

“This is my own decision according to the situation of my life”:
Perceptions of fertility and contraceptive use in Zanzibar

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Abstract

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Zanzibar, a semi – autonomous part of Tanzania on the East African Coast, has tripled its population in the last fifty years and continues to experience high fertility and projected population growth. The high population growth is challenging the government’s poverty reduction efforts. The adoption of modern contraception in the population has been slow and contraceptive prevalence rate is still less than 15 % for modern methods. Unmet need for family planning is high at 35 % (TDHS, 2010). This study explores the dynamics of fertility and contraceptive use in Zanzibar. With this, it aims to increase understanding of social and contextual structures and how these are related to fertility decisions and contraceptive use. The study employs a qualitative methodology using in – depth interviews with individuals from various backgrounds. The study found that the practice of spacing births is seen as beneficial in Zanzibar, but the idea of limiting births is more controversial. Traditional methods of family planning are widely accepted, although practiced inconsistently. Health concerns and misinformation about modern contraceptives is the most common reason for non- use among informants. Perceptions of what constitutes healthy or harmful behavior are strongly influenced by religious beliefs and Islamic teachings and medical traditions. Islam acts as a facilitator for spacing births, but also for high fertility. Traditional pro- natalist cultural and religious identities are currently being challenged by social and economic change, such as urbanization and increased costs of raising children. Established gender and family norms contribute to the continued high fertility through limited economic participation among women, poor spousal communication about reproductive matters and men’s dominance in fertility decision- making. The findings suggest the need to strengthen the relationship between the public health services and the population. Dissemination of reproductive health information is necessary to address fear and misconceptions. Public health services can be utilized to a higher degree if existing points of delivery are used to promote family planning to a larger extent.

Keywords: Fertility, contraception, family planning services, gender, Islam, Tanzania.

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Care
BTL	Bi - Tubal Ligation
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
DANIDA	Danish International Development Assistance
EC	Emergency Contraception
FGM/C	Female Genital Mutilation/Cutting
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GDP	Gross Domestic Product
HIV	Human Immuno Deficiency Syndrome
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IRCHU	Integrated Reproductive and Child Health Unit
IUD	Intrauterine Device
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NGO	Non – Governmental Organization
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
POP	Progestin- Only Pill
RGoZ	Revolutionary Government of Zanzibar
STIs	Sexually Transmitted Infections
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
THDS	Tanzania Demographic and Health Survey
TRCHS	Tanzania Reproductive and Child Health Survey

UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	The World Health Organization
ZFPP	Zanzibar Family Planning Programme

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Figure 1: Map of Tanzania and Zanzibar



Source: THDS, 2010.

Table 1: Zanzibar Key Facts

Geographical Location	East African Coast, Indian Ocean
Land Area	2, 654 square kilometers
Population Density	530 per square kilometer
People	
Population	1.3 million
% Urban/Rural	39.6/60.4
Population Growth Rate	2.8
% Population < 15 years	38.1
Government	
Government	Republic
Key political events	1963: Independence from Britain 1964: Revolution and establishment of the People's Republic of Zanzibar 1964: Enters into union with Tanganyika and forms the United Republic of Tanzania
% Seats held by Women in National Parliament	30
Economy	
GDP per capita	557 USD
GDP Growth Rate 2005 - 2010	5.9
Main Industries	Agriculture, fishing, forestry, tourism
% Employed in Agricultural Work - Rural/Urban/Total	60/11/41
Social indicators	
Human Development Index Rank	152 (Tanzania)
% of Population Below National Poverty Line	44.41
Life Expectancy at Birth	57
Infant Mortality Rate (per 1000 live births)	54
Under 5 Mortality Rate (per 1000 live births)	73
Maternal Mortality Ratio (per 100 000 live births)	450 (facility- based)
Health Expenditure (% Government Budget)	5.3
% Births Attended by Skilled Health Personnel	53.6
% Girls 15- 19 That Have Started Childbearing	6
People Living With HIV/AIDS	<1%
Adult Literacy Rate – Male/Female	90.5/81.4
Median Completed Years of Schooling - Male/Female	8.1/7.7
% Households Without Toilets	24.9

Data compiled from: ILO, 2010; NBS, 2013a, 2013b; RGoZ, 2013; THDS, 2010; UNDP, 2010, 2013; UNICEF, 2012.

1.0 Introduction

In the last fifty years fertility declines have occurred in many parts of the developing world, including large parts of Asia, Latin America, the Middle East and North Africa, and in some countries in sub-Saharan Africa. Women in developing countries now have about 2.5 children on average as compared to about six in 1960. An important contributing factor to this fertility decline has been a steep increase in the proportion of women in the developing world who are using modern contraceptive methods. From the 1960s, this proportion has risen from less than 10 percent to around 55 percent (Cleland et al, 2006; Singh & Darroch, 2012). Family planning programs have played an important part in increasing the contraceptive prevalence rate in many countries (Cleland et al, 2006). Investment in family planning promotion has a range of potential benefits: reduced maternal and child mortality, reduced poverty, and contributing to environmental sustainability. The lives of women are impacted by contraception in terms of improved maternal health, but additionally it facilitates women's socio-economic participation, through better education and employment. (Cleland et al, 2006; UNFPA, 2012a; WHO, 2012;). It is estimated that women in high-fertility societies spend about 70 percent of their lives in childrearing, as compared to about 14 percent in low-fertility societies (WHO, 2012).

Despite the significant increase in contraceptive use, many women are still lacking access. Every year there are 80 million unintended pregnancies and 40 million abortions worldwide. An estimated 222 million women in the developing world have an unmet need for contraception (Singh & Darroch, 2012). It is estimated that if these women got access, this would lead to 54 million fewer unplanned pregnancies annually, 26 million fewer abortions, 79 000 fewer maternal deaths, and 1.1 million fewer infant deaths (UNFPA, 2012b).

Current fertility in sub-Saharan Africa is 5.1, the highest rate in the world (UNFPA, 2012a). The region has lower contraceptive use than any other, at 20 percent, and unmet need is at 25 percent. In sub-Saharan Africa alone, 58 million women have an unmet need for contraception, and in the region's 39 poorest countries, the number has increased since 2008 (UNFPA, 2012b). Some factors proposed to influence this are lower levels of development and governance, less education among women, less urbanization, as well as weaker family planning programs than in other regions (Lauro, 2011). Preferences for larger family sizes

families in sub-Saharan Africa than in other regions play a role, but as fertility intentions are decreasing, unequal access to contraception is being seen as increasingly important (UNFPA, 2012a).

This study explores the dynamics of fertility decisions and contraceptive use in a high – fertility context in Zanzibar, Tanzania.

1.1 Structure of the Thesis

The thesis consists of eight chapters including this introductory chapter. Chapter two reviews the literature and presents the rationale for the study and its objectives. Chapter three lays out theoretical positions and relevant concepts for the focus of the study. Chapter four describes background information on Zanzibar to provide the reader with the contextual setting in which the study was conducted. In chapter five the research design and methodology is explained. In chapter six, the findings of the study are presented. Chapter seven entails a discussion of the findings with consideration of theoretical concepts and previous studies. Concluding remarks are given in chapter eight.

1.2 Definition of Terms

The term *family planning* is defined by the World Health Organization (WHO) (2013a) as allowing people to attain their desired number of children and determine the spacing of pregnancies through use of contraceptive methods and the treatment of infertility. The focus of this thesis will be on contraceptive methods. In this thesis, I use the terms “family planning” and “contraception” interchangeably. Even so, it is important to note that contraceptive services and information are important not only for married couples, but also for sexually active unmarried individuals and couples.

Contraceptive methods are grouped as modern and traditional methods. Modern methods include oral contraceptives, implants, injectable contraceptives, intrauterine contraceptive devices, male and female condoms, male and female sterilization, lactational amenorrhea method and emergency contraceptives. Traditional methods include *coitus interruptus*/ withdrawal and fertility awareness methods (WHO, 2013a). Women of reproductive age (15 – 49) are considered as being *in need of contraception* if they are using contraceptives – modern or traditional – or are not using any method but are sexually active, fertile and want to delay or stop childbearing, regard a current pregnancy as unintended, or are experiencing post – partum amenorrhea after an unintended pregnancy (Singh & Darroch, 2012). Fertile, sexually

active women women who want to delay or stop childbearing but are not using contraception are considered to have an *unmet need for family planning* (WHO, 2014).

Family planning is an essential part of the broader framework of Sexual and Reproductive Health and Rights (SRHR). Reproductive health is defined in the 1994 International Conference on Population and Development (ICPD) Programme of Action as:

A state of complete physical, mental and social well – being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health care therefore implies that people are able to have a safe and satisfying sex life and that they have capability to reproduce and the freedom to decide if, when and how often to do so (§ 7.2).

Implicit in this is the right to family planning services and information and women’s right to health services which enable them to go safely through pregnancy and childbirth, with the best chance for the infant to be healthy (ICPD Programme of Action). Sexual and reproductive rights are encompassed in already recognized human rights. At the core of these rights are “the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health” (ICPD Programme of Action, § 7.3). In the ICPD framework reproductive health services should include family planning, antenatal, delivery and post- natal services, infertility treatment, post- abortion care, treatment of infections, appropriate education and information, prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS, prevention of violence against women, care for survivors and actions to eliminate practices that harm women such as female genital mutilation/cutting (FGM/C) (ICPD Programme of Action). Increasingly, this rights- based approach to sexual and reproductive health is being used. It has become so accepted that human rights are now seen by some as fundamental for the progress towards reaching the Millennium Development Goals (MDGs) (Cottingham et al, 2010).

2.0 Literature Review and Research Objective

Finding the research topic for this thesis was a process that developed through several months of reading and reviewing literature, reflecting on what I had learnt, and how it fit together with my own interests and learning objectives for the master thesis. From the beginning of the master program, I knew I wanted to do my research on a topic related to gender and sexual and reproductive health and rights. Narrowing the focus and identifying a research problem and context was a longer process. I first decided that I wanted to do my research in Tanzania. I have long been interested in adolescent sexual and reproductive health and in the first phase of reviewing literature I wanted to find a research problem related to adolescents and their use of and access to contraceptives. However, after reviewing the literature, as well as discussing with my supervisor and people working in this field in Tanzania, I concluded that this topic, at least in some parts of Tanzania, has been the focus of a number of studies (e.g. Dilger, 2003; Masatu et al, 2003; Rasch et al 2000; Remes et al, 2010; Silberschmidt & Rasch, 2001; Wight et al, 2006). It was at this point that I became interested in Zanzibar. I had reviewed several studies from Tanzania Mainland, but it seemed that little research had been carried out in Zanzibar. I therefore decided to further explore the literature about sexual and reproductive health in Zanzibar. In this process, I shifted my focus from adolescents to adults, as adolescent pregnancy is less frequent in Zanzibar.

The process of reading and reviewing literature has been an ongoing process throughout the preparation of and writing of this thesis. After data collection and through the course of analysis, I have continually searched and read literature as I identified new themes that I had not anticipated. This has been an important part of the analysis and write- up of this thesis.

2.1 Methods Applied in the Review

Several databases were searched for relevant research articles. The databases used were PubMed, Cochrane Library, CINAHL, Ingenta Connect, Anthro Source, EBSCO Host, Psychinfo and Google Scholar. In addition, Bibsys was searched for relevant books, doctoral and master thesis's. Search words and combinations included "contraception", "family planning services", "abortion", "sexuality", "sexual behavior", "gender", "gender identity", "fertility", "Islam", "Africa", "East Africa", "Tanzania", "Zanzibar" and "developing countries". The reference lists of articles that were included in the review were also examined for further relevant material.

2.2 Organization of the Review

The literature review is organized in three parts: First, an introduction to the topic of family planning programs, second, a review of the current knowledge, existing gaps in the literature and rationale for this study. Finally, the objectives of the study will be presented. The literature on family planning is extensive, and reaches across continents and cultures. This literature review is therefore restricted to research that I consider relevant for the topic of this thesis, namely research focusing on fertility, reproductive decision- making, barriers to contraceptive use and family planning services. Further, the review is focused on research from Tanzania. In addition, some studies from other countries in sub- Saharan Africa are included for comparison. Both quantitative and qualitative studies are included in the review.

2.3 The Global Context of Family Planning Programs

The global family planning movement developed and expanded from the 1960s to 1990s. In the beginning, two distinctive streams or perspectives were prominent. One was the initial birth control movement mainly concerned with women's rights and focused on the individual woman's health and well – being, especially the right to avoid unwanted pregnancies and the negative outcomes associated with it. The other represented what has been referred to as neo-Malthusianism, as its foundation can be traced back to the writings of Thomas Malthus, who during the industrial revolution in Europe was concerned about the effects of rapid population growth and limited potential food production (Sinding, 2007). This second stream was less concerned with individual well - being but more with societies at large, and the primary concern was the rapid population growth in the developing world. Population control was seen as necessary to avoid hunger, unemployment, environmental destruction and political instability. This demographic rationale was dominant in the family planning programs in the 1960s and 70s (Seltzer, 2002; Sinding, 2007).

Eventually, a view developed that contained both individual reproductive choice but at the same time supported government policies to reduce population growth (Sinding, 2007). This view was the background for the establishment of the Population Council and the International Planned Parenthood Federation in the 1950's. In the 1960's, development agencies got increasingly involved in funding family planning programs. The emphasis by economists that the rapid population growth was hindering economic development was important for this commitment (Seltzer, 2002). The first programs were launched in South

Asia and East Asia, but in South Asia the first years were disappointing with very limited reductions in fertility. However, the results in East Asia were promising. This sparked the debate on what causes fertility decline. Demographic theory emphasized the idea that large-scale socio-economic change is necessary to reduce fertility, while the public health field focused on the effectiveness of the programs (Sinding, 2007). At the 1974 Bucharest Conference on Population and Development the direction of programs was subject to heated debate. Even so, the plan of action that resulted from the conference emphasized a mixed approach of family planning programs in combination with other socio-economic investments that would reduce the desire for children (Sinding, 2007). Following Bucharest, most countries adopted voluntary family planning programs, and by 1990, reproductive change had been established throughout most Asian and Latin American countries, including some of the world's poorest nations such as Bangladesh and Nepal. There were also signs of a beginning fertility transition in Sub-Saharan Africa (Caldwell, 2002; Cleland et al, 2006). From 1960 to 1975, the number of developing countries with policies to support family planning rose from two to 74, and by 1996, the number was 116 (Cleland et al, 2006).

In some of the Asian countries, policies were criticized for being coercive. Women's health and human rights activists opposed such measures. In time a political shift in attitude occurred towards population policies and programs (Seltzer, 2002). The Cairo ICPD in 1994 presented a change in the international community's approach to family planning and reproductive health, from demographic targets to human rights (Cleland et al, 2006). The focus shifted from family planning to curb population growth, to family planning as a part of a range of reproductive health services and other measures to secure women's rights. The individual's freedom to make reproductive decisions was placed within a human rights framework (Glaser et al, 2006). However, after the ICPD, donor support for family planning has fallen. After the Cairo agenda of making reproductive health services accessible for all was not included in the final version of the MDGs, attention to the issue has diminished. Even though overall fertility in developing regions has dropped to less than three births per woman, these numbers conceal substantial regional differences. Significant challenges remain, most profoundly in Sub-Saharan Africa (Cleland, et al, 2006).

2.4 Family Planning in Sub- Saharan Africa

Sub- Saharan Africa has higher fertility and expected future population growth (2.5 percent per annum) than any other region of the world (Bongaarts and Casterline, 2012; Cleland et al, 2011). In the last half of the 20th century, fertility dropped from 5.7 births per woman to 2.4 in Asia, and from 5.9 to 2.3 births per woman in Latin America. In Sub- Saharan Africa, fertility remains high, at a rate that is higher than five births per woman in the period of 2005 – 2010, more than double the replacement level (UNFPA, 2012a). Sub- Saharan Africa further has the world's highest unmet need for contraception, estimated between 20 and 30 percent in 15 Sub- Saharan countries, and exceeding 30 percent in an additional 13 countries (Cleland et al, 2006). There are variations across the region. Fertility has declined and contraceptive use increased across most of Southern Africa, and in some countries in East Africa. However, in West and Central Africa the development has been slower (Cleland et al, 2011). Overall, the fertility decline in Sub- Saharan Africa has been substantially slower than in Asia and Latin America, and in several countries, the decline seems to have stalled at around five births per woman (Bongaarts & Casterline, 2012).

Sub- Saharan Africa has overall lower levels of development than Asia and Latin America, which is thought to influence fertility levels. Low educational level, poverty and high child mortality contributes to a desire for large families and consequently in high fertility. Rising mortality from the HIV epidemic may have played a role. Cultural resistance to family planning has also been emphasized. Additionally, governments in Sub- Saharan Africa have historically not prioritized family planning and the programs have not been as strong as in other regions (Bongaarts, 2008; 2011; Caldwell & Caldwell, 2002).

2.5 Previous Studies and Rationale for This Study

As we have seen, since the beginning of family planning programs, different explanations on what influences the continued high fertility and low contraceptive use in some countries have been proposed. Often, researchers are discussing demand- side factors, and supply- side factors. Examples of demand- side factors can be issues such as low demand for contraceptives as a result of high desired family sizes in the population, religious opposition, gender disparities and fears and misconceptions of modern contraceptives. Supply- side factors often refer to issues regarding the health care system, the availability of services, distance to a facility, the cost of contraceptives and the quality of care in the facilities,

including provider's interaction with clients. Both approaches suggest a variety of policies that may be implemented to achieve higher rates contraceptive use, from influencing socioeconomic variables such as education and wealth to service variables such as availability, quality and accessibility of services (Beegle, 1995). Previous studies in Tanzania and other sub-Saharan African countries have investigated both supply- and demand- side factors to address the challenges of increasing contraceptive use.

2.5.1 Supply – side factors

In Tanzania, Beegle (1995) and Madulo (1995) both found that distance to facilities was a barrier to contraceptive use. On the other hand, Mroz et al (1999) found that perceived quality of the facility had a significant impact on contraceptive use, while time, distance and individual perceptions of accessibility had only minor impact. Arends- Kuennig and Kessy (2007), using the Bruce (1990) framework for quality of care, found that two of the six elements had a statistically significant impact on contraceptive use, namely technical competence in providers and information given to clients. Although not statistically significant in quantitative analysis, qualitative results indicated that lack of privacy in clinics represented a barrier for some women.

Several studies of contraceptive providers suggest that their attitudes are important for the access to contraceptives. In a survey of health workers on safe- sex counseling, perceived norms and attitudes towards counseling and self-efficacy were found to be strongly associated with whether the health workers provided counseling or not (Ngamuo et al, 1995). Speizer et al (2000) found that health personnel often restricted access to contraceptives on the basis of age, marital status or parity. Non- evidence- based medical, moral or religious restrictions were used to justify these restrictions. Especially for young, unmarried women, these restrictions pose a significant barrier. Similar results have been seen in Zimbabwe (Langhaug et al, 2003), Kenya and Zambia (Warenius et al, 2006), Uganda (Nalwadda et al, 2011) and South Africa (Holt et al, 2012).

2.5.2 Demand- side factors

Madulo (1995) found that husband's objection to contraception, high demand for children and fear of side effects were the most common reasons for non- use among women who were informed of at least one method. Fear of side effects and misconceptions was also emphasized

by Arends-Kuenning & Kessy (2007) and Bunce (2007). Pronatalist cultural norms have often been seen as a barrier to contraceptive use in sub-Saharan Africa (e.g. Caldwell & Caldwell 1987), and previous research has suggested that the contextual environment plays an important role. Stephenson et al (2007) found that the level of community approval of family planning had a larger impact on contraceptive use than did a woman's perception of her partner's attitude. But pronatalist values can be adapted to changes in the environment. Contraceptive use in sub-Saharan Africa is known to be associated with increased wealth (Creanga et al, 2011). Hollos & Larsen (1997) found that acceptance of limiting family size was associated with increased wage labor, diminishing dependence on land and lineage relations and a strengthening of the bond between husband and wife. Spousal communication about family size and contraception was associated with contraceptive use.

Evidence suggests that improved status of women contributes to increased contraceptive use, declining fertility and better reproductive outcomes. Female educational attainment has been found to be positively associated with contraceptive use and lower fertility in Tanzania in several studies. Husband's education also increases contraceptive use, but the effect of female schooling is higher (Arends- Kuennig and Kessy, 2007; Beegle, 1994; Hollos & Larsen, 2004; Madulo, 1995). Furthermore, Larsen & Hollos (2003) found that increased gender equity within families, increased age at marriage and free partner choice contributed to lower fertility. Other researchers have demonstrated how gender roles and traditional understandings of male and female sexuality can limit women's autonomy in sexual decision-making and reproductive matters and contribute to exposure to risks of unintended pregnancies and sexually transmitted diseases (Dilger, 2003; Mwanga et al, 2011; Wamoyi et al, 2010; Wight et al, 2006; Silverschmidt & Rasch, 2001).

Although Zanzibar has both lower contraceptive use and higher unmet need for family planning than Mainland Tanzania, the literature search identified few studies concerned with sexuality, fertility or contraception in Zanzibar. Beckman (2010) explored perceptions of sexuality in Zanzibar and how they relate to Islamic beliefs, but did not focus on family planning. Keele, Forste & Flake (2005), focused on cultural and religious barriers to contraceptive use in one village in North Unguja. In their study, Islam was perceived as the major barrier to contraceptive use. However, in Tanzania as a whole, Muslim women are more likely to use contraceptives than their Christian counterparts (Agadjanian et al, 2009; Clements & Madise, 2004). Some authors have suggested that both people and religious

leaders have a pragmatic approach to the issue (Keefe, 2006; Beckmann, 2010). Others have argued that the influence of religion on fertility and contraceptive use must be seen against the background of the social - political and economic context (Johnson- Hanks, 2006; Hughes, 2011; Obermeyer, 1994). Experience from Islamic countries with successful family planning programs, such as Iran, Tunisia, Morocco, Egypt, Turkey, Indonesia and Bangladesh among others, suggest that the effect of Islam on fertility is not linear. This indicates that cultural and religious barriers alone cannot sufficiently explain the reasons behind the continued low contraceptive use in Zanzibar. Increased understanding of the dynamics behind fertility decisions and contraceptive use in this context may be relevant also for other high- fertility countries in sub- Saharan Africa and elsewhere.

2.6 Research Objectives

Based on the literature review and available reproductive health data, the research objectives for the study were:

2.6.1 Overall objective

- To explore perceptions of fertility and contraception among people in Zanzibar.

2.6.2 Specific objectives

- To explore perceptions on use of contraceptives and access to contraceptive information and services.
- To increase understanding of how cultural and social norms relate to people's perceptions of fertility and contraception.
- To investigate possible barriers to increased contraceptive use.

The research process was guided by the literature review, but also by theoretical concepts that were seen as relating directly to the topic that was being investigated. The theoretical concepts and positions that informed the research design, data collection and analysis will be discussed in the following chapter.

3.0 Theoretical Position and Concepts

3.1 Determinants of Fertility and Theories of Fertility Decline

The fertility declines that have taken place in Asia, Latin America and in some parts of Africa in recent times have been the subject of numerous surveys and censuses, and the numbers are not disputed. However, what causes fertility decline has been an ongoing debate for decades and is still being discussed. In 1953, Frank Notestein formulated one of the most influential statements of what has become known as classical demographic transitional theory.

Traditionally, demographic theory has seen high fertility in low – income societies in the early stages of fertility transition as a consequence of high desired family size. A large number of children are needed to help the families in agriculture, and for security in old age. The high child mortality makes couples have more children to protect against future loss or to replace loss. Fertility decline occurs parallel to socioeconomic development such as rising levels of urbanization and education, bigger secondary and tertiary sectors, and declining mortality. Socioeconomic development leads to a decline in the benefits of children and an increase in their costs. These changes cause couples to prefer smaller families. To realize this, they rely on contraception or abortion, and family planning programs in many countries accelerate the uptake of contraception. The cost- benefit ratio of children and its effect on fertility decision- making has been central to the most influential interpretations of fertility decline, those by Richard Easterlin and John Caldwell (Bongaarts and Watkins, 1996; Bongaarts, 2005; 2008; Bongaarts & Casterline, 2012).

This view has been criticized by researchers pointing to evidence from countries experiencing fertility decline at different levels of development. In this context, the diffusion of information about contraceptive methods is seen as an important factor. However, the inverse correlation between development indicators and fertility is plausible and supported by much evidence (Bongaarts & Watkins, 1996). Bongaarts and Watkins (1996) argued that in addition to diffusion of ideas, social interaction is an important factor that should be considered in theories of fertility decline. They proposed that development alone is not sufficient to explain “observed variations in the timing of the onset of transitions or in variations in their pace, and that social interaction should be taken into account” (p. 669). Caldwell (2002) responded to this by arguing that in countries that started their fertility decline with a Human Development Index below 0.45 (Bangladesh, Egypt, India, Indonesia, Morocco, Tunisia and Turkey), a strong national family planning program was already in place. In the countries that

experienced fertility decline with less effort from governments, the index was already higher (Hong Kong, Malaysia, Mauritius, Phillipines, Singapore, Sri Lanka, Thailand and all of Latin America) (Caldwell & Caldwell, 2002). Women's educational attainment is another socioeconomic variable that greatly influences fertility. Some of the effect can be explained by higher rates of urbanization, higher income, and husband's education, but even after adjusting for these variables, the effect of women's education is significant, and greater than the effect of the husband's education or the family's income (Bongaarts, 2003).

Other factors that influence fertility levels are the "proximate determinants of fertility", of which use of contraception is seen as the most important (Mturi & Hinde, 2001). Bongaarts (2005) argued that fertility can only decline if a vast majority of the population adopts modern contraception. In pre- transitional societies, fertility is high and deliberate use of contraceptives to limit family size is low. At the end of the transition, fertility is low and the large majority of couples practice contraception. Other proximate determinants are the proportions married in the population, contraceptive effectiveness, abortion incidence, postpartum insusceptibility, and frequency of sexual intercourse. In the process of the fertility transition, changes in some of these determinants such as increased marital age will lower fertility, while others such as decreased duration of postpartum insusceptibility will have positive effects (Mturi & Hinde, 2001). However, the effect of these changes is usually relatively small when compared to the effects of increased contraceptive use (Bongaarts, 2005). The framework "ready, willing and able" refers to the conditions that need to be fulfilled for the population at large to adopt modern contraception. *Readyness* refers to the subjective need to space or cease childbearing. *Willingness* refers to a favorable attitude towards contraception and of certain contraceptive methods. *Ability* refers to having knowledge of contraceptive methods, where to locate them and having access to the supply source (Cleland et al, 2011).

3.2 Family Planning and Quality of Care

Bruce (1990) proposed a framework for assessing the quality of care in family planning which brought together the clinical and the subjective interpersonal dimensions of quality of care through six fundamental elements: choice of methods, information given to users, technical competence, interpersonal relations, follow- up or continuity mechanisms and appropriate constellation of services. These essentials of quality of care are thought to affect contraceptive

use. If clients are provided with a choice of methods and information about their side – effects in a comfortable environment, they will start using contraceptive methods and to continue to use them (Arends – Kuennig & Kessy, 2007). This framework has been used to study various aspects of the impact of quality of care in Tanzania (Arends- Kuennig & Kessy, 2007; Speizer & Bollen, 2000). Quality of care can also be considered in terms of human rights. Some organizations have used a set of rights for clients, including “receiving information, access to services, and choice, as well as safety, the right to privacy, confidentiality, maintenance of dignity, comfort, continuity, and expression of opinion.” (RamaRao & Mohanam, 2003, p. 228). In my study, I did not perform a systematic evaluation of the quality of care, but I used these frameworks in interviews as a way of guiding questions about family planning services, the needs of clients and providers and the way they relate to each other.

