

Hearing Native Voices: Contraceptive Use in Matemwe Village, East Africa

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ABSTRACT

Although fertility declines have been documented in various parts of Africa, fertility rates remain high in Tanzania. Widespread resistance to modern contraception is one factor associated with high fertility in Tanzania. The aim of this study was to identify cultural barriers to modern contraceptive use in Matemwe village, Zanzibar. In May 2003, more than 50 in-depth interviews were conducted with community leaders, health care workers and couples in Matemwe. Despite free and easy access to contraceptives, only 2% of Matemwe women participated in the village's family planning programme. Several factors were found to influence contraceptive use, including strong Muslim beliefs, male dominance over females (especially in polygynous relationships), and limited exposure to modern ideas via education and travel. Interviews indicated that in order to lower fertility in Matemwe, cultural barriers to family planning must be confronted. Successful implementation of a family planning programme hinges on the ability of policymakers to integrate modern ideas about contraception with Matemwe's traditional religious and political culture. (*Afr J Reprod Health* 2005; 9[1]: 32–41)

RÉSUMÉ

Entendre les voix indigènes: Usage des contraceptifs dans le village de Matemwe, Afrique de l'est. Bien que les déclin de la fécondité ont été documentés un peu partout en Afrique, les taux de fécondité restent élevés en Tanzanie. La résistance répandue à la contraception moderne est un facteur lié à la haute fécondité en Tanzanie. Cette étude a pour but d'identifier les obstacles à l'utilisation de la contraception moderne dans le village de Matemwe, Zanzibar. Au mois de mai 2003, plus de cinquante interviews en profondeur ont été menées au sein des leaders de la communauté, les membres du personnel soignant et des couples à Matemwe. Les interviews ont été transcrites et examinées pour découvrir des modèles. Malgré un accès facile et libre aux contraceptifs, seules 20% des femmes de Matemwe ont participé au programme de la planification dans le village. Plusieurs facteurs ont influencé l'utilisation des contraceptifs y compris les croyances islamiques, la domination des femmes par les hommes (surtout dans les rapports polygéniques) et l'exposition limitée aux idées modernes à travers l'éducation et le voyage. Les interviews ont montré que pour baisser la fécondité à Matemwe, il va falloir affronter les obstacles culturels à la planification familiale. La bonne réalisation du programme de la planification familiale est fondée sur la capacité des décideurs de la politique d'intégrer les idées modernes sur la contraception avec la culture traditionnelle, religieuse et politique de Matemwe. (*Rev Afr Santé Reprod* 2005; 9[1]: 32–41)

KEY WORDS: Contraception, fertility, barriers, tradition

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Introduction

Fertility declines in East Africa have been greatest in Kenya but less so in countries such as Tanzania.^{1,2} The primary factor associated with declines in fertility in these regions has been acceptance and use of modern contraception.^{1,2} Despite initial declines, fertility rates remain relatively high in Tanzania. Population statistics for 2001 report the total fertility rate (TFR) in East Africa as 5.7 births per woman. This total fertility rate is very similar to Tanzania's (TFR = 5.6), where approximately 25% of married women reported using contraception and only 17% reported using modern contraceptives.³

Various factors influence access to contraception in the eastern regions of Africa, including physical and cultural barriers. Traditionally, weak government programmes, lack of availability and cost of contraceptives have been blamed as causes of low contraceptive use.⁴ However, in many cases, even when modern contraceptives are easily accessible, cultural barriers continue to hinder acceptance and use. These cultural barriers must be addressed for the declines in fertility to continue. This study highlights such barriers using a case study of a small village, Matemwe, in Tanzania, East Africa.

One barrier to acceptance of modern contraceptives in Africa is religion, particularly Muslim beliefs that are pronatalist. In many parts of Africa, religious leaders and practices discourage acceptance and use of modern contraceptives even in areas where such methods are available.^{5,6} Without the support of local religious leaders, family planning efforts in African countries are not likely to succeed. Benefo⁷ argues that for the promotion of family planning to be successful in Africa, it must integrate modern contraceptive use with traditional beliefs, rather than supplant 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.

According to Benefo,⁷ there is evidence to suggest that when West Africans have adopted western reproductive perspectives, they have transformed these perspectives to fit their own culture. Local cultures are best able to adopt new ideas by relating them first to old ideas; weaknesses in the culture help determine what new ideas are borrowed. Benefo⁷ contends that languages and religions are structured hierarchically with different levels of meaning. Some of these levels are weaker than others and more pliable and open to reshaping when in contact with new ideas.

