (72 total)				
Young married women				
Recent adopters	6	6	6	18
Never users	4	4	4	12
Young married men				
Recent adopters	6	6	6	18
Never users	4	4	4	12
Key decision-makers	4	4	4	12
II. Focus group interviews (6 total)				
Women	1	1	1	3
Men	1	1	1	3

The data were collected through 72 open-ended, in-depth interviews (IDIs) conducted face-to-face by same-sex interviewers and six focus group discussions (FGDs), one with men and one with women in each of the three sites, with about six participants per group (Table 1). Twenty-four IDIs were conducted in each of the three sites—10 each with recently married (less than five years) men and women, and four with mothers-in-law and other key decision-makers (other relatives), as identified in the interviews with the young men and women. Six of the recently married men and women in each site had recently adopted contraception and four had formerly used or never used contraception. The samples of IDI and FGD participants did not overlap.

Participants were recruited from health clinics (two in each site) and clinic catchment areas, with assistance from nurses in the clinics.

Both the IDIs and the FGDs explored the cultural meanings of masculinity and femininity and men's and women's perceptions and expectations of both men's and women's roles in FP and FP decision-making. The IDIs explored men's and women's images and expectations of themselves and their spouses, their experiences in making (or avoiding) FP decisions and, where applicable, their experience in using contraceptives and cultural norms related to gender, reproduction, and FP. The data were collected in Kiswahili by four interviewers, two male and two female, using pre-tested semi-structured interview guides and FGD guides. Probing and follow-up questions were emphasized. The IDIs were conducted in a conversational style. In the FGDs, participants were encouraged to talk with one another. The interviews were digitally recorded, transcribed by the interviewers, and translated into English by independent translators.

A U.S.-based researcher developed a code book to guide thematic coding of the transcripts using the software program MAX-QDA. More codes were added after a small set of transcripts were coded. Upon completion of the data transcription, the Tanzanian field researchers reviewed their interviews and listed key themes. The U.S.- and Tanzania-based researchers then conducted a participatory analysis workshop in which the themes were reviewed, patterns identified, and preliminary conclusions drawn regarding the social processes through which gender norms influence the timing and spacing of births; discussions about use and non-use of FP methods; method choice; and intimate partner violence. Narrative analysis was also carried out using entire transcripts to provide context.

FINDINGS

Gender norms

The findings showed near universal agreement among women and men users and non-users about the norms related to men's and women's roles in the family and society.¹ Men were characterized as being the head of the household, the provider for the family, able to have sex and satisfy a woman, able to have children, and able to participate in society. As head of the household, a man was responsible for providing for the family financially, including providing money for clothing, food, education for children, and health care. Men's position as head of the household was also described in terms of dominance in decision-making, e.g., "...in charge in each and every decision. What makes me a good man is to have the first and last word on issues like having children. A man is the sole decision-maker, and it doesn't matter whether the woman has her views or not, she has to wait for the man to give the last word."

In addition to being able to satisfy their wives sexually, men were expected to be able to start a family soon after being married. Many participants said that a man who could not have children was still a man, but not a "complete man." However, only a very small minority of male participants said they wanted large families or that a large family would bring them prestige. Money spent on one's family was seen as an investment whereas outside relationships were seen

¹ There were no substantial differences in the views of male and female participants or of users and non-users except where noted. Rural and urban participants were quite similar as well, except that those in the rural sites often wanted larger families, and in a few cases men exercised dominance to the point of not allowing their wives to express their views.

as a drain on family resources and for personal pleasure only. Men were described as wanting and having a right to both love and sex on demand from their wives. Some participants said a real or ideal man did not have sex outside marriage, but many also said that men needed more than one woman to be sexually satisfied. According to one woman, it is all right for a man to have an affair as long as he does not flaunt it: “He can do it in secret so that his wife doesn’t find out, and that shows that he respects his marriage.”

