

**FORMS AND CHALLENGES OF ADULT EDUCATION PROGRAMMES
WHICH PROMOTE REPRODUCTIVE HEALTH IN MUNGWI DISTRICT**

BY

MPOTELA STANLEY

**DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE MASTER OF
EDUCATION IN ADULT EDUCATION DEGREE**

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2014

DEDICATION

I would like to dedicate this work to my dear wife (Margaret Nyoni Mpotela) and our four (4) children, namely Shadreck, Misheck, Lydia and Elizabeth. I salute them for their relentless support to me particularly during the period of my study. They were on hand as and when I needed them.

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AUTHORS DECLARATION

I, Stanley Mpotela do declare that this dissertation represents my own work and that it has not in part or in whole been presented as material for award of any degree at this or any other university. Where other people’s work has been used, acknowledgement has been made.

Signature of author:

Date:

Signature of the supervisor:

Date:

APPROVAL

The University of Zambia approves the dissertation of Stanley Mpotela as fulfilling part of the requirements for the award of the degree of Master of Education in Adult Education.

Signed: **Date:**

Signed: **Date:**

Signed: **Date:**

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ABSTRACT

This study sought to investigate the forms and challenges of adult education programmes on reproductive health in Mungwi District. Many Adult Education strategies are employed by health providers to disseminate information on reproductive health in Zambia and in Mungwi District in particular. However, not much is known nor documented about the forms and challenges of adult education programmes in Mungwi District.

This study used a case study design to help the researcher gain detailed insight into forms and challenges of adult education programmes which promote reproductive health in Mungwi District. Furthermore, a case study was used to collect in-depth information and subjective feelings from the respondents on the subject under study. This research design allowed the triangulation of data which in turn helped to explain fully the phenomenon under study.

Data was collected using both questionnaires and an interview guide. Qualitative data was analyzed by coding and classifying the themes that emerged from the responses. Quantitative data was analysed by the use of Statistical Package for Social Sciences (SPSS) Version 20 which was used to generate frequency tables through cross tabulation.

The study revealed that Vocation and Skills Training, Literacy, HIV and AIDS Education, Agriculture Extension and Health Education were the major forms of adult education in Mungwi District used to disseminate adult education reproductive health programmes. Health education was the most used form of adult education in the area. The greatest challenge faced by participants had to do with funding. The respondents indicated that lack of adequate funding for reproductive health programmes adversely affected the implementation of reproductive health programmes in Mungwi District.

The study recommended that: the Ministry of Health, Society for Family Health, Maristopes and other organizations whose mandate is to promote reproductive health should strengthen awareness campaigns for dissemination of information and early management of reproductive health related diseases such as cancers; programme implementers should sensitize men and women on the existence of gender disparity and the benefits of gender balance in matters related to reproductive health; and the government should empower women with knowledge, and skills to develop their self-esteem and assertiveness to enable them make positive decisions regarding their reproductive health.

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ACRONYMS

AIDS	– Acquired Immuno Deficiency Syndrome
CSO	– Central Statistical Office
DMO	– District Medical Officer
ECLAC	– Economic Commission for Latin America and the Caribbean
FNDP	– Fifth National Development Plan
HBM	– Health Belief Model
HIV	– Human Immunodeficiency Virus
ICPD	– International Conference on Population and Development
IEC	– Information Education and Communication
MCDMCH	– Ministry of Community Development, Mother and Child Health
MOE	– Ministry of Education
MOH	– Ministry of Health
NGOs	– Non-Governmental Organizations
PMO	– Provincial Medical Officer
RHCs	– Rural Health Centre
RHORP	– Reproductive Health Out-Reach Programme
SPSS	– Statistical Package for Social Sciences
STD	– Sexually Transmitted Diseases
TBAs	– Traditional Birth Attendants
TFR	– Total Fertility Rate
UNESCO	– United Nations Educational, Scientific and Cultural Organization
WHO	– World Health Organization
ZDHS	– Zambia Demographic Health Survey Report
SSDS	– Sector Skills Development Strategy
TEVETDP	– Technical Education, Vocational and Entrepreneurship Training Development Program
TEVET	– Technical Education, Vocational and Entrepreneurship Training

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

This chapter provides an overview of the study which was premised on the forms and challenges of reproductive health programmes in Mungwi District. The chapter also presents the background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, delimitation of the study, limitations of the study, operational definitions and organization of the study.

1.2 BACKGROUND

Dissemination of information in rural areas has generally been a challenge. In Mungwi District of Northern Province, for instance, distances to villages coupled with poor roads and illiteracy have been some of the major challenges (CSO, 2000). Reproductive health programmes have been using different forms of adult education in order to take messages to the masses as most approaches in adult education are also used in other fields when it comes to dissemination of information. Thus it was essential to know the forms of adult education and their challenges in Mungwi District. This was especially important because of the sensitivity of the subject of reproductive health; most people were believed to have avoided the programmes. Parents were not free to talk to their children about contraceptives which have also been wrongly viewed to be synonymous with reproductive health.

Provision of contraceptives has been a major activity in reproductive health in Zambia. According to the CSO (2010), the major providers of contraceptive methods in the country have been government-aided health institutions. The Report further alluded to the fact that the distribution of modern contraceptive materials for current users showed that most people (i.e. 68 %) obtained their contraceptives from the public sector. It also stated that the participation of the private medical sector in family planning service delivery had decreased steadily during the past 15 years from 36 % in 1992 to 17 % in 2007. According to the Zambia Demographic Health Survey Report (CSO, 2007), the current use of contraception in Zambia had increased from a rate of 15 % in 1992, 26 % in 1996 and 34 % in 2001-2002 to the rate of 41% in 2007.

The increase in contraceptive use discussed above is demonstrated by the low number of children by mothers in their late twenties. For instance:

Women in Zambia in their late twenties had about 3 children and by the time they reach the end of their reproductive years (i.e. age 45-49 years), they would have given birth, on average, to 7 children, with 6 surviving. The most significant difference in the total number of children ever born between all women and currently married women was found in the youngest age group (i.e. 15-19 years). This was because many women in this age group were not yet married and therefore the exposure to the risk of pregnancy was lower than for older women. Nevertheless, the differences at older ages (i.e. 40-44 years and 45-49 years) reflected the impact of marital dissolution (divorce or widowhood). Hence, the uniformity in the distribution of older women, that were currently married provided a measure of primary infertility, that is, the proportion of women who were unable to have children at all (CSO, 2002:25).

The survey pointed out the fact that issues of voluntary childlessness were rare in Zambia. Further, married women with no live births were likely to be unable to have children and about 2% of all women were unable to have children.

CSO (2010) clearly noted that levels of rural poverty were three times those in urban areas. Furthermore, the Report highlighted the fact that as of 2010, rural poverty had been estimated at 77.9% compared to urban levels at 27.5%. The Report further pointed out that health plays a very critical role in the development of the country hence, the need for a sound health policy. However, since 1991 the health sector has been making strides to improve the health delivery system in Zambia. Some of these efforts include moving from a strongly centralized health system to a decentralized one which has meant adding value to a rural population like Mungwi District. Correspondingly, there has been an improvement in the education sector, thereby contributing to high enrolment levels of girls and boys in both primary and secondary schools.

Poverty levels are still high despite recording economic growth between 2006 and 2010. The proportion of the population falling below the poverty line reduced from 62% in 2006 to 60.5 % in 2010. At independence in 1964, the economic structure of Zambia, like other countries which were mineral rich in the region, was based on exports of raw materials, mainly copper, zinc and cobalt. To date, the predominant factor in the Zambian economy is mining and processing of copper (CSO, 2010).

However, the country has since diversified in other sectors of economic growth such as manufacturing and agriculture. Despite all these economic efforts made so far, Zambians continue to have poor access to health care. This is due to the fact that 60.5% of the population still reside in the rural areas with very little or no proper health facilities at all, resulting in poor access to health related information.

CSO (2007) noted that:

Marriage patterns are an important determinant factor of fertility levels in a population. The median age at first marriage in Zambia among the womenfolk aged 25-49 is 18.2 years. Urban women marry one year later than rural women (19.1 and 17.8 years old, respectively). The median age at first marriage varies greatly by the woman's educational status. The median age at marriage for women aged 25-49 that have no education is 17.3 years compared with 24.4 years for women that have more than secondary education. Men enter into first union at a much later age than women; the median age at first marriage for men aged 25-49 is 23.5 years. The average man and woman in Zambia initiate sexual activity before marriage. Among the population aged 25-49, the median age at first Sexual intercourse is 17.9 years for men and 17.2 years for women. Teenage pregnancy is high in Zambia. About three in ten young women aged 15-19 have begun childbearing, that is, they have given birth already or are currently pregnant with their first child. (p.22)

On the other hand, CSO (2007) shows that 14 % of currently married women are married to men who are in a polygamous union. Older women, who live in rural areas, have less education. These are women in the lowest wealth quintiles. As such, they are more likely than other women to be in polygamous marriages. The prevalence of polygamy varies markedly across provinces, with Lusaka having the lowest level (i.e. 4%), while Southern province having the highest (i.e. 25 %). Overall, knowledge of family planning in Zambia has been nearly universal since 1996. Moreover, the Zambia Demographic Health Survey Report of 2007 points out that 97% of all women and 99% of all men know about a contraceptive method. The pill, male condoms, and injectables are the widely known methods.

CSO (2010: 7) show that:

Fertility in Zambia has remained at a high level over the last 15 years from 6.5 births per woman in 1992 to 6.2 births in 2007. On average, rural women are having three children more than urban women (7.5 and 4.3 children, respectively). The low level of fertility among urban women is also reflected in the lower fertility among women in the urban provinces of Lusaka and Copperbelt, where women on average are having 4.1 and 4.8 children respectively, compared with 6.2 or more children in other provinces. Fertility differentials by education and wealth are noticeable. Women who have no formal education and women in the lowest wealth quintile on average are having more than 8 children, while women with higher than a secondary education and women in the highest

wealth quintile are having 4 or less than 4 children. Unplanned pregnancies are common in Zambia. Overall, 16 % of births are unwanted, while 26% are mistimed (wanted later).

The WHO (2012) says that reducing the maternal mortality ratio by three quarters is one of the targets of the millennium development goal number five. Significant progress has been made globally in ensuring that all countries strive to achieve this important target. Globally, an estimated 287,000 maternal deaths occurred in 2010, a decline of 47% from levels in 1990 (WHO, 2012). Despite these results, Sub Saharan Africa still lags behind in many areas of health development particularly of the majority rural populous.

The Ministry of Health with the support of Society for Family Health (SFH) and other cooperating partners in Reproductive Health programmes developed the project (MOH, 2004). Socio-cultural factors like HIV and AIDS, sexual abuse and coercion are among the common problems that are prevalent in Mungwi District.

It is against such a background of the country's reproductive health status that the study sought to investigate how adult education was being used to disseminate information on reproductive health to the rural population of Mungwi District. The research endeavoured to investigate the various forms of adult education programmes that Government and Non-Governmental Organizations were involved in, as they pursued Zambia's health matters in the area of reproductive health.

1.3 STATEMENT OF THE PROBLEM

Many Adult Education strategies are employed by health providers to disseminate information on reproductive health in Zambia and in Mungwi District in particular. However, not much was known nor documented about the forms and challenges of adult education programmes in Mungwi District. Therefore, the task of the study was to find and learn the strategies employed by health providers to disseminate information on reproductive health in Zambia.

1.4.0 PURPOSE OF THE STUDY

The purpose of this study was to identify the forms and challenges of Adult Education Programmes in Mungwi District of Northern Province of Zambia.

1.5.1 PRINCIPAL OBJECTIVE

To establish forms of and challenges faced by adult education programmes in reproductive health in Mungwi District.

1.5.2 SPECIFIC OBJECTIVES

The specific objectives of the study were to:

1. investigate the different forms of adult education programmes used in the promotion of reproductive health in Mungwi District;
2. determine the major challenges that service providers in reproductive health faced during their work;
3. investigate the challenges that participants faced as they applied reproductive health practices acquired through Adult Education programmes; and
4. suggest possible solutions meant to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District.

1.6.1 PRINCIPAL RESEARCH QUESTION

The study was designed to seek answers to the question below:

What are the forms and challenges faced by adult education programmes which promote reproductive health in Mungwi District?

1.6.2 SPECIFIC RESEARCH QUESTIONS

The specific research questions of the study were:

- 1) what are the different forms of adult education programmes that are used in the promotion of reproductive health in Mungwi District?
- 2) what challenges do service providers encounter during the implementation of reproductive health programmes?
- 3) what challenges do participants face during the application of reproductive health practices?
- 4) what are the possible solutions that can be suggested in the mitigation of the challenges faced by service providers and recipients of reproductive health programmes?

1.7 SIGNIFICANCE OF THE STUDY

This study generated information for purposes of promoting various forms of Adult Education programmes which promote reproductive health. This could be useful to the Ministries of Health (MOH) and Community Development Mother and Child Health (MCDMCH) as well as other health providers. The aforementioned stakeholders could also be informed of the various challenges that service providers face in Mungwi District. Thus, informed stakeholders could make informed decisions regarding their future plans in the District. In addition, findings of the study are expected to add to the already existing body of knowledge on this subject.

1.8 DELIMITATION OF THE STUDY

The geographical scope of this research was to study rural populations, Mungwi District of Northern Province in particular. The District was chosen as the most conducive area for the study because it was one of the rural districts that were highly affected by reproductive health problems. Further, not much information on the forms of adult education used in the dissemination of Reproductive Health Messages was available. Hence, the researcher found it appropriate to conduct the study in four (4) villages around the catchment areas of four (4) clinics in the district. These were: Chitimukulu, Mungwi, Ngoli and Nseluka. Refer to map in Figure 1 below:

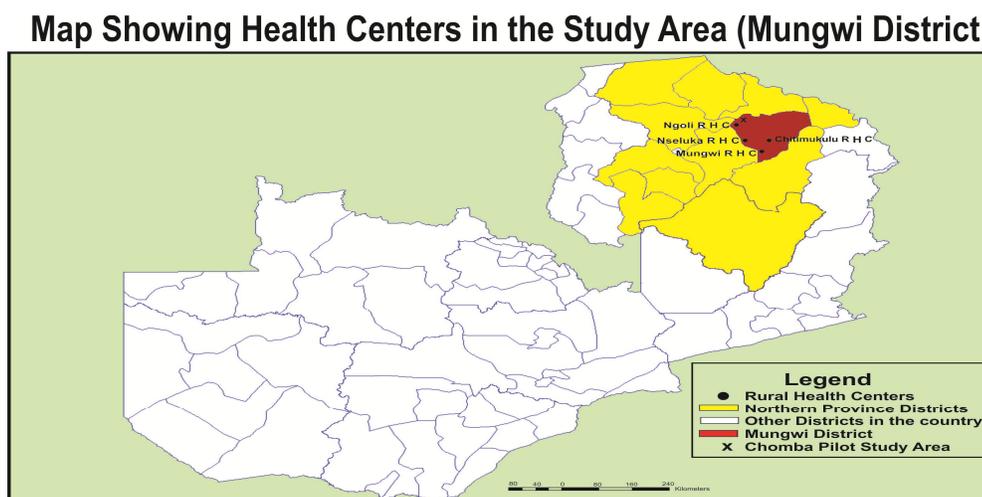


Figure 1

1.9.1 STATUS OF NORTHERN PROVINCE ON REPRODUCTIVE HEALTH AND FORMS OF ADULT EDUCATION

Northern Province is one of Zambia's ten provinces. It is here that Mungwi District is located. Mungwi has a population of 151,058 (CSO, 2010). The district recorded the lowest population growth rate of 2.9% in comparison to other districts in the province in 2010. The provincial population statistics compiled by CSO shows that out of a staggering 212,219 age 15-24, 166,597 make up the rural population while 45,662 live in the urban area of the Province. Age 15-64 total for the entire province was 535,909. Of this figure, 427,825 lives in the rural parts of the province while 108,084 live in the urban areas of the province (CSO, 2010).