Individuals employ their own logic in deciding whether or not to adopt new ideas or behaviours. For family planning policies to be effective, they need to present messages in ways that reproduce the logic used by individuals in accepting foreign ideas. Benefo⁷ suggests, for example, that family planning efforts in Africa focus not on the nuclear family and small family size – ideas foreign to local values – but they instead emphasise the role of family planning in obtaining healthy families or increasing sexual stamina.

To examine cultural barriers to family planning in greater detail, we use qualitative interviews to capture the processes underlying decisions regarding family planning in a small village in East Africa. Through personal interviews we highlight the role of religion, patriarchy and exposure to modern ideas in shaping decisions regarding family planning and point to local values that could be emphasised to introduce family planning into the village more effectively.

Matemwe Village

Matemwe, a small village located on the eastern shore of the principal island of Indian Ocean archipelago, Zanzibar (Republic of Tanzania), is an ideal location for studying fertility, for it remains like much of Africa: technologically traditional

and relatively undisturbed by western influences. Matemwe has a low rate of contraceptive use, coupled with a high fertility rate; less than 2% of the village women participate in family planning. Low use of contraception, however, is not due to a lack of access to modern contraceptives. In 1983, Maternal and Children's Health (MCH), a government run programme sponsored by UNICEF was initiated in the village. This unit provides modern contraceptives (oral, injectables and condoms) to village members at no cost. Few women, however, visit the clinic for contraceptives.

A devoutly religious community, Matemwe provides an interesting case study of the effects of Islam (the dominant religion in nearly half of the countries in sub-Saharan Africa) on fertility. Also, because of both its uniqueness from and commonalities with certain areas of Africa, Matemwe provides an interesting case for understanding fertility issues in Africa. It is in this village context that we examine through interviews why methods of fertility reduction are not utilised.

Village Interviews

During the spring of 2000, from May until July, the primary author lived in Matemwe and conducted more than 50 in-depth interviews with men and women in the village. The village leaders were very responsive to the project and encouraged other villagers to participate. Interview subjects were chosen from across the village. Individuals in the community with specific links to family planning were in particular interviewed, including medical clinic staff members, religious leaders and the village doctor. Because of access, most of the village members interviewed lived in the central part of the village rather than in the outlying communities. Interviews were conducted in the native language through a local interpreter. The interpreter also helped to recruit additional women for the interview, whom he knew would be open to discuss fertility issues. At least one or two village members were interviewed from each

of the 13 sub-villages in Matemwe during the three-month period.

The interview itself consisted of nearly 100 questions grouped by related topic. Most of the questions focused on understanding the respondent's views on reproductive health and fertility. In many cases, a particularly interesting aspect of the individual's experience was discussed further, necessitating frequent digression from the interview schedule. The interview schedule itself evolved from discussions during exploratory and preliminary interviews. Initial interview responses motivated the development of new questions asked in later interviews.

As noted previously, each interview was conducted largely with the aid of a translator and carried out in private to the extent possible. However, both the researcher and interpreter were males, therefore, interviewing women respondents in some cases made frank and honest communication difficult (especially on such subject as contraception regarded as a taboo). In Matemwe society, members of the opposite sex rarely interact with each other, and most villagers have seen only one or two white people in their lives. Working with women in groups of two seemed to strike a balance between having too many people present at the interview, while still allowing the woman to feel comfortable in the interview setting (particularly if the other woman was a close friend or relative).

We note that in some cases individuals were biased in their responses to interview questions. In some cases we suspected that respondents said what they thought the interviewer wanted to hear, usually a modern and progressive answer. When possible, attempts were made to identify these biases by talking with the spouse of the respondent who would then confirm or deny perspectives presented in the initial interview. On completion the interviews were transcribed and examined for patterns. In particular, barriers to modern contraceptive use were identified and examined in greater detail.

Contraceptive Use in Matemwe

In Matemwe village itself, about 100 women have been to the village MCH clinic for family planning programmes since it began to provide contraceptives in 1983. Out of the 1,377 women of reproductive age in the village, only 2% (27 women) were participating in family planning programmes sponsored by the clinic during the spring of 2000. All contraceptives dispensed by the clinic, including condoms, are free and are kept on-hand and made available at reasonable hours (the clinic is open from morning until evening throughout the week). The clinic is located in the centre of the complex of Matemwe village (with thirteen village sub-units spread across 25km²) and is accessible by foot, within one hour or less, to all villagers. Physical barriers to contraceptive use such as cost and availability of contraceptives are, therefore, minimal.

