IOSR Journal Of Humanities And Social Science (IOSR-JHSS)
Volume 21, Issue 7, Ver. 3 (July. 2016) PP 25-41
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Socio - Cultural Factors Influencing Fertility in MOROGORO District, Tanzania

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Abstract: *High fertility is among the dominant demographic features of the developing countries including those in Sub - Saharan Africa despite measures to control it. The average Total Fertility Rate for the period between 1975 and 1980 was 7.0 and 5.5 between 2000 and 2007. Tanzania has high TFR although there are signs of fertility decline from 7.0 to 5.4 in the years 1970 and 2007 respectively. The main objective of the study is to determine the influence of socio-cultural factors on fertility. Specifically the study estimates the mean number of children ever born per woman, shows how sex preference affects fertility, shows how value of children affects fertility, associates fertility levels and status of women and shows linkage between fertility levels and religiosity. This cross sectional study uses quantitative data collected from a randomly selected sample of 110 women aged 15-49 years and four group discussions within the same age range. The key findings indicate that there is a positive relationship between socio-cultural determinants and fertility in Morogoro District. The TFR in the area of study is 6.1 which are higher than the regional and national fertility. The mean number of children ever born in the area of study is 8.0. Sex preference within the area of study is strongly related to fertility. Value of children has positive effects on number of children. Highly religion affiliated respondents have high number of children. Status of women has positive effects on number of children. Low status women have higher number of children. The study argues for family planning program for men and women. Men should be given explanations on advantages of discussing with their wives/partners on reproductive matters. To the women focused in this study, women should stand firm in decision making particularly on reproductive matters.*

Keywords: *socio – cultural, factors and fertility.*

I. INTRODUCTION

Fertility is one of the most important components of population change hence it is an important subject for demographic analysis. Other components of population change are deaths and migration. Historically, the rapid population growth experienced by many developing countries has been a result of high and relative constant fertility and rapid decline of mortality (PRB, 2005). The rate at which a country's population grows and change over a period of time is accompanied by other demographic processes has a bearing on development prospects. Fertility refers to the number of live births women have. It differs from fecundity, which is defined as the physiological capacity of woman to reproduce which may lead to or may not lead to live birth (PSP, 2003; PRB, 2007).

The maximum number of children an average woman can reproduce is about 15, if she starts childbearing as soon as possible after menarche which occurs around ages 12-14 and continues until menopause in middle or late forties (McFalls, 2003). Some women are for various reasons unable to bear any children while according to the Guinness Book of Records the greatest number officially recorded is 69 whereby a woman living near Moscow during the 18th century had 16 pairs of twins, seven sets of triplets and four sets of quadruplet (Newell, 1988).

Davis and Blake (1956), cited in Heer (1987) and in PSP (2003), identified a set of eleven intermediate variables that influence fertility which are grouped into three main categories. Factors that influence the frequency of sexual relations, factors that affect the chances of conception and factors related to the outcome of pregnancy. In 1984 demographer John Bongaarts compressed these variables into eight proximate determinants as he termed them in order to facilitate quantification and accounting of the respective contribution of each variable in determining fertility levels (MacFalls, 2003). Bongaarts' list of proximate variables include the proportion of women married or in sexual unions, contraceptive prevalence, induced abortion, lactation infecundity, frequency of intercourse, natural sterility, spontaneous intrauterine mortality and pathological sterility (duration of the fertile period). Bongaarts quantified each variable and observed its contribution to the total fertility that are accounted for by four main variables or proximate determinants namely the proportion of women married or in sexual union, the percentage of women using contraception, the proportion of women who are in fecund or lactation and the level of induced abortion (Handwerker, 1986; PSP, 2003).

McFalls (2003), argues that, the importance of the intermediate variables differ around the world because of cultural practices and beliefs that affect peoples' behaviour. He continues that, in many African countries women marry young and rarely use contraceptives yet fertility is kept to six child average through

cultural factors. In accordance with ancient traditions and beliefs women in many African societies breast feed their babies until age of two or three thus prolonging the in fecund period following child birth (postpartum amenorrhea). In some African societies mothers are expected to abstain from sex for up to two years after child birth especially while they are breastfeeding (MacFalls, 2003). The proximate determinants however have a direct biological effect on fertility. Sub-Saharan Africa has the world's highest rate of natural increase in population, 2.5 percent per year. Its population is projected to grow by 132 percent by 2050, from about 700 million to 1.6 billion people. This large growth stems from the high total fertility rate (TFR) in Sub – Saharan Africa of 5.6 children per woman which is twice the world average, (Jones, 2002). The global trend of fertility decline in the last 50 years is much less pronounced in Africa. According to Jones (2002), the TFR for the entire continent (i.e. Sub –Saharan Africa and Northern Africa) fell from 6.6 children per woman in 1950 to 5.2 in 2002 (Zlidar *et al.,* 2003). Caldwell (1968) explained socio - cultural factors as the main indirect determinants of fertility in Africa. Among the factors explained include sex preference, value of children and religiosity.

Goliber (1997) documents that, the race between population growth and economic development in sub-Saharan Africa is one of the greatest dramas of the modern world. Highest rates of population increase and slow - growing or stagnating economies throughout much of the region have the wanted modernization and development efforts. Against this back drop, the drama remains as engaging and intense as ever. The nations are struggling to provide education, housing, jobs and health care for their burgeoning populations, while trying to compete in the world economy and cope with internal political conflicts.

Tanzania in particular experiences a relatively high fertility rate, although there are signs of fertility decline over time; by considering current fertility levels for Tanzania as whole, for urban and rural areas on the Mainland, and for Zanzibar. The TFR is 5.7 births per woman, which is considered to be among the highest rates in sub-Saharan Africa. The TFR in mainland rural areas is 6.5 compared with 3.6 in urban areas. Rural women have, on average, 3 more births than their urban counterparts. The TFR in Zanzibar is 5.3. It has been estimated that, the annual population increase is about births with the average growth rate of 2.7 (URT, 2002). At this rate of growth, it is estimated that by the year 2025 the population will be about 60 million on the assumption of a slight decline in fertility offset by continued falling mortality.

It is against this background that the government of the United Republic of Tanzania formulated the 2006 National Population Policy. Among other things, the policy encourages a reduction of fertility (Planning Commission, 1992, cited in Ngalinda, 1996).The revised National Population Policy of 2006 aims to enable Tanzania achieve improved standard of living and quality life including good health and education, adequate food and housing, stable environment, equity, gender equality and security of individuals.