However, the CSO (2000) says that adolescents and adults of this population (rural area) are often the last to be reached by education and social service programmes which translate into poor living conditions. These factors make this group particularly vulnerable to economic crisis, lack of employment, alcoholism, domestic violence, poor health, and low self-esteem, which perpetuate the cycle of poor quality of life and human underdevelopment in rural areas. The presence of a large number of children in poor families facilitates the intergenerational transmission of poverty. This population group has less access to information and family planning services to permit them to realize their reproductive expectations, which are much lower than actual fertility rates. Over 90% of urban households have electricity and less than one-third of rural households have electricity. Only 7% of females aged six and above living in urban areas have no education, whereas 24% of rural females have no formal schooling.

The percentage of females with at least secondary education in urban areas is 22% compared to 5% in rural areas. Regional and urban variations in fertility and mortality are also pronounced. For instance, infant mortality is three times higher in rural areas (71% versus 23%), and the total fertility rate (TFR) is twice as high (4.3% versus 2.2%). Child mortality is about one-half the level in other large cities and one-fourth the level in rural areas (i.e.85 per 1,000 in rural areas versus 23 in 1,000 in urban areas). Child mortality rates in some rural areas including Mungwi is as high as 108 per 1,000 (CSO, 2010).

Expectedly, culturally appropriate information, education and communication strategies for improving adolescent reproductive health in Zambia, are said to increase health risks for young adults, as do cultural norms regarding gender and sexual relationships. It is against such evidence that the research will seek to establish the various forms of Adult Education and how they contribute to informing the rural community of Mungwi District on matters concerning reproductive health (CSO, 2007).

With the information that has been collected through health surveys and reforms that the Ministry of Health (MoH) has been carrying out over the years since the early 90s, one of the action lines in health programme outreach has been the incorporation of the topics of Family and Sexual Education in the curricular structures of the different levels and modalities of the health structure. However, these actions have not been completed for diverse reasons. For example, most health stations are understaffed and extremely distant from would be beneficiaries of such activities. And those that are not understaffed may not have the materials for teaching or the trained community members to disseminate information on reproductive health.

Reproductive health information, education, and communication programmes and projects can contribute in many ways to increased knowledge, change attitudes, and enable action and mutuality, which are important goals for rural communities' well-being. Public education through radio can promote appropriate action in the home and community and can discourage unsafe practices that harm lives in rural communities especially adolescents' health. People in the rural areas of Northern Province have an urgent need to receive information about their sexual and reproductive health, keeping in mind their social and economic situations, educational levels, and attitudes and practices related to their sexual behavior. The Ministry of Health with the support of Society for Family Health (SFH) and other cooperating partners in Reproductive Health programmes developed the project (MOH, 2004). Socio-cultural factors like sexual abuse and coercion are among the common problems that are prevalent in Mungwi District.

According to MOH (2004), a comparative study of eight countries by policy project occasional papers (September 1998) showed that although Zambia made significant progress in expanding

access of services and improving the quality of care, the MOH did not yet have client-oriented services. It does not fully incorporate gender concerns and cultural perspectives into its programmes, nor does it always respect the reproductive and sexual rights of rural communities like the ones in Mungwi.

Youths between 15 and 24 years old make up one of the largest groups in rural Mungwi District and have special reproductive health and educational needs. The Ministry of Health estimates that the most frequent reasons for hospitalization among this group are obstetric causes, abortion complications, and violence (CSO, 2010). A serious problem is early adolescent pregnancy, which occurs because young people are not adequately informed about reproductive health, sex, and sexuality and gender issues. Patterns of early pregnancy restrict young people's possibilities for acquiring and developing abilities, knowledge and capacities that enable their entrance into the labour market. Nationally, more than 13.4% (about 175,000) of girls between the ages of 15-19 are already mothers or pregnant. In Mungwi District, 31% of the same age group were mothers (CSO, 2010). It is estimated that there are more than 270,000 induced abortions per year in Zambia, five for every 100 women of reproductive age (CSO, 2010).

1.10.2 FORMS AND TYPES OF ADULT EDUCATION

This section sheds light on the different forms and types of adult education that were known to exist in Mungwi District but not necessarily for reproductive health adult education programmes. Encyclopædia Britannica (2009) classifies these as will be discussed in the following subsections.

1.10.2.1 Education for vocational, technical, and professional competence.

This kind of education aims at preparing an adult for a first job or for a new job, or it may aim at keeping him up to date on new developments in his occupation or profession. Vocational education refers to instruction intended to equip persons for industrial or commercial occupations. It may be obtained either formally in trade schools, technical secondary schools, or in on-the-job training programs or, more informally, by picking up the necessary skills on the job (Encyclopædia Britannica, 2009).

In Zambia, vocational training is under the custody of the MESVTEE, and is responsible for the Technical Education, Vocational and Entrepreneurship Training Authority (TEVETA). TEVETA is an institution formed out of the TEVET Act No, 13 of 1998. It is responsible for the interpretation of the TEVET policy. It is the intention of the Government of the Republic of Zambia (GRZ) to develop a system of technical education, vocational and entrepreneurship training, which will satisfy the real demands and requirements of the labour market and socio-economic conditions, all of which have been recognized to be in a state of constant change. TEVET is designed in such a way that it satisfies the labour market, socio-economic concerns and resource based opportunities in the economy (www.teveta.org.zm).

The Government through the then Ministry of Science, Technology and Vocational Training, launched the Technical Education, Vocational and Entrepreneurship Training Development Program (TEVETDP) aimed at reforming the training system to make it responsive to the demands of the labour market. In the context of these reforms, the Technical Education, Vocational and Entrepreneurship Training Authority has developed the Sector Skills Development Strategy (SSDS) as an appropriate response to the requirement that the technical education, vocational and entrepreneurship training system should be demand-driven (www.teveta.org.zm).

1.10.2.2 Education for health, welfare, and family living. This education includes all kinds of education in health, family relations, consumer buying, planned parent-hood, hygiene, child care, and the like.

1.10.2.3 Education for civic, political, and community competence. It includes all kinds of education relating to government, community development, public and international affairs, voting and political participation.

1.10.2.4 Education for self-fulfillment. This education embraces all kinds of liberal education programs: education in music, the arts, dance, theatre, literature, arts and crafts, whether brief or long-term. These programs aim primarily at learning for the sake of learning rather than at achieving the aims included in the other categories.

1.10.2.5 Remedial education: fundamental and literacy education. Remedial education is a prerequisite for all other kinds of adult education and thus, as a category, stands somewhat apart from the other types of adult education (Encyclopædia Britannica, 2009).

In reference to remedial education, adults often need to compensate for inadequacies of earlier education. When these are not remedied, they inhibit recourse to modes of education that are adult, that is, in terms of sophistication in today's society and not in terms of age. This education is required most extensively in societies that are changing rapidly from subsistence to an industrial economy and concurrently changing politically and socially. Mass literacy acquires a new importance in these nations of Asia, Africa, and Latin America, and the establishment of universal primary education becomes a social imperative. To prevent a generation gap in reading skills and education while an effective school system is being created for the young, governments must attempt to provide parallel facilities for adults. Even in countries with mature systems of childhood education, however, opportunities for higher or even sometimes secondary education are unequal among various regional, occupational, and social groups. Hence there are adult programs for completing high school or preparing for examinations normally taken at the end of secondary school (Encyclopædia Britannica, 2009).

1.10.2.6 Agriculture extension

Agriculture extension is a form of adult education that mainly aims at passing agriculture technologies to small-scale farmers. This should be so because, the agricultural sector is responsible for encouraging the application of techniques for improving methods of cultivation and animal husbandry at all levels of farming. This could be achieved by increasing the use of animals that could withstand droughts, use of correct insecticides, fertilizers, other forms of manure, improved methods of cultivation and harvesting. It also focuses on encouraging the introduction of new crops. Another measure taken is getting research findings from farmers by putting what is on the ground to actuality. It is believed that farmers do have indigenous knowledge that needs to be improved on in order to better their lives. Through agricultural extension, farmers are helped to increase their understanding of issues that pertain to farming, since they have to be active participants in the programs. Culminating from these is increased

production through increased yields of diverse number of crops. When this is achieved, at household level then even at country level, there would be increased food security.

Therefore, education of small scale farmers cannot be separated from extension education. Extension work was born out of the need to develop agriculture. Bradifield (1966:11) in Chakanika (1989:47) further says that:

Extension has been developed as the only logical, scientific and successful way of bringing knowledge to farmers to help them farm their lands more efficiently... extension work, is about developing agricultural skills and knowledge of farmers, enables them to make more productive use of the country's natural resources.

It is generally believed that much of the learning that is offered to farmers is from extension programmes. It is common knowledge that it becomes essential that an extension programme should not only have the endorsement but also the patronage and whole hearted participation of a great multitude of persons living in the thousands of village communities who form the immense population of the under developed countries. It is these learners or participants who have to formulate, accept and execute the programme for their own improvement (Bradifield (1966) in Chakanika (1989).

1.10.2.7 In-service training

In-service training is a way of training a worker to update him/her with up-to-date information and techniques through seminars, workshops and long term courses. Improvement of the quality of personnel in public or private organizations is supplemented by in-service programmes. For instance, teacher management entails the establishment of an effective oversight body on quality control and quantitative improvements in teacher supply, which is complemented by an effective performance management system that monitors the performance of teachers at different levels, both in schools and teacher training institutions (MOE, 2007).

1.10.2.8 Literacy

It is observed that literacy plays a major role in fostering development of the economy. According to MOE (2007), Literacy is defined as a tool for promoting national

development in all spheres. This involves the acquisition of writing, reading and numeracy skills. However, development cannot take place by itself. It requires an educated, skilled and competent people. Therefore, a training curriculum must be tailored in line with the needs of the economy. With this in place, education is increasingly recognized as the key component to development process.

1.10.2.9 Mass media education

Radio, television, and the Internet - including e-mail and blogs are usually less influential than the social environment, but they are still significant, especially in affirming attitudes and opinions that are already established. The news media focus the public's attention on certain personalities and issues, leading many people to form opinions about them (Encyclopedia Britannica, 2009).

Research by Nielson (1998) and that of the Federation of Australian Commercial Television Stations (1995), Australian adults spend approximately three hours a day watching television.; 61% of Australian adults choose television viewing to stay informed and to access news; and 79% of Australian adults consider themselves to be most influenced by television advertising.

The mass media play another important role by letting individuals know what other people think and by giving political leaders large audiences. In this way the media makes it possible for the public opinion to encompass large numbers of individuals and wide geographic areas. It appears, in fact, that in some European countries the growth of broadcasting, especially television, affected the operation of the parliamentary system. Before television, national elections were seen largely as contests between a number of candidates or parties for parliamentary seats. As the electronic media grew more sophisticated technologically, elections increasingly assumed the appearance of a personal struggle between the leaders of the principal parties concerned. In the United States, presidential candidates have come to personify their parties. Once in office, a president can easily appeal to a national audience over the heads of elected legislative representatives (Encyclopedia Britannica, 2009).

1.10.2.10 Community development

United Nations defines community development as the process in which efforts of the people are united with those of governmental authorities to improve the socio-economic and cultural conditions of communities and to enable them to contribute fully to national progress. This process is said to be made up of two essential elements: the participation by the people themselves in efforts to improve their level of living, with as much reliance as possible on their own initiative; and the provision of technical and other services in ways that encourage initiative, self-help and cooperation (United Nations, 2001).

Adekambi and Modise (2000) in Nafukho, Amutai, and Otunga (2005) noted that adult education practices in Africa included evening classes, library services, extra-mural education, trade union education, secretarial training and popular theatre. Other terms used in place of adult education are: parallel degree programmes, self-sponsored degree programmes, mature entry programmes, privately sponsored degree programmes, prison education, non-formal education, informal education, distance education, experiential education, human resource development, AIDS awareness education, herbalists' education, and birth attendants' education. All these forms of adult education reflect the diversity of adult education programmes in Africa.

A number of authors have carried out studies on the forms of adult education used in different communities. In particular, Sichula (2012) found a number of forms of adult education used in community work in Chongwe District. The Forms of Community Adult Education Practices known by respondents in Chongwe included activities related to basic and functional literacy education such as learning how to read and write and acquisition of skills in agriculture related activities such as gardening and poultry. Since the main economic activity of the District was agriculture, activities related to functional or work related literacy were found to be more relevant in this environment as opposed to basic literacy. However, this study was designed to investigate the forms of adult education in the dissemination of reproductive health information.

Sichula (2012) indicated that top-down methods were used in the implementation of community adult education programmes. Most programmes were designed by specialists at the MCDSS headquarters and channeled to different districts and later on to sub-centres for implementation. Some respondents in Sichula's study explained that the practice had a problem of implementing programmes which were irrelevant to the needs of the people. Thus, relevancy of content is a key

aspect of adult education principles. It was also explained that learning needs differ from one community to another and, therefore, it was necessary to organize and implement community adult education programmes in full cognizance of the needs prevailing in the community. Added to this, the participants stated that the programmes were characterised by lack of relevant content. They explained that lessons such as, “limani nshaba”, (Grow groundnuts) or “limani chimanga” (Grow Maize) which were taught in all sub-centres had become boring and moreover some areas were known to be unsuitable for groundnuts and/ or maize cultivation. In the same vein, reproductive health messages were expected to be tailored to the particular focus group and the subject under consideration. On the other hand, it was indicated that the use of top-down methods in the implementation of community adult education programmes in the Chongwe District was not entirely rigid as it had some degree of flexibility. The respondents explained that other than the content which was designed by specialists, community development assistants working together with the community identified other learning needs which they integrated in the main content.

According to Nafukho, Amutai, and Otunga (2005), several terms and concepts have been used interchangeably with the term adult education as observed in the discussion above. This is probably because of the different forms and types in which adult education occurs. The other terms and concepts include continuing education which is defined by Tahir (2000) as a portion of education that endeavours to link the needs and aspirations of individuals with educational activities for the holistic development of a society. He further states that continuing education connotes that the learners have had some earlier schooling experience and are striving to develop into knowledge, skills and ideas already acquired.

