

KNOWLEDGE, ATTITUDES AND PRACTICE OF FAMILY PLANNING
IN A RURAL DISTRICT OF ZAMBIA

By

DR KILLIAN K. LIKE

THESIS

M.MED

LIK

1990

C-1

A dissertation submitted to the University of Zambia in partial fulfilment of the requirement for the degree of Master of Medicine (Obstetrics and Gynaecology).

University of Zambia
School of Medicine
P O Box 50110
LUSAKA

AUGUST 1990



Declaration

I hereby declare that this dissertation is the result of my individual effort and has not previously been submitted for any other degree.

The various sources to which I am indebted have been acknowledged in the paper and in the bibliography.

Signed 

Date 

Approval

This dissertation is approved as fulfilling part
of the requirement for the award of the degree of
Master of Medicine (Obstetrics and Gynaecology).

Signed: 

Title: HEAD OF DEPARTMENT OF OBSTETRICS AND
GYNAECOLOGY

Date: 01/10/90

ACKNOWLEDGEMENT

I am most grateful to members of staff of the department of obstetrics and Gynaecology, UTH, for their valuable comments and support during the study. Special thanks to Professor L.A.R. Mtimavalye for his valuable criticism and constructive suggestions. I also want to express my sincere thanks to Dr N.C. Sikazwe for his advice and encouragement during the programme.

I am indebted to my wife without whose care, patience and tolerance I would not have completed this dissertation.

Family Planning Programs have succeeded best
"where we have learned to speak the same language
as those we are trying to help
.....and where we have learned to build on the
positive aspects of local knowledge, attitudes and
behaviour."

Deidre Wulf, 1984, on the future of Family Planning
in sub-Saharan Africa.

APPENDIX

<u>Contents</u>	<u>Page</u>
1. Background information	1
2. History of Family Planning Service	2
3. Objectives of the Study	4
4. Study Design	5
5. Results	5
(i) Ever-Use of Contraceptives	6
(ii) Attitudes Towards Family Planning	10
6. Discussion	13
7. Conclusion	19
8. References	21

SUMMARY OF THE SURVEY

A survey was conducted in Chipata District, in the Eastern Province of Zambia from June to September 1986. The results revealed that 50 - 60 percent of wives had ever used traditional contraception (abstinence, prolonged lactation and rhythm). Ever-use of modern contraceptives (pill, IUD, Barrier methods, Tubal ligation) was shown to be as low as 6 percent and the desire for many children very strong, the mean ideal number of children was found to be 6.8.

Nearly 80 percent of women interviewed, however, expressed a willingness to attend a family planning clinic if one were accessible to them. This finding suggests that a significant interest in family planning exists in Chipata District.

BACKGROUND

The population of Zambia is estimated at 6.3 million of which 60% lives in rural areas while 40% lives in urban areas. The annual growth rate of population has increased from 2.9 to 3.1 percent in the last two decades. The vital statistics for Zambia from censuses carried out in 1969 and 1980 are as shown in Table 1. There is no doubt that such a rapid rate of natural increase would negate the effect of even the best economic growth the country could achieve.

Table 1

VITAL STATISTICS: ZAMBIA 1969, 1980, 1983

SOURCE: CENTRAL STATISTICS OFFICE, LUSAKA

RATE/INDICATOR	1969	1980	1983
Population (million)	4.06	5.68	6.20
Crude Birth Rate (per 1000)	47.7	48.3	50.0
Crude Death Rate (per 1000)	19.7	17.0	15.0
Natural Rate of Population increase	2.5	3.1	3.1
Infant Mortality Rate	141	127	115

The improvement and expansion of health services in rural areas has led to a decrease in mortality and an increased life expectancy for both males and females while the growth rate has increased to about 3.1%. The sex ratio (males/100 females) is 98.7. The total female population is approximately 2.8 million of which about 45% is in the reproductive age group of 15 - 45 years.

The age structure of the population shows that 47% of the total population consists of children below the age of 15 years; 40% is of the age group 15 - 44 years and the remaining 13% constituting the age group above 45 years. If one compares the age structures from the 1963 and 1969 censuses (see Table 2) the features of a population with a declining mortality and an increasing fertility are noted.

Table 2

AGE STRUCTURE OF THE POPULATION: 1963, 1969

Age Group (years)	% Population	
	1963 Census	1969 Census
0 - 14	44.7	46.5
15 - 44	43.9	40.5
45+	11.4	13.0
Total	100	100

HISTORY OF FAMILY PLANNING SERVICE

Family planning in Zambia was introduced in 1972 by a voluntary organisation, the Family Spacing and Welfare Association of Zambia. There was opposition and resistance to family planning at this time from policy-makers and the general public.