A woman in Tanzanian society was characterized as the supporter of the husband, a caretaker of the family, and a bearer of children. A woman’s ability to bear children was linked very closely to the definition of a woman. One male participant said that a woman who could not have children “... would not be described as a woman. She would be a human being but not a woman because I did not get married to her so that we can look at each other. I married her so that we can have a family and that is by getting children.” Most participants said that a woman should stick to one man, but some, even men, felt that it was understandable that a woman who was neglected emotionally, physically or economically might take another lover. Like men, women were described as needing love. As men were the main decision-makers in the family, women were expected to support their husbands’ decisions. It was considered disrespectful for a woman to disagree with and disobey her husband, though it was generally said to be acceptable for her to provide advice and state her opinion during the decision-making process: “She has...the right to be listened to when she advises on anything that affects the family.”

In contrast to the almost invariant responses regarding men as heads of the family and main decision-makers, nearly all participants said that gender roles were changing. They spoke about the economic roles that women were increasingly taking on as a result of women’s education and hard economic times. When asked about recent changes, participants voiced more liberal views about the roles women can play in the family and society. Participants drew contrasts to earlier expectations of women. Whereas then it was the norm for women to stay home and receive money from the husband for food and clothing, it was now becoming more and more acceptable, and even expected, for a woman to do some kind of work to contribute financially to the family. One female participant stated, “Long ago, women used to stay at home and wait for their husbands to do everything, even to buy them underwear, but now women have come out so strongly and they are doing all that men can do in order for them to get some money.” Another said, “Previously women used to rely on men, but now a man will not marry a woman who is jobless.”

Table 2 summarizes the gender norms that discourage contraceptive use and those that might facilitate it.

Table 2. Gender Norm Barriers and Facilitators to FP

BARRIERS
Sex Men need sex more than women. Men decide when to have sex. A woman should not refuse to have sex with her husband.
Childbearing and family size Only when a man/woman has a child is he/she “complete.” A real man has many children (Sukuma tribe). Large families give men social prestige (Sukuma tribe).
Communication and decision-making The man makes the final decision in the household. It is disrespectful for a woman to disagree with her husband. A woman should obey her husband. The man decides family size and spacing.
Contraceptive use The man decides whether to use family planning. A woman should not use family planning without her husband’s consent and should not use FP in secret. Women who want to use contraceptives want to have affairs. Men who use condoms are having affairs.
Violence It is all right for a man to beat his wife if she refuses to have sex with him. It is all right for a man to beat his wife if she disagrees with or speaks rudely to him. It is all right for a man to beat his wife if she uses contraceptives secretly.
FACILITATORS
Couples discuss family planning. A man is concerned about his wife’s health. A man is responsible for providing for the family. A man is dependable. A man should take care of his family. A woman cares for her family. A woman engages in work to help the family.

Demand for FP

The findings indicate a high level of unmet need, with 21 out of 23 non-users of modern contraceptives expressing a desire for spacing or limiting the number of children. Both users and non-users of modern FP methods often cited economic reasons for wanting to space and limit the number of children. Men’s and women’s reproductive intent was formed by their perceptions of how many children they could financially support, including providing adequate food, clothing, and education, particularly in the urban site. A male user stated, “The economy does not allow me to have more than two [children], and you are supposed to consider your capability [to support children] before you decide to go for more babies. Are you able to fulfill their needs—that is the question you should ask yourself.” A female non-user said she wanted three children because “I am able to feed them, dress them, and educate them well even when my husband is not there. Some women give birth to more than five children, and you find that she cannot feed or even dress them. It is not good to do that because it is a slow sure way to poverty.”

Additional benefits of FP were also mentioned by both users and non-users. They spoke about being able to space their children so that the woman had time to rest, regain her health, and remain youthful and attractive, and for parents to ensure the health and well-being of the children. A female user stated, “Family planning has proved to be of a great help to women in the villages. People are now planning their families well, and we like it so much that our houses are no longer filled with desperate children like it was in the days of our grandparents. ... It has brought freedom to the woman in the village.” Some women spoke about wanting to space their pregnancies so they could work without worrying about pregnancy. A female non-user said, “[Family planning] is good. You will get your children with a plan. You will get a chance to rest.” Virtually all participants recognized that the condom protects against sexually transmitted diseases as well as pregnancy, and many said specifically that men should or did use condoms in their extra-marital relationships.