Others understand adult education to be any form of learning undertaken by or provided for mature men and women (Encyclopædia Britannica, 2009). Adult education comprehends such diverse modes as independent study consciously pursued with or without the aid of libraries; broadcast programs or correspondence courses; group discussion and other “mutual aid” learning in study circles, colloquia, seminars or workshops, and residential conferences or meetings; and full- or part-time study in classes or courses in which the lecturer, teacher, or tutor has a formal leading role.

Youngman (1998) provided a summary of the various terms that have been used to refer to adult education. Some of them include: agriculture extension, in-service training, literacy, out-of-school education, audio-visual education for adults, mass media education, vocational education, in-service personnel training, community development, and cooperative education.

1.11 LIMITATION OF THE STUDY

The fact that a case study design was employed based on Mungwi District meant that its findings may not be generalized to other parts of the country. Further, some questionnaires were strayed. The researcher had to reprint and re-administer the instruments. It was also challenging to translate the questions from English to Bemba (local language) when administering the questionnaire to those who could not read and write. The researcher used some local people to assist with translation as well as an assistant in the field. Since Mungwi is a rural district, the availability of respondents was limited by the fact that farming activities dominated most of their time. In order to ensure that data was collected, the researcher took advantage of those moments when people gathered for community activities at clinics and when rainfall restricted them from going to the fields.

1.12 OPERATIONAL DEFINITION OF TERMS

The definition of terms provide the context in which they are used in the dissertation:

- i. **Adult Education:** education that prepares people regarded as adults to live effectively and efficiently in their own environment;
- ii. **Adult Education Participants:** these are people that have previously undergone different kinds of Adult Education programmes (for instance, campaigns against early marriages and malaria, dissemination of hygiene messages such as use of clean drinking water, creating a reasonable distance between pit-latrines and water wells and use of family planning methods);
- iii. **Forms of Adult Education:** They refer to types of adult education, which may include among others; workers education, skills training, agricultural extension education, health education, in- service training and adult literacy.

- iv. **Community Adult Education Programmes:** this refers to the kind of education that is provided to the community whose main purpose is to serve the needs of the entire community. This education is all inclusive;
- v. **Reproductive Health:** this refers to matters relating to maternal issues involving child bearing for women; and
- vi. **Family Planning:** decision to have or not to have children using one form of contraception or the other.

1.13 ORGANIZATION OF THE STUDY

Chapter one is the introduction of the study which discusses the background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, delimitation of the study, limitations of the study, and definition of terms.

Chapter two reviewed literature appropriate to the study; Chapter three discusses the methodology of the study while chapter four will present the findings of the study. Chapter five will discuss the findings of the study and chapter six, which is the final chapter, will provide a conclusion as well as make recommendations based on the findings of the study.

1.14 SUMMARY OF CHAPTER ONE

Chapter one introduced the study and discussed the background to the study. The statement of the problem was presented and went further to provide the purpose of the study, objectives of the study, research questions, significance of the study, delimitation of the study, limitations of the study, and definition of terms.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews literature relevant to the subject under study. The review is conducted under sub items of: theoretical framework, health education and behavioural change; teaching techniques, reproductive health and adult education; selected studies across the world; and summary of the chapter.

2.2 THEORETICAL FRAMEWORK

A theoretical framework is a “collection of interrelated ideas based on theories. It is a reasoned set of propositions, which are derived from and supported by data or evidence” (Kombo, 2006: 56). There are a number of theories that could guide this study. Some of these include: PRECEDE theory, social learning theory, diffusion learning theory, and health belief model. However, this study employed Knowles’ approach as a theoretical framework which is discussed below together with the other theories mentioned above. Knowles’ approach was more suitable for this study than the other theories because it has a strong link to the adult learners who were the target population on matters of reproductive health. Further, it is Knowles’ approach that conceptualized the adult education principles for the adult learner.

a) PRECEDE framework

PRECEDE stands for Predisposition, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation. Rukunga (2001) argues that it has become the standard approach to programme planning in health education. It provides for a series of sequential steps designed to help the planner move from the recognition of educational needs to the development of a programme designed to fulfil those needs.

b) Social learning theory

Social learning theory (SLT) has developed into an influential approach in regard to both personality and general learning theory. It is focused on people rather than ideas or objects. SLT deals with behaviour such as eating or exercise habits. It provides a framework for self-

regulation of behaviour. In the process it resolves the conflict between internal and external factors as determinants of behaviour. The theory states that there are three positive determinants of behaviour: genetically-based instincts, environmental influences and the application of free will.

c) Diffusion learning theory

Research has consistently found that technical compatibility, technical complexity, and relative advantage (perceived need) are important antecedents to the adoption of innovations (Bradford and Florin, 2003; Crum et. al., 1996). Innovations in health can also diffuse depending on the health behaviour of the population being considered. Armstrong and Yokum (2001) contend that health behaviour can be divided into two general types: compliance behaviour and innovation. Compliance behaviour is generally known and recognised by both the learner and society as important to health. Much personal health behaviour, especially that related to secondary and tertiary prevention is compliance behaviour for existing health problems. For instance, following prescribed medication and ceasing to smoke cigarettes. Compliance behaviour is mainly addressed by constraints such as legislation and laws.

d) Health Belief Model

According to Becker (1976), Health Belief Model (HBM) stresses beliefs. The model explains that a belief is something that one accepts as the truth regardless of whether or not it is actually true. Whether or not a particular belief is valid in the people's eyes has little to do with its effect on the holder's behaviour. Each belief has two components, cognitive and affective. The cognitive element is what one knows and what might happen as a result. The affective element is how deeply one cares about the consequences of benefits. Cues are another major element of the Health Belief Model. They serve to mobilize relevant beliefs into consciousness and thus bear upon particular health decisions (Becker, 1976; Champion, 1984).

e) Knowles' Model

This model was selected to guide this study because it has a strong link to the adult learners who were the target population on matters of reproductive health. Forms and challenges of adult education programmes can be well understood by way of andragogy. Malcolm Knowles

popularized the notion of andragogy. This was done by way of describing adult learning through his work on the subject. For Knowles, andragogy is premised on at least four crucial assumptions about the characteristics of adult learners that are different from the assumptions about child learners on which traditional pedagogy is premised:

- i. self-concept - as a person matures his self-concept moves from one of being a dependent personality toward one of being a self-directed human being;
- ii. experience - as a person matures he accumulates a growing reservoir of experience that becomes an increasing resource for learning;
- iii. readiness to learn - as a person matures his readiness to learn becomes oriented increasingly to the developmental tasks of his social roles;
- iv. orientation to learning - as a person matures his time perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly his orientation toward learning shifts from one of subject-centredness to one of problem centredness; and
- v. motivation to learn - as a person matures the motivation to learn is internal (Knowles, et al., 1984).

Each of these assertions and claims of differences between andragogy and pedagogy is the subject of considerable debate. Knowles' conception of andragogy is an attempt to build a comprehensive theory (or model) of adult learning that is anchored in the characteristics of adult learners.

Commenting on the challenges of modern times that necessitate an andragogical approach to learning, Malcolm Knowles stated that the major problems of our age deal with human relations; the solutions can be found only in education. Skill in human relations is a skill that must be learned; it is learned in the home, in the school, in the church, on the job, and wherever people gather together in small groups (Brockett and Hiemstra, 1991).

This fact makes the task of every leader of adult groups real, specific, and clear: Every adult of whatever nature, must become a laboratory of democracy, a place where people may have the experience of learning to live co-operatively. Attitudes and opinions are formed primarily in the study groups, work groups, and play groups with which adults affiliate voluntarily. These groups

are the foundation stones of democracy. Their goals largely determine the goals of our society. The following outcomes are expected to be produced by adult learning:

Adults should acquire a mature understanding of themselves. They should understand their needs, motivations, interests, capacities, and goals. They should be able to look at themselves objectively and maturely. They should accept themselves and respect themselves for what they are, while striving earnestly to become better (Brockett and Hiemstra, 1991).

Adults should develop an attitude of acceptance, love, and respect toward others. This is the attitude on which all human relations depend. Adults must learn to distinguish between people and ideas, and to challenge ideas without threatening people. Ideally, this attitude will go beyond acceptance, love, and respect, to empathy and the sincere desire to help others (Candy, 1991).

Adults should develop a dynamic attitude toward life. They should accept the fact of change and should think of themselves as always changing. They should acquire the habit of looking at every experience as an opportunity to learn and should become skillful in learning from it (Candy, 1991).

Adults should learn to react to the causes, not the symptoms, of behavior. Solutions to problems lie in their causes, not in their symptoms. We have learned to apply this lesson in the physical world, but have yet to learn to apply it in human relations (Brookfield, 1994).

Adults should acquire the skills necessary to achieve the potentials of their personalities. Every person has capacities that, if realized, will contribute to the well-being of himself and of society. To achieve these potentials requires skills of many kinds—vocational, social, recreational, civic, artistic, and the like. It should be a goal of education to give each individual those skills necessary for him to make full use of his capacities (Brookfield, 1994).

Adults should understand the essential values in the capital of human experience. They should be familiar with the heritage of knowledge, the great ideas, the great traditions, of the world in which they live. They should understand and respect the values that bind men together (Candy, 1991).

Adults should understand their society and should be skillful in directing social change. In a democracy the people participate in making decisions that affect the entire social order. It is imperative, therefore, that every factory worker, every salesman, every politician, every housewife, know enough about government, economics, international affairs, and other aspects of the social order to be able to take part in them intelligently (Brookfield, 1994).

The theory argues that the society of our age cannot wait for the next generation to solve its challenges as time was running out so quickly. Society's destiny rests with the intelligence, skill, and good will of those who are now the leaders (who are mostly adults). The instrument by which their abilities as citizen-rulers can be improved is adult education. This is the problem. This is the challenge (Brockett and Hiemstra, 1991). Similarly, it is the adults of today that formulate and direct the progression of reproductive health programmes in our societies. Thus, this study was focussed on the residents of Mungwi District in general and adults of the District in particular whom the programme implementers decided to include in the sensitization. It is this andragogical approach that made this theory more appropriate to this study than the other theories earlier alluded to. In fact, the theory is appropriate to use in the processes of health education and behavioural change which is discussed in the next section.

2.3 HEALTH EDUCATION AND BEHAVIOURAL CHANGE

Living in society exposes people to different habits, customs as well as practices which may have a bearing on health. Moreover, the environment in which people live does also contribute to their good or ill health. It is therefore imperative for health workers to realize that it is their duty to ensure that people are made aware of the environmental factors that can expose them to ill health. They should also ensure that what they provide to their communities changes people's attitudes, customs and habits which would enable them to alter their environmental conditions and consequently cause them to live healthily. It is for this reason that health education and promotion becomes an important portion of health care delivery service. Considering all the above, it becomes necessary to notice that the main objective of health education and promotion basically is to prevent the spread of disease and encourage healthy living through behavioral change. Moreover, the above does contribute towards early and effective treatment of disease which in the final analysis contributes to minimizing sufferings and disability on the part of any

human being. An ideal health education and promotion programme is one that contributes greatly to lowering the incidences of sickness and death which are heavily rampant mostly in developing countries (Glanz, et al., 2002; Rukunga, 2001).

2.3.1 HEALTH EDUCATION

Health education is a process that helps people to help themselves with better understanding of health matters. Glanz, et al., (2002) states that there are three components of health education, namely, information, goals and learning. In their view, information includes what is known about health. Ultimate health goals are viewed in terms of desirable individual and community patterns. Learning is achieved by means of various methodologies within the educational process.

2.3.2 ROLE OF HEALTH EDUCATORS

Change agents are the primary health educators. In an attempt to facilitate change, health educators are expected to highlight the prevalence, causes and nature of health problems that the community is experiencing. It is basically necessary bring to attention of the community those practices, beliefs, and taboos that do cause the occurrence of various health problems. Thus, they are expected to motivate people so that they change from harmful health practices to those which are conducive to good health. As such, health workers have a responsibility of encouraging the community to appreciate their role in taking appropriate measures and acting to improve and maintain their good health through their own efforts. This enables them to be responsible for their own health through participation in decision-making processes and in seeking possible solutions to the health problem affecting them. therefore, it is by performing the role of improving people's health status that health educators would be contributing to the socio-economic performance and development of the country (MoH, 2000).

Ethical practices and conduct are fundamental to the practice of any profession. According to Rukunga (2001), there are ethical practices and conduct that a health educator should follow:

The health educator is the contact officer between the community and the health department; thus, the department will be judged by the manner in which duties are performed. There is an old saying that it is not what you do but how you do it that makes the difference between success and failure. In the course of duty, the health educator should approach people as a sales person with persuasion and educational efforts. ... in dealing with the

public, the health educator should endeavor to explain to the public why certain requirements are necessary. The health educator's duty is to accomplish results and not to flaunt knowledge of health matters (p.12).

2.4 REPRODUCTIVE HEALTH AND ADULT EDUCATION

The quality of our lives is very much determined by the meaning we give to the expression of our sexuality. Everyone somehow expresses sexuality. Some people are heterosexual; some are homosexual. Some make love only to themselves, and some make love only in their minds. We have entered an era where sexuality is openly discussed; laws concerning our sexual and reproductive lives are being questioned. Homosexuals are demanding that their civil rights should not be impinged upon because of what they choose to do in the privacy of their own lives. Women are demanding the right not to bear children if they choose to. Voluntary and involuntary sterilization is a hotly debated issue. Women are now able to bear children that were conceived outside their own bodies, either in the body of another woman or in vitro. What are the moral and ethical considerations inherent in this technology? Felicia, et al. (1998) reveals that the Center for American Indian Research and Education designed and tested a culturally sensitive cervical cancer screening educational programme tailored for the American Indian population. The project was conducted in 1993–1997 in eight American Indian clinics in the United States of America. One facet of the programme was to test the efficacy of a culturally appropriate psychosocial counseling support group intervention for increasing knowledge, changing attitudes, and improving behaviors toward the adherence to cervical cancer screening and follow-up for American Indian women. Diseases are now inter linked due to loss of moral and culture in sexual behaviour in the world today as children start having sex at an early stage. As Gadducci, et al. (2007:3) argue:

... infection with some type of Human Papilloma Virus (HPV) is the greatest risk factor followed by smoking. Other risk factors include; Human Immunodeficiency Virus (HIV). Not all of the causes of cervical cancer are known, however the several other contributing factors include having sexual intercourse at an early age, having multiple sexual partners and multiple births....

Thus, sexuality, pregnancy, procreation, abortion, sterilization, and contraception are all issues that are deeply involved in the entire framework of biomedical ethics and reproductive health (Fromer, 1983).

