

**THE ROLE OF ISLAMIC TEACHING ON INFLUENCING
FAMILY SIZE:
THE CASE OF CENTRAL DISTRICT, ZANZIBAR**

By

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**Dissertation Submitted in Partial Fulfilment of the Requirement for the Degree of Master
of Arts (Demography) of the University of Dodoma**

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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by the University of Dodoma dissertation entitled *The Role of Islamic Teaching in Influencing Family Size: The Case of Zanzibar* in partial fulfilment of the requirements for the degree of Masters of Arts in Demography of the University of Dodoma.

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DEDICATION

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ABSTRACT

The study finds out how Islamic teaching influences family size in Zanzibar in Central District. It assumes that, the couples' preference toward Islamic religious beliefs influence the number of the children couples could have, hence affecting the family size. Literatures show that, studies on religious beliefs on child bearing behaviours concentrated on South Asian and Middle East countries due to strong impact of Islamic teachings in those areas but, little was known on the influence of Islamic teaching on family size in Tanzania. Therefore, a survey was conducted in Central District in Zanzibar to investigate this issue.

The study was conducted at three wards in Central District. A total of 120 households were surveyed. Purposive and simple random sampling was adopted to select households to be included in the study. Data analysis test was performed to test for the association Islamic teaching and family size.

Quantitative analysis from data progression ratio and childbearing stopping behaviour shows that couples preference for family size is upward in Central District. The findings show that couples continue having children according to religious beliefs. Also the study found that existing Islamic teaching in Central District which was associated with religious beliefs as well as socio-cultural beliefs determined fertility.

The study concluded that an Islamic religious belief was a factor toward large family size in Zanzibar. Owing to the influence of education in reducing the rate of childbearing, the study recommends the effort should be taken by government to reduce and control child bearing among muslims community by promoting education to both male and female prospective partners in the society.

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LIST OF ABBREVIATIONS

ACRWC	-African Charter on the Rights and Welfare of the Child
CBR	-Crude Birth Rate
CDR	-Crude Death Rate
CEB	-Children Ever Born
CFS	-Current Family Size
DHS	-Demographic and Health Survey
EFS	-Expected Family Size
IMR	-Infant Mortality Rate
IUCD	- Intrauterine Contraceptive Device
MOHSW	-Ministry of Health and Social Welfare
RGoZ	- Revolution Government of Zanzibar
SPSS	-Statistical Package for Social Sciences
SRB	-Sex Ratio at Birth
TFR	-Total Fertility Rate
TPB	-The Theory of Planned Behavior
UMATI	-Uzazi na Malezi bora Tanzania
UN	- United Nation
URT	-United Republic of Tanzania
WFS	-World Fertility Surveys
ZIADA	-Zanzibar Interfaith Association for Development and Aids
ZPR	-Zanzibar Poverty Reduction Plan

CHAPTER ONE

INTRODUCTION

1.1 Background of the Problem

One of the most important events of the twentieth century has been the demographic transition. All developed and many developing societies have experienced dramatic changes in their birth rates (Brass et al 1997). The 21st century is characterized by growth of human population in many societies mostly in the developing countries.

According to United Nations (2007) Muslim countries have high Total Fertility Rate than any other religious groups. Therefore, the growth rate of the Muslim population, which averaged 1.9% between 2000 and 2006, is also far higher than the world's population growth rate, which averaged 1.22% in the same period. It is also much faster than any other major religious group (UN, 2008).

According to Pew Research Center (2011), in Europe as a whole, the Muslim share of the population is expected to grow by nearly one third over the next 20 years, rising from 6% of the region's inhabitants in 2010 to 8% in 2030. Among the reasons which influence this high rate is that women in muslim-majority countries tend to marry at much younger ages than women in more-developed countries (Karim, 1999). Migratory people from Middle East countries and others African countries like Pakistan, Iran, Kuwait, Somalia, Tanzania, Senegal, and others, and the number of people who become muslims through conversion seems to be roughly equal to the number of muslims who leave the faith, but there is little difference between the average age of marriage in muslim-majority countries and in other less-developed

countries (Karim, 1979). Similarly among women in muslim-majority countries marry, on average, at 21.6 years, compared with 22.0 years in non-muslim-majority, less-developed countries and 26.2 years in more-developed countries (Pew Research Center, 2011).

The greatest increases in muslim population is driven mainly by continued migration are likely to occur in Western and Northern Europe, where Muslims will be approaching double-digit percentages of the population in several countries (Johnson 2006). In the United Kingdom, for example, muslims are expected to comprise 8.2% of the population in 2030, up from an estimated 4.6% in 2011. In Austria, muslims are projected to reach 9.3% of the population in 2030, up from 5.7% 2011; in Sweden, 9.9% (up from 4.9% 2011); in Belgium, 10.2% (up from 6% 2011); and in France, 10.3% (up from 7.5% 2011) (Pew Research Center 2011).

Generally, several factors account for the faster projected growth among muslims than non-Muslims worldwide. Muslim populations tend to have higher fertility rates (more children per woman) than non-muslim populations. In addition, a larger share of the muslim population is in, or soon will enter, the prime reproductive years (ages 15-29). Also, improved health and economic conditions in muslim-majority countries have led to greater-than-average declines in infant and child mortality rates, and life expectancy is rising even faster in muslim-majority countries than in other less-developed countries (Westoff and Frejka, 2007).

Adongo (1998) has shown that, Malaysian muslims constitute one of the three religious communities, which tend to have higher Total Fertility Rates than their

compatriots of Indians or Chinese decent. Thus, their beliefs and cultural attitudes toward contraceptives use, early marriages as well as polygamy are probably influencing the rate of Muslim family size. Chaudhry (1982) has shown that the lower socioeconomic status of the Muslim women in India is the major contributory factor to their higher fertility, not their religious affiliation.

In the *Demography of Islamic Nations*, Weeks (1988) found noticeable 'regional and temporal' diversity in fertility among Muslim countries. He contends that, as a group, Muslim countries are still in the early stages of demographic transition and that 'the single most remarkable demographic aspect of Islamic societies is the nearly universal high level of fertility.

In Pakistan, Karim (2004) suggested that following the Islamic teachings breastfeeding is quite common in muslim populations, with a minimum duration of breastfeeding being about 18 months. For most muslim-majority countries, 95 percent of women report breastfeeding their children at a minimum level 13 – 18 months (Karim, 2004). This situation influence to accelerate the child bearing behavior to continue because of lower interval of breast feeding from one child to another. Besides, in majority of these countries, for which data are available, the median duration of breastfeeding exceeds 18 months (Ngalinda, 1998).

Apparently, besides, in majority of these muslims countries, for which data are available, the median duration of breastfeeding exceeds 18 months (Casterline et al, 2001). In Pakistan, till the end of the 1980s, Total Fertility Rate (TFR) remained about 6 per woman and by the end of 1990s it was reduced to 5.1. However, the

most recent Pakistan Demographic Survey (2003) suggests that it has reached 4 children per woman.

According to Pew Research Center (2009) among the factors accounting for the faster projected growth among Muslims than non-Muslims worldwide, is that Total Fertility Rate (TFR) range 4 to 6 children per woman and that of non-Muslim populations range from 1.4 to 2.1 per women.

In addition to that, Karim (2004) suggested that, due to the different level of socio-economic development across the Muslim-majority countries, there is a great deal of variation in the reproductive health indicators of the population, specially their access to basic health services. Therefore, the improvement of health status and good nutrition among the some muslims countries has made total fertility rate to be high.

The Muslim population of East Africa, which includes Ethiopia, Kenya, Tanzania and Uganda, is projected to increase from 70.3 million in 2010 to 109.5 million in 2030. Over the same period, however, the share of East Africa's population that is Muslim is expected to decline slightly, from 21.5% to 21.1% in 2030 (Pew Research Center, 2010). For non muslim communities the fertility rate slow and the reasons for decline fertility rates include economic development and improved living standards, high level of education and people waiting until they are older to get married. Furthermore, extensive use of birth control is common among non muslim population (Thomas et al, 2003).

The increases of the number of muslims population size in sub-Saharan Africa is to be greater in the next 20 years than it was in the previous two decades. From 1990 to 2010, the number of Muslims in the region increased by about 103 million (Pew Research Center, 2011). In the next 20 years, the number of Muslims in sub-Saharan Africa is projected to increase by about 143 million (Levtzion and Pouwels, 2000). These situations are mainly influenced by level of education (particularly of women), economic well-being (standards of living), contraception and family planning , urbanization (movement from rural areas into cities and towns), and religious conversion (Basu, 2007)

During the 1990s, sub-Saharan Africa's non-muslim population size grew at a slightly faster rate than the muslim population. However, muslim population size growth in the region surpassed the growth of the non-Muslim population, largely because of higher fertility rates in Muslim-majority countries (Levtzion and Pouwels 2000). From 2010 to 2030, the growth rate of Sub-Saharan Africa's muslim population is expected to be very high than the growth rate for non-muslims in the region (United Nation, 2001).

In Demographic and Health Surveys Comparative Studies it was found that in sub-Saharan African countries 12-67 percent of women experienced intercourse one or more years prior to their first union with a partners (Arnold and Blanc, 1990). Sometimes these premarital sexual activities result in premarital pregnancies (Gage-Brandon and Meekers, 1992).

1.2 Statement of the Problem

The rapid population growth rate caused mainly by high fertility levels in Zanzibar contributes to a high population density which threatens food supplies where cultivable land is used more for human settlements. Likewise high population growth exerts pressure on other natural resources such as marine and forestry. Studies have also shown that rapid population growth in Tanzania has negative effects on the economy, health, education, employment, agriculture, environment and urbanization (Mturi, 1996).

It is against this background that the Government of the United Republic of Tanzania formulated the National Population Policy, announced in July 1992, which, among other things, encourages a reduction of fertility (URT, 1992).

In Zanzibar where large population is muslim is 99%, the rate of population growth is high. According to Blacker (2011) the rate of population growth as shown by intercensal increases has been appreciably higher in Zanzibar especially rural areas due to the low level of education among the communities. These differing rates of growth have been due principally to a lower level of fertility among the Afro-Arab population in Zanzibar town. The exceptionally low fertility of the Afro-Arabs in town presents a marked contrast to the fertility of the Afro-Arabs in Pemba and in the rural areas of Zanzibar Island.

Total Fertility rate (TFR) in Zanzibar shows that, the rate of fertility for rural areas is higher than that for urban areas mainly because of differences on age at marriage and level of literacy (URT 1997). According to the 1996 Demographic and Health Survey (DHS), the average marriage age for Zanzibar urban is 18 years and 16 years

for rural areas. Such low age at marriage exposes a woman to a long reproductive span in her lifetime (URT, 2006).

The 1996 DHS also shows, that willingness to use modern family planning methods such as contraceptives is directly related to levels of education of women. The percentage of women using contraceptives in the year 2000 was 19.9 percent. The lowest acceptance rates on contraceptive use in Zanzibar are found in North A district, Mkoani, Micheweni and Central districts which had 6.6 percent, 4.5 and 6.9 percent respectively (RGoZ, 2010).

Despite the efforts by the government and non-governmental organizations in Zanzibar to make family planning services available and accessible, contraceptive prevalence among women (15-49 years) is still low. It was found to be 16.1 percent for all women and 18.4 for currently married women (RGoZ, 2010).

The relationship between Islamic teaching and family size and overall fertility is generally an underdeveloped area as far as demographic research is concerned, especially in developing countries. For example in Zanzibar, most research has concentrated on other determinants of fertility and has ignored religious factor. Most researchers have assumed that unplanned bearing of many children is only caused by early marriage, low level of education, lack of contraceptive use, and poor socio economic condition (Ngalinda, 1998).

Accordingly, there is a need for Zanzibar to have a comprehensive Population Policy that will integrate different sector policies to address all population issues in an effort for sustaining the economy and improving the standard of living of its people.

However, there is no study that has been conducted to examine the role of Islamic teaching belief on influencing family size. This study is an attempt to bridge the knowledge gap about how the Islamic teaching influenced family size in Zanzibar.

1.3 GENERAL OBJECTIVE

The general objective of this study is to find out the extent to which Islamic teaching influences family size.

