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**SCHOOL OF MEDICINE**

**DEPARTMENT OF POST BASIC NURSING**

**A STUDY TO DETERMINE THE KNOWLEDGE AND  
PRACTICES OF FAMILY PLANNING AMONG WOMEN IN  
MUFULIRA DISTRICT**

**BY**

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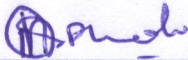
## LIST OF ABBREVIATIONS

<b>CBOH:</b>	Central Board of Health
<b>CMAZ:</b>	Churches Medical Association of Zambia
<b>CSO:</b>	Central Statistical Office
<b>DHO:</b>	District Health Office
<b>EDGS:</b>	End of Decade Goal Survey
<b>FGD:</b>	Focus Group Discussion
<b>IEC:</b>	Information Education and Communication
<b>MCH:</b>	Maternal and Child Health
<b>MOF:</b>	Ministry of Finance
<b>MOH:</b>	Ministry of Health
<b>MDHMB:</b>	Mufulira District Health Management Board
<b>NFHS:</b>	National Family Planning Health Survey
<b>NFP:</b>	Natural Family Planning
<b>NGO:</b>	Non Government Organisation
<b>PHC:</b>	Primary Health Care
<b>UNZA:</b>	University of Zambia
<b>SDA:</b>	Seventh Day Adventist
<b>UCZ:</b>	United Church of Zambia
<b>UNICEF:</b>	United Nations International Children's Fund
<b>UTH:</b>	University Teaching Hospital
<b>WHO:</b>	World Health Organisation
<b>ZDHS:</b>	Zambia Demographic Health Survey

## ***DECLARATION***

***I MARGARET CHILAMBWE MPUNDU, hereby declare that the work presented in this study for the Bachelor of Science Degree in Nursing has not been presented either partially or wholly for any other degree and it is currently not being submitted for any other degree.***

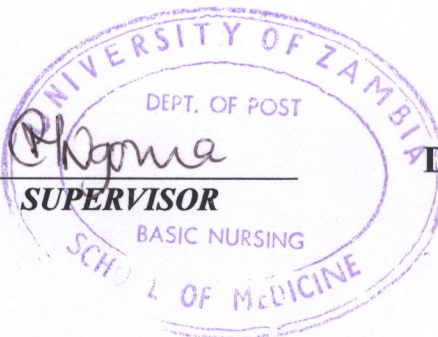
**SIGNED** \_\_\_\_\_



**CANDIDATE**

**DATE** 08-03-02

**APPROVED BY** \_\_\_\_\_



**SUPERVISOR**

**DATE** 8/03/02



## ***STATEMENT***

***I hereby certify that this study is entirely the results of own work and independent investigation. The various sources to which I am indebted are clearly acknowledged through out the text and the references.***

# ***ABSTRACT***

Reproductive Health in which Family Planning is a component is increasingly becoming a great concern to consumers of services, health care providers and policy makers. This is because of the escalating maternal and morbidity and mortality.

The main objective of the study was to determine the knowledge and practices of family planning among women in Mufulira District. The specific objectives were to determine the awareness of family planning services among women, determine the utilisation of family planning services and the factors that influence the utilisation of family planning services. The study was conducted between 6<sup>th</sup>-30<sup>th</sup> August, 2001.

Literature was reviewed globally, regionally and on the national level that showed factors associated with the knowledge and practices of family planning. Among these factors were the marital status, age, parity, educational level and socioeconomic status.

A non-interventional descriptive exploratory type of study was done. It was both quantitative and qualitative. Before the main study was undertaken, a pilot study was done at Chilenje clinic to test the instrument and changes were made where necessary.

A sample of eighty (80) women attending family planning were conveniently selected for structured interviews and FGDs in eight (8) health centres selected randomly by replacement. The coding, editing and data processing were done using a scientific calculator. The statistical data analysis presentation has been done using frequency tables, contingency tables, pie charts and bar graphs.

The findings of the study showed that all the respondents (100%) had heard about family planning, 94.8% were able to mention at least one modern method of family planning, 85% were able to define family planning correctly, 83% were knowledgeable about family planning and 17% had inadequate knowledge. Although most respondents had heard about family planning, there was a gap between their knowledge and practice of family planning.

It was also found that although most respondents (41.6%) had health care provider, 8.3% of these had inadequate knowledge about family planning and 11.6% were still not practicing family planning. The health care system, therefore need to improve and update the communication skills of health care providers for them to communicate with women effectively for family planning to be accepted by most women.

A link was established between women 's education, knowledge and practices of family planning, hence efforts to improve women awareness should be concentrated on the women with low or without formal education. A positive association was also found between women's age, parity, marital status and their knowledge and practices of family planning. Therefore, the teenagers, single women, widows and old women need special focus in the family planning services and development of programmes. The role of men in family was found to be predictor for non-use, hence the need to focus men in IEC strategies and programmes and theirs views on family planning use.

In this study, knowledge and practices of family planning was determined by the woman's age, marital status, parity, economic status, with educational level and employment as indicators.

From the findings of the study, it was concluded that IEC by the health care providers was not making much impact to improve the knowledge and practices of family planning among women. Several factors affecting the knowledge and

practices of family planning were identified. It has been recommended that there is need to re-orient health care providers in new trends in family planning and communication skills for them to be effective communicators to the clients. It was further recommended that MOH/CBOH need to develop positive and deliberate IEC strategies that are client oriented, involving men in family planning services and collaborating with other stakeholders in policy formulation and implementation of family planning programmes.