The Ministry of Health was, however, very concerned about the high infant mortality rate of 140 per 1,000 live births and the high maternal mortality and morbidity associated with pregnancy and childbirth. Various workshops were held in Lusaka, jointly sponsored by the Ministry of Health and the IPPF. The aim was to find ways to improve the Maternal and Child Health (MCH) services and to incorporate family planning in these services. In 1974 family planning was incorporated into MCH services with the objective of promoting the health of the mother and child through child spacing. The government now actively supports family planning activities and one of the major objectives in its primary health care programme is to expand MCH/Family Planning Services into the rural areas. Family planning services are offered within the Government institutions as well as in Clinics operated by non-governmental organisations such as the Planned Parenthood Association of Zambia (PPAZ) and the Family Life Movement of Zambia (FLMZ). Family planning has met with resistance from the rural population (PPAZ, Bulletin 1986). Annual Reports compiled by the PPAZ branches in all the districts of Zambia indicate that acceptance of family planning in the rural areas of Zambia is very low compared to the urban regions. Fertility remains persistently high in rural areas and the use of modern methods of contraception is extremely low. Couples in rural areas continue to rely on traditional methods of child-spacing such as, post-partum abstinence, prolonged breast feeding, withdrawal and other folk methods.

The low acceptability of modern methods of family planning in the rural areas could probably be due to:

- (a) Lack of knowledge about modern methods in rural areas.

- (b) Disparity in the provision of family planning service between urban and rural areas.
- (c) Lack of trained personnel and resources necessary for the expansion of family planning delivery into rural areas.
- (d) Lack of knowledge among health workers about the user's perceptions of family planning as influenced by cultural beliefs and values.

In order to investigate the fertility and contraception behaviour in rural areas, a survey was conducted in Chipata, a rural district in the Eastern province of Zambia.

OBJECTIVES

- i) To determine the knowledge of family planning among currently married women (15 - 44 Years).
- ii) To determine the prevalence of contraceptive use among currently married women (15 - 44 Years) in the district.
- iii) To identify the common contraceptive methods used in the area.
- iv) To determine the attitudes to family planning in the district.
- v) To identify how education level and distance from an urban centre can influence modern contraceptive use.
- vi) To use the information gained from the study in formulating appropriate intervention strategies to promote family planning in rural areas.

STUDY DESIGN

A descriptive study was carried out among wives in Chipata district. A multiple-stage cluster sampling technique was used to select a total of 926 currently married women in the age group 15 - 44 years in Chipata district. At the first stage 9 censory supervisory areas (CSA) were randomly selected out of 35 as primary sampling units (PSU). The district is divided into CSAs for the purpose of population and housing census in Zambia. Then 4 villages were randomly selected from each PSU. Within each village, households were randomly selected and eligible women found at the households interviewed. Approximately 102 currently married women were drawn from each PSU. Nine interviewers were recruited locally and trained to collect the data. A precoded pretested questionnaire was used and the respondents were asked about cultural practices relating to childbearing, ideal family size, contraceptive practice and attitudes towards family planning. The questionnaire used is attached in the appendix. The raw data was processed and analysed at the Central Statistics office computer unit and Ministry of Health in Lusaka.

RESULTS

Knowledge of Contraception

In the survey 77 percent of women knew at least one family planning method. Among modern methods, most women knew of the pill, the proportion being as high as 68 percent.

Ever-use of Contraceptives

Table 3 presents data on the ever-use of various contraceptive methods in Chipata district.

Table 3

PERCENT, EVER-USE OF CONTRACEPTION BY METHOD,
WIVES AGED 15 - 44: CHIPATA, 1986

METHOD	15-19	20-24	25-29	30-34	35-39	40-44	All Wives
Abstinence (a)	46	57	60	52	68	68	61
Prolonged (b) Lactation	41	44	52	47	61	61	54
Rhythm	47	51	52	57	60	59	58
Coitus Interruptus	27	28	32	27	26	26	27
Pill, IUD, Tubal Ligation	1	5	8	7	5	2	6
Number of Wives	(71)	(164)	(213)	(159)	(190)	(129)	(926)

(a) Abstaining from sexual intercourse for six months or more to avoid getting pregnant.

(b) Breastfeeding a baby for nine months or more to avoid getting pregnant.

