

FACTORS INFLUENCING DECISION MAKING REGARDING FAMILY
PLANNING AMONG WOMEN IN LIVINGSTONE DISTRICT

BY

Chongo Charity Lyambai

B.Sc.N, RM, RN

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF
SCIENCE IN NURSING

University of Zambia

Lusaka

March, 2015

DECLARATION

I declare that this Dissertation is my own work and that all the sources I have quoted have been indicated and acknowledged using complete references. I further declare that this Dissertation has not been previously submitted for a Diploma, a Degree or for any other qualifications at this or any other University. It has been written according to the guidelines for Master of Science in Nursing Degree Dissertations of the University of Zambia.

Signed.....Date.....

Candidate

Signed.....Date.....

Supervisor

CERTIFICATE OF APPROVAL

The University of Zambia approves this Dissertation on factors influencing women’s decision making regarding family planning use in Livingstone District in partial fulfilment for the requirements for the award of a Master of Science in Nursing Degree.

Examiner’s signature.....Date.....

Examiner’s signature.....Date.....

Examiner’s signature.....Date.....

DEDICATION

To the Nursing and Midwifery Profession, women who have experienced challenges regarding decision making on family planning use and the important people who have been a source of inspiration in my life;

My husband, Mr David Lyambai.

My daughters, Esther, and Chisela

My son Chembo.

My sisters, Josephine and Fridah and

My Brother, Derrick who was there always and made sure that i graduate

ACKNOWLEDGEMENTS

My heartfelt gratitude goes to my Lecturers and research supervisors, Dr C. M. Ngoma and Ms S. Mayimbo, who tirelessly and patiently guided me throughout the research process.

My sincere thanks also go to the following:

- The Ministry of Health, for sponsoring my studies.
- The Livingstone District Management Team and the MCH Coordinator and other staff at DHO for availing me with the data which I needed
- My friends and classmates, who encouraged me and gave me the moral support which I needed
- My family, for their continued support, understanding and encouragement throughout my period of study.
- Lastly but not the least I thank the Lord God Almighty who guided me, saw me through hard times, and gave me the strength to conduct the research (Psalm 23:1). Hallowed be His name.

ABSTRACT

The aim of this study was to determine factors influencing women's decision making regarding family planning use among women. The study was conducted in Livingstone District. A cross-sectional, descriptive study design with both qualitative and quantitative approach was used. The study population was the women of child bearing age residing in Livingstone peri urban district who had given birth in the last three months or those who were six (6) days postnatal at the time of the study.

Literature review high lights relevant research findings on factors influencing women's decision making regarding family planning use. Databases searched were, Pub med, Hinari, Internet, Google scholar, books, articles, professional papers and published and unpublished dissertations.

The purpose of the study was to determine the factors that influence women's decision making regarding family planning use among mothers delivered in Livingstone District.

A sample of 397 respondents was systematically sampled at Maramba health centre catchment population. Two Focus Group Discussions (FGDs) were conducted at the health centre. Interview schedules and focus group discussion guide were used to collect data for a period of three months. Data analysis was conducted using Statistical Package in Social Sciences (SPSS) version 16 software, and data were presented using frequency tables, pie charts, histograms and cross-tabulations. Data from open ended questions were categorized, coded, entered and analysed using SPSS version 16. Data from closed ended questions was coded, entered and analysed using SPSS version 16. Chi square test was used to test for associations between independent and dependent variables. FGDs were analysed by content analysis and the most useful information that emerged from the discussions was selected and used to illustrate the main points.

The study revealed that 99% respondents had adequate levels of knowledge about family planning, and that 74% heard it from health personnel, this was due to the information, education, and communication strategies coupled with service counselling and outreach programmes that are instituted in the district. The study revealed significant association between women's knowledge of family planning and their decision making on family planning use p value= 0.000

The study revealed significant association between women's level of education and their involvement in family planning decision making p value = 0.033, and Child gender preference was

also significantly associated with women's decision on family planning p value 0.000. Religious influence was not significantly associated with women's decision on family planning p value = .825. There was no significant association between fear of side effects and women's decision on family planning p value 0.261. The results will be disseminated to relevant stakeholders after data analysis.

This study recommends that the Ministry of Health should put in place measures to strengthen Information Education and Communication (IEC) programs in all health facilities to increase knowledge regarding family planning decision making among women and this will also improve their perceptions and usage for example to increase knowledge about family planning decision making among women and keep on training community based volunteers, like community health workers and reproductive health supporters so that they can teach women and communities where they live. A follow up study should be conducted to explore age, marital status, dowry payment and women's practices for family planning use and decision making challenges.

It is envisaged that the study results will be used by Maternal and Child Health programs to give evidence-based IEC and increase knowledge of family planning uptake among women so that they make their own decisions regarding family planning use. It is hoped that the findings will be useful to plan family planning programs according to the needs of the communities in Livingstone District, and to improve their reproductive health and decrease their risk of new-born and maternal health complications. This will help Zambia advance toward meeting Millennium Development Goals 4 and 5: to reduce child mortality and improve maternal health.

Key words: Factors, Influencing, Decision making, Family planning Use, Women

TABLE OF CONTENTS

CONTENT PAGE	
Title page.....	i
Declaration.....	i
Certificate of approval	ii
Dedication	iii
Acknowledgements	iv
Abstract	v
Table of contents	vi
List of tables	vii
List of figures	viii
Appendices	ix
Acronyms	x
CHAPTER ONE	
1.0 Introduction.....	1
1.1 Background information.....	1
1.2 Statement of the problem.....	3
1.3 Factors influencing women’s family planning use decision making among Women.....	8
1.3 Justification for the study	9
1.4 Research theory.....	10
1.5 Research questions.....	12
1.6 Research objectives.....	12
1.7 Hypothesis.....	13
1.8. Definition of terms.....	13
1.9 Research variables	16
1.9.1 Variables and cut off points.....	17
CHAPTER TWO	
2.0 Literature review.....	20

2.1 Introduction.....	20
2.2 discussion of literature According to variables.....	21
2.2.1 Knowledge.....	21
2.2.2 Male dominance.....	23
2.2.3 Polygamy.....	25
2.2.4 Dowry.....	27
2.2.5 Male gender preference.....	27
2.2.6 Fear of side effects	29
2.2.7. Religion.....	31
2.2.8. Level of education	32
2.3. Conclusion	33

CHAPTER THREE

3.0 Research methodology.....	34
3.1 Introduction.....	34
3.2 Research design.....	34
3.3 Research setting.....	35
3.4 Study population.....	35
3.4.1 Target population.....	36
3.4.2 Accessible population.....	36
3.5 Sample selection.....	36
3.5.1 Inclusion criteria	38
3.5.2 Exclusion criteria	38
3.6 Sample size.....	38
3.7 Data collection tools.....	40
3.7.1 Semi-structured Interview Schedule.....	40
3.7.1.1 Validity.....	41
3.7.1.2 Reliability	41
3.8 Focus Group Guide.....	41
3.9 Data collection techniques.....	44
3.9.1 Data collection technique for quantitative data.....	44

3.9.2 Data collection technique for qualitative data.....	44
3.10 Pretest.....	45
3.11 Ethical consideration.....	46

CHAPTER FOUR

4.0 Data analysis and presentation of findings.....	47
4.1 Introduction.....	47
4.2 Data processing and analysis.....	47
4.2.1 Data analysis.....	47
4.2.1.1 Quantitative data.....	48
4.2.1.2 Qualitative data.....	49
4.3 Data presentation.....	50
4.3.1 Quantitative data.....	50
4.3.2 Qualitative data.....	50
4.4 Focus Group Discussions.....	74
4.4.1 Demographic characteristics of participants.....	74
4.4.2 Knowledge about family planning.....	76
4.4.3 Male dominance.....	77
4.4.4 Religion influence in FP use decision making.....	77
4.4.5 Gender preference influence in women’s FP decision making.....	77
4.4.6 Side effects of family planning.....	78
4.4.7 Suggestions for improvement.....	78

CHAPTER FIVE

5.0 Discussion of findings.....	81
5.1 Introduction.....	81
5.2 Demographic characteristics of respondents.....	81
5.3 Knowledge about family planning.....	82

5.4 Male dominance in women’s FP decision making.....	83
5.5 Religious influence on women’s FP decision making.....	86
5.6 Male gender preference influence on women’s FP use.....	87
5.7 fear of side effects influence on women’s FP use decision making.....	88
5.8 level of education influence on women’s FP use decision making.....	89
5.9 Limitations of the study.....	91
5.10 Implications to nursing.....	91
5.10.1 Implications to nursing/midwifery practice.....	91
5.10.2 Implications to nursing administration.....	91
5.10.3 Implications to nursing education.....	92
5.10.4 Implications to nursing research.....	92
5.11 Conclusion and recommendations.....	92
5.11.1 Conclusion.....	92
5.11.2 Recommendations.....	93
5.11.2.1 Recommendations for improving women’s family planning use decision making.....	93
5.11.2.2 Recommendations for further research.....	94
5.12 Dissemination and utilization of findings.....	94
References.....	96

LIST OF APPENDICES

Appendix I Data collection tool.....	99
Appendix II Focus Group Discussion Guide	106
Appendix III Budget	108
Appendix IV Gantt chart	111
Appendix V Participant information sheet	112
Appendix VI Informed consent form.....	116
Appendix VII Marking key for the knowledge variable.....	118
Appendix VIII Letter to District Medical Officer	119
Appendix IX Letter from District Medical Officer	120
Appendix X Letter to Town Clerk	121
Appendix XI Letter from Research Ethics Committee	122

Appendix XII Map of catchment area for research.....	126
--	-----

LIST OF TABLES

Table 1: Utilization of modern family planning 1 st quarter 2014	5
Table 2: Variables cut off points and indicators	17
Table 3: population survey for simple Random Sampling	39
Table 4: Respondents background information.....	51
Table 5: Respondents responses on male involvement in family planning.....	57
Table 6: Reasons on whether polygamous marriage contributes to non-use of family planning method	61
Table 7: Respondents reasons why their religion forbids use of modern family planning method	63
Table 8: relationship between family planning use decision making and the respondents' demographic characteristics	68
Table 9: Relationship between family planning use decision making and male gender preference	70
Table 10: Relationship between family planning use decision making and religion... ..	71
Table 11: Relationship between family planning use decision making and Knowledge.....	71
Table 12: Relationship between family planning use decision making and fear of side effects	72
Table 13: Relationship between family planning use decision making and dowry.....	72
Table 14: Relationship between family planning use decision making and polygamy	73
Table 15: Relationship between family planning use decision making and male dominance	73

LIST OF FIGURES

Figure 1: Factors influencing women’s family planning use decision making among women	8
Figure 2: Health belief model, major components and linkages.....	10
Figure 3: Had heard about family planning	53
Figure 4: Definition of family planning by respondents.....	54
Figure 5: Respondents source of information.....	55
Figure 6: Awareness of family planning method by the respondents.....	56
Figure 7: Benefits of involving men in family planning	58
Figure 8: Respondents responses on decision on use of family planning method.....	59
Figure 9: Dowry payment hinders women’s decision about family planning use.....	60
Figure 10: Polygamous marriage contributes to women not using family planning method	61
Figure 11: Respondents responses on whether religion forbids use of modern family planning methods	62
Figure 12: Respondents responses on whether one gender of children hinders women from using family planning methods.....	64
Figure 13: Respondents responses on whether side effects of modern family planning methods can prevent women from using family planning methods	65
Figure 14: Respondents responses on the side effects that could prevent women from using modern family planning methods.....	66

LIST OF ACRONYMS

CSO	-	Central Statistical Office
DHO	-	District Health office
EHT	-	Environmental Health Technician
FGD	-	Focus Group Discussion
FP	-	Family planning
HBM	-	Health Belief Model
IEC	-	Information, Education and Communication
IUCD	-	Intrauterine Contraceptive Device
LAM	-	Lactation Amenorrhoea
LDHMT	-	Livingstone District Health Management Team
MDGs	-	Millennium Development Goals
MMR	-	Maternal Mortality Rate
MoH	-	Ministry of Health
SPSS	-	Statistical Package in Social Sciences
TDRC	-	Tropical Diseases Research Centre
UAE	-	United Arab Emirates
UNZA	-	University of Zambia
ZDHS	-	Zambia Demographic and Health Survey
ZDHS	-	Zambia Demographic and Health Survey
ZMK	-	Zambian Kwacha

CHAPTER ONE

1.0 INTRODUCTION

Chapter one provides information on the background to the study and statement of the problem where demographic health surveys in Zambia have consistently reported that many women of reproductive age group do not want any more children after the initial few births (CSO, 2007; CSO, 2010). The chapter also provides information on the justification for the study, in which Maimbolwa, (2003) reported that high population growth is intimately linked to poor economic growth. The government of Zambia is implementing a national Family Planning policy in an effort to decrease the country's population growth and, conversely, increase Zambia's economic growth. There are various socio-cultural factors that hinder the practice of family planning. It is only with an understanding of these factors that Zambia can be effective in its Family planning programing. The chapter discusses factors influencing women's decision making regarding family planning

This chapter also discussed researchtheory and research questions/objectives, hypothesis, definition of terms and variables were also discussed.

1.1 Background information

Family planning is known to influence fertility and save women's lives worldwide, however, there are still some barriers to the family planning uptake in developing countries including Zambia.

Zambia's high population growth constitutes a major challenge to its economic development. The current population growth rate is estimated at 3.5% (Central statistics Office (CSO), 2009). The country's rapid population growth is straining its educational and health infrastructures and services. Zambia's population growth has also led to high population density, 17 people per square kilometre in 2010, (ZDHS 2013-2014), which is a strain on the country's natural resources.

One contributory factorto Zambia's high population growth could be due to the low (34%) contraceptive prevalence rate (CSO, 2007). Although the relationship between

the country's high fertility rate and its low contraceptive rate is apparent, what is not clear are the reasons behind the population's limited practice of Family Planning (FP).

On average, Zambian women have 6.2 children (CSO, 2007). Fertility rates are highest among women in rural areas (6.3) as compared with women in urban areas (4.9). The literatures, however, showed a high rate of unmet need (27%) among women in Zambia (CSO, 2007) with married women expressing the desire to space or limit births but are not practicing any FP method. Maimbolwa (2003) stated that only 34% of married couples use contraception. According to ZDHS (2007), out of 51,460 women of child bearing age in Livingstone District, only 447 was reported to be using modern family planning methods.

Increasing women's access to modern Family Planning (FP) would serve to meet the contraceptive needs of women in Zambia, thereby slowing the country's high population growth rate and helping the country meet the Millennium Development Goals (MDGs) 4 and 5: to reduce child mortality and improve maternal health. In order to reduce the population growth rate and advancement toward meeting MDG 4 and 5, family planning is one of the cost-effective strategies which have been employed. According to Maimbolwa (2003) in order to reduce maternal mortality, there is need to plan for improved reproductive health services and family planning, which are all important in promoting reproductive health.

Family Planning has been among the national priorities of the Zambian Government. The country's National Family Planning Policy states the need for families to limit the number of children to one that is within the capacity of the household to support (Ministry of Health (MoH), 2006). Sunkutu et al (2002) defined family planning as a voluntary decision made by an individual or couple on the appropriate number of children they wish to have, when to have the children. In Zambia family planning services are offered at all the levels of health care by both private and public health institutions. However a study conducted by Belohlav and Karra (2013) in Lusaka, Chipata compound, revealed unmet need for family planning even though family planning services are readily available through public and private sources.

Livingstone District in southern province of Zambia implements and adheres to the policies and programme interventions of MoH and other agencies in relation to

increasing access to reproductive health services including family planning. These policies and programmes reflect in the information education and communication strategies coupled with service counselling and outreach programmes that are instituted in the district. Livingstone district is a major tourist centre serving visitors to the Victoria Falls and across the borders, increasing the risk of sexual activities in the town thereby increasing the need for family planning methods. Livingstone's inhabitants are a mixture of people- Lozi, Toka-leya, and Tonga. In recent years other languages are becoming common for example, Bemba and Nyanja. Therefore, the influence of people on the use of family planning methods, made it necessary to determine the factors influencing women's decision making regarding family planning.

While few studies have been conducted to assess the barriers to modern family planning (FP) uptake in Zambia, none of the studies has investigated the socio-cultural factors affecting decisions at the household level. The objective of the study was to determine the socio-cultural factors that are involved in making decisions related use of modern family planning methods.

1.2 STATEMENT OF THE PROBLEM

Family planning is known to influence fertility and save women's lives worldwide, however, there are still some barriers to the FP uptake in developing countries including Zambia. For example, demographic health surveys in Zambia have consistently reported that many women of reproductive age group do not want any more children after the initial few births (CSO, 2007; CSO, 2010). The survey findings also revealed that these women do not practice family planning (CSO, 2007; CSO, 2010). In order to reduce maternal mortality, there is need to plan for improved reproductive health services and family planning, which are all important in promoting reproductive health (MoH, 2004). Livingstone district has an estimated number of 51,460 women in child bearing age, out of this 447 are using modern family (CSO, 2007). Therefore, this situation is of great concern. Family planning methods available in urban area include female and male sterilization, the pill, IUCD, injectables, implants, female and male condoms, diaphragm, foam/jelly, lactational amenorrhoea (LAM), and emergency contraception, while traditional methods including, the rhythm, natural family planning, standard days

method and folk methods(cycle beads) are more common in rural areas (CSO, 2010). Currently only 34% of married couples use contraception (CSO, 2012-2014) and 9.0 % of women in rural areas use traditional methods of family planning while 6.3% in urban areas use traditional methods of family planning (6.3 Percent).

Out of 51,460 women of child bearing age in Livingstone district, only 447 are reported to be using modern family planning methods (CSO, 2009). The family planning methods available at Maramba health centre in Livingstone include; combined oral contraceptive, progesterone pill only, medroxyprogesterone injection, Norethisterane enarthate injection, implant and Intra-Uterine Contraceptive Device(IUCD). According to the statistics of 2014, only 982 women out of 5,990 had used modern family planning.

TABLE 1a: UTILIZATION OF FAMILY PLANNING BY WOMEN IN DAMBWA HEALTH CENTRE BETWEEN 2012-2014

Year	Number of women in reproductive age	Number of women on family planning	Percentage
2012	5,042	142	3%
2013	5,198	150	3%
2014	5,359	984	18.4%

Source: DHIS 2(HMIS)

TABLE 1b: UTILIZATION OF FAMILY PLANNING SERVICES AT MARAMBA HEALTH CENTRE. 2012-2014

Year	No. of women in reproductive Age	No. on family planning	percentage
2012	5,634	334	6%
2013	5,809	486	8.4%
2014	5,990	982	16.4%

Source: DHIS 2(HMIS)

The probable causes of poor use of family planning services could be;

- Low levels of knowledge and existence of variety of family planning methods
- Absence of all and /or certain family planning methods in the area
- Women’s autonomy and their socio-economic status(Mairiga,A.G. etal 2010)
- Provider bias and misinterpretation of family planning methods
- Educational status of women and their partners, type of residence area(Sable, etal, 2000)
- Access to media, knowledge about family planning methods, and their availability and mix (Wegs etal, 2011).

- Support to family planning methods by women, their partners and senior members of their family (Phiri, C.2011).
- Parity, experience of abortion and child death, religious beliefs, ethnic affiliations were some of the individual background characteristics that were associated to poor use of family planning methods (Maimbolwa,C.M., 2003).
- Apprehension about side effects of some family planning methods, and difficulty using family planning methods effectively(Muramutsa,F.,2007).

Perhaps a clear understanding of the social context in which women live would be the best approach to understanding the discrepancy between reported desires for family planning and behaviour. This is because the non-use of contraceptives by women has a corresponding effect on the women's wellbeing and that of their children. Poor use of family planning make women to begin child bearing at a young age and have more closely spaced pregnancies, this tend to be associated with poor maternal and child health, women will have more children than they wanted or intended to have (Maimbolwa 2003). Poor use of family planning also leads to bigger families and high population growth. Families and communities are unable to meet the educational, health and employment needs of young people when the population is growing at a fast rate (Belohlav and Karra 2013. Families tend to have low incomes and less savings due to increased demand by large families, this leads to youths in big families not to complete education which is key for earning higher incomes as adults (Mutombo, and Bakibinga 2014).

Livingstone District in southern province of Zambia implements and adheres to the policies and programme interventions of MoH and other agencies in relation to increasing access to reproductive health services including family planning. These policies and programmes reflect in the information education and communication strategies coupled with service counselling and outreach programmes that are instituted in the district. The district through the Ministry of Community Development, Mother and Child health, have put in place policies which allow girl child to continue school after falling pregnant(Ministry of Gender and Development, 2002). This has enabled girl child and women to have knowledge on reproductive health services. The ministry has also strengthened reproductive health services and has adopted integration of reproductive health services to enable women and men access the services at each visit to a health facility (Ministry of Gender and development, 2002). The district also has put emphasis

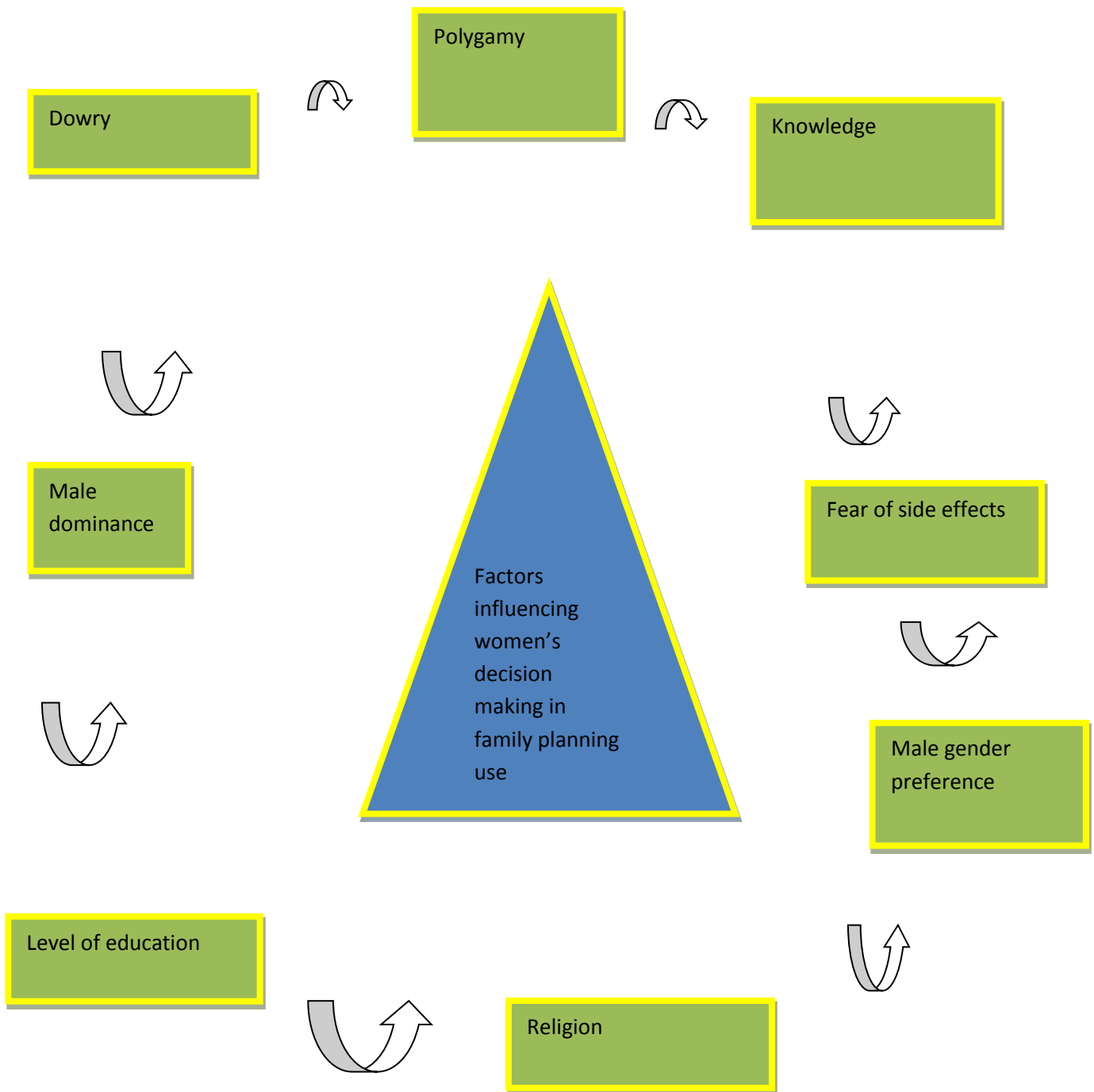
on male involvement in reproductive health services, since men are key decision makers in virtually all family matters (Phiri, 2011)

To a certain extent, the IEC strategies have yielded a positive outcome as the maternal mortality ratio has dropped from 729/100000 live births in 2002 to 591/100000 live births in 2007 to 398/100,000 live births in 2013 (CSO, 2013-14).

