Zanzibar, Tanzania is a predominantly Muslim, semi-autonomous, archipelago region, home to approximately one million people. In the region, maternal mortality is high, and the risks of complications in pregnancy, both wanted and unwanted, are significant. The social and financial costs of unwanted pregnancy burden all members of families, but most especially women. In Zanzibar few people use modern methods of contraception, despite the fact that many women (and men) wish to have smaller family sizes. To date there is almost no research about contraception in this region. We carried out a study in Zanzibar to learn what Zanibaris think about contraception and the consequences of unwanted pregnancy. We also disseminated research findings to in-country advocates, policy-makers and reproductive health practitioners.

Our research included group discussions with men and women in five communities, interviews of health care providers and other key community leaders, interviews with women who have had abortions, and hospital-based interviews with patients who came to the hospital for care after terminating a pregnancy or having a miscarriage.

Why do many Zanzibari women not adopt the available, highly effective, and affordable contraception methods, despite wanting to space or limit their births? We found that there were many barriers to contraceptive use for married women. These included, for example, many men having a desire for a large family; the belief that God (not people) should determine family size; widespread misconceptions of contraception’s consequences (such as infertility, cancer, and intolerable side-effects); tension between men and women over who should be responsible for reproductive decisions; and worries that contraceptive use would encourage women to have extra- and premarital sex. Men and religious leaders have little knowledge about contraceptive use even though they hold significant decision-making power about it.

For unmarried women in Zanzibar, using contraception can have several negative consequences. First, to access contraception is to admit sexual intercourse, which is not socially acceptable for unmarried women. Unmarried women thus fear hostility from providers, and hiding sexual intercourse precludes choosing contraception. These women have the same fears about side effects and future health problems that married women have.

While many Zanzibaris agree about avoiding pregnancy at certain times in life, women’s ability to use contraception is limited by norms around gender, sexuality and religion. To overcome fears about contraception’s health risks and side effects, men and women require high quality contraceptive counseling and positive examples of successful contraception use. To change social norms around contraception, dialogue about the safety and morality of contraception needs to include men and religious leaders. Many unmarried women expose themselves to possible bad consequences of pregnancy over certain bad consequences of using contraception. Until now, social norms against sexual intercourse among unmarried women have stifled discussion about contraceptive use in this group, and change in this arena represents the greatest challenge for policy makers and health care providers.

Upon completion of the research, we disseminated our findings to stakeholders, including the Zanzibar Ministry of Health, health care providers, and community-based organizations involved in family planning services in Zanzibar. This social science research provided data on the use, perceptions, and barriers to contraception use and the experiences and consequences of unwanted pregnancy in Zanzibar. These data are informing the development of programs to improve access to and use of contraception, thereby reducing unwanted pregnancy, abortion morbidity, and maternal mortality.