1.3.1 Research Objectives

- i. To examine the extent to which society practice Islamic teaching.
- ii. To identify the contribution of Islamic teaching on family size.
- iii. To examine the efforts taken by government to control family size.
- iv. To identify the impact of Islamic teaching on family size.

1.3.2 Research Questions

The main question of this study was; how Islamic teaching influences family size?

Specifically the study questions were:-

- i. To what the extent does society practice this Islamic teaching?
- ii. What are the contributions of Islamic teaching on influence family size?
- iii. What are the efforts done by government to control family size?
- iv. What are the impacts of Islamic teaching on family size?

1.4 Significances of the Study

This study will be of much value to a number of people interested in population studies. At theoretical level, the findings from this study will provide an understanding of the relationship between Islamic teaching and family size in Central District in Zanzibar because this area has experiencing high total fertility rates (6.5 children per women) (URT, 2013).

Also, the findings from this study will contribute to development of the methodology in researches regarding Islamic teaching belief and family size in Tanzania. Furthermore, understanding of the relationship between Islamic teaching and family size is of great importance for the policy makers in order to deal adequately with the problems related to family size and population growth.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0 Introduction

This chapter presents various literature related to the study. It aims at showing what has already been done, identify the gaps in knowledge and hence the need to fill them through this study. The reviewed literatures will focus on the conceptual analysis of the key concepts of the study, theoretical analysis, empirical analysis, research gap and the conceptual framework of the study.

2.1 Conceptual Analysis

2.1.1 Sources of Islamic Teaching

Islam is not a new religion, but the same truth that God revealed through all His prophets to every people. Islam is both a religion and a complete way of life. Muslims follow a religion of peace, mercy, and forgiveness, and the majority have nothing to do with the extremely grave events which have come to be associated with their faith. For Muslims, Islam is a belief system with moral and practical laws that have their source in the Qur'an. Islam's humanizing effects on concepts, morals, manners, human rights and responsibilities, law and order, justice, warfare, role of women, slavery and international relationships (Zubaida, 2003).

2.1.2 Family

United States census bureau defines family as those members of a household who are related through blood, adoption or marriage (Swanson and Stephan, 2004). It is a basic social group united through bonds of kinship or marriage, present in all

societies. The structure of the family and the needs that the family fulfills vary from society to society. The nuclear family which consists of a father, mother and their children is the main unit in some societies. In others, it is a subordinate part of an extended family, which also consists of grandparents and other relatives. A third family unit is the single-parent family, in which children live with an unmarried, divorced, or widowed mother or father (Simpson, 2007).

2.1.3 Family Size

Family size as defined by Kamuzora and Mkanta (2000) is the number of household members including children of the head wherever they live. However in demographic literature family size is synonymous with the technical term “parity” (Wilson, 1985). The term parity in demography means the number of the live births born to a woman (Swanson and Stephan, 2004). With this regard family size in this study will be used as the number of live on children.

2.1.4 Household

Either a single person or a group of people making provision for food and other essentials of living, occupying the whole, part of, or more than one housing unit or other provision of shelter. The definitions vary by country (Swanson and Stephan, 2004). This can be one or more persons who make common provision for food and other essentials for living (Wilson, 1985). This could be a group of persons who lived together and shared living expenses. Usually these are husband, wife and children. Other relatives, visitors and servants are included as members of the household, if they were present in the household on the census night. If one person lived and ate by himself or herself, then he or she can be one person household even

if he or she stayed in the same house with other people (United Republic of Tanzania (URT), 2006). Household size is defined by Kamuzora and Mkanta (2000) as the number of person usually residing in the household and share household expenses.

2.2.0 Types of Family Size

2.2.1 The Completed Family Size

The completed family size as defined by Swanson and Stephan (2004) is the number of children born by the end of the reproductive period of a woman's life. This is important for demographic analysis as the exercise involves following-up group of women born in a particular year for their entire reproductive life by recording the number of the children they bear. Due to time and financial constraints in developing countries the exercise is not widely used, instead the average parity of women aged 15- 49 is taken to represent the completed family size with the assumption that fertility of older group are equal to the current fertility experience of women in child bearing ages (URT, 2006).

2.2.2 Average Family Size

Average family size is defined as the mean number of living children (Swanson and Stephan, 2004). This type of family excludes mortality of earlier born children.

2.2.3 Desired Family Size

Desired family size is the total number of children desired by a woman or a couple (Swanson and Stephan, 2004). It used when demographers attempt to understand the motivation of couple's with regard to childbearing. A desired family size below current levels is commonly taken as indication of a latent desire for greater

availability of facilities for family planning. In addition to their use in understanding of fertility trends desired family size have also been used as the input to projections of future population (Wilson, 1985).

2.3.0 Measures of Family Size

The size of this measure is strongly influenced by the timing of childbearing, and especially by the moment at which people start their family (Testa, 2011). Family size ideals are relatively stable over the individuals' life, being influenced by enduring motivational traits and genetic factors. This measure is very close (only slightly lower than) to the mean ideal family size at ages 15-24 and tends to overlap the values of the mean actual family size at ages 40-54 among women but not among men who still intend to have children at these ages (ibid).

2.3.1 Children Ever Born (CEB)

The number of the children born alive to woman, reported usually in a census or sample survey (Swanson and Stephan, 2004). This is the measure of cumulative fertility but does not take into account child mortality. Since a great deal of evidence suggests that parents respond to child mortality by having additional births (Smith, 1981).

2.3.2 Current Family Size (CFS)

Current family size is defined as the number of surviving children a woman had at the time of interview or survey (Smith, 1981). Both CEB and CFS are strongly affected by age and marriage duration or by a woman's stage in the life cycle. A third measure adjusts for life cycle difference by focusing on expectations.

2.3.3 Expected Family Size (EFS)

Expected family size is the number of children a woman expects to have when she has completed child bearing (Smith, 1981). It is the sum of current family size and expected future fertility.

2.4 Theoretical Analysis

2.4.1 The theory of Demographic Transition

The theoretical explanation of childbearing behavior has a long history dating from Notestein's work in 1945 which first proposed the theory of demographic transition, This theory states that levels of fertility and mortality as measured by Crude Birth Rate (CBR) and Crude Death Rates (CDR) experienced the gradual changes from a pre-modern regime of high fertility and high mortality to a post-modern one in which both are low (Kirk, 1996).

Studies show that, fertility is high in traditional agricultural societies to offset high mortality and this ensures population survival. As a society develops, socio-economic changes such as industrialization, urbanization, rising education and investment in public health lead to decline in mortality and to a change in the cost and benefits of children. The rise in child survival together with the rising cost and declining economic value of children is considered to be the fundamental driving force of fertility transition. The desire for smaller family size leads to a demand for birth control and hence lowering actual fertility (Bongaarts, 2005).

Khan (2008) indicated that, the demographic transition involves four stages which social scientists have observed across countries. In the first stage, both fertility and mortality are high and population growth was low. In the second stage, mortality begins to fall without a change in fertility. Population growth rises over this stage. In the third stage fertility falls. In the fourth stage both mortality and fertility settle at low levels.

As a matter of fact, socio-economic and cultural factors are the reasons for demographic transition while too much attention on socio-economic factors as the reason of the demographic transition and paid little attention to cultural factors (Kirk, 1996).

In United Republic of Tanzania as a country with high fertility levels but with regular TFR trend showing a modest fertility decline during recent years. (URT, 2006). In Tanzania, the population grow rate has decline from 3.3 percent in 1967 to 2.7 percent in 2012. Tanzania Mainland shows a decline from 3.2 percent in 1967 to 2.7 percent in 2012. Tanzania Zanzibar show a different pattern of population growth. The growth rate increase from 2.7 percent in 1967 to 3.1 2002 (URT, 2012)

Once a region or a country starts the fertility decline, neighboring regions with the same language or culture followed after short delays even if they were un developed (Bongaarts, 2005).

The transition on set and the pace of decline in the early phase of the demographic transition are poorly predicted by socio-economic development. The most widely

accepted explanation for these unexpected findings is the role played by diffusion and social interaction processes. Diffusion refers to spread of information, ideas and behavior among individuals, communities and countries. Social interaction refers to the process whereby the reproductive attitudes and behaviors of individuals influence one another (ibid).

It is then concluded that, the classical and the diffusion perspectives are both important but their roles change over the course of transition. Specifically, diffusion and social interaction are important in the early phases of the transition. Once this process has largely run its course, fertility rate in the transition becomes more closely tied to level of social economic development (Mc Devitt and Johnson, 2004)

It should be mentioned here that, contemporary post-transitional societies, experience the level of fertility which is below replacement level. If the fertility in contemporary post-transitional societies had indeed leveled off at or near the replacement level, there would have been limited interest in the subject because this would have been expected. However fertility has dropped below the replacement level, in virtually every population that has moved through the demographic transition. If future fertility remains at these low levels, population will decline in size (Bongaarts, 2001: Van De Kaa, 2002).

With this regard, Van de Kaa (2002) indicates that the industrialized countries will experience the second transition which the death rate will exceed the birth rate for quite some time to come. This is due to the fact that, the death rate will further increase as a result of the ageing process, while fertility rates will remain low as a consequence of the fact that the number of women of reproductive age will be

comparatively small and the number of children born to them will, most likely, remain below replacement level.

However, as the developing countries approach the later stages of the transition (from higher to lower fertility), the pace of decline slow down (Bongaarts, 2002: McDevitt and Johnson, 2004). The decline of the pace of the fertility transition was attributed to the fact that early decline are attributable to diffusion and social interaction processes while later reductions are tied to the level of socio-economic development (Bongaarts, 2005).

On the other hand, McDevitt and Johnson (2004), indicate that, couples' childbearing decisions underlying the decline in the pace of transition (stalling fertility) are driven by policy and program related factors arguably determined by level of development but more directly tied to government and donor commitment to family planning.

This research considers the decline in the pace of transition in developing countries is the result of low level of education, socio-economic development as well as, the existence of Islamic teaching in these countries.

2.4.2 The Theory of Planned Behavior (TPB)

The theory of planned behavior is a social-psychological model to study human action and examine decision making process within their macro-level context (Ajzen, 2006).

According to theory of planned behavior, human action is guided by three kinds of considerations: behavioral beliefs, normative beliefs and control beliefs. In their respective aggregates, behavioral beliefs produce a favorable or unfavorable attitude toward the behavior; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioral control. In combination attitude toward the behavior, subjective norm and perception of the behavioral control lead to the formation of behavioral intentions. Finally, given a sufficient degree of actual control over the behavior, people are expected to carry out their intention when opportunity arises (Ajzen, 2006).

Demographers have adopted the theory of planned behavior to study reproductive decision making process with macro and micro perspectives (Xu, 2010).

However, the theory of planned behavior has not, until recently, been used to study fertility intentions. An operationalisation of the theory has been developed in the Max Planck Institute for Demographic Research. This operationalization has been tested on Bulgarian survey data and the theory has been found feasible to explain fertility intentions (Dommermuth, 2009).

2.5 Empirical evidences

Demographers have historically been interested in the relationship between fertility and religion in sub-Saharan Africa because of the region's high fertility and dynamic and influential religious environment. For example, John Caldwell and Pat Caldwell began their 1987 article with the statement: "Sub-Saharan Africa may well offer greater resistance to fertility decline than any other world region. The reasons are

cultural and have much to do with a religious belief system that operates directly to sustain high fertility but it also has molded a society in such a way as to bring rewards for high fertility” (Caldwell and Caldwell 1987). They were not alone in this sentiment: religion was and to an extent still is seen largely as a barrier to fertility decline and to family planning adoption in the region.

On average, Tanzanian woman marry at the age of 18 (Mturi, 1996) although this varies with the level of education, the area of residence, and religion. For example, Reining (1972) in a study of the Haya in Northwestern Tanzania found the average age at first marriage to be between 14-16 years. In most cases Haya women were found to start child bearing immediately after they got married. It is a fact that girls in Tanzania engage in early sexuality and subsequent early child bearing according to studies undertaken by Uzazi na Malezi bora Tanzania-UMATI (Mpangile et al., 1993). Statistics from the Ministry of Education also show that a large proportion of school girls in primary and secondary schools drop out from school due to pregnancies and early births (Sawaya, 1995).