Family planning is part of promotion of reproductive health. The task of planning one's family, along with the choice and use of a suitable contraceptive method, involves a decision-making process. It is not a simple and dichotomous issue, that is, one of use or none use of contraception or having children or not having them. Like any decision-making issue, it is complex and requires time, communication, and understanding of all related issues and concerns. Some families have difficulties controlling their reproductive capabilities for several reasons: the various conscious and unconscious motivations for childbearing that are operative at different times; the contraceptive method itself, that is, how it is obtained and used, and its side effects; and the dynamics of the man-woman relationship (Snyder, 1970).

The above discussion is an adult education matter, but not exclusively. This is because children who are about to attain puberty (thus being ushered into adulthood by the biological definition of adult education) are prone to become child-parents if they were to be excluded from such a discussion. The societies have modernized to the effect that children have been exposed to adult activities too early. This may call for a modern solution which should include education for adults (Snyder, 1970).

The achievement of modernization, a self-sustaining economy, national integration and political development is the work of men and women who are willing to accept and initiate change and innovation; who have acquired new technical skills and new attitudes; who participate in decision-making; who have been socialized not only by the family and the local community but by their education, the political party, their trade unions and other organizations so that they see themselves as national citizens; and who have problem-solving and national ways of thinking. The need for both adult and child education is recognized by the Zambian government and its provision must be seen in the perspective of the goals and problems outlined above (Snyder, 1970).

2.5 SELECTED STUDIES ON REPRODUCTIVE HEALTH ACROSS THE WORLD

According to the MOH (2004), in sub-Saharan Africa, Latin America and indeed, the entire world, there are a number of issues pointed out concerning the rural population of Zambia,

Bolivia, Peru, Mali and Mozambique, to mention but a section. These show clearly how the rural populous of these countries face challenges related to reproductive health issues.

It is from this that we note various Governments worldwide emphasizing improvements in capacity and quality of sexual care and reproductive health services. Moreover, WHO (2012) pointed out the fact that Bolivia has shown interventions to improve quality of care. For instance, more of this care has been focused on health services, thereby largely leaving out education, prevention and community participation.

Thus, health provision and care should provide the basic resources like information. Adult education in its various forms becomes very important in this case. Furthermore, the provision of information, guidance and support enables people to have a healthy, safe and fulfilled sexual life. This is a challenging responsibility the health care system shares with families, other sectors and institutions (MOH, 2000).

2.5.1 Latin America

Network en Espanol (1993) in WHO (2012) noted that the Bolivian Government had taken two major interventions. The first was aimed at improving the provisions of health services which are being provided to improving quality of care by changing provider attitudes and improving their capacity to interact with clients. Secondly, to stimulate client demand for services by aiming at putting in place several different strategies which address demand for services. For example, social marketing campaigns like informing the public about sexually transmitted diseases is one such strategy. This is what would be communicated through the mass media channels, such as radio, newspapers, television and posters. Another one of their strategies is to focus on community education and information with an emphasis on social-groups that are typically out of reach of very important youth related programmes.

On the other hand, the Economic Commission for Latin America and the Caribbean (ECLAC), states that Bolivia is said to be one of the poorest countries in the region. Wealth and Socio-economic services are concentrated in urban areas, meanwhile about 90% of the rural population most of whom are from indigenous families live in extreme poverty, with limited access to services such as health and education. Hence, the high levels of illiteracy and very poor health standards in rural areas. For example, disparities exist with regard to reproductive health: while

the average birth rate is 3.8%, it can be as high as 5.5% in the rural communities. WHO (2012) did point out this one fact that while women in urban areas would have an average of 5.2 children, their fellows in a rural set up would on average have 6.2 children.

Another example is drawn from Jamaica where the Reproductive Health Out-Reach Programmes for Young Adults (RHORP) for the ages 18 years and above reports that; in 1978, the Jamaica Women Centre was founded with a view to assisting girls who became pregnant while in school to re-enter the system after giving birth. The programme provided academic instructions to those who could return to school. Skills training and vocational counselling to those past school age is being provided to these girls. This youth programme in Jamaica has spread to six other main centres and thirteen outreach stations serving rural populations. Camacho, et al, (1996) in WHO (2012) argues that health providers have not been trained on how to best interact with the community. Therefore, fear, distrust and discrimination have to a larger extent developed among the populous of the rural area in Bolivia.

2.5.3 SUB-SAHARAN AFRICA

Ringheim and Gribble in WHO (2012) cite a number of improvements in reproductive health in Sub-Saharan Africa's youth. However, child marriage is still most common among the poor and the poorly educated. In Mozambique and Mali for example, almost 60% of 18 year olds have become or are about to become mothers. By contrast, less than 10% of 18 year olds in Rwanda have either been pregnant or have already become mothers. Countries with little or no decline in adolescent birth rates over the last 20 years included Zambia, where unintended pregnancies were highest in Africa.

According to WHO (2012), in many parts of the world and Africa in particular, adolescents have been a neglected group. This is because of the fact that cultural sensitivities as well as gender disputes regarding sexuality have been clung to by many African societies. Hence, it is very common in much of African societies for adolescents not to seek for help from adults in their families, communities, or professional settings. Girls in particular, are often kept from learning about sexuality and health issues due to cultural and religious beliefs. Various methods are used in the dissemination of such information. Among them is the concept of education or awareness campaigns.

Campaigns are an important aspect of information dissemination. Banda (2013) reviewed awareness campaigns in his study which investigated the impact of the Keep Zambia Clean Awareness Campaign on residents of Mtendere Township. The awareness campaigns reviewed in Banda's study included the following subjects in respective countries: literacy (Cuba, Nicaragua and Somalia) and waste management (United States of America – Keep America Beautiful). In the review, factors that can lead to a successful campaign were discussed. An Awareness Campaign is a set of messages in form of newsletters or follow-ups that can be sent out to a particular group of people. Larsen (2005) contends that the meaning of an awareness campaign in the communication industry is to make a targeted audience aware of an issue. For example, a new method of contraception would need publicity for it to be known by all communities. Whether the subject is on reproductive health or otherwise, there are factors that have to be in place for a campaign to be successful.

2.5.4 REPRODUCTIVE HEALTH SITUATION IN ZAMBIA

Zambia has generally had worrying health statistics as already discussed in detail in chapter one. Reproductive health was not an exception as CSO (2007) reported that marriage patterns contributed to the factors that increased fertility levels in a population. CSO (2010) also indicated that fertility in the country was still very high in the last two decades averaging 6.5 births per woman in 1992 to 6.2 births in 2007. WHO (2012) aims at reducing the maternal mortality ratio by 75% as one of the targets of the millennium development goal number five.

The challenge of addressing people's needs throughout their lives and a recognition of the shortcomings of existing health programmes has led to an expansion of maternal/child health, family planning and STD, HIV and AIDS to the broader concept of reproductive Health. The adoption of a comprehensive approach to reproductive health is now seen as a necessary response to expanding needs in reproductive health arising for instance, from increased demand for family planning, greater awareness of maternal and neonatal mortality and morbidity, and a growing burden of reproductive ill health. Reproductive ill health will result from reproductive tract infections, cancers, STDs including HIV and AIDS, infertility and the results of violence related to sexuality and reproduction. The urgent need to respond to the threat posed by the AIDS pandemic further encourages the recognition of sexuality and health as a major component of reproductive health.

Reproductive health therefore, as defined by the International Conference on Population and Development in MOH (2000), is not just the absence of disease; it refers to a spectrum of conditions, events and processes throughout life. These range from healthy sexual development, physical comfort and closeness and the joys of childbearing, to abuse, disease and even death. The reproductive health approach offers opportunities to improve not only the health of childbearing women, but also of the next generation, and to involve men in all aspects of reproductive health. In addition, reproductive health has multidimensional aspects and hence collaboration with other sectors, is vital. The reproductive health also raises issues of human rights, equity, and discrimination which must be addressed through participatory and inclusive processes that involve communities, families and individuals. The reproductive health policy will therefore provide guidelines to different sectors involved in the implementation of reproductive health programmes. The policy sets out to respond to the country's prevailing reproductive health situation so as to improve the standard of living and quality of life of Zambians (MOH, 2000).

2.5.4.1 Challenges in Provision of Reproductive Health

In 1991 the Government of Zambia embarked on a radical health reforms process that has been dedicated to providing Zambians with equity of access to cost effective quality health care as close to the family as possible. Despite this vision the government still faces a number of challenges.

Currently, there are 206 urban centres and 880 rural centres in Zambia. The urban centres serve a catchment population of about 30,000-50,000 around a 30 Km radius and the rural health centres serves the catchment of about 10,000 within the same radius of 30 Km. However, in rural areas most health centres have serious staff and equipment shortages and are unable to provide basic package of primary health services or provide 24 hours coverage. This situation is not only true for rural and urban health centres but also true for some hospitals. Though staff may be there in hospitals there are shortages of equipment and supplies (MOE, 2000).

Furthermore, the health system has an uneven workforce distribution. Some rural health centres have no nurses or midwives. Currently, registration figures indicate that 7051 enrolled nurses, 2901 registered nurses approximately 3,500 nurse-midwives, 531 physicians and 12,093 clinical

officers exist but it is not clear how many are in practice or where they practice. Also, systems of referral between levels of the health care system are weak, especially in rural areas where health centres are more likely to be inadequately staffed or where staff cannot manage due to lack of equipment, pharmaceutical or supplies. Communication between health centres and hospitals are sometimes not possible due to possibly lack of the telephone or two-way radio communications and transport (MOH, 2004).

Although information education and communication (IEC) have been acknowledged as important in reproductive health by many health workers, there has been sporadic IEC activities with little or no systematic documentation or evaluation of activities that exist. Limited information exists at the national level on IEC campaign design, areas of operations and the audiences for which messages and materials were developed.

2.5.4.2 Safe Motherhood

Safe Motherhood addresses service delivery for improvement of the health of the mother and the newborn. This means ensuring affordable quality care for the mother and the new born as close to the family as possible. Although safe motherhood services have been provided in the past, there has been no significant impact on health indicators of the mother and the newborn as earlier shown. In 1972, the MOH embarked on community-based service provision by introducing a programme for Traditional Birth Attendants (TBAs), in an effort to promote safe motherhood. A substantial number of TBAs has since been trained, especially through community initiatives. However, according to district health plans of action and district reports, only a limited number of the trained TBAs are reportedly still active, while those that are still active are underutilized. According to the MOH (1996), most women rely on a nurse or trained midwife for antenatal care. Less than 1% of women received antenatal care from trained TBAs, an indication that TBAs are minimally utilized as a source of antenatal care. Ninety-Six per cent of all pregnant women interviewed have received at least one antenatal check-up from either a doctor or trained nurse or midwife (MOH, 2000).

MOH (1996) further indicated that, more than half of the women delivered at home and most of those deliveries were attended to by relatives. The relatives might be family birth attendants and

are most likely to have no midwifery training. Factors that contribute to the choice of place of delivery include traditional practices and reluctance to be delivered by a male health worker.

The rates of postnatal care attendance in Zambia are very low. The rate of postnatal care attendance was estimated at 7.3% in 1994 (WHO, 2012). The Safe Motherhood Needs Assessment also reviewed that only 60 % of the women who attended antenatal clinic returned to the clinic for delivery and postnatal care. Most women do not see the need for a postnatal check-up, or they do not know that such services exist. According to the WHO 2012, factors associated with maternal mortality indicate that only 20.2% of women (Cases and Control combined) attend postnatal mostly at either hospitals or clinics. It also revealed that 60.6% of maternal deaths occurred after delivery.

2.5.4.3 Family Planning

Family Planning in Zambia was started early in the 1960s. Unfortunately contraceptive prevalence is still low. According to the findings of the 1996 Demographic Health Survey, 98% of married women in Zambia have heard of family planning, and 59% have used a family planning method despite this knowledge, only 26% of married women in Zambia are currently using a contraceptive method. Fourteen per cent of married women are using modern methods while 12% are using traditional methods. There is a higher percentage of use of family planning methods among urban women than rural women. In addition, contraceptive use tends to increase with increasing level of education. Better educated women are more likely to use modern methods than women with less education. The "Unmet need for family planning" defined as the number of women who would like to either delay the next pregnancy or stop childbearing but are not doing anything to achieve the desire, declined from 33% in 1992 to 27% in 1996. Of this number, 19% have Unmet need for spacing their next birth and 8% for limiting births or stopping child bearing (MOH, 2004).

The Contraceptive Needs Assessment of 1995 showed that provider bias was evident towards clients and affected their method choices. There was inadequacy of skills in performing certain screening procedures and poor client - provider interaction. In addition, there was poor motivation on the part of providers due to the fact that most of those assigned to family planning

duties have little or no training in family planning, and those that are trained have no extra financial incentives. The low prestige of family planning in comparison with other reproductive health areas is another factor of major importance. Management of information and logistics systems, and supervision are also ineffective (MOH, 2004).

2.5.4.4 Adolescent Sexuality and Reproductive Health

Adolescent sexuality is becoming an increasing concern in Zambia. Urbanization and modernization are giving rise to a new pattern of sexual behaviour in adolescents, including pre-marital sex which often leads to early pregnancy, induced abortion, STDs and HIV infection. Adolescents express concern about lack of information and understanding about their own sexuality (MOH, 2000).

Teenage fertility has increased over the years. The percentage contribution of teenagers to the total fertility rate increased from 9.2% in 1969 to 10.6% in 1980, 12% in 1992 and 13% in 1996. In 1992 and 1996, more than a quarter of adolescents had a child. Despite the increase in teenage fertility, adolescent pregnancies carry a higher chance of obstetric risk and prenatal loss (abortion). Unfortunately, pregnant adolescents rarely receive special care, assistance or emotional support. Apart from high risk pregnancies, the large number of adolescents who initiate sexual activity at an early age are at high risk of contracting STDs/HIV and AIDS. The population survey on HIV sero-prevalence of 1996 indicated an infection rate of 8.2% among girls aged 15-19 years and 14.3% among urban girls of the same age group, while the infection rate among both boys and girls were 7.2% in rural areas and 9.1% in urban areas. The adolescents remain excluded from and are under-served through the current health service delivery system (MOH, 2000).

This could be attributed to health workers who do not receive special training to deal with adolescents. Further, the adolescents remain excluded even from the guidance on sexuality and relationships within their own home environment. Mostly adolescents depend on their peer for information on reproductive health and sexuality. However, the Government's intervention by introducing youth friendly health services is very promising, though done on a small scale. Family life education has been widely promoted although it is encountering problems. Parents

and community members fear that moral values may be lost when talking to adolescents about sexuality and other related topics. Adolescents as a special group require special attention (MOH, 2000).

2.6 SUMMARY OF CHAPTER TWO

In conclusion, this chapter has reviewed relevant literature on reproductive health in several parts of the world. It has also given varying examples of challenges and strategies of how other countries in different parts of the world performed regarding reproductive health and how its messages are disseminated. The chapter has noted the prevailing situation in Zambia's Reproductive Health status considering Mungwi District in particular. The review has shown that forms and challenges of adult education programmes that promote reproductive health have not been adequately studied. Therefore, this study sought to fill the gap in as far as knowledge of forms and challenges of adult education programmes were concerned in Mungwi District.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

Kumar (2005) defines methodology as a systematic process of collecting research data aimed at providing answers to research questions. Implicit in the term methodology, is justifying decisions on: research design, universe population of the study, sample and sampling techniques, data collection procedure, data analysis and ethical considerations. This chapter presents the methodology which was employed in this study.