However, the still high maternal mortality is an indication of the consequences of complications resulting from un planned and un intended pregnancies. This warrants further research on the most appropriate and effective ways to communicate about family planning to these communities would enhance public efforts. Possible avenues include public information campaigns which while challenging to implement, have been found to be effective in promoting usage of family planning services (Kimani, V. and Olenja,J.,2001). Information about family planning options needs to be provided to the poor and minority communities in creative and accessible ways (Gule, 1994). By helping women to explore pregnancy intentions, and helping women who wish to avoid pregnancy to identify and understand the family planning method which is best for them, health care providers can positively impact women's ability to make choices about their fertility (Maimbolwa 2003). These solutions clearly do not address all aspects of the complex web which affect family planning disparities, including the inequitable social circumstances that impact a woman's ability to have and raise children (Mairiga, Kulima, Bako and Kolo 2010). According to Mairiga, Kulima, Bako and Kolo (2010) they offer a starting point from which to begin the process of ensuring that all women regardless of race/ethnicity or socioeconomic status have equal access to the knowledge and medical care necessary to make informed choices/decisions about family planning. According to Ajiboye (2012)In spite of social change and modernization, the Ogu people are still strongly adhere to their cultural practice as it relates to pregnancy and low patronage or inability to utilize the available various modern reproductive health services by the Ogu people.Maimbolwa(2003) stated that in order to reduce maternal and child mortality, there is need to plan for improved reproductive health services and family planning, which are all important in promoting reproductive health.

The study, therefore sought to determine socio-cultural factors that affect family planning use and decision making by women in order to inform family planning policy makers

FIGURE 1: FACTORS INFLUENCING DECISION MAKING AMONG WOMEN IN FAMILY PLANNING USE



1.3 JUSTIFICATION FOR THE STUDY

According to Maimbolwa (2003), high population growth is intimately linked to poor economic growth. The Government of Zambia is implementing a national Family Planning policy in an effort to decrease the country's population growth and, conversely, increase Zambia's economic growth.

Increasing women's access to modern family planning (FP) would serve to meet the contraceptive needs of women in Zambia, thereby slowing the country's high population growth rate and helping the country meet the Millennium Development Goals (MDGs) 4 and 5.

In order to reduce the population growth rate and meet the MDGs, family planning is one of the cost-effective strategies to employ. Maimbolwa (2003) stated that only 34% of married couples use contraception and that socio-cultural factors and lack of knowledge have prevented open dialogue of sexuality, and that 78% of primigravidae had never used any family planning method. In another study done by Banda, Bradley and Hardee (2004). It was reported that the women considered men to be a major barrier to condom use, further one provider revealed that most men are against their wives using family planning methods, as they believe that they can be barren, so women choose the injection, which cannot be detected by their husbands. Mutombo N. and Bakibinga P. (2014) stated that decisionmaking regarding fertility had been dominated by male decisions.

There are various socio-cultural factors that hinder the practice of Family Planning (FP). It is only with an understanding of these factors that Zambia can be effective in its FP programming. It is for this reason that the investigator of this research endeavoured to uncover those significant socio-cultural barriers to the uptake of FP in Zambia.

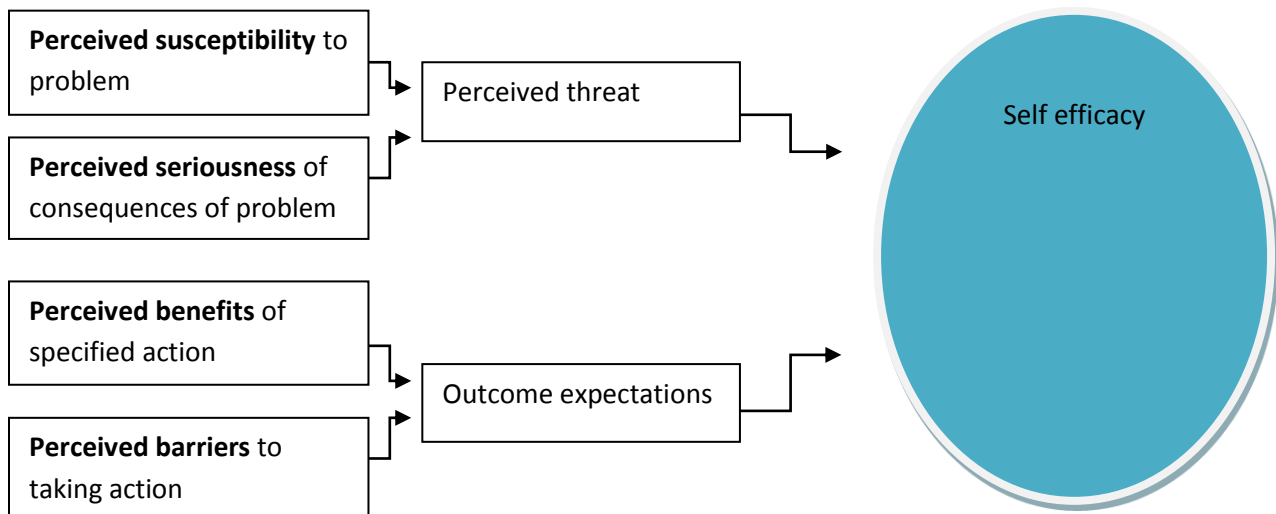
While few studies have been conducted to assess the barriers to modern FP uptake in Zambia, Livingstone in particular none of the studies have investigated the socio-cultural factors affecting decisions at the household level. The objective of the study was to determine the socio-cultural factors that are involved making decisions related use of modern family planning methods.

Study results will assist health care providers to plan the care according to the needs of the communities and render evidence based care and education concerning family planning use. The findings will be used to inform the design of Zambia's future FP programs and to give several recommendations which, it is hoped, will assist the Government to effectively address some of the challenges encountered in its operations.

1.4 RESEARCH THEORY

In this study, the Health Belief Model was applied to help to understand human behavior in family planning use. The health belief model (HBM) is designed to explain health behavior by better understanding beliefs about health. It was originally articulated to explain why individuals participate in Public health screening and immunization programs and has been developed for application to other types of health behavior. As its core, the model suggests that the likelihood of an individual taking action related to a given health problem is based on the interaction between four different types of belief (figure 2).

FIGURE 2: HEALTH BELIEF MODEL: MAJOR COMPONENTS AND LINKAGES



The model predicts that individuals will take action to protect or promote health. For example, if application of this model is to the need for families to limit the number of children to one, that is within the capacity of the household to support is considered, in order to adopt behaviors that minimize the risk of unwanted pregnancies the women, need to:

- Perceive themselves to be susceptible to have many children
- Perceive that having many pregnancies has potentially serious consequences
- Perceive that preventive measures are available that can reduce their susceptibility, or minimize the consequences of many children.
- Perceive that the benefits of taking action outweigh the costs or barriers.

The model applies to family planning if women know that they are susceptible to having many children, if they know that having many children has serious consequences on their lives, if they know that preventive measure are available that can reduce their susceptibility or minimize the consequences of unwanted pregnancies and that benefits outweigh the costs, they will be motivated to make decisions regarding family planning use. In this study if women perceive themselves to be susceptible to have many children, they will take action which is family planning methods to prevent having many children. If they also perceive that having many pregnancies have potentially serious consequences on their lives, they will take precautions not to have many pregnancies. If women perceive that preventive measures are available that can reduce their susceptibility, or minimize the consequences of many children, they will be willing to use family planning methods to minimize the consequences of many children. Also, if the women perceive that the benefits of taking action outweigh the costs or barriers to family planning uptake, they will be motivated to make their own decisions regarding family planning use.

1.5 RESEARCH QUESTION/S

For the purpose of this study, the research question was:

What are the factors influencing women's decision making in family planning use.

To what extent do these factors influence women's decision making in family planning

1.6 RESEARCH OBJECTIVES

The research objectives included general and specific objectives. These are discussed below.

1.6.1 General objective

The general objective of the study is to determine the factors that influence decision making regarding family planning use among mothers who delivered in Livingstone District.

1.6.2 Specific objectives

The specific objectives for this study were to:

- Assess whether the women's knowledge levels on family planning influences women's decision making in family planning use
- Establish whether male dominance play a role in women's decision making in family planning use.
- Determine if religion affects women's decision making in family planning use
- Establish whether male gender preference influences women's decision making in family planning use
- Assess whether fear of side effects influences women's decision making in family planning use
- Establish whether level of education influences women's decision making in family planning use

1.7 HYPOTHESIS

For the purpose of this study, a null hypothesis was considered and it is stated below.

1.7.1 Null Hypothesis

There is no association between women's decision making on family planning use and the following factors:

- Level of education
- Male dominance
- Male gender preference
- Dowry
- Polygamy
- Religion
- Knowledge
- Fear of side effects
- Family planning use decision making

1.8 DEFINITION OF TERMS

1.8.1 CONCEPTUAL DEFINITION OF TERMS

1.8.1.1 **Factors:** are the forces that characterize the relationships and activities of people in a specific region or area. They include: child rearing practices, cultural change and cross cultural differences. (Ethnicity Family Government and Regulatory Bodies Holidays Legal Military, 2009).

1.8.1.2 **Influencing:** To have an effect on other people (Cunningham, 1997).

1.8.1.3 **Women's decision making:** The process of selecting from several choices products or ideas, and taking action (© 2006-2013 decision-making-confidence.com).

Or it is the process of coming to a conclusion or making a judgment(Mosby's Medical Dictionary and Elsevier, 2009)

1.8.1.4**Family planning:** is a voluntary decision made by an individual or a couple on the appropriate number of children they wish to have, and when to have the children (Sunkutu et al. 2002).

1.8.1.5 **Women:** this refers to adult female human beings who are in the child- bearing age (Collins pocket English Dictionary, 2006).

1.8.1.6 Participation: to take part or become involved in an activity (Collins pocket English Dictionary, 2006).

1.8.1.7 **Contraceptive:** an agent to prevent contraception (Collins pocket English Dictionary, 2006).

1.8.1.8 **Uptake:** This is the rate or number of times of which women undertake contraceptives (Collins pocket English Dictionary, 2006).

1.8.1.9 **Dowry (lobola):** property or money brought by a bride to her husband on their marriage (Mosby's Medical Dictionary and Elsevier, 2009).

1.8.1.10 **Polygamy:** the practice or custom of having more than one wife at the same time(Mosby's Medical Dictionary and Elsevier, 2009)

1.8.1.11 **Religion:** a particular system of faith and worship (Collins pocket English Dictionary, 2006).

1.8.2 OPERATIONAL DEFINITIONS OF TERMS

1.8.2.1 **Knowledge:** This means the information and understanding women gained on family planning use through information, education and communication at the health facilities or through the media. In this study, women's knowledge levels on family planning use was measured by asking them 4 questions which included the definition of family planning, benefits of family planning, whether men can be involved in family planning and benefits of involving men in family planning. The knowledge levels were categorised into two categories namely adequate and inadequate. Respondents who scored below 6 on knowledge questions were classified as having inadequate knowledge and those who scored from 6 to 11 were classified as having adequate knowledge.

1.8.2.2 **Level of education:** This refers to stages of learning in the education system such as primary, secondary, College and University. This was assessed by asking the respondents the level of education they had attained.

1.8.2.3 **Male dominance:** This refers to males having influence or authority over women's decision making in family planning use. This was ascertained by asking women a yes and no question on whether husbands/partners had influence on decision making in family planning use. The respondents were asked to state whether dowry influences women's decision making in family planning use using a yes and no question and to state whether they were in polygamous marriage or not using a yes and no question.

1.8.2.4 **Gender preference:** These references to liking one gender than the other, for example liking male gender than the female. In this study women were asked to state whether gender preference influences women's decision making in family planning use.

1.8.2.5 **Fear of side effects:** In this study fear of side effect refers to not women not using modern family planning methods because of side effects of the methods. This was measured by asking the respondents a yes and no question on whether family planning methods side effects can prevent them from using the modern family planning methods.

1.8.2.6 **Religion:** This refers to particular system of faith and worship. This was measured by asking women to state their religion which could either be Christian or Muslim.

1.8.2.7 **Family planning use decision making:** This refers to who makes decides about use of modern family planning method. This was ascertained by asking the women state who makes decisions about modern family planning method use.

1.9 **STUDYVARIABLES**

The main variables for this study are the dependent variable and independent variable.

1.9.1 **Dependent variable**

The depended variable for this study is decision making in family planning use.

1.9.2 **Independent variable**

The independent variables for this study were knowledge, level of education, male dominance, polygamy, dowry, religion and fear of side effects.

TABLE 2: VARIABLES CUT OFF POINTS AND INDICATORS

Variables	Cut off point	Indicators
Dependent Variable		
Family planning use decision making	Yes	Makes decisions
	No	Does not make decisions
Independent variable		
Knowledge	High	Scores of 7 – 11 On knowledge
	Medium	Scores of 4-6 on knowledge
	low	A score below 3 on knowledge
Level of education	High	College or university education
	Medium	Secondary education
	Low	Primary or no education
Male dominance	Yes	Men involved in family planning decision making

Polygamy

No
Men not
involved in
family
planning
decision
making

Yes
In polygamous
marriage/think
polygamy
hinders
women
making
decision on fp
use

No
Not in
polygamous
marriage/
think being in
polygamy
does not
hinder women
making
decisions on
fp use

Dowry

Yes
Thinks dowry
payment
hinders
women
making
decisions on

Religion	No	fp use Does not think dowry payment hinders women making decisions on fp use
	Yes	Religion that discourage use of family planning
perception of side effects of fp	No	Religion that does not discourage use of fp
	Positive	Scores of 2 on side effects
	Negative	Scores 0-1on side effects

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the literature reviewed for this study is discussed. Burns and Grove, (2009) states that literature review is an organized written presentation of what has been written and published about a topic by other scholars and includes a presentation of research conducted in the selected field of study.

This chapter discusses the major factors influencing women's decision making in family planning use and focuses on primary sources of data with only selective secondary sources of data. The review highlights relevant research findings on factors influencing women's decision making regarding family planning use. Literature review helps to find out what others have reported on the problem, this helps the researcher to refine the problem statement and also to prevent duplication of work that has been done before. It also helps the researcher become familiar with different types of methodology as that may be used in the study, and to provide convincing arguments to why the particular study is needed. Literature review also provides the foundation on which to base new knowledge (Polit and Hungler, 2008).

Databases searched were, Pub med, Hinari, Internet, Google scholar, books, articles, professional papers and published and unpublished dissertations. In this chapter, literature review was conducted under the study variables giving the global, regional and national perspectives.

During this phase of literature review, the theoretical model will help to explain health behaviour by better understanding beliefs about health. It will explain why individuals participate in reproductive health services and also suggests that the likelihood of an individual taking part in family planning activities is based on their interaction between the four different types of the model. The model predicts that individuals will take action to promote health, only when they, perceive themselves to be susceptible to have many children, and that having many pregnancies has potentially serious

consequences, and perceive that family planning can reduce their susceptibility, or minimise the consequences of many children, and perceive that the benefits of taking family planning outweighs the barriers to family planning use.

2.2 DISCUSSION OF LITERATURE ACCORDING TO VARIABLES

2.2.1 Knowledge on family planning by women

Acquiring knowledge about fertility control is an important step towards gaining access to and then using a suitable contraceptive method in a timely and effective manner (Acharya et al 2010).

According to Frost and Lindberg (2013) for many women, sexual debut occurred prior to acquisition of adequate knowledge about contraception. The following quote depicts a woman's experience of an unplanned teen pregnancy: 'I didn't know anything about birth control when I was in high school. Me going to high school, I didn't even know I was pregnant. And I was still going through everything'. From this study, it can be seen that some women may not understand the seriousness of family planning and therefore cannot use family planning services.

According to a study conducted by Gule (1993) in Swaziland, knowledge of family planning methods, its impact on contraceptive use had been minimal, this was also found in a study conducted by Maimbolwa (2003) in Lusaka Zambia, which revealed minimal uptake of family planning methods. The study yielded virtually no data to explain why people who know of contraceptives, some of whom even desiring to use birth control, still do not use family planning. Salem in Roberts and Noyes (2009) found that women who had used contraception before were more inclined to have a greater awareness of different modern methods available. In countries where contraception uptake was low, for instance Eastern European countries and the United Arab Emirates (UAE), studies such as that by Kridli and Libbus (2001) in Roberts and Noyes (2009) showed that women with low previous experiences of contraception had a poor understanding of different available methods. Alpu and Fidan (2006) in Roberts and Noyes (2009) reported that women (of all ages) who had low contraceptive use were to have generally poor knowledge about contraceptive options with a stronger belief of

socio-economic traditions and religious beliefs. Further, poor contraceptive awareness and understanding was reported in many different societies, with large numbers of women over 40 years not believing in or using any contraceptive method at all (Binkowskset al., 2005; Ghazal-Aswadet al., 2001; Alpu and Fidan 2006) in Roberts and Noyes (2009). In another survey conducted by Sahin and Kharbouch (2007) in Turkey showed 80% of women not knowing at what age to stop using their chosen method (Roberts and Noyes 2009). Where contraceptive knowledge was limited, this subsequently influenced uptake and compliance. In the same study, Khan et al. (2002) found that women were more likely to miss pills, possibly up to 60% more if their understanding was poor. In a study done by Mumtaz and Salway (2007) in the Pakistan social context, knowledge of reproductive matters is considered 'shameful' and a 'culture of silence' surround these issues. Sable, Libbus, and Chiu (2000) revealed that lack of contraceptive use by women included inadequate knowledge about or problems with contraceptive methods.

In another study conducted by Kimani and Olenja (2001) educated women are more likely to delay marriage, use modern contraceptives, seek antenatal care, have fewer children, ensure their children are vaccinated, and experience lower infant and child mortality rates. The study also revealed that as levels of education rise among rural women, it influence their reproductive health decision-making. In another study done by Mairiga, Kullima, Bako and Kolo (2010) in Kanuri, Nigeria, showed that low patronage to modern contraceptives was a result of illiteracy. Another study conducted by Ajiboye, Olanrewaju and Adebayo (2012) revealed that individual and communal values, norms and perceptions are noted as responsible for the persistence of some cultural and religious practices, with its social concomitant effect on demographic behaviour in Africa and in particular among the Ogu community of Badagry.

According to the Zambia Demographic and Health Survey ZDHS (2007) knowledge on contraceptive method is almost universal with 98 per cent of women knowing one method of contraception. Modern methods are more widely known than traditional methods. Maimbolwa (2003) stated that socio-cultural factors and lack of knowledge

have prevented open dialogue of sexuality, and that 78% of primigravidas had never used any contraceptive method.

In conclusion, literature review found that women who had used contraception before were more inclined to have a greater awareness of different modern methods available. Where contraceptive knowledge was limited, this subsequently influenced uptake and compliance. Further, women who had low family planning use were to have generally poor knowledge about family planning options with a stronger belief of socio-economic traditions and religious beliefs.

2.2.2 Male dominance

Gender inequality in reproductive decision making is a key element of the social context of reproductive health. According to Frost, and Lindberg (2013), the male partner was often described as a barrier to effective family planning. One woman expressed her belief that the majority of men do not worry about preventing a pregnancy. A study done by Sable, Libbus and Chiu (2000) in Missouri found that among black women, the sexual partner was an important social referent in their use of oral contraceptives. In Rwanda, Muramutsa (2007) revealed that husbands or partners are key decision-makers in family planning and family size matters and that disapproval of the partner is a significant draw-back to contraceptive use.

According to Mundigo (1998), research shows that couples often disagree about the desirability of pregnancy and the use of contraceptives, and Speizer, White, and Cater (2005) in the same journal state, that women who have some decision-making power and autonomy often are better able than other women to meet their reproductive health goals. Ankra and Ettika (1997) in the same journal states that cultural norms in Kenya dictate that sex is for the man's pleasure and not the woman's.

In a study of socio-cultural factors affecting pregnancy outcomes among the Ogu people of Badagry, Lagos State, Nigeria, done by Ajiboye, Olanrewaju and Adebayo, (2012) attempt was made to examine the nexus of interaction between pregnancy outcome and cultural practices of the Ogu people of Badagry area of Lagos State, Nigeria. Further, maternal situation among the Ogu people of Badagry, Lagos State was exacerbated by

culture of patriarchy which gives men power over women in virtually all spheres of family decision life.

The dominance of the husband and his opposition to contraceptives, in conjunction with the woman's low social status, were reported by Beekle and McCabe (2006) in Roberts and Noyes (2009) to be limiting factors for African women. In the same study, Kamal (2000) reported that husband's approval of a chosen contraceptive method played a positive influence on acceptability and satisfaction in some communities. Beckman in Roberts and Noyes (2009) also found that the main influences on diaphragm usage were approval of the male partner and relationship factors. In another study done by Muramutsa (2007), Gender power in the couple unit was referred to by several female respondents as restricting women's ability to practice FP and, consequently, their ability to have more control over the number of children they bear. The research results suggested that family size was largely determined by the male partner. The study further revealed that, 'The respondents generally agreed that if a woman began using a contraceptive method without the knowledge of her husband, she would face serious consequences and that community health workers explained that male dominance was well accepted in the community (Muramutsa, 2007). The study further revealed that, family members (husbands, in-laws, parents) and community leaders (religious leaders) exerted considerable influence on women's decision to use a FP method; women were encouraged not to practice FP in order to perpetuate the family lineage. Husbands were referred to as exercising the most influence; that wives were told not to worry about having too many children because they would be provided for.

Men are decision leaders both at national and domestic levels. They have the greatest role to play if any change is to be encouraged in the home; they decide what is to be done in the home including matters of reproductive health. The ZDHS (2007) indicate that for married women, decision-making was highly dominated by husbands. However unmarried women were more likely than married women to make decisions by themselves, and that because unmarried women tend to be younger than married women and were often living with their parents or other relatives, decisions were often made by others.

Maimbolwa (2003) reported that, in Zambia the power sphere of many women is restricted to household work and that women have less say in reproductive health matters though it involves their bodies and sexuality. Maimbolwa (2003) further stated that decisions in matters of reproduction are usually made by the husband and that the husband is seen as the head of the family. In another study conducted by Banda, Bradley and Hardee (2004) in Lusaka, Zambia it was reported that the women considered men to be a major barrier to condom use, further one provider revealed that *‘most men are against their wives using contraceptives, as they believe that they can be barren, so women choose the injection, which cannot be detected by their husbands.’*

In another study conducted by Wegs et al. (2011) in Luapula province of Zambia it was revealed that men had final decision-making authority in the household, including making final decisions about family planning.

Mutombo and Bakibinga (2014) stated that decision-making regarding fertility has been dominated by males.

In conclusion, men are decision leaders both at national and domestic level; they have the greatest role to play if any change is to be encouraged in the home. Husbands were referred to as exercising the most influence in matters of reproduction; and that their wives were told not to worry about having too many children because they would be provided for.

2.2.3 Polygamy

In a study conducted by Gule (1994) it was reported that if in-laws were convinced that more children were still needed, they convinced, or even pushed the husband to take another wife, which is undesirable on the part of the first wife. This is true in most parts of Zambia especially southern province where polygamy is allowed.

In another study conducted by Mairiga, Kullima, Bako and Kolo (2010); it was reported that the Kanuri tribe where polygamous, as is the case in many African communities and one of the reasons for polygamy is to have many children. Kanuri men are polygamous and could marry up to four wives in order to form large families.