In Zanzibar religion influences age at first marriage and, this mean early age at first birth. The main reason for this encouragement (for Moslems to marry early) is the emphasis the Islam puts on premarital virginity (Adsera, 2006). However religion can also influence the level of contraceptive use and therefore has an effect on age at first and subsequent births (Ngalinda 1998).

Some religions like catholicism have negative attitudes towards the use of modern contraceptives while others for example, protestantism, have a more liberal stand. In

societies where traditional norms and values are fading away, Catholics are likely to have low ages at first birth and short intervals between subsequent births. Thus fertility might be high for Catholics (Stark and Finke, 2000). This statement relates to a study carried out in Sierra Leone by Gage (1986), which found that Catholics had a lower age at first birth than Moslems.

Ethnicity is associated with age at first birth, as one of the main functions of culture is to maintain the biological continuity of the members of the society. This fact is supported by Ohadike's (1979) argument that natural fertility variations are primarily determined by biological process. Which can also be modified by socio-cultural factors, every cultural group has its own socio-cultural ideologies of biological functions and their social accommodation (socio-continuities).

These ideologies comprise of the norms, beliefs and values as well as the practices that are likely to affect positively or negatively the reproductive performance of a given society thus affecting family size (Addai, 1999).

During the 1960s and 70s while trying to explain persistently high fertility in the developing countries, most Western Demographers had taken the view that high fertility was generally embedded in cultural and religious factors, which encouraged high fertility in most countries of Latin America, Africa and Asia. In this respect, much more has been written about high fertility among Muslims than about the followers of any other religion (Morgan et al, 2002).

Kirk (1996) in his review of Muslim fertility, observed that muslim populations tended to have high fertility, that there was no evidence of decline, and that in a given country, muslims tended to have higher fertility than adherents of other religions.

In many countries, education, particularly women's education, has been demonstrated to have a significant effect on fertility. Education brings in a new outlook on life as well as skills for taking advantage of new opportunities. A rise in the level of women's education leads to a rise in age at first birth and consequently to a decline in fertility (Ngalinda 1998). Women with higher educational levels are more likely to break with traditional patterns including early marriage and child bearing. Furthermore, education modified women's values and aspirations in life so that they are more aware of the use of contraception to delay the first birth (Garenne, 2004).

Education indirectly influences age at first birth, and change in the traditional work role. Women with gainful employment may be more likely to postpone marriage and even child bearing within marriage. Maxwell (1987) in a study of 5,000 US women observed a positive relationship between education and age at first birth. Women who start child bearing at early ages are likely to have lower levels of education. They are likely to be rural residents or urban poor.

According to Demographic and Health Survey (1997) Tanzanian women start child bearing at a relatively early age, 18.4 years on average but as early as 14.8 years for 10 percent of the women. According to the study, 50 percent of the women are

mothers by the age of 18.2. Data have revealed illiterates and muslim are found in this study to be more likely to start giving birth before 15 years of age (DHS 1997).

Caldwell and his colleagues, who attempted to explain the factors that influenced high fertility in sub-Saharan Africa, developed a first important concept. The 'wealth-flow' theory (Caldwell, 1976) is among Caldwell's early writings on the theory of fertility decline. The theory asserts that fertility decreases only when there is a change in economic relations (Caldwell, 1977).

In other words, the level of fertility depends on whether children are a financial asset or a burden to their parents. In industrial societies, children are known to be a financial burden, as education, food, clothing, and entertainment etc. cost parents a lot. In contrast to industrialized regions, children in traditional societies are generally considered an asset. They help working on the land and are involved in the collection of firewood and water (Caldwell, 1976). They also provide security for their parents when the latter become older and infirm.

In the late 1970s Caldwell (1977) argued further that high fertility is economically rational in traditional African economies where land is held by the lineage. An increasing number of direct family members provide the best form of investment available to control the land and its products. In the *Demography of Islamic Nations*, Weeks (1988) found noticeable 'regional and temporal' diversity in fertility among Muslim countries. He argued that, "The single most remarkable demographic aspect of Islamic societies is the nearly universal high level of fertility."

However, taking a broader view Bongaart theory of “proximate determinants of fertility” postulates that due to socio-biological factors, fertility is likely to be lower than its maximum value as a result of delayed female age at marriage, higher use of contraception, high prevalence of induced abortion and, prolonged practice of breastfeeding (Gobopamang and Letamo, 2001).

A long history of demographic research has identified the proximate determinant of fertility in population to be contraceptive use. Agadjainian (2005) observed that the adoption of contraception is a cultural process that depends on access to and accessibility to contraceptive. In most areas in sub-Saharan Africa the access to contraception is likely unrelated to religion in rural areas. The acceptability of contraceptive use is related to one’s faith or faith community.

Contraceptive use in rural areas is primarily intended to space children rather than limit the number of children (Cohen, 2000; Lesthaeghe et al. 1981).

However many women are still hesitant to use modern methods for fear of side effects. (Paz Soldan, 2004), in Zanzibar for example majority are Muslims society ignored the use of modern contraception methods like the pill, intrauterine device (IUD), injection, foam or jelly, barrier methods (diaphragm, condom), female or male sterilization (Ngalinda, 1991).

Anecdotal and empirical evidence from muslims in other parts of the world has led researchers to expect muslims in sub-Saharan Africa to have different contraceptive use patterns than others in their communities. Asian Muslims have more pro-natalist

attitudes than their christian counterparts (Morgan et al. 2002), and although Islam does not prohibit the use of contraception strictly speaking, some offer religious reasons for not using contraception (Caldwell and Barkat-e-Khuda 2000; Casterline et al. 2001). The majority of Islamic governments presently have passed family planning laws because of the risks of overpopulation (Levtzion, et al 2000).

In traditional, African societies, people believe that God has control over the human reproductive system or that children are a gift from God. Therefore, no one should prevent a child from coming into the world (Omari, 1989). Most women with traditional faiths are likely to advocate this ideology. Omari (1989) argued that Tanzanian women who follow traditional belief systems are less likely to use contraception than other women.

In Zanzibar among the never married women, only 5.6 percent were using a modern contraceptive method. These rates indicate that the use of contraception is very low in Zanzibar (Ngalinda 1998). Nevertheless there is a rising trend of contraceptive users as in the 1991/92 Tanzanian Demographic and Health Survey (TDHS) estimated contraceptive users to be 6.6 percent for married women and 2.6 percent un married women (Mturi, 1996). But in Muslims society Islamic law was seen as a central obstacle in prohibiting contraception among the masses (Levtzion, et al 2000).

The overall trends in fertility, however, mask a considerable amount of variation from country to country. Among Muslim-majority countries, the highest Total Fertility Rates currently are found in Niger, Afghanistan and Somalia, where the

average woman has more than six children during her lifetime. The lowest Total Fertility Rates (TFRs) are in Iran (1.7) and Tunisia (1.8), which are well below replacement levels - about 2.1 children per woman (Pew Research Centre 2011).

Women in muslim-majority countries tend to marry at much younger ages than women in more-developed countries, but there is little difference between the average age of marriage in Muslim-majority countries and in other less-developed countries. According to a United Nation (2007) Women in muslim-majority countries marry, on average, at 21.6 years, compared with 22.0 years in non-muslim-majority, which are less-developed countries and 26.2 years in more-developed countries. Similarly (Ngalinda, 1998) found that in Tanzanian the reproductive behavior of women average age at first sexual intercourse to be 16 years; age at first marriage to be 17 years, while average age at first child bearing was estimated to be 18 years. By age 15, almost 10 percent of juvenile women have given birth, but muslims have lower age at first birth than catholics 15-16 to 17 -18 (Ngalinda, 1998).

In 1982, the then President of the United Republic of Tanzania, Mwalimu Julius K. Nyerere cautioned the Nation that: *“Women in Tanzania are the greatest worker.... One cannot expect these people to give birth every year..... unless Tanzanians are careful, our daughters will be giving birth every year like rabbits”*(Kinemo, 1995).

In addition to that, the Revolution Government of Zanzibar cooperates with Ulezi na Malezi Bora Tanzania (UMATI) played a major and significant role in the promotion of family planning activities in Tanzania. UMATI played three major roles which were to motivate, educate and inform the general public on the need for child spacing, to train both government and non-government service providers on child

spacing benefits in Family Planning and to procure and distribute contraceptives to curb women from giving birth every year (Kinemo, 1995).

The government of Zanzibar has all along recognized the importance of family planning methods and family size which are registered and allowed by the Ministry of Health in Zanzibar. Some of the important population measures relating to health, fertility and family planning included the early child bearing and high infant and maternal mortality rates (RGoZ, 2010).

In 1969, while presenting the second Five Year Development Plan to the Annual General Meeting of the ruling Party (TANU) the then Mwalimu Julius K. Nyerere warned the nation that: *“Giving birth is something in which mankind and animals are equal, but rearing the off spring and especially educating them for many years is a unique gift and responsibility of man to look after them properly rather than thinking about the number of 6 children and the ability to give birth for it happens that man’s ability to give birth is greater than his ability to bring up the Children in a proper manner”*(Kinemo, 1995)

In 1973 the National Executive Committee declared its support for the Family Planning and directed the Government (Ministry of Health) to assist in promotion and delivery of child spacing services by using the above methods. In 1974 the Government (Ministry of Health) directed that child spacing advice and services be provided as an integral part of Maternal and Child Health Services (MCH) in all health facilities in the country (URT, 1993).

The Zanzibar Poverty Reduction Plan (ZPRP 2002–2005) includes health related issues aimed at improving the health of women and children. Specific activities geared towards improving the health of women and children include strategies aimed at increasing immunization coverage in children and women of child bearing age and creating equal opportunities for access to basic and essential quality health care (RGoZ, 2010).

Examination of literature shows that culture, Islamic teachings government policies and economic characteristics may have impacts on number of demographic variables such as contraceptive use, population ratio, age at first marriage, duration of breast-feeding and fertility behavior. The present study is an examine influence of Islamic teachings on fertility behavior and how they influence the family size of the couple's in Zanzibar context.

2.6 Research Gap

The existing literatures show that religious studies on religious concentrated on United States. Religious engagement and strength of religious belief have been shown to be good predictors of fertility behavior - those who are more religious have higher fertility and are less likely to use contraception (Hayford and Morgan, 2008; Zhang, 2008)

A great deal has been written about the fertility of Muslims and attitude of Islam toward population control. In the past, observations were made that Muslim populations tended to have high fertility, that there was no evidence of decline, and

that in a given country, Muslims tended to have higher fertility than adherents of other religions Kirk (1996).

In India, where fertility rates tend to be somewhat higher among Muslims than in other communities, the extent to which this relationship holds after controlling for economic disadvantages experienced by Indian Muslims. For example, in a review of 13 major studies on differential fertility by religion in India, Bose (1989) had concluded that “we do not know whether or not Muslim fertility is higher than Hindu fertility”. Similarly, Chaudhry (1982) has shown that the lower socioeconomic status of the Muslim women in India is the major contributory factor to their higher fertility, not their religious affiliation.

In a review of such studies, Kolleylon (1994) reports that fertility levels among Muslim as against Christian populations provide contradictory evidence. For example, while earlier studies of fertility in Israel, the former Soviet Union, Jordan, India, and tropical Africa have reported Muslim fertility to be higher than the fertility of other religious groups, fertility levels among Muslims in Cameroon, Ghana, Nigeria, West Africa, and sub-Saharan Africa are lower than among non-Muslim populations.