50 - 60 percent of all wives claimed to have used abstinence, prolonged lactation and rhythm methods of contraception. The older wives tend to have used them more often than the younger ones. Only 6 percent of all wives reported having used modern methods.

Table 4

PERCENT EVER-USE OF CONTRACEPTION BY DESIRE FOR
ADDITIONAL CHILDREN, BY METHOD, WIVES AGED
15 - 44: CHIPATA, 1986

Method	All Wives	Wives Wanting No Additional Children	Wives Wanting Additional Children
Abstinence	60	72	58
Prolonged Lactation	52	67	50
Rhythm	57	64	57
Coitus Interruptus	28	34	25
Condom	5	6	5
Pill, IUD, Tubal Ligation	3	7	2
Folk Methods	1	1	1
Number of Wives	(926)	(149)	(764) ^a

a. Excludes 13 undecided wives

As might be expected, the women wanting to cease childbearing used contraceptive methods in greater proportions than those desiring additional children.

Table 5

PERCENTAGE DISTRIBUTION OF WIVES AGED 15 - 44 BY LENGTH
OF BREAST FEEDING LAST CHILD: CHIPATA 1986

Length of Breastfeeding (in months)

Age Group	9	9-12	13-18	19+	Not Stated	Mean Length ^b	Number of wives
15 - 19	3	44	42	0	11	12.8	27
20 - 24	5	36	48	5	6	13.5	141
25 - 29	7	31	52	6	4	13.6	205
30 - 34	9	26	43	11	11	14.2	151
35 - 39	4	22	52	17	66	15.4	185
40 - 44	7	24	41	23	5	15.6	126
All Wives	6	28	48	11	6	14.6	845

a. Meanlength is calculated for numerical responses only.

b. Excludes wives who had no children and those who were
currently breastfeeding.

The mean length of lactation was 14.6 months, varying little
from one age group to another or between wives who wanted
additional children and those who did not (see Table 5 and 6).

Table 6

MEAN LENGTH OF BREASTFEEDING LAST CHILD BY DESIRE FOR
ADDITIONAL CHILDREN, WIVES AGED 15-44: CHIPATA 1986 (in months)

Wants Additional Children	Age Group			
	15 - 24	25 - 34	35 - 44	15 - 44
Yes	13.1	13.8	15.5	14.4
No	13.5	14.0	15.5	15.2
All Wives	13.1	13.8	15.5	14.6

NOTE: Calculation exclude wives who have no children and those
who were currently breastfeeding their last child, plus
5 wives who were undecided whether they wanted additional
children or not

TABLE 7

PERCENT EVER-USE OF CONDOMS AND OTHER MODERN CONTRACEPTIVES BY WIVES' EDUCATION, HUSBANDS' EDUCATION AND WIVES' VILLAGE OF RESIDENCE, WIVES AGED 15 - 44; CHIPATA DISTRICT 1986

Variable	Condom	Tubal Ligation, Pill, IUD	Number of Wives
<u>Wives Education</u>			
Grade 7 - 12	15	7	188
Grade 1 - 7	4	2	231
No schooling	3	2	507
<u>Husband's Education</u>			
Grade 12 or above	17	10	73
Grade 7 - 12	8	4	262
Grade 1 - 7	4	1	168
No schooling	3	1	423
<u>Wives' Village of Residence</u>			
Magwero (21 Km)	6	5	264
Khuzana (28 Km)	5	2	161
Makungwa (32 Km)	4	1	285
Nkule (39 Km)	3	1	216
All Wives	5	2	926

(a) Order of villages is by distance from an urban Centre with villages located nearest listed first.

The distance in Kilometres from an urban centre is showed in brackets.

Ever-use of modern methods was higher i.e. more than 10 percent in women who received upper primary school education or above. The same applied to women whose husbands had upper primary school education. Table 7 also shows that ever-use of modern methods in villages tends to decrease with distance from an urban centre.

INDUCE ABORTION

Available evidence suggest that induced abortion is indeed rarely practised by the women. Only 11 percent of wives answered affirmatively when asked if they approved of abortion. When asked about approval under specific conditions, the only condition under which as many as 30 percent of wives said they would approve of abortion is when pregnancy seriously endangers a woman's health. Less than 10 percent of wives approved of it as a means of birth spacing.