The government through its different departments together with the various local and international non-government organizations (NGOs) is working hard in different established development programmes such as to raise the standards of living of the people in Morogoro District, the campaign and establishment of family planning programmes. For example the Ministry of Health has a national planning programmes supported by NGOs e.g. UMATI. Despite these campaigns made by the government and the NGOs yet the fertility is still high in the district (IDRC, 1999).

The fertility levels and trends in Morogoro as it had been done by census in the years of 1967 and 2002 show that the region has high slightly declining TFR. The TFR are as follows; in the year 1967 the TFR was 6.0, 1978 was 6.3, 1988 was 6.3 (constant growth) and in the 2002 census was 5.9 births per woman. Like other countries in Sub- Saharan Africa, the high fertility levels pertaining in Tanzania is an outcome of a number of socio-economic and socio-cultural factors. This study examines the role of the latter. This is because they are country and locality specific.

1.1 Statement of the problem

The high population growth has some adverse effects on social and economic life or well being of the people. Some of the adverse effects are the presence of low per-capita income, high percentage of illiteracy and low education level, poor health and high level of dependants among many families (PSP, 2003). High fertility is one feature associated with poverty (URT, 1999). It is known fact that as life standard increases, population decreases.

The high level of fertility in Tanzania can be attributed to socio - cultural determinants. Most of which are unique because they are locality specific and the information (at local levels) on how they affect fertility are scanty. It is known that most of the studies so far conducted in Tanzania concerning fertility focus on the direct effect of socio – economic factors such as income, education and the like instead of balancing a combined approach for both socio- cultural, economic and proximate determinants. This claim can be evidenced by the lack of case studies in Tanzania (Marcella, 1994). This study therefore tries to show the impact of sex preference, value of children, religiosity and status of women on the prevailing level and pattern of fertility. It is expected that the study will add a theoretical knowledge concerning Tanzania's socio- cultural determinants of fertility.

1.2 Justification of the problem

The government of the United Republic of Tanzania considers the population growth rate (caused mainly by high fertility levels) to be very high. Population growth is linked to poverty. It has been demonstrated that the rapid population growth in Tanzania has negative effects on the economy, health, education employment, agriculture, environment and urbanization Ngalinda (1998).

This study is in line with the national population policy under section 2.3.4 says that Factors which contribute towards high fertility are rooted in the socio-cultural value - system and these are: value of children as a source of domestic and agricultural labour and old - age economic and social security for parents, male child preference, and low social and educational status of women in society which prevents them from taking decisions on their fertility and use of family planning services, large age differentials between spouses which constrain communication on issues related to reproductive health and socio-economic and gender roles (URT, 2006).

The national population policy encourages the regulation of population. The international policy which is Millennium Development Goals (MDGs), goal number one encourages the reduction of extreme poverty and hunger, lower fertility and slow population growth. Tanzania Development Vision 2025 and the National Strategy for Growth and Reduction of Poverty that aim at achieving high quality of livelihood. This study is in line with these efforts.

The need for more information on fertility issues is that, the findings of this study will bring a ground for further studies on the effects of sex preference, value of children, religiosity and status of women on fertility in this country.

1.3 Objectives of the study

1.3.1 General objective

The overall objective of the study is to determine the socio - cultural factors influencing fertility in Morogoro District.

1.3.2 Specific objectives

Specifically the study intended to:

i. Estimate the mean number of children born per woman.
ii. Determine how sex preferences affect fertility
iii. Shows the linkage between value of children and fertility
iv. Associate fertility levels in the district and religiosity
v. Determines how the status of women affects fertility

1.4 Conceptual framework

Conceptual frame work shows the fertility as the dependent variable as being affected by social - cultural determinants namely sex preference, value of children, religiosity, status of women these factors interact with socio - economic determinants which are education, occupation and policies as independent variables. The proximate determinants based on Davis-Blake and Bongaarts models. The proximate determinants include age at entry into union, proportion of women engaged in sexual intercourse, age at first birth, contraception, sterility and postpartum infecundability. This study is going to deal with socio-cultural determinants of fertility rather than socio-economic determinants and proximate determinants (Fig.1).

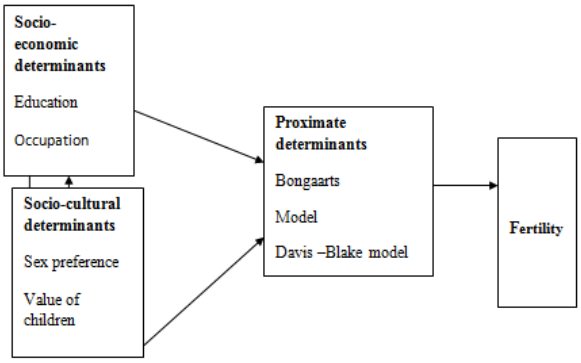

Figure 1: Conceptual frame work for the socio-cultural determinants of fertility
Source: Researchers' construct (2011)

1.5 Hypotheses

Null hypothesis (Ho) Fertility rate of Morogoro District is not significantly affected by social - cultural determinants. Alternative hypothesis (Hi) Fertility rate of Morogoro District is significantly affected by socio - cultural determinants.

II. LITERATURE REVIEW

2.1 Fertility

Fertility measures lifetime reproductive capacity of a woman. Therefore, fertility is demographic phenomenon observed in terms of live births. However, the number of births a woman will bear during the whole period of her reproduction career is a result of a complex and dynamic interaction of a biological process with socio-cultural, economic and environmental factors (Bongaarts, 1978). Fertility is one of the most important components of population change hence; it is an important subject for demographic analysis. Other components are deaths and migration (PRB, 2005).

2.1.1 Fertility levels around the world

2.1.1.1 General fertility levels and trends

Over the past few decades, the world has experienced more rapid and more extensive demographic change than in any other comparable period in history. The best known example of this change is the rapid increase in human numbers. The world population today stands at 6.5 billion, which is 4 billion more than in 1950, and growth will continue for several more decades. There are also a number of other important demographic trends. Around the world, women are having fewer children, people are living longer and healthier lives, increasing numbers of migrants are moving from one country to another, family and living arrangements are becoming increasingly diverse, urbanization is proceeding at a very rapid pace, and populations are aging. This note discusses several of these developments, in particular, the causes of population growth, population aging and policy responses (TDHS, 1997).

World population grew slowly from 1 billion in 1800 to 2.5 billion in 1950. Since then, population growth accelerated and today we stand at 6.5 billion and the United Nation (UN) expects this total to grow to 9.1 billion in 2050. The absolute increments in world population size remain large, about 75 million a year. Population trends vary widely among regions. Virtually all future growth will occur in the developing world, that is, Africa, Asia, and Latin America, while the developed world is expected to see little change. Asia is, by far, the largest region. It had a population of about 1.3 billion in 1950. Today, it stands at about 3.7 billion-almost tripling-and it is expected to add another 1.5 billion people in the next 50 years, primarily in already very densely populated South Asia. Africa was one of the smallest world regions in 1950, but nearly quadrupled in size to three-quarters of a billion, and it is expected to double again by 2050. This growth is projected to occur despite Africa's large AIDS epidemic. Latin America is smaller than the other two regions in the developing world, yet it has experienced rapid growth in the past, which will continue for decades.