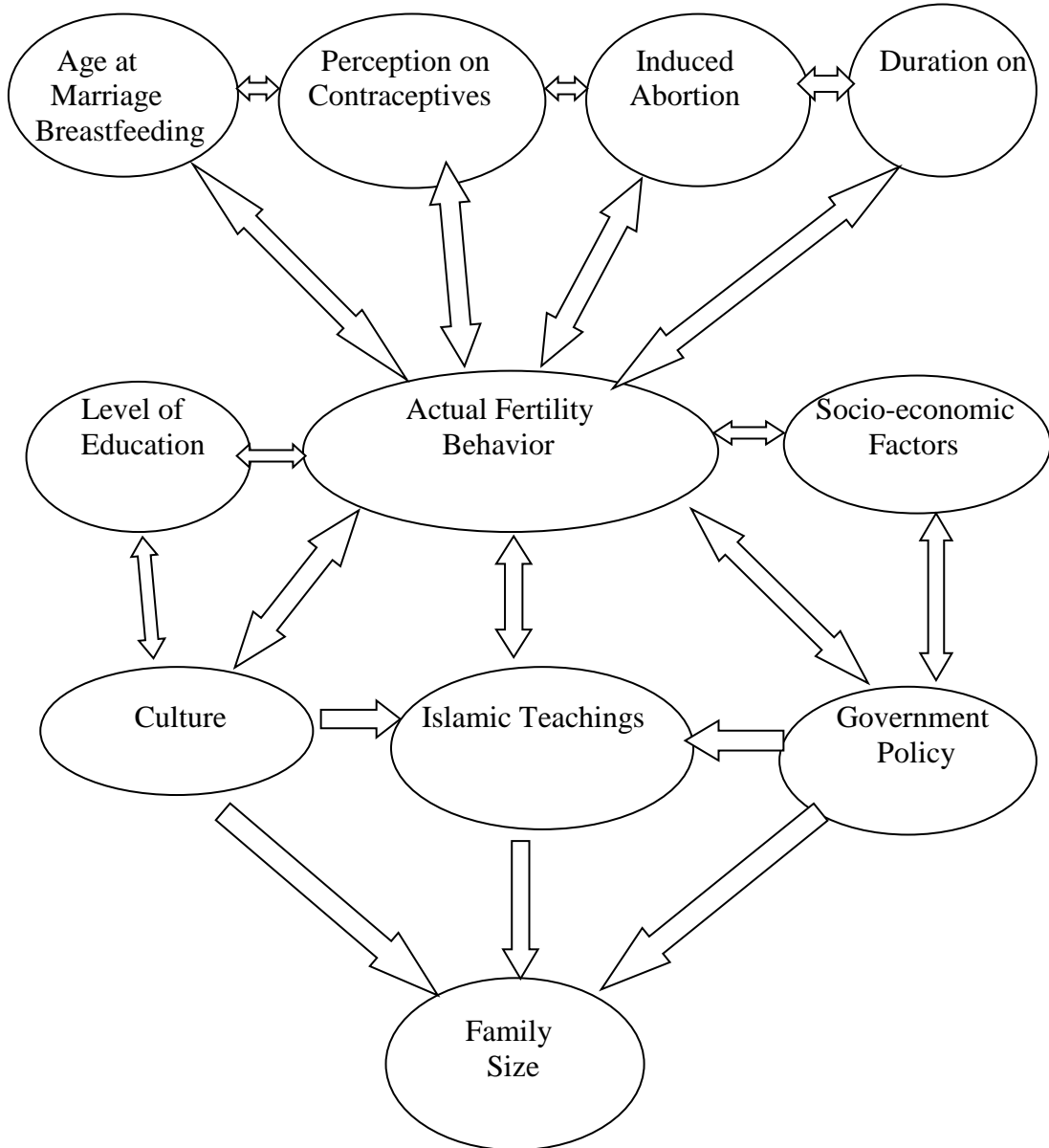
Kolleylon’s study of fertility in Liberia finds that Muslim fertility is only slightly higher than that of Catholics and Protestants. In fact, this difference was found to be attributable mainly to socioeconomic and demographic differentials and not to religious affiliation. Similarly, Garenne (2004) in earlier work on trends in age at marriage, monotheist religions were found to be associated with age at first marriage.

There is no specific study which investigates the relationship between Islamic teaching and family size in Zanzibar. This study is intended to bridge the gap by investigating the extent to which Islamic teaching influence family size in Zanzibar by using Central District in South Region Unguja as the case study.

2.7 Conceptual Framework

In this study, a simplified model has been developed to relate Islamic teaching and family size. Since this research find out the extent to which Islamic teaching influence family size, the framework will be used to examine how Islamic teaching affects family size by assuming that determinant of fertility (age at marriage, contraception, induced abortion and duration of breast feeding) , socio-economic characteristic, level of education, culture and government policy affect individual's attitude toward child bearing and which in turn affect the actual fertility behavior and the family size. Diagrammatically Figure 1 illustrates this relationship.

Figure 1 A Model of the Relationship between Islamic Teaching and Family Size



Source; Researcher 2012

2.7.1 Assumption of the Model

The model assumes that family size is the result of Islamic teaching associated with determinant of fertility (age at marriage, contraception, induced abortion and duration of breast feeding). These determinants can influence individual's beliefs toward child bearing hence affecting actual fertility behavior and family size of the

individuals. Socio-economic characteristics like income generation affect the attitudes toward child bearing behavior. Culture and level of education are some other factors both of which influence the family size.

Culture of individual is expected to affect Islamic teaching of an individual. Government Policies toward family planning methods also will influence child's attitudes toward birth behavior. Acquired attitude toward Islamic teaching is expected to affect the fertility behavior of the individual which in turn will adjust family size upward.

The determinant of fertility like age of marriage, abortion, contraception and duration of breastfeeding are influenced by level of education of an individual. These determinants are also affected by religious beliefs.

What is assumed here is that, the influence of Islamic teaching on family size determines fertility i.e. age at marriage, contraception use, induced abortion and duration of breast feeding. Also Socio-economic characteristics and culture influence family size, generally one would expect that, if couples will get child bearing behavior influenced by Islamic religious ethics of an individual, then the couples will continue actual fertility behavior to achieving more children.

2.8 Conclusion

This chapter began with the conceptual analysis of the key concepts used in this study.

It puts into context the way these concepts used in various literatures and the way which was used in this study. Then the theoretical analysis was done to examine theoretical frameworks which this study based on.

Furthermore, empirical analysis of the related studies was done in order to point out what was already known and what was missing in the influence of Islamic teaching on family size. Then the conceptual framework guiding this study described the relationship between independent and dependent variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Research methodology is a science of studying how research is conducted scientifically (Kothari, 2004). This chapter describes research design, the study area, study population, sampling procedures, data collection methods, validity and reliability of the study, data processing and analysis, and the logic behind the choice of the method.

3.1 Research Design

3.1.1 Research Approach

This study used both quantitative and qualitative approach. Quantitative approach was used because it involves generation of data in quantitative form which can be subjected to rigorous quantitative analysis in a formal and rigid fashion while, qualitative approach was used because it allows researcher to deal with subjective assessment of attitudes, opinions, and behaviour (Kothari, 2004).

3.1.2 Research Strategy

A survey design is a strategy for doing research which involves collection of standardised information from a sample (Bryan, 2004). Therefore, the survey design was used as the strategy of obtaining data from selected wards in Central District in Zanzibar. A total of randomly selected 120 households were involved in the survey. The rationale for adopting a survey design is to enable researcher to make generalization from the findings.

3.2 The Study Area

This study was carried out in Central District in Zanzibar. This region located in the Southern zone of Zanzibar and is bordered by three district namely; South district in the south, North district in the north and West district in the east. The region has three provisions namely; Chwaka, Koani and Uzini. Administratively, Central district is divided into eleven (11) wards (URT, 2006).

Accordingly, the study aimed to find out the extent to which Islamic belief influence the family size. Central district is specifically chosen because it is located at the crossroad to major centre in Zanzibar, attracting people of diverse culture and ethnicity from all parts of Zanzibar, and therefore it has the credibility of giving a the representative picture of the people in Zanzibar.

3.3 Study population.

Population refers to the complete collection of all elements to be studied (Triola, 2001). Since the study was about Islamic beliefs and family size in Central District in Zanzibar, the researcher chose households in Central district to form the population of this study. The total number of household in Central District was 11,937 (URT, 2006). The term household here is based on the group of persons who lived together and share living expenses, usually husband, wife and children (URT, 2006). The researcher considered household because, it is the unit in which the relationship between Islamic belief and family size can be observed.

3.4 Sample Size

Sample size is the number of items to be selected from the population to constitute a sample. The study sample was drawn from Central District, Thus, a total of 120 household from three wards in Central district was included in the sample. One member from each household was interviewed. This sample size was suitable to generalize results and to study the statistical relations between variables. The sample study was obtained through simple random sampling; that is in each street, a list of house holders was prepared. Basing on proportion in terms of size, one respondent was picked after another randomly until a required number of respondents was obtained that constituted a sample for study. According to Yamane, The following formula was used to obtain the sample size.

$$n = \frac{N}{1 + N(e)^2}$$

$$\underline{N} = 1 + N(e)^2$$

Where n= Sample Size

N = Total number of households

e = Precision level

$$N = 11937$$

$$e = 10\%$$

Therefore $n = \frac{11937}{1 + 11937 * (0.1)^2}$

$$n = 1 + 11937 * (0.1)^2$$

$$1 + 119.37$$

$$= 120.37$$

$$\approx 120$$

Therefore, an average of 40 household was selected from each ward.

Key informant interviews are advantageous because they often provide data and insight that cannot be obtained with other methods and they provided flexibility to explore new ideas and issues that had not been anticipated in planning the study but that are relevant to its purpose (Kumer, 1989).

Key informants were selected purposively and they included 3 government officials, 3 religious leaders (Shekh /Imam), 3 leaders one from each ward, 3 representatives of specialized groups like youth and women, and 3 Mother Child Health officer.

Table 1 the distribution of respondents in the wards and key informants

Distribution of Respondents in the wards and key informants			
S/No	Types of Respondents	Location	Number of Respondents
1	Households	Wards	120
2	Government Official	Government office	3
3	Religious leaders	Wards/ Institutions	4
4	Head of village	Wards /Villagers	3
5	Special groups	Wards /villagers	4
6	MCH Officers	Wards/villagers	3
	Total		137

3.5 Sampling Procedure

Sampling is the process of selecting units from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen (Trochim, 2006). Therefore, the purposive and simple random samplings were employed in this study.

3.5.1 Purposive Sampling

Purposive sampling is the type of sampling procedure in which decision with regard to which item should be included or excluded in the sample rests on researcher's judgment and intuition (Adam and Kamuzora, 2008). This method is specifically chosen because it is less expensive and quick for selecting a sample. In this study purposive sampling was used to select three wards in Central district namely Ndijani, Dunga and Chwaka, where the sample household was obtained. Also, this method was used to select respondents to participate in focus group discussion.

3.5.2 Simple Random Sampling

Simple random sampling is a probability sampling whereby all members in the population have equal chance of being selected to form a sample (Adam and Kamuzora, 2008). Simple random sampling is specifically chosen because, it ensures the law of statistical regularity which states that, if on average the sample chosen is a random one, then the sample will have the same composition and characteristics as the population (Kothari, 2004). Therefore, simple random sampling was employed to select households in selected wards to be included in the study.

3.6 Data Collection Methods

This study used two types of data that is primary and secondary data. Primary data is the data collected by researcher or research assistants from the field for the purpose of answering the research questions. On the other hand; secondary data consists of data obtained from literature sources or data collected by other people for other purposes (Adam and Kamuzora, 2008). Primary data were obtained from the selected sample through Questionnaire, focus group discussion and interview methods. Secondary data were collected from books, journals and internet.

3.6.1 Questionnaire

Questionnaire refers to a set of well formulated questions to probe and obtain responses from respondents (Panneerselvam, 2004). In this study self administered questionnaire with closed and open ended questions was used to collect data on the pattern in the selected household. This instrument is specifically selected because it is less expensive even when the sample is large and widely spread geographically.

Also, the respondents have adequate time to give well thought out answers (Kothari, 2004).

3.6.2 Focus Group Discussion

Focus group is a facilitator-led group discussion used for collecting data from a group of participants about a particular topic in a limited amount of time (Keyton, 2006). In this study, focus group discussion was used to collect qualitative data on the factors influencing different patterns of religious teaching. Also, the method was used to collect information on the strategies used to achieve certain Islamic religious teaching. This method is specifically chosen because it allows participants to offer their view-points relatives to the viewpoints of others (ibid).

3.6.3 Interview

Interview refers to a method which researcher and respondent engage in oral questioning or discussion (Adam and Kamuzora, 2008). In this study a personal interview was used to collect quantitative and qualitative data on the Islamic teaching on influencing different patterns of family size. Also, the method was used to collect information on the strategies used to achieve certain Islamic teaching from selected respondents. This instrument is specifically chosen because it allows more information of greater depth to be obtained. Also, there was greater flexibility under this method because of the opportunity to restructure questions (Kothari, 2004).