3.3 Gender and Power

The term *gender* refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. Gender is a social and cultural construct that differentiates women and men and their interactions with each other. The meaning of gender is culture-specific, and varies significantly from culture to culture. But there is a clear pattern across cultures that women and men have different roles, access to resources such as income, land and education, as well as decision- making authority. Men are typically seen as responsible for the productive activities outside the home, while the reproductive and productive activities at home are seen as the woman’s domain (Gupta, 2000). Following Helman (2007), *gender* is understood as the combination of the genetic, somatic, psychological and social gender of a person. Of all these aspects of gender identity, social gender is the most plastic, and the most influenced by the socio- cultural environment. Boys and girls are raised differently to suit the social dichotomy of “male” and “female”. They learn to have distinguished expectations of life, their emotional and mental development is differentiated, and their behavior and dress are governed by the customs of their surroundings. Cultural guidelines convey the appropriate self- image, feelings, thoughts and behavior for males or females in that society. The individual adopts these guidelines from an early age. These separated guidelines within a society can be understood as the *gender culture* of that society (Helman, 2007).

Kabeer (2005, p. 13) defines *power* as “the ability to make choices”. Disempowerment means being denied making choices, while empowerment means that someone who has been denied the ability to make choices, acquires this ability. After the ICPD, there has been a growing understanding of how gender inequalities restrict women’s decision-making power in family planning matters, as well as their ability to communicate with their partners about it (Do & Kurimoto, 2012).

In the theory of gender and power, presented in Raewyn Connell’s 1987 book by the same name, three major structures are emphasized as characteristics of the gendered relationships between women and men; the sexual division of labor, the sexual division of power and the structure of cathexis. These social structures exist on both societal level, through the historical and socio-political environment, segregation of power and enforcement of social norms on the basis of gender, and on the institutional level, such as in schools, working life, families, relationships, religious institutions, in medicine and the media. The sexual division of labor refers to the prioritization of male education, the allocation of women and men to certain occupations, as well as the expectations on women to be responsible for unpaid caring work, all of which leads to economic dependence on men. Inequalities in power between men and women in society form the basis for abuse of authority and control in relationships. The term *cathexis* refers to how different social norms and characteristics are applied to men and women. It directs appropriate sexual behavior for women and men, and the connection of female sexuality to other social concerns, especially notions of moral and purity. This structure is also expressed through social norms as to how women and men should express their sexuality, and the restrictions and taboos imposed on female sexuality, such as virginity, monogamy and having sex only for the reason of having children (Connell, 1987; Wingood & DiClemente, 2000).

3.4 Definitions of Sexuality

WHO (2010, p. 4) defines sexuality as:

A core human dimension that includes sex, gender, sexual identity and orientation, eroticism, attachment and reproduction, and is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, practices, roles and relationships. Sexuality is the result of the interplay of biological, psychological, socio-economic, cultural, ethical, and religious/spiritual factors.

Sexuality, and in particular how male and female sexuality is perceived, emerged as a significant theme during my work on this project. As the understanding of sexuality varies across cultures, it can be useful to clarify how the term “sexuality” is understood and used in this text. I take the position that sexuality is socially constructed and the way it is perceived and experienced is a result of individual’s social environment. Sexuality can be seen as “the social construction of a biological drive” (Gupta, 2000, p. 2). This social construction of sexuality is understood as a process “by which sexual thoughts, behaviors, and conditions (for instance, virginity) are interpreted and ascribed cultural meaning” (Dixon- Mueller, 1993, p. 275). This includes beliefs about the nature of the body, about what is considered to be sensual or offensive, and appropriate sexual actions and expressions for men and women. Sexuality is distinct from gender but is closely linked to it, through cultural notions of masculinity and femininity. People’s preferred sexual partners and practices, motivations and under which circumstances they engage in sexual activity and the results it produces, define their sexuality. Sexuality entails more than sexual behavior, and written and unwritten rules of society, according to gender, age, economic status, ethnicity and other factors, influence people’s sexuality (Dixon- Mueller, 1993; Gupta, 2000).

3.5 Power in Sexual Relationships

Gupta (2000, p. 2) refers to the components of sexuality as “the Ps of sexuality – practices, partners, pleasure/pressure/pain, and procreation”. The first two relate to behavior, while the latter refer to motivations. However, she sees an additional P of sexuality, namely *power*. Blanc (2001) explains the role of power in sexual relationships as the relative influence of one partner against the other, meaning the ability to act independently, dominate decision-making and to behave against the other’s wishes or to control the other’s behavior. Power can further be seen as the determining factor to how all the other components of sexuality are expressed and experienced. Power is hence a fundamental component of both sexuality and gender. Unequal power balance in gender relations that favor men, becomes unequal power balance in sexual relations, in which the male’s pleasure, preferences and wishes dominates the female’s (Gupta, 2000). Gender – based power relations can have direct influence on a woman’s ability to protect herself against unwanted sexual acts, unwanted pregnancies and sexually transmitted infections, as well as ability to acquire reproductive health information, ability to make health – related decisions, and the ability to protect or improve health (Dixon- Mueller, 1993; Blanc, 2001). An understanding of gender and sexuality as constructed by an

interaction of social, cultural and economic factors that determine the distribution of power, is therefore necessary for understanding sexual behavior, male or female (Gupta, 2000). As proposed by McDonald, “increased gender equity within families is not a sufficient condition for fertility transition; however, it is a necessary condition” (2000, p. 434).

3.6 Islamic Medical Traditions

Islamic medicine has roots back to the 7th century and was influenced by Greco- Roman, Chinese, Persian and Ayurvedic medical traditions. Other terms used to describe these healing traditions are Greco- Arabic medicine, *Unani tibb* (from *unani*, the Arabic word for Greek and *tibb*, the Arabic word for medicine) and *Tibb Nabawi* - “the medicine of the Prophet” (Al-Rawi and Fetters, 2012; Monette, 2012). Islamic medicine has been particularly influenced by the Hippocratic notion of the four humors and which was elaborated by Galen (130 – 200 AD), a Greek physician in Rome. In humoral theory, the body contains four liquids or humours: blood, phlegm, yellow bile and black bile. Health results from the optimal balance of these four humors, disease by an excess or deficiency in one of them. People’s personality types are determined by a dominance of one of the humors. Foods and medicines are classified according to degrees of heat, cold, moisture and dryness. In the 9th century, large parts of Galen’s work were translated into Arabic and this facilitated the spread of humoral theory into the Islamic world (Good, 1980; Helman, 2007; Monette, 2012). Al- Rawi and Fetters (2012, p. 165) define traditional Arabic and Islamic medicine as:

A system of healing practiced since antiquity in the Arab world within the context of religious influences of Islam and to be comprised of medicinal herbs, dietary practices, mind-body practices, spiritual healing and applied therapy whereby many of these elements reflect an enduring interconnectivity between Islamic medical and prophetic influences as well as regional healing practices emerging from specific geographical and cultural origins.

To treat illnesses, medicinal herbs are used in the form of teas, oils, infusions and syrups. One of the most commonly used herbs is the black seed, which is used to treat a variety of ailments across the Middle East and South East Asia. Dietary practices include using certain foods, such as honey, for their healing abilities. Fasting is also a part of these healing practices. It is seen as important for maintaining physical health and as rejuvenating the internal organs, as well as bringing spiritual rewards. Mind- body therapy includes prayer and chanting. Healers also use recital of the scriptures, in combination with a certain form of

breathing, to cure disease. Healers may also recite holy verses over certain foods or herbs, which are later consumed by the patient. Holy water from Mecca is seen as especially curative, but ordinary water can also be blessed through recital or immersion of Qur'anic verses into the water. Finally, healers apply various traditional methods such as massage, hydrotherapy and cupping (Adib, 2004; Al- Rawi and Fetter, 2012). Some Muslim historians and physicians separate between Islamic medicine and “the medicine of the Prophet”, which consists of a collection of *Hadiths* that relate to sickness, diet, hygiene and health. This prophetic medicine is regarded as credible solely because it is seen as originating from the Prophet Muhammad, and thus need no further explanation (Monette, 2012).

As laid out in this chapter, theory in this study has been used as a tool to consider fertility and contraceptive use in Zanzibar from a holistic perspective. The study takes the position that people's perceptions of fertility and contraception as well as their reproductive behaviors must be seen against the social, economic, religious and cultural context in which they take place. Theoretical concepts from different fields have thus been used, including public health, demography, sociology, anthropology and gender studies. The research process has not been guided by a singular theory and has not aimed to analyze the results against one such theory, but rather, concepts from different theories have been used to inform the research process and deepen the analysis. In the following chapter, an introduction to the socio- cultural and developmental context of Zanzibar will be given. This chapter aims to provide the reader with a background against which the findings can be viewed. This is also important in order to evaluate whether some of the findings of this study may be relevant in other, similar contexts.

4.0 The Context of Fertility and Contraceptive Use in Zanzibar

4.1 History

Zanzibar is located in the Indian Ocean, about 30 km off the coastline of Tanzania. It consists of two main islands, Unguja and Pemba, and a number of smaller islands. The land surface of Zanzibar is 2,654 square kilometers, and the size of Unguja is about the double of Pemba (RGoZ, 2009). It is assumed that the first people to settle in Zanzibar were Bantu-speaking Africans from the Mainland, but from early history there were immigration of Persians and Arabs. In the late 17th century, the Sultanate of Oman increased its influence on the East African coast and in the 1820s and 1830s effectively controlled the East African coast north of Mosambique. In 1840, Zanzibar became the political and economic center of the East African coast as Oman moved its capital from Muscat to Stone Town. In the 19th century, the Omani rule in Zanzibar benefited from an economic boom that was based on slave and ivory trade, as well as clove, palm tree and sugar cane plantations. In this period, Zanzibar became increasingly multi-cultural, as a result of immigration from Oman, India, Iran, other African countries and also Europeans. The influence of Arab culture was strong and it became common to adopt Arab ways of dressing as well as Arab names. In the late 19th century, it became a British protectorate. In this period, Zanzibar's economy declined, largely because of the gradual abolition of slavery that came as a result of international pressure (Loimeier, 2009).

In the 1950's, political mobilization increased and the call for independence became stronger. In 1963 Zanzibar regained its independence as a Sultanate, but just one month after independence, a revolution took place which became known as the Zanzibar Revolution. The Sultanate was overthrown, ending more 130 years of Omani rule. Zanzibar was renamed the "People's Republic of Zanzibar and Pemba". Quickly after, the new republic entered a union with Tanganyika, to form the United Republic of Tanzania (Loimeier, 2009). The ruling party merged with the dominant party on the Mainland and is now known as CCM (Chama cha Mapinduzi - Party of the Revolution). The new regime was influenced by socialism and started a process of nationalization of land and trade. The political line of the CCM eventually became known as *Umajaa* (African socialism) and was based on the idea of a "benign authoritarian state". The Union is still a controversial issue and is opposed by many Zanzibaris. The CCM regime is still in power, but in the last two decades it has moved ideologically towards Western neo-liberalism and has gradually opened up the economy.

Multi-party elections have been allowed since 1992, however the democratization process has been slow (Cameron, 2009).

4.2 Administration and legislation

Zanzibar retains its own president, revolutionary government and House of Representatives, as well as some ministries, including the Ministry of Health and Social Welfare. It is a semi-autonomous state, and the Zanzibari government is responsible for all matters on the islands that are not considered union matters in the constitution. These union matters mostly concern foreign affairs and security (RGoZ, 2009; LHRC, 2010). Zanzibar is divided into five administrative regions, three in Unguja and two in Pemba. In each region there are two districts, ten in total. Districts are divided into *Shehias*, which are the lowest public administrative structure (RGoZ, 2009). The ministerial structure is similar to that of Mainland Tanzania. Legislation is enacted through the House of Representatives. An important difference from legislation in the Mainland is that *Sharia* law is integrated into the legal system (UNICEF, 2012). The Islamic *Khadis* courts were originally responsible for jurisdiction regarding personal and family matters such as marriage, divorce and inheritance, but in 2003 their jurisdiction was expanded to all aspects of civil law (Bierwagen & Peter, 1989; Loimeier, 2009).

4.3 Religion and culture

Zanzibar is part of the Swahili (from the Arab word *sawahil*, meaning coast) culture of the East African coast. Zanzibari people have roots from many different countries, mainly from the Indian Ocean. Swahili culture has roots back to pre-Christian times when the people belonged to the northern Indian Ocean civilization. Historical accounts suggest that Islam came early to the East African coast through traders, and by year 1300, was common in the Indian Ocean. Thus the Swahili became more oriented towards the Middle East and India. Even today, the culture leans more towards oriental and oceanic cultures than those of continental Africa. Elements of this can be seen in food, dressing and popular culture such as the popularity of Hindi movies. Most Swahili, Somali and other African Muslims of eastern, central and southern Africa follow the *Shafii* school of Sunni Islam, and this is also the case for Zanzibar. There is also a minority of Shia followers, most of them are of Asian origin. East Africans of Omani descent usually belong to the *Ibadhi* group (Lodhi, 1994). Traditionally these groups have co-existed without tension. Zanzibar today is almost

exclusively Muslim (>95%), and Islam is inherent in the culture. Social norms and values in society are Islamic (Saleh, 2009). In the years after the revolution, religious activities in the public sphere were restricted, but since the 1980's the restrictions have been eased. Since then an Islamic revival has taken place, with more people learning Arabic, travelling to Medina, Khartoum and elsewhere, and a mushrooming of Islamic activities, such as schools, *madrassas*, health clinics, non- governmental organizations and various religious media, often funded by wealthy individuals from the Gulf (Turner, 2009).

4.4 Economy

Zanzibar's economy relies on agriculture, industry, trade and tourism. Agriculture, forestry and fishing employs about 40 percent of the population and accounts for about one quarter of the GDP, while tourism accounts for about half. In the 2005- 2010 period, the average growth rate was 5.9, but the country has been struggling with inflation and state debt (ILO, 2010). Poverty rates for Zanzibar have been calculated by using two separate measures of poverty: the basic needs poverty line and the food poverty line. The food poverty line is measures as the minimum expenditure required for meeting the calorific needs of an adult over a period of one month. It is based on the food expenses of the poorest 50% of households. The basic needs poverty line includes the funds needed for food plus other essential costs such as clothing and housing. It is calculated based on the food poverty line by looking at the proportion of food expenses for the 25% poorest of the population. The food and basic needs poverty lines in Zanzibar were calculated at around 12, 500 and 20, 000 Tanzania Shilling, respectively (ILO, 2010). Despite the economic growth, nearly half of the population lives below the basic needs poverty line and 13% below the food poverty line. Poverty is more frequent in rural areas compared to urban areas and on Pemba compared to Unguja. There is a relationship between educational attainment and poverty. The poorest households usually have more members with little or no formal education than the more affluent ones (UNICEF, 2012).

Table 2: Poverty in Zanzibar 2004 - 2005.

Poverty rate	Rural	Urban	Total
Food	15.9	8.9	13.2
Basic needs	54.6	40.5	49.1

Source: Adapted from ILO, 2010, p. 30.

4.5 Population and demography

The 49 least developed countries of the world, of which Tanzania is one, have the fastest growing populations in the world (UNDESA, 2013). Tanzania (including Tanzania Mainland and Zanzibar) has experienced high population growth over the last 50 years. The recent census from 2012 shows that the total population has more than tripled since 1967, from 12.3 million to 44.9 million in 2012. The annual growth rate for Tanzania Mainland is 2.7 and 2.8 percent for Zanzibar. With the current growth rate Tanzania will double its population in the next 26 years (UNFPA, 2013; NBS, 2012). Furthermore, the population is expected to increase five- fold by 2050 (UNDESA, 2013).

The population of Zanzibar has rapidly increased in the last 50 years (see Table 4) and is now about 1.3 million. It is a youthful population, with 38% below 15 years, and 42% between 15 and 35 years. About 45 percent of the population lives in the Urban West region, which includes Zanzibar Town. While Tanzania Mainland has a population density of 49 per square kilometers, Zanzibar has a population density of 530 per square kilometers (NBS, 2013). This makes Zanzibar one of the most densely populated states in Africa – other densely populated African countries such as Rwanda, Burundi and Nigeria, have population densities of 464, 384, and 185, respectively (World Bank, 2014). The average household size in Zanzibar is 5.1 and the sex ratio is 94 (NBS, 2013).

Table 3: Population Growth in Zanzibar 1967 - 2012.

Census	Population	Annual population growth
2012	1,303,569	2.8
2002	981,754	3.1
1988	640,675	3.0
1978	476,111	2.7
1967	354,815	-

Source: ILO, 2010; NBS, 2013.

4.6 Maternal and child health in Zanzibar

Significant progress has been made in recent years when it comes to child health and survival in Zanzibar. Under- five mortality has dropped to 73/1000; this can be largely attributed to a successful anti- malaria campaign. However, 40% of these deaths are neonatal. The rates of

malnutrition in children under five have decreased since the 1990s but remain high (UNICEF, 2012): 30% of Zanzibari children are stunted, which is lower than Mainland (42%), however Zanzibar has higher rates of wasting, 12 % compared to 4.6 % in Mainland (THDS 2010). The progress in maternal health has been slower. About 40% of pregnant women are anemic. Antenatal attendance is almost universal in Zanzibar (UNICEF, 2012), but according to the Ministry of Health and Social Welfare (RGoZ, 2005) only about 60 percent of women attending antenatal care are attended by trained personnel, the rest are attended by traditional birth attendants. Only about half of deliveries take place at a health facility, and skilled personnel attend about 53%. Maternal mortality ratio is estimated at 450, but this number includes only facility- based deliveries. Hemorrhage and hypertensive disease are the leading causes of institutional deaths. For surviving women, abortion is the leading cause of complications (UNICEF, 2012). Although the incidence of clandestine abortion is assumingly underreported in national surveys, hospital- based studies have found that the majority of women presenting with a miscarriage has had an unsafe induced abortion. In hospitals in Zanzibar, abortion complications are listed as one of top five reasons for admission (Rasch & Kipingili, 2009). The rate for post- natal check- ups has increased in recent years, but is still low at 32% (UNICEF; 2012).

4.7 Fertility and contraceptive use in Zanzibar

The total fertility rate (TFR) is high, at 5.1 in Zanzibar. The fertility rate is slightly lower than in Tanzania Mainland, which has a TFR of 5.5. Fertility varies between Unguja and Pemba, with TFR 4.6 and 6.4, respectively (THDS, 2010). Adolescent fertility has decreased over the last decade and is now at 6% (UNICEF, 2012). The majority of women in Zanzibar still want a large family, and the mean ideal number of children among women in Zanzibar in 2010 was 6.6. The contraceptive prevalence rate in Zanzibar is very low. In 2010, only 12.4 of married women were using a modern contraceptive method, less than half the rate for Mainland Tanzania (27.8). There is great variation between the regions (Table 3). Women in Mainland are more likely to stop childbearing than women in Zanzibar. Women in Zanzibar have a higher unmet need for family planning (35 percent) than women in Mainland (25 percent) (THDS 2010).

Table 4: Contraceptive use in Zanzibar by region.

	Any method	Any modern method
Zanzibar	18.4	12.4
Unguja	23.6	14.9
Unguja North	11.4	7.4
Town West	26.3	14.7
Unguja South	33.1	28.1
Pemba	9.2	8.1
Pemba North	7.1	6.6
Pemba South	11.1	9.4

Source: THDS 2010.

4.8 Health service delivery

Zanzibar's public health service infrastructure is organized in three levels of care. At the primary level are the Primary Health Care Units (PHCUs). Each PHCU is meant to serve 3,000 to 5,000 people. PHCU's are divided into two types; PHCU – 1 are meant to provide basic outpatient services, such as management of common diseases and injuries, maternal and child health services and family planning. PHCU – 2 provide the same services, but in addition they manage normal deliveries, basic laboratory services and dental care. At the secondary level are the Primary Health Care Centers, also called cottage hospitals. These serve as referral points in areas far from hospitals. They provide inpatient medical and basic surgical treatment, including cesarean sections. There are four Primary Health Care Centers in Zanzibar, two on Unguja and two on Pemba. On the tertiary level, there are two referral hospitals, one on Unguja and one on Pemba. Unguja also has a psychiatric hospital and a maternity hospital. There are also three private hospitals on Unguja and a number of private pharmacies (RGoZ, 2005; 2009). The geographical coverage of health facilities for primary health care is considered good, 95% of the population live less than five kilometers from a health facility (RGoZ, 2009). In a previous survey, about 5% of respondents stated that they had failed to seek medical attention due to the cost or distance to the facility (ILO, 2010). However, lack of equipment and qualified staff continue to challenge the ability of the health system to provide adequate services (RGoZ, 2009). As a region, Africa has 24% of the global burden of disease, but only 3% of health workers and spends less than 1% of world health expenditure. It is estimated that the health workforce in Africa needs to be increased by 140% to be able to deliver basic services such as obstetric care and immunization (WHO, 2006). Tanzania is the country in Africa with fewest physicians compared to the total population,

with only 0.008 physicians per 1000 population (WHO, 2014b). The number for Zanzibar is 0.05 per 1000 population (NBS, 2006), which is higher than Tanzania Mainland, but still lower than the median for the African region (WHO, 2014b). Assistant medical officers (AMOs) and clinical officers perform many of the functions of physicians (NBS, 2006). Nurses are the primary providers of contraception in Zanzibar. Many of these nurses are trained as maternal and child health nurses or public health nurses, which both are 2- year diploma courses where students specialize in maternal and child health, including midwifery.

4.9 Family planning programs in Zanzibar

Modern contraceptives were first introduced in Zanzibar in 1985 through the Family Planning Programme (ZFPP). The program is separate to that of Mainland Tanzania, as Zanzibar has its own Ministry of Health. From the start, family planning services were integrated as part of Maternal and Child Health (MCH) services. At the onset of the program, family planning services were available in six clinics only. From 1990 – 1995, family planning was integrated into existing MCH services and expanded its coverage from 70 clinics in 1990 to 104 in 1995. Today family planning services are available in all public health facilities, from primary health care units up to the referral hospital. The organizational structure of the program has changed several times, currently it is under the Integrated Reproductive and Child Health Unit (IRCH) in the Ministry of Health (RGoZ, 2002a; 2002b). Family planning programs in other Islamic countries, especially Indonesia, have influenced the program design. From the beginning, religious leaders were included in the development of the program, as part of an interdisciplinary advisory committee within the Ministry of Health. United Nations Population Fund (UNFPA) has been the main development partner for the program, and has supported clinic- and community- based service delivery, equipment and supplies, advocacy, capacity building and training. It has also provided technical assistance. Other development partners involved in different phases of the program have been WHO, UNICEF, GIZ, Danida and USAID (RGoZ, 2002a; 2002b). The program receives some funds from the Ministry of Health, but is still largely dependent on donor funding. However, donor support has been decreasing. The program is currently struggling with shortage of staff within the IRCH itself. Sufficient number of qualified providers, and supply of medicines and equipment also pose challenges. Another problem is the financial sustainability of the program if donors decide to phase out (MOHSW employee, personal communication 2013).

4.10 Strategic and policy environment

The Vision 2020, which was adopted in 2000, is the Zanzibari government's plan for socio-economic development. The overall goals are to eradicate absolute poverty by 2020 and to attain sustainable growth and development for all people in Zanzibar. In 2002 the government adopted the Zanzibar Poverty Reduction Plan (ZPRP), which was the strategic document for implementing the goals laid out in Vision 2020 and concurrently, the MDGs. The ZPRP was followed by the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP) in 2007, commonly known by its Swahili acronym of MKUZA I. MKUZA I was succeeded by MKUZA II, which covers the period 2010 – 2015 (RGoZ, 2010). Even so, MKUZA II represents a change from MKUZA I, where the association between poverty and population issues was not addressed (Oucho & Mtatifikolo, 2009). MKUZA II focuses on three clusters, which are growth and reduction of income poverty, well – being and social services, and good governance and national unity. MKUZA II explicitly states that the high population growth can undermine poverty reduction and economic growth, and that efforts should be made to stabilize the population growth at 2.8 percent by 2015. Zanzibar adopted its first Population Policy in 2002 but it has yet to be implemented (RGoZ, 2010).

Considering available development indicators, it seems a process of change is ongoing in Zanzibari society and economy. Urbanization has increased in recent years. Agriculture contributes less to the economy than before, and the service sector and industry is becoming more important. In the health sector, pronounced improvements have been seen on some health indicators, especially relating to child health. Progress in maternal health has been slower and in the area of family planning Zanzibar is lagging behind both Mainland Tanzania and other countries in the region. Family planning services have been integrated into primary health care and are accessible, but challenges remain in utilization of these services. The demographic composition of the population, with the majority being under 35, creates a high demand for job creation and puts a strain on the ability of the public sector to provide services such as education, healthcare and social protection. The healthcare system, including the provision of family planning services, is highly dependent on donor support. High population growth is impeding the government's poverty reduction strategies and the overall development of the Isles. Even so, it seems political commitment to address high fertility and population growth on policy level has so far been insufficient.

5.0 Methodology

5.1 Research Design

This study is concerned with the thoughts, opinions and lived experiences of people, their understanding of reality and how they make decisions related to fertility and reproductive health. Taking an interpretivist position, these decisions are seen as shaped by the social, economic and cultural context that people live in. Increasing understanding of this context is therefore important in order to understand health behavior. Based on this, a qualitative, explorative approach was chosen. As little previous research was available on the topic, a qualitative methodology was seen as fitting, because it allows the research process to be more flexible and adapting to new information emerging from the data, than what is possible in a quantitative design. As described in the literature, through the use of qualitative methods, the researcher aims to gain a holistic overview of the context that is being studied, and to see social phenomena from the viewpoint of people themselves (Miles & Huberman, 1994).

The content of this thesis is derived from interviews with contraceptive providers, clients in family planning clinics, and various individuals not connected with health services, hereafter referred to as community informants, which were conducted on Unguja Island, Zanzibar, in 2013.

5.2 Rationale for Choice of Method

The study used in- depth, semi- structured interviews as the method of data collection. The purpose of an interview is to get thorough and comprehensive information about how people perceive their life circumstances. The interview provides data about how participants understand experiences and events in their lives. The method gives an especially good opportunity to gain insight into experiences, thoughts and feelings (Thagaard, 2003; Kvale & Brinkmann, 2009).

Other qualitative methods were not used for data collection, although one could argue for their use. Thagaard (2003) points out that observation is especially suitable for studying the relationships between people. Observation is also frequently combined with interviews, as a way for the researcher to develop a deeper understanding of the environment in which the interviews are taking place. In the early preparation phase of this project, I was considering using observation as a way of supplementing the interviews. I was considering the possibility

of doing observation in family planning clinics, as well as places in the community such as religious events, weddings or perhaps simply social arenas where people meet. Although this might have given me additional insights, there would have been some methodological challenges with using observation for this study. In the case of family planning clinics, I would have had to observe without participating, as I could not take part in the activities of the clinic, either as a nurse or a patient. My presence in the clinic would surely have drawn a lot of attention and possibly have influenced the way people acted. For observation in the community, it is my perception that it requires more time than what was possible in this project to form relations with people in order for them to include you in their daily lives. Finally, the fact that I do not speak the local language would have made it difficult to collect meaningful information about this subject through observation. Living in a local village would also have been difficult due to security reasons.