In another study conducted by Muramutsa (2007) in Rwanda it was revealed that it was culturally acceptable for the male partner to practice extra-marital sex or polygamy for

the following reasons; to have a son. If a wife had only given birth to girls, she faced a lot of pressure from her husband's family to give birth to a boy and the wife was no longer able to sexually satisfy her husband. Further, men leave their wives and remarry in an attempt to have boys. The study further revealed that, the pro-birth tradition in Rwanda could be interpreted as resulting from the genocide. According to Muramutsa (2007), Rwandans still felt the need to compensate for the loss of human lives during the genocide by having many children through polygamy. The study further revealed that, in the community, some couples refused to use FP by arguing that they needed to have more children because they lost children and family during the genocide.

A study by Makinwa and Adebusoye (2001) found that the effect of polygamy on fertility is complex, as it was revealed by the Nigerian Demographic and Health Survey (NDHS, 1999), which revealed that 35.7% of all married women were in polygamous households. (The ZDHS (2013-14) revealed that 12% of married women and 7% of married men are in polygamous union.) The study further revealed that another consequence of polygamy was that women marry at a very early age, since men take several wives, and that they put pressure on supply of girls. In addition the pressure to have more than one wife leads older men to recruit young girls into marriage thereby increasing the likely hood of women marrying polygously to be withdrawn from school and marry at an early age.

Polygamy (the practice of having more than one wife at the same time) has implications for frequency of sexual activity and fertility. According to ZDHS (2007) 16 per cent of married women were in polygamous unions. Also those women in rural areas were more likely to be in polygamous unions, and that polygamy was high in Central, Eastern, Western and Northern provinces with more than 20 per cent of married women in polygamous unions.

In conclusion, polygamy is one of the reasons for large families, and that it is culturally acceptable for male partner to practice extra-marital sex or polygamy, if a wife had only given birth to girls and that she faced a lot of pressure from the husband's family to give birth to a boy to carry on the family name after death of partner/husband.

2.2.4 Dowry

McLean (1990) in Gule (1994) stated that Swazi women view the practice of *lobola* (payment of bride price to the wife's family) as a cultural barrier to family planning. According to Gule (1994), they feel duty bound to bear many children, or the number of children dictated by their in-laws. In fact, if a woman proves to be barren, the *lobola* may be recalled from her family (Gule, 1994). The more daughters' one had, the more cows, through *lobola*, one could expect (Gule, 1994).

According to Kim (2005), bride wealth is common among many communities in Kenya, and that those men able to afford the bride wealth were mostly old men, which encourages polygamy and that once married, a young woman had little control over sexual matters.

Dowry was found to be a barrier to the uptake of family planning by women as they feel duty bound to bear many children or the number dictated by their in-laws.

2.2.5 Male gender preference

Gule (1994) stated that, pressure to have at least one son stems from the fact that Swaziland is a patriarchal society, where male children are valued because they would continue the family name. A woman who only has girls is under pressure to continue giving birth until a boy is born. However, Gule (1994) further stated that daughters were considered of more value than in the past since they were viewed as more reliable and stable sources of support for their parents, particularly for their mothers, who in many cases are left alone after the death of their husbands

According to Muramutsa (2007), the study revealed that the preference for male children “*Even your own family wishes you to have a boy in order to make your mother in law happy.*” Men leave their wives and remarry in an attempt to have boys; Rwandan women would prefer to give birth to boys so as to please their husbands and in-laws. The following statement further illustrated the importance of gender as a factor in the non-use of FP: «*There is a Kinyarwanda saying that when a woman gives birth to boys*

the family line is continued but when a woman gives birth to girls, the family line ends. And so men tend to value boys over girls (Muramutsa, 2007). The preference for boys over girls in Rwanda was described by Muramutsa as overruling the concern for family size. This suggested that the female gender in Rwanda remains under-valued. The value of sons in Rwanda may be explained, in part, by a burial tradition that requires the male parent, spouse, or sibling to be buried by male kin. For example, 'a wife cannot bury her husband and a daughter cannot bury her father'.

In a Nigerian study conducted by Mairiga, Kullima, Bako and Kolo (2010) children were highly valued and desired irrespective of their gender as both sexes fill a very crucial gap in the social and cultural life of a Kanuri family. The study further revealed that Kanuri people believe that the sex of the child does not matter because it is a gift from God and a blessing to the family. Couples with many children were respected; having many children was considered as insurance against the high child mortality prevalent in the area. The Kanuri also believed that children represented not only heritage of their descendants but were an asset for the parents in their old age (Mairiga, Kullima, Bako and Kolo, 2010). The study further revealed that the desire to have many children in the Kanuri community was common among African communities and evidently seen in the northern region of Nigeria. The 2003 National HIV/AIDS and reproductive health survey of Nigeria, indicated that the desire by the Kanuri to have these number of children was next only to the communities in the north-western region of the country, where 91% of respondents indicated their desire to have five or more children and that the decision was often left 'up to God' (that means as many as God wishes), as against 84% in Kanuri-dominated north-east and 51% in the south-west (Mairiga, Kullima, Bako and Kolo, 2010).

In another study conducted by Wegs et al. (2011) conducted in Eastern Province of Zambia, it was found that husbands' parents can have a strong influence and referred to consequences of not meeting their fertility expectations. Furthermore the in-laws would not accept a woman who decided not to have any children because they take pride in having grandchildren so they would consider her to be useless. They can even chase her from their son's home and ask their son to marry someone else.

Green (1995) in Phiri (2011) reported that if men are left out of the reproductive health equation, they are unlikely to exercise responsible behaviour in the effort to achieving reproductive health rights. Green (1995) in Phiri (2011) further reported that as interest in men's participation in family planning has grown; more attention is being given to learning how to reach them effectively so that family programmes become more inclusive. Mbizvo and Bassett, (1996) in Phiri (2011) also reported that the failure to target men in programmes has weakened the impact of reproductive health programmes since men can significantly influence their partners' reproductive health decision-making and the use of health resources.

Most studies revealed that children were highly valued regardless of the gender since children fill a crucial gap in the social and cultural life of a family, and that the sex of the child does not really matter because children are a gift from God and a blessing to the family. But some studies revealed that men would leave their wives and remarry in an attempt to have boys, and that even your own family wishes you to have a boy in order to make your mother-in-law happy. Therefore male gender preference was seen as a barrier to uptake of family planning

2.2.6 Fear of side effects

A study conducted by Sable, Libbus and Chiu (2000) in Missouri revealed that worries about the injectables side effects and dislike for irregular periods were perceived as greater barriers to use by the more highly educated women.

In another study conducted by Gule (1994) in Swaziland, some women feel that they should first prove their fertility before they can use contraceptives. This is tied to the belief that certain forms of contraceptives, such as the pill, could result in sterility.

Gule (1994) further stated that false rumours regarding side effects of contraceptives, and ignorance about how these methods work were key deterrents to their use in Swaziland (Swaziland Ministry of Health, 1990; Gule, 1993). Some contraceptive methods were falsely associated with medical problems. For instance, the pill was believed to destroy the uterus and ovaries resulting in sterility among women (McLean, 1990) in Gule (1994). The pill was also believed to cause impotence in the man, and wetness in the woman, resulting in reduced sexual pleasure. People fear that the condom, if it came off during sexual intercourse, would become lodged in the vagina

and would cause serious physical harm, thus leading to female sterility (McClean, 1990 in Gule (1994). The condom was also associated with reduced sexual pleasure.

According to Muramutsa (2007), fear of contraceptive side effects is a major barrier to FP practice in Rwanda. Side effects that affect women's ability to sexually satisfy their husbands were among the main reasons stated by female respondents for non-use of FP methods. The side effects most commonly referred to by participants included:

a) Loss of vaginal lubrication.

This seemed to be the side effect most feared by women. Loss of vaginal lubrication due to contraceptive use was referred to by Muramutsa (2007) as one reason for the non-practice of FP. He stated that the loss of lubrication reduced the male partner's sexual pleasure which would inevitably lead him to court other women.

b) Heavy bleeding

Several respondents pointed to prolonged menstruation as restricting men's sexual desire. This is indicated in the following responses from two participants: *"I know a friend of mine who used to take long in her monthly periods and when the husband would feel like having sex, she was bleeding."*

"One woman spent 2 entire months menstruating, and her husband ordered her to stop FP."

c) Loss of female sexual desire.

Respondents referred to a decrease in the female libido as affecting a woman's ability to sexually satisfy her husband this is reflected in one respondent's response: *"Once I took pills, I no longer wanted to have sex and my husband wanted to chase me away"* (Muramutsa, 2007).

Mairiga, Kullima, Bako and Kolo (2010), cited fear of delay in return to fertility, damage to the reproductive systems (especially the uterus) and the belief that modern contraception was introduced to reduce the population of Muslim nations, as reasons for not using modern family planning methods.

Mutombo and Bakibinga (2014) reported that since long-acting methods are very effective and coupled with myths about some side effects, women who have not attained this family size are generally less likely to use ILAPMs.

Literature review revealed that apprehension about side effects of some family planning methods was a barrier to the uptake of family planning methods. False rumours regarding side effects of some family planning methods and ignorance about how these methods work were key deterrents to their use.

2.2.7. Religion

According to Muramutsa (2007), religious beliefs had a significant barrier to FP practice in Rwanda: *“Some men...prevent their wives from using modern FP methods because of religious beliefs...”* the study further revealed that using modern FP methods was a sin: *“Contraception is like murder...It is a sin to oppose God’s law of reproduction.”*

Muramutsa (2007) further stated that religious leaders influenced couples’ decision to use modern FP methods by arguing that hormonal methods were equivalent to murdering the embryo. He further described the difficulty of accessing needed modern FP methods in areas where the closest health centre was faith-based: *“At the HealthCentre, Catholic Nuns discourage the use of modern FP methods.*

Mutombo and Bakibinga (2014) stated that factors affecting unmet need for contraception in Zambia include religion, the study reported that non-Catholics have higher (30%) use of ILAPMs of contraception than Catholic women (24%).

Religion was found to be one of the causes of poor use of family planning methods as most studies revealed that using modern family planning was a sin and it opposes God’s law of reproduction.

2.2.8 Level of education

According to Acharya et al. (2010), highly educated women are more likely to take part in decision making in their own health care. Traditionally, older women (mothers-in-law) make decisions about young women's health care in Nepal (Acharya et al., 2010). In addition, it has been reported that the low patronage to modern contraceptives was as a result of illiteracy (Mairiga, Kullima, Bako and Kolo, 2010). Furthermore some researchers have documented that educated women were more likely to delay marriage, use modern contraceptives, seek antenatal care, have fewer children, ensure that their children are vaccinated and experience lower infant and child mortality (Kimani and Olenja, 2001). Other studies reported that levels of education were high among urban women than women in the rural areas, who were accessing FP (Ajboye and Adebayo, 2012). Maimbolwa (2003) reported that utilization of health care is often related to educational level and that education of girls may be one of the most important ways of preventing unplanned pregnancies as education would create awareness about the need to access and use reproductive health services in time there by contributing to the prevention of early births and pregnancy complications.

According to the ZDHS (2007), educated women were more likely to use contraceptives than those who were illiterate, and that women in urban areas were more likely to use contraceptive methods (46 Percent) than their rural counterparts (28 per cent). The ZDHS further reported that use of modern methods of contraception was more common in urban (39 per cent) than rural (14 per cent).

Most studies revealed that lack of education was another deterrent in the use of family planning methods by women, and that low patronage to modern family planning methods was as a result of illiteracy.

2.3 CONCLUSION

Studies on family planning uptake revealed that women's access to Family Planning services and contraceptive use are influenced by educational level, fear of side effects, religious and cultural beliefs, and women's socio standing. Family planning providers could enhance the quality of women's contraceptive decision-making if they took a more active role in contraceptive counselling-for example, by relating information on specific methods to women's personal circumstances and helping clients weigh the advantages and disadvantages of various methods.

The reviewed works illustrate the complex nature of factors that can have an influence on decision making on family planning use by women and uptake of contraceptives as well as the low patronage of family planning services in general.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

Methodology refers to investigations of the methods of obtaining, organizing and analysing data. It addresses the steps, procedures, validation and evaluation of research tools or techniques that are used in a research investigation (Polit and Hungler, 2008). This chapter describes the research methodology used in this research. It comprises of the study design, study population, selection, data collection techniques, ethical consideration, pre testing, data analysis, dissemination and utilization of results and limitation of the study.

3.2 RESEARCH DESIGN

A research design is a researcher's overall plan for answering the research questions or testing the research hypotheses (Polit and Beck, 2004). The study used a survey descriptive study design with both quantitative and qualitative non-experimental approach. It was descriptive in nature because it set out to describe and document aspects of a situation (Polit and Hungler, 2008). The overall research design was qualitative. Data was collected through Focus Group Discussions (FGD) and in-depth interviews. Focus Group Discussions incorporated. The survey focused on what women in Livingstone District do to space their children or prevent conception and what they think about family planning. The study was quantitative in nature because it involved identification and exploration of numbers related to variables that gave insight in the nature of establishing the opinions and perceptions of issues of crucial interest. A survey is designed to obtain information about the prevalence, distribution, and interrelations of variables within a population (Polit and Beck, 2004). Examples of survey designs are, sample survey which use samples of individuals as compared to census survey which covers the entire population (Polit and Beck, 2004). A Survey was used to obtain information from women by means of self-report that is study participants responded to

a series of questions posed by investigator. Qualitative studies use an emergent design that is a design that emerges as researchers make on going decisions reflecting what has already been learned (Polit and Beck, 2004). In this study, the researcher had the inquiry based on the realities and viewpoints of those under study regarding family planning use decision making.

3.3 RESEARCH SETTING

Research setting is the physical location and conditions in which data collection take place in the study (Burns and Grove, 2003). The study was conducted in Livingstone District, which is in the Southern Province of Zambia. According to Central Statistics Office (CSO) (2000) Livingstone District has a population of 1,212,124; women are estimated at 51, 460 (ZDHS, 2007). The District has 16 constituencies or compounds and 6 Health Centers and one 2nd level hospital (ZDHS, 2007). Out of the 16 compounds, in the district Maramba compound was selected purposely since it is located within the researcher's reach and has the largest catchment population and the least family planning attendances. It will further provide the researcher with information necessary to test the hypothesis. Maramba has a catchment population of 29,950, and out of this 5,990 are females. This research setting was selected because it was easily accessible. The study was both community and clinic based. The interviews were held with women at the clinic and in the community while focus group discussions were conducted at the Health Centre. The Health Centre was also likely to avail the researcher with the target population. It was hoped that the selected setting would provide the information necessary to test the hypothesis.

3.4 STUDY POPULATION

The study population is the entire aggregation of cases that meets a specified set of criteria (Polit and Hungler, 2008). It consists of people with characteristics meeting the criteria set by the researcher. The study population comprised of 5,990 women in the age group 18-49 years of Maramba compound who delivered in the last three (3) months, whether they are using a family planning method or not.

3.4.1 TARGET POPULATION

The target population is the entire set of individuals or elements who meet the sampling criteria (Burns and Grove, 2009).

The target population was all women between 18 -25 years six, (6) days after delivery. This group was selected because they are the right people to provide first-hand information on the subject under study and was the age group that could give consent for undertaking a research, according to Zambian laws, and were in the reproductive age and liable to use family planning methods. According to the National Health Research Act any participant below 18 years is treated as a minor and thus require parental or guardian consent to participate in the study.

3.4.2 ACCESSIBLE POPULATION

This is the portion of the target population to which the researcher has reasonable access (Burns and Grove, 2009 ;). For this study, the accessible population was the target population who were available and willing to take part in the study.

3.5. SAMPLE SELECTION

Sample selection or sampling is the process of selecting a portion of the population to represent the entire population (Polit and Beck, 2004). In order to obtain a representative sample of the population selected for the study; the sample was obtained from the target population. The compound was selected using purposeful sampling method. Purposeful sampling is based on the belief that researchers' knowledge about the population can be used to hand pick sample members (Polit and Beck, 2004). Maramba compound was purposely selected because it is located within the investigator's reach and has the largest catchment population with the least family planning attendances.

Maramba compound has five sections, A, B, C, D and E. Three sections were selected using simple random sampling frame, where the sections are numbered consecutively and random numbers used to draw a sample. The first three numbers to be picked representing the section were selected. Maramba Health Centre was chosen purposely

because it is one of the areas which have the largest catchment population and had the least family planning attendances. The list of households was obtained from the Environmental Health Technician and the community health workers for the five (5) communities' were the study was conducted using a sampling frame. The community was selected using convenient sampling method. Convenient sampling involves selection of the most readily available persons as participants in a study (Polit and Beck, 2004).

Systematic sampling was used to select the households where the respondents were gotten from. Systematic sampling involves the selection of every kth case from a list or group (Polit and Beck, 2004). The households were selected using systematic sampling; an element of randomness was introduced in this type of sampling by using random numbers to select the household with which to start. The first household was randomly selected using random numbers, thereafter, selecting every 5th household on the list thus maintaining a sampling interval. From each household, if only one woman were found who meets the inclusion criteria the respondent was enrolled. Where there was more than one eligible respondent residing in the chosen house, then simple random sampling method was used to select one respondent.

Simple random sampling involved writing yes and no on a slip of paper according to the number of women found, but only two (2) papers had yes. The papers were put into a box or bag, then they were thoroughly mixed and then each woman picked a paper. The required numbers of slips for the sample were picked one after the other without replacement, while doing this; it was ensured that in successive drawings each of the remaining elements of the population had an equal chance of being chosen. This method resulted in the same probability for each possible sample.

Therefore, systematic sampling and random sampling were used to select the women who had delivered and were attending postnatal care and in the community.

3.5.1 Inclusion criteria

- Women in the child bearing age
- All women between 18 and 49 years of age
- Post natal women aged between 18 and 49 years residing in the study area
- Only those women who consented to participate in the study

3 . 5 . 2 Exclusion criteria

- Women below the age of 18 years and above who were pregnant
- Women aged above 18 years old who delivered who did not consent
- Women aged above 18 years not residing in the study area
- All men
- Women below 18years and 49 years old. Women outside this age group were excluded from the study because they were not part of the study population.

Purposive sampling was used to select FGD participant a judgment sample was obtained according to the discretion of someone who is familiar with the relevant characteristics of the population (Polit and Beck, 2004).

3 . 6 . SAMPLE SIZE

This is the smallest part of the population selected in such a way that individuals in the sample represent the characteristics of the population typically as “n” (Burns and Grove, 2003).A sample of 397 women who had delivered were included in the study due to inadequate resources and time limit in which the study was to be conducted. The sample size was calculated using Epi info version 7 statcalc command for descriptive study as in on the next page.

TABLE 3: POPULATION SURVEY FOR SIMPLE RANDOM SAMPLING

Population survey or descriptive study			
For simple random sampling, leave design effect and clusters equal to 1.			
Population size:	<input type="text" value="5990"/>	Confidence Level	Cluster Size
Expected frequency:	<input type="text" value="50"/> %	80%	160
Confidence limits:	<input type="text" value="5"/> %	90%	259
Design effect:	<input type="text" value="1.0"/>	95%	361
Clusters:	<input type="text" value="1"/>	97%	437
		99%	597
		99.9%	917
		99.99%	1209

Population size=5,990

Expected frequency=50%

Confidence limits = 5%

Confidence interval = 95%

n =361

Increased by 10% = 36.1

n=397

Focus group discussion (FGD) is an interview with a group of individuals assembled to answer and discuss questions on a given topic (Polit and Beck, 2004). Purposive sampling was used to select FGD participants. The sample for the FGD consisted of 14 women.

3.7 DATA COLLECTION TOOLS

Data collection is a process of gathering information needed to address a research problem (Polit and Beck, 2004). Data was collected over a period of three months. Two types of data collection tools were employed in this study and these were semi structured interview schedule and focus group discussion guide. The data collection tools for this study were translated into Tonga which most respondents at the study site understood, to ease and ensure uniformity in data collection

3.7.1. Semi structured interview schedule (Appendix I)

A pre tested semi structured interview schedule, translated into Tonga was used to collect data. This is a formal instrument used in structural self-report studies that specifies the wording of all questions to be asked to respondents. This helped to ask the respondents especially those who were illiterate and could not read or write. A semi structured interview schedule data collection was chosen because of the following advantages:

- i. It could be used in both the literate and illiterate to ask questions
- ii. Respondents were collected from a wide range of subjects
- iii. Questions were be clarified if they were misunderstood
- iv. Responses were obtained in depth

However the disadvantages of using a semi structured interview schedule is that it is time consuming and expensive and it may pose difficulties for women who are not good at expressing themselves verbally.

The semi structured interview schedule contained five (5) sections; Section A comprised of questions eliciting information on background of participants. Section B had questions concerning knowledge of the benefits of family planning and section C was to elicit information on male dominance in decision making, section D elicited information on the regions influence

family planning use decision making, section E elicited information on whether gender preference plays a role in the women's family planning use decision making and Section F elicited information on whether side effects influences women's decision to use family planning methods.

3.7.1.1. Validity of the semi structured interview schedule

Validity is the degree to which an instrument measures what it is supposed to be measuring (Polit and Beck, 2004).

In this study validity was measured by ensuring that the research sample was representative of the population. The questions were clearly constructed to avoid ambiguity. Furthermore, an extensive literature review was conducted before designing the tool and it was based on literature review. Experts in reproductive health and the research supervisors checked the questions in the interview schedule and the focus group guide. Pre-testing of the instruments was done to determine whether they would bring out the desired information, then adjustments were made on the content and sequencing of questions asked. A statistician was consulted during the design of the research tool and data analysis in order to eliminate data analysis and data interpretation errors.

3.7.1.2 Reliability of the semi structured interview schedule

Reliability is the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit and Hungler, 2001). Instrument reliability was ensured by standardizing the data collection instrument. The instrument was pre- tested by using a pre-test study in a similar environment on women with similar characteristics.

3.8. Focus Group Discussion Guide (Appendix II)

A focus group discussion guide was used to collect qualitative data. The FGD guide comprised questions on background of participants, knowledge of family planning, male dominance in family planning use decision making, religious influence in family planning use decision making, gender influence in women's family planning decision making and side effects of family planning.

A Focus Group Discussion refers to an interview with a group of individuals assembled to answer questions on a given topic (Polit and Beck, 2004). Purposive sampling was used to select 14 women from each section of the study area. Women who were included in the FGDs were women in the child-bearing age that had given birth and were available and willing to take part in the study. All women who were not in the child-bearing age were excluded, together with all those from other districts other than Livingstone. The two (2) focus group discussions that were conducted were according to age groups to facilitate free discussion. One group comprised of women (aged from 18-29 years) while the other group comprised of women (aged from 30-49 years). The Focus Group Guide comprised of three (5) sections. Section A comprised of questions eliciting information on background of participants, and questions concerning knowledge of and the benefits of family planning and section B elicited information on male dominance in decision making, section C elicited information on religious influence on family planning use decision making, section D elicited information on whether gender preference plays a role in the women's family planning use decision making and Section E elicited information on whether side effects influences women's decision to use family planning methods.

The other items on the Focus Group Guide included place and date of interview, number and composition of participants and instructions to interviewer. According to Burns and Grove (2009), focus group discussions are desirable because group dynamics can help people to express and clarify their views in ways that are less likely to occur in a one-to-one interview. The group may give a sense of "security in number to those wary of researchers or those who are anxious". However Burns and Grove (2009) state that FGDs may fail to bring out people's views because some people are uncomfortable expressing their views or describing their experiences in front of a group. Participants were encouraged to actively participate by giving each one of them chance to express their views. Excessively talkative participants were thanked for their contributions but were asked to give chance to the quiet ones to express their views also so that the discussions would not be dominated by the same participants. Each FGD took about 45 minutes to one hour, participants were assured of confidentiality and anonymity of all the data that were collected and this encouraged maximum participation.