In contrast, the population of the developed world as a whole is expected to remain near its current size in the future, with modest increases in the United States being offset by declines in Europe and Japan. These differential growth rates among regions imply that the world will become increasingly African, Asian, and Latin American, and the proportion of the world's population in Europe, North America, and Japan will decline (ib.id).

Rapid urbanization is another key trend in the developing countries. In the past, most of the population lived in rural areas, but rural-to-urban migration is now so rapid the rural population is expected to level off in the developing world in the next few decades. The 6.5 billion people that were added to the planet in the past were absorbed in both the developed and developing worlds, and within these regions, growth occurred in rural and urban areas. Therefore, the next 2.6 billion people to be added to the planet will end up in cities in the developing world, and many of those inhabitants will live in shantytowns and slums in very difficult conditions and with very limited infrastructure and services.

2.1.1.2 Fertility levels and trends in Sub-Saharan Africa

The study of fertility in sub-Saharan Africa has been an area of interest for at least the past two decades. Since the early 1980s serious efforts were made to try to understand fertility trends and differentials in this part of the developing world. Surveys such as the CPS, WFS, and DHS have made a major contribution to the study of fertility in this region (Guttmatcher, 1994). For a large number of African countries fertility rates are very high (above 6.5 births per woman) and the use of modern contraceptive is very low (below 10%). Many analysts find it difficult to understand why massive further growth will take place in the future despite sharply declining fertility rates.

2.2 Determinants of fertility

2.2.1 Proximate determinants of fertility

It may seem superfluous to state that a birth is the result of the exposure to intercourse, the successful conception, gestation and parturition. In particular, fertility is directly determined only by a few variables: provide a link between social, cultural and economic factors on one hand, and the physiological process which ultimately determines fertility on the other hand. As noted by Freedman, the proximate variables stand between fertility and all other proceeding variables. They immediately determine fertility, and all other variables act through combinations of them (Freedman, 1986). Davis and Blake (1956) and Bongaarts (1978 and 1982) proposed sets of these variables.

2.2.1.1 Basic fertility model

Fertility results from biological and behavioral factors which are intermediate fertility variables or proximate determinants or direct factors. These factors are shaped by socio-economic, cultural and environmental variables or indirect determinants.

2.2.1.2 Davis – Blake model

Davis and Blake (1956) proposed a set of 11 variables that influence fertility. Variables were grouped into three categories and these include: Factors affecting/ influencing exposure to intercourse (six), these include factors like age at entry into sexual union, proportion of women who enter into sexual union, reproductive periods spent after or between unions (divorces, separations and widowhood), voluntary sexual abstinence, (postponements of sexual union), involuntary sexual abstinence (due to journeys, impotence and war) and frequency of sexual intercourse. Factors affecting chance of conception (two), these include contraception and sterility; and factors relating to outcome of a pregnancy (three) i.e. miscarriages, still births and foetal mortality due to involuntary cause (induced abortion). Davis and Blake were first to introduce direct determinants of fertility model.

2.2.1.3 Bongaarts model

Bongaarts described eight factors (proportion of women married or in sexual unions and frequency of intercourse). Deliberate marital fertility control factors (Lactational infecundity amenorrhea and breast feeding), natural sterility (duration of fertile period), contraceptive use, and induced abortion. He continues to argue that four factors are most important in many societies. These they include: the proportion of women of reproductive age that is regularly engaged in sexual intercourse is believed to be the major determinant of high fertility in sub- Saharan Africa since contraceptive use is still low (Hinde, 1994). The only sub-group of women whom we can assume to be sexually active is the currently married women, Post - partum infecundability; the primary cause of prolonged post partum infecundability is breastfeeding, which results in lactational amenorrhea. It is known that breastfeeding has an influence on fertility by lengthening the period of postpartum infecundability (Bongaarts and Potter, 1993). In societies where breast feeding is generally prolonged and universal and contraceptive use is rare, the primary determinant of birth interval length is the duration of breastfeeding), contraceptives use has been described as the most important proximate determinant of fertility (Sherris *et al*., 1985; Mauldin and Segal, 1988 as cited in Ngalinda, 1998). Robey and his colleagues have shown that differences in the levels of contraceptive use explain 92 percent of the variation in fertility among the 50 countries they studied (Robey *et al*., 1992).

2.2.1.4 Davis –Blake and Bongaarts models comparison

Both models look into factors influencing fertility in a society, both have classified factors into 3 categories, both models show that fertility has to be explained through direct and indirect factors.

The two models have also different ideas. When we look at Davis - Blake model; it is more qualitative unlike Bongaarts which is more quantitative. Davis – Blake model is more detailed; it has 11 variables where as Bongaarts has fewer variables which are 8 variables. Davis - Blake model put emphasis on all 11 variables where as Bongaarts put emphasis on only 4 variables. Davis – Blake explains this as a process unlike Bongaarts who explains this as factors that affect fertility. Davis - Blake focus on all women while Bongaarts focuses only on married women. Lastly, Bongaarts introduces an additional variable, lactational amenorrhea, whereby Davis-Blake does not.

2.3. Socio-cultural determinants of fertility

Socio - cultural factors are indirect determinants factors, which affect fertility through direct (proximate) variables. Culture may be considered as the total way of life or the design for living characterizing each human society. It includes in a complex integrated whole all learned and shared behaviours stemming from themes or values within an emotional matrix or ethos. Animal behavior seems to be dominated by instincts

which in man are greatly modified by cultural influences (Jennings, 1970). Even with improved economic conditions, nations, regions and societies will experience different demographic patterns due to varying cultural influences. The value placed upon large families (especially among underprivileged rural populations in less developed countries who benefit least from the process of development), the assurance of security for the elderly, sex preference, the ability of women to control reproduction, and the status of women within families and within societies are among significant cultural factors affecting family size and the demand for family planning services

2.3.1 Value of children

Gulhat (1983) documents that, large numbers in a family may be the only guarantee of security in fragmented, traditional societies where governments have not yet established the protective cover via the rule of law enforced effectively by a mobile, non – partisan, police force. While Cadwell (1968) documents that, having a big family is important because it will help during old age in the house and also for a family prestige. He continues to document that the primary cause of sub-Saharan Africa's high fertility can be found in its social and family patterns. Central cultural precepts include the notions that many descendents must be produced to ensure the survival of lineage, the equation of female virtue with the production of a large number of children, the stronger influence of the lineage than the nuclear family, and a belief in the power of ancestral spirits.