Focus groups have been widely used in studies of fertility, family planning and HIV/AIDS as a way of exploring attitudes, and practices towards contraception in developing countries. Focus groups can provide an opportunity for marginalized groups to be heard, and can be useful when the researchers and the target group for an intervention have very different perspectives (Morgan, 1996). Morgan & Krueger (1993) argue that focus groups are especially suitable for investigating complex behaviors and motivations, due to the interaction in the group, and to look at the degree of consensus and diversity of opinions in a group. Focus groups and interviews have also frequently been combined. Focus groups can be used as a way of validating individual interviews, as a way of collecting many different opinions in a short amount of time, or individual interviews can be used subsequently to focus groups in order to further explore some of the concepts emerging from the focus group discussions (Morgan, 1996).

Even so, there were some issues that made me decide against using focus groups for this study. In Zanzibar, the topic of family planning and contraception is still considered a personal and sensitive subject. During our interviews at clinics we found that several women did not use their local clinics, but travelled to the neighboring clinic. It is possible that this was in order not to be recognized by other clients or by providers. Assuring the participants of the confidentiality of the interview would have been challenging with the use of focus groups. Some women might not have been comfortable sharing their views in front of others. Interviews allowed us to be more flexible and adapt to the needs of the informants.

5.3 Timeframe

The data collection for this study took place during 16 weeks in 2013, from June 25 and until October 15. Part of the fieldwork was conducted during the fasting month of Ramadan.

5.4 Research Assistant

At the beginning of the data collection period, a research assistant was hired to assist in interviews and transcription of interviews. The research assistant was recruited with the help of Zanzibar College of Health Sciences. The research assistant was a newly graduated nurse from the biggest urban area of Zanzibar, Zanzibar Town on Unguja Island. She had previous experience with the topic through a project she had done about family planning during her nursing studies, and had an expressed interest in the topic. The research assistant was trained before the interviews to attain a clear understanding of the aims of the study, and the particular characteristics of qualitative methodology and interviewing. We also rehearsed with role-plays before the actual interviews. In addition, two test interviews with family planning clients were conducted, which were not recorded, but used as a rehearsal to secure good interaction between the research assistant, the informants and myself. The research assistant functioned as English- Swahili translator, but also had a role in recruiting community informants and in further developing of interview guides through our close contact and cooperation during the process of data collection.

5.5 Study Site

The data collection took place on Unguja, which is the most developed of the islands of Zanzibar, and where the majority of the population lives. Originally it was planned to include participants from both Pemba and Unguja, in order to get a sample as diverse as possible. However, after arriving in Zanzibar and during the initial phase of data collection, it became clear that including informants from both islands would be outside the scope of this project. The process of getting access to informants was time-consuming because it required approval from all levels of public administration. Gaining access to informants also requires forming relationships through spending time in the community. Furthermore, collecting data in Pemba would require finding and training a second research assistant from Pemba. It was therefore decided to collect data on Unguja only.

Most of the informants in the study lived in or around the area of Zanzibar Town, the capital of Zanzibar. It is situated on the West Coast of the island, and has a large port that connects the island to Mainland Tanzania. The community where I recruited many of my informants, is

a typical suburb of Zanzibar Town. All houses in this area were one-story, built from stone and mud and with tin roofs. Floors were usually made of concrete. Because of a recent power line from Mainland Tanzania, more people now have access to electricity, and this was also the case in the homes I visited. Most houses did not have running water, but water could be fetched from public taps. Most people had pit latrines in their homes.

The traditional sources of income in Zanzibar have been fishing and agriculture, and they still are, in the rural areas. In the city, most people I talked to worked in the governmental sector, with tourism, various kinds of small businesses or were self-employed in manual labor. Unemployment was a problem, and many people described living from “hand-to-mouth”. Some participants were also recruited from a rural area in the Northern part of Unguja. The rural villages in Zanzibar resemble the suburban villages, however more people live from agriculture and fishing in the rural areas, the standard of housing is often simpler and the people generally have less education and lower income.

5.6 Sampling Strategy

As common in qualitative studies, the sampling strategy was purposive, and informants were recruited because they were believed to possess important information about the topic. When recruiting informants, we aimed for maximum variation, in terms of age, gender, socio-economic background, parity and contraceptive history. The informants had an age span from 17 - 89 years, they came from urban and rural areas, their education ranged from no schooling to bachelor level, and parity from 0 – 12 children. In the protocol it was laid out that the participants in the study would be adults over the age of 18. This was due to two main issues; teenage pregnancies are far less common in Zanzibar than in Mainland Tanzania and other countries in the region such as Uganda and Kenya. 6 % of girls in Zanzibar have begun childbearing by age 19, compared 23% in Mainland Tanzania. It can be argued that in this context, the low contraceptive use among adult, married women and women’s continued childbearing throughout the reproductive lifespan is a bigger threat to women’s health and social participation than teenage pregnancies. Also, the issue of adolescent sexuality is culturally taboo, and sexual relations outside of marriage is viewed as unacceptable. Interviewing unmarried adolescents, e.g. in schools, would most likely require more time, resources and manpower in order to get access to informants. On the basis of this, I decided that the study should focus on adults. Both married and unmarried individuals could be included, but in the end all informants except one man were either married or divorced.

During the course of fieldwork, one 17- year old woman was interviewed. I chose to interview her because I felt she could be viewed as an adult when it came to the topics that were being discussed. She was married, had one child and was living in a nuclear family with her husband. Therefore it was my assessment that she fit the profile that I was looking for. Before including her interview I informed the medical ethics committee in Zanzibar about this deviation from the protocol and asked for permission to include her in the study, which was granted.

Although the sample was pre- specified, the sample composition evolved through the course of the fieldwork. Prior to the fieldwork, I had a focus on the health services and had planned to recruit participants mainly from clinics, in the form of health workers and family planning clients. I was focusing on the quality of services and how the clients experienced their interaction with providers. I had read several studies from Sub- Saharan Africa and developing countries that focused on the poor infrastructure of health services, the difficulty of accessing the clinics due to distance or transportation cost and the poor quality of services if women managed to get to a clinic. When I was preparing the project, I was expecting the situation in Zanzibar to be similar. However, when I arrived in Zanzibar and I interviewed the first health workers and clients, I got a different impression. According to the Ministry of Health and Social Welfare, more than 95% of people in Zanzibar live less than 5 kilometers from a facility. The infrastructure seemed fairly good for a low- income country such as Zanzibar. The geographical accessibility of services did not seem to be the most pressing issue. The services are free, thanks to joint efforts by the Zanzibari government and their development partners. The clients that I interviewed, while raising some important issues of concern, still seemed fairly content with the services that they got. I got the impression that the health services could only partly explain why contraceptive use in Zanzibar is still so low. It seemed clear to me that I would need to speak to the non- users as well. Thus, a larger number of people who had no experience with contraception or family planning services were included in the sample than what was originally planned.

5.7 Recruitment of Informants

Recruitment of participants took place through different channels. Contraceptive providers were recruited from three different health facilities: one primary health care clinic in a suburban community on the outskirts of Zanzibar Town, one hospital in North Unguja, and one hospital in Zanzibar Town. All providers who were asked agreed to participate. Clients

were recruited from the PHCU and the hospital in Zanzibar Town. In the hospital, clients were recruited by the research assistant and myself in the waiting area, as the family planning services are provided in a specialized clinic and so all the women in the waiting area were there to receive family planning services. In the PHCU, clients were recruited with the help of health providers. This was done for increased privacy of the women, as family planning clients and other patients share the waiting area. Providers therefore assisted us by asking women who came for family planning services if they would be willing to speak to us, while they were in the private room used for consultation. Providers were not involved in giving information about the study or obtaining informed consent. This was important to secure that women were not feeling pressured to participate. Providers only told the women that there was a research team conducting a study, and asked if they would be willing to speak with us. All clients who were asked except one agreed to be interviewed.

The system in Zanzibar requires the approval of the regional administrative office, as well as the community leader (*Sheha*) before entering any village. Getting access to these leaders can be difficult, especially for women, which normally need the help of a man to get a meeting with the Sheha. Even with the approval of the Sheha, approaching unknown people and asking them if they are willing to participate in an interview about family planning is difficult as this topic is still sensitive in Zanzibar. The aim of recruiting community informants was to obtain information from non- users as well as users, which we had the opportunity to recruit from clinics, but it would have been difficult to recruit non- users by approaching unknown households, and some may have seen this as inappropriate. It was therefore decided to recruit informants from the community where my research assistant was living. As she was familiar with the community and local Sheha, this was seen as a good way of getting access to the community and possible informants. The research assistant thus suggested the first two informants. As these first informants were acquainted with the research assistant, it is a risk that this may have affected their answers in the interviews. It is possible that they thus would give answers which they perceived to be in line with community norms and that they may have withheld some information. However, the great variety in their attitudes suggests that this was not a major issue. Consequently, snowball sampling was used to recruit other informants. We aimed at including an even number of men and women, however, being two female researchers made the recruitment of men somewhat complicated and as a result there is a majority of women in the sample.

Originally we had planned to recruit community informants from different parts of Unguja, in order to achieve a sample as diverse as possible. But due to the time limitations of the project, and the time-consuming processes of getting access to the villages, we found it more feasible to focus on recruiting participants from the area where we already had access, and where we had informants who were interested in the project and helped us with recruitment. However, we made sure to recruit informants with different characteristics. Additionally, some of the community participants were recruited from the cottage hospital in north Unguja. Overall, most people who were invited to participate agreed. Only three people refused.

5.8 Sample Characteristics

5.8.1 Family planning providers and other health professionals

This group of informants was recruited from three different health facilities and included public health nurses, nurse-midwives and one clinical officer. They all had several years of experience, ranging from three to thirty years. All providers were Muslim. In this group were also two employees of the Zanzibar Ministry of Health and Social Welfare, as well as one volunteer from an NGO that is promoting sexual and reproductive health. The interviews with the ministry employees and the NGO volunteer were used primarily for background information and the transcripts of their interviews were not used in the analysis of findings.

5.8.2 Family planning clients

The informants in this group were women of different ages, socio-economic status, and parity. All women were Muslim, married, and had at least 1 child. Most of the women were housewives, only one had work outside the home. These informants were recruited from the primary health care clinic and the referral hospital. Recruitment of clients from the cottage hospital was abandoned because the providers were reluctant to assist us in the recruitment.

5.8.3 Community informants

This group includes women and men of different backgrounds, who were recruited independently of family planning services. They had different ages, educational level and occupations. Most of these informants came from areas in or around Zanzibar Town, but three came from rural areas. This group also includes three religious scholars and one community leader who were recruited because they were seen as having an influence on people's beliefs, opinions and behavior. Most of these informants were either currently married or divorced. Parity varied, ranging from one to twelve children. Only one male participant was still unmarried with no children. All participants except one were Muslims. Both non-users and

users of contraception were included, but most of the participants in this group were non-users.

Table 5: List of informants

Family planning providers and other health professionals					
Informant no.	Sex	Age	Education	Occupation	Religion
1	F	55	Post- secondary education	Public health nurse	Muslim
5	F	45	Post- secondary education	Public health nurse	Muslim
17	F	38	Completed Form III	Volunteer	Muslim
18	M	30	Post- secondary education	Clinical officer	Muslim
19	F	52	Post- secondary education	Public health nurse	Muslim
23	F	55	Post- secondary education	Nurse-midwife	Muslim
26	F	52	Post- secondary education	Public health nurse	Muslim
27	M	55	Post- secondary education	Governmental employee	Muslim
28	M	30	Post- secondary education	Governmental employee	Muslim
Family planning clients					
Informant no.	Sex	Age	Education	Occupation	Religion
6	F	17	Completed Form II	Housewife	Muslim
7	F	27	Completed Form II	Housewife	Muslim
8	F	32	Completed Form II	Housewife	Muslim
9	F	30	Completed primary school	Works in family business	Muslim
24	F	43	Completed secondary school	Housewife	Muslim
25	F	22	Completed secondary school	Housewife	Muslim
Community informants					
Informant no.	Sex	Age	Education	Occupation	Religion
2	M	69	Completed primary school	Community leader	Muslim
3	F	32	Completed secondary school	Self- employed	Muslim
4	M	32	Completed secondary school	Governmental employee	Muslim
10	F	27	Post- secondary education	Governmental employee	Muslim
11	F	40	Post- secondary education	Self- employed	Muslim
12	M	33	Post- secondary education	Employed in private sector	Christian
13	M	46	Completed secondary school	Religious scholar	Muslim
14	F	35	Completed Form II	Employed in private sector	Muslim
15	M	89	Completed secondary school	Religious scholar	Muslim
16	M	38	Completed secondary school	Religious scholar	Muslim
20	M	40	Completed secondary school	Self- employed	Muslim
21	M	27	Post- secondary education	Clinical officer	Muslim
22	F	60	No schooling	Housewife	Muslim

5.9 Interview Guides

The interview guides were developed based on the literature review and stated objectives. They were continually evaluated and revised throughout data collection. The first interview guides were prepared before the data collection started and contained a number of themes with open- ended questions and follow- up questions based on the objectives of the study and the previous literature review. However, after the first interviews these specific questions were used more as a guide as I found a less structured and more conversational form to be more useful. In most interviews, I used a theme guide with a few, open- ended questions and added follow- up questions and probes during the course of the interview according to the information that I got from the informant. This also allowed informants to express themselves more freely. I experienced that some of the themes that I had assumed to be important, seemed less important to the informants, and that other factors were deemed as more significant. The interviews were not standardized, and questions varied between different participants according to their responses and also new themes that occurred spontaneously during interviews.

In interviews with health professionals, the questions focused on health providers' interaction with clients, and their feelings and needs in relation to their work. Further, they were asked to share their opinions, based on their experiences, on why the contraceptive prevalence rate is still comparatively low in Zanzibar. Quality indicators from previous studies were used to develop questions, but adapted to suit the qualitative methodology. The interviews focused less on the technical aspects of quality of care, as I see these aspects to be difficult to evaluate systematically in a qualitative research design.

In interviews with non- health professionals, the interviews were centered around their perceptions of contraception, experiences with contraception and family planning services, reproductive decision- making, gender roles and expectations and various socio- economic, cultural and religious factors that are believed to influence contraceptive use.

5.10 Conducting the Interviews

All interviews were conducted with the research assistant present. All interviews except five were conducted in Swahili, as most people in Zanzibar have no or very basic command of English. I would usually formulate the questions, and hence be the one who guided the direction of the conversation. The research assistant translated the questions to the informants,

and then translated the answers back to me. Sometimes the research assistant asked questions independently, but in general she acted more as a translator during interviews. This was in part a conscious strategy, as the research assistant and myself come from very different backgrounds, and our different perspectives on the subject were reflected in the kind of questions asked. To make sure that the interviews produced information in line with the study's objectives, I found it better to take a leading role in interviews throughout the data collection period. Also, since the interviews concerned some topics that are seen as sensitive in the Zanzibari context, the research assistant expressed that she found it easier to act as a translator and thus avoiding asking the sensitive questions herself.

The interviews with health providers and clients all took place in health facilities. For these interviews, we were given a private room within the clinic where it was possible to conduct the interview undisturbed and maintain the confidentiality of the informants. For the community informants, most of the interviews took place in their homes, or in the research assistant's home. These interviews required a more flexible approach in order to get access to the participants. In two of these interviews, other family members were present, in a nearby room or in the room itself. In these situations, the researcher asked the informant if he or she felt comfortable speaking with another family member present. On both occasions the answer was that this was natural and not a problem at all. Although this situation felt foreign to me, this may reflect different family relations and openness within the family about such subjects, as the family is the primary structure in which sexuality education and preparation for marriage is given. Even so, there is a possibility that the answers of these informants were influenced by the presence of a family member. However, as I found it important to include community informants as well as providers and clients, I decided to take a more flexible approach to these interviews and not insist on being alone with the informants, as they themselves expressed that they were comfortable. Further, two men who were recruited in a health facility said they were good friends and would feel more comfortable being interviewed together. Given the difficulties of getting access to male participants I accepted this condition. Most of the interviews lasted from 45 minutes to two hours. The informants' responses to questions varied greatly in length and depth. The shorter interviews were mostly with family planning clients. As these informants were approached in the clinics and asked to give an interview before or after their consultation on that same day, some did not have the opportunity to stay for a full hour due to their responsibilities at home. All informants were interviewed once.

5.11 Translation and Transcripts

As most interviews were conducted in Swahili, the research assistant functioned as an interpreter during interviews and would translate continually during the interviews. All interviews were audio- recorded, with the consent of the informants. The research assistant transcribed all interviews, except five interviews that were conducted in English that I transcribed myself. Interviews were transcribed and at the same time translated into English by the research assistant as soon as possible after the interview. Interviews were translated verbatim, however, only my questions, the translated answers of the informants and any additional questions or clarifying comments by the research assistant were included in the transcripts. The translations of the research assistant during the interviews were left out. The transcripts were then discussed in order to secure that they were correctly understood. At this point, Swahili or Arabic words would sometimes be entered in brackets into the transcripts when an English word for the concept described could not be found.

5.12 Ethical Considerations

5.12.1 Ethical clearances in Norway and Zanzibar

The study was considered not to need ethical clearance by the Regional Ethical Committee in Norway. The project was reviewed and approved by Norsk Samfunnsvitenskapelig Database. In Zanzibar, the research protocol was reviewed and approved by the Zanzibar Medical Research and Ethics Council (ZAMREC) before data collection started.

5.12.2 Other procedures for research permission

A general research permit was obtained from the responsible institution in Zanzibar: the Office of Chief Government Statistician. Health professionals and family planning clients were recruited with the consent of the administrative leader of each of the health facilities. Before recruiting any informant from outside of hospitals, permission had to be sought from the Regional Commissioner, the governmental administrative body for the different regions of Zanzibar, and from the local *Sheha*. This was a requirement from ZAMREC.

5.12.2 Informed consent

All informants in the study received written information in their preferred language (English or Swahili) about the purpose of the study, why they were being asked to participate and what their possible participation would entail. Further, that their participation was entirely voluntary, and that declining to participate would not have any consequences for them. The

information sheet also emphasized the confidentiality of the interview, and that it would not be possible to identify participants in the written materials produced from the interviews. Further, that they would not benefit economically or in other direct ways from participation, but that any expenses they had as a result of their participation would be reimbursed. Informants were provided contact information of both the principal investigator and the research assistant and explained that they had the opportunity to withdraw their consent at a later stage, and that this would have no consequences. All the information would also be verbally explained to them, in most cases by the research assistant, since most informants did not speak English. All informants were given the opportunity to ask questions before and after the interview. Written consent was obtained in all cases except one. On this occasion, the informant was illiterate and could not sign her name. Verbal consent was obtained from the informant and a relative signed on her behalf.

5.12.3 Vulnerability

Although the informants in this study did not belong to an especially vulnerable population as defined by international guidelines for medical research (CIOMS, 2002) it is my opinion that whenever a researcher from a high- income country does a study with participants from a low- income country, there is an element of vulnerability that must be considered. As earlier described, the informants in this study came from different backgrounds. Some of them belonged to the more privileged in Zanzibar, but others can be described as being poor. The informants, especially those who were not health professionals, in general had less education than both the research assistant and myself, and limited understanding of the concept of “research”. As a result, the power relation between the informants and us can be seen as asymmetrical, and created an opportunity for people to participate without fully understanding what they were taking part in. It was important to me during the fieldwork that both my research assistant and myself were continually aware of this, to ensure that participants understood the nature of the research.

Some aspects were especially important in this context, and were emphasized during the initial conversation before the interviews. To clarify that participation was voluntary became important during interviews with family planning clients. In Zanzibar, the power relations and interactions between health workers and patients or clients are very different from the situation in Europe. Health workers usually have a more authoritarian role, and patients or clients are less involved in decisions regarding their own treatment, but can be seen more as

receivers of a service. When we did the first interviews with family planning clients, we asked the nurses to help us with the recruitment. But during our conversation with the first client, we realized that the nurses had simply told her to talk to us before coming back to them and getting her injection. Hence, the client thought that the conversation with us was a part of the counseling. This experience made us realize how important it was to make it clear to the clients that we were not part of clinic staff or connected with the health system of Zanzibar in any way, and that if they declined to participate, this would not mean that they would not receive the service, or any other negative consequences. Also, that their opinions about the health services would not be shared with the providers.

As most participants who were not health professionals, did not have any relation to the concept “research”, it was important to make participants understand the purpose of the project and my role in the implementation of this project. This meant first that the project was not a health intervention or family planning promotion of any kind, and that it was not associated with any governmental or non- governmental organization. Second, that my role was not to provide any kind of education, counseling or other health service. Many people associate Europeans with aid or money in general, and it was therefore important to make it clear to possible informants that their participation entailed only sharing their views and experiences, and would not result in financial benefits. Only on some occasions, we reimbursed the participants for their time spent with us, if this meant a loss of income.

Family planning and contraception is still a sensitive issue in Zanzibar. Especially for the non- health professionals, making it clear that the interview was confidential, and that they would not be identified in the written material resulting from the data collection was essential to make participants feel comfortable in the interview situation and also for the quality of the data obtained. For some of the community informants who lived in the same area as the research assistant, we emphasized her role as part of the research team, and that the confidentiality applied to her as well, also after the completion of the project.

Sometimes during interviews the conversation would cause emotional responses in the informants. This could be due to painful memories, their difficult social or economic circumstances in life or marital or other familial relations. Sometimes informants would ask us for advice on how to handle a difficult situation. This was sometimes difficult to deal with both for my research assistant and myself. Unfortunately, there is no mental health counseling

system in Zanzibar that we could refer participants to when we faced emotional reactions in participants. In these situations, we could do little else but listen and give emotional support. Also, some informants who had had limited contact with health workers before would use the opportunity to ask questions at the end of the interview to ask for advice regarding family planning or other health issues. When it came to participants who wanted health advice from us, we sometimes provided information, such as what are the benefits of using family planning, or what is the working mechanism of a contraceptive. However, we emphasized that we were not there as health providers, but as researchers, and would advise them to seek services or treatment at the appropriate health facility.

5.12.4 Data handling and storage

In transcripts, participants were given a number and identifying information was removed. Transcripts of the recordings were kept securely on a password- locked computer. Only the research assistant and myself had access to the audio recorder and transcripts of interviews. Audio recordings and transcripts of interviews were kept during the period of completing this thesis and then deleted.

5.13 Data Analysis

Preliminary analysis was done continually during data collection. Transcripts were read, re-read and given codes and marginal remarks. Field notes and day- to- day reflections were gathered in a log. In this log I would also list current themes, initial findings at that point, questions and themes that needed to be further explored, and new ideas. The research assistant and myself would also discuss our impressions and thoughts after each interview. As transcripts were completed, we met to discuss them, to clear up any misunderstandings, and how to proceed from that point. All of this helped me to identify what to focus on in the following interviews. The analysis process was guided by the principles laid out by Miles & Huberman (1994). After completion of data collection, all transcripts were again read, and coded with the use of the software program Nvivo10. The audio recordings of the interviews that had been conducted in Swahili and transcribed by the research assistant were listened to again, to look for any information or clues that might not be clear in the transcript. After all interviews had been coded once, they were read again so that new codes that had emerged through the process could be added to the early interviews. Codes were developed inductively throughout the process, with emphasis on letting the data guide the creation of codes. Some codes were changed, and some were merged together in this process. After the second round

of coding I had a list of about 35 codes. I then organized the codes in networks according to emerging themes (Figure 3). The coded excerpts from the transcripts were then condensed into descriptive text. Matrix analysis was applied to build an explanatory framework (Miles & Huberman, 1994).

Table 6: List of codes.

Code	Relates to specific objective	Code	Relates to specific objective
Family planning history	1	Traditional medicine	3, 4
Motivation for use	1, 2	Economy	2, 4
Preferred methods	1	Lack of knowledge	4
Side effects	1, 4	Misconceptions	4
Sources of information	1	Male opposition	4
Family planning promotion	1	Secret use	2, 3
Communication	2, 3, 4	Abortion	2, 3
Availability	1	Menstruation	3, 4
Consultation	1	Gender	3
Client characteristics	1	Marriage	3
Restrictions on access	4	Polygyny	3, 4
Provider challenges	1, 4	Fertility	2, 3
Provider knowledge	1, 4	Family	2, 3
Resources	1, 4	Social interaction	2, 3, 4
Client satisfaction	1, 4	Changes	3
Male involvement	2, 3, 4	Sexuality	3, 4
Health	1, 3, 4	Reproductive decision-making	2
Islam	1, 2, 3, 4		

Source: Own design.

5.14 Validity and Reliability

Validity of findings in qualitative studies has long been the subject of discussion. Supporters of quantitative and experimental researchers have criticized the lack of “standard” ways of assessing validity, such as quantitative measurement, control of threats to validity and formal hypothesis testing. Qualitative researchers have often replied by saying that the quantitative models are not applicable to qualitative research, or that qualitative research simply has different ways of assuring validity (Maxwell, 1992; Kvale & Brinkmann, 2009). Researchers have proposed different terms on how to review the strengths of conclusions in qualitative research, but often, the concepts are centered around making the research process as clear as possible, and giving rich descriptions of the context, how the data was collected and the

analysis process. Concepts such as credibility, confirmability, dependability and transferability are also used to describe validity in qualitative research (Miles & Huberman, 1994; Malterud, 2001). Confirmability is sometimes also referred to as “external reliability” and relates to the “relative neutrality and reasonable freedom from unacknowledged researcher biases – at the minimum, explicitness about the inevitable biases that exist” (Miles & Huberman, 1994, p. 278). This means essentially that the conclusions should depend on the phenomena that are being studied, rather than researcher him/herself (Miles & Huberman, 1994). On the other hand, some authors have argued that any account of a phenomenon will be influenced by the researcher’s own position:

As observers and interpreters of the world, we are inextricably part of it; we cannot step outside our own experience to obtain some observer- independent account of what we experience. Thus, it is always possible for there to be different, equally valid accounts from different perspectives (Maxwell, 1992, p. 47).

Dependability relates to the consistency of the study process, across researchers and methods. The study design should be congruent with the research questions, and the findings consistent across data sources. Credibility conveys whether the findings of the study makes sense, and if they are an authentic account of what was being studied. Transferability can be explained as the extent to which the conclusions of the study are transferable to other contexts (Miles & Humberman, 1994). Kvale & Brinkmann (2009) describe reliability as connected to the consistency and trustworthiness of the findings. Reliability is often discussed relating to whether the results could be reproduced by another researcher. However, as they point out, an interview is influenced by the personal dynamic between the interviewer and the informant, and can hardly be reproduced. Credibility and transferability is sometimes described as internal and external validity. Internal validity is referring to whether the study investigates what it was supposed to, and external validity to what extent the findings can be applied in other settings (Malterud, 2001).

The methods and procedures that were applied in the study has been described in detail in with the aim of giving the reader as much information as possible. Further, how the data was collected, analyzed and transformed into the final text is thoroughly explained. Additionally, my own background and values are described and made visible throughout the text, as well as my role in the study, and that of my research assistant. This study employed triangulation of informants in the form of age, gender, residence and background. The findings were

consistent across these different information sources. Divergent views that were observed are thoroughly described and discussed. This adds to the credibility of the findings. Another factor that may increase the credibility of the findings is that the fieldwork was carried out in close co- operation with a local assistant. The “inside perspective” of the research assistant, contributed to my cultural and contextual understanding and increases the likelihood that the findings reported in this study are representative of the meanings conveyed by the informants. At the same time, my perspective as an outsider may make it easier to analyze the findings in a broader context. Finally, the context in which the study was conducted, as well as the characteristics of the sample, is described in as much detail as possible to clarify to which settings the findings of this study may be transferable.