3.2 RESEARCH DESIGN

Orodho (2003) defines research design as the scheme, outline or plan used to generate answers to research problems. It is a programme to guide the researcher in collecting, analyzing and interpreting observed facts. It may also mean a specification of most adequate operations to be performed in order to test specific hypothesis under any given conditions. In this study, research design refers to a plan to guide the overall research process.

This study used a case study design to help the researcher gain detailed insight into forms and challenges of adult education programmes which promote reproductive health in Mungwi District. Furthermore, a case study was used to collect in-depth information and subjective feelings from the respondents on the subject under study. Meanwhile, Kombo (2006) defines case study as a description of a unit in context and detail. The design enabled the integration of both qualitative and quantitative methods which were integrated in the analysis of data. This research design allowed the triangulation of data which in turn helped to explain fully the phenomenon under study.

According to UNESCO (2005), qualitative research is the type of research in which the researcher carries out research about people's experiences. This type of research is also carried out in natural settings using a variety of techniques such as interviews and observations, mainly

in words rather than statistics. Unlike qualitative research, quantitative research's principle feature is that it is based on numbers and statistical analysis.

3.3 PILOT STUDY

A pilot study was conducted in Mungwi District to test the data collection instruments in particular. It was conducted in Chomba area which was not part of the main study area. The number of participants that were sampled for the pilot study was 20, which comprised men and women who had participated in adult education programmes on reproductive health. The purpose of the study was explained and instructions were given to the respondents. An interview guide was used to collect data from the Community Development Assistant in Chomba area. The questionnaire was self-administered to all respondents. The observations on the research instrument particularly the questionnaire were managed to deal with the main issues of the study guided by the research questions.

3.4 MAIN STUDY

The main study was conducted following the evaluation of the appropriateness and clarity of the data collection instruments.

3.5 UNIVERSE POPULATION

Kombo (2005) defines population as a group of individuals, objects or items from which samples are taken for measurements (for example, a population of students). In this study, the population comprised members of the Community, health workers as well as Adult Education Programme Officers in Mungwi District. The total number of community adult education participants that had been selected for this study in Mungwi District included all the people surrounding the sampled health centers in Mungwi.

3.6 SAMPLE AND SAMPLING TECHNIQUES

3.6.1 Sample

According to Orodho and Kombo (2002), a sample is a subset of the entire population. Sampling is a procedure that a researcher uses to gather people, select places or things to study. Further, it is a process of selecting individuals or objects from an entire population such that the selected group contains elements representative of the characteristics found in the entire group (Orodho

and Kombo, 2002). The sample size for this study was generated from the total population of Mungwi District. The study sampled populations around four clinics in the district. In-depth interviews were conducted with officers in charge, clinical officers and the District Medical Officer (DMO) of Mungwi District. A sample size of 120 people was engaged in the exercise.

3.6.2 Sampling techniques

According to Kasonde-Ngandu (2013), sampling technique has to do with a portion of research project that shows the way cases were selected to be part of a study. Purposive sampling was used to sample key informants. Purposive sampling is a method of sampling where a researcher purposely targets a group of people or objects believed to be reliable for the study; and not every case in a universe population has a chance of being part of the sample (Kombo, 2002). Simple random sampling is the technique that gives every case in the population an equal chance to be selected (Kasonde-Ngandu, 2013).

The participants for quantitative data were selected using cluster sampling technique. Cluster sampling is a sampling technique used to sample "... a population that is dispersed across a wide geographic region..." (Kombo, 2002: 80, 81). The method allows for the division of the population into clusters that may include countries, regions, provinces or other boundaries (villages in this study). After sampling clusters, individual cases were randomly sampled. Simple random sampling technique is a technique that allows every case in the population to have a chance to be picked or sampled.

Clusters were selected purposively. Thereafter, respondents were drawn into the sample by going to the nearest houses to those sampled. In this study, four (4) cluster villages around the area clinics were chosen from Mungwi District. These were: Chitimukulu, Mungwi, Nseluka and Ngoli.

3.7 RESEARCH INSTRUMENTS

Two different instruments were used in order to collect both qualitative and quantitative data; these were semi-structured interview guide and a semi-structured questionnaire for staff from clinics. This study used both an interview guide and a questionnaire to take care of the

limitations of each instrument. The use of both qualitative and quantitative instruments enabled the researcher to check the reliability of the instruments so that validity of data collected can be enhanced. This is what is usually referred to as triangulation.

3.7.1 Interview Guide

According to UNESCO (2005), interviews can be divided into individual and focus group interviews. An individual interview is a conversation or interaction between the researcher and the research participant. Conversely, a focus group discussion is an interview for 8-12 people who are asked questions so that details may be given. This is conducted by the researcher to allow participation from every person.

3.7.2 Questionnaire

Kombo (2006) says a questionnaire is a research instrument used to gather data over a large sample. In this study, a semi-structured questionnaire was used to collect data from community adult education participants in Mungwi District. A semi-structured questionnaire allows for the collection of both qualitative and quantitative data hence its adoption.

3.8 DATA COLLECTION PROCEDURE

This study used both qualitative and quantitative procedures. Qualitative procedures were focused on subjective realities and feelings of the respondents obtained through interviews and questionnaires.

The researcher began by obtaining a letter from the Directorate of Research and Graduate Studies permitting him to undertake research and introducing him to the Provincial Medical Officer (PMO). A very good and cordial welcome was given to the researcher. Having been granted authority into Mungwi District, the researcher presented himself to the office of the District Medical Officer who warmly welcomed him. Immediately authority to carry out research at Mungwi, Nseluka, Ngoli and Chitimukulu Rural Health Centres (RHCs) was granted and out of 15 rural health centres 4 were sampled. On Thursday, December 5th 2013, the researcher visited Mungwi Rural Health Centre, upon winding work at Mungwi Health Centre, the researcher proceeded to Nseluka and Ngoli rural health centres respectively, and this was

between 14:24 and 16:30 hrs. This tour of duty continued on Saturday December 7th 2013 to Chitimukulu Rural Health Centre in Malole Area of Mungwi District. Nonetheless, this having been in the middle of the rainy season and at the pick of several farming activities, it was very challenging to find and meet with all those with whom arrangements had been made to conduct an interview. However, the researcher, with the support from officers in-charge from all four (4) rural health centres mentioned above, did accomplish all his tasks.

3.9 DATA ANALYSIS

According to Kumar (2005), qualitative data analysis is a process of analyzing the content of an interview in order to identify the main themes that emerge from the responses given by the respondents.

According to Dawson (2002), qualitative data analysis is a four step process that involves; identifying the main themes, assigning codes to these themes, classifying responses under the main area of study and integrating themes and responses into the text of the report. Therefore, in this study, qualitative data was analyzed by coding and classifying the themes that emerged from the responses. With regard to data that had been collected quantitatively, its analysis was done using Statistical Package for Social Sciences (SPSS). This was used to do cross-tabulation of variables to compare, for instance, the distribution of respondents according to age and marital status. The result gave the researcher an understanding of the trend in marital status versus the age groups. The software was also used to generate frequency tables to present the data.

3.10 ETHICAL CONSIDERATIONS

According to Syrett and Rudner (1996), ethical consideration is a code of conduct that respects informed consent by observing confidentiality, describes the role of the participant, and considers foreseeable risks, anticipated benefits, compensation and voluntarism.

This study observed the elements of informed consent mentioned in the definition above. This was done by preparing a letter of consent which was read and explained in the local language (Bemba) since most of the respondents could not read and write. When every participant expressed understanding of what the study was all about, the

researcher allowed them to state that they would participate. This ensured voluntarily participation and their benefits for participating in the study were explained. A letter of introduction also introduced the researcher to would be participants. It also stated that respondents did not need to reveal their personal identity.

Consent was sought in person from the participants for their willingness to take part in the study. It was made clear that the information they would provide would purely be for academic purposes and their participation would solely be voluntary. They were also assured that they were free to withdraw from the research at any stage whenever they felt uncomfortable with any question. As for those who could not read and write, the researcher had to explain in the local language.

There are three basic ethical principles that guide researchers. These are: respect for respondents, beneficence and justice. The principle of respect for persons involves two convictions:

- a) individuals are autonomous (that is, they have the right to self-determination and this right should be respected); and
- b) individuals with diminished autonomy require protection (this group would include children, the mentally impaired, unconscious patients and institutionalized persons). The right to self-determination means that individuals have the right to decide voluntarily whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Syrett and Rudner, 1996).

Beneficence

The principle of beneficence involves an effort to secure the well-being of persons. It states that one should do good and above all do no harm. The researcher made every effort to protect the respondents from discomforts and harm especially that the study was on a fairly sensitive matter (Syrett and Rudner, 1996).

Justice

The principle of justice includes the subjects' right to fair selection and treatment and their right to privacy. Subjects were selected for reasons directly related to the problem being studied and

not because they were easily available or could be manipulated or were poor or because the researcher liked them and wanted them to receive the specific benefits of a study. Subjects were treated respectfully and courteously (Syrett and Rudner, 1996).

3.11 SUMMARY OF CHAPTER THREE

This chapter discussed the methodology of the study which involved: research design, universe population of the study, sample and sampling techniques, data collection procedure, data analysis and ethical considerations.

CHAPTER FOUR PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the study. The findings will be presented in relation to the research questions which are presented in the following order: What are the different forms of adult education programmes that are used in the promotion of reproductive health in Mungwi District? What challenges do service providers encounter during the implementation of reproductive health programmes? What challenges do participants face during the application of reproductive health practices? What are the possible solutions that can be used to mitigate the challenges faced by service providers and recipients of reproductive health programmes? A summary of the chapter will then be given.

4.2 FINDINGS FROM ADULT EDUCATION PARTICIPANTS IN REPRODUCTIVE HEALTH

4.2.1 Forms of adult education programmes used in the promotion of reproductive health in Mungwi District.

Table 1: Distribution of Respondents by Age

Age Group	Frequency	Percentage (%)
12-15	1	0.8
16-21	4	3.3
22-27	10	8.3
28+	105	87.5
Total	120	100

Table 1 above shows that 1 (i.e. 0.8%) respondent was in the group 12-15 years; 4 (i.e. 3.3%) respondents were in the age group 16-21 years; 10 (i.e. 8.3%) respondents were in the age group 22-27 years; and 105 (i.e. 87.5%) were in the 28 years and above range. Therefore, the largest age group was in the range of 28 years and above who numbered 105, thus representing 87.5% of the total sample.

Table 2: Distribution of Respondents by Sex

Sex	Frequency	Percentage (%)
Male	58	48
Female	62	52
Total	120	100

Table 2 above shows the distribution of respondents by sex. Fifty-Eight (i.e. 48%) respondents were male and 62 (i.e. 52%) were female. This shows more female than male respondents having participated in the study.

Table 3: Forms of Adult Education in Reproductive Health in Mungwi District

Responses	Frequency	Percentage (%)
Vocation and Skills Training	9	7.4
Adult Education Literacy	11	9
HIV AND AIDS Education	17	10.6
Agriculture Extension	41	12.3
Health Education	44	36.1
Total	120	100

Table 3 above shows the forms of adult education in reproductive health in Mungwi District. Nine (i.e. 7.4%) respondents said they were aware that vocation and skills training were being carried out in the district; 11 (i.e. 9%) said they had known that adult education literacy was being practiced; 17 (i.e. 10.6%) said HIV and AIDS education was practiced; 41 (i.e. 12.3%) said agriculture extension was practiced in the district; and 44 (i.e. 36.1%) respondents said they were participating in health education.

Thus, the findings revealed that health education was the most practiced form of adult education in relation to reproductive health programmes (i.e. 44=36.1%). The least practiced form of adult education was vocation and skills training (i.e. 9=7.4%).

Table 4: Distribution of respondents by age, marital status

Age group	Marital status										Total	
	Single		Married		Divorced		Widow		Widower			
	F	%	F	%	F	%	F	%	F	%	F	%
12-15	0	0	1	100	0	0	0	0	0	0	1	1
16-21	2	50	1	25	1	25	0	0	0	0	4	3
22-27	4	40	2	20	3	30	0	0	1	10	10	8
28 +	17	16	80	76	2	2	2	2	4	4	105	88
Total	23	19	84	70	6	5	2	2	5	5	120	100

Note: F=Frequency in Table 4 above.

Table 4 above shows distribution of respondents by age and marital status.

Age group 12-15 years: the only respondent in this age group was married; none was divorced, widowed or widowered. None of the respondents in this age group were ever married as noted in table 2 above.

Age group 16-21 years: 2 (i.e. 50%) respondents in this age group were single; 1 (i.e. 25%) was married; while 1 (25%) was divorced; and none were either a widow or a widower.

Age group 22-27 years: in this age group, 4 (i.e. 40%) respondents were single; meanwhile 2 (i.e. 20%) were married; 3 (i.e. 30%) was divorced; and 1 (10%) was a widower.

Age group 28 years and above: 17 (i.e. 16%) respondents were single; while 80 (i.e. 76%) were married. Two (i.e. 2%) were divorced; 2 (i.e. 2%) were widows; and 4 (i.e. 4%) were widowers.

These findings indicate more married respondents in this study were in the age group 28 years and above (i.e. 105=88%) while the lowest in the age group 12-15 years with one respondent (i.e. 1=1%) who was married.

Table 5: Distribution of respondents by receipt of any form of education

Response	Frequency	Percentage (%)
Yes	108	90
No	12	10
Total	120	100

Table 5 above shows the distribution of respondents by receipt of any form of education. It also shows that 108 (i.e. 90%) respondents said that they had received some form of education while 12 (i.e. 10%) did not receive any form of education.

The findings in Table 5 above have shown that there were more (i.e. 108=90%) respondents who had received some form of education while fewer (i.e. 12=10%) respondents did not receive any form of education.

Table 6: Distribution of respondents by the type of health education received most

Type of Health Education	Frequency	Percentage (%)
HIV and AIDS Education	76	64
Reproductive Health Education	26	22
Public Health (issues of hygiene)	17	14
Total	120	100

Table 6 above shows the distribution of respondents by type of health education received. Seventy-Eight (i.e. 64%) respondents said they received HIV and AIDS education; 26 (i.e. 22%) said they received reproductive health education; and 17 (i.e. 14%) responded that they received public health education (issues of hygiene).

Thus, it is clear that the type of health education received most by participants was HIV and AIDS education (i.e. 76=64%) followed by reproductive health education (i.e. 26=22%) and lastly, Public Health (i.e. 17=14%).