As Table 3 illustrates, women were more motivated than men to practice FP but not overwhelmingly so (a difference of three cases).

Table 3. Husbands’ and wives’ motivation to use contraceptives

	Modern method users	Non-users	Traditional method users
Woman motivated Man motivated	31*		1
Woman motivated Man not motivated	2 (used secretly)	1	4
Woman not motivated Man motivated	2 (husband imposed)	1	1
Woman not motivated Man not motivated		5	6
Man not motivated Woman’s motivation unclear		1	2

*In 14 cases, communication on FP was initiated by women; in 11, men; and in six, it was unclear who initiated communication.

Perceptions of modern FP methods

Both users and non-users often held mixed views of modern FP methods, recognizing both the benefits for limiting and spacing children, but also expressing strong fears about the harmful side effects. Some common beliefs about contraceptives were that they caused cancer, weight gain or loss among women, continuous bleeding, cessation of periods all together (which was seen as harmful to the woman), or barrenness. Many also believed that an implant could travel throughout the body and become lost. Among non-users, fear of side effects was the most commonly cited reason for not adopting modern contraceptives.

Out of the 21 respondents desiring birth spacing or limiting, 15 held negative opinions or misconceptions about FP methods and stated that either their fear or their partner's fear was the main reason for not using contraceptives. A male non-user stated that he wanted to have his second child after three years but when asked why he was not using FP, he said, "I don't like to because of the effects they have. I have heard people complaining about them." Another male non-user said, "One [contraceptive method] is the pill, which causes cancer. Implant, you have to have an operation for them to be inserted, and it really irritates where they have been inserted. Injectable method is the one that makes someone add too much weight, so these things make me very scared. I've told my wife not to use them." Even condoms, according to a few, contained cancer-causing lubricants, were infected with HIV, or contained harmful bacteria. Others simply thought the lubricant made women's genitals itch. Several men also described the condom as unreliable; for example, one male focus group participant said, "The condom is good, but there are times when, even if you use it properly, it heats up due to friction and then bursts, causing harm to the users." Several men also said they objected to the IUD because a doctor would need to touch their wives' "private parts" to insert it.

While users tended to view contraceptives positively overall, they still worried about the presumed side effects, and this often influenced method choice. For example, one female user of injections stated, "I don't think [pills] are a good method because some people complain that it ... causes cancer." A female user of condoms said about injections that "if the person giving you the injection makes a small mistake, then you will be paralyzed. There is a lady who got paralyzed because the nurse injected her wrongly."

The difference between users and non-users in their perceptions of FP was surprisingly small. Both men and women among the couples using FP initially feared side effects from contraceptives but somehow overcame their fears to try a method.

A few male participants objected to contraceptives for fear they would enable their wives to be promiscuous. One non-user from Dar es Salaam explained, "Of course if you are in love, you are jealous most of the time, and if I use a family planning method I will never feel at peace because I would fear she may have extramarital affairs, knowing she cannot conceive. ... We opt for other natural ways [of birth control]."

Couple communication and decision-making

It was common for husbands and wives to discuss FP and whether they would adopt a modern method. However, men had the right to decide, and there was little evidence that couples negotiated about FP. Out of the 12 female non-users, four women wanted to use FP methods but

did not because their husbands would not permit them to do so. One woman thought further discussion would be fruitless:

Moderator: Have you ever used or will you ever use the injection?

Respondent: I have no plans to use the injection or any family planning method.

M: Why?

R: Because of the agreement that we have, I and my husband. He does not want anything to do with family planning methods.

M: What about the pills?