3.8.1 Trustworthiness of qualitative data is the degrees of confidence qualitative researchers have in their data, using the criteria of credibility, transferability, dependability, and conformability (Polit and Beck, 2004). Credibility refers to confidence in the truth of the data and interpretations of them, in this study credibility was ensured by carrying out the study in such a way that enhanced the credibility of the findings, by the investment of sufficient time collecting data to have an in-depth understanding of the culture, language, or views of the group under study and to test for misinformation and distortions (Polit and Beck, 2004). The researcher focused on the characteristics or aspects of a situation or a conversation that were relevant to the phenomena being studied, this involved interviewing the women who had delivered and were in the study area. The data was collected at different times of the day so as to determine the congruence of the phenomenon across time (Polit and Beck, 2004) and by collecting data from different sites in study area to validate the data by testing for cross-tie consistency. The investigator used two researchers (supervisors) to analyze and interpret the data to reduce the possibility of a biased interpretation of the data. The researcher also used multiple methods of data collection through interviews and focus group discussions to develop a comprehensive understanding of a phenomenon. These methods provided an opportunity to evaluate the extent to which an internally consistent picture of the phenomenon emerged (Polit and Beck, 2004). The other way credibility was ensured was by ensuring that the research report contained information about the researchers, including information about credentials. In this research, the researcher is a nurse with a bachelor of science in nursing and majoring in maternal and child health.

The other criterion used to assess trustworthiness was dependability. Dependability of qualitative data refers to the stability of data over time and over conditions (Polit and Beck, 2004). The researcher ensured dependability by scrutiny of the data and other relevant supporting documents by an external reviewer.

The other criterion used to assess trustworthiness was on the confirmability of the data. Confirmability refers to the objectivity or neutrality of the data (Polit and Beck, 2004). Confirmability was ensured by developing an audit trail, that is a systematic collection of materials and documentation that allowed an independent auditor to come to conclusion about the data (Polit and Beck, 2004). The last method used to ensure trustworthiness was by

transferability. This refers to the generalization of the data that is the extent to which the findings can be transferred to other settings or groups (Polit and Beck, 2004). The researcher ensured transferability by generalizing the data to the entire District and by conducting a pre-test.

3.9 DATA COLLECTION TECHNIQUE

This refers to a method used to systematically gather information relevant to the research purpose, or the specific objectives, questions or hypotheses of a study (Burns and Grove, 2009).

The data collection techniques that were used for this study were face to face interviews and FGDs.

3.9.1. Data collection technique for quantitative data

Data collection technique is a procedure of collection of data needed to address a problem (Pilot and Hungler, 2008). Face to face interviews were conducted with each respondent. The semi structured interview schedule was translated into local languages namely Lozi and Tonga with the help of Language experts. Before the interview, the respondents were put at ease by establishing rapport. Then the purpose of the study was explained to the participants and permission was sought from them before the interview commenced. The respondents were interviewed by the researcher and were asked the same questions in the same order. The interviewer wrote down the respondents' responses as they answered the questions. The interviewer conducted at least six (6) interviews per day lasting about 30 to 45 minutes. The respondents were interviewed in a private room one at a time. At the end of the interview, the respondents were given the opportunity to ask questions and were thanked for participating in the interview.

3.9.2 Data collection for qualitative data

Focus group discussion is an interview with a group of individuals assembled to answer and discuss questions on a given topic (Polit and Beck, 2004). Two focus group discussions were conducted using a focus group discussion guide, one involving the age group 18 to 29, the second one involving those between 30-49 years old. The researcher engaged two (2) research assistants to help with recording and time keeping while the researcher was moderating the

discussion. The purpose of the FGD was to generate a lot of dialogue from the participants on the topic though other participants may be uncomfortable expressing their views or describing their experiences in front of a group (Polit and Hungler, 2001). Each focus group discussion consisted of 7 persons. Before the discussion, the moderator introduced herself and introduced the recorder. The participants were also asked to introduce themselves. The moderator encouraged participation by trying to avoid a question and answer session, clarifications were encouraged instead. The moderator led the discussion according to the set questions where as one of the research assistants acted as a recorder, and then the discussion was recorded on the audiotape. Each individual was given a chance to express her views freely to ensure maximum participation. Each FGD took about 45 minutes to one hour, anonymity and confidentiality were maintained.

3.10 PRE-TEST

A pre-test is the total group of individuals or objects meeting the designated criteria of the interest of the researcher. The purpose of the pre-test was to assess the feasibility of the study, the validity of the data collection tool and the possibility of processing and analysing the data collected. The pre-test was conducted at Linda Health Centre and community to find out on the socio cultural factors influencing women's family planning use decision making among women. Linda community, was purposely chosen because it was representative of the socio-cultural and economic background of the study population that was included in the main study. Thereafter, adjustments were made to the data collection tool as necessary. Forty (40) respondents were selected for the pilot study, which was ten per cent (10%) of the sample.

Two sections from the Health Centre catchment population were conveniently selected to conduct the pilot study. The first household was randomly selected using random numbers and thereafter, households were systematically selected and participants were interviewed using an interview schedule. If more than two eligible respondents were found in a household, simple random sampling was used to select only two respondents from each household.

One focus group discussion was conducted with 7 women in the age group 18 to 30 years to facilitate free discussion. These respondents were not part of those who were interviewed individually

After the pre-test, a few adjustments were made to the interview schedule as follows:-

- A provision was made on question 10 for respondents who had no monthly income.
- Respondents who responded that they had never heard of family planning on question 13 were, at that point asked what family planning is to enable them answer questions 15 downwards.

The pre-test helped identify weaknesses in the data collection tools.

3.11 ETHICAL CONSIDERATIONS

Ethics can be defined as a system of moral values that is concerned with the degree to which research procedures adhere to professionals. Legal and social obligations to the study participants (Polit et al., 2004). Ethics are moral values that are concerned with the degree to which the research procedures adhere to professional, legal and social obligations to the study participants (Polit and Beck, 2004). In this study, the researcher got written and consents from the Livingstone District Medical officer, and from the Town Clerk of Livingstone Municipal Council. Ethics clearance was obtained from the Eres Converge IRB. Verbal permission was obtained from the Health Centre, Community Health Workers and

Ward chairman where the study was conducted. The purpose and nature of the study was explained to the study participants. Those declined to participate were reassured that no privileges would be taken away from them. Those who agreed to take part in the study were requested to sign a consent form and the Illiterate women were made to thumb stamp the consent. Those who participated in the study were not remunerated in any way, due to inadequacy of funds. The respondents were in the natural setting and hence were not exposed to any physical and emotional danger or harm. Confidentiality and anonymity were maintained in that no names appeared on the answer sheets. Respondents were interviewed in a room where there were no other people to ensure privacy. After each interview the investigator put all questionnaires under lock and key and no other person was allowed access to the collected data.

Participants were not subjected to any physical harm as the study did not involve invasive procedures.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Data analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using those data (Polit and Hungler, 2008). Data were collected using semi structured interview schedules and a focus group guide. Semi structured interview schedules were used on 397 respondents and there was 100% response rate, and the Focus Group Guide was used on 2 groups of 7 women each, consisting of younger and older women respectively. The data were collected from 3 sections in Maramba catchment area in Livingstone District. A Pilot study was done at Linda, one of the Health Centres in Livingstone District, after which the main study was undertaken.

4.2 DATA PROCESSING AND ANALYSIS

4.2.1 DATA ANALYSIS

Data analysis entails reducing, organizing and giving meaning to the data (Burns and Grove, 2009). After data were collected, the data collecting instruments were checked for completeness, consistency, legibility and accuracy daily. Semi-structured interview schedules not completely filled in were clarified by through the note book to check for clarifications. Categorization of open ended questions, which involved reading through all responses and grouping answers that belonged together, was done. This enabled the researcher to report percentage of respondents giving answers that fell in each category. Codes were assigned to each category, entered and analysed using Statistical Package in Social Sciences (SPSS) version 16 program. Coding is the process of transforming data into numerical symbols that can be entered easily into the computer (Burns and Grove, 2009).

Closed ended questions were assigned numerical codes and entered into the computer and analysis was carried out using SPSS version 16 program. Confidence interval was set at 95 %. This means

that if the experiment were repeated several times and confidence limits were calculated from each sample, 95 % of the time they would include the true mean. Confidence interval is the range in which the value of the population parameter is estimated to be (Burns and Grove, 2009). A 5 % level of significance was set, only p values of 0.05 or less were considered statistically significant, thereby rejecting the null hypothesis. The Chi-Square test was used to test for associations between independent variables and dependent variables, which are knowledge, level of education, male dominance, polygamy, dowry, religion, fear of side effects and family planning use decision making. Data were displayed in 2 by 2 tables with 1 degree of freedom. Data were presented using frequency tables, histograms, pie charts and cross-tabulations to communicate research findings. Content analysis was used to analyse data from FGDs. Focus group data were transcribed, and translated. A full report of the Focus Group Discussions reflecting much of the information discussed was prepared. Data were analysed at both the individual level and group level, with participant's own words used to list the key statements, ideas, and attitudes. Comparisons were made across groups and consensus and interest in the topic generated in the discussion was attended to. Organization and integration of narrative, qualitative information according to emerging themes and concepts was done. The findings were then interpreted and the most useful information that emerged from the discussions was selected to illustrate the main ideas.

4.2.1.1 Quantitative data

Data analysis is the systematic organization and synthesis of research data, and the testing of research hypotheses using the data (Polit and Hungler, 2008). After data collection, the semi-structured interviews were sorted out and edited for internal consistency, completeness, legibility and accuracy. This was done to ensure quality control. For the interview schedules that were not completely filled in, the investigator checked the note book and tape recorder for clarification. Closed ended questions were assigned numerical codes. Coding is a method used to convert the data gathered during the study into symbols. Coding was done to ensure easy entry and analyses of data using the computer. Open-ended questions were assigned numerical codes and were processed as follows: the researcher read through the data in its entirety to identify and group answers that belong together. This process is known as categorization (Polit and Hungler, 2008). Following categorization, the investigator then assigned numerical codes (1, 2, 3, 4 and others) to different

categories. Categorization of open-ended questions in this way enables the researcher to report percentages of respondents giving answers that fall in each category. The codes were then entered and analyzed using Epi-info version 7 soft-ware and SPSS computer package version 20. In order to show variable associations, the researcher applied the chi-square. The chi-square tests the hypothesis that two variables are related only by chance. Chi-square was used to test for associations between independent and dependent variables. Independent variables were level of education, polygamy, male gender preference, dowry, religion, and fear of side effects. Basic bivariate cross-tabulations, followed by multivariate logistic regression methods were used to explore relationships between various socio-cultural factors and family planning decision making use. The confidence interval was set at 95% that is being 95% confident that the sample mean represents the population mean. Level of significance was set at 5%, only P values of 0.05 or less will be considered statistically significant thereby rejecting the null hypothesis. The data was presented using frequent tables, histograms, pie charts and cross tabulations which are an effective way of communicating research results. A full report of the focus group discussion was prepared that reflects the discussion as much as possible.

4.2.1.2 Qualitative data

After each focus group discussion, the tape recorder was played to the participants to check for consistency of the information recorded and study participants were asked to clarify any points which were not clear. Transcription of the data was done which involved writing a full report of the focus group discussions in Tonga. The data were then translated into English, using participants' own words and expressions. Data were read through to get the key points and general ideas expressed. Using the participant's own words, the key statements were listed, including the ideas, and attitudes expressed for each topic of discussion. Statements for each topic were categorized. Answers of the two subgroups (those 18-29 and 30 to 44) were compared. Data was analyzed using content analysis. Content analysis technique is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts; classically, a procedure for analyzing written or verbal communications in a systematic fashion (Polit and Hungler, 2001) and it provides a systematic means of measuring the frequency, order, or intensity of the occurrence of words, phrases, or sentences (Burns and Grove, 2003). Bivariate and multivariate analysis was

done. The findings were interpreted and the most useful quotations that emerged from the discussions to illustrate the main ideas were selected.

4.3 DATA PRESENTATION

4.3.1 Quantitative data

Research findings have been presented according to the sections of the semi structured interviews schedules. Some data have been grouped together to give an overall picture. Data have been presented using frequency tables, pie charts, histograms and cross-tabulations to communicate research findings. Tables were used because they are easy to understand and can be used for all types of data. Charts were used to avoid monotony in data presentation, while cross-tabulations were used to show relationships between variables

Table 3 in section A communicates the demographic characteristics of respondents and the tables, bar charts and pie charts in section B represent respondents' knowledge on family planning use. Section C represents male dominance, and the tables and pie chart in section D represent respondents' religious influence regarding family planning decision making.

Frequency tables, bars and charts in section E represent respondents, gender preference, while tables, bars and charts in section F represents side effects of family planning influence on family planning decision making. The cross-tabulations represent the relationship between variables.

4.3.2 Qualitative data

Focus group discussion data were summarized using a narrative. The narratives from the research participants have been presented in the chapter five.

SECTION A: RESPONDENTS' BACKGROUND INFORMATION
TABLE 4: RESPONDENTS' BACKGROUND INFORMATION

VARIABLE	FEQUENCY	PERCENT
Age		
15-24	173	43.6%
25-34	173	43.6%
35 and above	51	12.8%
Total	397	100%
Marital status		
Single	99	24.9 %
Married	294	74.1 %
Divorced	2	5 %
Widowed	1	3 %
Separated	1	3 %
Total	397	100%
Educational level		
None	12	3.0 %
Primary	98	24.7 %
Secondary	248	62.5 %
College	38	9.6 %
University	1	.3 %
Total	397	100%
Religion	395	99.5
Christian	2	.5
Muslim	397	100%
Total		
Occupation		
House wife	186	46.9
Self employed	77	19.4
Formally employed	40	10.1
Un employed	57	14.4
Students	37	9.3
Total	397	100%
Years in present marriage		
Above 5 years		
4-5 years	131	44.4 %
2-3 years	48	16.3%
Below 2 Years	52	17.6 %
Total	64	21.7 %
	397	100%
Type of marriage		
Monogamy	280	94.9 %
Polygamy	15	5.1 %
Total	397	100%
Payment of dowry		
Yes	239	60.2 %
No	158	39.8 %
Total	397	100%
Number of children		
1-2	262	66.0
3-4	80	20.2
4-5	41	10.3
above 5	14	3.5
Total	397	100%
Level of education of spouse		
None	12	3.0 %
Primary	98	24.7 %
Secondary	248	62.5 %
College	38	9.6 %
University	1	.3 %
Total	397	100%
Monthly income		
Below K500	52	13.1 %
K500-K1,000	45	11.3 %
K1,000 and above	25	6.3 %
None	275	69.3 %
Total	397	100%

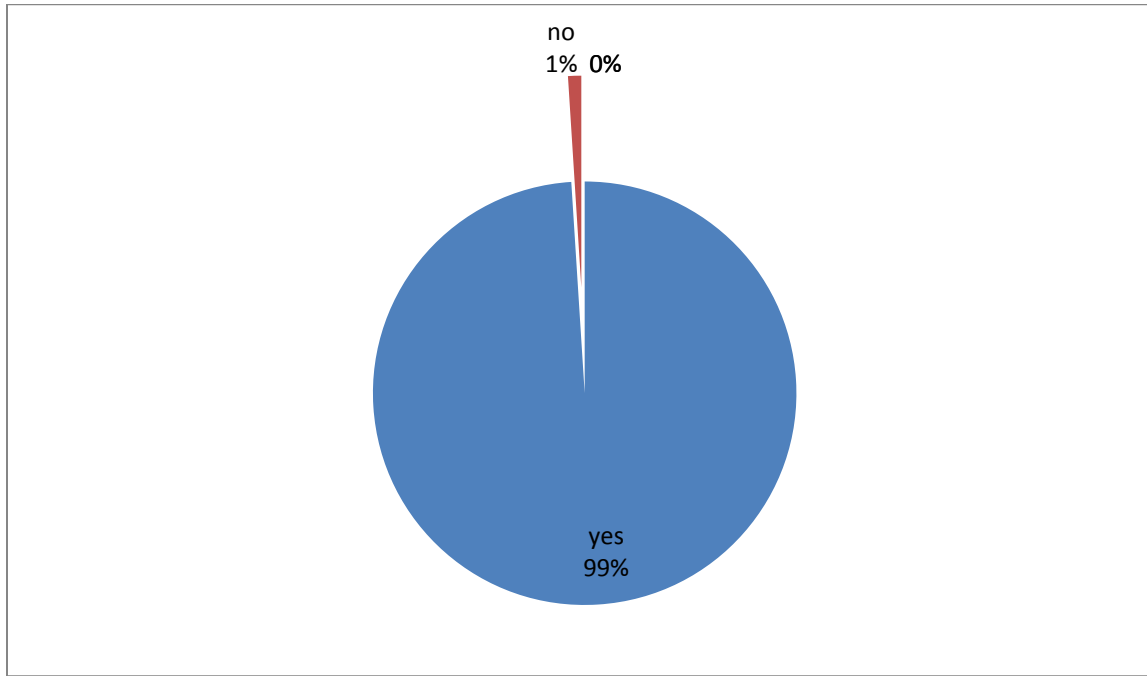
As indicated in Table 4, a total of 397 women were interviewed and their age data was categorised into three (3) age groups. The study revealed that 43.6% or 173 respondents were between 15 and 24 years, another 43.6% (173) were between 25 and 34 years whereas 12% (51) were in the last age group of between 35 and 44 years. The study revealed that 99 respondents (24.9%) were single whereas the majority constituting 74.1% of the total or 294 respondents were married. 2 respondents were divorced, 1 was separated and another 1 was widowed.

The findings were that 280 respondents, constituting 94.9% of the total sample, were in monogamous marriage and 15 or 5.1% were in polygamous marriage. Nearly all the respondents (99.5%) were Christians and only 2(.5%) were Muslim by religion. Most of the respondents (62.5%) had attained secondary education. These were followed by those who had attained primary education who made up 24.7% of the total respondents, which translates into 98 responses, 38 respondents or 9.6% had attained college education, 12 respondents (3%) had not attained any level of education whereas only 1 respondent (.3%) had attained university education.

The study revealed that majority 186 (46.9%) of respondents were housewives, 19.4% were self-employed and 10.1% were in formal employment, while 14.4% were unemployed and these were mostly singles. The study further revealed that the majority 69.3% had no source of income, 13.1% earned below K500, 11.3% earned between K500 and K1, 000 per month, while 6.3% earned above K1, 000 per month. The majority (66%) of the respondents had 1-2 children, 20.2% had 3-4 children, and 10.3% had 4-5 children, while 3.5% had above 5 children.

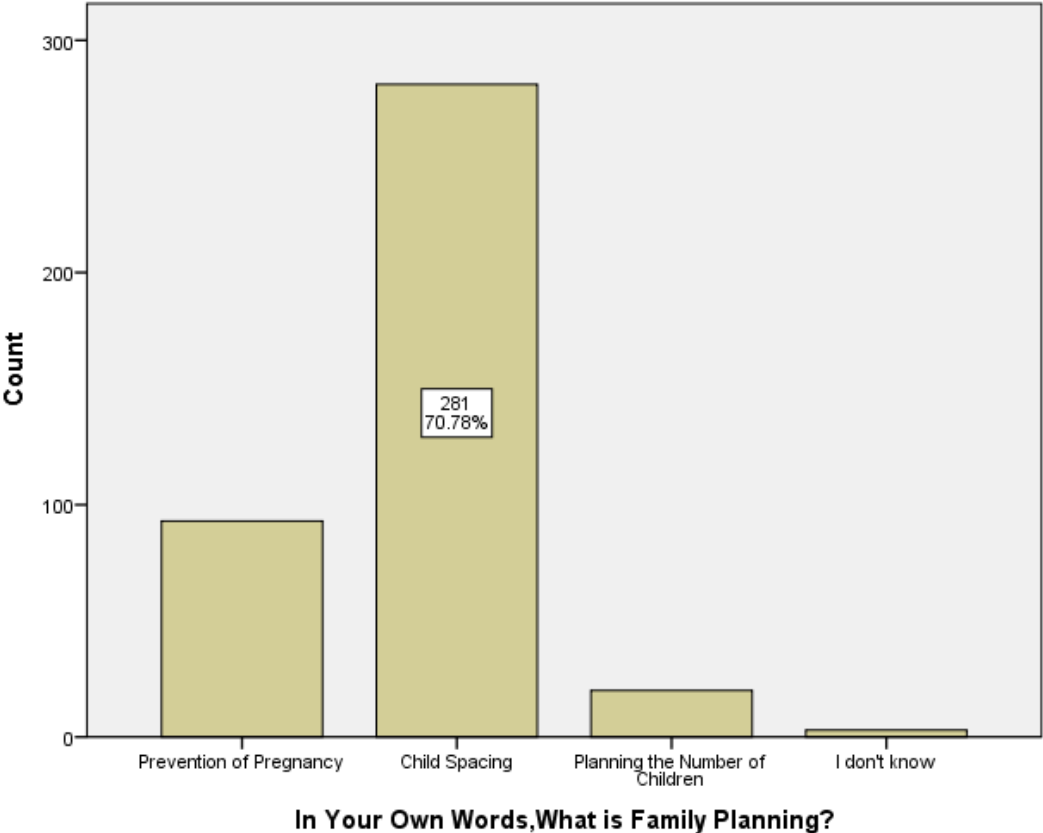
SECTION B: INFLUENCES OF KNOWLEDGE ON WOMEN'S DECISION MAKING IN FAMILY PLANNING USE

FIGURE 3: HAD HEARD ABOUT FAMILY PLANNING (n=397)



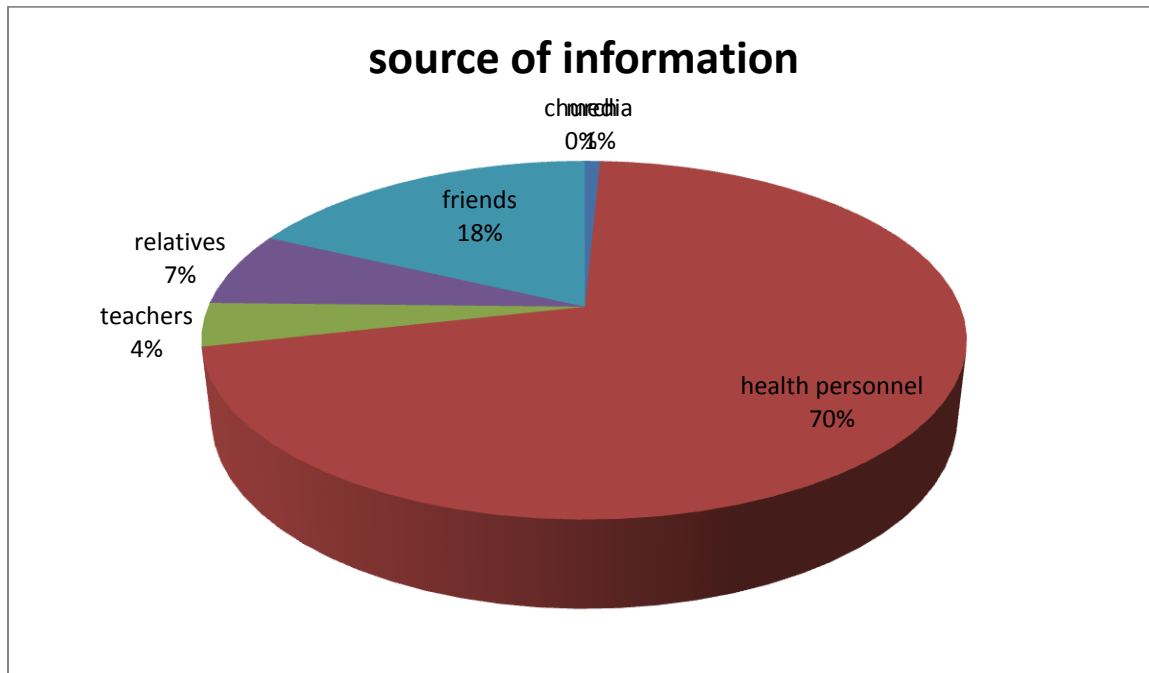
The study revealed that the majority (99.0%) of respondents had heard about family planning, while 1% had not heard about family planning.