In the Matemwe MCH clinic, oral contraceptives, Depo-Provera injections and condoms are donated by UNICEF and provided free to clients. Oral contraceptives are by far the most popular modern contraceptive method dispensed by the clinic. Of all village women using some form of modern contraception, almost two thirds used oral contraceptives. Interviews with MCH clinic staff indicate that the fear of needles, ease of use and ability to monitor and control daily contact with the contraceptive are possible explanations for the relatively higher usage of oral contraceptives than other methods.

MCH clinic staff also dispense injections of Depo-Provera hormonal contraceptives in the clinic (although it is possible for one of the clinic staff to travel to a residence to administer the injection). The clinic staff considered injections appealing because of their "invisibility." This enables women to participate in family planning programmes without the daily risk of being discovered, a feature that is inevitably associated with oral contraceptives. A woman is also free from the daily obligations of taking her contraceptive and only needs to be concerned

about it every few months. With the help of MCH clinic staff, some women in Matemwe disguise their quarterly visit to the clinic to receive injection by combining such visits with regular check-ups. Despite these appeals, only about one third of women participating in family planning in Matemwe through the clinic receive Depo-Provera injections.

Condom use in Matemwe is very minimal. During the interview with MCH clinic staff they struggled to remember having dispensed even one condom over the past several years. Condom use in Zanzibar appears to be restricted mostly to urban centres. Contraceptive methods that depend entirely on the man are not well received in this male-dominated society. Unfortunately, condoms are the only form of contraception that can effectively prevent the spread of HIV, and it may become critical to the viability and health of the village if the epidemic reaches Matemwe. As the economic activities of the villagers change from traditional local farming to business and trade, many more men and women spend time in the main city of the island, and in other large cities of mainland Africa, thus increasing the likelihood of exposure to AIDS.

Concerning the potential side effects of modern contraceptives, Matemwe villagers claimed to fear headaches, irregular bleeding, weight gain and fatigue resulting from the use of modern contraceptives. Despite these commonly reported concerns in interviews with women in the village, MCH clinic staff denied ever having seen any negative side effects of hormonal contraceptives among women who participated in family planning in Matemwe. Staff members did not report any weight gain, but they rather stated that some women had become "stronger" with the use of contraceptives. Thus, use of modern contraceptives was thought to be associated with improved maternal health by the MCH staff.

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. In addition, there were reports of self-sterilisation practices in Matemwe and in other parts of Unguja Island. Most women reporting knowledge of self-sterilization knew nothing of the details or methods of the practice but claimed to have heard of it happening on several occasions. It is possible that such practices exist in Matemwe but secretly.

Several madawa (medicine men) on the island likewise confirmed the existence of certain herbs and roots that might act as contraceptives (ranging from indigenous trees to the juice of young papaya, to a cinnamon concoction taken for several weeks after delivery of a baby). None of the village women interviewed reported engaging in this type of contraceptive practice, although many of them reported having knowledge of its incidence. Home-made or other self-fashioned materials (such as a piece of cloth or leaf placed in the vagina), although reportedly used commonly in Africa, were not reported in Matemwe. Post-coital occlusion of the uterine mouth (again apparently somewhat common elsewhere in Africa) was likewise not reported in Matemwe.⁸

Ostensibly, the problem of high fertility in Matemwe does not stem from an inability to access modern contraceptives, but rather from other cultural or social barriers. Most men and women in Matemwe desire large families and are for the most part resistant to participating in any programme aimed at reducing fertility. High fertility is a pervasive and underlying social norm in Matemwe society.

Religious Barriers to Modern Contraceptive Use
Family planning programmes in Africa have been slow to take hold. Religious fervour may be a reason for this apparent lack of acceptance. Much of the continent is either Catholic or Islam, with African adherents of both faiths being notable

for their zealous attention to religious laws. In sub-Saharan Africa, family planning programmes have fared better in predominantly Catholic countries, but are notably less successful in predominantly Muslim nations like Tanzania.

In Matemwe, the Q'uran is the ultimate source of moral authority for nearly all the villagers. Because the majority of village women are illiterates, they are typically not well versed in the text and they base their religious understanding on vague conceptions of Islamic tenets, memories from Q'uranic school and/or their husband's beliefs. Despite this eclectic and vague understanding of Islamic law, women consistently responded with force and conviction about religious doctrine, the will of God, and judgments of right and wrong. Women's views on family planning are heavily influenced by their religion, as most 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.