R: Even the pills, I mean he does not want any kind of family planning methods.

M: What about you?

R: I support my husband; I do not want anything to do with that.

M: OK, has your husband ever insisted that you should use family planning methods?

R: He has never.

M: Have you ever discussed with your husband on the family planning methods?

R: I have never.

M: You have never used it at all?

R: I have never discussed it with him.

M: Why?

R: Because I always see that he does not like it, so I just support him.

M: How do you think about the issue—do you mean you have never discussed anything with him in regard to family planning?

R: I have never done it, and I don't think I will do it.

M: Maybe you have not tried asking him what he thinks about family planning methods?

R: He will refuse when I ask him.

M: Have you ever tried asking him?

R: I once asked him what do you think if we used a family planning method...but he said no and told me to leave everything up to God, whatever he has for us, let it be.

As that dialogue illustrates, women's decision-making power related to contraceptive use was limited by the norm that a woman should respect her husband and obey his decisions. While many women were the first to raise the subject of FP, they typically consulted their husbands and sought approval before initiating use of contraceptives. A female non-user shared a discussion she had with her husband about FP:

Moderator: Have you ever talked with your husband about family planning?

Respondent: We have talked about it.

M: What did you talk about?

R: We discussed using them for one year.

M: How did you start the conversation and what did you say?

R: I told him we should begin using family planning so that I would not give birth every year and so that I could go back to school.

M: What did he say?

R: He refused.

M: Why did he refuse?

R: He said you cannot go to school now. That is why he refused.

A male non-user described a conversation he had with his wife, in which he told her that he wanted four children: “She did not question me nor ask the reason why. She told me that I’m the one who makes the decisions and that she cannot decide anything for me.” A male user said that telling his wife to use contraceptives “was a command, not a request. I told her that it was a must for us to use it.” Another male user said, “I do involve her [in decisions] because when I want to have a child, I tell her and she agrees. But she can’t tell me that we should stop having more children because I am the one to make that decision.” One urban woman was afraid to raise the subject at all: “For example, if I made myself out as knowing too much and started talking about family planning, I would definitely get a beating. That is why I choose to remain silent.”

Women rarely initiated contraceptive use on their own, without the husband’s consent. A female non-user stated, “If he ever finds out that I’m using any type of family planning method, then my marriage would be in trouble. He refuses because he says that I might never be able to deliver again and that is why I’ve decided to take his advice. I’m not going to use any kind of family planning method just in case he discovers it and this brings problems in our relationship.”

A large minority of the female non-users said they wanted to use modern contraceptives but did not because their husbands did not allow it. In several other cases, men imposed contraceptive use on their wives rather than blocked its use.

Many of the men had made misinformed decisions about contraception, as it is not normative for men to seek information from sources such as health clinics. Three out of the 11 male non-users directly stated that they did not have enough information on contraceptives to make an informed decision, but that did not stop them from deciding that neither they nor their wives would use them, for fear of side effects.

Four women acknowledged that they had initiated contraceptive use without their husbands’ involvement or consent. One was switching methods from condoms to pills, and a second began using pills after visiting a health clinic and then discussed this with her husband. The remaining two did so in secret, fearing serious conflict, including violence or divorce if they openly went against their husbands’ wishes. We suspect the actual the number might have been higher. One woman began using contraceptives secretly after having marital problems. Her husband had threatened to divorce her, and she did not want to be pregnant if that happened. So she decided to protect herself by using injections: “... I got scared of getting pregnant at that time when there are problems. So I decided to use injectable contraceptives until the problem was over. Because it reached a point that he threatened to get a divorce, so what would have happened if he divorced me while I was pregnant?”