3.7 Data Processing and Analysis

According to Bogdan & Bicklen (1992), cited in Mngarah (2008), data analysis is a process of systematically working with data or applying statistical and logical

techniques to describe, organize, summarize and compare the data collected and divide them into manageable portions. Data processing involved data editing, coding and classification. Then the researcher prepared a code book for entering the data, followed by data cleaning. This was done manually through proof reading of the data to catch and correct errors and inconsistent codes. Then the data was exported to Statistical package for Social Science (SPSS) for windows version 17.0 for analysis. Data collected were tabulated by using SPSS together with the analysis of frequency counts and percent distributions.

Qualitative data was analyzed through content analysis and be translated and categorized into various themes and sub themes based on the objective of the study. In addition, quantitative data from the questionnaires were coded, summarized and analysed. Descriptive statistics were used to obtain frequency counts of various coded responses and to compare means of quantitative responses of variables.

3.8 Validity and Reliability

The validity of data refers to how well the instrument measure what they are supposed to measure (Triola, 2001). Validity of the data is important to assure the study findings were measured accurately by instrument used. On the other hand, reliability is the degree to which the instrument produces stable and consistent result (Phelan and Wren, 2005).

In quantitative and qualitative research validity and reliability has different meaning. As noted by Golafshani (2003) that, in both quantitative and qualitative research approach research need to be demonstrated as valid and reliable. Reliability in

quantitative research ensures that the result is replicable while, validity ensures the means of measurements are accurate and they actually measure what they supposed to measure. In qualitative research validity and reliability is to eliminate researcher's bias and increase truthfulness of a proposition about some social phenomenon. To ensure validity and reliability the following were done.

Firstly, the questionnaire was translated into Swahili language in order to make sure respondents understand the questions clearly. Swahili language was understood by all respondents included in this study. Also, focus group discussions were done by using Swahili language in order to assure respondents discuss issues in the language which they were understood.

Secondly, a pilot study was done in Ndijani ward, in order to check whether the questions were understood clearly and the questionnaire provided intended results. This was important to assure that the questionnaire measures what it was intended to measure.

Thirdly, research assistants were trained on data collection procedures. This was important because this survey engaged research assistants. So training was important to assure consistent result from all research assistant involved in the survey.

Finally, two instruments were used in data collection. Quantitative data was collected through questionnaire survey and qualitative data were obtained through focus group discussions. Engaging on more than one method of data collection, lead to more valid, reliable and diverse construction of realities (Golafshani, 2003)

3.9 Conclusion

This chapter described research methodology employed in this study. It started by describing the research design of the study.

The study used a survey design employing both quantitative and qualitative approach. Then the study area, population and sample size was described, followed by explanation on sampling procedures, data collection methods and aspect of data processing and analysis. Finally, it describes the validity and reliability of the study.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

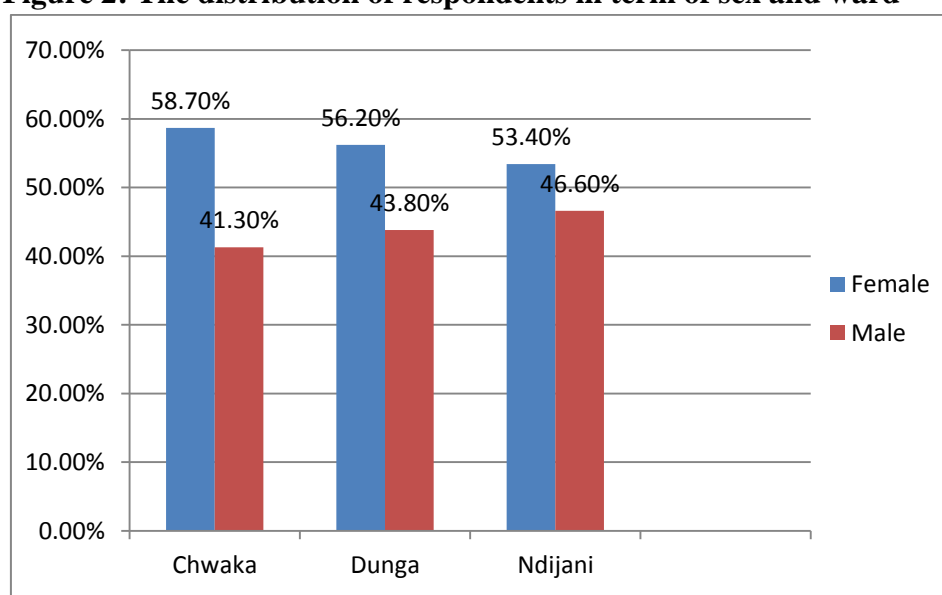
4.0 Introduction

This chapter presents findings of data analysis and discussion of the study. It describes the respondents' profile, followed by analysis of the contributions on how Islamic teaching influences family size in Central District in Zanzibar, the effort taken by the government. The chapter proceed to discuss the effects of large family size to the household communities in Zanzibar.

4.1 Respondents Profile

The study respondents were drawn from three wards in Central District namely Ndjani 33.3%, Chwaka 33.3% and Dunga 33.3%. Regarding respondents' sex, the results in Figure 2 show that the majority of respondents were females (56.1%) and only 43.9 % were males.

Figure 2: The distribution of respondents in term of sex and ward



Source: Field Data 2013

By examining age of the respondents starting from 15-19 years which constitutes the group of 15.8% and majority were between 20 to 24 years consisting of 42.5% , 24.5% were from age group 25-29 years, while only 7.5 % were of age group of 35 years and above. Table 2 shows age of the study respondents.

Table 2: Distributions of Respondents by Age Groups.

Age	Frequency	Percentage %
15 -19	19	15.8
20-24	51	42.5
25-29	29	24.2
30-34	12	10.0
35 and above	9	7.5
Total	120	100.00

Source: Field Data 2013

The study findings shown that most of respondents were married, i.e., 63.3%, and 16.7% were widowed, another 15.0% were divorced, and 5.0% were single. Table 3 shows marital status respondents.

Table 3 Marital status of respondents

Marital status	Frequencies	Percentages
Married	76	63.3
Widow	20	16.0
Divorced	18	15.0
Single	6	5.0
Total	120	100

Source: Field Data 2013

In terms of the level of education, Table 4 shows that 26.7% of the respondents had acquired secondary education, 17.5% had primary education, 25.0% had higher level education and 30.8% had informal education.

Table 4 Respondents Educational Level.

Level of education	Frequency	Percentages (%)
Informal education	37	30.8
Primary education	21	17.5
Secondary education	32	26.7
Higher level and above	30	25.0
Total	120	100.00

Sources: Field Data 2013

The data sources regarding major economic activities which listed in Table 5 show that majority of respondents were farmers who form 26.7%, public employee formed 22.5% and 28.8% were pastoralists, and 14.2% of the respondents were engaged in business while those who were dealing with mixed farming activities 13.3% and only 2.5% were involved in other activities.

Table 5 Occupations of respondents

Occupation	Frequency	Percentages
Pastoralist	25	20.8
Farmer	32	26.7
Farmer and pastoralist	16	13.3
Business	17	14.2
Employed	27	22.5
Other activities	3	2.5
Total	120	100.00

Source: Field Data 2013

4.2 Islamic Teaching and Family Size

The research has shown that many of the respondents understood the relationship between child bearing and religious teachings on influencing family size. As seen in Table 6, a total of 81.7% of the respondents understood the concepts of Islamic

teaching on childbearing and family size, and only 18.3% of respondents did not understand any concept of child bearing and family size which exist in their religious teaching.

Table 6: The awareness relationship of Islamic Teaching on Family size

Respondents Answer	Frequency	Percentages
Yes	98	81.7
No	22	18.3
Total	120	100.0

Source: Field Data 2013

Also, several respondents felt that they share the ideas with their partners or couples on child bearing and family size according to religious beliefs. As shown in Table 7 about 76.7% of the respondents discussed and decided with their partner about child bearing. Only 23.3% were ignorant and never talked with their partners about childbearing.

The high population consciousness about religious teaching and family size is probably due to the efforts made in Zanzibar to educate the people. For example Hamid Nasser, a member of the Zanzibar Aids Commission and co-ordinator of the Zanzibar Faith-Based Organisations group, which works with Ziada advocates that. "The people follow the Qur'an, but the interpretation has to link to modern ways." Condom use, he argues, is a modern equivalent of the traditional "withdrawal" method.

He says that while it is used to be the husband's decisions when to have a child, religious leaders now teach that the Qur'an says both partners should decide together (Damian, 2011).

Table 7: The awareness of couples on child bearing in Islamic teaching

Respondents Answer	Frequency	Percentages
Yes	92	76.7
No	28	23.3
Total	120	100.0

Source: Field Data 2013

The findings show that the majority of the respondents accepted to follow the religious belief on decision about child bearing. As shown in Table 8 about 73.3% of respondents complied with religious doctrine or foundations on birth decisions, however finding show that 26.7% could not follow the religious beliefs on birth.

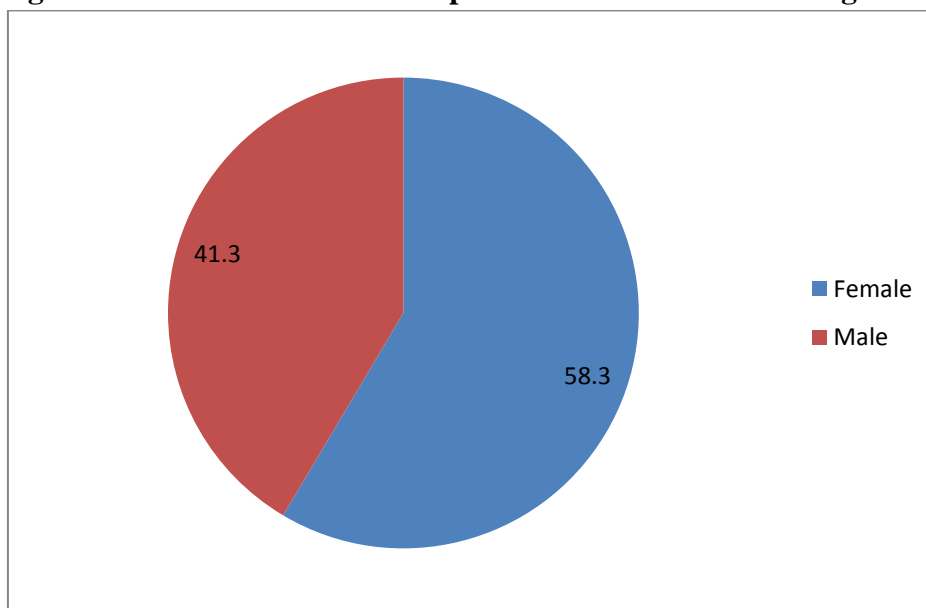
Table 8: Respondents Willingness to child bearing in Islamic Teaching

Respondents Answer	Frequency	Percentages
Yes	88	73.3
No	32	26.7
Total	120	100.0

Source: Field Data 2013

Most of the respondents who preferred to decide child bearing were female who had no doubt to follow the religious belief on child bearing behaviour. As shown on Figure 3 58.3% female respondents accepted to follow religious teaching in child bearing and 41.3% male respondents refused. These results suggest that Islamic teaching had impacts on family size in Zanzibar.

Figure 3: Distribution of Sex Respondents on Islamic Teaching



Source: Field Data 2013

Most of respondents as shown in table 9 preferred large family size i.e., 91.7% and only 8.3% of the respondent's preferred small family size. Majority of respondents argued that child bearing is gift from the God and suggested that each child / person is supposed to live in the world. It was also widely argued that each child has the opportunity to survive and children manifest wealth in the communities, since they are a human resource in the family.

Table 9: Islamic Teaching and Family size

Respondents Answer	Frequency	Percentages
Yes	110	91.7
No	10	8.3
Total	120	100.0

Source: Field Data 2013

4.3 Islamic Teachings on Influencing Family Size

With regard to how family size is perceived in the communities against the Islam some respondents (Muslims scholar) view that "Although the Qur'an is 1,400 years old, it is still functional," says secretary of both the Zanzibar Imams Association and the Zanzibar Interfaith Association for Development and Aids (Ziada). The verses are still current and functional until today (Damian, 2011).