FIGURE4: DEFINITION OF FAMILY PLANNING BY THE RESPONDENTS



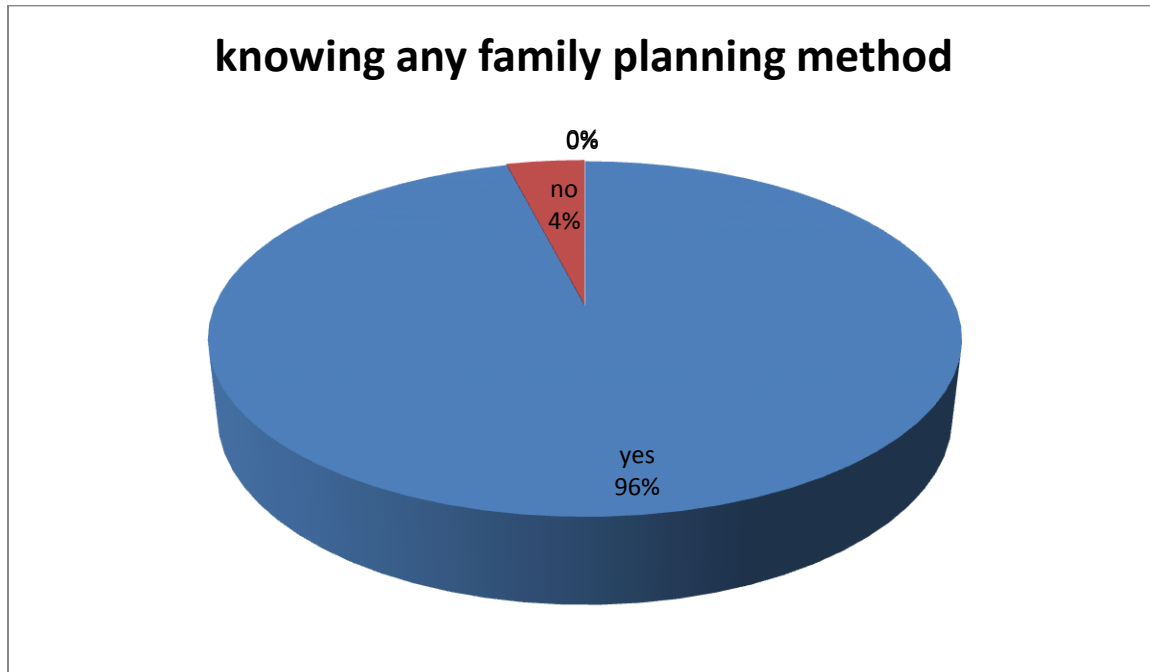
Majority (70.8%) of respondents said that family planning was child spacing, 23.4% said it was prevention of pregnancy, 5% said it was planning the number of children and .8% did not know the definition of family planning.

FIGURE 5:RESPONDENTS SOURCE OF INFORMATION ON FAMILY PLANNING



Majority 74.1% of the respondents source of information on family planning were health personnel,18.8% got the information from friends, and 4.1% got the information from teachers, 1.8% from relatives , and .5% got the information from the church.

FIGURE 6: AWARENESS OF FAMILY PLANNING METHOD BY THE RESPONDENTS (n=397)



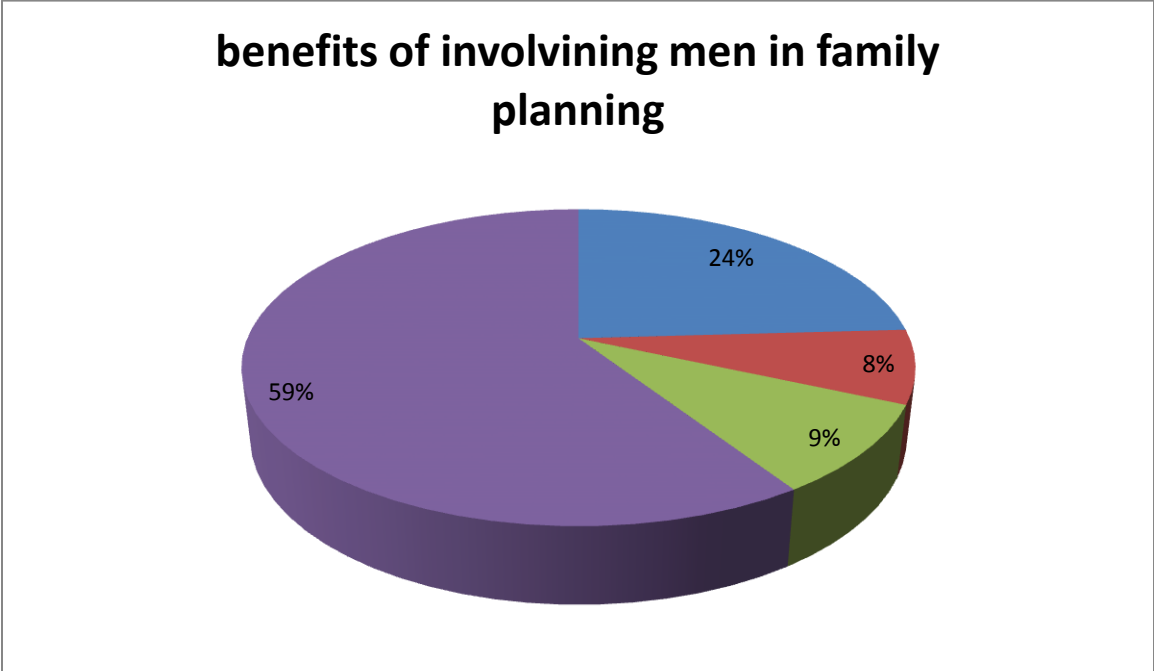
The majority 96.0% of respondents know about some family planning method and 4.0% do not know of any family planning method.

TABLE5: RESPONDENTS RESPONSES ON MALE INVOLVEMENT IN FAMILY PLANNING

MALE INVOLVEMENT	FREQUENCY	PERCENT
Yes	204	51.4 %
No	193	48.6 %
Total	397	100%

Majority 51.4% thought that men could be involved in family planning, and 48.6% thought men could not be involved in family planning

FIGURE 7: BENEFITS OF INVOLVING MEN IN FAMILY PLANNING



Most of the respondents (59%) stated that the benefits of involving men in family planning were to avoid problems at home, 24% said that it is important that men know the importance of child spacing, 9% said that they encourage you to take family planning pills and 8% thought that the benefits were that it helps to plan the family well.

SECTION C: INFLUENCES OF MALE DOMINANCE ON WOMEN'S DECISION MAKING IN FAMILY PLANNING USE

FIGURE 8: RESPONDENTS' RESPONSES ON DECISIONON USE OF FAMILY PLANNING METHOD

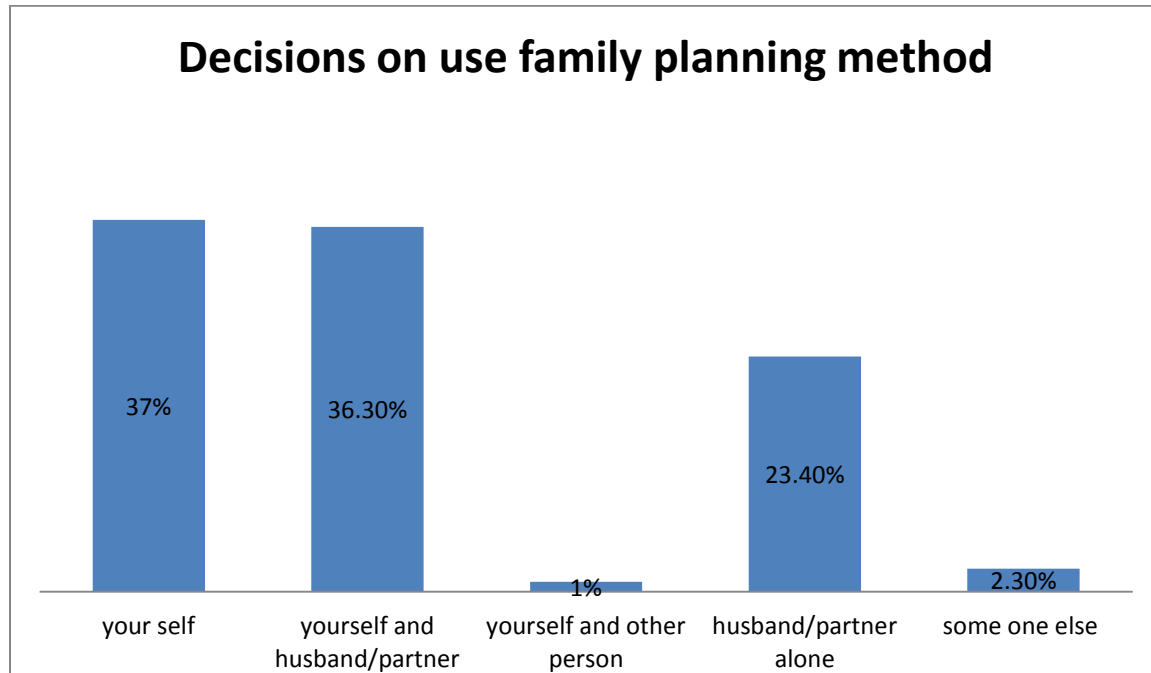
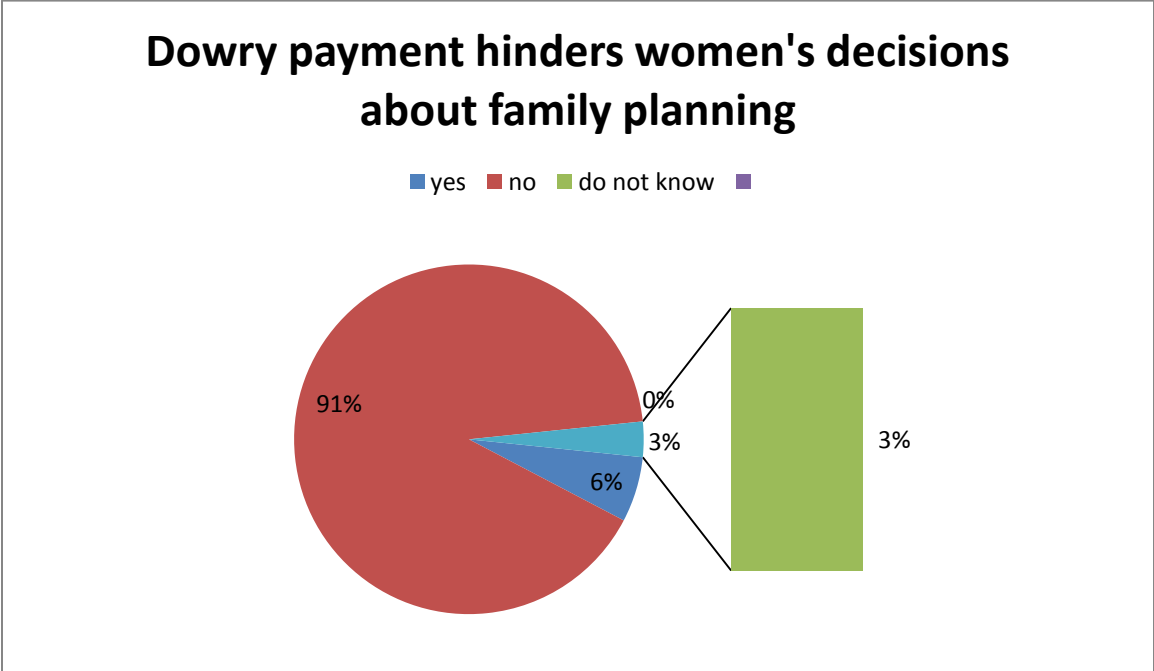


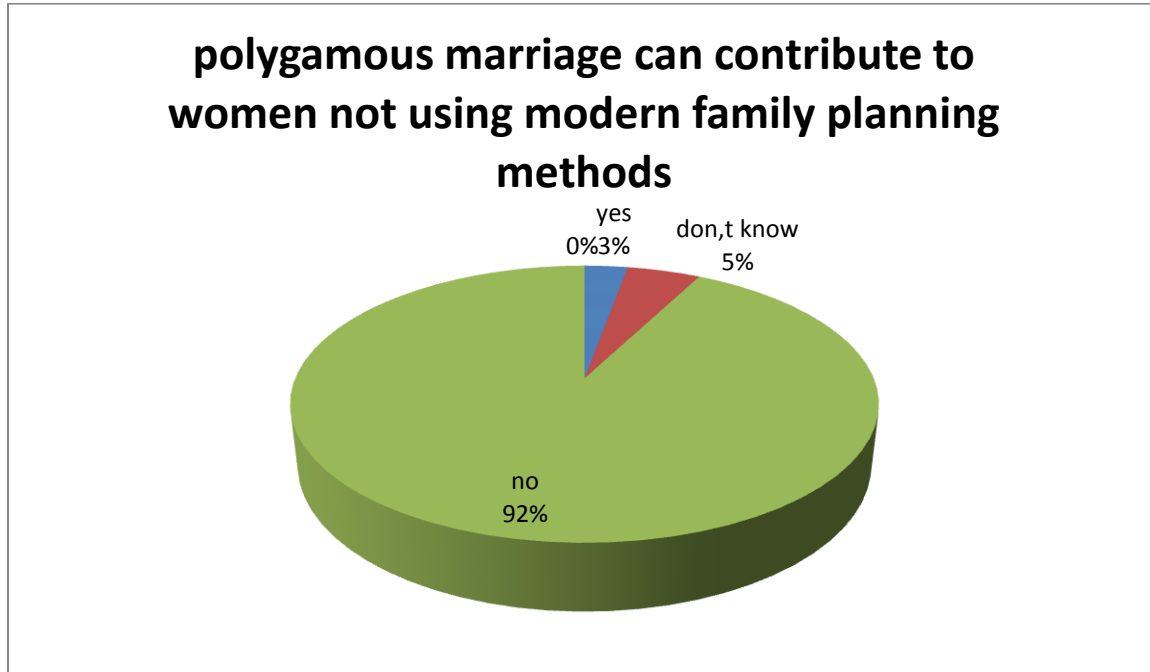
Figure 8 shows that some 37% of the respondents reported making family planning decisions by themselves , 36.3% made the decision together with their husband/partner, 23.4% reported that the decision was made by their husbands/partner alone, 2.3% reported that the decision was made by someone else and 1% reported that the decision was made by themselves and another person.

FIGURE 9:DOWRY PAYMENT HINDERS WOMEN ‘S DECISIONS ABOUT FAMILY PLANNING USE (n=397)



In figure 9,the study revealed that the majority (91%) of the respondents thought that dowry payment by the husband does not hinder women’s decisions about family planning use, while 6% thought that dowry payment hinders women’s decision about family planning use. 3% of the respondents did not know whether dowry payment hinders women’s decision about family planning use .

FIGURE 10: POLYGAMOUS MARRIAGE CONTRIBUTES TO WOMEN NOT USING FP METHODS



Majority (92%) of the respondents did not think being in polygamous marriage could contribute to women not deciding to use family planning methods, (3%) thought otherwise, while (5%) did not know.

TABLE 6: REASONS ON WHETHER POLYGAMOUS MARRIAGE CONTRIBUTES TO NON USE OF FAMILY PLANNING METHOD

REASON	FREQUENCY	PERCENT
Competition to have more children	16	94.1%
Man makes decision on family planning use	1	5.9%
Total	17	100%

Of those who said that polygamous marriage could contribute to women not using family planning method, 16(94.1%) gave a reason that there was competition to have more children than other wives in a polygamous marriage, 1(5.9%) mentioned that it is a man who has to decide that a wife uses a family planning method

SECTION D: RELIGIOUS INFLUENCE ON WOMEN'S DECISION MAKING IN FAMILY PLANNING USE

Figure 11 shows that majority 343(86.4%) of respondents reported that religion does not forbid use of family planning methods, 38(9.6%) reported that religion forbids use of family planning methods, while 16(4.0%) did not know.

FIGURE 11: RESPONDENTS RESPONSES ON WHETHER RELIGION FORBIDS USE OF MODERN FAMILY PLANNING METHODS

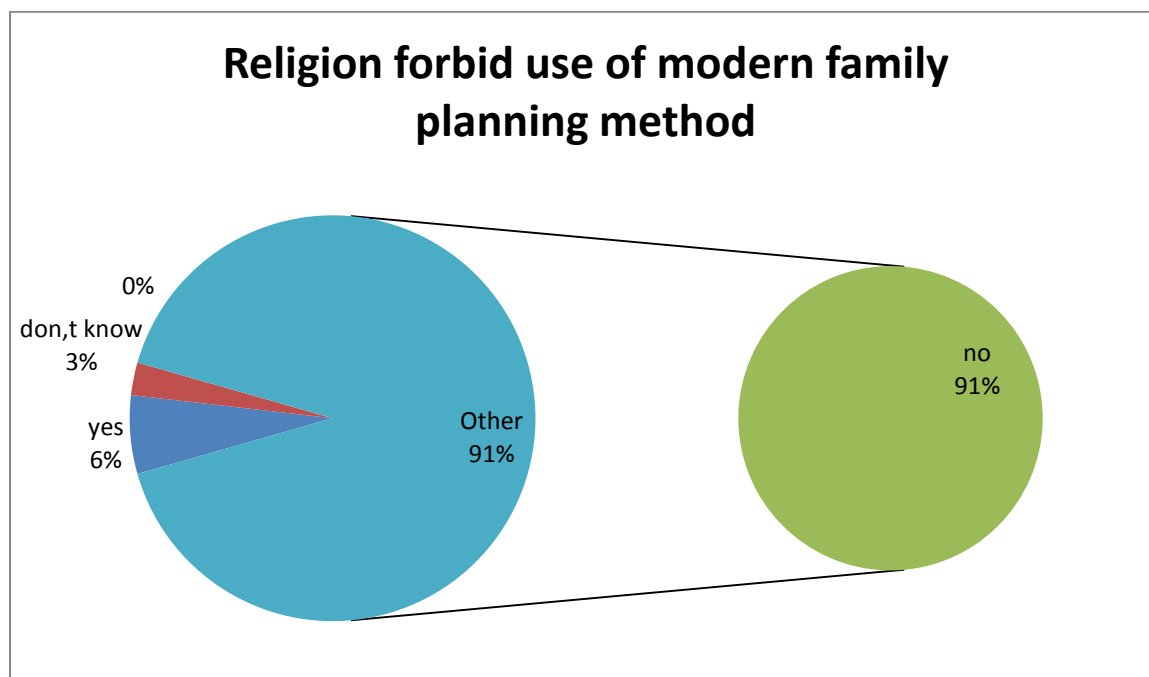


Figure 11, shows that most (91%) of the respondents stated that their religion did not forbid them from using modern family planning methods.

TABLE 7: RESPONDENTS REASONS WHY THEIR RELIGION FORBIDS USE OF MODERN FAMILY PLANNING METHODS

Reason	Frequency	Percent
Family planning kills children	18	47.4
Family planning is a sin	16	42.1
God forbids use of family planning because He told mankind to go out and multiply	4	10.5
Total	38	100

Table 7 indicates that of the respondents who stated that their religion forbid use of modern family planning, 47.4% gave a reason that family planning kills children, 42.1% stated that use of family planning is a sin and 10.5% stated that God forbids use of family planning because he told mankind to go out and multiply.

SECTION E: GENDER PREFERENCE

FIGURE 12: RESPONDENTS RESPONSES ON WHETHER ONE GENDER OF CHILDREN HINDERS WOMEN FROM USING FAMILY PLANNING METHODS

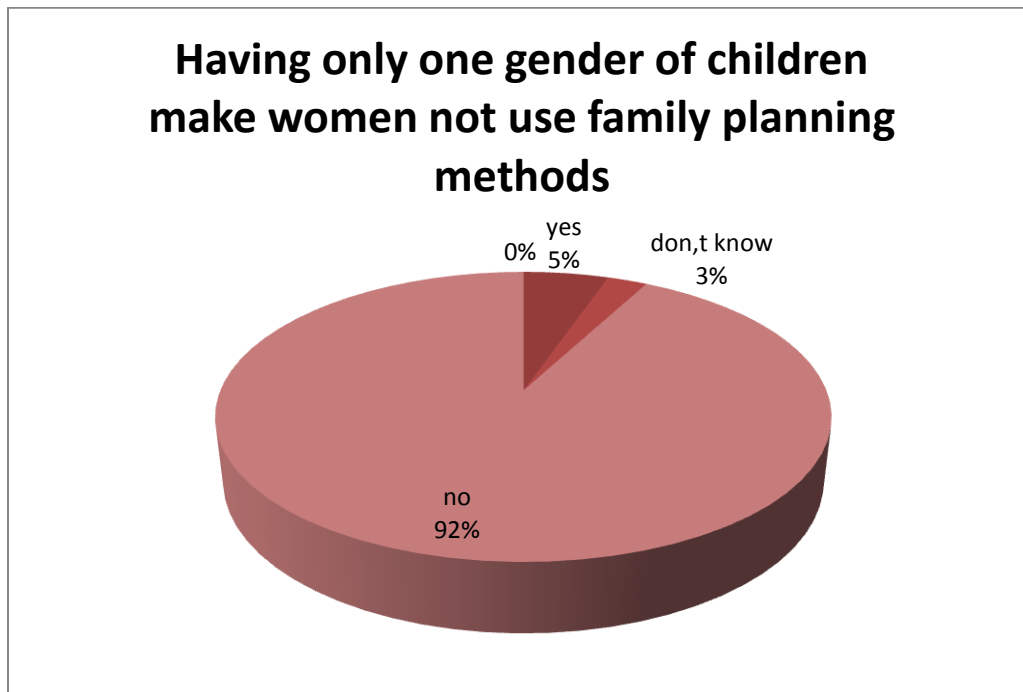


Figure 12 indicates that majority 92% of respondents did not think that having only one gender of children make women not use family planning methods, 5% thought having only one gender of children make women not use family planning methods, while 3% did not know.