Unless family planning services are made available, accessible and affordable to all women, the reduction of the escalating maternal and infant morbidity and mortality will not become a reality.

# **CHAPTER ONE**

## **1.0. INTRODUCTION**

### **1.1 BACKGROUND INFORMATION**

Zambia is situated in the southern part of Africa, a region called Sub-Saharan African. It covers an area of 752,612 square kilometres, and consists of about 2.5% of the total area of Africa (EDGS, 2000).

The country is landlocked and surrounded by eight neighbouring countries namely; the Democratic Republic of Congo and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia and Angola in the west.

For administrative purposes, the country is divided into nine provinces, each with its respective provincial headquarters. These are Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, North western, Southern and Western Provinces.

The Zambian population has increased rapidly over the past 30 years. The population grew from 3.5 million in 1963 to 4.1 million in 1969 at an annual rate of 2.6 percent. From 1969, the growth rate remained high and increased to 3.1 per annum. The population grew to 5.7 million in 1980 and 7.4 million in 1990. By 1999, the population grew to 10.4 million at an annual rate growth rate of 3.7 percent (CSO, 1999).

Although Zambia is sparsely populated by international standards, the growth in population has increased the population density from 5.6 persons per square kilometre in 1969 to almost 10 persons by 1990. While the majority of Zambians continue living in rural areas, Zambia is one of the most urbanised countries of Africa. In 1963, roughly 20 percent of the population lived in urban areas and by 1990, 40 percent of Zambia's population was estimated to be residing in urban areas (CSO, 1992). However, urbanisation varies



considerably between provinces with about 90 and 85 percent of the population of Copperbelt and Lusaka Provinces living in urban areas respectively (Nsemukila, et al, 1998).

The rapid growth rate of the urban population results mainly from high natural increase in urban population and the rural urban migration estimated at 6 percent between 1969 and 1980 inter-censal period.

The fertility levels in Zambia have remained persistently high for decades. The growth patterns in Zambia's population have meant a population structure where children under the age of five make up 17 percent of the population. Children aged less than 15 and those adults with at least 65 years of age constitute about 49 percent and 3 percent of Zambia's population respectively. Women of reproductive age category (15-49) constitute nearly 26 percent of the total population (CSO, 1995).

According to both 1980 and 1990 census data, total fertility rate declined from 7.2% in 1980 to 6.7% in 1990. This decline was also observed in 1992 and 1996 Zambia Demographic Health Surveys (ZDHS), which estimated Zambia's fertility at 6.5-6.1 percent from 1992 and 1996 respectively. Although the trend has been showing the decline, fertility rate in rural areas is about 6.9% compared to urban women of about 5.1 percent. The fertility levels are highest in Northern and Luapula Provinces and lowest in Lusaka Province.

However, Zambia's fertility rates falls below Angola, the Democratic Republic of Congo, Mozambique and Malawi (6.2-6.7 percent) and above that of Swaziland, Lesotho and Namibia (4.7-4.9 percent) and about the same as Madagascar and Tanzania (5.4 percent) – (United Nations, 2000).

In 1989, the Government of the Republic of Zambia adopted explicit National Population and Family Planning Policies as an integral component of its Fourth National Development Plan (1989 – 1993) and within the framework of the New Economic Recovery Programme.

These policies were in recognition of the effects of the nation's demographic situation on her attempts at accelerated socioeconomic development and the consequent need to systematically integrate population factors into the nations development planning and in the implementation process.

The overall goal of this policy is to improve the standard of living and quality of life of all Zambians. The immediate objectives among others of the policy were: -

- Initiating and sustaining measures aimed at slowing the nation's high population growth rate.
- Enhancing people's health and welfare and preventing premature death and children.
- Ensuring that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so.
- Systematically integrate population factors into nation's development planning and plan implementation process and illness, especially among the high health risk groups of mothers

The main targets for the 1990-population policy, among others are:

- To reduce the rate of population growth from the current 3.7 percent per annum to 3.4 percent per annum by the year 2000 and 2.5 percent per annum by the year 2015.
- To reduce the total fertility rate from 7.2 percent at present to 6 by the year 2000 and 4 by the year 2015.
- To reduce infant mortality rate from 97 per 1000 live births to 65 per 1000 live births by the year 2000 and to 50 per 1000 live births by the year 2015.
- To make family planning services available, accessible and affordable by at least 30 percent of all adults in need of such services by the year 2000 (EDGS, 2000).

To give effect and achieve the policy objectives, a comprehensive National Family Planning Programme and National Population Information, Education

and Communication programme were prepared for the period 1992 – 2000. Important strategies include among others: -

- The formulation and implementation of family planning programmes within the context of the nation's health care and related systems.
- Expanding the coverage of family life education to all schools and institutions of higher learning so as to prepare the young people for responsible parenthood.
- Providing necessary IEC on the advantages of small family size for the individual, family and the nation as a whole in achieving self-reliance.
- Improving status of woman through the removal of various barriers to their effective participation in national affairs and a way of ensuring demographic transition from high to low population growth rates.
- Integration of family planning services and information into all Primary Health Care activities.
- Training various levels of family planning providers and periodically updating them according to service provision standards.
- Enhancing and strengthening multi-sectoral involvement and collaboration for distribution of family planning methods to increase access to family planning services and information.
- Providing family planning method mix to meet the varying needs of clients taking into account personal values and moral needs.
- Provision of family planning services and information at no cost by the Government, and facilitating free services to be provided by the private sectors.
- Involving men in family planning services and in responsible sexuality in a variety of means.
- Addressing family planning as a priority to special groups such as the young, couples/ individuals, rural and urban poor, sex workers, the physically and mentally disabled.
- Strengthening family planning services and information through options such as community-based services, commercial and private sectors.