5.14.1 Limitations of the study design

There are some limitations inherent in the study design. In- depth interview was the sole method of data collection. It may be possible that triangulation of methods such as focus groups and observation would have yielded additional information and insights. Additionally, most informants were recruited from urban areas, and the study therefore has limited data on the rural population of Zanzibar. The recruitment of community informants was complicated by limitations in access to communities as well as social and cultural constraints. This required a flexible approach in order to get access to informants and it is possible that this influenced interview data.

I was the primary investigator of the study and was solely responsible for the analysis. Therefore the conclusions of this study are based on my analysis, and not that by a team of researchers. Most interview transcriptions were done by the research assistant. Although she was instructed to transcribe verbatim, there is a possibility that some information was left out in the transcripts. Further, that some information that I would have found relevant was deemed to be irrelevant by the research assistant and left out. There is also a possibility that some words may have been altered in the translations. Even though the research assistant had a good command of English, there were limitations to her vocabulary. However, due to the research assistants’ medical background and contextual insight, as well as our trusting relationship and communication, I am confident that the translations and transcriptions reflected what was expressed by the informants and captured the meaning of their answers correctly. To further confirm the authenticity of the translations and thereby the findings,

three interviews were transcribed by a Tanzanian medical doctor in Norway. These were coherent with the transcriptions done by the research assistant.

5.15 Reflexivity and pre- Conceptions

Malterud (2001) writes of reflexivity in qualitative research: “A researcher’s background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions” (p. 483). In qualitative research, the researcher is the primary instrument through which the study is designed, the data are collected, and how they are analyzed and presented. According to Malterud (2001) the question is less if the researcher affects the process and how this can be avoided, but rather how the researcher affects it, and to assess one’s subjectivity. Similarly, Kvale & Brinkmann (2009) describes a *reflexive objectivity* in interview research, understood as reflecting on the researcher’s contribution to the production of knowledge - aiming towards “objectivity about subjectivity” (p. 247).

In line with this, it is important to reflect on one’s own position and pre- understandings and how this might have influenced various aspects of the study. In my case, having undertaken the data collection in close cooperation with a local research assistant, it should also be considered how her presence and input might have influenced the study.

My professional background is nursing and I have mainly worked in psychiatric nursing care. I also have experience from the non- governmental sector working with volunteer management and sexual health and HIV awareness programs in Norway and abroad. I grew up with a single mother and enjoyed a lot of freedom in how I was raised. My family and friends are largely secular. I have never been married and I do not have children. My understanding of the individual, the community, the family, and gender is also very different from many Zanzibaris. All of this placed me fundamentally on the outside of the world my informants, and my research assistant, were living in. Even though one of the goals of qualitative research can be said to be seeing the world through the eyes of the informants, my interpretations of their experiences will be influenced by my own background, life experiences and values that have inspired me, such as feminism, humanitarian and democratic values. During fieldwork, I would try as much as possible to make the gap between me and the local people narrow, for example by ways of dressing. I usually wore long skirts and

dresses, and made sure that my arms and chest were fully covered. When interviewing the religious scholars I wore a headscarf, so as to avoid projecting a provocative image towards them. I received a lot of positive feedback both from informants and from people that I met all around about the way I dressed. Some people seemed pleasantly surprised, and expressed it, by seeing a Western woman dress in a way that was more culturally appropriate, as many tourists do not. I also tried to stay as neutral as possible during interviews, so that the informants would not feel judged by me. Even so, it is clear that the informants saw me as an outsider.

I believe the fact that my background was so different sometimes worked to my advantage and sometimes not. It is my perception that most of my informants spoke very openly during interviews and that they felt quite relaxed in the situation. Sometimes informants were curious about my opinions and this would sometimes spark very interesting conversations. One example is the issue of polygyny, which to me is a very foreign concept, but for Zanzibaris is something that they are used to. The fact that it was so unknown and surprising to me, led the informants to describe their perceptions and experiences in a different, and perhaps more extensive way, than what they would usually do. I believe this holds true for a number of the subjects that were discussed.

The fact that both me and my research assistant were female, was clearly an advantage when interviewing women, as they shared their opinions about for example marriage and gender expectations in a way I believe they would not have done with a man present. When interviewing men (excluding the health professionals) one might assume that they would feel threatened by a woman who represented something very different from what they were used to. In my impression, some of the men acted a bit dominant as compared to the women, taking charge of the conversation and expressing themselves very confidently. This may have been a way for them to reassert their masculinity and position in relation to a woman who was more educated than them and who interacted with them in a non- submissive way. Some of the men perhaps needed a little time to realize that the intention of the interview was not to challenge or criticize them, and during the course of the interview, they became more personal and less concerned with showing their knowledge.

I think my background as a nurse also affected some of the interviews. Some of the informants used the interview situation to ask questions and advice on family planning or

health in general. Being a nurse and researcher from Europe, I think was seen as a positive thing in general, but may also have led some informants to think of me as an authority that I am not. As previously discussed, I took care to make it clear that I was there as a researcher and not to promote family planning or to provide a service, but it is still possible that the difference in education and professional background affected some of the answers that I got. For example, it could be that some informants were afraid to show that they had limited knowledge about the subject. As for some of the interviews that were done in clinics, there were some discrepancies between the information coming from some of the nurses and clients, regarding how consultations about family planning were taking place. It is possible that some of the nurses perceived me as an authority and therefore gave answers they thought I wanted to hear, but that did not reflect their actual practices.

The presence of the research assistant of course also had an impact on the interview situation and perhaps also on the way informants responded to questions. As before, I think her presence may have had both positive and negative effects on how people expressed themselves. I think my research assistant had an important role not only as a translator, but as a cultural link between the informants and me. Because she was able to explain culturally specific expressions to me and also to sometimes explain my questions to make the informants understand them, she made communication easier. I think if I had spoken Swahili or conducted all the interviews in English without an assistant, valuable information may have been lost. I believe she also functioned as an equalizer in the power dynamic between the informants and me, because they could see that a local woman was an important part of the process. Finally, that she was a Muslim, as nearly all the informants, I think also bridged a bit of the gap between the informants and me. On the other hand, it may be that some informants spoke less freely because she was there if they were afraid that she would judge them. This was not my impression, but cannot be ruled out completely.

It should be made clear that the research enquiry, design and analysis of this project have been influenced by my personal views on society and development, and in particular on issues relating to gender. When planning and designing this study, I was coming from the position that high fertility and population growth, negatively affect the social and economic development of a country, and is especially limiting for its women. In my account of the social structures that shape fertility decisions in Zanzibar, a gender equality perspective is employed.

6.0 Findings

This study sought to explore people's perceptions of fertility and contraception in Zanzibar and their access to contraceptive information and services. Further, how their perceptions of fertility and contraception relate to cultural and social norms in their environment. Finally, to investigate possible barriers to increased contraceptive use. In the following chapter, the findings of the study will be presented. Throughout, interview quotes are used to illuminate the various themes. The numbers in parenthesis following the quotes refer to the number of the informant as presented in Table 6 in the previous chapter.

6.1 Fertility, Health and Islam Negotiated

6.1.1 Contraceptive history and choices of informants

Among the modern methods, long-acting methods seemed to be the most popular, as expressed both by informants and providers, and in particular injectables (hereafter referred to as "the injection") and implants (Implanon). Intrauterine devices (IUDs) were less known, and was used by only one informant. She had tried a number of other methods but had suffered from intolerable side effects. According to providers, many women are suspicious of the IUD and some refuse to have it inserted. Some informants mentioned female sterilization (also referred to as "the operation", "removal of the uterus", or "BTL") as a good way of stopping childbearing altogether. Male sterilization was not used by any of the informants and seemed to be less known. Injection was the most common modern method among informants. Both users and providers explained its popularity by being easy to use, and without the "disturbance" of taking pills every day. According to providers, implants are becoming increasingly popular. The big advantage of implants was described as their long-acting function.

Among the twelve community informants who were asked about their contraceptive history, two informants said that they or their partners had used a modern method at some point in their lives, in both cases injection. One man said that his wife had had female sterilization after giving birth to eight children. Nine of these informants said that they preferred traditional contraceptive methods such as periodic abstinence (mostly referred to as "calendar"), coitus interruptus (withdrawal) and breastfeeding. Two of these informants had used periodic abstinence at some point, while six had never used any method. Some informants separated not between modern methods and traditional methods, but between

hormonal and non- hormonal methods. As a result, condoms were sometimes placed in the category of traditional methods. In addition, three male informants mentioned polygyny as a family planning method, as exemplified here:

RA: You are a husband so in general, not in case of Islam, do you allow your wife to use FP?

I: I will allow my wife to use FP, but I should know how to plan it myself. First I will try with calendar but if I see my wife’s periods are not regular I will try another, like to use condom or to ejaculate outside in order to give my wife space for childbearing and for her health. But I will not allow my wife to use the modern methods. So if that is going to be difficult, Islam allows you to marry another wife in order to give your wife time, and for better growth of the children (*Man 4*).

Among these informants, the “traditional” or non- hormonal methods were seen as safe and beneficial for the health of mothers and children, while hormonal methods were seen as having dangerous side effects.

Several informants described non- physiological or non- evidence- based ways of controlling fertility. One woman explained that she had used a family planning method coming from Masai traditional medicine, consisting of a string of beads tied around the waist. As long as the beads are worn, the woman will not conceive. One man, one of the religious scholars interviewed, believed that without the intention of conceiving a child, sexual intercourse would not lead to a pregnancy. He explained that he and his wife never used any method of contraception, but in the breastfeeding period they did not have sexual intercourse with the wish of having another child and thus were able to space pregnancies by two years. After having eight children, he told his wife to “close the uterus” (female sterilization).

Table 7: Contraceptive history of non - professional informants

Current or previous use of	Community	Clients
Any modern method	3	5
Any traditional method	2	0
Never users	7	1

6.1.2 Spacing or limiting births?

Birth spacing as used here refers to the interval between a live birth and the next pregnancy. WHO recommends waiting 24 months after a live birth before attempting another pregnancy.

Shorter intervals are associated with adverse maternal, perinatal and infant outcomes (WHO, 2007). All informants who practiced some method of family planning, modern or traditional, stated that they used it for spacing births. The women usually expressed this as a desire to “rest” before having another baby. Nobody stated that they used contraception to stop childbearing altogether. None of the informants had used any form of contraception before having at least one child. All providers interviewed also stated that most clients used contraception for spacing pregnancies.

All the informants, including the informants who had never practiced any method, accepted the idea of spacing pregnancies. In particular the health advantages for women and children were emphasized. The informants agreed that having a child every year makes women tired, and can lead to health problems. Some women expressed wishing to have the time to do other things than care for small children. When probed for examples of what these things could be, several women mentioned going to weddings. In the Zanzibari culture, weddings usually last for three to four days, so it is possible weddings were used as an example to illustrate having the freedom to leave the house for longer periods and socialize.

For children, being breastfed longer, as well as getting more attention and care from parents, in the absence of younger children, was seen as beneficial, and commonly expressed as “making our children grow better”.

It can never be healthy for me to have three children in three years of marriage. How can I get the chance of just to play with my child? And how can my child have the chance to play with her parents? She will never have the chance. Because there is another, you are carrying another baby, so she can never get good health either, because you need to feed the others also. So I need to take care of my child for two years. Then after two years, I can think about another (*Woman 10*).

Some women said that they used contraception now because they were already “tired” after multiple pregnancies with no use of contraception and little space between them. Some women had medical indications for spacing, such as delivering with cesarean section or other complications during childbirth. One thirty- year old woman with six children explained how she decided to start using an implant after having many complications during the delivery of her forth child:

RA: When you had your first 1 – 3 children did the hospital nurses tell you about family planning?

I: No! But they told me when I had my fourth baby, and only because I got a problem during delivery so they told me to wait for 6 years before having another baby. But I didn't use it, I stayed only 9 months, then I had another pregnancy. So in that case I told myself "It is time to use family planning." Then I came to the hospital and I decided to use Implanon because it lasts for three years (*Woman 9*).

6.1.3 Myths and misconceptions

As mentioned earlier, informants frequently expressed fear and skepticism towards hormonal methods. Eight informants described misconceptions about the physiological effects and side effects of modern contraceptives, including one who used injection. These often stemmed from rumors and stories they had heard from friends, family or neighbors. A frequent belief among these informants was that modern contraceptives could lead to infertility or that fertility would return only after several years after stopping the method. Other beliefs mentioned by these informants were that modern contraceptives would lead to heavy weight loss or gain, abdominal pain, vaginal discharge, pain during sexual intercourse, decreased sexual desire, tumors or cancers or that contraceptive implants would move inside the body.

NW: Why did you choose injection?

I: I heard that pills have the effect that when you use it they do not get absorbed inside the stomach. And also about Implanon when you insert it, it doesn't stay in one place, it moves around all over the body and you can even (*may even have to*) remove out the intestine due to that (*Woman 6*).

Several informants expressed concerns over the effect that modern contraceptive methods can have on the menstrual cycle. Having your menstrual period every month was described as important and the disruption of a normal cycle was seen as a sign that modern methods are not good for health. Especially amenorrhea was believed to be dangerous and a cause of disease. One woman explained that she stopped using injection because she did not get her menstrual period and as a result, got pregnant. One man described the importance of the monthly bleeding in this way:

We believe that a woman must get her period every month in order to clean the body. So if you put something and you are not getting period that is going to be a problem and it may cause disease (*Religious scholar 13*).

Having a monthly bleeding was sometimes described as a way of knowing whether you are pregnant or not. Providers also described the perceived importance of regular menstrual periods as something that could pose a challenge in their work. One nurse described how many clients refused to use progestin- only pills, as recommended in the breastfeeding period, because it affected their cycle.

But we try hard to explain to them that the problem is because the eggs are not matured yet, that's why you can't get period, and then they understand (*Nurse 5*).

Two informants mentioned the Islamic fasting month of Ramadan as an important issue. According to religious custom, women are not supposed to fast when they are bleeding. The days of fasting that they miss due to bleeding must be "paid" later, in the form of individual fasting days. One clinical officer working in a rural area explained that the irregular bleeding or blood spotting that sometimes occur lead women to refuse to use modern contraceptives. One family planning client also mentioned this problem. She said that she had not been able to fast during Ramadan due to irregular bleeding, and as a result she now wanted to remove her implant.

Several providers described the problem of persuading clients to accept the use of modern methods. They explained that many women believe that modern methods will lead to diseases. Another problem described by providers was that women frequently discontinued use of contraception or in case of implants wanted to have them removed after a few months, because of rumors they heard in their communities.

We spend a lot of our time discussing and explaining to our clients about Implanon. But when they come home, they say "You can get cancer" or "The Implanon will be lost in your body". "With IUCD you can get pregnant, and at delivery, the baby is coming without the head. Or another head on the baby." Like this - she believes (*Nurse 26*).

Sometimes the misconceptions of contraceptives seemed to originate from health workers or providers themselves. One woman explained that she got a book from her doctor saying that when you use modern methods you can get many diseases, including cancer. One woman was told by health workers in the hospital where she delivered that "if you have only one or two children you should not use injection, because you can become infertile". Another woman told us that her doctor had told her only to use the calendar method, because of all the side

effects of other methods. The same woman also told us a story about a friend of hers who went to the doctor because her abdomen was swollen. She had an operation and according to the informant they removed something like “a ball” from her stomach. This example illustrates how misconceptions spread in the community and impede the uptake of contraceptives.

So when she asked, “What is this”? The doctor told her “this is the pills of family planning.” So the lady said, “Why has this become like that?” the doctor asked her “Since when did you use FP pills?” So the lady said “Since 1994”. Yeah. So they told her that it means that all the pills are not absorbed in the stomach (*Woman 10*).

6.1.4 The religious permissibility of contraceptives

The informants differed in their view on the permissibility of contraceptives in Islam. Among the health workers, there was an agreement that religion is a major reason why people oppose the use of family planning. The health workers explained that people often say that “Only God knows” or “Allah will provide” when it comes to the question of regulating fertility and that there is a common opinion that interfering with “God’s plan” is a sin. Several informants recalled had heard that family planning is not permitted for Muslims. Some had heard directly from a religious scholar (*Sheikh*) or Imam, and some had heard from cassettes that were distributed or on the radio or television. Some had heard in the *madrassa* when they were younger. Among the informants we interviewed, no one opposed the use of family planning altogether. Even so, there was a great variety in their views on when, how and for what reasons it is acceptable.

There was agreement among the informants that breastfeeding is a religious requirement and that all children should be breastfed for two years. One of the religious scholars referred to a certain verse in the Qur’an in which breastfeeding is discussed, as the reason for this requirement:

“And mothers shall suckle their children two full years for those who wish to complete breast-feeding” (al- Baqarah, Sura 2:233, in Omran, 1992).

This verse has been commonly used in Islamic discourse as an argument for child spacing (Omran, 1992). In the words of the informants, it was often explained simply as “God said we

have to breastfeed our children for two years”. Further, there was a common opinion among the informants that breastfeeding is very important for the health and development of the child. Several informants expressed that if you do not breastfeed, you have to “pay” the child, however it was not clear what this payment entailed. One of the religious scholars explained that if a mother cannot breastfeed her child, a wet nurse should be provided, however, children who have been breastfed by the same mother will be regarded as brother and sister and should not get married. The same informant, along with another man, also believed that breastfeeding a child while pregnant was dangerous, that the milk would become “spoiled”. He explained that the nursing child would get kwashiorkor from the milk of a pregnant mother and that is why it is forbidden in Islam.

As a result of the emphasis on breastfeeding, some informants saw spacing pregnancies as something required in religion, to avoid early weaning due to a new pregnancy. Thus, the idea of family planning in the form of spacing births was seen as fully compatible with religion, or even as a religious requirement.

According to our religion family planning is 100% accepted, that’s why God said to breastfeed the baby for two years. So that means family planning (*Man 20*).

All providers also explained that they used these Islamic regulations regarding breastfeeding as an argument in their efforts to motivate people to accept the use of contraceptives:

In Islam it says that “You have to breastfeed your baby for two years, if you do not then you have to pay that baby”. So Islam allows family planning, because you can’t stay two years without getting pregnant and you are not using family planning. (...) So we use that concept to convince people, who refuse because of Islam (*Nurse 5*).

In addition to the requirement of breastfeeding, spacing was also seen as beneficial for the mother’s health and there was a realization among the informants that annual childbirth is not good for women’s health. Among some of the male informants, including the religious scholars, polygyny was seen as natural method of family planning. The men explained that when a man has multiple wives, this is beneficial for the health of the wives and their children, because when the first wife has given birth, the husband can go to the next wife, hence the first can have time to rest after the pregnancy and regain her strength. This also makes it easier to fulfill the requirement of two years of breastfeeding. When the second wife

gets pregnant, he can go to the third, up until four wives. When the last wife is pregnant, he can return to the first.

Although spacing children by 2- 3 years to allow breastfeeding was generally accepted among the informants, their opinions differed when it came to the continued use of family planning after the breastfeeding period. Some informants believed that after two years, it is a religious requirement to stop using family planning and have another child. They believed that child spacing is good for the health of mothers and their children, and is accepted for this reason, but not for decreasing the number of children. Some informants believed that God has planned every person's lifespan before birth, and that he will create the number of people that he wants regardless; the concept of pre-destination (Omran, 1992). Deciding the number of children was therefore seen as the responsibility of God, something that man should not interfere with. For the same reason, some informants rejected permanent contraception.

Even so, some informants stated that they used family planning because of their difficult circumstances in life, especially financially. Regarding the question whether it is allowed to limit the number of children because of difficult circumstances in life, there was a difference between the male and female informants. Some male informants believed that family planning was not allowed on the basis of "the hardship of life" – mostly referring to limited financial resources and poverty. This perception was based on the idea of reliance on God. Limiting the number of children is not necessary because God will provide for "everything and everyone". In contrast, the female informants frequently negotiated their religious beliefs against their economic and social realities and still made decisions to limit their number of children. Women's experiences of physical exhaustion after multiple pregnancies and the strain of being responsible, sometimes solely, for many children in a situation of poverty and limited opportunities, was expressed as "having no way out". This led them to use contraception contrary to their religious beliefs and their sadness of "committing a sin". One woman explained that she and her husband had made the decision to have six children, which was seen by their peers as a very low number:

In Islam they say every two years you have to get another baby and it is not allowed for you to say how many children you want. But this is my own decision according to the situation of my life (*Woman 11*).

The religious scholars interviewed also differed on this issue. One of the scholars said that family planning is allowed only on the basis of health, while the two others said that adapting the number of children to your life circumstances is acceptable.

In this case people must know that all the people in the world are poor except God. He is the only one who is rich. So you are supposed to have all the ten children and God will help you to take care of them. (...) The important thing is the health of the mother. If your health is good and you can bear even ten children, then you're supposed to have all of them. And if your health allows you to get only one child, it is also ok (*Religious scholar 15*).

You have to use your own mind. For example: "God provides you everything" – If you are going to sleep all day, will you find all the things you need in your bed? Of course not (*Religious scholar 16*).

Another recurrent issue was the concept of multitude, and the perceived requirement in Islam to have large families, in order to increase the number of Muslims. The participants often referred to a *hadith* that has been interpreted as the Prophet Mohammad instructing his followers to multiply:

"Marry and multiply, for I shall make a display of you before other nations on the Day of Judgment" (in Omran, 1992, p. 100).

In the words of the informants, this verse was usually retold simply as "Prophet Mohammad/ God said 'have many children in order to make me proud on the Day of Judgment'." Thus, this verse was seen as a direct instruction to have a high number of children.

A somewhat surprising finding among the community informants was the differentiation between different contraceptive methods and their legality in Islam. Some of the community informants believed that family planning was allowed in Islam, but that their religion separated between natural methods and modern methods, and only traditional methods such as periodic abstinence, breastfeeding and withdrawal were allowed. One women stated that she preferred the calendar method because she had been told by religious leaders or scholars that this was the suitable method for Muslims, and that it was described in the Qur'an. Again, the distinction between hormonal and non- hormonal methods came up, as some informants would include condoms in the traditional methods group perceived to be allowed. But perceptions differed also regarding the traditional methods. While all informants accepted the

calendar method, some rejected withdrawal as a sin (*dhambi*). The reason was that withdrawal was seen as “killing the babies”, similar to infanticide.

NW: What about the different methods according to Islam?

I: In Islam modern methods are not allowed and condom also, but calendar is accepted.

RA: So what about withdrawal is that accepted?

R: No! It is not accepted because it is like killing the babies. So it is a crime, because it is like you are not giving them a chance to live and who knows, maybe among those children are a doctor, Imam, minister or teacher, so why do you kill them? But when you use calendar it is accepted because it is only planning, like you are waiting for something (*Man 20*).

The perception of modern methods as illegal in Islam were given different explanations. One man stated that modern methods were not allowed because they were not mentioned in the Qur'an – a reversal of the practice in the Islamic traditions to allow a practice unless it is explicitly prohibited in the Qur'an or the *Sunnah* (Omran, 1992). But more often, health concerns about modern methods were given a religious meaning. Even though informants accepted the idea of family planning for spacing or other reasons, as modern methods were believed to be harmful, they were rejected and this was given a religious justification. This illustrates the synergy of religion in Zanzibar with other areas of life such as health.

NW: It seems you have some fears of the side effects of these (*modern*) methods. You are not convinced that they are good for the body?

I: Yes! That's why in Islam they do not allow to use these methods, instead they brought other methods because Islam cares for both male and female. That's why they choose good methods for them in order not to get these effects and they say 'if you need to use family planning it's better to use natural methods or condom and not hormonal methods' (*Man 4*).

Among the religious scholars, opinions differed about which methods are permitted and not. One said that modern methods were not allowed in religion because they are harmful to health. He accepted traditional methods, polygyny and also advocated remedies from traditional medicine. Another said that there was no difference between traditional and modern methods according to religion, but that withdrawal is a sin, and also abortion, which he described as “killing a child”, unless there was a threat to the mother's health. In this case, it was acceptable. Similarly, he believed that female sterilization is forbidden if you still have the physical ability to bear another child, but can be acceptable if there is a medical indication for it. His own wife had undergone female sterilization after giving birth to eight children.

The third scholar believed that any method that is not harmful to health is acceptable in religion. Further, that family planning was primarily a health issue and not a religious issue. He also believed that modern methods were not safe, but this was based on his own experiences after his wife had used an implant in secret. He found out because she had irregular bleedings, and he believed this was not healthy. Even so, he did not give this a religious justification, and said that any method that husband and wife agreed upon was permitted in religion.

Providers confirmed the impression that the question of traditional versus modern methods is a frequent issue. Providers explained that they tried to convince patients that natural methods carried a high risk of getting pregnant, but did not always succeed. One nurse explained that many Muslims insist on using withdrawal, and only after this method had failed, did they accept using a modern method. Providers explained that they tried to convince people that modern methods are nothing else than an improvement of the methods already used in the time of the Prophet. In one *hadith*, it is said that early followers of the Prophet Muhammad practiced withdrawal and that the Prophet accepted it. Many Muslim theologians have interpreted this as contraception being permissible in Islam. Consequently, modern methods are also allowed, by the principle of analogy in Islamic law. Analogy in this context means that if a practice was previously allowed or disallowed, then a similar practice will be looked upon in the same way, as a parallel to the one described in the scriptures (Omran, 1992).

NW: Do you sometimes hear people oppose family planning on the basis of religion?

I: They say, but it's not true. Because the Prophet Muhammad, and their friends, they used family planning (...) This is the modern family planning we use nowadays. But withdrawal before (*Nurse 23*).

Similarly, one of the religious scholars answered in this way when I asked him how they can determine which methods are allowed and not, when modern contraceptives did not exist in the time of the Prophet Muhammad:

The Qur'an has not changed since the day it was brought to the world and until now. The thing that changes is the life of the people. So people interpret the Qur'an according to the present time. For example, in earlier times, there were no airplanes and mobile phones (...). But we are going to die and the people who will come they will introduce other things than these. And all of this is already written in the Qur'an (*Religious scholar 15*).

Among the users of modern contraception, there was a general opinion that modern methods are preferable because they are safer than the traditional ones. Some of these women had heard that modern methods were not allowed in Islam, however, when asked how they felt about it, most stated that they did not know, or that they just did not believe in it. One man working as clinical officer but not within reproductive health believed that modern methods were not permitted in Islam, and using them is a sin. However, he believed that because of the population pressure in today's world, there is "no way out", other than to use modern methods, which are safer than the traditional ones. Again, the negotiation between religious beliefs, traditional pro-natalist values and modern realities is present.

6.1.5 Fertility and the value of children

Zanzibar has traditionally been a pronatalist society with very high fertility. Social expectations around fertility could be seen in the way informants talked about the timing and number of children. According to the informants, there is a social norm that when you first get married, you are supposed to have a child within the next year. If you do not, especially women can get negative reactions from their surroundings, like rumors of infertility. If it takes too long to conceive, the result can even be divorce or that the husband will take a second wife. For the informants, it was unheard of that someone would use contraception before having at least one child.

Regarding fertility intentions, there were two ways of thinking that dominated among the informants. One group had no intention of limiting births, while the other wanted to do so. Their understanding of the implications of high fertility was fundamentally different. Some of the informants in the first group would practice birth spacing, but still have very high fertility intentions, from six up until ten children. These informants expressed that children are always valuable. They often referred to a Swahili saying; *tajiri na mali yake, maskini na watoto wake*, which can be translated as "rich people with their properties, poor people with their children". It means that for poor people, children will be their wealth. These informants stated that the reason to have a lot of children, was that the children could help them in the future, and especially in old age. As one woman who had four children, but wanted to have ten, explained, these informants felt that having many children meant making sure that at least some of them would be able to provide for them later:

NW: Why do you want to have many children?