SECTION F: INFLUENCES OF FEAR OF SIDE EFFECTS ON WOMEN'S DECISION MAKING IN FAMILY PLANNING USE

Figure 13: Respondents responses on whether side effects of modern family planning methods can prevent women from using family planning methods

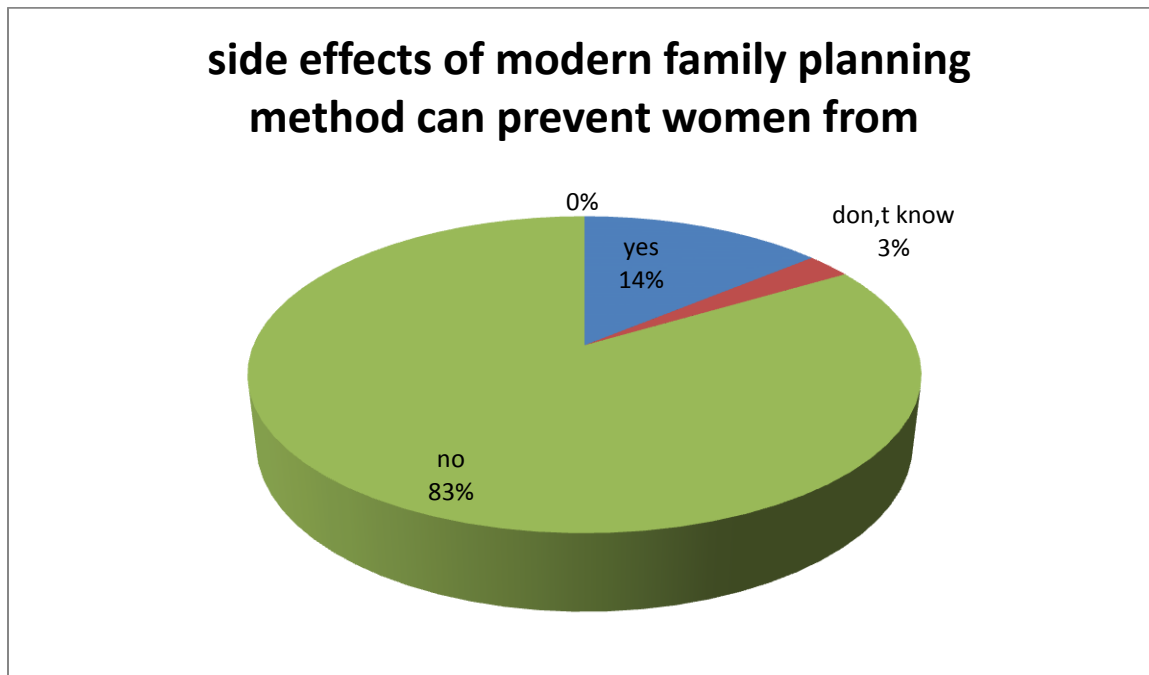


Figure 13 shows that majority 83% of respondents thought that side effects of some family planning methods could not prevent women from using a family planning method, 14% thought that fear of side effects of some family planning methods could prevent women from using a family planning method, while 3% did not know

Figure 14: Respondents responses on the side effects that could prevent women from using modern family planning methods

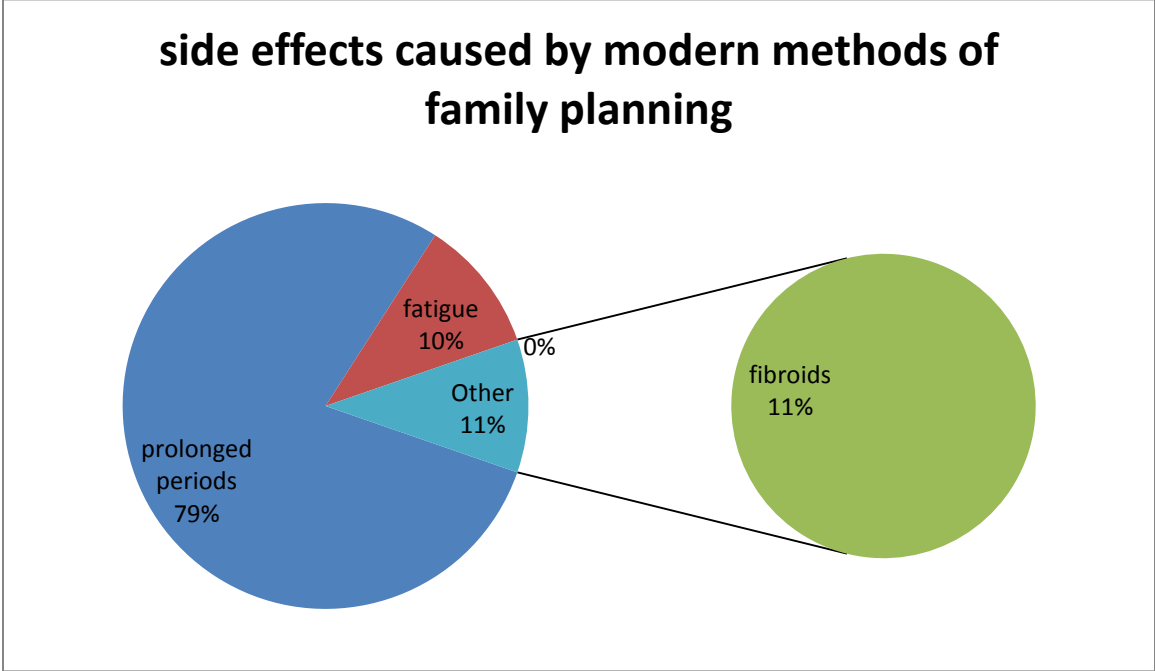


Figure 14 above shows family planning methods side effects that prevent women from using modern methods of family planning, 79% of the respondents mentioned that family planning caused prolonged periods, 11% mentioned fibroids and 10% mentioned fatigue.

SECTION G: RELATIONSHIP BETWEEN KNOWLEDGE AND WOMEN'S DECISIONS ON FAMILY PLANNING USE

There is no association between women's decision making on family planning use and the following factors:

- Level of education
- Male dominance
- Male gender preference
- Dowry
- Polygamy
- Religion
- Knowledge
- Fear of side effects

Table 8: Relationship between decision making in family planning use and the respondents' demographic characteristics

Demographic data	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Age						.014
15-24	64	55	4	41	9	
25-34	62	69	0	42	0	
35 and above	21	20	0	10	0	
Marital status						.000
Single	53	18	3	17	8	
Married	92	124	1	76	1	
Divorced	1	1	0	0	0	
Widowed	1	0	0	0	0	
Separated	0	1	0	0	0	
Education level						.033
None	2	6	0	3	1	
Primary	35	30	0	31	2	
Secondary	101	83	4	54	6	
College	8	25	0	5	0	
University	1	0	0	0	0	
Occupation						.000
House wife	65	68	1	51	1	
student	18	8	2	5	4	
Formally employed	7	28	0	5	0	
Self employed	29	33	0	15	0	
Unemployed	28	7	1	17	4	
Years in marriage						.572
Below 2years	20	30	1	14	1	
2-3 years	15	27	0	13	0	
4-5 years	18	16	0	14	0	

Above 5 years	41	56	0	35	0	
Type of marriage						
monogamy	88	127	1	70	1	.613
polygamy	6	4	0	6	0	
Dowry						
Yes	75	103	1	59	1	.000
No	72	41	3	34	8	
Number of children						
1-2	98	91	4	60	9	.382
3-4	27	35	0	18	0	
4-5	16	16	0	9	0	
Above 5	6	2	0	6	0	
Spouse's occupation						
Formally employed	35	50	1	26	0	.908
Self employed	51	69	0	42	1	
Un employed	7	10	0	8	0	
Monthly income						
Below k500	15	22	0	15	0	.001
Between k500- k1,000	21	18	0	6	0	
Above k1,000	2	20	0	3	0	
none	109	84	4	69	9	

Table 8 shows associations between demographic characteristics of the respondents with family planning use decision making. Six factors Age, marital status, education level, occupation, dowry, and monthly were significantly associated with family planning use decision making. Respondents who were aged 15-24 were able to make decisions about family planning use themselves than the other age groups (43.5%, p value= 0 .014).

Respondents who had secondary education were able to make own decisions about family planning use (69%, p value = 0.033) than those with lower levels of education. Respondents who were

married were able to make decisions either by themselves (62.5%, p value =0.000) or with their partners (86%, p value = 0.000) than those who were not married. Respondents who had dowry paid by their husbands/partners were able to make decisions on family planning use together with their husbands/partners (71.5%, p value =0.000) than those whose husbands/partners did not pay dowry. Respondents who had no source of income were able to make decisions on family planning use by themselves (74%, p value =0.001) or with their husbands/partners (58.3%, p value = 0.001).

Table 9: Relationship between decision making in family planning use and male gender preference

Male gender preference	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Yes	6	8	0	6	1	.272
No	138	135	4	81	8	
Do not know	3	1	0	6	0	

Table9, above shows association between decision making in family planning use and male gender preference. Respondents who said no to male gender preference made decision on family planning use by either themselves 138 (94%) or together with their husband/partner135 (92%,) p value= 0.272). Male gender preference was not significantly associated with decision making in family planning use.

Table: 10 Relationship between decision making in family planning use and religion

religion	Family planning decision making					P -Value
	Self	Self/husband/ partner	Self/another person	Husband/Partner alone	Someone else	
Christian	146	144	4	91	9	.825
Muslim	1	0	0	1	0	

Table 10 shows association between religion and decision making in family planning use. Christians had no significant associations between religious influence and women’s decision on family planning use (99.3%, p value =0.825)

Table: 11 Relationship between decision making in family planning use and knowledge

knowledge	Family planning decision making					P -Value
	Self	Self/husband/ partner	Self/another person	Husband/Partner alone	Someone else	
Yes	146	142	3	93	9	.000
No	1	2	1	0	0	

Table11, above shows significant association between decision making in family planning use and knowledge levels. Respondents who had knowledge on family planning use made decisions by either themselves (99.3%, p value = 0.000) or with their husbands/partners (99%, p value =0.000).

Table: 12 Relationship between decision making in family planning use and fear of side effects

Fear of side effects	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Yes	37	22	1	29	4	0.261
No	105	113	3	61	4	
Do not know	5	8	0	0	1	

Table 12 above shows no significant association decision making in family planning use and fear of side effects.

Table: 13 Relationship between decision making in family planning use and dowry

dowry	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Yes	75	103	1	59	1	.000
No	72	41	3	34	8	

Table 13 shows significant association between decision making in family planning use and payment of dowry. Respondents who had dowry paid by their husbands'/partners, revealed that the respondents either made decisions by themselves 75 (51%, p value = 0.000) or made decisions with

their husbands/partners 103 (71.5%, p value = 0.000). Further their husbands made decision alone on family planning use 59 (63.4%, p value = 0.000) than those whose husbands did not pay dowry.

Table: 14 Relationship between decision making in family planning use and polygamy

Polygamy	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Yes	6	10	0	1	0	.689
No	132	122	3	86	8	
Do not know	9	12	1	6	1	

Table 14 shows associations between polygamy and decision making in family planning use. The table showed no significant relationship between polygamy and family planning use decision making p value = .689)

Table: 15 Relationship between decision making in family planning use and male dominance

Male dominance	Family planning decision making					P -Value
	Self	Self/husband/partner	Self/another person	Husband/Partner alone	Someone else	
Yes	140	140	4	90	7	.066
No	7	4	0	3	2	

Table 15 showed no significant association between male dominance and decision making in family planning use p value = 0.066)

4.4. FOCUS GROUP DISCUSSIONS

4.4.0 PRESENTATION OF FINDINGS

Focus group discussion data were summarized using a narrative. The narratives from the research participants have been presented in this chapter

After each focus group discussion, the tape recorder was played to the participants to check for consistency of the information recorded and study participants were asked to clarify any points which were not clear. Transcription of the data was done which involved writing a full report of the focus group discussions in Tonga. The data were then translated into English, using participants' own words and expressions. Data were read through to get the key points and general ideas expressed. Content analysis, which involves classifying words in a text into a few categories chosen because of their theoretical importance (Burns and Grove, 2009) was used to analyse data. Answers from the 2 groups of women (the younger and the older women) were compared.

4.4.1 DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANT

VARIABLE	FEQUENCY	PERCENT
Age		
15-24	4	28.6%
25-29	3	21.4%
30-49	7	50.0%
Total	14	100%
Marital status		
Single	0	
Married	10	57.1%
Divorced	2	14.3%
Widowed	0	%
Separated	2	14.3
Total	14	100%
Educational level		
None	5	35.7%
Primary	5	35.7%
Secondary	3	28.6 %
Total	14	100%
Religion		
Christian	14	100%
Muslim	0	
Total	14	100%
Occupation		
House wife	8	57.1%
Self employed	0	
Formally employed	1	7.1%
Un employed	4	28.6%
Students	1	7.1%
Total	14	100%
Years in present marriage		
Above 5 years	8	57.1%
4-5 years	4	28.6%
2-3 years	2	14.3%

Below 2 Years	0	
Total	14	100%
Type of marriage		
Monogamy	7	50.0 %
Polygamy	7	50.0%
Total	14	100%
Payment of dowry		
Yes	12	85.7 %
No	2	14.3 %
Total	14	100%
Number of children		
1-2		
3-4	4	28.6
4-5	3	21.4%
above 5	7	50.0%
Total	14	100%
Monthly income		
None	13	92.9%
Below k500	0	-
Between K500-K1000	0	-
Above K1000.00	1	7.1%
Total	14	100%

All the respondents were from Maramba Health Centre catchment population in Livingstone District. The participants were divided into two groups which consisted of older women aged 30-49 years, and younger women aged 15-29 years. The groups comprised of 7 participants each.

The first group comprised younger women aged 15-29 years of age, who had given birth before. Three, of them were married and had no education. Two of them had attained primary education and were in polygamous marriage. Two of them had attained secondary education, with one in formal employment and the other one was a secondary school pupil but were 6 days postnatal at the time of the study. They were all Christian by religion .The second group comprised of older women aged 30- 49 years.

Three of them had primary education. Two of them were separated and had no formal education, two of them were divorced and had secondary education. All the respondents were Christian by religion.

All the respondents were 6 days postnatal; five of them were in polygamous marriage while the other two were in monogamous marriage.

From the two groups, 4 of the respondents had 3-4 children, 3 of them had 4- 5 children while 7 of them had 5 and above children.

Those who were married were above 5 years in present marriage, all of them had dowry paid by their husband/partner

The major themes that were identified during data analysis were:-

- Knowledge of family planning
- Male dominance in family planning use decision making
- Religious influence in family planning use decision making
- Gender preference in women's family planning decision making
- Side effects of family planning methods

4.4.2 KNOWLEDGE OF FAMILY PLANNING

The participants were asked to define family planning in their own understanding and most of them were not able to give a complete definition. Some of the respondents said that family planning *“means child spacing, or prevention of pregnancy or delay in bearing children”*.

Some of the responses given were as follows:

Participant number 3 (age group 15-29 years) said, *“family planning means delay in getting pregnant”*.

Participant 6 said, *“It means child spacing”*.

In the age group 30-49 years, most of the participants responded unanimously and said, *“family planning means that you prevent getting pregnant”*. Participant 7 said, *“It means having the number of children you want.”*

The respondents were also asked to mention the methods of family planning they knew and both groups mentioned about 3 family planning methods each. The family planning methods mentioned were as follows:

- *Oral pills*
- *Injectables*
- *Jadelle implant*

Participant 2 said *“condoms”*, participant 5 said, *“loop”*,

The other respondents agreed with the above answers that were given

When asked what are the benefits of family planning?

Participant 2 said *“some family planning methods like condoms prevent you from getting sexually transmitted infections”*. The rest of the respondents agreed with her. Participant 4 from the older group said *family planning helps the child to grow well and gives time to woman to rest*. All respondents agreed that these were some of the benefits of family planning.

4.4.3 Male dominance in decision making in family planning use

When asked whether they thought men influence women’s family planning use decision making Most of them said” it depends on the type of men one is married to as some men forbids use of family planning saying it encourages promiscuity in women” . The older women said *“men allow women to use family planning method in order to reduce on the number of children”*

Three respondents from the older group said *“men refuse unless they give you permission, without their permission you cannot decide to use family planning methods, because they fear that if you use family planning then you can misbehave with other men”* and other respondents agreed.

4.4.4. Religious influence in decision making in family planning use

When asked whether religious influence plays a role in women’s decision making in family planning use ‘all the participants answered that their religion forbids as it’s a sin or killing of unborn child while others said it was abortion and God said go and multiply.’ Participant 6 from the older group said *“in the past there was no such thing as family planning being taught in churches, it is only now that we here some churches encourage the use of family planning methods.”*

Participant 1 from the young group said *“it is killing the un born child” and God does not allow murder.*” All respondents agreed with what she said.

4.4.5 Gender influence in women’ decision making in family planning use

When asked whether gender preference influences women’s decision making in family planning use? Most of the respondents said that

Participant 3 said *“yes because you want to have the gender of child you do not have, I have 4 girls and this is the fifth girl all because I want to have a baby boy “*

Participant 1 said *“it’s God who gives children so gender does not really matter as long as you are able to have children.”*

Participant 6 a young woman said” *No because you need to plan the number of children you can take care of economically”*

Participant 7 from the older group said *“it depends on the man if he wants the gender you do not have then you cannot use family planning”*Participant 5 from the older group said *“yes it does since*

*you want the gender of child you do not have,*The other respondents agreed with her saying it is better to balance the sexes of children before using family planning methods or stopping having children.”

4.4.6 Side effects of family planning

When asked whether side effects of some family planning methods influence women’s decision making in family planning use? Most of the respondents said that they fear to use some family planning methods because of their side effects. Participant 5 said” *some family planning methods causes’ “fikotomumimba”- meaning fibroids especially pills as they don’t get absorbed and tend to stay at one place then you have fibroids*” participant 3 said *some family planning methods makes you have prolonged periods*” participant 6 from the young group said “*some of the methods causes you to stop having any more children since they destroy the womb.*” Participant 4 from older group said “*some family planning methods makes you to have continuous bleeding with clots*” participant 2 from the older group “*said some family planning methods causes you to become infertile as they destroy the womb*” participant 1 from older group said “*it causes cancer*” Participant 7 from the young group said “*some family planning methods makes you feel tired all the time*”.

Participant 1 said, “*Women who take family planning pills are at risk of developing complications because the pills make a lump in the uterus*” participant 5 from the older group said “*it is true because of prolonged bleeding, before I had this baby i was on injection, and I bled for almost two months that’s when I stopped and had this baby.*” Participant 4 from the young group said “*that men complain that the condom reduces sexual pleasure so I fear to use it*”.

Most of the participants’ from both groups agreed that they fear to take family planning methods because of the reasons given above.

4.4.7 SUGGESTION FOR IMPROVEMENT

All the participants felt that the topic of decision making and family planning use was a very important one, and that all women should have this knowledge. They felt that even women who were beyond the child-bearing age should know as they were the ones who usually advised younger women in the villages, and were usually consulted for reproductive health problems and complications.

Participants suggested that health workers should intensify in teaching about importance of family planning so that all women got the message. Participants also suggested that

Traditional Birth Attendants (TBAs) should be taught so that they could, in turn, teach women in the communities where they lived and that these should work hand in hand with community health workers. Participants also suggested that continued sensitization through drama groups and

involving the youths in reproductive health services with emphasis on women decision making using family planning as women are the ones that bear the consequences of unplanned and unwanted pregnancies. The participants also felt that men should be fully involved in family planning issues since they are key decision makers in homes and that women fear to disobey them for fear of being divorced.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The main objective of the study was to investigate the factors that influence decision making regarding family planning use among mothers who delivered in Livingstone District in order to find possible solutions. The specific objectives were to assess whether the women's knowledge levels on family planning influences their decision making in family planning use, establish whether male dominance play a role in women's decision making in family planning use, determine if religion affects women's decision making in family planning use, establish whether male gender preference influences women's decision making in family planning use and assess whether fear of side effects influences women's decision making in family planning use and assess whether fear of side effects influences women's decision making in family planning use. The discussion of findings is based on the specific objectives of the study.

5.2 DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

The demographic characteristics are shown in Table 4. Most of the respondents interviewed were in the age group 15-24 years (43.6%) and in the age group 25-34 years (43.6%). These were the eligible target population in the reproductive age group. The majority (74.1%) of the respondents were married and only (24.9%) of them were single. Two respondents were divorced (.5%) the other one was separated, while the other one was widowed (.3% each). Majority of women in the study were married because Maramba is peri urban and predominantly a tourist centre attracting visitors from across the borders and from other tribes across the country. The other reason could be that most of the women were house wives (46.9%) and had no source of income (69.3%) therefore marriage was a source of economic support. ZDHS (2013-14) revealed that women with no education and wealth marry early than women with education and women from the highest wealth quintile. Respondents who were aged 15-24 were able to make decisions on the use of family planning themselves than the other age groups (43.5%, p value=0.014).

Almost all the respondents (99.9%) interviewed were Christians (Table No4) this could be because Zambia is a Christian nation. Livingstone is predominantly Roman Catholic and protestant maybe because the first missionaries to go to the area were Methodist from whom the District got its name,

but due to mixture of people other denominations are found and therefore most of the women interviewed belonged together Roman Catholic or protestant.

Most of the respondents (62.5%) had attained secondary education or primary (24.7%) education (Table No.4). This could be due many High Schools in the District and because many pupils could access Grades 8 and 9 education at Basic schools; and that the Government of Zambia has taken measures to enhance girls' retention rates in schools. Such measures allow girls who drop out of school due to pregnancy to return and continue their education after delivery. Low levels of education (24.7%) could be because of early marriages which are still practiced in some areas (Gender in Development Division, 2002). Livingstone has 8 Secondary Schools, 30 Primary and 8 Community Schools (Establishment Register for Ministry of Education, 2010).

The findings from this study revealed that 46.9% of the respondents were housewives (Table 4). Respondents who were house wives were able to make decisions on using family planning themselves than those who were in formal employment (P value 0.000). Occupation was significantly associated with decision making with p value 0.000.

Majority (82.4%) of respondents had low levels of monthly income (none or below K500, 000.00 per month) the explanation for this could be that most of the respondents had low levels of education and could therefore not secure good-paying jobs (Table4). Poverty and illiteracy levels are higher among women and this is in line with what is contained in the Gender in Development Division (GIDD, 2002) and ZDHS (2013-2014). Respondents who had no source of income were able to make decisions on family planning use by themselves (74%, p value= 0.001) or with their husbands/partners (58.3%, p value =0.001). There is no clear association between income level and decision making in family planning use.

Majority of respondents (66.0%) had 1-2 children (Table4). The explanation could be that most of them are still planning to have more children, looking at the age groups mostly represented (18-29 years), who are still young women and sexually active. The other explanation could be that couples have started limiting their families owing to the Family Planning messages that are being taught and IEC strategies coupled with service counselling and outreach programmes that are instituted in the District. There was no significant relationship between number of children and decision making in family planning use p value 0.383.

5.3 WOMEN'S KNOWLEDGE LEVELS ON FAMILY PLANNING USE

The first specific objective of the study was to assess whether the women's knowledge levels on family planning influences their decision making on family planning use. The respondents' knowledge levels were assessed by asking them four (4) questions which included the definition of family planning, whether men can be involved in family planning and benefits of family planning. The knowledge levels were categorised into two categories namely adequate and inadequate. Respondents who scored below 6 on knowledge questions were classified as having inadequate knowledge and those who scored from 6 to 11 were classified as having adequate knowledge, meaning those who scored from 6 to 11 had knowledge on family planning and probably could make their own decisions on family planning use.

The research findings showed that 99.0% of the respondents had heard family planning (figure No 3). The commonest source of information (74.0%) was health personnel, probably because most of the women in the study attended postnatal clinics and could have heard about family planning at the health centre (figure No 5). Of the respondents who had heard family planning, 70.8 % of them defined family planning as child spacing, 23.4% as prevention of pregnancy while 5% as planning the number of children you want to have. Most of the respondents (96.0%) had high levels of knowledge (figure No 6), high levels of knowledge were also found with Focus Group Discussion clients who were able to mention that family planning is child spacing or planning the number of children you want to have in both groups. Knowledge was significantly associated with women's decision making in family planning use p value .000, thus rejecting the null hypothesis.

These finding is in line with the studies done in Nigeria by Kimani and Olenja (2001), who found that educated women are more likely to delay marriage, and use modern family planning methods, the findings also agrees with a study done by, Khan et al. (2002) who stated that women were more likely to miss pills, possibly up to 60% more if their understanding was poor. Similar study conducted by Maimbolwa (2003) in Lusaka, Zambia revealed that knowledge of family planning had an impact on the use of family planning methods; however, the study yielded no data to explain why people who know of family planning methods, some of them who desire to use birth

control, still do not use family planning. Salem and Bobak in Roberts and Noyes (2009) found that women who had used family planning before were inclined to have a greater awareness of different modern methods available, and that women with low previous experiences of family planning methods had a poor understanding of different available methods. In the same study, Apu and Fidan, reported that women who had low contraceptive use had generally poor knowledge about family planning methods with a stronger belief of socio-economic traditions and religious beliefs, and that women whose family planning knowledge was limited, had low family planning uptake and compliance. However, Frost and Linberg (2013) stated that for many women sexual activity occurred prior to acquisition of adequate knowledge about family planning methods. The findings are similar to that found in Sable, Libbus, and Chiu (2002) where it was found that lack of contraceptive use by women included inadequate knowledge about or problems with family planning methods. These findings are similar to the study done in Turkey by Sahin and Kharbouch (2007) where contraceptive knowledge was limited, this subsequently influenced uptake and compliance it further showed 80% of women not knowing at what age to stop using their chosen method (Roberts and Noyes 2009).

This was echoed by Mumtaz and Salway (2002) in Pakistan, where social context, knowledge of reproductive matters is considered shameful and a “culture of silence” surrounds these matters. Similarly, Mairiga et al (2010) in a Nigerian study, reported that low patronage to modern family planning was a result of illiteracy. Maimbolwa (2003) reported that socio-cultural factors and lack of knowledge have prevented open dialogue of sexuality and that 78% of primigravidae had never used a family planning method.

5.4 MALE DOMINANCE IN WOMEN’S FAMILY PLANNING DECISION MAKING

The second specific objective was to establish whether male dominance play a role in women’s decision making regarding family planning use. Male dominance was measured by asking them 4 questions which included who decides that they use a family planning method, whether dowry payment by husbands to their spouse’s family make women unable to make decisions about family planning, and whether they thought that being in polygamous marriage can contribute to women not deciding to use family planning methods.