- IEC to be a crucial strategy by educating individuals and couples about various family planning methods available and information about the safety and use of specific methods. The IEC to be disseminated through family planning programmes and the media.
- Ensuring a continuous flow of contraceptive supplies and commodities to all service delivery points including community based social marketing, private health institutions and employment based programmes.
- The Ministry of Health has created and adopted a logo “Family Planning Circle” as a visual symbol for family planning. The logo is to help clients identify location to receive quality family planning information and services. Trained service providers wear their logo pin and family planning counselling rooms are identified with a logo sticker, poster or sign.

Family planning is a component of Reproductive Health and has been included in the Essential Health Care Package in the Health Reforms. It is recognised as having a larger impact on the well being of individuals and families as well as on the socioeconomic situation of the country.

WHO defines family planning as: -

“The process by which families, couples or individuals decide how they will regulate their reproduction and take necessary action to do so”. (WHO, 1995).

The basis for the action on family planning as stated in the International Conference Population and Development Programme in action and in Zambia’s family planning Strategies and Services is to enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have the information and means to do so, to ensure informed choices and make available a full range of safe and effective family planning methods through a variety of formal and informal service outlets.

In 1984, the United Nations held a conference on population and the conference identified three major rationales, which account for family planning expansion.

- The first rationale was the human rights rationale, which is considered as the first and basis from which other freedoms of individuals flow.
- The second rationale was the demographic rationale, as family planning emerged in response to concerns about negative effects of rapid population growth on socioeconomic development. The objective for this was to reduce birth rate and thus facilitate socioeconomic development.
- Thirdly was the context of health rationale. Family planning delays pregnancy until the most convenient and appropriate.

To uphold the three major rationale, the United Nations Conference on Population urged all Government “to support family planning as a health measure in MCH programmes as a way of reducing births occurring too early, too closely spaced, too late or too many in the mothers life, of increasing the interval between births and of diminishing higher birth rates and by giving special consideration to the needs of those in the postpartum and/or breast feeding period (WHO, 1999).

Family planning is an effective way of improving the health of mothers, children, family, community and an important factor of achieving Zambia’s population goals.

According to WHO, 2000, the following are the benefits of family planning: -

- **WOMEN**

Family planning saves women’s lives and improves their health by allowing them to avoid unwanted and poorly timed pregnancies. Some methods of family planning such as condoms protect women from sexually transmitted infections. Family planning empower women by allowing them to decide the number and spacing of their children, which in turn



provides them with increased opportunities for participation in educational, economic and social activities.

- **CHILDREN**

Family planning saves children's lives and improves their health by allowing parents to delay and adequately space births. More food is available and other resources with better opportunities for education. Adequately spaced children have greater opportunity for emotional support from parents contributing to stable emotional growth of the children.

- **ADOLESCENT/YOUTHS**

Family planning helps them to maintain their health and promotes normal growth and development. This is so because family planning protects from too early and unwanted pregnancy and childbirth that endanger the health of the adolescents. The prevention against unwanted pregnancies prevents them from unsafe abortions and is able to stay longer in education. Some methods of family planning such as condoms provide protection from sexually transmitted infection among the youth.

- **COUPLE/FAMILY**

The couple using family planning has the freedom to decide when to have children and enjoy their sexual relationship freely without fear of unwanted pregnancy. A small family is less stressed emotionally and with increased economic opportunities. A small family has the resources distributed according to everyone's needs, have more energy for household activities, personal development and community activities.

- **MEN**

Some methods of family planning such as condoms provide protection from sexually transmitted infections, hence improving the quality of life. Men using family planning are less emotionally and economically strained and have greater care to each child.

## • COMMUNITY

Family planning reduces fertility and can help to reduce the pressures that rapidly growing population place on economic, social and natural resources. The community where family planning has been accepted, individuals have greater participation in community affairs.

It has been universally accepted that family planning improves and maintains the health of women. However, accessibility to family planning services varies widely between regions. Some 95% of women in East Asia have easy access, 57% in South East Asia and Latin America, 54%, South Asia. In Muslim world, the proportion falls to 13.25% and Sub-Saharan Africa merely 9%. It has been estimated that at least 350 million couples worldwide have no access to modern family planning methods (WHO, 1999 – 2000 Report).

In Zambia, accessibility to family planning information and services varies between urban and rural, and between provinces. It has been estimated that about 33% of women have an unmet and 12% for limiting births. Women in Lusaka, Copperbelt have the highest accessibility to family planning services followed by Northwestern, while Western and Luapula have the least accessibility (ZDHS, 1996).

The reasons for this are many but include inadequate supplies, restricted method mix, poor logistics, distance to health facilities, lack of knowledge of the available services, opposition to family planning and inadequate capacity on part of service providers. For example, a study conducted at UTH in 1997 revealed that more than 50% of 75 service providers did not feel confident about counselling women on contraception and worse in rural areas where about only less than 10% of the services had confidence in counselling woman on contraception (MOH/CBOH, 1998).