I: (*Laughing*) Because you don't know which one is going to help you. You can get many children, but all of them didn't study and haven't got work to do. Maybe just two of them get work, that's why I would like to have many children (*Woman 3*).

The informants in the other group had a different approach to this issue. They explained that they wanted to limit births because it meant that they could care better for their children. They often talked about "the hardship of life", that because of economic difficulties, they could not care for many children. There was an opinion in this group that life in general is becoming more expensive. Children cost more money than in the past, and it is difficult to provide the things they need if you have a high number of children.

NW: How would it have affected your life if you had many more children?

I: It would affect me really horrible, when you see me I would not look young like this, I would look like an old man, because I have to think a lot, because you know, we need clothes, we need food, they need to go to school, sometimes they get sick and the hospital costs money, so it would be difficult for me. So one or two is enough. We can manage that (*Man 12*).

As previously said, among the informants the idea of birth spacing was generally accepted, but limiting the number of children was a more problematic issue. Providers from the different facilities agreed that it was difficult to advise people to reduce the number of children during counseling. Some providers expressed that promoting smaller families was too controversial to talk about, that if they did, the clients would never come back to the clinic. Providers also differed in their personal views about reducing fertility. Some providers supported promotion of family planning to decrease the population growth, while others felt it was un-Islamic to promote smaller families.

I: Here they have freedom, how many children they want. She can get how many children she wants, six, seven, eight, nine or ten. But we tell them it's better to make distance between one child and another, at least two years.

NW: You don't encourage them to get fewer children?

I: No, no. It's not Muslim.

NW: Can you explain a little more about that?

I: Yes! Muslims, they can get children whatever they want. For Muslims it's not like China, they have only one child. They can get whatever they want, but it's good to have space between the children in order for the mothers to regain their health. When I tell the mother "Only two children are enough" -

(Laughing) she will not show up here again. (...) You know, when they put space between them for two years, when they reach 40, they don't want more *(Nurse 23)*.

6.2 Conflicting Messages

6.2.1 Knowledge of the reproductive system and contraceptive methods

Modern methods were well known among the informants, and even the informants who had never used any method could list several methods. However, how contraceptives function within the body was not well understood. Even the users of modern contraceptives could not explain their function within the body. Some explained that they had not received any information from the health workers when they had started to use it or during follow-up consultations. Others simply could not remember any of the information that they had been given. It seemed that the contraceptive users' limited understanding of these mechanisms sometimes resulted in fear and discontinuation of the method, especially when experiencing side effects. Some informants had alternative understandings of how the reproductive system functions and is affected by modern contraceptives:

If you are afraid of getting pregnant, you can do sexual intercourse morning, evening and night, because if your blood groups are not matching, you can't get pregnant *(Religious scholar 15)*.

A woman has 1500 eggs since the day she was born, and maybe you use injection to stop pregnancy, but when you use it you can't say: "This injection will go to egg number nine". But if it goes there it's going to affect all the eggs. So there is a high possibility to become infertile *(Religious scholar 13)*.

The lack of knowledge could also be seen in the way informants described their use of non-hormonal methods. Knowledge about how these methods work and do not work was very limited. Several informants stated that they had used breastfeeding as a contraceptive method after giving birth. But when probed about how they used it, it became clear that they did not know how and under which conditions breastfeeding can be used, as they stated things like "I used breastfeeding, but it did not work, because I got pregnant when the baby was 1 ½ years." Similarly, none of the informants who said that they used periodic abstinence or that this was their preferred method if they were to use contraceptives could state how it works, or they stated the wrong days in the menstrual cycle as safe or unsafe. Several informants or their partners had got pregnant while using periodic abstinence. One man who was working in the

tourist business, far away from his family, said that his wife used “beads”, but he did not know how, and when he was home, they would not abstain from sexual activity.

Providers also stressed that lack of knowledge about the reproductive system and about contraceptive methods is a problem. They explained that especially in rural areas, there is a pressing need for information about family planning. Although family planning messages are being spread through the media, not everybody has access to television or radio. They live in remote areas, and do not have access to information. The result is often unplanned pregnancies, and sometimes abortions.

You know, the women here, they don't know about family planning. So they stay at home, and then they get pregnant. If they get information before delivery, it's better (*Nurse 23*).

Several informants also said that the religious leaders and scholars who oppose family planning do so because they do not have knowledge about it. One nurse said that the religious leaders who have the knowledge agree that family planning is permitted in religion. Similarly, one of the religious scholars said that people oppose because they do not have knowledge, not because it is not permitted in Islam. If the government would work together with the *Sheikhs*, then the situation could be improved, he said. Yet another nurse said that if the *Shehas*, *Sheikhs* and the school teachers would get education about family planning and could spread the knowledge to the people, then a lot could be achieved. The *Sheha* that we interviewed, said that he would be willing to take part in family planning promotion in the community if it was initiated by the government, as he had done for example in the very successful malaria program in Zanzibar. But so far no such programs had been started in his village. Providers explained that the hospitals sometimes have outreach activities in the villages where they provide reproductive health services and give health education. In addition there are some community health workers. But providers all expressed that it is not enough, both because they do not reach the remote villages, and because these activities depend on funding from the MoHSW which is limited.

6.2.2 Sources of information about reproduction and contraceptive methods

The informants based their opinions and choices about contraceptives on a number of different sources of information. A common pattern was that they were first introduced to

contraceptive methods when they were already married and had at least one child – none of the informants said that they had learnt about contraception or been to a family planning clinic before they were pregnant with their first child or had already given birth. Among the community informants, only those who had completed secondary school, had received any reproductive health information in school. Among my informants, there were few who had reached this level except for the health professionals. One woman explained that although they got information about the reproductive anatomy and physiology, they never got information about how to prevent a pregnancy. Only two of the informants, one man and one woman who had both got their education in Tanzania Mainland, had received some sexuality education while they were in school. The man explained the content of the education in this way:

I: They teach us a lot of things, about the body, how it is, women, men, how sex is. But they didn't tell us about injection or any of that.

NW: So they told you how are pregnancy happens, but not how to prevent it?

R: How to prevent, you never go to make sex. If you go, you will get pregnant. This way, that's how they tell us (*Man 12*).

For the others, it meant that they left school without any information about reproductive health, and they would not get this information until they came in contact with the health services through pregnancy and childbirth. The women who were not health professionals, all said that they first heard about contraceptive methods in the hospital after they had given birth. Moreover, several women said that the health workers did not approach them about family planning until they had already had two or three children, unless they had complications such as a cesarean section. Even then, some women said that they were only told that they had to wait for several years to have another child because of the cesarean section, but not given information about contraceptive methods or how to access them. The only time that they had talked to health professionals about family planning was in connection with a pregnancy, usually during post-natal care or when they came with the child for immunization.

For the men, it seemed they had even less contact with reproductive health services, or none at all. None of the men, who were not health professionals, had had a conversation with a health professional about contraceptives, or read any information about it coming from a professional source. These men and the women who were not using modern contraceptives

seemed had formed their opinions and reproductive health choices on various informal, non-professional sources.

Important sources of information were the people around them, their friends, family, neighbors and colleagues. Even though family planning was said to be a “secret issue”, it seemed that on some social arenas it is acceptable to talk about it. Stories from people in informants’ surroundings were frequently referred to, and were often decisive for their choice of using a contraceptive or not, and for their choice of method. As providers had emphasized, it appeared that rumors about contraceptives circulate frequently.

Some informants had also got information from religious sources, from leaders or scholars, in the madrassa, or through religious media. One of the religious scholars, who opposed modern methods, said that family planning was an issue that had been discussed extensively during his Islamic education and referred to a special book of Islamic jurisprudence solely devoted to family planning and its’ relationship to Islam. Other informants simply stated the Qur’an as their source:

NW: Was there any reason why you chose the calendar method?

I: Yeah...Because in Islam...There is a calendar...So all Muslims are supposed to use calendar. We are not supposed to use maybe tablets or syringe, we are supposed to use calendar. That’s why I chose calendar.

NW: And how did you learn that this was the way it was supposed to be for Muslims?

I: In Qur’an. All this, they explain in Qur’an (*Woman 10*).

Some informants had also heard about family planning from the media in the form of promotion messages, however, none of them stated that information that they got through the media had influenced their choices regarding contraceptive use. Rather, they accentuated the information that they got from other sources.

Several informants explained that members of the family fill the role of preparing for adulthood, usually older women referred to as “grandmothers” or “aunts.” These women have the task of educating the young girls when they enter into puberty and teach them about menstruation, marriage and sexuality. One woman told us that when she was thirteen, the “aunts” had told her that after a few months “something will come from your body”

(*menstruation*). When it came, she had to tell her mother. The women also taught her how to relate to men:

I: So they used to say, “When you go to men, you get pregnant. So you have to stay in your home. If they just touch like this (*touches herself lightly on the arm*), you’ll get pregnant. So you have to stay far from men”. So when they say these things to us, we say “Ah, we have to protect ourselves from men.”

Yeah, the men are not supposed to be near to us, we have to be far from men.

NW: They didn’t tell you how a pregnancy actually happens?

I: No, they didn’t (*Woman 10*).

This type of informal education continues when a girl is getting married. Several women explained that if she has not been married before, the parents will ask her if she has already practiced sex, or not. If she says yes, she will not be told anything because people will say that she already knows everything, which is regarded shameful. But if she says no, she will be taught what to expect on the wedding night and how to behave with the groom:

If you didn’t ever do something with a man before marriage, they have to tell you that “Today, you are getting married. And there is a husband there. And that husband there, he has something. And that something, you’re supposed to use that thing. You see? Sometimes it makes you angry. “Why they tell me these things? I don’t want to hear it!” You see? So, sometimes, they say “When you go there, you’re not supposed to wear the dress, you have to be just open”. So “Why? Why I have to be empty without my dress?” So, this is the education that we get from them. You’re not supposed to use pen, or paper (*laughs*) (*Woman 10*).

The experiences of a “supervisor” is not always pleasant:

Those older women don’t care if that day is your first day to have sex and it is so painful. But they insist that you have to do it today and do it fast because they don’t want to stay there any longer. And they have their own medication if you do it after you finish they take you and bathe you with hot water and they add a little amount of salt in order to make you fit and not feel pain again (*Woman 25*).

The social expectation of “fulfilling the marriage” on the wedding night, appeared to be very strong. Several women explained that the “aunts” told them that the wedding night will be painful, but they have to endure it, and after a while, they can start to enjoy it too. Previously, one woman explained, it was common for one of the women to stay in the room with the bride and the groom to supervise them on the first night. But now, she said, they stay outside the door and listen. Even though the wedding night and the sexual initiation that is expected

were referred to as something intimidating, the presence of the “supervisor” was something that the women related to as positive.

6.2.3 Competing medical systems

In previous sections I have described how the informants often based their opinions and practices regarding reproduction and family planning on a number of different sources of information. They often placed high value on the non- medical or informal sources when making decisions. The distinctions between “school” medicine, health, religion and traditional medicine were often blurry. In particular, religion was integrated into the understanding of all aspects of health. One example of this is when health concerns about the safety of modern contraceptives were given a religious meaning and justification. Another, when the religious requirement of breastfeeding for two years is emphasized and justified with medical evidence about the benefits of breastfeeding and child spacing. Thus the religious convictions of informants were influenced by their understanding and knowledge of health.

This synergy of different medical and religious traditions was also present in the way that some informants related to health services and health providers. Informants did not always distinguish between health professionals in the public healthcare, and various types of traditional and religious healers. Sometimes healers without any medical training were also simply referred to as doctors. Two of the religious scholars we interviewed, explained that a central duty in their role as religious scholars and leaders, was to treat different illnesses and ailments. One of these worked as a teacher in a *madrassa* in the suburban community where we conducted some of our interviews. When asked about what his responsibilities were, he described himself as a “doctor of Islam” and of the medicine of the Qur’an. While talking to us in his *madrassa*, he showed us the Qur’an, the Bible and an English teaching book in biology and explained how he used these books in his practice as a scholar and to treat different conditions. He explained that he treated a variety of conditions with these tools as well as traditional remedies such as flowers, fruits and herbs:

NW: When you say that you are a doctor (*of Islam*), do you mean to give people spiritual advice?

I: An example: Castard apple treats leukemia if you don’t have white blood cells. I learnt it in the biology book. And also the Qur’an and *hadith* already teach about this fruit, that it treats leukemia. So according to my knowledge people get sick with only three causes: Excessive vitamins, decrease of vitamins and broken vitamins, so when people come and tell me “I have this disease”, I know it is because of excessive vitamins (*Religious scholar 13*).

He explained that many people would come to him to seek advice about reproductive and child health issues, and he would treat them according to his beliefs. For example, a woman had come to him and complained that she could not get a child, that she had had a miscarriage. He told her that the problem was that she was drinking cold water:

So inside, the baby knows that, “My environment is going to be cold”. So maybe the day you are going to deliver, it’s going to be the hot season. So it’s going to be difficult for the child to know “Ah, also there is hot”. So maybe he will faint and die. So maybe she says “I can’t get a child, maybe my grandmamma or my neighbor use the witch doctor for me”, but no, the problem is yourself, when you are pregnant, always you drink cold water (*Religious scholar 13*).

He had an ambivalent relationship to the public health care services, which he felt did not acknowledge his competencies. Even so, he sometimes told patients to seek care at the referral hospital, but this seemed to be based on other criteria than the severity of the disease.

The other, who worked as an Imam as well as a madrassa teacher, explained that he used the Qur’an to treat “spiritual diseases”. The treatment consisted of reading from the Qur’an for the people who suffered from this problem. Some informants used this term to describe different forms of erratic behavior, hallucinations, or paranoid thinking. One woman told us that some years ago, she had been pregnant with her first child. At seven months she went into labor but when she came to the hospital, “nothing came out” – only the placenta. She did not know what had happened to the fetus. She told us that after this experience, she started suffering from a spiritual disease – a devil (*mashetani*). She told us she was “screaming, running around like a crazy person” and was afraid to be alone, because she felt that a shadow was following her. At first, she was treated in the hospital, but the doctor had told her that the problem could not be treated in the hospital – she needed to see a traditional healer (*dawa za kienyeji*). The healer told her that the problem was that another woman had sent the devil because she wanted her husband. He gave her some medicine and after a while she felt well again. Similar stories were given by some other informants. These stories illustrate how religion, traditional understandings of health and illness, and medicine is combined and used to understand health and disease. People navigate between public health care, religious and traditional healers. These healers function as alternative providers but also as auxiliaries to the public health care, as in the case of mental health, where public services are very limited.

6.3 Availability and Access to Services

As previously mentioned, Zanzibar has a fairly dense network of primary health care units, which all provide contraceptives. In the PHCU where we conducted interviews, COCs, POPs, Depo- Provera, Implanon and condoms were available, and they also provided counseling on traditional methods. The same was the case for the two hospitals, but their services also included IUD's, male and female sterilization. Family planning services were available during working hours all day of the week. Counseling took place in a separate room. The staff in all three units consisted of public health nurses, MCH nurses and nurse- midwives. In the hospitals, clinical officers and medical doctors were available if needed, but nurses were usually the ones who dealt with the clients.

The women that had some experiences with family planning services, whether they were current users or had some past contact with the services, were asked about their experiences with the services and the providers. All women initially answered that they were happy with the services and that providers treated them friendly. Even though some women described long waiting hours, they did not seem to see this as a big problem.

Both the women and the providers were asked to describe the contents of a normal consultation, how counseling took place regarding choice of method, what information was given and what type of examinations or tests that were conducted. The way the women and the providers answered to these questions were sometimes conflicted. All of the women stated that they had been given the choice between different methods. Some women said that providers had explained possible side effects, but they could not remember what these were, others said they were never explained anything. On the other hand, all providers stated that before providing a contraceptive, they would teach the women about all methods and explain possible side effects in detail. None of the women who used the public facilities said they had been subjected to any physical examination in their first consultation or in follow- up consultations, while providers described a variety of different examinations and tests.

Some of the procedures described by both women and providers, can be described as “medical barriers.” Shelton et al (1992) defined medical barriers as “practices, derived at least partly, from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception.” Examples of medical barriers are inappropriate contraindications, unnecessary examinations or laboratory tests, waiting periods or eligibility restrictions

(Shelton et al, 1992; Speizer et al, 2000). Some providers described measuring only weight, blood pressure and to perform a urinary pregnancy test. Others described a “head to toe” examination process, including checking breasts, abdominal palpitation, pelvic examination and checking for varicose veins on the legs. One provider also mentioned checking the eyes for signs of anemia and checking blood glucose in case of diabetes. These practices are not in accordance with the WHO family planning handbook (WHO, 2011), which clearly states that COC’s, POP’s, Depo- Provera and Implanon can be provided without such examinations. It is possible that these examinations can act as a barrier for women to seek contraception. Several providers mentioned that women do not like to be subjected to pelvic examinations, and it is possible that this acts as a barrier for some women.

I: We do head to toe examinations. But in the case of pelvic examination we perform it in a special day but some mothers they don’t like to have pelvic examination.

RA: Why is that?

R: Everyone has their own thinking, especially here in the villages. They think like you just want to look at her secret place but she does not know that it is only an examination in order to determine if there is any problem. But we try hard to educate them (*Nurse 19*).

Some providers also described taking a medical history from the women to check for contraindications, but they differed in their views on what conditions and diseases that contraindicated use of contraceptives. One provider listed anemia as a contraindication because sometimes contraception can cause increased bleeding, while another said anemic women should use contraceptive pills to bleed less. Several providers mentioned hypertension, diabetes, asthma and varicose veins as contraindications. Further, they explained that they would advice these women to use non- hormonal methods such as condoms or periodic abstinence. Asthma and varicose veins do not contraindicate any contraceptive method, and most women with hypertension and diabetes can use methods without estrogen (WHO, 2011). These findings suggest that women with chronic disease or other conditions may face significant barriers when they request a safe and efficient contraceptive. Some women explained that they had been asked if they were in their menstrual period and if not, to return when they were:

NW: Can you describe what happens when you come to get your injection?

I: Actually! They tell us nothing, we just bring the card and we get the injection, then goodbye. They tell us nothing at all.

RA: What about the first time you came for family planning?

I: They did nothing, not even physical examination. They only told me that if you are not in period you do not get injection, so you must come here with period.

N: How did you feel about that?

I: I felt so bad because I was already waiting for so long and then they told me like that. So I just returned home and came again next time (*Woman 8*).

One provider explained why she checked whether the women were in their menstrual period or not.

NW: What kind of questions do you ask the clients who come for family planning?

I: First of all we ask them if they have their period or not. Because some women come with the pregnancy and they think that if they take family planning pills, they will abort their pregnancies (...) So we ask them; "If you won't mind can you how us if you really have your period" in order to make sure she is not lying (*Nurse 1*).

However, most of the providers stated that they used urinary pregnancy tests. As women and providers gave different answers whether the women were required to come during their menstrual period, it is difficult to say how widespread this practice is. It should also be noted that the women who said that they had been required to have their periods were clients of the primary health care unit, and also one woman who was using a private clinic. Still, these reports from women indicate that this is a barrier that more women may face.

Other types of barriers that are sometimes imposed by providers can be restrictions on access due to age, marital status or parity (e.g. Speizer et al, 2000). None of the providers stated that they restricted access on the basis of such criteria. Also, none of the providers said that they required consent from husbands or parents. There was agreement among providers that women in Zanzibar frequently keep their contraceptive use a secret from their husbands, but none of them saw this as a reason to deny them the service. Likewise, none of the providers said that they would refuse to provide the service to unmarried women. The providers also stressed that providing family planning to unmarried adolescents is important to prevent early pregnancies as well as abortions. One nurse explained the case of unmarried adolescents in this way:

I will accept her because if she is willing to come, you have to understand that she started to have sex in secret, so it is better to give her family planning in order to prevent early pregnancy (*Nurse 1*).

However, they all stated that adolescents very rarely came to the clinics. The providers believed that this was due to cultural taboos surrounding pre-marital sex, fear of being seen or of criticism or judgment from health workers. Although none of the providers we interviewed said that they practiced moral or religious eligibility criteria for provision of contraceptives, two women that were interviewed told us that had been denied female sterilization on based on such criteria. Both women had requested female sterilization in connection with caesarian sections, but the doctors had refused to perform the procedure. One 43- year old woman with five children had tried several times to get sterilized but the doctors had told her “it is not time yet” and they also required the signature of her husband. But she was not sure whether her husband would agree. The other woman had requested the operation when she was 29 years old, and had five children. But the doctor had refused. When she asked why, the doctor had told her “you’re still young”. Although the providers that were in interviewed in this study all said that they used the Ministry of Health guidelines for the provision of contraception, these findings indicate that guidelines are not always followed or understood by providers.

6.4 A Gendered Social Reality

6.4.1 Gender norms and expectations

Among the eleven women I interviewed who were not health professionals, five had some kind of income. Out of these five, two were employed in a non- family run business. Among the men who were not health professionals, two had wives who were working outside the home. When asked about their role in the family, and that of their husband, the women who were housewives described the husband as the breadwinner, the wife as responsible for the home, and that they cooperated in raising the children. These women had clear expectations of the husband to provide financially for the family, and saw themselves in a purely domestic role. Still, they said that as “mother of the house”, they did have an influence on how the family’s money was spent.

NW: Can you explain a little about your role as a wife and the role of your husband in the family?

I: Thank God the husband that I got he knows his responsibility, because he doesn’t leave home until he has made sure I have all the things that I need and maybe if I want something, I just call him and he brings it to me. And when he returns back home he helps me to take care of the children. So we help each other (*Woman 25*).

Also among some women who were working there seemed to be an expectation that the husband should be the primary provider, and if the woman made money she could keep that money to herself. Even so, neither the female or male informants had a principal objection to women participating in work or education, including the religious scholars. The religious scholars that I interviewed agreed that there was nothing in religion that prohibited women from getting an education or from working. The informants also seemed to agree that both women and men should take care of children. When asked about how they saw the power relationship between women and men, both male and female informants would usually say that they are equal, that there is no difference. However, when probed, several informants would say that the man should be the head of the family, and that if there was a disagreement between husband and wife, the wife should let the husband decide. Further, after marriage, a woman should ask her husband for permission for anything she wants to do, from leaving the house, to whether she wants to study or work. Learning to be obedient is also part of the traditional pre- marital education, as one woman explained:

N: Can you tell us a little more how they teach you?

I: They teach you how to live with your husband, like a husband is like a baby so you have to live with him like you live with a little baby, everything you're supposed to do for him and if he doesn't want you to go somewhere don't go, because if you go without his permission you are going to get sins
(Woman 14).

If the husband says no, she has to accept his decision. If she does not, it may have serious consequences, as in the story of one woman who told us that she had been divorced from her husband because she wanted to keep working. Her husband had said that women are not supposed to work and promised her a salary if she stayed at home. But after a few months, he stopped giving her money. When she told him she wanted to return to her old job, he filed for divorce and she had to move back to her parents' house with their child.

I: You see, we treat badly the women, women have no words to men. The men have the power of saying anything, and we will never crush them. Because I can say, here in Zanzibar, I can never crush my husband, especially these words, going to job, but I crushed him, and feel sorry for myself, but I have to. (...) If they say that we have to do this, we have to say yes. But if I can say, "my husband, we have to do this and this, we have to plan this and that", if he understands, it can be that. If he says no, it has to be no. We can never say another word. That's why we have to follow and do anything they say.

N: Do you believe that that's the way it should always be? Do you think it's right?

I: I guess it's right. I guess it's right, for us, Muslims. The women are not supposed to be head of the family. The men have to be head of the family, not the women. The women are the assistants of men. So if there is no man in the house, the women can be head. But Muslim, if there is husband and wife, the man has to be head. So if he says anything you have to follow that (*Woman 10*).

In this context, when informants said that men and women are equal, it can be understood more as "of equal worth" than in terms of power. Still, there were signs among some informants that things may change in the years to come. Some of the women who were working were challenging the idea of the man as the provider, as they said that men do not always fulfill their obligations, and women have to look after themselves if they want to have a good life. Some of the men also stated that they appreciated what women could contribute, and that they supported women's increased social and economic participation.

N: From your point of view, what is the role of a man and woman, in society and in general?

I: Ahh... For now, I think there is no difference. Everybody is the same now. As we can see there is a woman pilot in the plane, they can play football as well, so I think, we are the same. In the years to come, I think the women are going to be *up* (*they will be higher than men*) because they are showing how strong they are. For now we are the same, but I think after some years they will be up.

N: Do you think that's a good thing?

I: A very good thing. I like it.

N: And in the family? How do you see the role of men and women?

I: For me I think it's the same. Within my family it will be the same. I don't need to control everything, like "what you need to do today". But some families, they are still like long time ago, like our grandfathers. All the men are *up*. They are the head of the family.

N: So you like that your wife has a job?

I: Yeah, it's good for me, make easy. If she has no job, she will call all the time "I don't have money"... Ahhh, headache. It's easy (*Man 12*).

6.4.2 Sexuality and marriage

The social expectations relating to marriage and sexuality were reflected in the way my informants spoke about these subjects. Based on their statements, I would argue that marriage is seen as the only acceptable form of romantic or sexual relationship between a man and a woman, and their sexual lives are confined to exist only in marriage. I found that informants spoke relatively freely about sexual experiences in marriage, but especially the women always underlined that their sexual experiences had taken place within marriage.

Before getting married I didn't know anything, I only heard the stories like if you have sex you get pregnant, but I didn't do it before, I waited until when I got married (...) Many times the girls are the ones who are being taught because there you're supposed to be asked if you have already practiced sex before marriage or not. If yes, you are not going to get many things because people will see everything you know, nothing new. But if no, you are going to get many things and to be taught very well and even to get a person as a supervisor on the first day of doing sex with your husband in order for the boy not to hurt you. That's why to say yes in our culture is like a shame to your parents (*Woman 14*).

In the social reality described by these women, the virginal ideal is strong, and being sexually experienced is seen as shameful. Being knowledgeable about sex and reproduction is associated with pre-marital sex, and is therefore also stigmatizing. In this kind of environment, people may avoid seeking knowledge about sex and reproduction, out of fear of being seen as breaking the social norm. Parents may see no need to educate their children about sex before they are about to get married because the possibility of them engaging in pre-marital sex is so heavily stigmatized it becomes a "non-issue". The transition period of adolescence, in this worldview, does not exist, because people go from being children one day and adults the next, on the day of their wedding.

Another subject that is related to the confinement of sexuality to marriage, but also to the gendered views of sexuality that is dominant in Zanzibari culture, is the issue of polygyny. 29 percent of women in Zanzibar live in polygynous unions (THDS, 2010). Among the group of informants, there was nobody who was currently living in such a union, but polygyny was still a subject that frequently came up during interviews. As mentioned, several men thought of polygyny as a good method of family planning, especially since they perceived it to be sanctified in Islam. In their view, polygyny is beneficial because it facilitates birth spacing, which they saw as good for the health of women and children. But they did not perceive birth spacing as the primary cause for why polygyny is allowed. When asked about this, the men justified polygyny by a difference in sexual desire in men and women. Men were seen as having a higher sex drive, which one woman cannot easily fulfill, especially after childbirth. The main objective of polygyny, they said, is therefore to keep men from having sex outside of marriage (*zinna*), which is seen as a great sin. According to these men, it is the right of the husband to take another wife if he wants to, but as a rule, he should ask his first wife to agree to the second marriage. Nevertheless, if the wife says no, the man can marry again if he wants too.