Table 7: Distribution of respondents by the type of health education received most and provider of education

Type of health education received most	Provider of Education								Total	
	Ministry of Health		Ministry of Community Development, Mother and Child Health		NGO		Other			
	F	%	F	%	F	%	F	%	F	%
HIV and AIDS education	39	33	11	9	8	8	18	14	76	64
Reproductive Health Education	17	14	5	4	1	1	3	3	26	22
Public health (issues of hygiene)	9	7	3	3	0	0	5	4	17	14
Total	66	54	19	15	9	9	26	21	120	100

Note: F = Frequency in Table 7 above.

Table 7 above shows the distribution of respondents by the type of health education received and the provider of that type of education.

HIV and AIDS education:

The study also revealed that 39 (i.e. 33%) said this type of education was provided by the Ministry of Health; 11 (i.e. 9%) responded that it was provided by the MCDMCH; 8 (i.e. 8%) said it was provided by NGOs; and 18 (i.e. 14%) said that HIV and AIDS Education was provided by other agencies who were not mentioned by the respondents. It is therefore apparent that the HIV and AIDS education was mostly provided by the MOH.

Reproductive Health Education:

It was found that 17 (i.e. 14%) respondents said MOH provided this type of health education; 5 (i.e. 4%) respondents said health education they received was provided by MCDMCH; 1 (i.e. 1%) said it was provided by NGOs; and 3 (i.e. 3%) said that it was provided by other agencies.

Just like HIV and AIDS education, it is clear that the reproductive health education was mostly provided by the MOH.

Public health (issues of hygiene):

The study found that 7 (i.e. 9%) respondents said that public health (issues of hygiene) was provided by the MOH; 3 (i.e. 3 %) respondents said the health education they received was provided by the MCDMCH; 5 (i.e. 4%) said it was provided by other agencies; and none of the respondents said it was provided by an NGO. Just like HIV and AIDS education and reproductive health education, public health education was mostly provided by the MOH.

Table 8: Distribution of respondents by type of health education received most and mode of dissemination of education messages

Type of health education received most	awareness campaign		posters		Radio		television		Drama		peer/friends		church groups		Total	
	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
HIV and AIDS education	51	43	4	3	11	9	1	1	7	6	1	1	1	1	76	64
Reproductive health education	20	17	2	1	2	1	0	0	1	1	0	0	1	1	26	21
Public health (issues of hygiene)	6	5	8	7	3	3	0	0	0	0	0	0	0	0	17	15
Total	77	64	14	11.6	16	13	1	1	8	7	2	1	2	2	120	100

Note: F=Frequency in Table 8 above.

Table 8 above is a description of the distribution of respondents by the type of health education received the most and mode of dissemination of education messages.

HIV and AIDS education:

Under this category, 51 (i.e. 43%) respondents indicated that HIV and AIDS education messages were disseminated through awareness campaigns; 4 (i.e. 3.3%) said they were disseminated through posters; 11 (i.e. 9.1%) said the messages were disseminated through radio; 1 (i.e. 1%)

indicated that it was disseminated through television; 7 (i.e. 6%) said that it was disseminated through use of drama; 1 (i.e. 1%) said it was provided through peer/friends; while 1 (i.e. 1%) said it was provided through church groups. Therefore, HIV and AIDS education was mostly provided through awareness campaigns.

Reproductive health education:

It was found that 20 (i.e. 17%) respondents said that reproductive health education was provided through awareness campaigns; 2 (i.e. 1%) respondents said that it was disseminated through posters; 2 (i.e. 1%) respondents said that it was disseminated through radio; none indicated that the messages were disseminated through television or peer/friends; 1 (i.e. 1%) said it was through drama; and 1 (i.e. 1%) said it was through church groups. This shows that reproductive health education was provided through awareness campaigns.

Public health (issues of hygiene) education:

The results of the study showed that 6 (i.e. 5%) respondents said that public health (issues of hygiene) messages were disseminated through awareness campaigns; 8 (i.e. 7%) respondents said they were disseminated through posters; 3 (i.e. 3%) said it was through radio; and none of the respondents who received public health (issues of hygiene) messages did so through television, drama, peer/friends and church groups. The findings indicate that this type of education was disseminated mostly through posters.

Table 9: Distribution of respondents by their understanding of adult education reproductive health programmes

Perceived meaning of adult education	Frequency	Percentage (%)
Maternal health that involves child bearing	113	94
Health of human beings and animals	7	6
Total	120	100

Table 9 above shows how the respondents understood the meaning of adult education reproductive health programmes. It was found out that 113 (i.e. 94%) respondents understood the meaning of adult education as maternal health that involves child bearing, while 7 (i.e. 6%) understood it to be the health of human beings and animals. Most of the respondents (i.e. 113=94%) understood reproductive health to be maternal health that involves child bearing.

Table 10: How adult education reproductive health programmes affect the health of women without education on reproductive health

Response	Frequency	Percentage (%)
Positively	42	35
Negatively	78	65
Total	120	100

Table 10 above shows how adult education reproductive health programmes affect the health of women. Forty-two (i.e. 35%) respondents said that adult education health programmes affected their lives positively and 78 (i.e. 65%) indicated that the programmes affected them negatively. It is apparent from Table 10 above that most respondents (i.e. 78=65%) who did not have enough reproductive health education as a result of failure to attend the programmes in most cases were negatively affected; whereas 42 (i.e. 35%) were positively affected.

Table 11: Whether or not clinic provides adult education reproductive health activities

Response	Frequency	Percentage (%)
Yes	115	96
No	5	4
Total	120	100

Table 11 above shows a distribution of responses according to whether or not a clinic provided adult education reproductive health activities. Hundred and fifteen (i.e. 96%) respondents agreed

that the clinic in their area provided adult education reproductive health activities and 5 (i.e. 4%) disagreed that the clinic in the area did not provide adult education reproductive health activities. Thus, most (i.e. 115=96%) respondents said that their clinic provided adult education reproductive health activities.

Table 12: Attendance at adult education activities on reproductive health

Response	Frequency	Percentage (%)
Yes	97	81
No	23	19
Total	120	100

Table 12 above shows responses on attendance at adult education activities on reproductive health. Ninety-seven (i.e. 81%) respondents said that they attended adult education activities on reproductive health in their area whereas 23 (i.e. 19%) respondents did not attend the activities.

Table 13: Distribution of respondents by frequency of attendance in adult education activities on reproductive health

Response	Frequency	Percentage (%)
Every time they are conducted	93	77.5
Only when I do not have anything to do	10	8.3
I have never attended	7	5.8
None of the above	10	8.3
Total	120	100

Table 13 above shows the distribution of respondents by frequency of attendance in adult education activities on reproductive health. Ninety-three (i.e. 77.5%) respondents attended the activities every time they were conducted; 10 (i.e. 8.3%) respondents said they attended only when they did not have anything to do; 7 (i.e. 5.8%) said they had never attended the activities; and 10 (i.e. 8.3%) said otherwise. Table 13 above thus indicates that most respondents (i.e. 93=77.5%) attended the adult education activities every time they were held and those who never attended numbered the least (i.e. 7=5.8%).

4.2.2 Major challenges that service providers in reproductive health faced during their work

Chitimukulu Clinic health staff: the staff at this clinic indicated lack of transport, lack of personnel, and lack of funds and teaching materials as the main challenges they faced during the provision or implementation of reproductive health programme. Staff in other clinics like Mungwi said that since the early 90s, one of the action lines in health programme outreach has been the incorporation of the topics on family and sexual education in the curricular structures at different levels and modalities of the health systems. However, these actions had not been completed for diverse reasons. For example, most health stations were under staffed and extremely distant from would be beneficiaries of such activities. Those that were not understaffed may not have had the materials for teaching or trained community members to disseminate information on reproductive health.

Health personnel have received training to improve their sensitivity towards clients who need “quality and warmth,” regrettably, health personnel did not put the knowledge acquired into practice. This is because most health care providers do not speak the local language, hence, the cultural gap between them and the population they serve in indigenous language speaking areas. This causes serious effects on the quality of care. Cultural misunderstandings are also a major obstacle to reducing, for example, maternal mortality as indigenous women prefer to give birth at home because the health posts do not follow traditional practices for example, giving soup to mothers after childbirth, returning the placenta to them to be buried in a field, among others.

In Nseluka, health providers stated that information dissemination was another challenge. Information on reproductive health, education, and communication programmes and projects could contribute in many ways to increase knowledge, change attitudes, and enable action and mutuality, which were important goals for rural communities’ well-being. Public education through radio could promote appropriate action in the home and community and could discourage unsafe practices that harm lives in rural communities especially adolescents’ health. They said that people in the rural areas of Northern Province had an urgent need to receive information about their sexual and reproductive health, keeping in mind their social and

economic situations, educational levels, and attitudes and practices related to their sexual behaviour. However, the radio signals and television were not reliable in the area.

4.2.3 Challenges that participants faced as they applied reproductive health practices acquired through adult education programmes

Table 14: Challenges in practicing reproductive health

Response	Frequency	Percentage (%)
Yes	64	53.5
No	56	46.7
Total	120	100

Table 14 above shows the distribution of responses by challenges they faced in practicing reproductive health. Sixty-four (53.3%) respondents said that they faced challenges in practicing reproductive health; and 56 (46.7%) did not face challenges in practicing or applying the knowledge from reproductive health activities. Therefore, most respondents (i.e. 64=53.5%) faced challenges in applying the knowledge they gained from the programmes; whereas fewer respondents (i.e. 56=46.7%) did not face any challenges.

Table 15: Distribution of respondents by nature of challenges in learning and practicing reproductive health

Response	Nature of challenges in learning and practicing reproductive health								Total	
	Lack of resources		Language		Wrong timing of programme		Other			
	F	%	F	%	F	%	F	%	F	%
Respondents with challenges	41	64.1	5	7.8	10	15.6	8	12.5	64	100

Note: F=Frequency in Table 15 above.

Table 15 above shows the distribution of respondents by nature of challenges in learning and practicing reproductive health. Among the 64 (i.e. 53%) of the total distribution who said there

were challenges in learning and applying what was being learnt, 41 (i.e. 64.1%) attributed the problem to lack of resources, 5 (i.e. 7.8%) said it was due to language of instruction or dissemination of information, 10 (i.e. 15.6%) said it was due to wrong timing of programmes, and 8 (i.e. 12.5%) attributed the source of the challenges to other reasons they did not mention. This shows that of the respondents who had challenges in applying the knowledge gained, most of them (i.e. 41=64.1%) said they had to do with lack of resources; while language challenges were the least (i.e. 5=7.8%).

4.2.3.1 Responses to open-ended questions in the questionnaire for participants (villagers)

Benefits of adult education programmes

Question: how beneficial are the adult education activities on reproductive health to your community?

Verbatim Responses:

- a. “It helps families in child spacing”
- b. “I have reduced unwanted pregnancies”
- c. “There has been a good response from mothers bringing their children to under-five clinics”
- d. “Less maternal death and child mortality”
- e. “It helps the community to be sensitized about health awareness and how to keep themselves and children healthy”
- f. “Very beneficial because a lot of people lack the information, so with the education they are empowered with information”
- g. “It provides safety information to married people and those who intend to enter marriage for better health”
- h. “People are benefiting in terms of changing behaviour in the community”
- i. “It helps to make people respect human life”
- j. “Mothers are now able to deliver at the clinic”
- k. “These programmes help the community to understand the issues related to reproductive health, thereby eliminating any possible effects that may arise”
- l. “Health workers assist where there is a problem”

4.2.4 Suggesting possible solutions to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District.

The second research question sought to establish possible solutions to mitigate the challenges faced by implementers of the reproductive health programmes in Mungwi District. The responses were given qualitatively in the following sub-sections.

4.2.4.1 Qualitative responses on possible solutions to challenges encountered.

4.2.4.2 Responses from Key Informants

Key informants said that it was necessary to introduce a monthly programme, to teach or disseminate information in local language, to encourage men involvement, to source for more resources, build infrastructure, and to employ more staff.

4.2.4.2 Responses from Participants

Most participants argued that it was important to introduce a monthly programme on reproductive health while others believed that men should get involved in reproductive health programmes as reproductive health was not a woman's or mother's issue. Others suggested that being a believer who attends church services is important to most of the problems being faced then. The programmes should be conducted on a door to door campaign basis. Further, respondents said the work should involve community health workers, village headmen and civic leaders. The participants expressed their desire to see reproductive health programmes broadcasted on radio.

The respondents also implored government to provide more resources for the acquisition of learning materials, training community volunteers as facilitators; and to build more health centres. In the obtaining circumstances, the participants needed transport for campaign purposes as they go to venues and when helping other community members. As a solution to the challenges faced, refresher courses for health personnel at different levels in the MCDMCH need to be carried out. This would improve the number of peer educators and trained traditional birth attendants. More responses included: employment of more health workers especially in rural

areas, to sensitize people to go to the nearest health facility to access reproductive health information, to provide contraceptives free of charge and introduction of more contraceptive products, and to introduce reproductive health lessons in schools.

4.3 SUMMARY OF CHAPTER FOUR

Chapter four presented findings of the study. The findings were presented using tables and narrations. They included presentations on the different forms of adult education programmes that are used in the promotion of reproductive health in Mungwi District. The challenges that service providers encountered during the implementation of reproductive health programmes; the challenges participants faced during the application of reproductive health practices, and the possible solutions that could be used to mitigate the challenges faced by service providers and recipients of reproductive health programmes were also presented.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter will discuss the findings of the study. The discussion will be based on the specific research objectives, literature review and findings. The objectives of the study were as follows: to investigate the different forms of adult education used in the promotion of reproductive health in Mungwi District; to determine the major challenges that service providers in reproductive health faced during their work; to investigate the challenges that participants faced as they applied reproductive health practices acquired through adult education programmes; and to establish possible solutions meant to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District.

5.2. Different forms of adult education used in the promotion of reproductive health in Mungwi District.

The study findings revealed that many adult education strategies were employed by health providers to disseminate information on reproductive health in Mungwi District. Notable among them were: Vocation and Skills Training, Adult Literacy, HIV and AIDS Education, Agriculture Extension and Health Education (Table 3, p.53). These are discussed below.

5.2.1 Vocation and Skills Training

As one of the forms of adult education used in Mungwi District to disseminate reproductive health messages, Vocation and Skills Training was the least commonly used. This was not encouraging because Mungwi is a rural district where the government would love to create employment through training of youths in vocational skills as much as they want to do so in the urban areas. The messages were taken to some training centres in the area to target students. Accordingly, TEVETA has developed the Sector Skills Development Strategy (SSDS) as an appropriate response to the requirement that the technical education, vocational and entrepreneurship training system should be

demand-driven. The main point here is that training should reflect the needs of the labour market, both formal and informal (www.Teveta.org.zm).

5.2.2 Adult Literacy

Adult Literacy was only 9% popular in Mungwi District. It was second from last meaning that it was not used much despite its importance in most, if not all endeavours of education. In agreement with this thought on the low usage of literacy, MOE (2007) argues that it is a tool for promoting national development in all spheres. This involves the acquisition of writing, reading and numeracy skills. Hence, literacy is a stepping stone to all types of education which should be encouraged in Mungwi District.