"Unnatural" methods of contraception, such as hormonal contraceptives dispensed by the clinic, were criticised by most of the religious leaders in the community. The Q'uran warns against using "unnatural" methods of birth control, suggesting that in using such methods (such as hormonal contraceptives), the woman is killing life inside of her, rather than simply preventing the possibility of life (apparently this is an interpretation of a passage found in Sura 17, verses 31–33, which speaks mostly of the avoidance of taking the life of one's children). It is interesting to note, however, that a Muslim woman on pilgrimage to Mecca is allowed to take the pill to prevent menstruation. Apparently this does not qualify as the taking of life perhaps because of limited sexual relations at the time of pilgrimage.

The two contraceptive methods mentioned by religious leaders, which are considered natural and ethical by most villagers, were coitus interruptus and breastfeeding for two years after

the birth of a baby. Abstinence from sexual relations (even in marriage), although not specifically mentioned in the Q'uran, is nonetheless rooted in Islamic tradition and is quite prevalent in Matemwe. 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. Most women report having spent some time (one to two years is not uncommon) away from their husband after a child's birth. Abstinence is a culturally approved method of fertility reduction.

Despite the support of family planning programmes by the Zanzibari government, most Matemwe villagers are reluctant to accept family planning methods aside from the natural methods prescribed by the Q'uran. According to village members, most religious leaders have spoken out against family planning programmes. A nurse at the MCH clinic reported that a village religious leader interrupted the MCH staff while they were teaching a group of women about family planning. He quoted from the Q'uran and condemned the clinic staff as well as the women. It appears religious instructors have impacted women's attitudes towards contraception, as many of the women interviewed believed that the MCH clinic staff was committing sin by encouraging family planning programmes and by "tampering with God's affairs."

Patriarchy and Contraceptive Use

In Matemwe families, men are the head of the household and they dominate decisions. Marriage patterns largely dictated by overarching religious beliefs promote male dominance through the institution of polygyny. Islamic societies allow as many as four brides to be chosen by a man who is financially able to support multiple wives. There appears to be strong male authority over women in polygynous relationships,⁹ probably because a man with multiple wives and many children has higher social status in the village and is likely to exercise absolute authority in his own home.¹⁰ A

woman in a polygamous relationship is less likely to work outside the home than her monogamous counterpart and, therefore, has less autonomy in social, economic and reproductive decision-making.¹⁰

Past studies concerning the effect of polygyny on reproductive decision-making report that polygynous men are less likely to want to cease childbearing than their monogamous peers.⁹ In general, male villagers were considerably less supportive of the MCH clinic's family planning initiatives than the females. Interviews with men in Matemwe revealed several reasons for opposing family planning. Some feared that a wife who uses contraceptives may become promiscuous. Others condemned contraceptive use because it is outside their control and can be done secretly with the full support of the community medical staff.¹¹ Because Matemwe men tightly control the activities of their wives, family planning initiatives appear to threaten the normal functioning of patriarchy within the family.

Male authority in Matemwe also extends beyond the family setting and into village leadership. Women are excluded from involvement in community government, or in making decisions for the village regarding issues such as family planning. The role of women is well-defined and wholly subservient, with most of the decision-making ability resting in the hands of husbands, fathers and village elders. Thus, male dominance in decision-making, both in the family and in the community, hinders the ability of women to participate in family planning.

Exposure to Modern Ideas and Contraceptive Use

Given their position in society, Matemwe women have very limited exposure to modern views and non-traditional influences. Matemwe is technologically traditional and relatively isolated from western influences, thus villagers' exposure to modern ideas is minimal and women in the village have less exposure to modernisation than men.

Young women in Matemwe are not afforded the same access to education as young men. Although they are permitted to attend primary and secondary school, girls are not allowed to attend review sessions aimed at preparing students for important cumulative examinations that determine if students will continue on to the university. Unable to participate in the review sessions, young women in Matemwe are disadvantaged and typically unable to continue their education. The resulting low levels of educational attainment hamper family planning efforts, as female educational attainment is directly linked to a lower overall number of children desired. Studies in Zanzibar have found women with no formal education desiring an average of 6.98 children while women with post-secondary education desire 5.44 children.¹² Education was also positively associated with contraceptive use in Matemwe. One third of contraceptive users in Matemwe had completed high school, whereas a much smaller percentage of women in the village had high school education.