The consequences for women using FP methods in secret were described as very severe. Both men and women, users and non-users, said that if a woman was caught using contraceptives secretly a husband would warn, beat, or divorce her. Most believed that a decision like that should not be made without involving the husband, and that if the husband refused, his decision should be obeyed. Many also said that using contraceptives secretly would create mistrust and cause a husband to think his wife is doing other things in secret, such as having an affair. A man in a Dar es Salaam focus group described his own experience: “My wife was using the pill in

secret and it took me a very long time to find out. It was after not having a baby for a long time that I discovered it. To be honest, I kicked her out of the house. ... It was very hard.” Speaking hypothetically, another man said, “I think the marriage would end because [it would mean] she was not faithful.” A woman in a Dar es Salaam focus group said, “If he discovers it, you will see that your bags have been thrown out and your divorce papers are on the table. If he discovers it at night, then the beatings will start, and at 5:00 in the morning you will be kicked out.”

DISCUSSION AND CONCLUSIONS

The study identified a combination of gender norms and other factors that function as barriers to the use of modern contraceptives in Tanzania. Many of the gender norm barriers in Table 2 (above) function as barriers only in combination with other factors. For example, the three items under “Sex” discourage FP only insofar as men lack the knowledge and motivation to practice it and women cannot decide by themselves to use contraception nor confine sexual intercourse to days when they are not fertile (although a significant number were using the calendar method). Similarly, men’s dominance in decision-making is a barrier to contraceptive use only insofar as men want large families (only a few wanted very large families, though others said they wanted as many as four or five children) or are against contraceptive use for another reason. In several cases, men imposed contraceptive use on their wives rather than blocked its use.

Oyediran et al. (2006) found that significant proportions of study participants in Nigeria reported couple communication on RH issues and concluded that this was a sign of an emerging egalitarian society where equity and respect are becoming norms. However, in our study, while nearly all men and women discussed FP, gender inequity was still evident in FP decision-making, where the final decision was left to the man. Our findings suggest that couple communication alone is not enough to determine that relationships are equitable; equitable discussions and decision-making might be more meaningful indicators.

Most of the male non-users we interviewed were against contraception because they were misinformed about its side effects and feared it would harm their wives. Because FP was considered a woman’s domain, men rarely sought FP information from reputable sources. However, the women seemed to harbor similar misconceptions and fears about side effects. Sexual jealousy also discouraged contraceptive use, and the threat of conflict and violence discouraged women who wanted to space or limit their pregnancies from taking a stronger stand. Participants mentioned these factors, but in hypothetical contexts or with reference to other people. It should be noted as well that the gender norm facilitators of FP that we identified in the study (bottom of Table 2) do not always function as such. For example, while men’s role in looking after the welfare of the family and the health of their wives was mentioned in virtually every interview, in many cases this translated into opposition to FP based on exaggerated fears about side effects, rather than into support for FP, as one might expect.

Thus, on balance, despite ample evidence of gender inequality and gender norms that were potential barriers to the use of contraception, fears and misconceptions about side effects appeared to be more powerful deterrents to contraceptive use than non-egalitarian gender norms. As Table 3 illustrates, in this relatively small sample, women on the whole were somewhat more motivated to practice family FP than men were, but not overwhelmingly so (a difference of three cases). As we did not interview couples, half of the cases in the table reflect men’s accounts of

their wives' family size desires and preferences about whether to use contraception, which might be questionable. (The other half reflects women's accounts of their husbands' preferences.)

There seemed to be only small differences between users and non-users with respect to their fears and misconceptions about contraceptive methods, but the small differences were decisive. To users, the benefits of being able to space their children apparently outweighed the risks of side effects, and after trying one method and finding minimal problems with side effects, they continued to use contraceptives.

RECOMMENDATIONS FOR COMMUNICATORS

In conclusion, the findings from this study underscore the importance of addressing factors related to both gender and to misinformation and exaggerated fears about modern contraceptive methods in the design of communications interventions. FP messages and interventions should engage both men and women and encourage equitable decision-making. Men should be encouraged both to seek information about modern contraceptive methods from reliable sources and to encourage their wives or partners to do so. In addition, the capacity of clinics and other sources of contraception to provide accurate information might need to be strengthened.

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