According to recent surveys, family planning services are provided by Government health institutions, military, mines missions and non-Governmental organisations. Half of all family planning users rely on non-clinic based services such as private pharmacies, drug stores, Community

Based Distributes, Local Healers and Traditional Birth Attendants. The quality of service delivery among the service providers is quite uneven (WHO, 1996).

The priority target groups for family planning services and information include these groups:

- Women with children less than two years
- Young adults
- Parents with satisfied parity
- Couples/individuals wanting to delay their first pregnancy
- Men
- Sexually Transmitted infected persons
- Sex workers
- Clients with physical disabilities
- Clients with mental retardation, drug or alcohol addiction or with major psychiatric disorders.

## **1.2 STATEMENT OF THE RESEARCH PROBLEM**

All over the world, a woman is reverend in recognition of the vital contribution to the continuation of human race and nuturing of the young. Statues are made, paintings are created, poems, stories and songs are composed to glorify the mother and her role. Yet, it has been estimated that more than half a million women die from childbirth everyday globally (WHO, 1999-2000 Report).

This silent tragedy which hardly make headline is happening here in Zambia. Most maternal deaths could be prevented if family planning services were made affordable and accessible to all women.

According to Reproductive Health in World-Bare Facts 2000, it is estimated that:

- Over 100 million acts of sexual intercourse take place each day. These result in 910,000 conceptions and 356,000 Sexually Transmitted Infections, bacterial and viral infections. About 50% are definitely unwanted.

- About 150,000 unwanted pregnancies are terminated everyday by induced abortions. One third of these abortions are performed under unsafe conditions and in adverse social and legal climate, resulting in some 500 deaths everyday.
- About 1,370 women die everyday in the course of their physiological and social duty of pregnancy and childbirth, and many times more of this number have a narrow escape though not without significant physical and psychological injuries (WHO, 2000).

According to the available statistics, half of the conceptions that take place everyday end up in criminal abortion, its complications and it is a major cause of maternal death. Most of these maternal deaths could be averted if family planning information and services were made accessible, available and affordable to all women.

In Zambia, sexual activity and child bearing begins at an early age. By the age of 17, nearly one third of all women have either been pregnant or have already had a first child. By the age of 19, the proportion of child bearing increases to two thirds. The consequences of such early pregnancies are many and include clandestine and unsafe abortion (Nsemukila, et al, 1998).

It has been estimated that in Zambia, about 18,000 criminal abortions are conducted every year and are seen at hospitals due to complications that arise. Qualified personnel conduct only about 1,000 therapeutic abortions (Mwandila, 1996).

According to the 1996 Zambian Demographic and Health Surveys (ZDHS), maternal mortality has been estimated at 649 deaths per 100,000 live births as a country, the mortality rate is more in rural areas than urban areas about 800 and 500 per 100,000 live births respectively. In some rural areas like Northern and Western Provinces, it is estimated at 900 and 1400 per live births respectively.

These are among the highest in the Sub-Saharan Africa and the entire world. The high maternal infant mortality rate is to a greater extent caused by unwanted, unplanned, too early, too many and too closely spaced pregnancies. Family planning not only prevents births, it also saves the lives of women and children, and this fact is universally accepted.

It is most likely that if family planning services were fully utilised in Zambia, up to about 42% of maternal deaths could be averted (WHO, 1999-2000).

According to 2000, End of Decade Goal Survey (EDGS), approximately 90% of sexually active women were reported aware of at least one method of family planning method, only 19% of all women of reproductive age (15-49) is said to be using some kind of contraception. Over all this 19%, 80% use effective method (modern) of contraception while 20% use less effect (traditional) methods of contraception.

About 28% of women in urban areas are reported using modern contraception compared to 13% in rural areas. The utilisation rate is higher on the Copperbelt (33%) and Lusaka (29%) while Northwestern and Western have the lowest rate of 5% and 9% respectively.

Mufulira District, which is situated on the Copperbelt Province of Zambia, covers an area of 1,258 square kilometres. The district has a projected population of 218,949 at a growth rate of 3.5% for 1999 Central Statistical Office estimation while the Council head count is 341,440 in 1997.

One of the target groups for family planning are women of the reproductive age, which is 26% of the total population according to CSO, 1995. This gives an estimated population of women in the reproductive age in Mufulira to be about 56,926.

The District has 3 hospitals; two are Government, while Mopani Copper Mines PLC owns one. There are 24 health centres of which 5 are run by Mopani Copper Mines, while Kafironda PLC, Zambia Army and Mufulira Municipal Council run one each. Out of the 24 health centres, two are privately owned. All the health facilities in the district are offering family planning services.



According to 1999 - 2000 self-quarterly assessments by the District Health Office (DHO), out of the estimated population of the reproductive age, only 2% are currently using the modern method of family planning. This implies that out of the 56,926 women in the reproductive age, 1,138 women are using the modern methods of family planning. These figures indicate that the family planning Information, Education and Communication has not been effective in changing women's behavior and a lot still needs to be done.

Where there is under utilisation of family planning services, there is absence of fertility regulation, unplanned pregnancies will occur, and most of them are unwanted. The consequences of such pregnancies are many and include clandestine and unsafe abortions, chances of dying from maternal causes are high due to complications resulting from too closely spaced pregnancies, too early pregnancies, too late pregnancies and increased infant mortality.

Several factors may influence the knowledge and practices of family planning in Mufulira District among women of the reproductive age. These factors may include the following:

- **SERVICE FACTORS**

One of the service delivery factors that may affect utilisation of family planning services is distance to the health facility. Women near the health facilities are more likely to use the services than those who have to walk long distances to health facilities offering family planning services, especially those that live in the peri-urban and rural areas.