5.2.3 HIV and AIDS education

HIV and AIDS education is one of the forms of adult education used in Mungwi District's reproductive health programmes. People living with HIV often learn a lot about keeping the virus at bay, and some even become "HIV experts", helping those newly diagnosed get educated too. However, living well with HIV takes more than just understanding how to keep track of HIV medications and laboratory reports (Ernest, et al., 2008).

Because of the magnitude of the disease in Africa, and in sub-Saharan Africa in particular, the governments of this region have tried to fight the disease in a variety of ways. Some countries have made arrangements with multinational pharmaceutical companies to make HIV drugs available in Africa at lower costs. Other countries, such as South Africa, have begun manufacturing these drugs themselves instead of importing them. Plants indigenous to Africa are also being scrutinized for their usefulness in developing various HIV treatments (Encyclopaedia Britannica, 2009).

In the absence of financial resources to pay for new drug therapies, many African countries have found education to be the best defence against the disease. In Uganda, for example, songs about the disease, nationally distributed posters, and public awareness campaigns starting as early as kindergarten have all helped to stem off the spread of AIDS (Encyclopaedia Britannica, 2009). Prostitutes in Senegal are licensed and regularly tested for HIV, and the clergy, including Islamic religious leaders, work to inform the

public about the disease. Other parts of Africa, however, have seen little progress. For example, the practice of sexually violating very young girls has developed among some HIV-positive African men because of the misguided belief that such acts will somehow cure them of the disease. In the opinion of many, only better education can battle the damaging stereotypes, misinformation, and disturbing practices associated with AIDS (Encyclopaedia Britannica, 2009).

Laws concerning HIV and AIDS typically fall into four broad categories: mandatory reporting, mandatory testing, laws against transmission, and immigration. The mandatory reporting of newly discovered HIV infections is meant to encourage early treatment. Many countries, including Canada, Switzerland, Denmark, and Germany, have enacted mandatory screening laws for HIV. Some countries, such as Estonia, require mandatory testing of prison populations (in response to explosive rates of infection among the incarcerated). Most of the United States requires some form of testing for convicted sex offenders. Other legal and international issues concern the criminalization of knowing or unknowing transmission (more prevalent in the United States and Canada) and the rights of HIV-positive individuals to immigrate to or even enter foreign countries (Encyclopaedia Britannica, 2009).

5.2.4 Agriculture Extension

Agriculture extension was only second to health education as a form of adult education used in Mungwi District. Reproductive health providers target this type of education because most of the people depend on agriculture as a major economic activity and source of livelihood. This is common to most rural areas in Zambia and many other countries in Africa. In agriculture, the use of participatory methods through the agricultural extension programmes in Zambia has become popular due to the good results it yields (Hansen, et al., 1980).

5.2.5 Health Education

It is clear that health education received the greatest number of responses (44=36.1%). Looking at the results, it shows how broad or wide health education and reproductive

health in particular is. Encyclopaedia Britannica (2009) reports that education for health includes welfare and family living. Further, it includes all kinds of education in health, family relations, consumer buying, planned parenthood, hygiene and child care.

Reproductive health involves the totality of the health of an individual. The different forms of adult education used in reproductive health programmes in Mungwi District were few of the many that exist. Youngman (1998) summarized them as: agriculture extension, in-service training, literacy, out-of-school education, audiovisual education for adults, mass media education, vocational education, in-service personnel training, community development, and cooperative education. It was surprising to note that health education was the most common as opposed to agriculture extension and literacy both of which were part of the list provided by Youngman (1998) above.

The study also found that young adults should not be left out in reproductive health programmes as they were sexually active. This was clear in Table 4 which indicates that one respondent in the age group 12-15 years were married and were under the legal age for marriage in Zambia. This finding suggests that reproductive health information should be designed for all biologically mature individuals. This calls for more appropriate methods and techniques that are expected to be of adult education in nature where issues can be discussed openly among young and older adults. This finding is supported by Fromer (1983) who argued that modern society had entered an era where sexuality is openly discussed. Open discussion on matters of sexuality has come into being owing to the gravity of the problems arising from sexuality especially among the youths.

In agreement with this thought, MOH (2000) stated that adolescent sexuality was becoming an increasing concern in Zambia due to urbanization and modernization which gave rise to a new pattern of sexual behaviour including pre-marital sex which often led to early pregnancy, induced abortion, STDs, HIV infection and cervical cancer in females. Further, adolescents were intimating concern regarding the lack of information and understanding about their own sexuality.

Teenage fertility has increased over the years. Despite the increase, adolescent pregnancies carried a higher chance of obstetric risk and prenatal loss (abortion). Unfortunately, pregnant adolescents rarely receive special care, information, assistance or emotional support. Apart from high risk pregnancies, the large number of adolescents who initiated sexual activity at an early age were at high risk of contracting STDs, HIV and AIDS and cervical cancer. In this regard, Felicia, et al., (1998) reported that scientists have designed and tested a culturally sensitive cervical cancer screening educational programme. One facet of the programme was to test the efficacy of a culturally appropriate psychosocial counselling support group intervention for increasing knowledge, changing attitudes, and improving behaviours toward the adherence to cervical cancer screening and follow-up for American Indian women.

Prior contact with the school system (i.e. having been enrolled in school but stopped) was another significant variable to study in relation to how much benefit a participant would derive from adult education programmes. In this study, most respondents received some form of education during their lifetime. However, health education in particular, HIV and AIDS education dominated the forms of adult education. It was interesting to see HIV and AIDS education leading in its dissemination in Mungwi District. This suggests that HIV prevalence was still high and a bigger problem than other reproductive health problems studied in this study. Similarly, MOH (2004) reported socio-cultural factors such as sexual abuse and coercion; and especially HIV and AIDS as being among the common problems that were prevalent in Mungwi District. This form of adult education can be expected to increase as the MOH seems to be moving in the direction of re-strategizing the fight against Aids. Thus, the ministry which is the custodian of all health issues country wide attached the greatest importance to it in terms of dissemination of health information (i.e. HIV and AIDS) as indicated by 39 (i.e. 33%) respondents who received this kind of education and said it was provided by the MOH in the district. This service was provided to a population of 151,058 (CSO, 2010).

Awareness campaign. The study also revealed that awareness campaign was the most common mode of dissemination of messages as indicated in Table 8. Banda (2013)

argues that a campaign is an effective mode of disseminating messages in highly populated places. He reviewed some of the factors that contributed to a successful campaign in the dissemination of messages.

Factors that can lead to a successful campaign include political will, popular education, training of executors, language, and monitoring and evaluation. Public support can influence public health outcomes when economic, social, and intellectual resources are committed to address an issue (Johari, 2004).

In adult learning, the mode of dissemination of messages depends so much on the nature of the problem under consideration. When cross-tabulated by type of health education received the most and mode of dissemination of education messages, the results show that HIV and AIDS education messages were disseminated through awareness campaigns, posters, radio, television, drama, peer/friends, church groups. However, health education messages were mostly disseminated through awareness campaigns in Mungwi District. Therefore, HIV and AIDS information is seen to be best disseminated through awareness campaigns. This is probably because there is urgent need to pass on the messages even to rural dwellers as the population grows. This analogy can be compared with the dissemination of reproductive health messages or provision of education which may equally be disseminated through campaigns and popular education.

Popular education is a collective effort in which a high degree of participation is expected from everybody. In popular education, the learning process starts with identifying and describing everyone's own personal experience and that knowledge is built upon through various activities done in groups. Freire (1972) affirms that through the generation of this new knowledge, people are able to reflect more profoundly about themselves and how they fit into the world. This new understanding of society is a preparation to actively work towards social change. In fact, in popular education, the education process is not considered to be complete without action on what is learned; whether it be on a personal or political level (www.projectsouth.org).

Campaigns are very effective modes of dissemination of information as already mentioned above. This is more likely when appropriate factors are put in place. For instance, Banda (2013) reviewed some of the factors that contribute to a successful campaign in the dissemination of messages.

Meanwhile, awareness campaigns were predominantly used in dissemination of reproductive health. Awareness campaigns are an important feature of adult education which is compatible with a number of forms of adult education, such as Adult Literacy. According to Chakanika and Sumbwa (2013), most Southern African countries are struggling with the challenge of how to deal with growing levels of illiteracy among illiterate adults especially. In Zambia, efforts have been made towards a policy on Adult Education since 1964 but all have been in vain. What guides the field instead are a number of documents. These include: the National Policy on Community Development, Educating Our Future, National Youth Policy, National Agriculture Policy, Gender Policy, National Employment and Labour Market Policy (Chakanika and Sumbwa (2013).

Public health education has for a long time enjoyed good publicity. Issues of having clean drinking water, washing hands before handling food, washing hands after using the toilet and boiling or chlorinating drinking water are constantly in the media. However, it is surprising that reproductive health education received more publicity in Mungwi District. As for the mode of dissemination, posters were the most used in the dissemination of public health messages in Mungwi District.

5.3 Major challenges faced by reproductive health service providers during their work.

The second objective of the study was to establish the challenges encountered in the provision of reproductive health messages in Mungwi District. From the findings of the study, it was established that reproductive health education programmes were faced with a number of implementation challenges.

The greatest challenge faced by participants had to do with funding. It is said in a common adage that 'money makes the world revolve'. However, poor planning renders money useless. The participants were mostly adults and so were expected to grasp as much as they could since they learn when they want to. The respondents indicated that lack of adequate funding for reproductive health programmes adversely affected the implementation of reproductive health programmes in Mungwi District.

Funding is directly related to policy. The funding of adult education programmes has for a long time remained low. Aitchison and Hassana (2009: 101) agree:

The fact that no policy still exists shows that there has been a lack of political will. In addition, funding of adult literacy programmes in Zambia, and the world over, is usually inadequate, inconsistent and uncoordinated.

Supporting this view, Nnazor (2005) contends that lack of funding for adult education, which includes agricultural extension, health education and adult literacy, has been consistently at the apex of most challenges which have negatively affected the implementation of adult education reproductive health programmes. He reveals that the field often receives a small portion of the education sector's budgetary allocation. This compromises the efficiency of the health provider as a change agent.

Being a change agent is the primary role of the health educator. In an attempt to facilitate change, health educators must first and foremost highlight the prevalence, causes and nature of health problems that the community is experiencing. It is primarily important to draw the community's attention to those particular practices, beliefs, and taboos that do cause the occurrence of various health problems. Thus, they are expected to motivate people so that they change from harmful health practices to those which are conducive to good health. As such, health workers have a responsibility of encouraging the community to appreciate their role in taking appropriate measures and acting to improve and maintain their good health through their own efforts. This makes them responsible for their own health through participation in decision-making processes and in seeking possible solutions to the health problem affecting them. Hence, it is by playing this role of improving people's health status that health educators would be contributing to the socio-economic performance and development of the country (MoH, 2000).

5.4 Challenges faced by participants as they applied reproductive health knowledge acquired through Adult Education programmes.

The third objective of the study was to establish the challenges encountered in the application of reproductive health knowledge acquired through adult education programmes. From the findings of the study, it was established that participants in adult education encountered two major challenges. These were: long distance to health centres where most of the programmes were taking place and language of instruction or dissemination.

5.4.1 Long distance to health centres

Participation rates in adult literacy programmes have been seen to be low or decline owing to a number of reasons. Long distance to the learning places has been one of the major factors. These arise from inadequate infrastructure compounded by under staffing especially in the rural areas. Currently, there are 206 urban centres and 880 rural centres in Zambia. As earlier mentioned, the urban centres serves a catchment population of about 30,000-50,000 around a radius of 30 Kilometres and the rural health centres serves the catchment of about 10,000 within the same radius of 30 Km (MOH, 2004).

5.4.2 Language of instruction or dissemination

Language of instruction or dissemination can as well be an impediment to knowledge acquisition in education campaigns. Larsen (2005) argues that language, which is a system of communication, is composed of symbols and a set of rules permitting various combinations of symbols. One of the most significant symbols in language is the concept. A concept is an abstraction representing an object, a property of an object, or a certain phenomenon. Through language we can connect with other people and make sense of our experiences. The campaign which was done in Cuba and other countries yielded positive results because it was conducted in vernacular languages which enhanced proper communication amongst the participants.

Generative words- are fundamental to the improvement of education. The object of knowledge is to be understood through dialogue among those organizing the awareness campaigns and the communities in order to bring about change of attitude in reproductive health in their environment (www.amazon.com/dp/1564147045).

The comments by key informants were in tandem with those given in the reproductive health Policy. The Key informants who happened to be health practitioners also gave their view as to the nature of challenges that participants faced during learning and practicing reproductive health.

Some of the challenges included the difficulty to address the reproductive health needs of individuals and families. Supporting physical, mental, emotional and social development throughout their life cycles was another challenge. Grasping the concept of reproductive health also proved to be a problem. The concept involves safe motherhood, including Safe Abortion Care; Family Planning; Adolescent Health; HIV and AIDS; and gender issues throughout the life of individuals, within the context of population and sustainable development, and reduction of poverty. Failure to provide reproductive health information and services to all regardless of age, gender, and marital or socio-economic status; or failure to take into account the religious, social and cultural factors in the provision of sexual and reproductive health information and services in the various communities and groups of people; in protecting the rights of the clients in the course of obtaining appropriate medical information and services and ensuring maximum confidentiality and privacy; and or failure to involve traditional practitioners /healers in the promotion of safe practices for all aspects of sexual and reproductive health are also challenges that were encountered.

5.5 Suggestions of possible solutions meant to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District.

The fourth objective of the study was to suggest possible solutions meant to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District. This study brought out a number of possible solutions to help mitigate the problem. Without the correct understanding of the concept of reproductive health, participants could not be well placed to suggest solutions. Therefore, the knowledge of and level of understanding of respondents of reproductive health was sought. Many participants had an average/medium (Table 9) level of understanding also implying that the messages were generally well disseminated. This can be attributed to the effectiveness of the forms of adult education used in the process. In order to deal with challenges, programme implementers suggested the

following solutions: to introduce a monthly programme which will teach or disseminate messages in the local language, to encourage men involvement, source for more resources, build infrastructure, and employ more staff.

Participants gave a number of solutions meant to mitigate the above challenges. Notable among them were the need for the MOH to introduce a monthly reproductive health sensitization programme in Mungwi District. Most importantly, the campaigns should be conducted on a door to door basis in order to cover as many people as possible and the work should involve community health workers, village headmen and civic leaders. Others were for the idea of broadcasting the programme on radio. The challenge though would be that not so many people may have radio receivers.

This study was premised on the Knowles' Model which has a strong link to the adult learners who were the target population on matters of reproductive health. The model provided a framework to understand forms and challenges of adult education reproductive health programmes by way of andragogy – a concept popularized by Malcolm Knowles. This was done by way of describing adult learning through his work on the subject. For Knowles, andragogy is premised on basically four crucial assumptions (principles) about the characteristics of adult learners that are different from the assumptions about child learners on which traditional pedagogy is premised.