In addition to education, exposure to the outside world, whether through employment or travel, also appears to be related to participation in family planning in Matemwe. Approximately one third of the women using modern contraceptives in Matemwe had occupations other than housewife or seaweed cultivator — most of them were maids in hotels outside of town. This relationship is especially striking given that only about 5% of Matemwe women work in non-traditional jobs that require a commute. Also apparent is a relationship between men and women who have travelled away from the island and contraceptive use. Many of the women participating in family planning had been away from Zanzibar for some period, whether for school, business or other reasons. It appears that exposure to more modern and progressive communities is an important influence on openness to family planning.

Exposure to the media also appears to influence participation in family planning in

Matemwe. Several forms of media are prevalent on the island of Unguja, and many carry messages of fertility reduction to the Zanzibari people. In Matemwe, where there is no electricity, posters in the clinic communicate messages about family planning to villagers. These posters are very simple and contain few (if any) words. One of such posters portrays a pregnant woman with a child on her back and a toddler at her knees, while proclaiming: "... having children like this is not good for the health of mothers and children" (translated from Swahili). Travelling lecturers and small acting companies tour the island, offering informative fertility reduction messages to villagers. This medium is geared to rural villagers and often contains humour and other forms of entertainment. Because the radio is somewhat widely listened to in Matemwe, it is also an important means of communication about family planning. Among village women currently participating in a family planning programme, 40% heard about it through radio announcements, another 15% received information from a friend or relative, 10% from their husbands, and less than 5% from the newspaper.

The MCH clinic plays an important role in advertising family planning. Approximately one third of Matemwe women were first introduced to family planning by the MCH clinic staff, travelling lecturers, and/or performers. The staff are constantly capitalising on opportunities to teach villagers about contraceptive use. For example, each time men and women come to the clinic for any reason, be it sick children or for regular check-ups, the clinic staff teach them about family planning programmes. Their efforts help develop and sustain programmes in the village and provide an important source of information and education for villagers.¹³

Thus, in Matemwe the inability to pursue higher education and limited exposure to modern influences outside of Matemwe appear to inhibit the participation of village women in family planning. In contrast, opportunities for university study or travel outside the village help expose

women to non-traditional perspectives and seem to make them more receptive to modern contraceptive use.

Discussion

Fertility declines in East Africa have not been as dramatic as those occurring in other parts of the continent. The total fertility rate in East Africa remains among the highest in the world, and is due in large part to East Africans' reluctance to accept and use modern contraception.^{1,2} The present study explores cultural barriers to contraceptive use in Matemwe, a remote community situated on the Zanzibari archipelago of Tanzania. Through in-depth interviews, we examine how religion, patriarchy and exposure to modern ideas in Matemwe influence decisions regarding modern contraceptive use.

In particular, Islamic beliefs and practices appear to be the greatest barrier to modern contraceptive use in the village. The faith's powerful pronatalist stance, coupled with its restrictions on contraceptive use, proves a formidable barrier to the acceptance of family planning. Furthermore, the Islam-sanctioned practice of polygyny reinforces patriarchal dominance over females, effectively limiting a woman's ability to decide her reproductive behaviour. In addition, villagers' exposure to modern ideas is limited. Education, non-traditional employment, travels and media outlets are effective mechanisms for exposing people to modern ideas. Unfortunately, few residents of Matemwe, and few women in particular, have opportunities for such exposure.

Lowering fertility in Matemwe and other East African communities is not a simple undertaking. If family planning interventions are to be successful, they must not only work to educate couples about the benefits of family planning, but also reconcile family planning with pervading religious and patriarchal norms. Past family planning programmes have often operated under the modernisation paradigm, asserting that

exposure to western ideas is imperative to initiating changes in reproductive behaviour in Africa. Policy strategies emphasised formal schooling, family planning programmes and mass media as the vehicles through which to expose African societies to western ideas.⁷ Our interviews provide some support for the link between modernisation and modern contraceptive use.

In recent years, however, family planning programmes have moved away from the modernisation paradigm and have focused more on integrating western ideas with traditional community values. Benefo⁷ argues that working within the African culture is critical, since local culture is able to accommodate a new idea only by first associating it with traditional ideas. For example, many couples in Matemwe are reluctant to use contraceptives because it runs counter to Islam's pronatalist beliefs. Rather than trying to convince villagers that contraceptives are not prohibited by their religion, family planning programmes might be more effective if they emphasise in particular that contraceptive use enables couples to have large healthy families in compliance with religious beliefs.