The other factor is the availability of a variety of family planning methods at the service delivery points. This is likely to attract women to visit the centres and use the services, while unavailability of some family planning methods that are preferred by the clients like injection may negatively affect the clients seeking behaviour of the services.

The family planning delivery system approach or system may have an influence on the use of services by women. Rigid clinic schedules are not appealing to most women as compared to the supermarket approach.

The attitudes of family planning service providers may have an influence on the acceptance and use of family planning services. Positive attitudes towards work and clients by service providers advertise the services available. Negative attitudes, poor communication and counselling skills, and judgmental attitudes are likely to discourage most women in need of the services.

In addition, the effectiveness of the methods available at the health facility may influence most women to use the family planning services. Increase in failure rate especially those that are breastfeeding may make the mothers lose confidence in both the service providers and the health facilities. The failure may be generalised to other methods available at the health facilities.

The time spent at the health facility may either encourage or discourage mothers from using the services. For example long time spent on queues may discourage them while efficient services are well accepted by most women. The maintenance of privacy by service providers during counselling and screening may also encourage or discourage some clients to use the available services.

When family planning services are integrated in other primary health care activities, the services are more likely to be accessible to all women especially those living far from health facilities.

Furthermore, a well-established community based programme for distribution of family planning contraceptives may ensure continuity of services, and new acceptors may access the services. Currently, most of these services are coordinated by Non-Governmental Organisations involved in Reproductive Health. Moreover, non-collaboration with

stakeholders may deprive most women the knowledge they need to access the services available for them.

IEC is a key to knowledge that positively affects behaviour of an individual. Inadequate sensitization of women by service providers on the services available at the health facility may contribute to under utilisation of the services available by women.

The other factor that may contribute to the utilisation of family planning services is the availability of skilled service providers who are more likely to create a good impression on the clients by provision of quality services of the client's choice. Shortage of skilled service providers may contribute to negative attitudes of women towards the services provided and service providers. This may negatively affect women's service seeking behaviour and knowledge about the services available.

- **CLIENT FACTORS**

The educational level of a woman may have a bearing on family planning acceptance, knowledge and utilisation of the services. Educated women are likely to access the services than women of low education level as they are knowledgeable of the services available for them and where to access them.

The age of the woman may have a role to play on how a woman seeks the family planning services. It has been observed that women below 20 years rarely seek these services as they may think it is for older women, while after 40 years, most women feel uncomfortable to mix with young women of the same age with their children at the family planning clinic.

The family planning services may be viewed as services for women with high or satisfied parity. Women with low parity or with no children may not seek family planning services due to misconception that family planning is for women with high or satisfied parity. This misconception

may affect low parity and young women with no children to delay or space the pregnancies.

The marital status of a woman influences the seeking of services for family planning. Most women and the society at large associate family planning to married women. Women who are single, separated, divorced or widowed may be viewed as being promiscuous if known or found seeking family planning services. Women in these categories may shun the services available at the health facilities and use other ineffective traditional family planning methods.

Women who are in the formal employment tend to delay pregnancies and use have low education level, may be unaware of the family planning services available and becoming pregnant may be self-fulfilling, regarded as part of their responsibility as a wife and a mother.

Positive attitudes of women towards modern family planning methods may motivate women to seek the services, while negative attitudes by women towards these services and service providers affects how women appreciate the services available and provided.

- **SOCIO-CULTURAL FACTORS**

Most women in Zambia still believe that having many children is a sign of prestige for a man, security against divorce and a sign for man's love. Many also think that becoming pregnant more frequently may keep a man at home and prevent him from having extramarital sexual affairs for fear of the outcome of the pregnancy. Women with this belief may rarely seek family planning services. It is widely believed that modern family planning methods cause cancer of the breast and/or of the uterus, and infertility. The more recent belief is that injectable contraceptives are infected with HIV/AIDS virus meant to wipe away the entire African continent. These kinds of rumors may make women to shun the services.

Traditionally, most women lack power to make decisions about their own fertility, men make such decisions in the family. Some men may disapprove the use of family planning for fear of their wives becoming promiscuous. In addition, some women may be battered by their husbands on account of being in possession of or using family planning secretly. Women empowerment in fertility decision-making may enable them acquire the necessary knowledge and practice family planning.

- **RELIGIOUS BELIEFS AND PRACTICES**

Christian denominations and churches especially the Roman Catholic Church preach against the use of artificial methods of family planning except Natural Family Planning. The use of modern methods of family planning contradicts the teachings of the Christian churches and it is considered ungodly and a danger to human life.

All Christian churches, including Muslim teaching regard sexual activity as sacred and when outside legal marriage it is a sin against God, and encourages abstinence until one is married. This is universally accepted even in all cultures.

The use of condoms is condemned as well as all the adverts in the media about them as this is strongly believed to encourage promiscuity. The use of intrauterine contraceptive devices and the emergency contraception is regarded as the waste form of killing the innocent and it is regarded as equivalent to termination of pregnancy. This is believed so and preached against as it does not prevent fertilisation, but interferes with the already fertilised ovum, and life has already started. These teachings of the churches may influence women members in their search for knowledge of family planning services, while the accepted NFP may not be available at most of the health facilities in the country especially in rural areas.

- **ECONOMIC FACTORS**

Economic status may influence a woman's health seeking behaviour including family planning services. Low economic status women live far

from health facilities and may not afford transport costs to the health facilities for family planning services. If the method of choice is not available at the health facility, a poor woman may not afford to buy from the drug stores or pharmacies.