The findings were that 37% of the respondents made decision on family planning use by themselves, 36.3% of respondents made decision on family planning use with their

husbands/partners, 23, 4% the decision on family planning use was made by their husband/partner alone, while 2.3% of the respondents made the decision on family planning use with another person (friend) and 1% the decision on family planning use was made by another person (mother) (figure 8). There was no significant association between male dominance and decision making in family planning use (Table 15), thus, accepting the null hypothesis.

However, in a study done by Sable, Libbus, and Chiu (2000) in Missouri found that among black women, the sexual partner was a key decision maker in their use of family planning methods. The findings disagree with a study done by Gule (1994) in Swaziland which revealed that husbands or partners are key decision-makers in family planning and family size matters and that disapproval of the partner is a significant draw-back to family planning use.

However, Mundigo (1998) also found that couples often disagree about the desirability of pregnancy and the use of family planning methods. These findings are similar to the study done by Beekle and McCabe (2006) in Roberts and Noyes (2009) where the dominance of the husband and his opposition to contraceptives, in conjunction with the woman's low social status, were reported to be limiting factors for African women. In the same study, Kamal (2000) reported that husband's approval of a chosen family planning method played a positive influence on acceptability and satisfaction in some communities.

Similar findings were found in a study done by Muramutsa,(2007), that, family members (husbands, in-laws, parents) and community leaders (religious leaders) exerted considerable influence on women's decision to use a family planning method; women were encouraged not to practice family planning in order to perpetuate the family lineage. Furthermore,Husbands were referred to as exercising the most influence; that wives were told not to worry about having too many children because they would be provided for.

The findings were similar to a study conducted by Maimbolwa (2003) who reported that, in Zambia the power sphere of many women is restricted to household work and that women have less say in reproductive health matters though it involves their bodies and sexuality. Maimbolwa (2003) further stated that decisions in matters of reproduction are usually made by the husband and that the husband is seen as the head of the family. Similar findings were found in a study done by Banda N.

H., Bradley S. and Hardee H (2004) in Chipata compound Lusaka, where it was reported that women considered men to be a major barrier to condom use.

The findings are similar to another study conducted by Wegs C.etal (2011) in Eastern Province of Zambia revealed that men had the final decision-making authority in the household, including making final decisions about family planning.

Similarly, Mutombo N. and Bakibinga P. (2014) stated that decision-making regarding fertility has been dominated by male decisions.

The findings showed that 351(88.4%) of respondents did not think that being in polygamous marriage could contribute to women not deciding to use family planning methods, 29(7.3%) of the respondents did not know, while 17(4.3%) of respondents thought that being in polygamous marriage could contribute to women not deciding to use family planning methods (figure No 10). Of those who thought that being in polygamous marriage could contribute to women not deciding to use family planning methods, 4% mentioned that because of competition to have more children than other wives, .3% said that the man has to decide the use of family planning methods(Table No 6).

Similar findings were reported by Gule (1994), where it was found that if in-laws were convinced that more children were still needed, they convinced, or even pushed the husband to take another wife, which is undesirable on the part of the first wife.

A study by Makinwa and Adebusoye (2001), found that the effect of polygamy on fertility is complex, as it was revealed by the Nigerian Demographic and Health Survey (NDHS, 1999), which revealed that 35.7% of all married women were in polygamous households. The ZDHS (2013-2014) revealed that 12% of married women and 7% of married men are in polygamous unions.

Findings were that 90.7% of respondents did not think that payment of dowry by husbands to spouses' family make women unable to make decisions about family planning use, 6% of the respondents thought dowry payment by husbands to spouses' family make women unable to make decisions about family planning use, while 3.3% did not know (Figure No 9).

However, McLean, (1990) in Gule (1994) stated that Swazi women view the practice of *lobola* (payment of bride price to the wife's family) as a cultural barrier to family

planning. According to Muramutsa (2007), they feel duty bound to bear many children, or the number of children dictated by their in-laws. In fact, if a woman proves to be barren, the *lobola* may be recalled from her family. The more daughters' one had, the more cows, through *lobola*, one could expect (Mairiga, 2010).

According to Kim (2005), bride wealth is common among many communities in Kenya, and that those men able to afford the bride wealth were mostly old men, which encourages polygamy and that once married, a young woman had little control over sexual matters. These also come out in focus group discussions where one respondent said that her husband had to take another wife, because she had taken long to have a child.

5.5 RELIGIOUS INFLUENCE ON WOMEN'S DECISION MAKING ON FAMILY PLANNING USE

The third specific objective for this study was to determine if religion affects women's decision making in family planning use. The findings were that in women where religion forbids usage of family planning, fewer women (71.1%) reported being involved in decision making as compared to women in which religion does not forbid 74.6% use of family planning methods. The findings revealed that there is no significant relationship between religious influence and women's decision making on family planning p value .825, thus accepting the null hypothesis. However, Mutombo N. and Bakibinga P. (2014) reported that factors affecting unmet need for family planning in Zambia included religion and that non-Catholics have higher (30%) use of modern family planning methods, than Catholic women 24%. Similar findings were reported by Muramutsa (2007) that religious beliefs had a significant barrier to family planning practice in Rwanda. The study further revealed that using modern family planning methods was a sin, and that religious leaders influenced couples decision to use modern family planning methods by arguing that hormonal methods were equivalent to murdering the embryo, and that at Health Centres, Catholic Nuns discourage the use of modern family planning methods.

Similar findings were reported by Ajiboye et al. (2012) that individual and communal values, norms and perceptions are noted as responsible for the persistence of some cultural and religious practices with its social concomitant effect on demographic behaviour in Africa, particularly among the Ogu community of Badagry in Nigeria. The findings are similar to what come out during focus group

discussion where respondents said religion forbids the use of family planning methods and “*that at church they say that using family planning methods is same as killing unborn children to use modern family planning methods*”.

5.6 MALE GENDER PREFERENCE INFLUENCES ON WOMEN’S DECISION MAKING IN FAMILY PLANNING

The fourth specific objective of the study was to establish whether male gender preference influences women’s decision making in family planning use. This was assessed by asking respondents whether they thought having only one gender of children make women not use family planning methods and if they thought so, what were their reasons for saying so.

The findings revealed that where women thought having only one gender of children make women not use family planning, majority (99.2%) of respondents thought having only one gender of children make women not use family planning. This is in line with Muramutsa (2007) where it was reported that in Rwanda it was culturally acceptable for the male partner to practice extra-marital sex or polygamy in order to have a son and that Rwandan women would prefer to have boys so as to please their husbands and in laws. Further Muramutsa (2007) revealed that the preference for male children “*even your own family wishes you to have a boy in order to make your mother in-law happy*”, and that preference for boys over girls in Rwanda was described by Muramutsa as overruling the concern for family size. However, a study done by Gule(1994) in Swaziland revealed that girls were considered of more value in the past since they were viewed as more reliable and stable sources of support for their parents especially mothers who are left alone after the death of their husbands. Similarly, Mairiga et al. (2010) reported that children were highly valued and desired irrespective of their gender as both sexes fill a very crucial gap in the social and cultural life of a Kanuri family, and that couples with many children were respected and having many children was considered as insurance against the high child mortality prevalent in the area. In a similar study conducted in Eastern Province of Zambia by Wegs C. etal (2010) found that in-laws to the woman can have strong influence and referred to consequences of not meeting their fertility expectations, further in laws would not accept a woman who decided not to have any children because they take pride in having grandchildren so they would consider her to be useless. Similarly, Green (1995) in Phiri (2011) reported that if men are left out of the reproductive equation, they are unlikely to exercise responsible behaviour in the effort to achieving reproductive health rights and that failure

to target men in programmes has weakened the impact of reproductive health programmes since men can significantly influence their partners' reproductive health decision making. The focus group discussion revealed that most respondents said gender preference made them not use family planning methods; one respondent actually said *"this is my fifth child all because I want to have a boy."*

5.7 FEAR OF SIDE EFFECTS INFLUENCES ON WOMEN'S DECISION MAKING IN FAMILY PLANNING USE

The fifth specific objective of the study was to assess whether fear of side effects influences women's decision making in family planning use. Fear of side effects was assessed by asking the respondents if they thought that side effects of some family planning methods can prevent women from using a family planning method. If their response was yes, the respondents were expected to explain the reason for saying so.

The findings were that 72.3% of respondents thought side effects of some family planning methods could not prevent women from using a family planning method as compared to women who thought that side effects of some family planning methods could prevent women from using a family planning method 23.4% (figure 13). This is in agreement with Gule (1994) who reported that false rumours regarding side effects of family planning and ignorance about how these methods work were key deterrents to their use in Swaziland. However, the findings were that there was no association between decision making in family planning use and fear of side effects p value .261 (Table 12), thus accepting the null hypothesis.

The study revealed that respondents who said that some family planning methods could prevent women from using a family planning method 72.0% mentioned that family planning causes prolonged periods, 18.3% mentioned that family planning causes fibroids, while 9.7% mentioned that family planning causes fatigue. Similar findings by Sable et al. (2000) showed that mean values for two individual side effects statements indicate that worries about injectables side effects and dislike for irregular periods were perceived as greater barriers in family planning methods by the more highly educated than by less educated women. Mairiga (2010) found similar findings in Nigeria, that some women feel they should first prove their fertility before they can use family planning methods, and the belief that certain forms of family planning such as pills could result in sterility. Further, the pill was believed to destroy the uterus and ovaries resulting in sterility among women and also to cause impotence in the man and wetness in the woman, resulting in reduced

sexual pleasure. Mairiga (2010) also reported that people fear that the condom if it came off during sexual intercourse, would become lodged in the vagina and cause serious physical harm- thus leading to female sterility, it was also associated with reduced sexual pleasure. Similarly, Muramutsa (2007) reported that fear of family planning side effects is a major barrier to family planning practice in Rwanda. Side effects were among the main reasons for non-use of family planning methods Muramutsa (2007), side effects side effects commonly referred to by participants included, loss of vaginal lubrication, heavy bleeding, and respondents pointed to prolonged menstruation as restricting men's sexual desire. Similar findings by Mairiga et al. (2010) cited fear of delay in returning to fertility, damage to reproductive system as reason for not using modern family planning methods. Similarly, Mutombo N. and Bakibinga P. (2014) reported that since long acting methods are very effective and coupled with myths about some side effects, women who have not attained their family size are generally less likely to use modern family planning methods. The findings were that 99.0% of respondents had heard about family planning while 1% had not heard about family planning.

Of the women who had heard about family planning, (72.3%) of them said that not every woman could develop side effects, except those who were unfortunate. This also came out during Focus Group Discussions where one respondent said, "*It is only the unlucky women who develop side effects*". Some of respondents (18.3%) said family planning causes fibroids. This could be because women did not really understand what side effects of family planning were.

5.8 LEVEL OF EDUCATION INFLUENCES ON WOMEN'S FAMILY PLANNING USE DECISION MAKING

The last specific objective of the study was to assess whether level of education influences women's decision making in family planning use. This was assessed by asking respondents what educational level they have attained.

Most of the respondents had attained secondary education. These were 284, constituting 62.5% of the total respondents. These were followed by those who had attained primary education who made up 24.7% of the total respondents, 9.6% had attained college education, 3% had not attained any level of education, whereas 0.3% had attained university education (Table 4).

Similar findings were found by Acharya et al (2010) who reported that highly educated women are more likely to take part in decision making in their own health care. In Nigeria, Kimani and Olenja (2001) reported that educated women were more likely to use modern family planning methods. Similarly, Ajiboye et al. (2012) reported that levels of education were higher among urban women than women in rural areas who were accessing family planning services. The same findings were reported by Maimbolwa (2003) that utilization of health care is often related to educational level and that education of girls maybe one of the most important ways of preventing un planned pregnancies as education creates awareness about the need to access and use reproductive health services in time thereby contributing to the prevention of early births and pregnancy complications.

5.8 STRENGTHS OF THE STUDY

The strengths of the study were:

1. The study found that majority(99.0%) of respondents had heard about family planning
2. The study also found that the majority 74.1% got the information on family planning from health personnel
3. Majority(96.%) of respondents know about any family planning method
4. The study also found that 37% of respondents made decision to use family planning methods by themselves
5. The study revealed that 90.7% of respondents thought that payment of dowry does not hinder women from making family planning decisions about family planning use.
6. The study also revealed that religion was not significantly associated with women's decisions on family planning (99.3%, p value 0.825).
7. The study revealed that male gender preference was not significantly associated with women's decision making on family planning use p value 0.272
8. The study also revealed that fear of side effects was not significantly associated with women's decision making in family planning use p value 0.261

5.9 LIMITATIONS OF THE STUDY

The limitations of the study were:

1. The study was only conducted in Livingstone District and therefore these findings could not be generalized to other Districts in Zambia.
2. The presence of interviewer may have affected respondents' responses and they may not have brought out the true facts about the topic.
3. Translation of the transcripts from FGDs from the local language to English may have affected the initial views of the respondents.
4. Respondents may have failed to bring out their views in FGDs because some women are uncomfortable expressing their views or experiences in front of a group.
5. There could have been recall bias for the participants who used family planning methods a long time ago.

5.10 IMPLICATIONS TO NURSING

5.10.1 Implications to nursing/midwifery practice

The study findings showed that most (99.0%) of the women in this study had heard about family planning, and were able to define what family planning mean. The study also found that the majority (51.4%) of women thought men could be involved in family planning.

There is also a shift in the topics taught and mostly, clients are taught about HIV/AIDS, while other topics are almost neglected. There is therefore a need to strengthen IEC on all reproductive health topics by the nurse/midwife practitioners, at every opportunity, to empower women with more knowledge on family planning decision making so that they make informed decisions if they uptake family planning methods.

5.10.2 Implications to nursing administration

The study revealed that women did not know the benefits of involving men in family planning, there is need to ensure that health personnel at the centre encourage male involvement in family planning. More support visits should also be made to the Centre to guide the staff on reproductive health issues.

5.10.3 Implications to nursing education

The study revealed that women longed to have information, education and communication, including physical examinations before giving them the chosen method of family planning and give them enough time with the nurses to ask questions. Nurse educators should instil this sense of responsibility, and the need to maintain high professional standards in nursing and midwifery students so that they are able to practise it and offer a total package of care to the women as they begin and continue their midwifery practice. Teaching women about side effects of some family planning methods and other relevant topics should be emphasized in the schools of nursing and midwifery so that women are empowered with knowledge in order to make informed and right decisions, especially in issues concerning family planning use.

5.10.4 Implications to nursing research

From the literature reviewed, it was found that few research studies have been conducted in the area of socio-cultural factors influencing women's decision making regarding family planning use, especially locally. It is therefore necessary for nurse researchers to conduct more studies in the area of socio-cultural factors influencing women's decision making regarding family planning use and reproductive health so that evidence based care can be given according to the findings.

5.11. CONCLUSION AND RECOMMENDATIONS

5.10.1 Conclusion

The study was conducted to determine the factors that influence women's decision making regarding family planning use among mothers delivered in Livingstone District in order to find possible solutions.

The study revealed that 99.0% of the respondents had heard family planning and 70.8% were able to give a correct definition of family planning. However, some of the respondents 23.4% thought that side effects of some family planning methods could prevent women from using a family planning method. This is not a good belief as some women will not be ready to use family planning methods. All women are at risk of developing side effects due to family planning uptake and should therefore be ready to handle any side effects that arises at anytime

Therefore, this should be made clear to the women and they should be taught side effects so as to be prepared.

The study further revealed no significant association between fear of side effects and women's decision on family planning use. Therefore there is need to counsel and teach women about the side effects they experience so that they have more information about them.

The study revealed that 31.3% of women are not involved in decision making regarding family planning use and that 23.6% of respondents revealed that it was their husbands/partners who decide that they use a family planning method. There is need therefore to involve men in family planning as they are the ones who make decision in their homes and in the community.

The study also revealed that payment of dowry by husbands to the spouse's family make women unable to make decisions about family planning use. This calls for more awareness campaigns to discourage negative perception towards family planning decision making among women, so that they are able to uptake family planning methods.

5.11.2 RECOMMENDATIONS

5.11.2.1 Recommendations to ministry of community development mother, and child health /ministry of health for improving women's decision making in family planning use

1. The Ministry of Health needs to put in place measures to strengthen IEC programs in all Health facilities to increase knowledge about family planning decision making among women. This will also improve their uptake of family planning.
2. There is a need for Ministry of Health to work with General Nursing Council to ensure that nursing and midwifery students graduate with the skills to teach women and communities about family planning use decision making.
3. Ministry of Health should put measures in place to ensure that more midwives are trained and deployed equally to areas where they are needed to provide women and communities with the reproductive health services they need.
4. Ministry of Health should continue working with other Ministries, like Ministry of

Education and Non-Governmental Organizations to ensure that equal opportunities are accorded to girls to go to school. This will help them broaden their knowledge about reproductive health services and enable them to make independent decisions regarding family planning uptake.

6. The Ministry of Health and District Health Offices need to keep on training community based volunteers, like community health workers and reproductive health supporters so that they can help teach women and communities where they live.

5.11.2.2 Recommendations for further research

1. Another study should be conducted in Livingstone District on factors influencing women's decision making regarding family planning uptake, to cover a larger area.

This study was only conducted in Maramba.

2. A follow up study should be conducted in Livingstone District to determine socio-cultural Factors influencing women's decision making regarding family planning use period in order to find out the source of the problem of unmet need for family planning.

3. A further study should be conducted to explore women's practices for family planning in Livingstone District

5.12 DISSEMINATION AND UTILIZATION OF FINDINGS

The findings will first be presented to the faculty of Department of Nursing Sciences in the School of Medicine, University of Zambia (UNZA). Following this presentation, a report of the research will be written and submitted to Department of Nursing Sciences and University of Zambia library, the results of the study will be disseminated to major stakeholders involved in design of Zambia's future Family Planning programmes and teaching of family planning decision making at various foras, workshops and conferences. These include Ministry of Health and its' partners and Provincial Health Office for Southern Province.

Livingstone DHMT will be given a report of the study results so that the District would use them to render evidence based care, as they provided reproductive health services to the study site.

Money will be sourced from Livingstone District Health Office research fund to organize a dissemination workshop which was attended by the District Commissioner, members from the District Development Committee and other cooperating partners. Staff members from Livingstone Central Hospital and the Health Centres were also invited to hear the study results so that they

would use the results to render evidence based care. The respondents will be communicated to using Musi-o-tunya community radio, Radio Zambezi and sky FM.

In addition, four copies of the research report will be printed and submitted to the following:-

- Department of Nursing Sciences for lecturers and student references.
- University of Zambia Medical library and main library for lecturers and student references.
- Ministry of Health to guide policy makers in decision making.
- Investigator for own use and reference.

REFERENCES

- Acharya, D.R, Bell, S.J., Simkhada, P., Teijlingen, E.R.Vand Regimi, P.R. (2010). Women's autonomy in household-decision making: a demographic study in Nepal, journal.com/article/10.1186/1742/4755/14266336876 accessed 02/04/2014
- Adebusoye, P. M. (2002). workshop on prospective for fertility decline in High Fertility Countries; Population Division, Department of Economic and Socio Affairs, United Nations Secretariat, New York , accessed 03/03/2014
- Ajboye, O, E. and Adebayo, K. A, (2012) Socio-cultural factors affecting pregnancy outcome among the Egu speaking people of Badagry area of Lagos state, international Journal of Humanities and social science Vol.2 No.4, accessed on 1/04/2014
- Banda, N.H., Bradley S., and Hardee H. (2004) Provision and Use of Family Planning in the context of HIV/AIDS in Zambia: Perspectives of providers, Family planning and Antenatal care, and Hiv-positive women.
- Burns, N and Grove S. K. (2003) Understanding Nursing Research, 3rd edition, Saunders company, Philadelphia, Pennsylvania 1906; ISBN 0-7216-0011-5
- Burns, N. and Grove, S. K. (2009) The Practice of Nursing Research.Appraisal, Synthesis and Generation of Evidence.6th edition. Saunders. St Louis. Missouri63146.
- Central statistical office (CSO), Ministry of Health (MoH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009.Zambia Demographic and Health Survey 2007. Calverton, Maryland, USA: CSO and Macro International Inc.
- Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007.Calverton, Maryland, USA: CSO and Macro International Inc.
- Central statistical office (CSO) Zambia, Ministry of Health (MOH), and ICF international, 2014. Zambia Demographic and Health survey 2013-2014. Rockville, Maryland, USA: Central Statistical office, Ministry of Health, and ICF international
- Chirwa, B., Tembo, J. and Moonze, E. (2002).Integrated Technical Guidelines for Frontline Health Workers (ITG), 2nd edition, Lusaka, Zambia 5(128)

Cunningham, W. TED (1997). The Nelson contemporary English Dictionary, Thomas Nelson and sons Ltd, Nelson House, May field Road Walton-on-Thames surrey, ISBN 0-17-443304-2

Ethnicity Family Government and Regulatory Bodies Holidays Legal Military accessed 01-04-2014. Ask Eraser-careers-Ask Blog-Mobile-Help-Feedback ©Ask.com.[http:// theknow.ask.com](http://theknow.ask.com)

Frost, J.J., and Lindberg, L.D. (2013). Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics, *contraception* volume87, Issue4 (465-472) accessed 09/04/2014

GIDD. (2002). Strategic Plan of Action for the National Gender Policy (2004-2008).Cabinet Office. Lusaka.

Gule, G. (1994). *Canadian Studies in Population*, Vol. 21(1) 35-49, socio-cultural constraints to Family planning in Swaziland, accessed 03/03/2014

Kabber, N. (1999). Resources, Agency, Achievements: Reflection on the measurement of women's empowerment; *Development and change* 30(3):435-64, [http://www.pdhre.org/rights/women in power.html/01/04/2014](http://www.pdhre.org/rights/women_in_power.html/01/04/2014)

Kimani, V. and Olenja, J.(2001).Infertility: cultural Dimensions and Impact on women in selected Communities in Kenya *Nursing Journal* Vol 35. No 1

Maimbolwa C.M. (2003) *Maternity care in Zambia with special reference to social support*, ISBN 91-7349-612-X

Mairiga, A. G, Kulima, A. A, Bako, B and Kolo,M.A.(2010) Socio cultural factors influencing decision-making related to fertility among the Kanuri tribe of North-Eastern Nigeria.*Afr.Prm Health care Fam Med.*2 (1), Art. #94,4pages.DoI:10.4102/phcfm.v2:1.94

Ministry of Gender and Development. (2002). National Gender policy. Ministry of Gender and Development, Lusaka, Zambia

Mumtaz, Z. and Salway, S.M. (2007).Gender, Pregnancy and uptake of antenatal care in Pakistan. *Sociology of Health and illness*, 29:1-26.doi:10.1111/j.1467-9566.2007.00519.x accessed 5/4/2014

Muramutsa, F. (2007). Knowledge-sharing on socio-cultural Factors Affecting Family Planning Practice in Rwanda, Smart Consultancy Ltd Kigali accessed 05/03/2014

Mutombo, N., and Bakibinga, P. (2014) The effect of joint contraceptive decisions on the use of injectables, Long-Acting and Permanent Methods (ILAPMS) among married female(15-49) contraceptive users in Zambia a cross-sectional study.

Phiri, C., (2011) Brief the socio and cultural background of involving men in Family Planning

Polit, D.F, Beck, B.P and Hungler, H. (2001), Essentials of Nursing Research; Methods, Appraisal and utilization, 5th edition, Lippincott, Philadelphia, New York, Baltimore; ISBN 0-7817-2557-7

Polit, D.F., and Beck, C., T. (2004).Nursing Research: Principles and Methods 7th edition, Lippincott Williams and Wilkins, Philadelphia, ISBN 0-7817-3733—8

Roberts, A and Noyes, J. (2010). Contraception and women over 40years of age: mixed-method systematic review, Journal of Advanced Nursing,65:1155-1170.doi:10.1111/j.1365-2648.2009.04976.x accessed 01/04/2014

Sable, M.R., Libbus, M.K, Chiu, J.E. (2000).Family planning perspectives Vol.32 No3; Factors Affecting contraception use in women seeking pregnancy Tests: Missouri, 1997 accessed 05/03/2014

Wegs C., B. Feyistetan, J. Alaii, P. Cheeba, and F. Mbewe (2011). Socio and Behavior Change Communication to Address Family Planning Uptake in an Integrated Program in Zambia. Washington, DC: C-Change/FHI 360 Accessed on 19/09/2014

APPENDICES

APPENDIX I: DATA COLLECTION TOOL

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

Semi-structured interview schedule on socio-cultural factors influencing women’s decision making regarding family planning in Livingstone district.