The results from this study supported the notion that parents preferred more Islamic teaching in their family in child bearing behaviour hence suggested existence of Islamic teachings is influencing the family size in Central District in Zanzibar. In Islamic scriptures, as recorded in the Holy book the Quran and Hadith (saying of the Prophet) views on influencing childbearing behaviour are obvious. These issues have also been widely debated in the writing of the early muslims jurists and scholars (Karim 2004).

However, Islamic teaching is not the only factor which induced child bearing behaviour in Central District in Zanzibar, others factors like education and cultural values, economic factors as well as government policies, contribute to family size in the District.

4.3.1 Induce Abortion

All major world religions consider life to be sacred, beginning with conception and ending with death. Islam is no exception in this matter. This study shows that 89.2% of the respondents believed abortion as sin according to the religious faith and belief and clarified that abortion has many socio-health effects to the life of people and

only 10.8% considered abortion has no side effect to people. However, abortion is not considered to be morally objectionable by many respondents when the treatment given to save the life of the mother results in an abortion.

Kinemo (1985) observes that abortion has been considered to be absolutely forbidden in muslims societies or to be treated with strong disdain and limited. In addition to that the Catholic Church does not allow abortion under any circumstances (Stark, et al 2000).

In fact, abortion is forbidden under normal circumstances by nearly all the major world religions. Traditionally, abortion was not deemed permissible by muslim scholars. However, The Journal of Medical Ethics (2006) classical Islamic scholarship had only considered threats to maternal health as a reason for therapeutic abortion. Recently, scholars have begun to consider the effect of severe foetus deformities on the mother, the families and society. This has led some scholars to reconsider the prohibition on abortion in limited circumstances.

Rahman (1996) argued that the Qur'an does not explicitly refer to abortion but offers guidance on related matters. Scholars accept that this guidance can properly be applied to abortion. The Qur'an makes it clear that a foetus must not be aborted on grounds that the family fear that they will not be able to provide for it - they should trust Allah to look after things: *“Kill not your offspring for fear of poverty; it is we who provide for them and for you. Surely, killing them is a great sin.” Qur'an 17:32.* The same (and similar) texts also banned abortion on social or financial grounds relating to the mother or the rest of the family. For example, the pregnancy wasn't

planned and a baby would be seen to interfere with the mother's life, education or career. However, the texts had concessions that a woman could terminate a pregnancy if she was in immediate danger (Ebrahim, 1989).

Islam does not permit abortion where an unwanted pregnancy is the result of unforced adultery. Therefore, according to the source of Islamic law and shariah (the holly book Quran and hadith) Islamic teaching direct or indirect influences the family size in the society compared to another reasons.

In Zanzibar, Several *madawa* (herbalists) explained that there is existence of certain herbs and roots that might act as contraceptives to induce abortion (Jeremy, 2005). However, none of the respondents described engaging in this type of abortion practice, although many of them indicated having knowledge of it.

4.3.2 Contraception

The findings shown in the Table 10, shows 80.8% of the respondents have never utilized any types of modern contraceptives and only 19.2% used contraceptives. Some respondents i.e., 38.3% felt that low level of contraceptive is not accepted according to morally and spiritual beliefs in Islamic teaching.

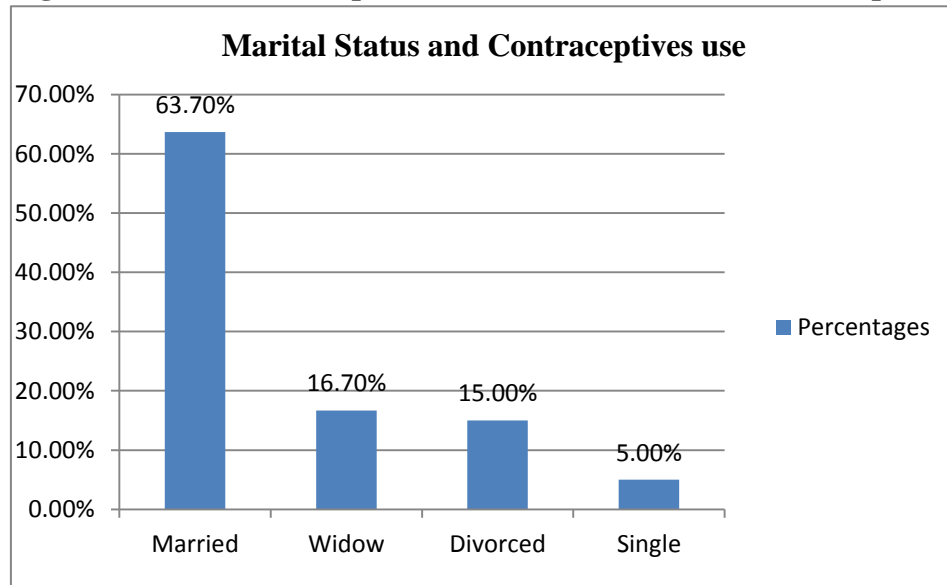
Table 10: Respondents ratio on contraceptive use

Respondents Answer	Frequency	Percentages
Yes	23	19.2
No	97	80.3
Total	120	100.0

Source: Field Data 2013

The findings as shown in Figure 4 show that, majority user of contraceptive are married people who consist of 63.3%, followed by the widow (16.7%), 15.0% divorced and 5.0% were single people.

Figure 4: The relationship between marital status and contraceptives use



Source: Field Data 2013

The analysis indicates that there are various traditional contraceptive methods, and also shows that the practice of *azl* or withdrawal (i.e., to engage in sexual intercourse, but prior to ejaculation the man removes his penis and allows the ejaculation to take place outside the vagina) is morally acceptable since it was practiced by the prophet Muhammad. Sunni doctrine in favor of contraception suggests that any contraceptive that does not produce sterility is morally the same as *azl* and is therefore accepted (Muslim Access, 2008).

Wide spread variation on contraception attitudes can be found in the Islamic faith, because contraception is not expressly prohibited in the Qur'an. Many Muslim scholars and other respondents approve it for family planning (Jeremy, 2005).

Although few women in the village use modern contraception, various forms of traditional contraceptive methods were reported by women in the village. These included withdrawal, abstinence and other herbal methods. It is possible that such practices exist in Central District but secretly.

The finding from the discussion shows that, there is some contraceptive methods used and emphasized by religious leaders, which are considered natural and ethical by most villagers. These include breastfeeding for two years after the birth of a baby and abstinence from sexual relations (even in marriage). Although the latter is not specifically mentioned in the Quran, it is nonetheless rooted in Islamic tradition and is quite prevalent in Central District. Many women leave their husbands after the birth of a baby (taking the child with them) and live in their maternal village for up to two years. Some women claimed having spent some time one to two years away from their husband after a child's birth in order to entice sexual intercourse. Abstinence is a culturally approved method of fertility reduction.

Despite the support of family planning programmed by the Zanzibar government to make sure that maternal mortality rate is decreasing in the isle, including, training service providers especially on family planning, providing free health services for all expectant mothers and improving the health facilities and to keep their young girls in school and not marry them off at a tender age but, many Central District villagers are reluctant to accept family planning methods instead they uphold the natural methods prescribed by the Quran.

According to respondents, most religious leaders have criticized family planning programmed by the government. A nurse at the MCH clinic often denounced that a village religious leader interrupted the MCH staff while they were teaching a group of women about family planning. He quoted from the Quran and condemned the clinic staff as well as the women. It appeared religious instructors have inculcated women's attitudes towards contraception, some of women interviewed believed that the MCH clinic staff was committing sin by encouraging family planning programmed and by "tampering with God's affairs."

The findings have shown that respondents oppose family planning for political, economic and social reasons; religious authorities generally have held that Islam does not prohibit the use of birth control. A number of Islamic jurists have endorsed birth control for the health of the mother and the economic well-being of the family, often citing a verse from the Koran that states: "Allah desires for you ease; He desires no hardship for you" (Mudzhar, 1993).

One barrier to acceptance of modern contraceptives in Central District is religion, particularly muslim believers. In many parts of Zanzibar, religious leaders and practices convince people against the use of modern contraceptives even in areas where government is supporting such methods. Accordingly, without the support of local religious leaders, family planning efforts in Zanzibar is unlikely to succeed.

Benefo (1999) observed that of the promotion of family planning is to be achieved in Africa, it must integrate modern contraceptive with traditional beliefs, rather than including traditional beliefs with Western perspectives. Family planning policies in

Africa should present ideas about family planning in ways that affirm, not displace, existing African values. For family planning policies to be effective, they need to present messages in a ways that reproduce the logic used by individuals in implementing foreign ideas.

In Central District, the Quran is the ultimate source of moral authority for nearly all the villagers. They are typically not well versed in the text and they are relied on their religious understanding on vague conceptions of Islamic tenets, memories from Quran School and/or their husband's beliefs. Women's view on family planning are heavily influenced by their religion, as most interviewed women interviewed felt strongly that the number of children they should have is "God's business" and that parents should not try to interfere with God's will.

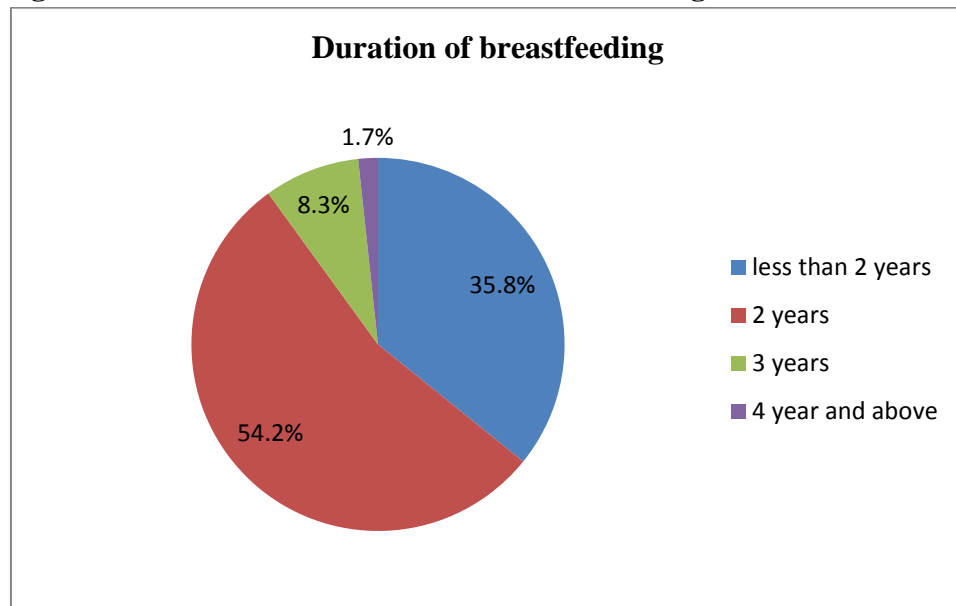
4.2.4 Child bearing and duration of breastfeeding

The findings from this study as shown in Figure 5 show that 54.2% of respondents breastfed their children for two years, 35.8% of respondents breastfed their children for less than two years. Furthermore, 8.3% breastfed their children for three years and only 1.7% respondents breastfed their children for four years, these data indicate that, duration of breast-feeding is one among the key factors which influence family size in Central District Zanzibar.

Also these results are strongly influenced by Islamic teachings." Islam encourages mothers to breastfeed their babies for prolonged periods up to two years (Khalif, 2008). For example, one interviewee felt that *"A mother should nurse her baby even*

if she was the daughter of the king. She is not exempted from that duty, unless she is incapable of nursing”

Figure 5: The distribution duration of breastfeeding in women



Source: Field Data 2013

In Islamic scriptures, as Khalif (2008) observes, Allah has stated the child's right to be breastfed in Surat al- Baqarah; "The mothers shall breastfeed their children for two whole years, (that is) for those (parents) who desire to complete the term of breastfeeding" [al-Baqarah 2:233] (*ibid*).