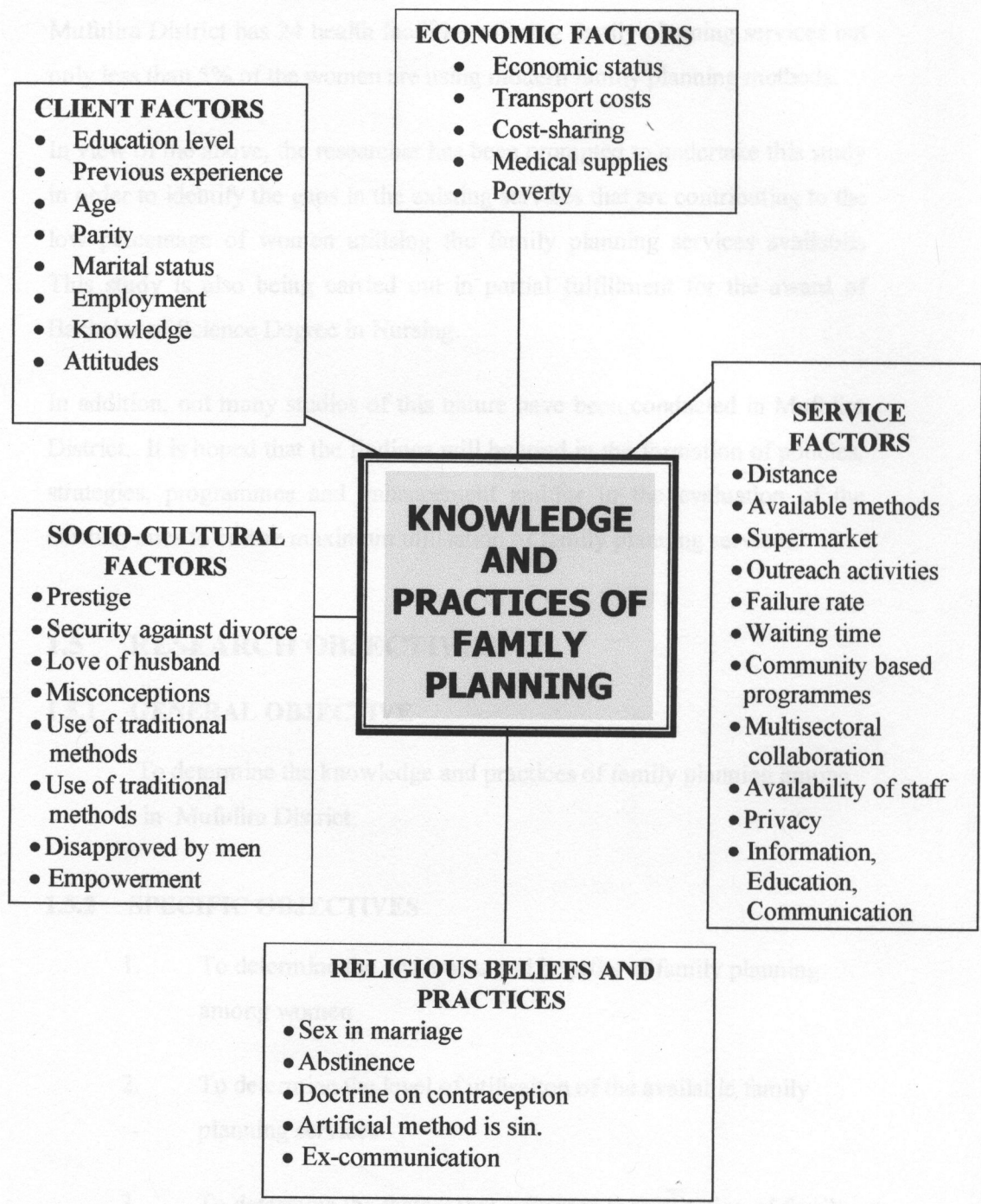
Needles and syringes are in short supply in almost all Government health facilities. Women are asked to buy these before they can have the injectable contraceptives or have nor-plant inserted. Women of low income may not afford to buy needles and syringes.

Health facilities charge for Bilateral Tubal Ligation making it unaffordable to women of low economic status who are mostly of high parity.

Family planning clinics are social gatherings. Women of low economic class may not afford presentable clothes such as a chitenge or unable to afford bathing soap for them to look clean and visit the health facility for family planning services.

The diagrammatic analysis of the possible factors influencing the knowledge and practices of family planning among women in Mufulira District discussed in this chapter have been presented on the next page.

**1.3. DIAGRAM ANALYSIS OF POSSIBLE FACTORS INFLUENCING KNOWLEDGE AND PRACTICES OF FAMILY PLANNING AMONG WOMEN**



## **1.4 JUSTIFICATION OF THE STUDY**

This study strives and seeks to determine the knowledge and practices of family planning among women in Mufulira District.

Mufulira District has 24 health facilities offering family planning services but only less than 5% of the women are using modern family planning methods.

In view of the above, the researcher has been prompted to undertake this study *in order to identify the gaps in the existing services that are contributing to the low percentage of women utilising the family planning services available.* This study is also being carried out in partial fulfillment for the award of Bachelor of Science Degree in Nursing.