2.3.2 Mortality risks

Desire for many children is a characteristic of the African household that has direct bearing on demand for children is its durability. It is generally accepted that lineage does not die; members die and replaced through births. Consequently, there is a need to ensure that fertility levels remain higher than mortality levels if the lineage is not ultimately to disappear. Considerable expansion of membership enhances the power and prestige of the lineage and reduces the likelihood of extinction through death.

2.3.3 Sex preference

The preference of couples to have a child of particular desired sex is called sex preference. In some societies parents are said to prefer sons to daughters, while in others it is vice versa. But the existing literature shows that sons' preference is common, particularly in Asian countries like Bangladesh, China, Korea, Pakistan (Ahmed, 1998; Arnold and Zhaoxing, 1986; Anord, 1985; Farooqui, 1990; Das, 1987; Zafar, 1994 as cited in Mwageni, 1996).

While there exist many studies on sex preference in most parts of the world, few such studies have focused on African societies. However, there is evidence of sex preference in African societies, and sons are reported to be preferred more than daughters (Bhatia, 1984; McCarthy and Oni, 1987; Campbell, 1981;

2.3.4 Religiosity

Religiosity is an important aspect of religion which often is viewed as the intensity of religious beliefs and participation (Myers, 1996). Religious beliefs are, notably, beliefs in hell, heaven, and an afterlife. Religious participation includes such behaviors as church attendance, participating in church-related activities, viewing/listening to religious broadcasts, and reading the holy books of the religion (Barro and McCleary 2003; Corijn, 2001; Myers, 1996). Strong religiosity usually is marked by strong daily influence of religious beliefs on individual decisions and frequent participation in religious activities.

Although previous religious studies mainly focused on examining fertility differences among religious groups, empirical analyses have shown some evidence that religiosity impacts demographic behavior. In terms of the effect of religious participation on fertility and fertility-related behavior, researchers observe that religious participation among young people is linked strongly to more positive attitudes towards marriage and having children (Marchena and Waite, 2001).

2.3.5 Status of women

Women often bear the disproportionate burdens of poverty, poor education, lack of jobs and limited social mobility. In many cases, their inferior roles, low status, and restricted access to birth control are manifested in their high fertility. According to this argument, population growth is a natural outcome of women's lack of economic opportunity. If women's health, education, and economic wellbeing are improved along with their role and status on both the family and community, this empowerment of women will inevitably lead to smaller families and lower population growth. This was the principle message of the United Nations International Conference on Population and Development held in Cairo 1994 (Todaro, 2003).

On the basis of Change in African Family Project in Nigeria (CAFN) Caldwell (1987) advanced the argument that men and their lineages rule over reproduction and decide on matters of family size in Nigeria and elsewhere in Africa. Although no study has evaluated that hypothesis with empirical data, the view continues to persist that men are dominant decision makers on fertility matters in Africa (Makinwa, 1995).

2.3.6 Ethnicity

Ethnicity is associated with age at first birth, as one of the main functions of culture is to maintain the biological continuity of members of the society. This is supported by Ohadike's (1979) argument that although natural fertility variations are primarily determined by biological process, it might 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 are comprised 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. It is likely that each cultural group may stress certain aspects in their reproductive institutions. These may serve to explain fertility differentials and levels to a greater or lesser extent from the fertility levels of other cultural groups.

Studies done in India indicate that Hindus marry and bear children at younger ages than non – Hindus (Bloom and Reddy, 1986). Hinde and Mturi (1994) document that in Tanzania religion influences age at first marriage and of course age at first birth in religions such as Islam religion that encourages early marriage. This will ultimately mean early age at first birth.

2.4 Status of research on socio-cultural determinants of fertility in Tanzania

2.4.1. Fertility levels and trends in Tanzania

Sources to assess fertility trends include comparison with estimates obtained in earlier surveys, censuses, or vital registration data. These sources include the 1991-92 TDHS, the 1996 TDHS, the 1999 TRCHS, the 2002 Tanzania Population and Housing Census, and the 2004-05 TDHS. The TFR estimated in 1991-92 was 6.3 children per woman. However, the 2004-05 TDHS TFR of 5.7 is statistically at the same level as rates estimated by the 1996 TDHS (5.8 births) and the 1999 TRCHS (5.6) births. Thus, there is no evidence of fertility decline in Tanzania over the last eight years. Although the 2002 Population and Housing Census TFR is 6.3, higher than all three DHS surveys since 1996, the Census TFR is calculated using indirect methods and, thus, comparison is difficult (TDHS, 2005).

2.4.2 Proximate determinants of fertility

2.4.2.1 Proportion of women engaged in sexual relations

The frequency of sexual intercourse is the underlying variable of interest, but information on this is rarely available. The proportion of women of reproductive age that is regularly engaged in sexual intercourse is believed to be the major determinant of high fertility in Sub-Saharan Africa since contraceptive prevalence is still low (Hinde, 1994). In studying recent trends in age at first marriage using data from 14 regions in Tanzania, Van de Walle observed that the proportion of women never marrying progressively along age distribution. This influenced him to conclude that 'the Tanzanian data suggest the old norm of universal female marriage may change' (Van de Walle, 1993).

2.4.2.2 Age at first birth

Age at first birth in a non - contracepting society becomes an important determinant of the length of reproductive life and thus is highly and negatively correlated with fertility. Late age at first birth shortens the reproductive period of a woman, which will consequently reduce the total number of children ever born (and vice versa). This pattern holds for age at first marriage, and age at first sexual intercourse except for the pattern given for women aged less than 25 years.

The data of older Tanzanian women at the age of 35- 49 show that women who engaged in sexual intercourse earlier than age 15 had approximately three births more than those who had first sex experience at age 25 or more. A similar pattern is repeated for women who started child bearing before age 15, they have about three births more than women married after age 24. Exposure to the risk of child bearing at very early age can be associated with high fertility as compared to the late entry for all three broad age groups. On the other hand, early exposure to the risk of child bearing could have a negative effect on the level of fertility because physical maturity especially of the pelvis often lags behind the ability to conceive. As such, the pelvis and other reproductive organs may not be mature enough for delivery of the foetus when conception takes place.