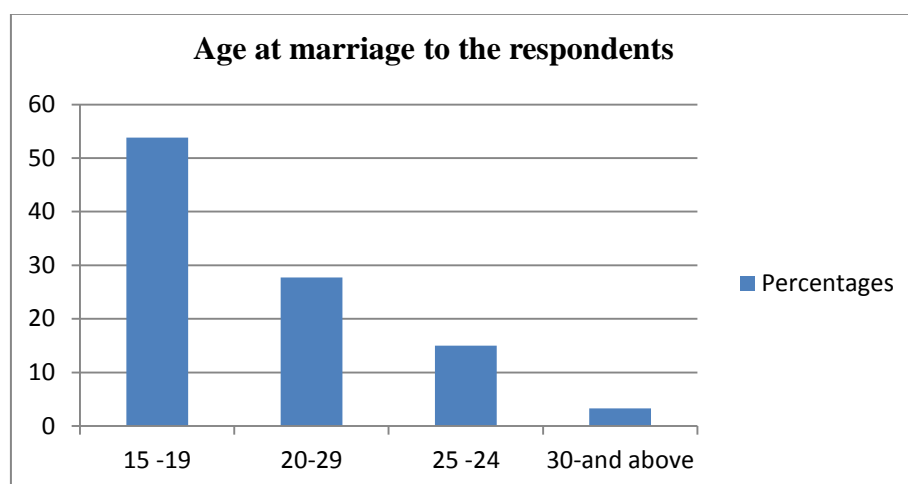
Similarly the Secretary of both the Zanzibar Imams Association and the Zanzibar Interfaith Association for Development and Aids (Ziada) stated that "The verses can be interpreted for today. "The woman giving birth should breastfeed for two years. He argued further that the verse demands a spacing of children of almost three years between births, signifying that the spacing of children is endorsed by the Qur'an (Damian, 2011).

Accordingly to Islamic teachings breastfeeding is quite common in muslim communities. In Zanzibar, for which data are available about 95 per cent of women asserted that they breastfeed their children for 15 to 24 months (Mohammed, 1986). However in majority of muslim countries, for which data are available, the median duration of breastfeeding exceeds 18 months (*ibid*).

4.3.4 Marriage and Sexual intercourse

The findings from this study as shown in Figure 6, show that the large proportion i.e., 53.8% of the respondents were involved in the sexual intercourses in early ages between age 15 – 19, 27.7% of the respondents married between age 20 -24, 15.1% of were engaged for marriage between the ages of 25 -29 and only 3.4% married between the ages 30 -34 and above. This indicate that many people mary early and indulge early in sexual intercourse in Zanzibar. In other words, around ages of 15 – 24, 81.5% of the people become married and influenced by Islamic religios teaching and beliefs.

Figure 6: The distribution of age groups in at first marriage



Sources: Field Data 2013

Many Studies have shown that in sub-Saharan African countries 12-67 percent of women experienced intercourse one or more years prior to their first union (Arnold and Blanc, 1990). Zanzibar society is one the societies inflicted with the problem of childhood marriages in Sub Sahara Africa; the trend of which becomes a developmental burden on the island (Khier, 2011). Practising children marriage is immoral and against the UN convention on the right of children article 34 and African Charter on the Rights and Welfare of the Child (ACRWC). However due to modernization, we expect the age at menarche in Zanzibar to decline due to better nutrition and household health.

In Zanzibar religious belief significantly influence early child marriage because larger part of Zanzibar population is muslims and many people tend to follow Islamic Shariah which restrict sexual relationship out of marriage (Kheir, 2011). Although Zanzibar follow the general law of Tanzania which is non- religious law, however people of Central District follow Islamic norms where a girl can be married when she reaches puberty as early as to 9 years (*ibid*).

This tendency create environment for the parents to arrange marriage for the young girl just often being born. Out of the respondents in questionnaires and interview claimed this as a major reason for their consent to get marriage.

4.3.5 Social - economic factor and Family size

Traditionally, the reasons for marriage included to achieve a large family size necessary for meeting economic, social, and psychological needs. Girls received parental coaching on motherhood and household roles from both their immediate

family and the society, popularly known in Tanzania as Unyago (Mpangile, et al, 1993).

However, many traditional values and social practices have undergone changes during the course of modernization, and it is likely that the traditional premarital sexual abstinence is on the decrease. This study found that although religious beliefs are one of the reasons for desires for bearing many children, some families want more children to increase works force. These Parents see additional children as wealth-producing human resources rather than as wealth-draining obligations.

The Children are regarded as economic assets and security in the old age of parents even though it could mean more mouths to be fed. Economic security is one of the most important factors contributing towards large family size.

Some respondents argued that one of the reasons of having large family size by the lower social status group is due to the fact that the numbers of male children determine the social status of an individual in the rural community.

4.3.6 Level of education and family size

The results have shown that low levels of educational constrain family planning efforts. Studies found that women with no formal education desired an average of 6.98 children while women with post-secondary education desired 5.44 an average of children (Jeremy, 2005). Education was also positively associated with contraceptive use in Central District in Zanzibar. One third of contraceptive users in Central

District had completed high school, whereas a much smaller percentage of women in the village had high school education.

4.3.7 Government Policy and Family Size

Law in Tanzania states that a male person can marry when he has attained the minimum age of eighteen years, and for female to have attained a minimum age of fifteen years (The Marriage Act of 1971 section 13). Today, the Zanzibar government is reviewing the country's Marriage Act with an aim to rise the girl's age for marriage from 15 to 18 years. The government's rationale is that the 15-17 year old girls are not physically and psychologically mature enough for marriage (Kheir, 2011).

On the other hand, according to UNICEF, early marriage means marriage involving a person who is child as stipulated by Article 1 of the Convention on the Right of the Child whose age is less than 18 years (UNICEF, 2001).

The Revolutionary Government of Zanzibar is the executive body responsible for introducing legislation on the islands and has a duty to draft and implement domestic legislation to give full force to the principles of the UN Convention and the African Charter (UN 1989). This means that theoretically, Zanzibar must respect the UN convention, as well as the African Charter on the Rights and Welfare of the Child (ACRWC).

In defining the parameters that label a marriage as early, the most common is marrying at the age as early as 13 and below 18 years. The context of Zanzibar, early

marriage is a government policy against pre-mature marriage as well as religious practice that starts when society sends off teenage-wives to complete womanhood, the tendency used to select girls as future wives while there were at young ages (Kheir, 2011).

Family planning is another arena in which the role of religion is not as simple as it might seem. Islamic edicts generally have supported the use of birth control, and a number of majority respondent never encouraged family planning programs. But many people in Central District are uneasy about contraceptives and women reported using birth control at lower rates. In addition, many muslim scholar interviewed forbid or strictly limit abortions.

This suggests that, Islamic teaching in general and in particular in Zanzibar may boost the number of children per woman. In Zanzibar the most important reason for child marriage is religious belief, as larger part of Central District population constituted by muslims have a tendency to follow Islamic Sharia which restrict sexual relationship out of marriage. For one to be accepted to have sex she or he must be married first this encourages early marriages.

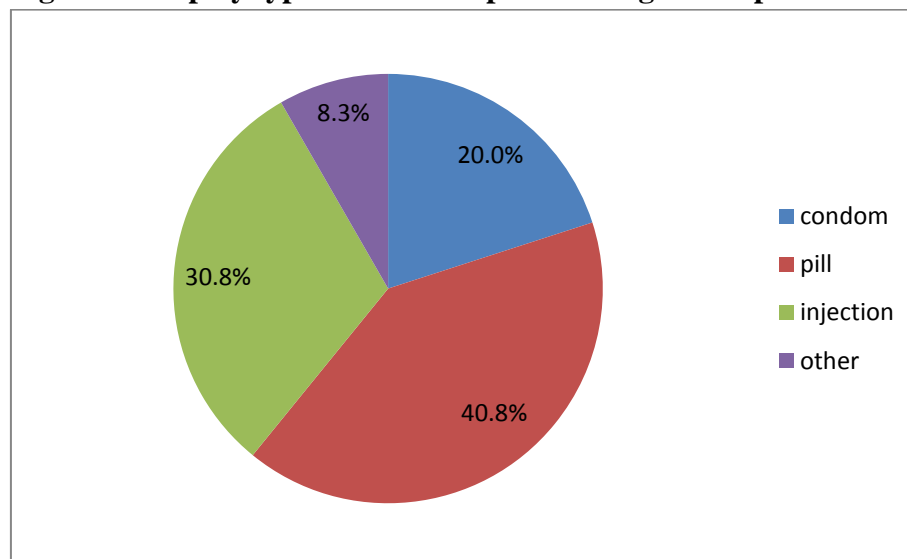
4.4 Government efforts on family size

The findings show that the majority of the respondents understood and knew the different type of institutions introduced by the government about family size and family planning activities. Nearly 56.7% of the respondents knew the different institutions which are running to combat family size and childbearing behaviours, 43.3% of the respondents were unaware about the responsible institutions. These

institutions are such as Uzazi na Malezi Bora Tanzania (UMATI), Zanzibar Interfaith Association for Development and Aids (ZIADA), Zanzibar Poverty Reduction Plan (ZPRP), Maternal and Child Health Services (MCH), Sexual and Reproductive Health (SRH), Ministry of Health and Social Welfare (MOHSW).

Findings indicate that the majority of the respondents wished to use some of modern contraceptives as shown in Figure 7, 40.8% prefer to use pill, 30.8% of respondents desired injection while 20.0% of the respondents desired condom especially for diseases prevention and only 8.3% desired other types of contraceptives such as barrier used by women and herbal medicine. A report done by Demographic Health Survey cited the modern methods commonly used in Zanzibar by women as pills (15 percent) condoms (7 percent) and injection (6 percent); while traditional methods frequently used are withdrawal (9 percent) and calendar (8 percent). The use of contraception is higher for sexually active unmarried woman than currently married women (Tanzania Demographic Health Survey, 1996).

Figure 7: Display types of contraceptive among the respondents



Source: Field Data 2013

In a the discussion with key government officers and health officers from the health Centre, this study found that, several legislation and regulations are in place to promote the health and social well-being of women and young children. They directly or indirectly encourage the practice of child spacing and family planning development at large. For instance, the law governing maternity leave of 84 days for employed female workers once every three years encourages child spacing and hence family planning development at large. The income tax relief of up to four (4) children or dependents for all workers discouraged the parents from bearing many children. The provision of travel allowance for up to four (4) children once every (two) years when going on annual leave again encourage parents not to bear more than four children (Zanzibar Ministry of Health, 1988).

According to the United Nations report World Population Policies 2003, since the early 1970s, the United Nations Population Division has regularly sent inquiries to governments worldwide about their views and policies related to population. This means that majority of muslim population countries responding to the 2003 inquiry stated that they support family planning services either directly through government-sponsored outlets or indirectly through support of nongovernmental sources (UN, 2003).

In Zanzibar, as in other parts of the world, family planning services are usually provided as part of maternal, child health, and primary health care. Governments believe that their role in providing family planning information and services is not only legitimate but necessary to improve maternal and child health by preventing unplanned pregnancies.

Also, the government underscored that young men aged 18-24 had sexual intercourse before the age of 18. In order to reverse this situation there is need to increase the availability of life skills and Sexual and Reproductive Health (SRH) information and services to young people. Furthermore, family planning and family size activities focusing on advocacy, availability of and accessibility to family planning methods, such as Intrauterine Contraceptive Device (IUCD), implants, and vasectomy, have increased in new family planning clients (RGoZ, 2010).

The family quality of life domain of health includes a family's health status, health care, and health impact. The consequences of large family size on health relate to Limited Access to Health Care. Large family affects all family members' health because of the family's inability to afford health services from doctors, dentists, or psychologists, or health supplies, such as prescription drugs or first aid materials. Park (2002) clearly outlined the recent expansions in medicaid coverage that they have relieved many poor families from the burden of health insurance for their children.

The findings of this study revealed that, major challenges facing provision of family planning services are such as erratic supply of family planning commodities and limited range of choices, insufficient funding for contraceptives, and negative attitude of providers towards Family Planning. These situations were aggravated by limited spouse communication, inadequate male involvement and social cultural values including religious barriers.

4.5 Results caused by Childbearing Behavior

4.5.1 In danger Reproductive health of Mother

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capacity to reproduce, and freedom to decide if, when and how often to do so. Pregnancy in the teen age and for women of older age poses risk both for the mother and the baby. If a mother experiences pregnancies at short interval she exposes herself to the new danger when she had not recovered from previous pregnancies while already has a small baby whom she is nursing.

The finding from this study revealed that 54.2% of respondents breastfed their children for two years, 35.8% of respondents breastfed their children for less than two years. A mother who enjoys good health and is free from disease has much better chances of undergoing a healthy and successful delivery. There is a direct relationship between maternal health and out-come of pregnancy.