In addition, not many studies of this nature have been conducted in Mufulira District. It is hoped that the findings will be used in the formation of policies, strategies, programmes and enhancement and/or in the evaluation of the existing ones to ensure maximum utilisation of family planning services.

## **1.5 RESEARCH OBJECTIVES**

### **1.5.1 GENERAL OBJECTIVE**

To determine the knowledge and practices of family planning among in Mufulira District.

### **1.5.2 SPECIFIC OBJECTIVES**

1. To determine the awareness and benefits of family planning among women
2. To determine the level of utilisation of the available family planning services
3. To determine the factors that influence the utilisation of family planning services



4. To make recommendations to all the concerned parties on how to increase family planning awareness among women in order to improve family planning services utilisation.

## **1.6 RESEARCH HYPOTHESIS**

### **1.6.1 HYPOTHESIS STATEMENTS**

1. Women who are aware of family planning are more likely to practice family planning services than those who lack the knowledge.
2. The knowledge and practices of family planning of women are related to the education level.
3. Women of high socioeconomic status are more likely to be knowledgeable and practice family planning services than women of low socioeconomic status.

## **1.7 RESEARCH STUDY VARIABLES**

This is the quality, property or characteristics of persons, objects or phenomena that change or vary and can take different values.

### **1.7.1 INDEPENDENT VARIABLES**

These are variables that are assumed to cause, contribute, determine or influence the problem under study. This include:

- Socioeconomic status
- Level of education
- Distance
- Cost-sharing
- Marital status
- Age
- Parity
- Beliefs etc

**1.7.2 DEPENDENT VARIABLES**

These variables are used to describe or measure the problem understudy. These are the assumed effects or response to the independent variables. These are:

- Knowledge
- Practices

**1.7.3 INDICATORS AND CUT-OFF POINTS FOR VARIABLES**

VARIABLE	INDICATORS	CUT-OFF POINTS
Knowledge	<ul style="list-style-type: none"><li>• Adequate knowledge</li><li>• Inadequate knowledge</li></ul>	<ul style="list-style-type: none"><li>• Most of questions 10-21 answered correctly</li><li>• Less than 5 questions from 10-21 answered correctly</li></ul>
Practices	<ul style="list-style-type: none"><li>• Good</li><li>• Bad</li></ul>	<ul style="list-style-type: none"><li>• Current modern family planning user</li><li>• Non-user</li></ul>

**1.8 OPERATIONAL DEFINITIONS**

These are the signed meaning to variables and will describe the activities required to measure it in the research study.

1. **ACCESSIBILITY:** The minimum cost, amount of time and waiting time to get the family planning service.
2. **ATTITUDE:** A way of thinking, feeling and behaving
3. **ACCEPTOR:** A woman practicing modern family planning

4. **CONTRACEPTION:** Methods and practices used to prevent or delay pregnancy.
5. **FAMILY PLANNING:** The process by which families, couples or individuals decide how they regulate their reproduction and take necessary measures to do so (WHO).
6. **FAMILY PLANNING SERVICE:** Any type of service provided to the woman for the purpose of family planning as defined by WHO.
7. **KNOWLEDGE:** Awareness of family planning methods and their availability
8. **PRACTICE:** *The methods of family planning methods that are commonly used by the women.*
9. **UNDER UTILISATION:** The failure by women to use the available family planning services as expected target population.
10. **UTILISATION:** The ability of the woman to use the available family planning services.
11. **WOMAN:** Female within the reproductive age of 15-49 years old.

# **CHAPTER TWO**

## **2.0 LITERATURE REVIEW**

### **2.1 INTRODUCTION**

Family planning is a component of Reproductive Health, which aims at the maintainance, and promotion of health for women.

In view of this; there has been a lot of researches conducted globally, regionally and on national level in an attempt to identify the gaps in the delivery of family planning services, its acceptance and delivery system.

In this literature review, the researcher has reviewed some published and unpublished research studies that have been conducted globally, regionally and on national level as relevant to the study topic of determining the knowledge and practice of family planning among women of the reproductive age (15-49 years). Not only for demographic reasons, universally, family planning has been accepted to improve and maintain health of women if only it can be made accessible to all women.

In view of the above, various studies have been conducted worldwide;

### **2.2 GLOBAL PERSPECTIVE**

It has been estimated that 910,000 conceptions take place everyday globally, and 50% are unplanned and 25% are unwanted. About 150,000 unwanted pregnancies are terminated everyday by induced abortion most of which are performed under unsafe conditions resulting in 500 deaths everyday (WHO, 2000). Yet, this maternal mortality can be reduced if only family planning services were made available and accessible to all women.

A study was conducted in Chiapas, Mexico by Halperin, et al (1994) to determine the relationships between education and non-use of contraceptives among poor women of Chiapas, a boarder region with 30% women who cannot read or write.

A random sample of 883 women aged 15-49 years was interviewed as part of regional survey of reproductive health.

The results of the study were that majority of women (65%) had not finished school, 80% did not have health insurance while 87% were not in paid employment. Overall, 36% had never practiced contraception. The proportion of those who had never used a method was far higher among illiterate women (49%) than among those who had completed secondary school (31%). The proportion of rural women who had never used any method of contraception was 43% compared to urban women (30%). Similarly, the proportions of those who had never practiced contraception were higher among women who had experienced death of at least two children (58%), among those who had at least 6 live born children (56%) and among those aged 40-49 years (54%).

In this study, illiteracy among women, plus other socioeconomic factors were associated with the likelihood of non-use of contraception. Illiteracy still remains a strong predictor of never-use of contraception globally among women, as well as inaccessibility to other health services available. However, the study did not show the percentage of illiterate women and the type of family planning methods they used.