The first is self-concept: as a person matures his self-concept moves from one of being a dependent personality toward one of being a self-directed human being. Thus, the adult education reproductive health providers were anticipated to take into account this important aspect of adult education. The study showed that this was the case to some extent.

The second is experience: as a person matures he accumulates a growing reservoir of experience that becomes an increasing resource for learning. Thus, adult education in all its forms (agriculture extension, adult literacy, vocational training or health education) as found by this study was expected to make use of the experience of adult learners. In Mungwi District, the forms of adult education that this study found to be in existence provided that chance to participants as they engaged in adult education activities (Knowles, et al., 1984).

The third is readiness to learn: as a person matures his readiness to learn becomes oriented increasingly to the developmental tasks of his social roles. This was another evident feature of the outcomes of the study in that participation was high. Most respondents said that they participated in the reproductive health programmes every time they were held in the area.

Orientation to learning is the fourth principle: as a person matures his time perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly his orientation toward learning shifts from one of subject-centredness to one of problem centredness. It was for this reason that some participants seemed to have been affected by poor timing of the adult education reproductive health programmes. For instance, when they learn something on the subject of agriculture, they applied the knowledge in the field. That is why they are unmovable during the time they want to apply the benefit of their attendance of previous programmes and other activities always do not get their attention (Knowles, et al., 1984).

The fourth principle is motivation to learn: as a person matures the motivation to learn is internal. It therefore shows by frequency of attendance, level of participation and promptness of submission of assignments given (Knowles, et al., 1984).

5.6 SUMMARY OF CHAPTER FIVE

Chapter five discussed the findings of the study. The discussion centred on the objectives of the study and the literature review. The objectives were as follows: to investigate the different forms of adult education programmes that are used in the promotion of reproductive health in Mungwi District, to determine the challenges service providers encounter during the implementation of reproductive health programmes, to determine the challenges participants face during the application of reproductive health practices, and to determine the possible solutions that could be used to mitigate the challenges faced by service providers and recipients of reproductive health programmes. The study achieved all the objectives that were set.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the conclusion and recommendations of the study based on the findings and discussions on forms and challenges of adult education programmes which promote reproductive health in Mungwi District. The recommendations specify the institutions responsible for carrying out recommended action.

6.2 CONCLUSION

This study was based on four objectives and responded to four research questions. The first objective and research question set out to identify the main forms of adult education programmes premised on the idea that reproductive health programmes used adult education methods which emanate from the different forms of adult education. The study came up with a number of interesting findings. Notable among them were the discovery that in Mungwi District, the most commonly used forms of adult education were HIV and AIDS education, Agriculture extension and Health education.

The study investigated the forms of adult education in the dissemination of reproductive health information and the challenges thereof. Thus, health provision and care should provide the basic resources like information. Adult education in its various forms was seen to be pivotal in the success of the programmes.

The second objective and research question sought to find out the challenges encountered by service providers in the implementation of adult education programmes that promote reproductive health in Mungwi District. From the findings of the study, it was established that reproductive health education programmes were faced with a number of implementation challenges.

The greatest challenge faced by implementers had to do with funding. It is said in a common adage that ‘money makes the world revolve. However, poor planning renders money useless.

The respondents indicated that lack of adequate funding for reproductive health programmes adversely affected the implementation of reproductive health programmes in Mungwi District.

The third objective and research question sought to establish the challenges participants faced as they applied reproductive health practices they acquired through adult education programmes. From the findings of the study, it was revealed that participants in adult education encountered three major challenges. These were: long distance to health centres where most of the programmes were taking place and language of instruction or dissemination. Long distance to the learning places negatively affected the respondents' participation as they walked long distances on foot. Language of instruction or dissemination was also an impediment to knowledge acquisition in education campaigns on reproductive health in Mungwi District.

The fourth objective and research question were aimed at finding possible solutions meant to mitigate the challenges encountered during the implementation of reproductive health programmes in Mungwi District. This study brought out a number of possible solutions to help mitigate the problems. In order to deal with challenges, programme implementers suggested the following solutions: to introduce monthly programmes, to teach or disseminate in local language, to encourage men involvement, source for more resources, build infrastructure, and to employ more staff.

Participants gave more solutions in mitigating the above challenges. It was also noted that there was need for the MOH to introduce a monthly programme on reproductive health education for men and women, fathers and mothers, husbands and wives. Most importantly, the campaigns should be conducted on a door to door campaign basis in order to cover as many people as possible and the work should involve community health workers, village headmen and civic leaders. Others were for the idea of broadcasting the programme on radio. The challenge though is that not so many people had radios.

It can be concluded that participation levels of the communities around the clinics under study (Chitimukulu, Mungwi, Ngoli, Nseluka) were good. This follows the fact that most participants in the reproductive health programmes attended the adult education activities on reproductive health every time they were held. Those who attended did not always benefit from the programmes as a number of hindrances were pointed out. Funding was the greatest challenge

faced by participants followed by poor timing of the programmes. The poor programming has to do with failure to take cognizance of the weather conditions, farming seasons and harvest. This also included events such as elections. Yet another challenge encountered by the respondents in Mungwi District was related to medium of instruction. The language of instruction or dissemination can as well be an impediment to knowledge acquisition in education campaigns.

It can also be concluded that the study findings showed literacy to be among the forms of adult education used in Mungwi District were in line with the efforts the Ministry of Science, Vocational Training, Education meant to improve literacy levels in the country and reproductive health by implication. According to MOE (2008), the Adult Learning and Education Sub Sector focused on a number of areas related to reproductive health and health in general during the fifth National Development Plan (FNDP) which covered the period 2006 to 2010. Among them were: provision of literacy and functional literacy education to functionally illiterate adults and youths, focusing more on skills development; reduction of illiteracy and poverty through the provision of income generation skills aimed at self-employment and job creation; provision of productive occupational and managerial skills for the purpose of promoting and enhancing efficiency of high quality work; to sustain environmental and social conditions, which enhance the quality of life, produce responsible citizenship and an orderly society; to enhance self-reliance and self-sufficiency at individual and national levels so as to reflect the country's cultural heritage and national aspiration; to promote creativity in the provision of life skills so as to enhance full participation in societal development; to guarantee healthy living and the reduction of mortality rate among the Zambian people through the provision of programmes that address primary health care delivery system, eradication of diseases and the creation of awareness about HIV and AIDS; to develop and provide library services so as to promote a reading culture; to provide specialized literacy programmes to the blind and deaf adults; to provide gender education to literacy learners and instructors; to review literacy curricula to include citizenship, education and healthy life styles; to develop specific literacy programmes for youths, particularly female youths; to address, maternal and child mortality, malnutrition, HIV prevention, family planning and risky behaviours and reduce intergenerational transmission of poverty; and provide equitable access to literacy education by targeting women and rural communities.

Adult learning in reproductive health generally entails teaching about family life, sex, and family planning. Young people use family planning methods to simply prevent pregnancy. The use of family planning helps youths to prevent pregnancy. Knowles' model endeavoured to explain the foregoing.

6.3 RECOMMENDATIONS

In light of the findings, the following recommendations are made:

1. the Ministry of Health and other organizations whose mandate is to promote reproductive health such as Society for Family Health and Maristopes should strengthen awareness campaigns for dissemination of information by including community members both at planning and implementation stages. This includes early management of reproductive health related diseases such as cancers;
2. programme developers and implementers should sensitize men and women on the existence of gender disparity and the benefits of gender balance in matters related to reproductive health. This can be done through radio broadcasts, schools and churches;
3. empower women with knowledge and skills that can develop their self-esteem and assertiveness to enable them make positive decisions regarding their reproductive health such as participation in reproductive health programmes; and
4. the Ministry of Health should support male involvement in reproductive health, information, counselling and care.

6.4 SUMMARY OF CHAPTER SIX

Chapter six provided a conclusion and made recommendations of the study. The conclusion was based on the objectives and research questions of the study while recommendations were drawn from the findings. The study concluded that HIV and AIDS education, agriculture extension, and health education were the main forms of adult education used in the implementation of reproductive health programmes in Mungwi District.

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APPENDICES

Appendix 1: Research Schedule of Activities

ACTIVITIES	MAY 2013	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013
Identification of the Problem						
Formation of Topic						
Proposal Development						
Development of Instruments						
Data Collection						

ACTIVITIES	NOV 2013	DEC 2013	JAN 2014	FEB 2014	MAR 2014	APRIL 2014	JULY 2014
Data Collection							
Data Cleaning							
Data Presentation							
Data Analysis							
Report Writing							
Submission of first draft							
Final							

Report							
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Appendix 2: Budget

ITEM	QUANTITY	UNIT PRICE (ZMK)	TOTAL PRICE (ZMK)
REAMS OF PAPER	10	30	300
BALL PENS	2 boxes	14	28
PENCILS	2 packets	12	24
STAPLER	1	35	35
NOTE PAD	4 pads	10	40
TAPE RECODER	1	300	300
TAPES	12	10	120
CALCULATOR	1	100	100
CANON INK	1	300	300
		Sub-total	1,247

Appendix 3: Questionnaire and Interview Guide

SEMI-STRUCTURED QUESTIONNAIRE FOR ADULT EDUCATION PARTICIPANTS IN REPRODUCTIVE HEALTH

Dear Respondent, the researcher of this study is a postgraduate student at the University of Zambia in the School of Education pursuing a Master's degree of Education in Adult Education. The study title is 'Forms and challenges of Adult Education in Reproductive Health Programmes in Mungwi District.'

You are therefore kindly requested to voluntarily participate in this study. You do not have to indicate your name on the questionnaire. Be rest assured that the information you will provide will be confidential, and will only be used for academic purposes and feel free to remind the researcher on any question you may not be comfortable with.

Please indicate your choice by ticking.

1. What do you understand by the term adult education?

- (a) Education that helps adults to live and do things better to improve their livelihood [1]
- (b) Teaching adults how to read and write [2]
- (c) Education for adults who never finished their schooling [3]

2. In which forms is adult education practiced in your community?

- (a) Vocation and Skills training [1]
- (b) Adult Education Literacy [2]
- (c) HIV AND AIDS education [3]
- (d) Agriculture extension [4]
- (e) Health education [5]
- (f) Other _____ [6]

3. What is your understanding of Adult Education Reproductive Health programmes?

- a) Maternal health that involves child bearing [1]
- b) Health of Human beings and animals [2]
- c) Health that affects men only [3]

4. If the answer in question 3 is (a), how does it affect the health of women who have no education on Reproductive Health?

- a) Positively [1]
- b) Negatively [2]

5. Does the Health Centre in this area provide any Adult Education activities on Reproductive Health?

- a) Yes [1]
- b) No [2]

6. If Yes in Q5 above, do you attend Adult Education activities on Reproductive Health?

- a) Yes [1]
- b) No [2]

7. How often are the Adult Education activities on Reproductive Health conducted?

- a) Every week [1]
- b) Every month [2]
- c) Every three months [3]
- d) Every six months [4]
- e) Every year [5]
- f) Between two and five years [6]

8. How beneficial are the Adult Education activities on Reproductive Health to your community?

9. Are you able to tell a difference in your maternal health or that of other community members from the time Adult Education activities in Reproductive Health started and before they started?

10. For how long have these Adult Education activities been running in your community?

- a) For one month [1]

- b) For three months [2]
- c) For six months [3]
- d) For one year [4]
- e) For two to five years [5]
- f) Above five years [6]

11. Do these methods help you to learn and understand what Reproductive Health is all about?

12. Do you face any difficulties or challenges in understanding and practicing what you learn on Reproductive health?

- a) Yes [1]
- b) No [2]

13. If yes in Q12 above, what difficulties or challenges do you face in understanding and practicing what you learn on Reproductive health?

- a) Lack of resources [1]
- b) language [2]
- c) Wrong timing of the Adult Education Programmes [3]
- d) Other _____ [4]

14. What solutions would you suggest in order to mitigate some challenges you face in the accessibility of reproductive health programmes?

15. How would you rate your level of understanding in the area of Reproductive Health?

- a) low [1]
- b) medium [2]
- c) high [3]
- d) very high [4]

End of Questionnaire

Thank you for participating in this study

For any information contact the researcher at Kasama General Hospital, P.O. Box 410056 Kasama. Email: selmmopotela@yahoo.com Phone #: 0978 615971 or 0966220603

INTERVIEW GUIDE FOR HEALTH PERSONNEL

Dear Respondent, the researcher of this study is a postgraduate student at the University of Zambia in the School of Education pursuing a Master's degree of Education in Adult Education. The study title is 'Forms and challenges of Adult Education in Reproductive Health Programmes in Mungwi District.'

You are therefore kindly requested to voluntarily participate in this study. You do not have to indicate your name on the questionnaire. Be rest assured that the information you will provide will be confidential, and will only be used for academic purposes and feel free to remind the researcher on any question you may not be comfortable with.

Please indicate your choice by ticking.

1. What role do you play in adult education programmes that deal with Reproductive health?

(Programme designing, Facilitating class sessions, Participant mobilization)

2. Do you carry out any health education campaigns in this area? If yes, what are they?

3. Do you carry out any reproductive health education campaigns in this area? (If this was mentioned after probing above, skip this question)

4. Who are the main providers of adult education programmes in Reproductive Health in this district?

5. Who are the partners in the provision of Reproductive health adult education programmes?

6. Which sections of health are adult education methods being practiced in the community or area you serve? *(Hygiene and Sanitation, HIV AND AIDS, Disease Prevention, Reproductive Health, Maternal and Child health)*

7. Do community members attend and participate in any of these programmes? Probe

8. What Adult Education programme(s) do community members participate in mostly?

(Hygiene and Sanitation, HIV AND AIDS, Disease Prevention, Reproductive Health, Maternal and Child health)

9. What is the main reason for their participating in these programmes?

10. How would you describe the attitude of learners toward you as a facilitator?

11. Who are the main providers of adult education programmes in Reproductive Health in the district? (*Ministry of Community Development Mother and Child Health, Ministry of Education, Ministry of Agriculture and cooperatives, Ministry of Health, NGO*)

12. Who are the main participants in these programmes?

(Men only, Women only, Both Men and Women)

13. What methods are used to implement adult education programmes in Reproductive Health in your community?

(Top-down i.e. expert centred, Bottom-up i.e. learner centred, Eclectic i.e. collaborative)

14. How do these methods help you in your teaching Reproductive Health lessons?

(They encourage learner participation which enhances my skill and experience, The absence of learner participation makes my delivering of lessons difficult)

15. In your opinion, how effective are these methods in implementing adult education programmes in Reproductive Health in the community? (*They are effective, They are not effective*)

16. How do you rate the level of knowledge of your learners in the area of Reproductive Health before and after a lesson using your adult education skills?

17. How do you measure the level of Reproductive Health methods being practiced by community members?

18. What are some of the challenges encountered in the implementation of community adult education programmes in Reproductive Health?

(Lack of funding, Scattered settlement, Dependence on government welfare assistance, Poor roads)

19. What are the possible solutions that can be used to mitigate some of the challenges faced by service providers and recipients of reproductive health programmes?

Appendix 4: Letter (s)