2.4.2.3 Contraception

Use of contraception has been described as the most important proximate determinant of fertility (Sherris *et.al.,* 1985). Some studies have indicated that differences in levels of contraception explain 92% of the variation in fertility (Robey, *et al.,* 1992). This implies that where use of contraception is widespread, fertility is low. It is therefore unsurprising that a major cause of the declining fertility in Tanzania during the 1990s is thought to have been the slow but the study shows that there is an increase in use of contraceptive. This was demonstrated by Larsen, (1997), who showed, using data from the 1991-92 TDHS, those women who had ever used contraception had longer waiting times to conception (median 22 months) than other women (median 15

months). Only 23% of women however, had ever used a method of family planning, and only 10.4 percent of women aged 15-49 years were using a contraceptive method at the time of the 1991-92 TDHS (Ngallaba *et al.,* 1993). The current use rate doubled to 22% by the time of the TRCHS in 1999 (NBS and Macro International Inc., 2000). The use of modern method used by Tanzanian men and women include injectables, the pill and (male) condom.

As contraception is not widespread in Tanzania, fertility could, among other factors, be mostly determined by age at sexual intercourse as well as the duration of exposure to the risk of pregnancy, age at first marriage, frequency of intercourse, and age at first birth. Behavioural factors that may be modified by the level of education, religion, place of residence may also play a key role in determining fertility. Studies have hypothesized that women who start child bearing at an early age especially in the non- contraception societies are likely to end up with higher completed family size than their counterparts who start at later age provided other fertility depressing factors do not intervene.

2.4.2.4 Sterility

Sterility, whether primary or secondary, has been known to affect fertility particularly in areas where there is high incidence of sterility. In Gabon for example, the key determinant of the exceptionally low fertility (TFR 4.1) was noted to be widespread pathological sterility (Bongaarts and Frank, 1988). If sterility is reduced, fertility is likely to rise- this is the trend in countries where the prevalence of sterility is high. However, sterility seems to be relatively lower in East and West Africa compared with Central Africa. Larsen (1977) has argued that 'sub-fertility is prevalent in Tanzania' and that 'the prevalence of infertility is relatively high in Tanzania, compared with neighbouring countries'. It seems that most of this sub-fertility and infertility takes the form of secondary sterility, as only two percent of women aged 40 - 49 in 1996 had borne no children (NBS and Macro International Inc., 1997). There is some evidence that fertility varies regionally within the country: Southern regions of Lindi and (especially) Mtwara, for example, have the lowest fertility rates in the country outside Dar es Salaam, but are far from having the highest rates of contraceptive use. They do, however, have high rates of self-reporting of sexually transmitted disease among them (Hinde and Mturi, 2001)

2.4.2.5 Post - partum infecundability

The primary cause of prolonged post partum infecundability is breastfeeding, which results in lactational amenorrhea. It is known that breastfeeding has an influence on fertility by lengthening the period of postpartum infecundability (Bongaarts and Potter, 1993). In societies where breast feeding is generally prolonged and universal and contraceptive use is rare, the primary determinant of birth interval length is the duration of breastfeeding.

The mean duration of breastfeeding observed in Kibaha, Tanzania was between 18 and 19 months and the mean duration of amenorrhea were between 7 and 10 months for different educational groups (Kamuzora and Komba, 1988 as cited in Ngalinda, 1998). The general observation is that the duration of breastfeeding declines with development. In particular, breastfeeding declines with urbanization and education (Lesthaege *et al.,* 1981). Therefore breastfeeding is still a potential factor in reducing fertility in sub-Saharan Africa.

III. RESEARCH METHODOLOGY

3.1 Research design

The study employed cross-sectional research design of which survey approach was used for data collection. This design allows collection of data on different groups of respondents at one time. According to IDRC (2003), the method can be used for descriptive study as well as for determination of relationships between variables. The design also was considered to be favorable because of time and limit resources available for data collection.

3.2 Description of study area

The research was conducted in Morogoro District in Morogoro Region. Morogoro District was selected for this study because the district has high fertility rate of 4.8 close to that of the national level which is 5.4 (PRB, 2007). Most of social - cultural determinants are unique because of their locality specific.

3.3 Population, sample size and sampling procedures

3.3.1 Target population

The target population of the study was women aged 15 and above years in Morogoro District.

3.3.2 Sample size

Sample size of the study was 110 respondents of the reproductive age of 15-49 from two selected wards and each ward provided one village and each village provided 55 respondents. The sample constituted different ethnic groups i.e. different marital status, religion and different tribes.

3.3.2 Sampling techniques

Simple random sampling was employed to select sample for this study. In Morogoro Region, one district was purposely selected. The wards selected in Morogoro District included Mikese and Mkambarani. From Mikese ward Fulwe village was randomly selected while in Mkambarani, Mkono wa Mara was randomly selected. Each village provided 55 respondents.

3.4 Data collection tools

3.4.1 Primary data collection

A structured questionnaire with open and closed ended questions was developed and administered to the selected household respondents for collection of primary data. Focused group discussions (FGD) were also conducted and a total of four FGDs were conducted in both wards of Mikese and Mkambarani involving 48 participants targeting rural women. The FGDs were guided by focused topics including attitude towards status of women, value of children, religiosity and the sex preference.

3.4.2 Secondary data collection

Secondary data of this study were obtained from population census reports and National Population Policy. Other information was obtained from the internet sources and from Demographic Training Unit at the University of Dar es Salaam.

3.5 Data analysis

3.5.1 Quantitative data analysis

The analysis of quantitative data was done by employing descriptive statistics to obtain frequencies and percentages, histograms and statistical means. Frequency distribution, which is important for drawing frequency distribution tables and graphs, was calculated. Cross tabulation were used to test association between variables, and to qualify associations existing between different variables and socio-cultural determinants of fertility under the aid of statistical package for Social Sciences. Cross tabulation is both a powerful way of communicating information and the commonest form of data presentation (Casley and Kumar, 1998).

3.5.2 Qualitative data analysis

Qualitative data collected was subjected to content analysis and in many cases respondents' actual words have been reported. Qualitative data results are reported concurrently with quantitative data, that is, are used to support results obtained from the former.

IV. RESULTS AND DISCUSSION

The determination of socio – cultural factors influencing fertility in Morogoro District in Tanzania was conducted by following flow of the five specific objectives of the article. The flow of presentation and discussion is according to those objectives as well.

4.1 Mean number of children ever born (MNCEB)

Estimations on the number of children ever born per woman were done by grouping age of respondents into five years intervals. The MNCEB by each age group in the area of study is shown in Table 9. The results in Table 9 reveal further that the mean number of children ever born increases monotonically with age as expected, even at older ages where memory lapse is expected to be higher. As years increase MNCEB becomes higher. The MNCEB from the time of reproduction to the end of reproductive age is 8.0. Therefore, number of children varies significantly by age.