You are allowed to get married even if your wife doesn't agree. Because maybe your ability does not fulfill his ability. So in that case maybe he decides, in order not to go outside the marriage, it's better to marry another wife. It is a *Shari'ah* and accepted in Qur'an but before that you are supposed to give an expensive gift to your wife, then to ask the permission to marry. Because that gift may make your wife agree so easily. But nowadays men don't do that, they just go and marry, and don't give anything to their first wife (*Religious scholar 13*).

When asked about how they thought the women would feel in this situation, the men did not seem to think of this as a problem. The important thing to them was that the man should have his sexual desires fulfilled, and to avoid extra-marital sex. A gendered view on sexuality where male sexuality is seen as active and aggressive, while female sexuality is passive and dependent on the male, is thus necessary to provide the rationale for polygyny. The female informants did not express the same positive views about polygyny, but they seemed to accept it as a part of life, and as a law from God that could not be challenged, even if it did make them unhappy.

The way that both male and female informants related to this subject says something of a view of marriage and of the spousal bond that is fundamentally different from the Western concept of marriage. It seems, that being a husband or wife, is more about fulfilling certain expectations and needs, more than the spiritual and romantic bond that is idealized in Western culture. The idea of a husband who, after his wife has just given birth, seeks another woman to fulfill his sexual needs, would contradict all social norms relating to relationships in Western culture. However, following the logic of these informants, it is acceptable because the spousal bond is more practical than personal.

However, this logic does not apply equally to women and men. While a man can take a second wife, or divorce his wife, if she does not fulfill her obligations the way he perceives it, a woman needs a specific reason as well as the husband's consent, to obtain a divorce. As mentioned, Islamic law is incorporated into the legal system in Zanzibar. Men retain the right to divorce their wives by repudiation (*talaka*), where the man simply states: "I divorce you", without even involving the court, and this is the way most divorces are handled. The divorce rate in Zanzibar is high, and has been increasing in recent years (Stiles, 2003; IRIN, 2006). Out of the twelve community informants in this study, six had been divorced once or twice. Some women had been divorced because they did not become pregnant within a certain time, or because they wanted to keep working after being married.

I am divorced because I stayed with my husband for 4 years without getting a baby so he decided to divorce me because of that. But now I have a child of 4 years. (...) But while I was pregnant I already got divorced, but my husband didn't know that I was pregnant. And even myself also, because when I was pregnant I was getting my period as normal. So after getting divorced I returned back home. And my husband married another wife (*Woman 14*).

After a divorce, the woman is expected to move back to her parents' house until she remarries, as was the case with several women that I interviewed. They lose their home, and in some cases the custody of their children. Their stories illustrate women's limited autonomy when it comes to divorce. This was also reflected in the way male and female informants spoke about being divorced. When women referred to divorce, they would express it as "my husband divorced me", while the men would say "I gave my wife a divorce".

6.5 Spousal Relationships and Unmet Needs

Perceptions and experiences of how the number and timing of children should be planned, was one of the core topics I wanted to explore in this study. During interviews with family planning clients and community informants, I would ask questions around if and how they had planned their families, how they communicated with their spouse about this, and what factors influenced the choices they made.

There was a lot of diversity in the way the informants responded to these questions. The women who were using modern contraceptive methods seemed to have made a conscious choice to use contraception, either to protect their health, or because of financial constraints. These women seemed, in general, to have a husband and family around them who supported them and who was involved in the planning and choices that were being made. For some of these women, the husband was the one who had decided that they should start using contraceptives, and he was also the one who decided when to stop, and to get a new pregnancy.

Contrary to this, there were some informants who did not have a desired number of children, and who had never talked to their spouse about the number of children or the timing and spacing of births. This seemed to be a result of limited spousal communication, and a somewhat fatalist outlook, where life events are seen as controlled by God and should not be

subjected to human intervention.

NW: How many children do you plan to have?

I: I didn't plan how many, I will accept all I will have. Because for African people children are always like a wealth. The more, the better.

NW: Did you and your wife talk about how many children you want and how you want them to come?

I: Not yet.

RA: But after the age of 35, it may be dangerous for a woman to have another baby, so how did you plan about this with your wife?

I: Telling the truth I didn't plan about that but I pray to God it won't happen (*Man 20*).

There were also several women who wanted to space or limit births but who were not using any contraception – what is usually called an unmet need for contraception. All of these women said that they had discussed and agreed with their husbands about the number of children they wanted, but still did not use contraception.

NW: Can you tell us what your husband thinks about family planning?

I: Actually I can't say what he's thinking because I didn't discuss about this issue with him even once. But I think many times men do not agree with this issue. So you have to use your own mind if you want family planning.

NW: Did you and your husband discuss how many children you want to have?

I: Yes! We decided to have 6 children (*Woman 24*).

Among both family planning providers and the non- health workers, there was a general opinion that men are more inclined to reject contraceptive use than women. Because of the established gender norms, it is difficult for women to continue the discussion about contraceptive use if the husband has already said no. Many women therefore use it in secret. Among the informants, there were two women who were using, or wanted to start using, contraceptives, but had not revealed their plans to their husbands. The women said that their husbands wanted more children than they did, and did not understand that this was dangerous and tiring for their wives. As one 30- year old woman with six children explained, she was also the breadwinner in the family, and could not manage another pregnancy at this point. She felt that her husband did not understand her, so she hid her intentions to delay getting pregnant again from him.

NW: Can you tell us how you discussed (*using contraceptives*) with your husband?

I: Actually I didn't tell him the truth that I want to rest for maybe seven years. I just told him "See my

husband, I got many problems when I went to hospital for delivery so it's better for now to rest for two or three years, then I will remove it and I will get another baby". So he believes when our baby reaches two years he's going to have another baby.

NW: Why didn't you tell him the truth?

I: Because he's going to refuse it. He is disturbed.

NW: Why is he going to refuse?

I: Because he wants more children. For him children are not enough.

RA: How many children does he want?

I: More than ten though he hasn't got any job, but he wants that every room in the house should have its own baby. (...) But I take care of all of them by myself. And still my husband doesn't see that (*Woman 9*).

Family planning providers were also asked about their impressions of how couples plan their families. The providers who worked in a rural area believed that most couples do not talk at all about this issue, and that they rely on "God's plan." However, in the urban areas, some providers said that men are slowly becoming more involved. While before, the men would never come to the clinic, these days some men will accompany their wives to the clinic, and even participate in counseling. However, all providers agreed that opposition from men is still a significant barrier to increased use of contraceptives. The providers said that many men reject family planning of any kind and that they do not understand the situation this puts their wives in.

NW: Why do you think the men refuse to accept?

I: (*Laughing*) Because they think women are like machines, that they produce things – children! And also they are not the ones who get the problems so they do not think about this issue (*Nurse 19*).

The majority of men they do not accept family planning. They say "If I got many children, what is the problem, because I am the one who is responsible for the basic needs of my children like food, clothes and shelter and God is the one who is helping me, so what is the reason of using family planning?" And the minority who planned their future are the ones who use family planning methods (*Nurse 1*).

This chapter demonstrates that there is a great variety in perceptions of fertility and contraceptive use among people in Zanzibar. Fertility intentions appear to be relatively high. A pronatalist cultural identity that Africans favor large families seems to contribute to this, as well as children being seen as a value in themselves, and having many children as a security in old age. However, there are signs that these perceptions may be changing. Rising costs of raising children, as well as the need for education to succeed in life, seem to be influencing

people to want fewer children. Additionally, there seems to be a growing recognition of the burden placed on women by unlimited childbearing. Perceptions of fertility and contraceptive use are highly influenced by religious beliefs. However, what is perceived as permitted in religion or as religious instructions for righteous behavior is subject to interpretation. It seems that birth spacing is widely accepted, but that limiting family sizes is a more complicated issue. Those who oppose limiting family size often do so based on religious beliefs of reliance on God and a belief that God should control life and death. On the other side, proponents of family planning, including providers, use religious instructions of breastfeeding as an argument for birth spacing and thus see family planning as a religious obligation. Seemingly, traditional methods of contraception such as postpartum abstinence, breastfeeding, calendar methods and withdrawal are generally accepted, but there is considerable skepticism against modern, hormonal methods. Fears and misconceptions about these methods seem prevalent, and also form the basis for much of the religious opposition against these methods.

There is limited availability of sexual and reproductive health information in the public sphere and it seems that the task of educating young people about these issues fall on traditional family structures. As a result, women may hear about contraceptives only after delivering their first child or even later. Although geographically accessible, access to contraceptive services are constrained for some women due to cultural constraints against pre- marital sex, or social values that favor large families, so that nulliparous women or women with few children will feel it difficult to ask for or use contraceptives. The lack of quality sexual and reproductive health information leaves room for fears and misconceptions about modern contraception to prevail. As a result, available services are not utilized. Traditional healers and religious leaders appear to fill some of the functions of the public health system.

Social pressure requiring large families, and traditional gender norms contribute to high fertility and may inhibit adoption of contraception. Women have limited decision- making power and men's fertility intentions seem to often dominate those of women. The possibility of getting divorced or getting a co- wife as a result of not producing enough children makes it difficult for women to openly disagree with husbands who desire many children. It seems that lack of knowledge, fears and misconceptions about contraception, religious opposition, lack of contact with health services, and gender inequalities are major barriers to increased use of contraception.

7.0 A Discussion of the Findings

This study aimed to explore perceptions of fertility and contraceptive use, access to contraceptive information and services, and how this is related to social and cultural norms. Finally, to investigate possible barriers to increased contraceptive use. The previous sections demonstrate how perceptions of the initiation and timing of births, the number of children and whether to use contraception or not, as well of what kind of contraception, is shaped by an interplay of social, cultural, religious and structural factors. An attempt to explain the low contraceptive prevalence in Zanzibar thus requires a holistic approach that takes different aspects into consideration, both from the supply- side and the demand- side. Based on the findings of the study, I argue that there are three main problem areas that need to be addressed if the contraceptive prevalence is to increase and fertility is to decrease:

- Lack of knowledge and frequent misconceptions about modern contraceptive methods in the population that prevent increased use of modern contraceptives.
- Under- utilization of existing health services and infrastructure.
- A social and institutional environment that facilitates high fertility and traditional gender norms and expectations.

In the following, each of these problem areas will be discussed against relevant literature and theoretical perspectives.

7.1 Cultural Understandings of the Body, Fertility and Health

7.1.1 Fears and misconceptions.

Awareness of modern contraceptive methods among the informants was high: all the informants in this study could name a number of different modern contraceptive methods, and they knew where to obtain them if they wanted to. This is consistent with findings from the 2010 THDS, which found that knowledge of at least one hormonal or barrier method was almost universal among respondents. However, biomedical knowledge about the human body, the reproductive system and how modern contraceptives affect the body, was very low. Existing knowledge was often built on communication with peers rather than interaction with professionals, and knowledge shared in this way, along with perceived and experienced side effects, contributed to fear, skepticism and rejection of modern methods.

I argue that this lack of biomedical knowledge acts as a significant barrier to increased use of contraceptives for several reasons: First, because lack of understanding about the health risks of high parity, annual pregnancies and continued childbearing in the very early or late reproductive years, may facilitate continued high fertility. Second, because limited understanding of side effects of modern methods may lead to increased fear of these effects, inappropriate attribution of health problems to side effects of modern contraceptives and the discontinuation of contraceptive use due to perceived or experienced non-harmful side effects such as affection of the menstrual cycle. The lack of knowledge gives greater room for fears and misconceptions about modern contraceptive methods. Such fears and misconceptions were common among my informants, and one of the major reasons why some refused to use modern contraception. Similar findings have been seen in previous studies in Tanzania (Madulo, 1995; Marchant et al, 2004; Bunce et al, 2007), Uganda (Nalwadda et al, 2010), South Africa (Wood & Jewkes, 2006), Malawi (Chipeta et al, 2010) and Ghana (Hindin et al, 2014).

7.1.2 Perceptions of health and disease

Understanding of the anatomy and physiology of the body, the reproductive system and the effect of modern contraceptive methods on this system was low among informants. It thus seemed that other medical systems than the Western provided some of the basis of how informants related to fertility and contraceptive use. Lay understandings of the body, its anatomy and physiology, and what constitutes health and illness influenced the way people formed their opinions on these subjects, and the decisions they made. In its most obvious form, this could be seen through use of traditional remedies, the weight placed on advice and information given by traditional healers, and the non-distinction between biomedical practitioners and other practitioners, all referred to as “doctor” (*daktari*).

Differences between biomedical and folk understandings could also be seen in the way informants related to bodily functions, and how they perceived signs and symptoms of illness. The clearest example of this is the understanding of the menstrual period, and the perceived importance and symbolic meaning applied to menstruation. Fear of disturbances in the menstrual period caused by modern contraceptives was a barrier against use for many of the informants. Having a monthly bleeding was known to be a sign of health, and also as representing a “cleansing” of the body. Amenorrhea was thus widely understood as something unwanted, and capable of causing disease and infertility. Disturbance of the menstrual system

was at times interpreted as a sign of “destruction” of a woman’s eggs, and possibly the entire reproductive system. Given understandings like these, menstrual changes become a barrier to use of hormonal contraceptives because it is understood as a threat to health.

The way informants related to the side effects of modern contraceptives was of course also influenced by prevailing understandings of the body. Among my informants, the fear of possible side effects as well as some of the perceived side effects reported by women, acted as barriers against contraceptive use. Some of these perceived side effects such as palpitations, blurred vision, fainting and “heart-burn”, are not found in product information by the producers of modern contraceptives or in guidelines for the provision of family planning (e.g. WHO, 2011).

While fear of side effects and misconceptions about modern contraceptives are frequently described in literature as barriers to contraceptive use in developing countries, the relationship between non- biomedical healing systems and beliefs and perceptions of side effects in women has been less explored. In an early article building on research in Iran, Good (1980) concluded that locally prevailing understandings of the female physiology grounded in Islamic medicine provided the basis for women’s reporting of heart palpitations, weakened nerves, and changes in temper as side effects of the contraceptive pill. From a biomedical perspective, these symptoms were interpreted as psychosomatic and resulting from the stresses and anxiety of women’s lives in Iran, associated with fertility and contraception, sexual intercourse, female sexuality, being a wife and mother, social isolation, worry, grief and poverty. From a biomedical point of view, it would seem plausible to assume that similar dynamics are present among women in Zanzibar.

7.1.3 Local adaptations and practices of Islamic and traditional medicine

A prominent feature of the local understandings of health and illness in Zanzibar is the way religion is influencing healing practices, both in folk medicine and in the biomedical field. Religious scholars have significant roles also as healers, and the Islamic medical tradition appears to be in high regard among many people.

To my knowledge no study has been conducted to map or understand the medical practices and pluralisms of Zanzibar, however some researchers have explored medical practices of the Swahili in coastal Kenya and it is likely that these will have some commonalities with the

practices that prevail in Zanzibar. Beckerleg (1994, p. 300) describes “Swahili conceptions of illness and its treatment” as “inseparable from changing local Islamic ideology and practice”. She describes Swahili medical practices as using local adaptations of concepts that are largely derived from humoral theory. Beckerleg found that lay people used humoral concepts in everyday discourse of health and illness. For lay people, these concepts were simplified into hot – cold, and of the four humors, blood was the one most common in everyday speech. Blood was “associated with strength, loudness and speed” (p. 307). Similarly, Schwartz (1997) found that the Swahili of Mombasa almost universally explained disease causation in humoral terms. In Beckerleg’s study, the study population was influenced by more essentialist Islamic ideology that rejected the belief of spirit possession, to return to humoral beliefs of balance and unbalance, and rejected the idea of disease being caused by interference from outside. However, among the individuals in Schwartz’ study, spirit possession, the evil eye and the existence of *jinn*s, were widely used to explain and understand certain illnesses.

Similarly to what is described in the literature, the religious scholars I interviewed in Zanzibar used recital of the Qur’an, herbal remedies and special foods to treat various conditions. Emphasis was put on the importance of diet to maintain health. The notion of hot and cold was not so prominent, but one of the scholars referred to “coldness” as the cause of miscarriages. The religious scholars described their healing practices as derived directly from the Qur’an and *Hadith*, and thus understood themselves to be practicing “the medicine of the Prophet”. Similarly, the other informants were often drawing on what they perceived to be religious imperatives when explaining their health behaviors in general and regarding fertility and family planning in particular. This was true both for the “lay” people and for the health professionals, in the way they used Islam to argue in favor of birth spacing and breastfeeding. As described in the findings section, breastfeeding for two years was often referred to as a practice prescribed in the Qur’an, and consequently birth spacing for minimum two years was seen as recommended in religion to allow for breastfeeding. A main reason for this prolonged breastfeeding was “helping the child to grow”. The justification for the two years was not frequently explained by biomedical knowledge of health benefits for the child, as there was no emphasis on exclusive breastfeeding or how and when to wean the children.

Among both religious scholars and the “lay” people, it was commonly referred to a complete system of prescribed health behavior, including reproductive practices, which can be found in the Qur’an and other holy scriptures of Islam. The “medicine of the Prophet” was perceived

as transcending time, and was in some ways seen as superior to biomedical practices, because it is natural and without harmful side effects. Moreover, the insights of biomedicine were seen as confirming what can already be found in the Qur'an.

These perceptions may indicate that people trust more the advice they get from religious scholars and healers, than the information they get from public health services. Healers are themselves part of the communities in which they work and thus have a closer contact and relationship with local people. Lack of biomedical knowledge, limited available health information in the public sphere and little contact with the public health services, is likely to be part of the explanation for why biomedical explanatory models do not have a stronger foothold in Zanzibar. Furthermore, the perception that biomedical medicine does not really offer anything that is not already described in the Qur'an, and that Qur'anic remedies are superior to those of modern medicine, may act as a barrier towards using the public health services, for reproductive health purposes or in general. While Islamic treatment may not be harmful in itself, from a biomedical point of view, it becomes dangerous if it keeps people from using evidence-based medicine, such as modern contraceptives. These findings highlight the need for disseminating health information in the population and strengthening the contact between the public health services and local people, possibly through extending the arenas of contact from the PHC clinics to community-based services or through schools.

7.1.4 Islam as a barrier

The way that religion, medicine and health are perceived as intimately connected also has implications for perceptions of reproductive health issues. These will be influenced by what individuals see as sanctified in religion and not. It is also likely to influence what sources of information are being regarded as credible. As described earlier, many informants described hearing messages from religious leaders and scholars about what is allowed and forbidden in Islam when it comes to fertility and contraceptive use. Because of the synergy of religion and health, these messages are likely to be given greater weight than they would in a more secularized context.

A previous study on contraceptive use in a rural area of Zanzibar concluded that religious opposition was one of the major causes that contribute to the low contraceptive use on the island (Keele et al, 2005). Also amongst my informants, religion was frequently cited as a

reason for not using contraceptive methods. Further, all the providers that were interviewed perceived religious opposition to family planning in the population as a barrier to contraceptive use. The ways in which perceptions of Islam acted as barriers can be divided into these categories:

- Pre-destination and reliance: God has planned everything in this world, and God provides for all living beings. Therefore, there is no need for family planning.
- Spacing, but not limiting: Couples are allowed to space their children by two years or more, but should then continue childbearing.
- Islam permits only certain family planning methods.

A minority of the informants held views as in the first category. Those informants who expressed such opinions were all male. This is seen as connected to socially constructed gender norms and will be discussed later in this chapter. As discussed in the previous chapter, none of the informants opposed family planning altogether. Still, some of the male informants saw no need to play an active role in spacing or limiting births, as they believed every life to be planned by Allah. Spacing or limiting births on the basis of economic constraints was consequently not necessary as they relied on Allah to provide for them the things they needed. Similar opinions could be seen among groups of Afghan refugees in Iran (Tober et al, 2006), and among some Muslim Malian immigrants in France (Sargent, 2006).

Tober describes the interaction of low literacy, a pro-natalist cultural identity and the conception that family planning is against Islam, as the major cause of why some of her informants refused the use of contraceptives. Further, a belief that life and death is entirely controlled by God, and a notion of “submitting to divine will” (p. 63). However, the difference in men and women’s perceptions of this issue seem to be influenced by the prevailing gender family model of men as breadwinners and women as caretakers. Women are carrying forward multiple pregnancies and births, and are subject to the burdens that can be associated with both, but are also the main caretakers for the resulting large number of children.

Some informants had also been taught that family planning was allowed for spacing, but after the breastfeeding period is over, one should stop the method and attempt to conceive again.

However, the female informants frequently negotiated what they perceived as religious imperatives to continue childbearing against their own social and economic realities. Hence, the religious encouragement to continue childbearing was deemed as less important than reducing the burden of multiple pregnancies and births, raising a large number of children and managing poverty. Previous researchers have made similar observations in a diversity of Islamic settings. Tober (2006) describes the notion “fewer children, better life” among Iranian women, and how economic difficulties lead them to limit their family size. In Morocco, Hughes (2011) observed that passages from the Qur’an were reinterpreted according to contemporary understandings of reality, where “life is hard” and children are expensive. Hughes’ informants believed that even though Muslims are encouraged to have children, God does not want to burden anyone, and that God does not want people to have more children than they can take care of. Similar to my findings from Zanzibar, Sahu & Hutter (2012) found that Muslim women in India and Bangladesh negotiate religious beliefs against their own fertility intentions:

A Muslim woman often finds herself torn between religious normative expectations and her own aspirations. However, she often makes her choice in the best interests of her family, even at the risk of transgressing the religious norms surrounding reproduction (p. 532).

Likewise, Keefe (2006) found that Muslim women in Tanzania undergoing female sterilization, made their decisions based on their own health and happiness and that of their families, despite what they perceived to be the stance of Islam regarding sterilization.

Although the informants in this study stated that religion is important for shaping their opinions and in guiding their decisions regarding fertility and contraceptive use, when examined more closely, it was clear that their physical and psychological well-being, the opportunity of social participation outside of the home, and the ability to provide for the needs of their children, played a significant role in their decisions about family planning. These Muslim women and men are thus not simply adhering to what they interpret as Islamic doctrine, but make conscious choices according to their situation of life. The variety of interpretations of the relation of Islam to family planning, illustrates that there is no clear answer to this question, but that the religion can be used to advocate for different points of view.

An interesting discovery was the way some informants separated between the different methods of family planning. Prohibition of permanent contraception in the form of male or female sterilization has been described in previous research on family planning in Islamic contexts (Keefe, 2006; Sahu & Hutter, 2012). Similarly, Omran (1992) describes the discourse among scholars regarding *coitus interruptus*/withdrawal. However, the perception that Islam explicitly forbids hormonal contraceptive methods seems to be a local adaptation of religious practices. Similar views were found among religious leaders in the study by Keele et al (2005). Yet, judging from the explanations the informants gave, the prohibition of modern methods seemed to be a result of health concerns about modern methods, rather than religious norms. Repeatedly, the informants referred to the dangers that modern contraceptives posed to women's health, and explained that this is why they are forbidden in Islam. None of the informants gave a theologically framed explanation to why modern methods are forbidden. Rather, concerns about the safety of modern contraceptives were given a religious explanation through the notion that "God wants us to be healthy" and that Islam does not permit that, which is harmful to health. Based on these findings, it is a possibility that much of the opposition to family planning would subside if the level of insight into biomedical rationales in the population would increase.

7.1.5 Changing perceptions of fertility?

According to some classic theories of fertility decline, fertility declines along with modernization, as the cost of children increases and the focus shifts from "quantity" to "quality" of children. According to Caldwell (1982), a central part of this transition is that the wealth flow changes from child – parent, to parent – child. In traditional, agricultural societies, children are economic and social assets through their labor, and the increased social influence that comes with a large family. High fertility thus is an economically rational response. But as a society develops, the cost of children increases with school and medical fees, and high fertility thus becomes an economic burden.

Among my informants, a contrast was observed between those who thought of children as "wealth" to those who said that "life these days is so expensive, we cannot afford many children". Clearly, there was an economic aspect in the way informants related to fertility. However, those informants who wanted a higher number of children (six to ten), or who had no expressed desired number, did not explain this by referring to the economic benefits of having children because of their labor. Neither did they refer to structures of lineage, or land-

sharing, as has been emphasized by some previous researchers (Caldwell & Caldwell, 1987; Hollos & Larsen, 1997). The latter may be related to the composition of the sample, which consisted of a majority of (sub) urban dwellers that were not employed in agriculture. Rather, they consistently explained the benefits of high fertility as providing security in old age. Frequently, this was expressed as: “you don’t know which one will take care of you”. What was implied in this sentence, was that having many children, will secure that at least one or two of them will have a job and can provide for their parents later. Old-age security has been described in previous literature as a risk-coping mechanism. The influence of old age security on fertility can be seen as related to how parents assess their ability to support themselves during old age, and of other sources of support besides income (Caseres- Delpiano, 2013). Nugent (1985) suggested eight-factors that should be present for the old-age security motive to influence fertility decisions. His framework included several factors that may be relevant for the Zanzibari context:

- An underdeveloped economy
- Uncertainty about the possibility of acquiring the necessary financial security for old age or disability
- Lack of available old-age and disability insurance programs
- Confidence that children will be loyal to their parents
- Absence of well-developed work opportunities for women

When interpreted against this outline, the old age security motive seems relevant in the Zanzibari context. The public pension program covers only a minor percentage of the population. The private sector is also missing regulation, and most people work with no social protection rights (ILO, 2010). For women, who earn less than men, and whose chances of accumulating wealth are further restricted due to the practice of Islamic marriage, divorce and inheritance laws, their dependence on their children will be even greater.

On the other hand, some informants wanted to limit births because of what they described as increased costs of living and of raising children. They described that before, “everything was free”, but these days, life is expensive, and children need education and healthcare, which costs money. These informants expressed similar feelings as what Tober (2006) described in

Iran, namely “fewer children, better life”. These informants connected education with succeeding in a society undergoing significant changes.

These seemingly opposite perceptions of fertility and the value placed on children can be read against the development of Zanzibari society as a whole. Increasing urbanization, migration and a transition from informal employment to wage employment, is likely to change the criteria on which economic prosperity and security is built. The demand for formal education in employment is likely to increase and the demand for unskilled workers to decrease. This may lead more people to want to reduce their family size in order to be able to provide higher education for their children.

7.2 Gender and Power Relations

In the theory of gender and power, Raewyn Connell (1987) argues that there are three major structures that make the basis for gender relations; the sexual division of labour, power and cathexis. In the following, I discuss the decision- making processes and perceptions of fertility and contraception in Zanzibar based on the concepts laid out by Connell. Gender and power dynamics in Zanzibari society is thus understood as a primary dynamism in fertility decisions and contraceptive use.

7.2.1 Understanding gender across cultures

Hence, when discussing gender roles in a specific culture, one naturally has to acknowledge that the meaning of gender and gender relations is perceived differently across cultures. What is perceived as gender inequalities from a Western point of view might not be experienced as such by the people living in that particular society.

An observation on this is that the women I interviewed in Zanzibar did not seem to think of themselves as assertively oppressed. Rather, both women and men seemed to think of the dominance of men as a form of protecting women. Male dominance was thus not seen as suppressing women, but as a way of supporting and protecting them, much like a parent would support and protect a child. Even so, it was apparent that women saw these gender differences as sanctified in religion and thus, if they did have objections, the perceived “God-given” nature of these differences, or inequalities, made them hard to criticize. However,

some women did express disapproval of polygyny and divorce practices that differentiates between men and women. This might be interpreted as a growing awareness and resistance towards the structural discrimination of women, and perhaps changing gender relations.