Date of interview: _____

Place of interview: _____

Name of interviewer: _____

Serial number: _____

INSTRUCTIONS FOR THE INTERVIEWER

1. Introduce yourself to the respondent
2. Ensure that the respondent is eligible for the interview and can be included in the study.
3. Explain the purpose of the study and assure respondent of confidentiality
4. Request respondent for a written consent before you start the interview.
5. Do not write name of respondent on interview schedule.
6. Ensure that you get a response for each question.
7. Circle the most appropriate response, or write answer on space provided.
8. Provide time for respondent to ask questions at the end of the interview.
9. Thank the respondent at the end of the interview

For official use

SECTION A: DEMOGRAPHIC DATA

1. Age at last birthday

- 1. 15 – 24 years
- 2. 25 – 34 years
- 3. 35 – 44 years
- 4. 45 – 49 years

2. Marital status

- 1. Single
- 2. Married
- 3. Divorced
- 4. Separated
- 5. Widowed

3. Years in present marriage

- 1. Below 2 years
- 2. 2-3 years
- 3. 4-5years
- 4. Above 5 years

4. Type of marriage

- 1. Monogamy
- 2. Polygamy

5. Did your husband /partner pay dowry?

- 1. Yes
- 2. No

6. How many children do you have?

- 1. 1-2 children
- 2. 3-4 children
- 3. 4-5 children
- 4. Above 5 children

7. What is your religion?

1. Christian
2. Muslim
3. Hindu
4. Buddhist

Others (specify) _____

8. What is your education Level?

1. None
2. Primary
3. Secondary
4. College
5. University

9. What is your Occupation?

1. House wife
2. Student
3. Formally employed
4. Self employed
5. Unemployed

10. What is your income?

1. Below ZMK 500.00 per month
2. Between ZMK500.00 and ZMK1, 000 per month
3. Above ZMK1, 000.00 per month
4. None

11. What is your husband's occupation?

1. Formally employed
2. Self employed
3. Unemployed

12. What is your husband's income?

1. Below ZMK 500.00 per month

2. Between ZMK 500.00 and ZMK1, 000.00 per month

3. Above ZMK1, 000.00 per month

4. None

SECTION B: KNOWLEDGE ON FAMILY PLANING USE

13. Have you heard of family planning?

1. Yes

2. No

14. If yes, which is the source of information?

1. Media

2. Health personnel

3. Teachers

4. Relatives

5. Friends

6. Church

15. In your own words what is family planning? (Explain)

16. Do you know any family planning method?

1. Yes

2. No

17. If yes which method do you know?

1. Oral pill

2. Injectable

3. Intra -uterine device

4. Vaginal methods

- 5. Norplant implants
- 6. Female /male sterilization
- 7. Fertility awareness – based methods
- 8. Lactation amenorrhea method
- 9. Others specify_____

18. Can men be involved in family planning?

- 1. Yes
- 2. No

19. What are the benefits of involving men in family planning?

SECTION C: MALE DOMINANCE

20. Who decides that you use family planning method?

- 1. Your self
- 2. Yourself and husband/partner
- 3. Yourself and other Person
- 4. Husband/partner alone
- 5. Someone else
- 6. Others specify_____

21. Do you think that dowry payment by husbands to the spouse's their family

make women unable to make decisions about family planning use?

- a) Yes
- b) No
- c) Don't know

22. If your response to Question 21 is "Yes" Explain?

23. In your opinion, do you think that being in polygamous marriage can contribute to women not deciding to use family methods?

- a) Yes
 - b) No
 - c) Don't know
-

SECTION D: RELIGIOUS INFLUENCE

24. Does your religion forbid use of family planning methods?

- a) Yes
- b) No
- c) Don't know

25. If your response to question 21 is "Yes", explain.

SECTION E: GENDER PREFERENCE

26. In your opinion, do you think having only one gender of children make women not use family planning methods?

- a) Yes
- b) No
- c) Don't know

27. If your response to question 23 is "Yes", explain

SECTION F: SIDE EFFECTS

28. Do think that side effects of some family planning methods can prevent women from using a family planning method?

- a) Yes
- b) No
- c) Don't know

29. If your response to question 25 above is “Yes”, explain

We have come to the end of our interview. Thank you so much for your participation and time

APPENDIX II: FOCUS GROUP DISCUSSION GUIDE

TOPIC: FACTORS INFLUENCING WOMEN’S DECISION MAKING REGARDING FAMILY PLANNING IN LIVINGSTONE DISTRICT

- Number of participants**
- Composition of participants**
- Language used during discussion**
- Place of discussion**
- Duration of discussion**
- Date**

INSTRUCTIONS

1. Welcome the participants.
2. Introduce yourself and the assistants to the respondents.
3. Explain the purpose of the discussion.
4. Obtain verbal consent from the participants to continue with the discussion.
5. Assign number to each participant to ease discussion.
6. Assure the participants of anonymity and confidentiality and encourage free participation in the discussion.
7. Respect each participant’s views.
8. Thank the participants at the end of the discussion.

DISCUSSION GUIDE

A. Knowledge of family planning methods

1. What is family planning?
2. What methods of family planning do you know?
3. What are the benefits of family planning?

B. Male dominance in family planning use decision making

Do you think men influence women’s family planning use decisions making?

C. Religious influence in family planning use decision making

Do you think religion plays a part in women’s family planning use decision making?

D. Gender influence in women's family planning decision making

Do you think gender preference influence women's family planning use decision making?

E. Side effects of family planning methods

Do you think side effects of some family planning methods influence women's family planning use decision making?

F. Suggestions for improving family planning decision making among women.

What measures do you think should be undertaken to increase family planning decision making use?

**We have come to the end of our discussion. Thank you very much for your
Participation**

APPENDIX III: BUDGET

BUDGET CATEGORY	UNIT COST (ZMK)	QUANTITY	TOTAL
1. STATIONERY			
a) Flash Disk	300.00	X1	300.00
b) Bond paper	30.00	X10	300.00
c) Pens	1.00	X10	10.00
d) Pencils	0.50	X6	3.00
e) Rubbers	1.00	X3	3.00
f) Note book	8.00	X2	16.00
g) Tippex	10.00	X1	10.00
h) Bag for interview schedules	100.00	X1	100.00
i) Stapler	50.00	X1	50.00
j) Staples	10.00	X1 Box	10.00
SUBTOTAL			802.00
PERSONNEL			
Lunch allowance	50.00		
• Principal researcher	30.00	X1 x 60 days	
• Research assistant		X3 x 60 days	
Transport allowance	30.00		3,000.00
• Principal researcher	20.00	X1 x 60 days	5,400.00
• Research assistant		X3 x 60 days	1,800.00
			3,600.00
SUBTOTAL			13,800.00
2. SERVICES			
a) Ethics committee	150.00	1	150.00
b) Data entry	100.00	1	100.00
c) Data analysis	1,000.00	1	1,000.00
d) Typing proposal	50.00	100 pages	50.00
e) Printing proposal (Tonner)	700.00	100 pages	700.00

f) Typing report	100.00	150 pages	100.00
g) Printing report (Tonner)	-	-	-
h) Binding	150.00	5 copies	750.00
SUBTOTAL			2,850.00
TOTAL			17,452.00
CONTIGENCY FUND 10%			1,745.20
GRAND TOTAL			19,197.20

JUSTIFICATION FOR THE BUDGET

STATIONARY

The 10 reams of bond paper will be used for the research proposal development and the final report. Paper will also be required to make extra copies of the proposal for submission to the Research Ethics committee and the board of graduate studies. In addition the interview schedule will consist of 10 pages that will need photocopying.

The bag for interview schedules is for the researcher to ensure that the interview schedules are kept safe. The flash disc is for copying, storage and safe keeping of research data. Other accessories such as pens, pencils rubbers, stapler and staple and note books are required for the routine collection of research data.

PERSONNEL

Data collection will be conducted throughout the day as such the researcher will need transport and lunch allowance. The research has been allocated 60 days to allow adequate time for administration of interview schedules and for observations.

SECRETARIAL SERVICES

The researcher will do the typing but funds for tonner to use for printing the proposal, the final report and binding of the proposal and report will be needed. The researcher will need five copies of the proposal to submit to Post Graduate Research Committee for dissertation and dissemination.

CONTIGENCY

Contingency fund which is 10% of the budget is required for any extra costs due to inflation and for any eventualities.

APPENDIX IV: GANTT CHART

NO	TASK TO BE PERFORMED	RESPONSIBLE PERSON	2014											
			APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN		
1	Literature review	researcher	■	■	■									
2	Proposal development	researcher		■	■	■								
3	Presentation to Graduate studies	researcher				■								
4	Approval by REC	researcher					■	■						
5	Data collection	researcher							■	■				
6	Data analysis	researcher										■		
7	Report writing	researcher											■	
8	Submission of draft report	researcher												
9	Submission of final report	researcher												
10	Dissemination of results	researcher												

APPENDIX V: INFORMED CONSENT

FACTORS INFLUENCING WOMEN'S DECISION MAKING REGARDING FAMILY PLANING AMONG WOMEN 18-49 YEARS IN LIVINSTONE DISTRICT

INTRODUCTION

I Charity Chongo Lyambai; a student of Masters of Science in Nursing at the University of Zambia is kindly requesting for your participation in the research study mentioned above, because it is important to assess socio-cultural factors influencing women's decision making regarding family planning. Before you decide whether or not to participate in this study, I would like to explain to you the purpose of the study, any risks or benefits and what is expected of you. Your participation in this study is entirely voluntary. You are under no obligation to participate; you may choose to participate or not to participate. If you decline to participate, no privileges will be taken away from you. If you agree to participate, you will be asked to sign this consent in front of someone. Agreement to participate will not result in any immediate benefits.

PURPOSE OF THE STUDY

The study will determine factors influencing women's decision making regarding family planning. This is important as the information obtained will help the district health office in Livingstone and the Ministry of Health to effectively address some of the challenges encountered in its operations and also assist policy makers and implementers of family planning programs to redirect policy and program implementation and offer better services which will meet the needs of the people.

PROCEDURE

The study involves a face-to-face interview with the staff that will ask you a set of questions using a structured questionnaire. After signing the consent form, the staff will proceed to ask you the relevant questions and your responses will be recorded on the questionnaire. The interview will take about 40 minutes.

RISKS AND DISCOMFORTS

There is no risk involved in this research though part of your time will be utilized to answer some questions. Some questions may seem to be sensitive and personal. The participant is free not to answer any questions deemed un comfortable or sensitive.

BENEFITS

There is no direct benefit to you by participating in this study, but the information which will be obtained will help the policy makers to take measures to address some of the challenges encountered in family planning programs. No monetary favors will be given in exchange for information obtained, but education will be given on family planning use decision making.

CONFIDENTIALITY

Your research records and any information you will give will be confidential to the extent permitted by law. You will be identified by a number, and personal information will not be released without your written permission except when required by law. The Ministry of Health, the University of Zambia Research Ethics Committee or the School of Medicine may review your records again but this will be done with confidentiality.

ZIKUMBATIZYO

CIKUMBATIZYO CITAANZI

CIPEPA CIJISI TWAAMBO TWAZITOLA LUBAZU

Bupanduluzi

Mebonde Charity Chongo Lyambai, ndilicikolowiiyabusilisibusumpukidebwadigili a cikolocipaticamu Zambia (UNZA), ndilombakutolalubazukwanumulwiiyolwaambwaatalaaawa.Ndilamupandulwidamuzeezomupatiwal wiiyonaabuvuntauzyi, a bubotubwakwandanyaluzyaloncomweeledekucitakamutanakutolalubazu, naamwasalakutolalubazu. Naamwasalakutatolalubazu, kwiinancomungamwasweekelwa.Kutinaamwalyaabakutolalubazu, ingandamulombakutimulembecizuminanocingacilandizumizyakumubuzyamibuzyo.Kutolalubazukw anumukuvuntauzyaookukunyinabubotumbomungamwajanacakufwambaana.

Muzeezowabuvuntauzyi

Muzeezomupatiwabuvuntauzyioobungwakuyandakuzyibanaabamakaintubalijisiluzyibolwakwandany aluzyalo, nkamboeciingacagwashabamfulumendekuletalunsupukomucisicalibingi,akugwashakumanamapenzi mumilimoyamfulemende.

Machililanwa

Mubuvuntauzyiboonsekuyoobaciindicakubuziyigwamibuzyomulomompandemwaakumanakusimbaci pepacacizuminano.Bwiinguzibwanubuyoolembwamupepalyamibuzyo.Kubuziyigwaookukuyootolacii ndicifwaafwituwvalu-vwalutulimakumiyonekusikilakuciselacawoola.

Ntendaakutalimvwakabotu

Ciindicanunotuyocibelesyakuvvwuwamibuzyo.Mpoonakwiinantendailiwomukuvwuntauzyaooku.Mi buzyoimwiiinooliyacigamininapeletuyoosolakutimutakafwinsoni.

Bubotu

Kwiinabubotubwacigamininabuzwamukuvwuntauzyaooku.Nokubaboobo,
twaambotutikapegwetuyoogwasyabasikubambamaniaansebakutibakabambeweendelezibutindiny
weabamakaintubamwikuciindicakulangwabwandanyobwaluzyalo.Kwiinamaliayoopegwamubuvwunt
auzioobu,
peletuyooingulamibuzyoayanukujatikizyazitondezyozyabubotubwakwandanyakuzyalamukaintu.

Maseseke

Twaambotoonsetujatikizyabuvwuntauzyiatwaambotoonsetutipegwekuciindieecintwamaseseskecitak
utimulawowazumizyakucitaobo.Muyoopegwabuyonambayaloinoolicizyibyocanu.Zyoonsezijatikizy
andinywekwiinanoziyoozyibwaakupegwakumuntuuumbicitakutimwazumizyakwiindamukulemba.Ci
beelaceendelezyazyamaseseke, abweendebubotubwazintu, naacikolocamisamu,
alimwiamutabiwansebawamfulumendeingawatambulatawambotwanupelezyoonseziyoocitwacakusisa
.

APPENDIX VI

INFORMED CONSENT FORM

The Purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that:

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary.

I _____ (Names)

Agree to take part in this study.

Signed: _____ Date: _____ (Participant)

Participant's signature or thumb print

Signed: _____ Date: _____ (Witness)

Signed: _____ Date: _____ (Researcher)

PERSONS TO CONTACT FOR PROBLEMS OR QUESTIONS

1. Chairperson, Eres Converge IRB,33 Joseph Mwilwa Road, Rhodes Park, Lusaka, **Tel:260 955 155 633/4** , cell:260 966 765 503, email:eresconverge@yahoo.co.uk
2. Head of Department of Nursing Sciences, University of Zambia, Department of Nursing Sciences, P.O. Box 50110, Lusaka. Phone no. 0211252453.
3. The principal investigator, Mrs. Charity Chongo Lyambai, Livingstone School of Nursing, P.O. Box 60091 Livingstone ,Tel:260 03321883, cell: 260 961 924573 email:ccllyambai@yahoo.co.uk

IPEPA LYACIZUMINANO

Buwvuntauzyiboonsebwapandululwakulindimealimwindaswiililisyamuzeezo, bubotu, Ntendaakutalimvwakabotukubikilizyaamasesekeajatikizyabuvwuntauzyi. Ndajanaalimwiluzyi bolwakutinaandazuminakutolalubazumukuvwuntauzyaooku, ingandalekaakatikatikakunyinakupatwaambo. Alimwindazyibakutikutolalubazumubuvwuntauzyioobucakulyaababuya.

Mebonde..... (Names)

Ndazuminakutolalubazumukuvwuntauzyaooku.

Kusimba..... Buzubabwamwezi.....

Kusimba..... Buzubabwamwezi.....
(kamboni)

Kusimba..... Buzubabwamwezi.....
(sikuvwuntauzya)

Naamujisimibuzyonokubamakatazyo, amulembelekuli;-

1. Chairperson, Eres Converge IRB,33 Joseph Mwilwa Road, Rhodes Park, Lusaka, **Tel:260** 955 155 633/4 , cell:260 966 765 503, email:eresconverge@yahoo.co.uk
2. Head of Department of Nursing Sciences, University of Zambia, Department of Nursing Sciences, P.O. Box 50110, Lusaka. Phone no. 0211252453.
3. The principal investigator, Mrs. Charity Chongo Lyambai, Livingstone School of Nursing, P.O. Box 60091 Livingstone ,Tel:260 03321883 cell: 260961924573,email:cclyambai@yahoo.co.uk

APPENDIX VII

Marking Key for the knowledge variable

QUESTION	ANSWERS	MARKS
1. What is family planning?	Family planning is a voluntary decision made by an individual or a couple on the appropriate number of children they wish to have, and when to have the children	1
2. Which method of family planning do you know	<p>Oral pill</p> <p>Injectable</p> <p>Intra –uterine device</p> <p>Vaginal methods</p> <p>Norplant implants</p> <p>Female /male sterilization</p> <p>Fertility awareness – based methods</p> <p>Lactation amenorrhea method</p>	8
3. Can men be involved in family planning	Yes	1
4. What are the benefits of involving men in family planning?	The benefit of involving men is to prevent misunderstandings by couples and promote the idea of joint decision making regarding family planning use	1
Total Marks		11

APPENDIX VIII: LETTER TO THE DISTRICT MEDICAL OFFICER

The University of Zambia,
School of Medicine,
Department of Nursing Sciences,
P. O. Box 50110,
LUSAKA.

01st August, 2014.
UFS: The Head of Department,
Department of Nursing Sciences,
School of Medicine (UNZA),
P. O. Box 50110,
LUSAKA.

The District Medical officer,
Livingstone District Health Office,
LIVINGSTONE.

Dear Sir/Madam,

RE: PERMISSION TO COLLECT RESEARCH DATA

I am a student at the above named institution, currently pursuing a Master of Science in nursing degree. In partial fulfilment of this program, I am required to conduct a research study. My research topic is, "Factors influencing women's decision making regarding family planning use in Livingstone district". The study will involve interviewing women in the child-bearing age (15-49 years) at Maramba Health centre and in the community, and will be conducted from October, 2014 to November, 2014.

I am, therefore asking for permission to collect the research data from the above mentioned area. Find attached the letter of clearance from UNZA Biomedical Research Ethics Committee.

Your favourable consideration on my request will be highly appreciated.

Yours, faithfully,

Chongo Charity Lyambai (Mrs).

APPENDIX IX: LETTER TO THE TOWN CLARK

The University of Zambia,
School of Medicine,
Department of Nursing Sciences,
P. O. Box 50110,
LUSAKA.

1st August, 2014.
UFS: The Head of Department,
Department of Nursing Sciences,
School of Medicine (UNZA),
P. O. Box 50110,
LUSAKA.

The Town Clark,
Livingstone Municipal council,
LIVINGSTONE.

Dear Sir/Madam,

RE: PERMISSION TO COLLECT RESEARCH DATA

I am a student at the above named institution currently pursuing a Master of Science in nursing degree. In partial fulfilment of this program, I am required to conduct a research study. My research topic is "Factors influencing women's decision making regarding family planning use in Livingstone district". The study will involve interviewing women in the child-bearing age (15-49 years), and will be conducted from October, 2014 to November, 2014 at Maramba Health Centre and in the community.

I am therefore asking for permission to collect the research data from the above mentioned area.

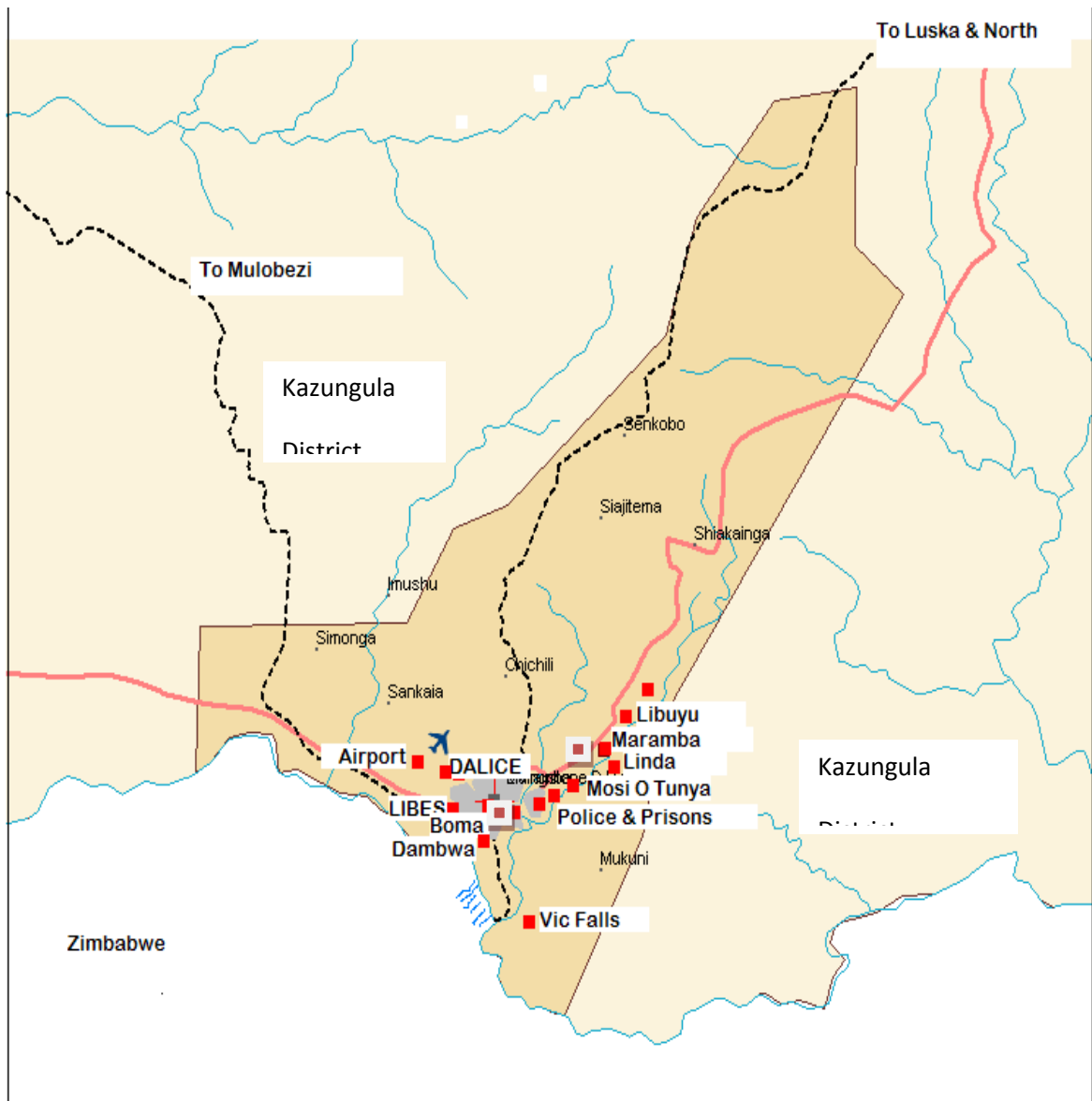
Attached is the letter of clearance from UNZA Biomedical Research Ethics Committee.

Your favourable consideration on my request will be highly appreciated.

Yours, faithfully,

Chongo Charity Lyambai (Mrs).

APPENDIX X: MAP OF LIVINGSTONE DISTRICT



LEGEND

- | | |
|---|--|
| ■ Health Centre | ■ Town |
| — River/Stream | ■ Settlement |
| — Main Road | |
| - - - Railway line | |
| + General Hospital | |
| Water Falls | |