Table 1: Mean number of children ever born/MNCEB

Age group	Number of women	Number of births	MNCEB
15-19	11	24	2.2
20-24	13	33	2.5
25-29	26	75	2.9
30-34	12	37	3.1
35-39	17	79	4.6
40-44	8	62	7.8
45-49	23	185	8.0
Total	**110**	**495**	

4.2 Effect of sex preference on fertility

In order to determine the effect of sex preference of the respondents the results show that there are five categories as follows: those who preferred boys, those who preferred girls, those who preferred same number of boys and girls, those who preferred not to have children and those who did not respond.

As it is indicated in Table 2 within the area of study there is higher boy preference than preference for girls. Half (50.0%) of the sample preferred boys to girls, one third (30.0%) did not respond to any of the alternatives while others made neutral decision on sex preference, they make a quarter (25.0%) of the respondents. According to these data researcher judged that the area is highly dominated by boys preference to girls. Rural families with no sons are looked down upon. Sons are expected to carry on the family lineage, increase the reputation of the family, and protect the family's interests.

Data in Table 3 present the results of the findings on the effect of sex preference on fertility. The results explain that the respondents with boy preference have strong effect on fertility in the area of study. Women who prefer boys have higher MNCB than those with girls preference or with neutral preference. Boys' preference women have about 6 children higher than girls preference (4 children) while those with neutral preference have about 3 children. Women who preferred boys to girls have higher number of children than their counterparts who preferred girls (and those who preferred neutral sex of children) due to the need of more sons.

Table 2: Summary for the sex preference of respondents

Sex preference (N=110)	**Percent**
Who preferred boys to girls	50.0
Who did not respond to any of the alternatives	30.9
Who preferred girls to boys	25.5
Who preferred equal number of children	22.7
Who preferred not to have children	8.2

Table 3: Summary for the sex preference and MNCB

Sex preference (N=110)	**MNCB**	**F-value**	**P**
Who preferred boys to girls	5.9		
Who preferred girls to boys	3.6		
Who preferred not to have children	3.3	32.001	0.000
Who did not respond to any of the alternatives	3.2		
Who preferred equal number of children	2.9		

4.3 Value of children and fertility

The aim of this subsection of the study is to show the linkage between value of children and fertility. The findings shown in Table 4 of the single statements given by respondents regarding their attitude towards value of children show that majority of the respondents from the area of study strongly agreed with the statement favoring value of children. This is an indication that women do prefer to have many children due to some aspects like survival for the lineage, family prestige, and guarantee of security, help in the house and help during old ages as well as help in doing house works. As indicated earlier, attitude towards value of children is higher in the area of study. Majority strongly agreed on the attitudinal aspects towards value of children. For example 32.7% of them strongly agreed that they prefer many children because they provide security in the family. Among them 43.6% also strongly agreed on the statement that many children are helpful during old age. Near half of them (46.4 %) strongly agreed with the statement that children are valued for the lineage to survive. More than one third (39.1%) strongly agreed that children are born many because children are used as cheap labour for farm activities and they provide house help. Others (32.7%) supported the statement that children are born many for family prestige. About 42% strongly agreed that it is good to have many children to overcome mortality risks.

Table 4: Value of children and fertility (%)

			Response		
Attitudinal aspect (N=110)	**Strongly agree**	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**
Guarantee of security	32.7	17.3	22.7	7.3	10.9
Help during old age	43.6	12.7	26.4	8.2	9.1
Survival for the lineage	46.4	17.3	21.8	6.4	8.2
Help in the house	39.1	20.9	17.3	8.2	14.5
Many children for prestige	44.5	26.4	17.3	1.8	21.8
Mortality risk	41.8	22.7	19.1	5.5	8.2

Then, the single responses on to whether these women strongly agreed, agreed, undecided, disagreed or strongly disagreed on the statements concerning values of children were combined to form the scale of value of children. The findings revealed that two thirds of respondents (61.0%) scored between 16 to 30, they were placed into high category referred to have positive attitude towards the value of children. More than one fifth had 16 scores and considered to have neutral attitude towards the value of children where as those at the lower rank scored between 6 to 30. They represented slightly one tenth (11.2%) of the respondents. These are considered to have negative attitude towards the value of children.

Table 5: Category for the value of children

Category (N=110)	Percent
High	61.8
Moderate	27.0
Low	11.2

Data in Table 6 reveal that there is a strong linkage between value of children and fertility in the area of study. From the table we can see that women with positive attitude towards value of children have three times more children than those with negative attitude towards value of children. This shows that there is a significant relationship between value of children and fertility. That is to say that the value of children has positive effects on fertility.

Table 6: Relationship between value of children and MNCB

Category (N=110)	MNCB	F-value	P
High	6.4		
Moderate	5.9	44.8	0.000
Low	2.2		
Mean number of children	**4.5**		

In FGDs, participants were asked about their attitude towards value of children, survival for the lineage was found to be the major reason of having many children in the family. Participants in these groups reported to prefer many children for the survival of their lineage.

"In order for my clan to grow we have to maintain the big number of children. We need our lineage to grow, become big and strong. Many children results into a powerful clan," (rural woman aged 35-40 years from Mkono wa Mara village).
"There is no clan with few people, they might be few in the clan because of deaths but not because some people wanted to have few children. We have to protect our lineage from getting loss," (woman aged 40-47 years from Fulwe village).
"My children help me in different farm activities, help in the house especially my only daughter take care of her young sisters and brothers while I am at the farm, she fetches water, collects firewood and do many house works in my absence," (rural woman aged 35 – 40 years from Mkono wa Mara village)

Regardless of life being hard some people still have the tradition of having few children as a shame among others in the traditional societies. Women in the study area explained this during FGDs. Not only men lye to have many children but also women does like that for the various reasons.

When asked of the factors leading to this they said, children bring honour for the family because your husband will not be looked down upon by the elders or grandparents or other men in the society. Many children strengthen the clan, make the clan strong. They said during the discussion that children are the guarantee for the security. Nearly all participants agreed with the statement which says that children provide the guarantee for the security.

"Children when born pass through different stages they get different diseases others might die on the way before they reach your age. They might get disabilities hence depend on your assistance in doing everything. If some children die others continue to survive. I had seven children but three of them had died and I have remained with four and among those four one has crippled legs. " (Rural woman 36-40 years from Fulwe village).

Despite the fact that majority agreed that it is good to have many children as they guarantee security for the family, help in the house, ensure survival for the lineage, and help during old age of the parents and many children are born for family prestige. Minority said, you can have many children but unfortunately might die before they grow up. In addition they continued to argue that,

"...you cannot judge which children you are going to bear they will be good so that when you ask them to help you in the house they will help you smoothly without friction." (Rural woman aged 28-32 from Fulwe village). Another woman stood and said that,

".....Some children are born rude they do not want to work or do anything when told by their parents. Sometime there will be no difference between those with many children and those with no children. Yes it is true that many children are helpful but sometimes it becomes very difficult to take care of them especially in providing them with basic needs due to the tough life we have now days……." (Young woman 18-23 years from Mkono wa Mara Village).