ATTITUDES TOWARDS FAMILY PLANNING

TABLE 8

ATTITUDE TOWARD ATTENDING A FAMILY PLANNING CLINIC BY AGE GROUP AND WIVES VILLAGE OF RESIDENCE: CHIPATA 1986

Wife Would Attend Clinic

Age Group	Yes %	No %	Uncertain	Number of Wives
15 - 19	89	7	4	(71)
20 - 24	74	21	4	(164)
25 - 29	84	12	4	(213)
30 - 34	79	20	2	(159)
35 - 39	78	17	5	(190)
40 - 44	68	23	9	(129)

Wives Village of Residence

Magwero	80	17	4	(264)
Khuzana	84	13	3	(101)
Makungwa	78	16	4	(285)
Nkule	78	19	3	(216)
All Wives	78	17	4	(921)

78 percent of wives expressed a willingness to attend a family planning clinic. Only 17 percent expressed opposition.

TABLE 9

PERCENTAGE DISTRIBUTION OF WIVES AGED 15 - 44 BY HUSBANDS' ATTITUDES TOWARDS WIVES ATTENDANCE AT FAMILY PLANNING CLINIC; BY HUSBANDS' AGE GROUP: CHIPATA 1986

Husbands' Age Group	Husbands Attitude			Number of Wives
	Favourable	Unfavourable	Uncertain	
15 - 24	58	42	0	(12)
25 - 29	43	47	10	(57)
30 - 34	46	42	12	(84)
35 - 39	40	46	14	(149)
40 - 44	46	44	11	(134)
45 - 49	41	47	12	(173)
50+	24	35	41	(317)
All Wives 15-44	34	40	26	(926)

NOTE: Indicates wife's perceptions of their husbands' attitudes; however during the actual interview, husbands of 46 percent of respondents were present.

Only 34% of all wives reported that they would have their husband's approval to attend a Family Planning Clinic, 40% thought their husbands would oppose the idea and 26% were uncertain. The presence or absence of husbands during the interview did not seem to significantly influence the responses of the wives about their husband's attitudes. Of the 46 percent of women interviewed in the presence of their husbands, 45 percent reported that their husbands would disapprove their attending a Family Planning Clinic and 32 percent thought their husbands would approve the idea. In the group interviewed in the absence of their husbands 42 percent thought their husbands would oppose the idea and 34 percent reported that their husbands would have a favourable attitude.

Table 10

PERCENTAGE DISTRIBUTION OF WIVES AGED 15-44 BY WIVES' ATTITUDES TOWARD FAMILY PLANNING CLINIC ATTENDANCE AND BY HUSBANDS' ATTITUDES, BY WIVES AGE GROUP:
CHIPATA 1986

Husband's Attitude	Wife's Attitude		
	Favourable	Unfavourable	Uncertain
- Wives aged 15-24 (N = 236) -			
Favourable	36	1	1
Unfavourable	33	15	2
Uncertain	11	0	1
- Wives aged 25-34 (N = 372) -			
Favourable	40	1	0
Unfavourable	34	14	1
Uncertain	8	1	1
- Wives aged 35-44 (N = 318) -			
Favourable	36	2	1
Unfavourable	30	16	2
Uncertain	8	1	4
- Wives aged 15-44 (N = 926) -			
Favourable	38	2	11
Unfavourable	32	15	1
Uncertain	9	1	2

38% of all wives aged 15-44 years had favourable attitudes. The proportion is larger among younger wives than among older ones. 32% of all wives reported that they would like to attend Family Planning Clinic but would be opposed by their husbands. But the proportion of instances in which both husband and wife would disapprove of Family Planning Clinic attendance appears to be small in each age group of wives (14 - 1.5%).

DISCUSSION

Knowledge of Contraception

Despite the high level of knowledge of modern methods (over 60 percent), the percentage of current users was only 6 percent. These figures are comparable to findings of world surveys (WFS) in some African Countries. WFS data revealed that in Africa, the percentage of women who knew at least one method ranged from 32 percent in Nigeria to 94 percent in Kenya and averaged over 60 percent. In addition it was found that the lowest contraceptive prevalence rates are largely in Africa - under 5 percent in most African countries with national data, whereas in all developed countries the prevalence was well over 40 percent.

In Africa the reason for the discrepancies between levels of knowledge and prevalence of use might be due to the popularity of "Traditional" contraceptive methods and to a large extent the unavailability and inaccessibility of services and supplies (Acsadia Johnson, 1985). Other factors responsible for the discrepancy include, the disapproval of the modern methods by husbands and traditional leaders (Carlos, 1984) and the existence of false rumours about the side effects of modern contraceptics.