Other cultural ideals such as polygyny and patriarchy need to be considered by family planning policies in order to encourage greater acceptance. Participation in family planning should be perceived as a benefit and not a threat to male authority. For example, one approach might be to teach men that using modern contraceptives increases sexual stamina and makes women physically stronger.⁷ Lowering fertility rates hinges upon the recognition by family planning programmes of the role patriarchy plays in Matemwe society. Because men typically have equal or more say than women in decisions regarding reproductive behaviour, it is critical that family planning programmes actively involve men. Dadoo and van Landewijk⁹ theorised that the reason sub-Saharan Africa has been slow to adopt family planning is that programmes fail to target men. They conclude that unless the preferences

of males change, fertility rates will not significantly decrease, regardless of the fertility preferences of females.

Given the cultural barriers to family planning prevalent in African society, implementing an effective family planning programme in Matemwe and other East African communities poses an undeniably daunting challenge. The challenge, however, is not insurmountable. Successful family planning programmes have taken hold in other developing Islamic countries throughout the world. Indonesia, for example, has a highly successful family planning programme that could serve as a model of fertility control in an Islamic context.¹⁴ The Indonesian programme has particular relevance for East African communities like Matemwe since the region shares similar cultural traits known to influence family planning, including religion, patriarchy and exposure to modern ideas.

Instigated in 1970 under the "New Order" regime of President Suharto, Indonesia's family planning programme sought to lower fertility through the widespread adoption of modern contraception. The total fertility rate in Indonesia has declined from 5.6 children per woman in the 1960s to 2.8 children per woman in 1995. These declines have been attributed to unprecedented increases in modern contraceptive use.¹⁵

Several factors contributed to the effectiveness of Indonesia's family planning programme. First and foremost, government provided strong and consistent support for the programme.¹⁶ The National Family Planning Coordinating Board (BKKBN) was established in 1970 and worked closely with governmental and non-governmental agencies to promote contraceptive use. As in Matemwe, community resistance was one of the largest obstacles to family planning acceptance in Indonesia. Heavily influenced by Islam, many Indonesian women believed they were destined to have large families.¹⁴ Contraceptive use was perceived by women to interfere with God's plan.

To change such attitudes, the BKKBN heavily involved Muslim leaders in family planning efforts.

Government made personal contacts with religious leaders and explained the programme to them, while soliciting their recommendations for implementation. Some religious leaders even received formal training from the government.¹⁴ The BKKBN landed a major victory when the state-sponsored Council of Muslim Scholars declared that family planning practices for the sake of maternal and child health were permitted by Islam.¹⁷ Further support came from the Department of Religious Affairs, which considered family planning to be consistent with Islam.

Having secured the active support of Muslim leaders, BKKBN was free to begin implementing family planning among couples. Religious leaders again played a key role in developing community acceptance of contraceptives, assuring community members that family planning is in accordance with the Q'uran. They also included family planning messages at wedding and other religious ceremonies.¹⁴ Religious and community leaders were also asked to participate in family planning in order to set example for their communities. The willingness of village leaders to participate in the programme was one of the most important determinants of community acceptance of family planning.¹⁴

As with Indonesia, we conclude that the successful implementation of family planning in Matemwe will depend primarily on the support of political and religious leaders. In its current form, village leaders, and men in general, feel threatened by family planning efforts. They consider the dispensing of contraceptives by the medical clinic to be subversive in nature. Indeed, many of the few women receiving modern contraceptives "disguise" their visits to the clinic. Changing Islamic leaders' stance from hostility to support is possible, and would be integral to fertility reduction in Matemwe. This would likely require greater legitimacy from religious and government leaders above the village level influencing village leaders to accept family planning efforts. A culturally sensitive approach

to family planning, in which local customs, traditions and beliefs are respected and reinforced, is needed for family planning to be accepted.

Modernisation also, will likely moderate pronatalist social influences, as it has been done elsewhere in Africa. Today, Zanzibar's expanding network of power lines stops a mere seven kilometres short of Matemwe. When villagers are connected via electricity to the rest of the world for the first time, fertility dynamics are likely to undergo changes, as exposure to the mass media increases. Thus, in addition to impending modernisation, the integration of family planning messages with traditional beliefs supporting large healthy families and the introduction of these messages via the support of government and religious leaders should provide greater acceptance of modern contraceptive use in villages like Matemwe. This is in contrast to the current system of dispensing free contraceptives to women at the clinic, in opposition to male and religious authority.

Policymakers, therefore, need to take into consideration and build upon local reproductive beliefs and practices in order to legitimise 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 villages such as Matemwe. Future research is needed to further define the mechanisms through which family planning can be integrated with traditional pronatalist belief structures. Listening to native voices is an important place to start in this process.

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