In addition, (Todaro, 2003) argues that children in poor societies are seen partially as return in the form of both child labour and the provision of financial support for parents.

4.4 Religiosity and fertility

This sub – section determines the association of religiosity with fertility. To determine the association of fertility with religiosity, respondents were asked a series of questions in order to measure their intensity towards religiosity.

The findings of the study reveal that majority of respondents are highly religious. Data in Table 7 show that more than three quarters (76.5%) go to church or mosque, among them 69.4% reported to be going to church or mosque very often; minority (4.7%) do not go to church or mosque at all while there are others who are either going to church or mosque once or twice a week. These make a total of 21.7%; many of the respondents do some religious activities like giving offering to the poor (54.9%), pay toughies or ten percent (59.4%). More than half of the women have the habit of having self prayers; others have the habit of fasting during the holly month for the Muslims and during lent for Christians (54.9%). The more frequently people attend religious services, the more children they will have, controlling for religious affiliation and other factors. Besides religious participation, religious beliefs also are important. Researchers observe that non-religious persons have a lower marital rate than religious persons. Non-religious women also have a lower rate of first childbearing than religious ones (Pfeiffer and Nowak, 2001).

Table 7: Religiosity of respondents

Religious attribute (N = 110)	**Yes**	**No**
Do you go to church/mosque?	**76.5**	**23.5**
How many times in a week?*		
Once or twice a week	17.5	82.5
Not very often	8.2	91.8
Very often	69.4	30.6
Do you have the habit of having self prayers	54.9	45.1
Do you fast during holy month or lent	54.9	45.1
Do you give offering to the poor	60.9	39.1
Do you give ten % or toughies	59.4	40.6

Results in Table 8 indicate that above two thirds (62.5%) of the respondents scored between 5 to 7 while more than one third (22.2%) scored 4 while above one tenth of them scored between 2 and 3. Majority of respondents are highly affiliated with religion; they are considered to have positive attitude towards religiosity, while others have neutral/moderate affiliation to religion and the rest were put into "low category".

Table 8: Religiosity of respondents (%)

Category (N= 110)	**Percent**
High	62.5
Moderate	22.2
Low	15.3

Result in table 9 show that respondents in "high category" have 7 children while those with low category show to have fewer children (2 children). People who have strong religious beliefs are more likely to have more children than people without such beliefs. Because as the researcher hypothesized that religiosity is significantly related to fertility, results show that fertility differentials among various religious groups may be due partly to the level of religiosity among members of religious groups. Having stronger religious beliefs is expected to have a positive effect on fertility.

Table 9: Relationship between category of religiosity and MNCB

Category (N=110)	MNCB	F-value	P
High	6.8		
Moderate	3.4	40.0	0.000
Low	2.1		
Mean number of children	**4.5**		

The results in Table 9 are supported by answers from FGDs that some women due to religious principles it is not easy for them to use birth control methods. Many women are at high rank. The results show that there is relationship between number of children and religiosity. Many of them are highly religious and their fertility levels are high. To support these results Ohadike (1979) argue that although natural fertility variations are primarily determined by biological process, it might be modified by social accommodation (socio-continuities). These ideologies are comprised 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. It is likely that each cultural group and /or religious group may stress certain aspects in their reproductive institutions. These may form peculiar elements that may serve to explain fertility differentials and levels to a greater or lesser extent from the fertility levels of other cultural groups or religious groups.

About two thirds of participants said that religion makes them afraid of discussing family planning issue. Their religious leaders do not allow them to discuss about these issue because it is sin to stop from giving what God has put in women. They say that it is against God to use contraception as the way of controlling births. Women are afraid of disobeying God. They try natural method of controlling births. As we are aware that religion is among the factors that affect fertility due to early marriages, also religion is among the factor that prohibits people from using contraception. One woman said,

"*Our leader at the mosque used to explain to us that it is immortal going against God Almighty. If you want to control births do not dare to use artificial methods like injection, pills, condoms and the like"* (Woman between 36-40 years from Fulwe village).

4.5 Status of women and fertility

To ascertain the status of women in making decisions for the family, respondents were asked whether they have ever discussed with their husbands or partners during the past twelve months about reproduction aspects, economic or production matters and about social aspects. The summary of these findings is presented in Table 10.

Then, the single responses on whether these women have ever discussed with their husbands or partners in family decision making process were combined to form an index of status of women.

Data in table 10 indicate that more than half of the women (54.9%) in the area of study had ever discussed with their husbands or partners in the past 12 months in making decision about business for the family, least (16.2%) of them had ever discussed. The results show that women within this area are given little chance of making decision in the family not only in reproduction attributes but also in production, reproduction matters also in social aspects.

Table 10: Husband and partner discussions on family matters (%)

Items discussed (N=110)	**Percent**
Women who have ever discussed with partners in the past 12 months	
Reproduction matters	
Family planning	36.9
To have a baby or not	33.3
Space between one child and another	25.2
Number of children	24.3
Sex of the baby	16.2
Production matters	
Business for the family	54.9
Income distribution for the family	22.6
Total year income obtained in the family	22.6
Social Matters	
Sending children to school	29.9
Burial activities, sickness in the community	23.5
Buying things for the family	21.1

Table 11: Status of women

Item	**Percent**
High	17.6
Moderate	10.8
Low	71.6

As presented in table 11 the lower the status of women the higher the fertility. Women with low status have about three times more children than those in the high status category. This shows that there is inverse relationship between status of women and fertility. Thus, status of women has a negative impact on fertility.

In FGDs most of the participants in the area of study reported that they do not have the habit of discussing with their husbands or partners about either reproductive issue, economic or social matters in the family. When asked by the researcher what could be the reasons, majority said that due to the low levels of education they have their husbands do not consider them as important creatures to discuss with or in making decisions of the family. They continued to say that their husbands or partners are not ready to discuss with them about anything in the family.

"What! Asking my husband on family planning, sex of the baby, whether to add a baby in the family or not, wee! You will create quarrel and no one is going to dissolve it. When you try to explain to him that the number of babies we have is enough because lie is difficult now days compared to our times he says go and pack your things. I will take another woman who will obey my rules and principles and regard me as her husband and the head of the house. What do you want to do with the small number of children, you are uneducated you cannot go to the office to work, your office is here and I am the boss of this office. Do what I want and not what you want. What is your value, you are nothing here take me as your head……" (A rural woman aged 40-45).
Another woman said, *"….these men are not like normal people, when you try to talk with them you create a conflict that will reach to the point of no return. I one day tried to tell my husband on the effects of giving birth to many children without an ample time to rest and he replied, ' if your parents could have the habit that you are using to think you would not be under this sun today, you could have been in hell'.*
Most of the participants agreed and said that there is no peace at all if you try to explain this matter. Others do not even try to discuss with their husbands or partners.