The position of women in Islamic societies has often been the subject of heated debate. Secular feminists have frequently criticized the religion as oppressive and incompatible with feminism. The interlinking of state, religion and the law is seen as negative and as a barrier to women's liberation (Treacher, 2003). The question of whether or not Islam as a religion can act as the foundation for gender equality has been central. The argument made against has been that Islam, as a non-egalitarian ideology, cannot provide the basis for equality and therefore is not capable of feminism. In contrast, Muslim feminists have argued that Islam itself is egalitarian, but that its practice has reproduced gender inequalities that predate Islam (Ramirez, 2006). Other Islamic feminists have interpreted women's place and rights within the Islamic framework. Western culture is seen as exploiting women as sex objects and cheap labor. Women have a double burden of working and domestic responsibilities. Contrary to this Islam offers women true freedom *as women*, not through "becoming like men" (Treacher, 2003).

Whether Islam as a religion is essentially misogynistic or not, is a question I do not claim to know the answer to. I doubt that this question can be answered with a yes or no, as the practice of Islam, as every other religion, varies across individuals, cultures, and political systems. It is therefore difficult to know what constitutes "the true Islam", and what its position on gender relations really is. In the following section some social and institutional practices in Zanzibar are discussed from a gender equality perspective. I argue that these practices are part of a gendered social structure that contributes to the continued high fertility and low contraceptive use in Zanzibar. In the local context, these practices are justified as being part of religious law, or *Shari'ah*. My critique is thus directed at the way Islam is interpreted and practiced in this context, and does not concern the theology of Islam.

7.2.2 Fertility and the division of labor

The sexual division of labor is according to Connell "at its simplest an allocation of particular types of work to particular categories of people" (1987, p. 99). This division is seen as a social rule that allocates men and women to different types of work, and eventually becomes

different professional skilling and training. This provides the rationale for discriminatory employment from employers that become an apparently technical division of labor that cannot be targeted by traditional anti-discriminatory measures. Further, Connell sees the sexual division of labor as part of a larger, gendered system of “production, consumption and distribution” (1987, p. 103) that limits women’s ability to accumulate wealth, and consistently allocates childcare to women, and especially young women (Connell, 1987).

In Zanzibar, the sexual division of labor is seen in the allocation of domestic work, rearing of children and types of employment. Society is built around the concept of the man as breadwinner. Women are largely confined to childcare and various types of unpaid or marginally paid work; domestic or agricultural work, or in small family-run businesses such as shops. Very few women take part in wage employment (ILO, 2010). Even for men, a minority are wage laborers, and Zanzibar is still a society where many people rely on traditional work such as agriculture and fishing. However, in this difficult economic environment, women are further restricted from work opportunities by gender norms that define which kind of work is “suitable” for women. These norms prohibit them from working in jobs where they interact with men in a way that may lead to sexual attention. An example of this can be seen in the tourism industry, which provides income for a growing part of the population. In tourism, Zanzibari women can be seen working as maids or performing secretarial tasks, but rarely as managers, tourist guides, waitresses, bartenders, or other jobs where they are in direct contact with tourists.

This sexual division of labor is connected to social systems that define roles and responsibilities for men and women, in the family and in society in general. My informants, not counting the health professionals, expressed a social system where men are providers, and women are caretakers. Sargent (2006) portrayed a similar family system in her study of Malian immigrants in France. She describes an interview with a respected imam from this community, who explains the ideal Islamic family, as he perceives it. In this family system, the man is the head of the household, and the wife is responsible for the upbringing of the children. The husband is granted submission and authority and should provide moral guidance to his wife. A man is responsible to provide materially for his family. He can take up to four wives but must treat them equally.

Essentially, the man is seen as solely responsible for providing food, shelter, clothes and everything else the family needs. If the woman works, she has a more auxiliary role, where the role as mother supersedes the role as worker, as she is expected to stay home if she has small children. Even though none of the informants thought that it was inappropriate or prohibited for women to work outside the home, there was still clearly defined roles for the division of labor in the family. Although not generalizable, my findings suggest that women who challenge these established norms might suffer social repercussions. Among the community informants, three out of the five women who had paid work were divorced, one of them as a direct result of her intention to work outside of the home. But even for her, she explained that her primary motivation to go back to work after quitting when she married was that her husband did not provide for her the way he should have.

The notion that a woman's primary task is the rearing of children, taking care of the home and her husband, has implications for fertility and contraceptive use. It means that there is less of an incentive of limiting births, because women may not share the career aspirations that many women do in societies with more gender equity. High fertility is therefore less of an obstacle to realize one's career objectives. Further, the acceptance of spacing births and the realization of the health benefits of spacing are intrinsically connected to perceived gender roles and division of labor. Spacing of children, while contributing to better maternal and child health, still allows for high fertility throughout a woman's reproductive lifespan and thus does not challenge the division of labor, as the woman's primary task is still the upbringing of children. McDonald (2000) claims that changing of the family organization is usually a gradual process. Social norms may allow women increased control over fertility as long as this does not threaten the prevailing male- dominated family system.

Contrary to this, the stopping of childbearing while still in the reproductive age almost automatically provides women the opportunity to expand their social and economic participation. It thereby challenges the established norm on a more essential level. It can be argued that the same dynamic is underlying the acceptance of contraceptives, with the exception of male or female sterilization, even though this resistance is expressed through religious objections based on ideas of pre-destination. In line with this argument, McDonald (2000) challenges the conventional proposition of demographic enquiry that major changes in the nature of women's lives will lead to sustained lowered fertility. Instead he argues that lowered fertility will in itself lead to fundamental changes in women's lives and the division

of labor. Women in high- fertility societies, he writes, may choose to have fewer children, not as a result of a set of characteristics they have already obtained, but in the attempt of improving their future lives. Even so, he emphasizes the consideration of the values of the women and men in a particular society, and whether the women find the existing gender inequalities and division of labor to be unfair. As he points out, women are unlikely to express such feelings using academic terms:

In high fertility contexts, gender inequity within the family may be experienced by women as, *inter alia*, a generalized dissatisfaction with the rigors and dangers of a constant round of childbearing and childrearing imposed by spousal, familial, and societal expectations (p. 428).

I find this quote to be accurate for the women I met in Zanzibar. During interviews, I would repeatedly try to understand my informants' thoughts on whether there is a link between fertility, contraceptive use and women's general status, but I found that my informants did not really relate to these questions. They did however express tiredness after multiple childbirths and a feeling that having to care for many small children at the same time is very difficult. Further, that having less children gives women the opportunity to do other things, such as going to weddings or a journey. It seemed that some women did have a desire for greater social participation or freedom, but for that the prospect of greater economic participation was a more foreign concept.

7.2.3 Power in spousal relationships

Connell (1987) emphasizes that we must see beyond individual events involving power, to the structure of power, "a set of social relations with some scope and permanence (p. 107)". When individual acts of force and oppression are understood against the underlying social order of power inequalities and male dominance, they are seen not as breaking the social order, but enforcing it. Connell writes that while in earlier feminist thought, the family was often seen as the key to oppression of women, much of the focus has now shifted towards the struggles of working- class women, as the male dominance within the family has decreased. In Zanzibar, this shift has yet to take place. While power relations between couples no doubt vary, and some women may have a lot of influence on decisions being made, especially relating to domestic matters, there is little doubt that the overall distribution of power is in favor of men. The dominance of men is enforced through a gendered social order that

encompasses a woman's entire lifespan. This order is inherent in the culture and in the way religion is practiced. Connell (1987) uses the male hierarchy in the Catholic Church to exemplify the way culture is used to impose gender norms, through the emphasizing of female "purity, meekness and obedience". The similarity to the gender order in Zanzibar is striking. The male-dominated Islamic leadership, as well as popular understandings of the religion, supports a system where women are expected to be chaste, obedient, and where they are socially and economically dependent on men.

In a sense, the gender order in Zanzibar is at its core a social system where women never reach the state of adulthood, when this is understood as independence and autonomy in decision-making. Throughout their lives, a woman is under the control of men she is related to in different ways. Growing up, she learns obedience towards her parents and teachers. In adolescence she is under strict social control to guard her chastity and virginity. When getting married, she is taught obedience towards her husband. The power to control her life is then transferred from her father to her husband, whom she may or in many cases may not have chosen herself. After marriage, she is expected to ask her husband for permission to undertake any action. If he wants, he can take one or several other wives. From early age, she has been taught to accept this as a part of life, a practice condoned or even encouraged in the *Shari'ah*, which is seen as direct instructions from God and thus cannot be questioned. If her husband decides to divorce her, he is free to do so, and she has no right to the home they have shared. She is then expected to move back to her parents', again falling under their authority. Even though she might be in her thirties or forties, and a mother of several children, the social norms do not allow her to live alone, with or without her children.

Male dominance over women is not only upheld by social structures, but is strengthened by the institutional environment. Zanzibari authorities have made efforts to increase gender equality and have achieved good results in increasing female education, and female representation in parliament. Despite these positive developments, other institutional changes are necessary if greater equality is to be achieved, particularly in the legal system. The lawfulness of polygyny, in combination with discriminative divorce laws, create a situation where women are disposable and can be replaced, or forced to share their husbands with one or several other women, if they do not fulfill their role as this is perceived by their husbands.

7.2.4 Implications for fertility and contraceptive use

This social system also has implications for fertility and women's autonomy in reproductive decision-making. As presented in the findings, male resistance to contraceptive use and their desire for big families, was seen by my informants as a major reason for women's non-use of contraception, first because perceived opposition from husbands leads women to avoid raising the subject, and second because husbands directly refuse use of contraception.

The findings thus indicate that male hegemony within families contributes to lack of communication about desired family size, contraceptive use and a general lack of planning of reproductive matters. Further, that if the husbands' and wives' fertility goals differ, the husbands' is likely to have precedence. The unequal power balance in the spousal relationship is founded in culture and reinforced through discriminatory civil laws, and it increases men's ability to assert their fertility goals even if they differ from those of their wives. Women who try to oppose their husbands risk not only a conflict, but also having to share their husbands or getting divorced.

A number of studies have examined the relationship between relative power in sexual relationships and fertility and contraceptive use. In a study comparing five Asian countries, Mason and Smith (2000) found that in contexts where women have greater autonomy, the influence of their fertility goals are more likely to be equal or exceed those of their husbands' in the decision to use contraceptives or not. In Kenya, Kimuna and Adamchak (2001) argued that women's subordinate position restricted their ability to limit family size if their husbands wanted more children. In Uganda, Snow et al (2013) concluded that male-dominant attitudes in young men were predictive of high fertility aspirations. Several authors have suggested that the overall empowerment of women is associated with contraceptive use (Blanc, 2001; Hollos and Larsen, 2003; Hollos and Larsen, 2004; Do and Korimoto, 2012).

7.2.5 Gendered sexual norms

Connell (1987) writes that to understand a social structure in sexuality, one must accept the assumption that sexuality is socially constructed:

It's bodily dimension does not exist before, or outside, the social practices in which relationships between people are formed and carried on. Sexuality is enacted or conducted, it is not expressed (p. 111).

To define the social structures in sexuality, Connell (1987) uses the term *cathexis*, which in the theory of gender and power can be understood as attachment of emotions to social relationships between people. The social patterning of desire is governed by certain norms and prohibitions, such as prohibition of incest, rape and homosexuality in some cultures. Desire is usually understood through the opposition of feminine and masculine, and the couple relationship is the main sphere of sexual practices. However, to Connell, heterosexual relationships are characterized not only by the gender differences, but also by distinct gender inequalities. She argues that the erotic exchange in heterosexual relationships is in essence unequal, and that there are material reasons why women participate in these relationships.

Different norms and expectations apply to male and female sexuality in Zanzibar. As previously described, sexuality is (at least officially) confined to marriage, and pre- marital or extra- marital sexual activity is seen as socially unacceptable. Also for men, sexual activities outside of marriage is seen as sinful, but not to the same extent as for women. This can be seen by the way young women are educated about sexual practices and marital relations before marriage, while young men are not, at least not to the same degree. A young girl must maintain her virginity to not bring shame on the family, for young men, while not endorsed, their sexual activity is more or less assumed. This description of sexual norms is supported by previous research on sexuality in Zanzibar (Beckmann, 2010). Also later in life, a woman must take care not to cause sexual arousal in men, through dressing modestly and working in "appropriate" jobs. Men are understood to have a higher sex drive than women. Treacher (2003) describes "Islamic sexuality" in similar terms: "Beliefs about sexuality and virtue are of primary significance" (p. 62). Women are expected to be virtuous, modest and to uphold the moral order. Men are seen as easily corruptible and tempted by female bodies. For this reason, men and women are segregated in the mosques. This argument has also led to the encouragement of various forms of veiling, from the *hijab* (headscarf) to the *burqa* (total coverage of the body, including the eyes). The clearest example of these differentiated sexual norms is the way men's supposedly higher sexual desire is used to legitimize polygyny. However, when viewed from a gender perspective, the sanctioning of polygyny is a result of a

social structure of male dominance, one that women accept because they are still dependent on men for survival. As Connell notes (p.113):

The “double standard”, permitting promiscuous sexuality to men and forbidding it to women, has nothing to do with greater desire on the part of men; it has everything to do with greater power.

I argue that the conservative norms around sexuality, particularly for women, are contributing to the continued high fertility and low contraceptive use in Zanzibar. The “double standard” for women and men reinforces male dominance and make women less capable of realizing their own fertility intentions. Further, the stigma of pre- marital or extra- marital sexual relations is restricting access to information and services, especially for young people.

7.3 Family Planning Services: Does the Supply Meet the Demand?

According to the SRHR framework, contraceptive services should be available, accessible, acceptable, and of good quality. It means that a full range of methods must be available, that information and services are provided on a non- discriminatory basis, that services are affordable and physically accessible. Legal and practical barriers are an impediment to access. Services should be provided in a culturally sensitive way, be of medical good quality, and treat clients respectfully (UNFPA, 2010). In some aspects of this framework, the family planning program in Zanzibar has made great progress. Services are geographically easy to access. Contraceptives are provided for free. Most facilities offer a range of methods, even though IUD’s, male and female sterilization, and EC are not available in PHCUs. Even so, modern contraceptives are fairly easily available and affordable. Rather, the problem seems to be that the services are not being utilized by the population. Some of this may be explained by low demand for contraceptives due to high desired family sizes. However, the very high unmet need for contraceptives, 35 % in the 2010 THDS, suggest that there is a potential to increase contraceptive use. The providers I interviewed expressed that unsafe abortion is a problem. It is possible that clandestine abortion is substituting contraception for some women who experience unplanned pregnancies. Previous research has referred to hospital statistics that support this impression (Rasch & Kipingili, 2009).

Compared with findings from Mainland Tanzania, the geographical accessibility of clinics is not likely to impede access in Zanzibar. Further, lack of awareness about contraceptives or where to obtain them is less probable to represent a barrier. However, there seems to be other factors that limit access for certain women. The lack of privacy in clinics may represent a

barrier for some groups of women, especially adolescents, unmarried women and those with no children or low parity. Additionally, the PHCUs have limited contact with men. According to my informants, opposition from men is a major cause of unmet need for contraceptives among Zanzibari women. The family planning program should implement measures to increase the participation of men in reproductive health matters in order to address this issue.

The high unmet need for contraception further suggests that the contact between family planning services and the communities need to be strengthened. The lack of knowledge and frequent misconceptions that I observed accentuates this picture. Fears of side effects and misconceptions most likely contribute significantly to unmet need in Zanzibari women. This is consistent with findings from other developing countries (Bongaarts & Bruce, 1995). The pluralism of medical systems, and the anti- family planning propaganda that was frequently described among my informants, further emphasizes the need to establish or improve links between the public health system and the communities they serve. Also, there is a need to disseminate quality contraceptive information that is understandable to the population, both to promote contraceptive use, but also to counteract the impact of the misinformation that is provided by traditional healers and religious extremists.

In the 2010 TDHS, only five percent of women who were not using contraceptives reported having discussed family planning with a field worker in the last twelve months. It can be argued that the clinic- based distribution system that is employed in Zanzibar, is ill- fitted to the needs of the population regarding this issue. In their essay on the causes of unmet need for contraception, Bongaarts and Bruce (1995) argued for the use of female community health workers in settings “where information sharing is inhibited by gender- segregated roles and communication patterns, low literacy and women’s limited geographical movements (p. 67). Female community- based health workers have the ability to address a range of social factors that hinder knowledge of contraception or action on that knowledge, as well as representing new role models for women. As emphasized in the article, this is especially important in low- prevalence settings, such as Zanzibar, because people naturally will have few examples of satisfied users.

It is possible that if the program would focus more on community- based distribution with trained community health workers who visited families at home, this would increase the uptake as the community health workers could reach women who would not come to the

clinics by themselves. This approach has been applied successfully in Indonesia and Bangladesh (Gertler & Molyneux, 1994; Bongaarts & Bruce, 1995; Cleland et al, 2006; Streatfield & Kamal, 2013).

7.3.1 Provider based barriers and quality of care

Information from interviews with family planning clients in this study, suggests that even after coming in contact with health services, women do not get the contraceptive information they need. The providers who were interviewed all stated that they explained how the contraceptive methods work, and about possible side effects. However, the clients' descriptions of the consultations were quite different, as they could not recall having been given this information, and they could not explain how contraceptives work in the body. I see two possible explanations for this discrepancy in information. One is that providers were not truthful in their accounts, and gave the "right" answers, the ones they thought they were expected to give. Another explanation could be that the information was given, but was not suited to the needs of the clients, and therefore was forgotten, or not understood. In either case, these findings indicate that the information given to clients needs to be improved. This requires that providers receive the training and supervision they need to convey the information to clients, and to adequately address health concerns.

In addition, the findings indicate that barriers placed by providers sometimes restrict access to contraception. The information from interviews with providers suggests that eligibility criteria on contraceptives that are not based on the medical eligibility criteria recognized by WHO and others are sometimes practiced. On the positive side, none of the providers stated that they practice restrictions such as spousal or parental consent, or age and parity requirements on non- permanent forms of contraceptives. However, cultural barriers may still restrict access for adolescents or unmarried women. Further, some women reported having been denied female sterilization on the basis of age and required consent from the husband. These findings indicate need for continued in- service training and supervision of providers to secure all women's right to contraceptive services.

7.3.2 Missed opportunities of contraceptive initiation

Information from interviews with women suggests that existing venues for contraceptive counseling and provision are not being utilized by the health care services. The women were

first introduced to family planning after they had their first child, or even later. The fact that antenatal care and immunization is almost universal in Zanzibar means that women are in contact with health services. These contact points should be used to actively promote contraceptive use. This finding is supported by the results from the 2010 DHS, which show that among the non- users who visited a health facility in the last year, only 12.6 percent discussed family planning. Similar results were found by Arends- Kuennig & Kessy (2007) in Mainland Tanzania. They argued that expanding information to women would likely increase contraceptive use.

7.3.3 Limited access for young people

The taboo of pre- marital sex is also present in the educational system, and is restricting adolescents' access to sexual and reproductive health information. The "Family Life Education" curriculum of comprehensive sexuality education that has been introduced in Mainland Tanzania, was introduced in Zanzibar in 1990 (UNFPA, 2013), but was found to be culturally unacceptable by the Zanzibari authorities (Ministry of Health employee, personal communication, 2013). In Zanzibar, "Family Life Education" was renamed "Moral Ethics and Environmental Education". According to a 2012 publication by UNFPA, the subjects of family planning, pregnancy and its possible complications is not well covered in the framework for life skills and SRH education for adolescents and youth (UNFPA, 2013). The education policy of Zanzibar states that the focus of this education should be on abstinence (RGoZ, 2006).

Even though the providers in this study claimed to provide services on a non- discriminatory basis, the stigma of pre- marital sex may also restrict adolescents' access to contraception and other sexual and reproductive health services, as they may find it too risky to attend the PHCU clinics. Previous research has suggested that fear of judgment and lack of confidentiality can be a contributing factor for non- use of contraceptives by adolescents. Further, that fear of being exposed in a waiting room can deter young people from seeking care. (Langhaug et al, 2003; Wood & Jewkes, 2006; Tylee et al, 2007; Bearinger et al, 2007; Nalwadda, 2010).

The task of educating young people, and in particular young women, about sexuality, pregnancy and childbirth, relationships and marriage, is therefore largely left to the traditional structures within the family, to older family members with no medical or educational

background. As previously described, this education comes only as the young person is about to get married. This traditional information sharing focuses more on sexual practices, how to learn to enjoy sex and to how please your husband and be a good wife, than health information about reproduction or contraception. Previous research has described these practices in similar terms (Beckmann, 2010; Decker, 2013). While these teachings may contain valuable information in this cultural context, they do not equip young women with the skills to control their fertility according to their needs. Today there is strong evidence that comprehensive sexuality education for adolescents and young people do not lead to earlier sexual debut, increased sexual activity or “promiscuity” (Grunseit et al, 1997; Kirby et al, 2007; Bearinger et al, 2007; Mavedzenge et al, 2010). On the contrary, the evidence suggests that it reduces risky sexual behavior.

The lack of sexuality and relationship education and contraceptive information in school and the lack of youth- friendly reproductive health services result in a situation where young people are unprepared for the realities of sexuality, marriage and childbirth. The social prohibition of pre- marital sex, contributes to the situation described by the women in this study, where women get information about contraception for the first time only after giving birth to their first child, or even later. This is likely to reduce their ability to plan their families and expose them to unplanned pregnancies. Introduction of comprehensive sexuality education from primary school level, as well as increasing efforts to provide youth- friendly services, might equip young people, and especially women, with more of the skills they need to realize their reproductive aspirations.

7.4 Fertility, Religion and Politics

It is often assumed that Islam is essentially pro- natalist and opposes family planning completely, and supposedly high rates of Muslim fertility is used as evidence of this. However, some authors have suggested that this is highly influenced by the national, cultural and political context (Johnson- Hanks, 2006; Keefe, 2006; Hughes, 2011). Johnson- Hanks (2006) argues that fertility rates are social products, and while Islam influences social structures and local politics, its influence on fertility is not uniform across social, economic and demographic contexts. As she puts it: “There is no single, coherent Muslim reproductive pattern: the real story is local” (p. 14). The steep fertility decline in various Muslim countries in the Middle East as well as some in North Africa illustrates the contextual influence on

Muslim fertility. As proposed by Obermeyer, (1994, p. 41) “the impact of Islam on gender and reproduction is largely a function of the political context in which these issues are defined”. She uses the family planning programs in Iran and Tunisia to exemplify how leaders use Islam to justify conflicting views on gender and reproduction. In Tunisia, political leaders outlawed polygyny while arguing within the Islamic framework. In Iran, the administration has justified seemingly opposite population policies with religion. In the years after the revolution, the administration was more pro- natalist and high fertility was encouraged to strengthen the Islamic nation. The funding for the family planning program initiated by the ousted Shah was severely reduced, and abortion and sterilization outlawed. In the late eighties, the population growth, in combination with economic difficulties and the war with Iraq, started to threaten the regime’s ability to provide basic services for its people. As a result, the administration reversed its course and began actively promoting family planning and fertility reduction (Obermeyer, 1994). In family planning clinics and outreach efforts all over Iran, smaller families are actively promoted with slogans such as “not too soon, not too late, not too many” and “fewer children, better life”. Since then, fertility has fallen to replacement- level (Tober, 2006). In Pakistan, Varley (2012) observed that contraceptive providers as well as women used “Islamized family planning” inspired by Qur’anic texts and *hadith*, to legitimize contraceptive use.

In Zanzibar, the health authorities have advocated spacing of births, but have been reluctant to promote smaller family sizes. According to the MoHSW employees that I interviewed for this study, it is presumed that advocating for smaller families is “culturally unacceptable” and therefore difficult in the Zanzibari context. Further, it is assumed that if child spacing is more widely practiced, fertility will “naturally” be reduced. Family planning providers thus encourage women to space births, but do not actively promote smaller families. Some providers perceived promoting smaller families as “un- Islamic”, but they believed that when women space their pregnancies, their fertility will also be reduced. The family planning program has followed the example of other Islamic countries such as Indonesia, where religious leaders were used to advocate for contraceptive use. However, in Indonesia, the program actively promotes two – child families and uses the slogan *dua anak kupup* (only two children are enough). Fertility in Indonesia declined from >5 children per woman in the 1970’s to 2.6 today, and the government has set the target of reaching replacement- level fertility by 2025 (Gertler & Molyneux, 1994; Seiff, 2014).

Fertility in Zanzibar *has* declined since the onset of the family planning program, from 6.4 births per woman in 1991 – 92, to 5.6 in 1999, to 5.3 in 2004 – 2005, to 5.1 births in 2010 (THDS 1991 – 92; TRCHS 1999; THDS 2004 - 05; 2010). Still, this is still more than double the replacement level of 2.1 births per woman. The fertility decline also seems to have stalled in later years. The continued high fertility is likely to be connected to the fact that the majority of Zanzibaris still desire large families. The latest DHS data show that women in Zanzibar have a mean ideal family size of 6.6 children, nearly two children higher than women in Mainland Tanzania (4.8 children) (TDHS, 2010). Previous research has shown that family planning programs that include campaigns that focus on the benefits of contraception and smaller families, can have a significant impact on reproductive behavior and preferences (Bongaarts, 2011). To legitimize the idea of modern methods and smaller families is key in the initial stages. This requires the support of traditional and religious power structures as well as secular stakeholders (Cleland et al., 2006). The government may need to take a more active role in trying to influence fertility preferences and demand for contraceptives if fertility is to fall to replacement level within the next decades. This means providers' attitudes must be changed as well. Experience from other Islamic countries such as Iran and Indonesia shows that it is possible to advocate for smaller families within the Islamic framework, and thus remain within what is culturally acceptable for the population. Further, it shows that fertility preferences and demand for contraceptives can be changed if the political will exists to do so.

7.5 Recommendations for further research

This study employed a qualitative methodology and the results are not generalizable to the entire population of Zanzibar. Quantitative research is needed to assess whether the findings of this study are representable for the general population. Future research should include investigation into the causes of unmet need for contraception. The findings of this study suggest that male opposition to family planning contributes substantially to unmet need in Zanzibari women. Additional research is needed to increase understanding of men's attitudes towards family planning, reasons for male opposition against family planning, as well as their reproductive health needs.

Chapter 8: Concluding Remarks

This study explored perceptions of fertility and contraceptive use in Zanzibar. Doing so, it started from the point that the factors that shape these are highly contextual and that programs that are adapted to local needs will have a larger impact. The findings suggest that cultural and social norms around fertility are changing, and that the idea of planning the timing and number of children is becoming increasingly accepted. However, challenges remain in increasing acceptance and adoption of modern contraceptive methods and in utilizing the existing health infrastructure to a higher degree.

The latest Tanzania DHS estimated unmet need for contraception in Zanzibar to be at 35%, which is a very high number even in the sub-Saharan African context. It seems probable that in the years to come, more people will wish to plan and limit their family sizes. Thus, the demand for contraception will further increase. This presents significant challenges for the public health system, which has to find ways to meet the demand.

The concept of birth spacing in the Zanzibari context is closely connected to the cultural emphasis on extended breastfeeding. Extended breastfeeding is seen as a vital part of caring for children in their first years of life. It is founded in Islamic tradition, which through the perceived requirement of two years breastfeeding facilitates birth spacing. Moreover, there seems to be a general recognition of birth spacing as being beneficial for the health of mothers and children. This is founded in Islamic beliefs as well as in biomedical medicine.