Ever-use of Contraceptives

In the survey, the traditional methods of Contraception i.e abstinence, prolonged lactation and rhythm are the principal methods of avoiding unwanted pregnancies (more than 50 percent of wives claimed to have used these methods). The condoms, pill and other modern methods have hardly ever been used. Table 4 indicates that, as might be expected, the women wanting to cease childbearing use contraceptive methods in greater proportions than those desiring additional children.

In order to understand why traditional methods are more popular in most African Societies, it is important to note the cultural practices relating to these methods. In traditional Zambian society, even today, it is customary for a young woman to return to her parent's home for delivery. Since her husband is unable to perform all traditional rites associated with childbirth. This practice frequently resulted in a long period of separation of husband and wife. A substantial proportion of the abstinence reported by wives might have been associated with such practices. Following delivery, it is customary in rural areas for women to breastfeed their babies for a prolonged period of time - until the baby has started walking. The mean length of lactation in our study was just over a year, varying little from one group to another or between wives who wanted additional children and those who did not (see Table 5 and 6). By custom people believe that once a baby has started walking it is signal for the couple to try to conceive again if they so wish. Parents, elder relatives and friends take a keen interest in advising young couples to adhere to the cultural practices relating to childbirth. Taking this into consideration, it is not surprising that abstinence and prolonged lactation are the commonly used means of birth spacing in the survey district. Other methods used to some extent are rhythm, coitus interruptus and folk methods. Survey in other parts of Africa also indicate that lactation and post-partum abstinence are the important fertility regulating methods practiced. A survey in Nigeria showed that about 80% of married couples knew of some form of modern contraception but only 10% actually practiced any. The most prevalent method of fertility control was abstinence. Other surveys, for example, in Togo, Nigeria and Zaire, demonstrated the importance of abstinence for child spacing (Ohaideke and Kocher, 1981).

With changing patterns of education, job opportunities for women, economic circumstances, and living conditions, abstinence is practiced for much shorter periods. In 1977, 90% of Nigerian women who were studied abstained for less than a year. (Okediji, 1978). According to other recent reports, the majority of Kenyan women stopped abstaining by 6 months after birth; about 50% stopped abstaining by 3 months (Caldwell and Ware, 1981).

The important result of these changing practices of abstinence is that many breast feeding mothers now rely on breast feeding alone, without abstinence or modern contraceptive, to delay their next pregnancy.

Folk methods were reported by only 1 percent of all wives, but they are worth mentioning briefly because of their wide variety and inherent ineffectiveness. The folk methods cited can be divided into two categories:

1. Methods mentioned by uneducated wives: Wearing a charm around the waist during coitus, sitting up for a while immediately after coitus, urinating immediately after coitus.
2. Methods mentioned by educated wives: Drinking a hot beverage such as Brandy or Whisky, taking quinine or chloroquine tablets after coitus or as soon as pregnancy is suspected.

The above listing clearly shows that some women who do not want certain pregnancies would try any available method to terminate such pregnancies. The methods known to them, however, are crude and ineffective and some that are abortifacients are quite dangerous.

The very small proportion of ever-use of the pill, the IUD, and tubal ligation agrees with earlier reports of Caldwell and Igan (1970) and Ekanem (1973), that modern contraceptives have hardly ever been used by wives in rural regions of Africa. The data on ever-use of modern contraceptives presented in Table 7 tend to support the findings of Caldwell and Igan (1970), that the major determinants of modern contraceptive practice are urbanization and formal education. The table shows that ever-use of modern contraceptives in villages tends to increase with education and to decrease with distance from an urban centre.

The women who received upper primary education or above and those whose husbands received college level education constituted nearly all the cases of ever-use. The women who lived in community areas near town (i.e. Chipata Boma) had used contraceptives in greater proportions than those who lived in community areas in the rural heart land. Although the percentages of ever-use of condom and other modern contraceptives are small in each local community area the differences between them are real, being significant at the .01 level (Table 7).

In addition to the limited availability of modern contraceptives and the traditionalism suggested by Caldwell and Igan (1970), the low use of modern contraceptives among wives in rural parts of sub-Saharan Africa may be traced to other sources. A common problem mentioned by nearly all the midwives in study areas is that uneducated women fear that modern contraceptives may cause permanent sterility. These attitudes imply that women understand contraception to be something desirable only after they have achieved their ideal number of children. Another problem is that few medical personnel work in the rural areas. Because of staff shortages, no family planning clinics are in operation. Thus, the major factors affecting modern contraceptive use in Chipata district are education of women, availability of services and availability of medical personnel to organise family planning activities. Unfamiliarity of the rural population to modern methods of family planning is another factor responsible for resistance to use of these methods.