"My husband threw my things out when I tried to explain these things to him. I told him that officers at the clinic taught us matters concerning reproductive health, contraception methods and their advantages and disadvantages of each method, you know what? He pulled me out of the house locked the door threw my things and went away without saying a word. He went to the mosque and talked to their elder Sheikh. After some hours they came home furiously and what they told me that you have to give birth, that word is still pains to date. I promised myself not to tell anything to him again. I am tired of giving birth every day but what could I do so that I can escape all the troubles I get." (One rural woman residing at Mikese)

Economic wise still men are rude and selfish. They do not want to share anything with their families especially the wives or their partners. They are selfish. They still consider women as nobody; women are given low status in the society. Men dare to hate their wives/partners because they are trying themselves to run businesses for their families. One woman said;
"My husband does not want me to be involved in any of our income matters. He says, a woman's place is at her husband's home and no to follow what the husband is doing. The husband is looking for the money for you to use and not to know the amount or know what he has planned to start. Sit down and take care of the children…"another woman from Fulwe village said, that my husband started business for me. He gave me the initial capital but the trouble began when I asked him to give me money for the family to buy food and school equipments for the children. (One rural woman residing at Fulwe village).
"He says, 'you have a business so what do you want from me, control your income, I gave you the capital, use your common sense, and do not follow my business……' Since my husband gave me capital to start the shop he does not want me to ask him for money for the meals, children and the like. He gets a lot of money by selling vegetables and fruits in Morogoro market but I and my family do not enjoy the money. Soon after the selling he goes straight to the bar with his friends and relatives. Our life here at home is terrible; no help comes from him; it is like hell."

Despite the predominance of the low status of women in the study area, minority are given the chance in the family to make decision and discuss about distribution of income, discuss on the total annual income. One woman said,

"My man is not rude to that extent; he feels my presence in the family hence gives me the chance to discuss with him. He distribute the money we get from selling our crops, some puts on his account, some for me and some on our two kids' account". . (One rural woman residing at Mkono wa Mara village).

Surprisingly most women are still not given the chance to make decision in the family. Women are not involved in social matters like sending the kids to school, buying things for the family go and be involved in matters like funerals and go and visit the sic, make decision for the sick and where and when to bury the dead if it has occurred and the husband is not around or has already died. Men do believe that a woman cannot decide on anything even on marriage arrangements are not allowed to talk. Men are still ruling over women.

"My husband in front of his relatives asked me to sit down when I was trying to protect my child from getting married before she completes the school. He said I have nothing in my head thus I have to take my seat back. 'You are not allowed to stand and talk before men and talk'." (One rural woman residing at Mkono wa Mara village).

V. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The study shows that number of children born per woman increases monotonically with age. The Lower the age the fewer numbers of children.

a) The study findings have shown that women interviewed are not aware of the reproductive matters due to the low status. Low status makes women not to be given the chance to discuss with their husbands/partners the family matters not only reproductive matters but also social and economic matters. Thus, low status of women in the area result high fertility in the area of study.
b) Women in the area of study have positive attitude towards value of children. They still have the notion that, many children are for guarantee of security, help during old ages, and help in the house, for family prestige also to cover mortality risk.
c) Majority of the women have high fertility due to the fact that, they do prefer boys to girls. Boys' preference is highly practiced in the area of study. This results into high fertility in the area of study.
d) Women in the area of study are highly affiliated by religion. Highly religious affiliated women have higher number of children than less religious affiliated women.

5.2 Recommendations

The following recommendations put forward are based on the conclusions of the study as explained here under.

5.2.1 Policy/ Programme makers

The study revealed that, most of the women in the area of study do not know the impact of having many children that is why they still prefer having many children; organizations like UMATI, World Vision (T), PSI and the like should come out with strategies. They can influence policy though which will encourage fertility reduction. Together with Ministry of health these organizations can do better in practicing the population policy or the reproductive health policy.

There should be peer group program through which youths, elders and school children should be getting information, without fearing who is giving information without fearing age, sex or the like so that people can be free when visiting the centers for services.

The promotions of contraceptives free of charge because others are willing to use contraceptives but due to poverty they cannot afford to buy them. Also the access to get contraceptives should be improved. Every ward, street or ten cell leader should be provided with contraceptives so that for those who are in need it will be easy for them to get them without using much energy to find them or use transport to reach them.

5.2.2 Community level

Reproductive health experts should encourage men and women to use of contraceptives. They should be explained the methods of contraceptives, advantages and disadvantages of each method, to choose which can easily be obtained in terms of accessibility and affordability. They should be told the facts of raising many children health wise and financially. Men should allow their wives/partners to visit health centers, clinics and even hospitals for advice from health experts.

Religious leaders should first be attending meetings conducted by health experts if any in order to be aware of reproductive health to get knowledge on reproduction matters. This situation will make them flexible to their followers; hence they can allow them to use contraceptives. In addition I would like to advise religious leaders to teach their followers on reproduction matters and family planning.

5.2.3 House hold level

Women should be encouraged to visit health centers for advice from health experts from them they can get knowledge or can achieve the knowledge on the use of family planning methods even without their husbands to find out if they are using contraceptives. For the women with rude husbands/partners they must be keen on the use of contraceptive methods. They need to choose methods which cannot easily be recognized by their husbands or partners.

Researcher recommended that the husbands/partners to be the first to tell their wives/partners to use contraceptives for they are aware on the impacts of having big number of children in terms of health to the mothers, socially and economically. They should also be using contraceptives in order to reduce the number of children born per woman.

5.3 Areas for further research

This study has determined the effectiveness of socio-cultural factors influencing fertility in Morogoro District. However there are some areas that require further research, namely:

a) There is a tendency at which respondents prefer mostly male children. This issue is of deep significance, as a social issue, and government in general since it results into population growth of a country due to high

fertility levels when in need of sons. There is a need to conduct research to examine the factors which are behind this scenario and to look at what, if anything might be done to stop this.

b) In all focused group discussions held with respondents across all study sites, there arose complaints that their male counterparts deprive them of the chance discuss all family matters including family planning matters thus resulting into high number of children born per woman. Thus there exists a problem of low status of women in the area of study. Therefore there is a need to conducted further research in order to know in deep the reasons behind this so that can be solved scientifically.

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