Even so, it appears many people still want relatively large families. There seems to be extensive social pressure on women both to prove fertility at the start of a marriage, and to continue childbearing. Established gender norms are seen as influencing fertility rates and contraceptive use through the confinement of women to the domestic sphere and by limiting women's autonomy in reproductive decisions. Limited social and economic participation by women as well as structural norms that favor men contributes to an unequal distribution of power between spouses. This leads to poor communication about reproductive matters, as well as men's fertility intentions dominating those of women. The findings suggest that male opposition is one of the main factors contributing to unmet need for contraception in Zanzibari women.

The idea of limiting births or stopping childbearing while still fecund is still somewhat culturally and religiously controversial. A cultural identity that “Zanzibaris like to have many children” is contributing to this. Additionally, beliefs that life and death are in the hands of God, that Muslims are required to have many children, and that God should determine the number, facilitate continued high fertility.

However, the research demonstrates that while clearly having an influence, religious beliefs are but one factor that affects perceptions of fertility. Social and economic factors appear to be just as, or more, important than religion in this sense. Zanzibar is experiencing societal changes through the process of modernization, increased urbanization, migration and a changing labor market. A larger cash economy, demand for skilled workers, and increasing living costs contribute in challenging traditional pro-natalist cultural notions. Where children have traditionally been seen as “wealth”, they are gradually becoming more expensive. The traditional meaning of *tajiri na mali yake, maskini na watoto wake* - “rich people with their properties, poor people with their children” is being questioned, as parents face the costs of providing education, health services and other needs of their children. This leads couples to want to reduce the number of children they have to be able to provide for them. Furthermore, it seems the wish to care for one’s children and to spend time with them leads couples to want to limit their family size. This may partly be a result of urbanization, with more families being nuclear and relying less on extended family networks and fostering of children. Additionally, among some female informants, lower fertility aspirations were based on their desire for having time for other activities than childbearing and rearing. This may indicate that the traditional family model is being challenged.

The findings of this study suggest that fears and misconceptions about modern contraception represent a major impediment to increased contraceptive uptake. Traditional contraceptive methods such as extended breastfeeding, fertility awareness methods and withdrawal seem to be widely accepted, whereas considerable skepticism exists towards modern methods. This seems to be linked to cultural understandings of the body, especially on the significance placed on having regular menstrual periods. Affection of the menstrual cycle caused by modern contraceptives seems to be a barrier against use for some women. Health concerns about the side effects of modern contraceptives was the main reason for non-use among informants in this study. Misconceptions seem to be spread through rumors, or sometimes

from health workers themselves. The plurality of medical systems that prevail contribute to the spread of misinformation about modern contraception.

The apparent active discouragement of family planning from some religious leaders is a further obstacle to increased use. Based on interview data, there seems to be considerable opposition towards family planning and especially modern contraceptive methods among some religious leaders. A notion that modern contraceptive methods are not permissible in Islam seems to stem from religious propaganda from some scholars. However, much of the religious opposition among my informants was essentially based on health concerns regarding modern contraception, which were given a religious meaning. This suggests the need to disseminate correct reproductive health information that also addresses religious concerns. Sensitization and use of religious leaders to promote family planning may be effective in increasing use.

Fears and misconceptions about modern contraception are given greater room because of limited access to reproductive health information in schools and communities and limited contact with reproductive health services. The data further suggests that the information women are provided from health workers is either not sufficient or is not being understood. This creates an information void that is filled by non- biomedical healing systems and practitioners.

To counteract misconceptions and misinformation, dissemination of sexual and reproductive health information including family planning is needed in the communities where people live. Furthermore, comprehensive sexuality and relationship education should be implemented in schools. Providing young people, and especially young women, with reproductive health and family planning information before their first childbirth could potentially reduce the number of unplanned pregnancies and leave young people better equipped to plan their families and their lives.

Family planning services should be prioritized in order to achieve existing health targets as well as socioeconomic development. Providing more women the means to control their fertility will contribute to reduce the number of unplanned pregnancies, as well as maternal and child mortality. Furthermore, it will facilitate increased empowerment of Zanzibari women through improved opportunities of education and employment. The current high

population growth is impeding sustainable development in Zanzibar and should be of political concern. Voluntary adoption of modern contraception is the most effective way of curbing the population growth. Promotion of birth spacing alone appears insufficient to substantially reduce fertility. It should also include information about the benefits of smaller families in order to legitimize this concept in the population.

The findings indicate that provider – based barriers sometimes restrict access to certain methods. This suggests the need for continued training and support to providers. Furthermore, restrictive cultural norms around sexuality may limit access to services, especially for young and unmarried people, due to the lack of privacy in the clinic environment. Development of youth- friendly delivery points could potentially make access easier for young people. The findings further suggest that there is a need to involve men to a larger degree in family planning and reproductive health services in order to decrease male opposition to family planning. Where possible, men should be invited to take part in contraceptive counseling. Promotion of family planning should also address this issue and provide information suited to the needs of men. Existing delivery points can be better utilized by discussing family planning with all women who use the health services. Additionally, outreach services should be expanded to reach more women who do not use the existing services.

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Glossary

<i>Hadith</i>	Sayings that are attributed to the Prophet Muhammad
<i>Imam</i>	Leader of the prayer, Muslim leader
<i>Khadis</i>	Islamic judge
<i>Madrassa</i>	Qur'anic school
<i>Shari'ah</i>	Islamic law
<i>Sheha</i>	Leader of Shehia
<i>Shehia</i>	Lowest governmental administrative level in Zanzibar
<i>Sheikh</i>	Islamic scholar
<i>Sunnah</i>	The tradition of the Prophet Muhammad

Appendices

Appendix I:

Interview guides

Theme guide for interviews with clients/community informants

Theme: Family and children.

- 1) Your age, education, occupation, religion?
- 2) Can you describe an ordinary day in your life?
- 2) Can you describe your family?
- 3) Do you have children?
- 4) How many children would you like to have?

Theme: The community

- 1) Can you describe the community you live in?
- 2) What are the common sources of income in your community? (Agriculture, industry, tourism...?)
- 3) How many children are typical for the families in your community?
- 4) Can you describe the common family structure in your community? (Nuclear, extended family, single parent etc.)
- 5) Can you describe the FP services that are available in your community? Is it easy to access contraceptives in your community?
- 6) Can you tell me how people in your community think about contraceptive methods?

Theme: Contraception/family planning experiences

- 1) How did you first hear about family planning?
- 2) What methods do you know/have heard about?
- 3) Are you/your partner currently using a contraceptive method?

If yes:

For you, what is the purpose of using contraception?

Can you tell me how you started using it?

For how long have you used it?

Are you planning to keep using it in the future?

Do you have a preferred method?

Are there any methods that you would not like to use?

If no:

Are there specific reasons why you are not using it?

If relevant;

Would you like to use it? If yes; what is the reason why you are not?

What would make it easier for you to use contraceptives?

- 3) In your opinion, who should/should not use contraceptive methods?

Theme: Communication and decision- making

- 1) Who do you talk to about contraception?
- 2) Do you discuss contraception with your partner/husband/wife?
- 3) What do you think is his/hers opinion about contraception?
- 4) In your family, who decided whether you should use contraception or not? Are there other people around you who have influence on the decision?

Theme: Gender roles/power

- 1) Can you tell me about the roles and responsibilities of the members of your family?
- 2) How do you see the role of women in society in Zanzibar? (Do you feel this is right or should it change?)
- 3) How do you see the role of men in relation to family planning?

Theme: Religion

- 1) In your understanding, how does Islam see FP/contraception? (Permitted/not permitted, when, how?)
 - How did you come to this conclusion/Where did you learn/hear about it?

Theme: Family planning services

- 1) Do you know where FP services are available where you live?
 - 2) Have you ever visited a health facility providing such services?
- If yes:**
- 1) Can you tell me how you made the decision to go to the clinic?
 - 2) Can you describe the environment in the clinic? Crowded? Privacy? Confidentiality?
 - 3) Can you describe the information and services that you were provided in the clinic? (What methods are available there/ Were you given the choice? EC). What examinations were performed? Any requirements from the providers?
 - 4) Can you describe your own role in the consultation?
 - 5) Are you satisfied with the information and services that you got?
 - 6) What is your impression of the clinic and the people who work there? How were you treated?
 - 7) How did you feel after the visit?
 - 8) What is important to you in order to feel comfortable when you visit a family planning clinic?

Theme guide for interviews – Providers

Theme: Background

1. Can you tell me about this clinic and the work you are doing here? Describe the staff? How many days a week do you provide FP? Opening hours?
2. What is your professional background?
3. How did you start working in this clinic?
4. For how long have you been working here?

Theme: Clinic environment

1. Can you tell me about the different methods you are providing?
 - Hormonal contraceptives; combined, progestin- only pills/injections?
2. From where do you get your equipment and supplies? Do you have enough resources and supplies? (for examinations, infection control, availability of methods)
3. Do you have any problems/challenges running this clinic? Please elaborate.

Theme: Interaction with clients

1. Can you tell me about the clients of this clinic?
2. Can you describe how you are counseling women with regards to contraception and choice of method? How do you see the role of the clients? (Privacy? Confidentiality assured? Individual client cards? Visual aids? Examinations – BP/weight/pelvic?)
3. Is there any method you would not recommend?
4. Are there any circumstances where you would refuse a client? Is there anyone to whom you would not provide contraceptives? (Do you require consent from husband or parents?)

Theme: Feelings and needs of providers

1. Can you describe a typical working day for you?
2. Do you like working here?
3. Did you receive any additional training before starting to work in this clinic?
4. Do you feel confident in your work here?
5. Do you feel that you get sufficient support/supervision/training from the management?
6. What are the challenges of working here?

Theme: The community

1. Can you tell me how people in your community think about contraceptive methods?
2. In your experience, how do people in your community make decisions about using contraceptives or not?
3. In your experience, what is the role of men in the decision- making process? Other family members? Other people in the community?
4. Why do you think few women are using contraceptives in Zanzibar?

Theme guide for interviews with other possible participants

Theme: Background.

- 1) Your age, education, occupation, religion?
- 2) Can you describe an ordinary day in your life?
- 2) Can you describe your family?
- 3) Do you have children?
- 4) How many children would you like to have?

Theme: The community

- 1) Can you describe the community you live in?
- 2) What are the common sources of income in your community? (Agriculture, industry, tourism...??)
- 3) How many children are typical for the families in your community?
- 4) Can you describe the common family structure in your community? (Nuclear, extended family, single parent etc.)

Theme: Contraception/FP

- 1) Can you tell me about the FP services that are available in this community?
- 2) Can you tell me how people in your community think about FP?
- 3) Can you describe your own opinion about FP? How did you first come to know about FP?
- 4) In Zanzibar, how do you think people decide to use contraceptives or not?
- 5) Why do you think few women are using contraceptives in Zanzibar?

Theme: Gender roles

- 1) How do you see the role of women in society in Zanzibar? (Do you feel this is right or should it change?)
- 2) What is the role of men in decision – making about having children and using contraception? Are there other people who have an important role in this decision- making process?

Theme: Religion

- 1) In your understanding, how does Islam see FP/contraception? (Permitted/not permitted, when, how?)

Appendix II:

Information sheet English version

Request for participation in a research project “Views on contraception on Zanzibar Island, Tanzania”

Background and purpose

This is a request for you to participate in a research study that intends to look at people’s opinions about contraceptives. You have been asked to participate because the researcher thinks that you can share important information about this topic. This study is part of a master thesis of the program “International Community Health” at the University of Oslo.

What does the study entail?

The study will require your participation in an interview of about one hour.

Potential advantages and disadvantages

There will be no direct benefit to you, but your participation may lead to increased understanding of the low contraceptive use in Zanzibar, and this could benefit the society. During the interview you might share some personal or confidential information. You may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the interview if you do not wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

You will not be provided any incentive to take part in the research. However, any expenses you may have as a result of your participation in the research will be reimbursed.

What will happen to the information about you?

We will not be sharing information about you to anyone outside of the research team. The data that are registered about you will only be used in accordance with the purpose of the study as described above. All the data will be handled without name, ID number or other directly recognizable type of information. A list of names with a number will be the only link between you and the data. Only the researcher and the research assistant will have access to the list of names and be able to identify you. It will not be possible to identify you in the results of the study when these are published.

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. This will not have any consequences for you. If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent without any consequences for you. If you later on wish to withdraw your consent or have questions concerning the study, you may contact:

Natalia Egiazarov Wiik
Mobile: 0772260701
Email: nataliaewiik@gmail.com

Further information on the study can be found in Chapter A. The declaration of consent follows Chapter A.

Chapter A – Further elaboration of what the study entails

Background information about the study

My name is Natalia Egiazarov Wiik and I am a nurse and research student at the University of Oslo. During the preparation phase of this study, I became interested in why few women are using contraceptives in Zanzibar. In this study, my goal is to better understand how people in Zanzibar think about this issue. I am also interested in how people in Zanzibar look at the role of women and men in society and within the family.

Inclusion criteria

I am asking you to help me learn more about how people think about contraceptives in your community. I am inviting you to take part in this research project because I believe that you can share important information about this.

This study takes place over a period of 4 months in total. If you accept, my research assistant and I will interview you once during that time. The interview will last for about one hour. You may be contacted again during the research period, if there is a need for additional or clarifying information.

During the interview you will be asked questions about your opinions about contraceptive use, family planning and your experiences with the family planning services in your community. You will also be asked questions about your opinions about marriage and family. During the interview, my research assistant and I will sit down with you in a comfortable place. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there.

Privacy

The information recorded is confidential, and no one else except my research assistant and I will have access to the information documented during your interview. The entire interview will be tape-recorded, but nobody will be identified by name on the tape. The tape will be kept in a secure place. The information recorded is confidential, and no one else except my research assistant and I and will have access to the tapes. The tapes will be destroyed after the project is finished.

Right to access and right to delete your data

If you agree to participate in the study, you are entitled to have access to what information is registered about you. You are further entitled to correct any mistakes in the information I have registered. If you withdraw from the study, you are entitled to demand that the collected data are deleted, unless the data have already been incorporated in analyses or used in scientific publications.

Information about the outcome of the study

The knowledge that we get from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results.

Consent for participation in the study

I am willing to participate in the study.

(Signed by the project participant, date)

I confirm that I have given information about the study.

(Signed, role in the study, date)

Appendix III:

Information form Swahili version

CHUO KIKUU CHA OSLO, NORWAY

FOMU YA OMBI LA RIDHAA YA KUFANYA UTAFITI

Madhumuni

Maombi ya kushiriki katika utafiti wa njia za uzazi wa mpango Zanzibar, Tanzania.

Yaliomo na malengo

Hili ni ombi kwako la kushiriki katika somo la utafiti ambalo linakusudia katika kutizama mawazo ya watu kuhusu utumiaji wa njia za uzazi wa mpango. Unaombwa kushiriki kwa sababu mtafiti anafikiri kwamba unaweza kutoa maelezo muhimu kuhusu suala hili. Somo hili ni sehemu ya mpango wa afya ya jamii kimataifa na ni sehemu ya masomo yangu ya shahada ya pili ya afya ya jamii kimataifa katika chuo kikuu cha Oslo, Norway.

Nini lengo la utafiti huu?

Utafiti huu unahitaji ushiriki wako katika majadiliano yatakayodumu kwa muda wa saa moja.

Uwezekano wa kuwepo faida na hasara

Hakutakuwa na faida ya moja kwa moja kwako, lakini ushiriki wako unaweza kupelekea kuengeza ufahamu wa utumiaji mdogo sana wa njia za uzazi wa mpango Zanzibar, na hili unaweza kufaidisha jamii. Wakati wa mahojiano unaweza kutoa baadhi ya mchango wako binafsi. Unaweza kujisikia aibu kuzungumzia baadhi ya mambo katika mada hii. Pia hutopaswa kujibu suala lolote katika mahojiano haya ukiwa hutaki kufanya hivyo, na yote ni sawa kwani hakutokuwa na tatiza lolote kwetu sisi. Na hupaswi kutupa sababu yeyote kwanini umekataa kujibu maswali, ua kwa kukataa kushiriki katika mahojiano haya.

Hutotakiwa kutoa kichocheo chochote katika utafiti huu, ingawaje unaweza kupata gharama yeyote katika utafiti huu zitarejeshwa.

Nini kitatokea katika maelezo kuhusu wewe?

Utafiti utafanyika katika jamii, unaweza kuchukuwa umakini, na kama utashiriki unaweza kuulizwa maswali na watu wengine katika jamii. hatutampa maelezo yako mtu mwengine yeyote Yule nje ya kikundi cha utafiti. Habari zitakazochukuliwa kuhusu wewe zitatumika kwa lengo la utafiti huu kama lilivyoielezwa hapo juu.

Taarifa zote zitakusanywa bila ya majina nambari ya kitambulisho au utambulisho wowote utakaoweza kutoa taarifa kuhusu wewe. Idadi ya majina na nambari itakuwa kama ni mpaka baina yako na taarifa. Mtafiti na msaidizi wake tu watafuatilia orodha ya majina ili wapate kuwatambua, haitatokezea kuweza kujulikana kupitia majibu ya utafiti huu wakati wa uchapishaji.

Ushiriki wa kujitolea

Ushiriki katika utafiti huu ni wa kujitolea, unaweza kujitolea katika makubaliano ya ushiriki katika utafiti huu wakati wowote bila kueleza sababu yoyote ile. Hii haitakuwa na kipingamizi chochote kwako, Kama utataka kushiriki katika utafiti huu saina makubaliano ya mkataba huu katika ukurasa wa mwisho. Na kama utakubali kushiriki mwanzoni na baadae ukaamua kujitolea katika makubaliano bila ya kikwazo inawezekana kwa ajili yako. Endapo

utaamua kujitoa au utakua na maswali kuhusiana na utafika huu unaweza kuwasiliana na mtafiti kwa anuani ifuatayo:

Natalia Egiazarov Wiik

Simu +255 772260701

Tovuti nataliaewiik@gmail.com.

Thuwaiba Said

Simu +255 773013357

Maelezo zaidi ya utafiti huu yanapatikana katika sehemu A

Sehemu A- Maelezo zaidi kuhusu utafiti huu kwa undani

Madhumuni ya maelezo kuhusu utafiti

Jina langu Natalia Egiazarov wiik, ni muuguzi na ni mwanafunzi wa utafiti katika chuo kikuu cha Oslo, Norway. Kipindi naandaa utafiti huu nimekuwa na hamu kubwa ya kutaka kujua kwa nini wanawake kidogo sana wa Zanzibar wanatumia njia za uzazi wa mpango kuliko wa Tanzania bara. Katika somo hili lengo langu ni kufahamu vizuri zaidi vipi wazanzibari hususani wanawake na wafanyakazi wa afya wana fikiria kuhusu jambo hili. Pia ninahamu vipi wanawake wa Zanzibar wanashughulikia ndoa na familia zao.

Gharama za huduma zote

Nakuomba unisaidie kusoma zaidi kuhusu vipi watu wanafikiria njia za uzazi wa mpango katika jamii. Ninakualika kuchukua nafasi katika utafiti huu kwa sababu ninaamini kwamba unaweza kushiki kutoa taarifa muhimu kuhusu suala hili. Utafiti huu unachukua muda wa kipindi cha miezi 4 kwa ujumla. kama utakubali kushiriki katika utafiti wangu mimi pamoja na msaidizi wangu tutakuuliza maswli mara moja kwa wakati huu. Na mahojiano yatadumu kwa muda wa saa moja, ninaweza kukutafuta tena wakati wa kipindi cha utafiti kama kutakuwa na mahitaji ya ziada au kuweka maelezo sawa. Wakati wa mahojiano utaulizwa maswali kuhusu ushauri wako juu ya utumiaji wa njia za uzazi wa mpango, kupanga familia na uzoefu wako kuhusu utoaji wa huduma za uzazi wa mpango katika jamii. Pia utaulizwa maswali kuhusu uoni wako juu ya ndoa na familia.

Wakati wa mahojiano mimi na msaidizi mtafiti wangu tutakuwa pamoja na tutakaa katika sehemu nzuri ya faragha. kama itakua sawa kwako, mahojiano yatachukuwa nafasi kwako au nyumbani kwa rafiki yako. Kama utakataa kujibu swala lolote wakati wa mahojiano, utasema na wahojaji watauliza suali jengine. Hakuna mtu mwengine atakae kuwepo hadi pale muhojiwa atake mtu mwengine awepo.

Usalama wa taarifa zako

Maelezo yatakayorekodiwa yatakuwa salama, hakutokuwa na mtu yoyote isipokuwa mimi na mtafiti wangu msaidizi tutazipitia habari za takwimu wakati wa mahojiano. Mahojiano yote yatarekodiwa katika kinasa sauti, lakini hakuna mtu atakaejulikana jina katika kinasa sauti, kitawekwa sehemu salama. maelezo yaliyorekodiwa yatakuwa katika hali ya usalama na hakuna mtu atakaejua isipokuwa mimi na msaidizi wangu mtafiti na kaseti zitafutwa baada ya utafiti kumalizika.

Haki ya kukubali na haki ya kufuta maelezo yako

Kama utakubali kushiriki katika utafiti huu utakuwa huru kuzingatia vipi maelezo yamekuzingatia wewe. Pia utakuwa huru zaidi katika kurekebisha makosa yoyote katika maelezo niliyoyazingatia. Kama utajitoa katika utafiti una haki ya kudai taarifa zako zifutwe isipokuwa maelezo ambayo yameshawekwa katika uchambuzi au kutumika katika uchapishwaji wa kisayansi.

Taarifa kuhusu utolewaji wa utafiti

Elimu ambayo utaipata kutoka katika utafiti tutashirikiana pamoja na nyinyi kabla ya haijatengenezwa kupatikana katika jamii. kila mshiriki atapokea ujumuisho wa matokeo wa utafiti huu.

Makubaliano ya ushiriki katika utafiti

Mimi niko tayari kushiriki kwa hiyari yangu katika utafiti huu

.....
Saini ya mshiriki

.....
Tarehe

Ninathibitisha kwamba nimetoa taarifa kuhusu utafiti huu.

Saini
Cheo chako
Tarehe

Appendix IV:

Assessment from the Regional Ethical Committee in Norway

Ethical Clearance from Zanzibar Medical Research and Ethics Council



Natalia Wiik <nataliaewiik@gmail.com>

Sv: REK sør-øst 2013/688 Oppfatninger av seksualitet og prevensjon på Zanzibar, Tanzania

post@helseforskning.etikkom.no <post@helseforskning.etikkom.no>

Mon, Apr 22, 2013 at
11:14 AM

To: nataliaewiik@gmail.com

Dear Natalia E. Wiik,

we hereby confirm that the project "Perspectives on sexuality and contraception; A qualitative study from Zanzibar", falls outside the remit of the Norwegian Health Research Act.

The project can be done without ethical approval from the Norwegian Regional Ethical Committees.

Yours sincerely,
Emil Lahlum
REC south-east

SERIKALI YA MAPINDUZI - ZANZIBAR
ZANZIBAR REVOLUTIONARY GOVERNMENT
WIZARA YA AFYA
MINISTRY OF HEALTH



BARAZA LA UTAFITI, WAU
TEL: 31059/90
FAX: +255 54 35591
TELEGRAM: HEALTHMIN



MOH RESEARCH COUNCIL
P.O. BOX 206
ZANZIBAR

ETHICAL CLEARANCE LETTER

PROTOCOL NUMBER: ZAMREC /0002/MAY/013

DATE: 05 JULY,2013

Natalia Egiazrov Wiik
Principal Investigator

PROTOCOL TITLE: Views on contraception on Zanzibar Island, Tanzania

RE: ETHICAL CLEARANCE FOR CONDUCTING MEDICAL RESEARCH IN ZANZIBAR.

This is to certify that the research protocol entitled "Views on contraception on Zanzibar Island, Tanzania" was received and reviewed by the Zanzibar Medical Research and Ethics Committee on July, 2013.

We would like to inform you that the decision of the committee to this protocol was "Approved".

The permission to undertake data collection is for one year beginning from the date of this letter.

The principal investigator must ensure that the progress report is made available to the Ministry of Health and the Zanzibar Medical Research and Ethics Committee.

Any change made to the protocol needs to be submitted to the committee for approval prior to its implementation.

Thanks in advance,

DR. JAMALA A. TAIB
CHAIRPERSON
ZAMREC
ZANZIBAR.



DR. MSAFIRI MARIJANI
SECRETARY
ZAMREC
ZANZIBAR.

Appendix V:

General research permit for Zanzibar

REVOLUTIONARY GOVERNMENT OF ZANZIBAR

SECRETARY
ZANZIBAR RESEARCH COMMITTEE
P. O Box 239
Tel: 2230806
FAX: 2233788



RESEARCH/FILMING PERMIT

(This Permit is only Applicable in Zanzibar for a duration specified)

SECTION

Name: NATALIA WIIK
Date and Place of Birth: 29/03/1984 SWEDEN
Nationality: NORWEGIAN
Passport Number: 29314900
Date and Place of Issue: 06/08/2012
Date of arrival in Zanzibar: 26/06/2013
Duration of stay: THREE MONTHS AND TWO WEEKS
Research Tittles: "VIEWS ON CONTRACEPTION ON ZANZIBAR ISLAND TANZANIA "
Full address of Sponsor: -



This is to endorse that I have received and duly considered applicant's request I am satisfied with the descriptions outlined above.

Name of the authorizing officer: HASSAN LILA MRISHO

Signature and seal:

Institution: Office of Chief Government Statistician

Address: P. O Box 2321

Zanzibar

Date:

12/07/2013



Appendix VI:

Approval from Norsk Samfunnsvitenskapelig Database

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Johanne Sundby
Institutt for helse og samfunn
Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Harald Hårfagres gate 2
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org nr. 985 321 884

Vår dato: 02.05.2013

Vår ref:34235 / 3 / LMR

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 16.04.2013. Meldingen gjelder prosjektet:

34235	<i>Perspectives on Sexuality and Contraceptives in Zanzibar</i>
Behandlingsansvarlig	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Johanne Sundby</i>
Student	<i>Natalia Egiazarov Wiik</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i melde skjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 30.05.2014, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Linn-Merethe Rød

Kontaktperson: Linn-Merethe Rød tlf: 55 58 89 11
Vedlegg: Prosjektvurdering
Kopi: Natalia Egiazarov Wiik, Thor Olsens gate 8, 0177 OSLO



Ifølge prosjektmeldingen skal det innhentes skriftlig samtykke basert på skriftlig informasjon om prosjektet og behandling av personopplysninger. Personvernombudet finner informasjonsskrivet tilfredsstillende utformet i henhold til personopplysningslovens vilkår, forutsatt at dato for prosjektslutt og anonymisering av opplysningene tas med.

Ombudet forstår at det legges opp til at helsepersonell ikke skal uttale seg om identifiserbare enkeltpasienter. Det anbefales at prosjektleder i tillegg minner utvalget om dette, i forkant av hvert intervju.

Innsamlede opplysninger registreres på privat pc. Personvernombudet legger til grunn at veileder og student setter seg inn i og etterfølger Universitetet i Oslo sine interne rutiner for datasikkerhet, spesielt med tanke på bruk av privat pc til oppbevaring av personidentifiserende data.

Prosjektet skal avsluttes 30.05.2014 og innsamlede opplysninger skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn/koblingsnøkkel slettes, og at indirekte personidentifiserende opplysninger (sammenstilling av bakgrunnsopplysninger som f.eks. yrke, alder, kjønn) fjernes eller grovkategoriseres slik at ingen enkeltpersoner kan gjenkjennes i materialet.