Attitudes Toward Family Planning

The women expressed a favourable attitude towards attending a family planning clinic. The data in Table 8 suggest that a strong potential demand for family planning exists in the study district. Husbands' attitudes or wives' perceptions of these attitudes, however, must also be examined in assessing potential acceptance of family planning, especially in such

an African society in which the authority of the husband is very strong. Husband's attitudes as reported by their wives tended to be unfavourable toward their wives' attendance at a family planning clinic (Table 9). Only one third of all wives thought that their husbands would allow them to attend. Wives whose husbands are better educated and those living near urban areas stated more frequently that their husbands would support their desire to attend a family planning clinic than did those with less educated husbands and living in the villages.

Thus, although a larger proportion of wives expressed a desire to attend a family planning clinic, only the relatively small proportion (38%) whose favourable attitudes are shared by their husbands would be likely to attend a family planning clinic initially if the service was available to them.

Apart from the level of education, the other important factor affecting the attitude of wives is the number of children. The proportion of wives who felt they would have their husband's approval to attend a family planning clinic was higher among wives wanting no additional children.

This suggests that women who have achieved their ideal number of children would be more likely to have their husband's approval to use contraceptives. This stresses the important point of involving the husbands in family planning programmes. Almost, if not all, organised family planning programmes are women orientated. Very few programmes are aimed at men as clients. (Carlos, 1984). Such women orientation of family planning programmes is usually justified by the fact that women have more of a stake in family planning, because it is they, not men, who get pregnant and bear the physical and emotional strain of pregnancy and childbirth. While this is a physiologically sound fact, there are, however, some sociological factors which point to the importance of male involvement in all stages of contraceptive acceptance i.e. in the actual decision to use contraceptives, the choice of method and the length of time contraception is practised.

Experience of family planning workers and research studies reveal that men's support or opposition to their partner's practice of family planning has a strong impact on contraceptive use in many parts of the world. An evaluation of male contraceptive acceptance in rural Ghana, published in studies in Family Planning, August 1978, revealed that half the fertility reduction in the area was due to the acceptance by men of family planning. There are also studies such as those done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives.

The involvement of men in family planning matters will therefore not only ease up the responsibility borne by women in terms of decision making for family planning matters, but will also accelerate the understanding and practice of family planning in general (Onyanyo - Omonda, 1984).

CONCLUSION

Traditional methods of contraception are the best known and most popular methods among wives in the Chipata district. Women desiring to cease childbearing used these methods in greater proportions than women desiring additional children. The percentage ever-use of modern methods is very small. This could probably be due to lack of education about modern contraceptives. The majority of women expressed a favourable attitude towards attending a family planning clinic. This attitude appears to stem from a desire to learn more about modern methods of child spacing. Thus, if measures are taken by the Ministry of Health and PPAZ to embark on a family planning information and educational campaign in the rural areas, wives would be motivated to accept modern contraceptives. The educational campaign should be aimed at wives and husbands as well, since approval of the modern methods by the husbands can significantly increase their acceptance. Eventually, as women acquire education and as the early programme acceptors find contraceptives safe and effective, more and more couples will be motivated to join the programme.

RECOMMENDATIONS:

In order to promote modern contraceptive use in the rural areas, the following intervention strategies are recommended:

1. To organise information and motivational campaigns aimed at the women, the men and opinion leaders. This could be in the form of Lectures and open forums in the villages. Programmes of information and education for family planning should stress that family size and its regulation is a couple responsibility. Family planning programmes should involve both spouses in the use of any method and engage the active participation and commitment of each.
2. To promote community participation in family planning activities. Participation of the community in all aspects of programme planning ensures that all new technology is adapted to people's lifestyles.

During implementation, the programme is more likely to draw on an available local resources (traditional healers/midwives, formal and informal leaders etc). In that way new technology finds its place alongside familiar and respected community resources and becomes part of the indigenous way of life.

3. To intergrate family planning into the primary health care system being implemented in the country.

4. To expand family planning delivery services at village level.

Village health workers, social workers or rural development officers should be trained to deliver services within their communities.

Contraceptive methods such as IUD's and sterilization can be provided through referral from community channels to the nearest family planning clinic.

If a family planning programme is planned in such a way that the above measures are taken into consideration, there will definitely be a significant increase in acceptability and in the use of modern contraceptives.

REFERENCES

Caldwell J C 1969: "Anti-natal practice in tropical Africa." Paper presented at the International Union for the Scientific Study of Population, London, 1974 "Basic Population Policy Consideration for African Countries." Paper presented at the Inaugural Conference of the Population Association of Africa, University of Ibadan, 9 - 14 May.