4.5.2 Destructions of Natural resources

As the population expands, a greater amount of environmental resources are needed for housing, roads and agriculture. Land is often passed down to children and can be divided many times in large families, eventually running out. This can mean that children do not inherit enough land to provide for their families.

Even for families without land, such as urban squatters, environmental resources like water and food are essential for survival. Many families rely on environmental resources for survival. Often couples desire smaller families because they recognize that they do not have the environmental resources to provide for many children.

4.5.4. Shortage of Employment

It is well known that population growth will tend to have a lagged effect on unemployment. For example, if population growth is the outcome of relatively high fertility or of an age distribution that is heavily concentrated in the childbearing years, the growth in any year will have its impact on employment distribution.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary, conclusion of the key findings, recommendations and areas of the further study. The summary part gives the general characteristics of the study while, the conclusions drawn were based on the objectives of the study. The recommendations were outlined with reference to findings obtained.

5.1 Summary of the Major Research Findings and Conclusions

This study was prompted by the need to study how Islamic Teachings influences family size. The study focused on the households in Central District in Zanzibar to find out the influence of Islamic Teachings on family size. The following conclusion was drawn from the study.

5.1.1 Influence of Islamic teachings on child bearing behavior

The study found Islamic teaching effects childbearing behavior since, couples continue childbearing until they reach desired number of child. On average the proportion of couples who follow the religious doctrine and beliefs in child bearing was very high, about 58.3% accepted to follow religious beliefs in child birth and only 41.7% did not understand and accept. This result suggests that most couples continue having children according their religious beliefs and do not stop childbearing even if there was a concrete reason, hence influencing the number of children born (family size).

5.1.2 Islamic teaching on influence family size

The study found that, the individual's behavior towards continuous child bearing was attributed to several reasons such as Induced Abortion. An abortion is among the factors which determined the level of family size among the Islamic community. This is because most couples do not practice induced abortion as it is considered sinfully to them and illegal, hence couples preferred more children by following their religious beliefs.

Contraceptive use among the Muslims societies is very minimum, especially modern contraceptive use because it is not legally easily permissible. Duration of breastfeeding was seen to have effects on Islamic teaching, because majority of couples breastfeed their children from less than two year and two years.

According to evolved data the majority of the respondents married at early ages due to the influences of Islamic teachings. Low level of education is seen to prompt early marriages as Islamic teachings were preferred and hence leading to large family size in the society. It was also found that socio-economic factor practices in the society was deep rooted in the societal cultural beliefs mainly the patriarchal system.

5.1.3 Government efforts

The government's role is particularly important in removing economic barriers to family planning by making it available free of charge or at a subsidized price for low-income families who otherwise would not be able to afford it. Governments also can play an important role in removing social and cultural barriers through the

educational system and the media, as cultural and religious beliefs can sometimes prevent couples from using health services.

Moreover, the government should keep more serious religious factors as among the key determinant for growing family size in Tanzania; hence the government should cooperate with religious leaders on issues of family planning and population growth.

5.2 Recommendations

5.2.1 Recommendations for Actions

This study found that low level of education reduces skills on childbearing. Therefore, formal education should be encouraged for both of male and female partners to reduce the negative impact of Islamic teaching on issues of family size.

However, religious leaders again should play a key role in developing community acceptance of contraceptives, assuring community members that family planning is in accordance with the Quran. They also should include family planning messages at wedding and other religious ceremonies. Religious and community leaders should to participate in family planning in order to set example for their communities. The willingness of village leaders to participate in family planning programmes is crucial in determining community acceptance of family planning.

Policymakers, therefore, need to take into consideration and build upon local reproductive beliefs and practices in order to legitimize the use of modern contraceptives. Access to contraceptives in terms of cost and availability are necessary, but not sufficient to produce widespread use of family planning in Central District.

Religious leaders should play a key role in developing community acceptance of contraceptives, assuring community members that family planning is in accordance with the Quran.

They should include family planning messages at wedding and other religious ceremonies. Religious and community leaders should participate in family planning in order to set example for their communities. The existing population policy should take into account the role of Islamic teaching in influencing family size.

The government should encourage the private sector and local communities to be actively involved in initiating, implementation and financing population planning programmes, because according to data from the respondent majority of respondents argued that most of institutions have no ability to perform their duties due to the financing problem and low level of knowledge of instructors. Also government should create awareness to the masses on the link between population, resources, environment, poverty eradication and sustainable development.

5.2.2 Recommendations for Further Research

This research has brought to the position of understanding that Islamic teaching influences family size in Central District in Zanzibar in particular based on cross-sectional data and period analysis of fertility. Therefore, it is recommended that a research based on longitudinal data and cohort analysis of fertility being conducted in order to examine aspects such as change of Islamic teaching over time, and examining whether there was difference in Islamic teaching within proximate determinate of fertility and different social values.

Furthermore; the study covered only Central District in Zanzibar. For this reason, the results from this study should not be taken as conclusion. There is a need to replicate the study in other districts in Tanzania and in relatively larger sample in order to generalize the findings obtained.

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Appendix 1

Questionnaire for the study on Islamic teaching and family size in central district, Zanzibar (For household people)

Dear Respondent;

My name is Vuai Said H, a student at the University of Dodoma. I am conducting a study on Islamic teaching and family size in order to understand how the family size is influenced by Islamic teaching.

You are kindly requested to respond genuinely to these questions. Your responses are taken with strict confidentiality and shall be used for the purposes of this research only. Thank you for your understanding and time.

No.....

Ward.....

Street/Village.....

SECTION A: Demographic information (*please circle the response that correspond to you*)

1. Sex

- a) Male
- b) Female

2. Age

- a) 15 – 24years
- b) 25 – 34 years
- c) 45 -54 years
- d) 55 or above

3. Marital status

- a) Single
- b) Married
- c) Divorce
- d) Widow
- e) Other (please specify)

4. Education level

- a) Informal
- b) Primary

- c) Secondary
- d) Above secondary

5. Major livelihood promotion activities
- a) Pastorals
 - b) Farming
 - c) Mixed farming
 - d) Business
 - e) Employed worked
 - f) Other (please specify)

6. Income level
- a) Below 90,000/= per month
 - b) 90,000/= to 150,000/= per month
 - c) 150,000/= 250,000/= per month
 - d) Above 250,000/= per month

SECTION B: Perception and awareness about Islamic religions on childbearing behavior and family size. (Please circle the response that correspond to you)

7. Are you aware of Islamic belief on childbearing behavior?
- a) Yes
 - b) No
8. Have you follow Islamic teaching on childbearing behavior
- a) Yes
 - b) No
9. If yes, since when?
-
10. If no, why
-
11. Have you discuss with your spouse/partner about the childbearing behavior at any time respect with your religious belief.
- a) Yes
 - b) No
12. Did your partner agree to follow the religious belief on the childbearing behavior and family size
- a) Yes
 - b) No

13. If no, why (give reasons)

.....
.....
.....

14. If yes, why (give reasons)

.....
.....
.....

15. Do you think that Islamic teaching is more dominant on childbearing behavior?

- a) Yes
- b) No
- c) I don't know

16. If yes, give the reasons (at least three)

.....
.....
.....

17. What is your perception about large family in Islamic point of view?

- a) One child
- b) Two – four
- c) Four to six
- d) Six and above

18. Do you think that Islamic teaching prefer to large family size?

- a) Yes
- b) No

19. If yes, give reasons for your answer above

.....
.....

SECTION D: Efficiency of programs/institution, problems/barrier related to childbearing behavior and family size as well as influences toward the adoption of the Islamic culture. (Please circle the response that correspond to you)

20. Are there any program/institution advocating by government to control childbearing behavior and family size

- a) Yes
- b) No

21. If yes, mention them

.....
.....

22. Do you think these programs/ institution are popular/effective in provision of services

- a) Yes
- b) No

23. If no, what could be the reasons? (mention at least three)

.....
.....
.....

24. Do you think that Islamic teaching act as a barrier to implement the efforts introduce by the government?

- a) Yes
- b) No

25. If yes, how does it act as barrier?

.....
.....

SECTION C: Information about various ways on which Islamic teaching contribute to the influences childbearing behavior and family size. (Please circle the response that correspond to you)

26. Are you aware of contraceptive use for controlling births and space children

- a) Yes
- b) No

27. Have you been using any contraceptive in your life

- a) Yes
- b) No

28. If yes, since when?

..... (Year)

29. If no, why (give reasons)

.....
.....

30. Did you think that your religious beliefs prefer to use any types of modern contraceptive use?

- a) Yes
- b) No

31. If no, why (give reasons)

.....
.....
.....

32. If yes, what type of contraceptive methods are your prefer (mention them)

.....
.....

33. Which types of contraceptive methods are more the most preferred to your society (mention them)

.....
.....

34. Why, use it (above Q. 33)

.....

35. Did you think that your religious beliefs encourage early marriage

- a) Yes
- b) No

36. If yes, why give reasons

.....
.....

37. How many years have you when at first marriages

- a) 15 -19 years
- b) 20 -24 years
- c) 25 – 29 years
- d) 30 -34 years
- e) 35 – above

38. What is the perception of early marriage toward cultural altitudes in the society?

.....
.....

39. Have you ever heard about induced abortion

- a) Yes
- b) No

40. Did you think that Islamic teaching allow induced abortion to their believers

- a) Yes
- b) No

41. If no, why give reasons (give at least two)

.....
.....

42. Did you think, is there any problems related to the induced abortions

- a) Yes
- b) No

43. If yes, what are they? (at least three)

.....
.....
.....

44. What are perception of your society values and cultural attitudes toward the induced abortion

.....
.....
.....

45. How many year will you take in breastfeeding your child

- a) Less than two year
- b) 2 years
- c) 3 years
- d) 4 years and above

46. Do you think, is there any impacts on household and society in general on large family size.

.....
.....

Appendix 2

Discussion guide for the study on Islamic teaching and family size in central district, Zanzibar

(For official religious leader)

Dear Respondent;

My name is Vuai Said H, a student at the University of Dodoma. I am conducting a study on Islamic teaching and family size in order to understand how the family size is influenced by Islamic teaching.

You are kindly requested to participate in this focus group discussion. Your responses are taken with strict confidentiality and shall be used for the purposes of this research only. Thank you for your understanding and time.

1. Do you think the society follow religious ideologies as ways of life?
2. If yes, to what extent does society practice to follow religious doctrines in the of life
3. In what ways and means does Islamic teaching encourage childbearing behavior on influencing family size in the society? Namely
4. Do you think that Islamic teaching contributes childbearing behavior and influencing family size
5. If yes, namely the ways that Islamic teaching can be sources childbearing behavior
6. What is your perception about contraceptive use in Islamic point of view?
7. If it is not allow, is there any side effects on contraceptives use to the people.
8. What are they? Namely
9. Is there any religious and cultural perception about child bearing behavior and family size

10. Are any impacts to the house hold and society in generally to prefer large family size?
11. Namely ,
12. What is your opinion to research, stakeholder and government to rectify it?

Appendix 3

Discussion guide for the study on Islamic teaching and family size in central district, Zanzibar

(Interview question for government officers and other key informants)

Dear Respondent;

My name is Vuai Said H, a student at the University of Dodoma. I am conducting a study on Islamic teaching and family size in order to understand how the family size is influenced by Islamic teaching.

You are kindly requested to participate in this focus group discussion. Your responses are taken with strict confidentiality and shall be used for the purposes of this research only. Thank you for your understanding and time.

1. What is the situation of religious beliefs in these areas?
2. What is the situation of childbearing behavior and family size in the areas?
3. What are the key factor that contributes the childbearing behavior and family size in the areas?
4. Do you think that Islamic teaching contributes child bearing behavior and family size?
5. What are they? Namely
6. Is there any institution/organs or non-government organization introduce to control childbearing bearing behaviors?
7. What are they? Namely
8. Is there any efforts taken by these organizations/institutions to control childbearing behavior and family size?
9. If there is, namely

10. Is there any barrier/obstacles occur during the implementation?
11. What are they? Namely
12. Does Islamic religious act as barrier to control family planning?
13. Do you think, is there any impacts to the people who prefer to continuous childbearing behavior and large family size
14. If there, what are they? Namely
15. What is your advice to people who prefer these impacts