Reproductive health care in Tanzania

Introduction
Tanzania is located on the eastern coast of Africa between the tropics, and comprises the mainland and Zanzibar Island, the latter having two parts, Unguja and Pemba. In common with many other developing countries, Tanzania is faced by multiple social and economic problems, including rapid population growth. The Bureau of Census estimates that by 2025, Tanzania’s population will increase by approximately 60%. Unfortunately this change is not matched by economic growth.

Although the population growth report states that between 1990 and 2005 the fertility rate (i.e. the average number of children that a woman gives birth to in her lifetime) has dropped from 6.5 to 5.3, it is still high given the resource-poor setting. The Reproductive and Child Health Department of the Ministry of Health has made great efforts to ensure family planning and child health services are available, accessible and affordable to all areas including the underserved communities. Through the national family planning programme, the Ministry of Health has worked closely with international organisations and non-governmental organisations such as EngenderHealth and other faith-based organisations. These efforts have proved effective. The C of contraceptive use increased from 10% in 1991 to 25% in 2004. However, progress is considered to be slow when compared with neighbouring countries like Kenya and Zimbabwe.

The commonly used contraceptive methods in Tanzania are oral contraceptives and injectables. There is very low use of permanent surgical methods, especially vasectomy, and other methods like spermicides. Many factors could be contributing to this scenario, including inadequate dissemination of information to clients, unavailability of the service, and unskilled personnel. The following three recently published articles describe some of the challenges of reproductive health care provision in Tanzania.

Knowledge, attitude and acceptability of spermicidal contraception among university students in Dar es Salaam, Tanzania.


Mwambete and Mogasa report on a study that aimed to increase knowledge, attitude and acceptability of spermicidal contraception amongst university students in Dar es Salaam. This topic is very important since spermicides are a key method of contraception (oral and injectable forms of contraception are the most popular methods). Furthermore, some of the spermicides such as nonoxynol-9 (N-9) are said to have a dual action of contraception, also killing sperm. There were obtained from this small, qualitative study cannot be generalised to other settings. It would also be interesting to ascertain views about acceptability of venous thromboembolism among men and women who are neither potential, nor actual, sterilisation clients.

Knowledge, attitude and acceptability of venous thromboembolism among university students in Dar es Salaam, Tanzania.


Hattori and Larsen assessed the effect of a premarital first birth on entrance into a first union in the Moshi urban area of Tanzania. The data were obtained from the Moshi Household Infertility Survey of 2002–2003, in which 199 women in the reproductive age group of 20–44 years were interviewed. Noted previously that there has been an increase in age at first union in sub-Saharan Africa. Many studies have shown that the high level of education and urbanisation could be contributing factors. Women from such backgrounds delay making a marriage commitment. However, there is concern that the increase in age at first union may result in a high rate of maternal mortality, as many of these women do not practise abstinence, nor do they use family planning methods, and at the same time abortion services are still illegal in most African countries. The authors found that women who spent less than a year as single mothers were significantly more likely than childless women to enter into a first union, although the magnitude of this association was weaker for more recent cohorts.

Risk factors for arterial and venous thrombosis


Smoking increases the risk of venous thrombosis and acts synergistically with oral contraceptive use. Pomp ER, Rosendaal FR, Doggen CJM. Am J Hematol 2008; 83: 97–102

It has generally been held that the risk factors for arterial and venous thrombosis (VTE) are different, though in recent years it has been recognised that obesity is an important risk factor for both conditions. Three papers have recently been published from a systematic review/meta-analysis (Agno et al., 2008), and a large case control study (Pomp et al., 2007, 2008), which suggest that smoking, hypertension and diabetes (as well as obesity) are significantly associated with VTE. Although the design of the case-control study has flaws, if anything, these might diminish the magnitude of the effects seen. The researchers found that smokers who did not take the pill were at twice the risk of VTE of non-smoking, non-pill users, while smokers who took the pill had eight times the risk (odd ratio (OR) 8.79, 95% CI 5.73–13.49), suggesting a synergistic relationship between the two. Women with a body mass index (BMI) >30 who took the pill had an OR of 23.78 (95% CI 13.35–42.34) for VTE, while those with a BMI >50 who did not take the pill had an OR of 3.04 (95% CI 1.66–5.57). Apart from the prescribing implications, the findings are of interest when looking at other studies of the pill and VTE, which have often not controlled for these factors. In addition, it highlights the potential for prescriber bias in studies prior to 1995, since it was a widely held view that third-generation pills would be safer for those with arterial risk.