Caldwell J C and A Igun 1970: "The Spread of Anti-natal Knowledge and Practice in Nigeria." Population Studies 241 No. 1 (March): 21 - 34.

Molnos Angela (ed) 1973: Cultural Source Materials for Population Planning in East Africa Vol. 3. Beliefs and Practices Institute of African Studies, University of Nairobi, Kenya.

Nortman Dorothy 1974: "Population and Family Planning Programmes: A Factbook." Report on Population/Family Planning No. 2 6th edition (December).

Page H J and A J Coole 1969: "Estimates of Fertility and Child Mortality in Africa South of the Sahara." Seminar on Population Growth and Economic Development University College Nairobi 14 - 22 December.

Watson W B and R J Lapham 1975: "Family Planning Programmes: World Review 1974." Studies in Family Planning 6 No. 8 (August).

WFS - "Fertility and Family Planning Surveys:

Population Reports 8: 1985.

Davis K and Blake J (1956): "Social Structure and Fertility: An Analytic Framework." Economic Development and Cultural Change, In: 211 - 35.

Lorimer F (1954): Culture and Human Fertility:
A Study of Relation of Culture Conditions to Fertility in Non-industrial and Transitional Societies, UNESCO Paris.

Page H (1975): "Fertility Levels: Partterns and Trends."
In Caldwell et al: OP Cit 29 - 57.

Swartz M S (1969): "Some Cultural Influences on Family Size in Three East African Societies."
Anthropological Quareterly 42: 75 -88.

Ware H (1976): Population Studies 30: 413 - 427.

Ohadike D and J, Kocher (1981): Child - Spacing and Fertility in sub-sahara Africa: an overview of issues. - New York, Academic Press, 1981.

Okediji, F.O. ; Caldwell, J; Caldwell, P; Ware, H.

The changing African Family Project: a report with special reference to the Nigerian segment.
Studies in Family Planning 7(5): 124 - 135, 1976.

Bongaarts, J: the ~~imp~~act on Fertility of Traditional and changing child spacing practices. In Page, J.H; Lesthaghe, R. (Editors). Child spacing in Tropical Africa. New York Academic press, 1981.

Waife, R.S : Traditional methods of birth control in Zaire. Pathfinder
No. 4. Chestnut Hill, Massachusetts, Pathfinder Fund,
December 1978.

Caldwell, J; Caldwell, P: The role of Marital sexual abstinence in
determining fertility: a study of the Yoruba in Nigeria.
Population studies 3. (2) : 193 - 217, 1977.

This investigation received financial support from the World Health
Organisation, special programme of Research, Development and Research
Training in Human Reproduction.

CARD

--	--

1 2

1. Country:.....2. Province:.....3. District:.....
 4. Urban/Rural:.....
 5. Village/Township:.....6. Household No.....
 7. Name of Respondent:.....8. Respondent's No.....
 9. Tribe:.....
 10. Name of Interviewer:.....11. Interviewer's Code:.....
 12. Date of Interview:.....

--	--

3 4

--

5

--	--	--	--

6 7 8 9

--	--	--	--

10 11 12 13

--

14

13. What is your marital status?

1. Married
2. Widw
3. Divorced
4. Separated
5. Other:.....

--

15

14. What is your date of birth?

DAY MONTH YEAR

--	--	--	--

--	--

16

15. What is your Religion?

1. Catholic
2. Anglican
3. U.C.Z
4. Seventh Day Adventist
5. Dutch Reformed
6. Baptist
7. None
8. Others(Specify).....
9. Dont Know

--

18

16. What is the highest education level attained?

1. Primary School
2. Secondary School
3. College/University
4. Adult Education
5. None
6. Dont Know

--

19

17. What is the highest level of education your husband has attained?

- 1. Primary School
- 2. Secondary School
- 3. College/University
- 4. Adult Education
- 5. None

20

18. What is your husband's date of birth?

d- DAY MONTH YEAR

21

2

19. Is your husband working?

- 1. Yes - go to 20
- 2. No - go to 21

23

20. If the answer to 19 is yes, specify his employment status?

- 1. Self employed(specify).....
- 2. Working for wages(specify).....
- 3. Peasant farmer
- 4. Other(specify).....
- 5. Dont know

24

21. What is your occupational status?

- 1. Business woman
- 2. typist
- 3. Nurse
- 4. Teacher
- 5. Farmer
- 6. Clerk
- 7. Others(specify).....

25

22. How many children do you have?

1. Boys

26

2. Girls

27

23. Would you like to have more children?

- 1. Yes - go to question 24
- 2. No - go to question 25
- 3. Not sure
- 4. Not applicable

24. How many more children would you like to have?

31	32

1. Boys

2. Girls

33

25. What do you consider to be an ideal number of children for you?

- 1. 1-2
- 2. 3-4
- 3. 5-6
- 4. 7-8
- 5. More than 8
- 6. Dont know

34

26 Why do you consider this to be an ideal number of children?

- 1. High cost of living
- 2. To replace those who mihgt die
- 3. Religious beliefs(God's gift)
- 4. Prefernce for boys
- 5. Preference for girls
- 6. Old age care
- 7. Old enough to bear any more children
- 8. Husband's influence
- 9. Dont know

35

27. How old is your last child?

..... Months

36	37

28 Did you breast feed your last child?

- 1. Yes - go to Q. 30
- 2. No - go to Q. 31
- 3. Still breast feeding - go to Q. 29

38

29. Up to what age will you breast feed your child?

..... Months

39	40

30. How long did you breast feed your last child?

..... Months

41	42

31. Have you already started having sexual intercourse with your husband?

- 1. Yes - go to Q. 32
- 2. No - go to Q. 33

43

32. How many months after the birth of your last child, did you start having sexual contact with your husband?

- 1. 0-6 months
- 2. 7-12 months
- 3. 13-18 months
- 4. 10-24 months
- 5. over 24 months

44	45

33. After the birth of your last child, how many months would you wait to have sexual contact with husband?

..... months

46	47

34. In your view can breast feeding prevent a woman from becoming pregnant?

- 1. Yes
- 2. No
- 3. Dont know

48	49

35. What do you consider to be a reasonable period between the births of children?

- 1. 1 year or less
- 2. 2 years
- 3. 3 years
- 4. 4 years or more

50

36. Do you consider that your last pregnancy came sooner than you intended?

- 1. Yes
- 2. No
- 3. Unsure/undecided

51

37. Do you know of any methods a couple can use to delay the next pregnancy?

- 1. Yes
- 2. No

52

38. Which of the following methods do you know?
(tick in column 1 below)

	1	2	3
METHOD	KNOWLEDGE	EVER USED	CURRENT USE
1. Pill			
2. I.U.D			
3. Condom			
4. Sterilization			
5. Abortion			
6. Rhythm			
7. Withdrawal			
8. Lactation			
9. Traditional			
10. Abstinence			
11. Others(specify)			

Note: Yes - 1
No - 2

39. Which methods have ever used to delay the next pregnancy?
(tick in colum 2 above)

40. Are you now using some method(s) to avoid pregnancy?

- 1. Yes - go to Q. 41
- 2. No - go to Q. 42

52

41. Which methods?(tick in colum 3 above)

42. What are your reasons for currently not using any family planning methods?

- 1. Pregnant now
- 2. Planning to have a baby soon
- 3. Service not available ,
- 4. Other reasons(specify).....
.....

53

43. Would you attend a family planning clinic if one were available in this area

- 1. Yes
- 2. No
- 3. Dont know

54

44. What is your attitude to attending a family planning clinic

- 1. Favourable
- 2. Unfavourable
- 3. Dont know

55

45. What would be your husbands attitude towards you attending a clinic?

- 1. Favourable
- 2. Unfavourable
- 3. Dont know

56

46. Have you and your husband ever discussed methods of child spacing?

- 1. Yes
- 2. No

57

47. Does your husband approve of any methods of family planning

- 1. Yes - go to Q. 48
- 2. No - go to Q. 49

58

48. If the answer to Q. 47 is yes, state which ones

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

49. If the answer to Q.47 is no, state why?

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

50. Where did you stay after the birth of your last child?

- 1. Own home
- 2. Mother's home
- 3. Mother in law
- 4. Other(specify)

59

51. For how long did you stay away from your own home?

..... months

60

61

52. Have you ever had any miscarriage?

- 1. Yes
- 2. No

62

53. How many were spontaneous?

.....

63

54. How many were induced?

- 1. None
- 2. 1
- 3. 2
- 4. 3 plus
- 5. Refused to answer
- 6. Dont know

64

55. Why did you induce the abortion?

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

56. What methods did you use to induce the abortion?

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

57. Do you approve of induce abortion as a means of child spacing?

- 1. Yes
- 2. No
- 3. Dont know

65