In another study in 1998, Lee, et al from the London School of Hygiene and Tropical Medicine, Health Policy Unit conducted a study to compare family planning policies and programmes in eight low-income countries. This comparative study had four pairs of low-income countries (Bangladesh, /Pakistan, Thailand/Philippines, Tunisia/Algeria and Zimbabwe/Zambia). The main objective of the study was to understand why some countries develop appropriate and effective programmes while others do not. The study found that the formation of coalitions among the policy elites, spread of policy risk, institutional and financial stability were factors which supported or inhibited the adoption of strong population policies and family planning programmes. The extent to which family planning programmes are successful at reducing fertility remains in the nation's commitment to implementing these programmes.

A National Family Health Survey (NFHS) was conducted in India in 1999 and the main objective was to determine the knowledge, use, potential demand for

contraceptive use and the level of unwanted fertility. The survey was conducted in three phases and about 87,777 and 66,322 ever-married women were interviewed in urban and rural areas respectively.

The findings showed that 96% of women knew at least one method of contraception, 89% knew where they could access the modern method. Among the 96%, 37% used modern contraceptive method and 4% used traditional method. Contraception use were higher in urban (51%) than rural areas (37%). It was also higher among literate women (56%) than illiterate (34%). The results also showed a higher contraceptive rate among Buddhists and the Sikhs (51-63%) than among the Hindus and Christians (42-48%) and the rate was the lowest among Muslims (28%).

The study results also showed positive relationships between the number of living children a woman had and contraceptive use. 59% of women with three children were using contraception compared to only 4% of women without children.

In the same study, it was also discovered that education was an important determinant of proposed family planning use. For instance 94% of educated women approved the use of family planning compared to 70% of illiterate women. Joint family planning approval by the couple among illiterate was 85%, compared to 97% among literate. In rural India, above 74% women approved family planning compared to 86% in urban. Nearly three out of five non-users of contraceptive did not intend to use family planning in future regardless of the number of children, and there was very little attempt to space children.

In the same study, 30% of women had unmet need for family planning. The unmet need for spacing was higher (11%) compared to unmet need for limiting (9%). The lack of intentions to use family planning suggests that it will be difficult for family planning programmes to be successful without a strong IEC component to motivate individuals/couples to use contraception.

The unmet needs indicate that potential demand for modern methods is quite strong and suggest that increasing attention should be paid to effective spacing

methods as part of a balanced programme to satisfy the contraceptive needs to women.

The accessibility and the quality of services also need to be improved to overcome low motivation and encourage continued use among contraceptive users.

## **2.3 REGIONAL PERSPECTIVE**

A lot of research works have been done on many aspect of family planning within the Sub-Saharan African region. For instance, a study conducted in Zimbabwe by Schwartz, et al (1999) from the Department of Community Medicine, University of Zimbabwe in Harare.

The main objective of the study was to determine the knowledge and practices of family planning among women of reproductive age (15 - 49 years) in Zimbabwe. The total number of women recruited for the study was 6,083 respondents, 5,849 (96.2%) knew at least one method of family planning (modern) and 4,743 (78%) had ever used contraceptive in their life. Health concerns were the main reason for both discontinuation (28.5%) and postponement (22.8%) of contraceptive use. The contraceptive prevalence was 59%.

The results of this study showed a great improvement in knowledge and coverage of family planning services compared to the 1991 survey results. The improvement in knowledge and coverage of family planning services were attributed to the introduction of injectable methods of family planning. The study also revealed that women of high parity still remained under served, there was low knowledge and low use of condoms as contraceptive and high level of health concerns among current and potential users.

Although almost all women in Zimbabwe are knowledgeable about family planning, contraceptive prevalence is still very low for all women to access.

Gray, et al (1999) conducted studies in Zambia and Liberia. The aim of the studies was to evaluate the use effectiveness and cost effectiveness of natural family planning (NFP). The Liberian programme provided unipurpose NFP services to 1,055 clients mainly in rural areas while the Zambian programme

provided NFP services integrated with MCH to 2,709 clients predominantly in urban areas. The one-year life table continuation was 78.9 and unplanned pregnancy was 4.3 per 100 women in Liberia compared to 71.2 and 8.9 per 100 women in Zambia. More women progressed to autonomous NFP use in Liberia (58%) than in Zambia (35.3%).

However, programme costs per couple-year protection were lower in Zambia (US\$ 35.7) than in Liberia (US \$ 47.1), costs per couple-year protection were higher during the learning than autonomy periods and declined over time.

NFP is cost-effective, once learnt, it is for life and can be learnt by any women regardless of the socioeconomic status, and furthermore, it is universally accepted. However, NFP is not available to most women especially those in the rural Africa, and most family planning providers are not confident to counsel women about this method. These studies suggest that NFP programme can achieve acceptable use and cost- effectiveness in Africa. For family planning to be accessible to all women in Africa, there is need to enhance the effective integration of NFP in other family planning services that are currently being offered so that women who can not access modern family method because of financial, religious beliefs etc can successfully use NFP.

Another study was conducted by Jato, et al (1996) in Tanzania. The purpose of the study was to examine the impact of mass media on family planning promotion on the contraceptive behaviour of women. Nationally, a sample of 4,225 women participated in the study.

The results of the study showed that the more women were exposed to different types of the media, the higher the contraception practice was. Women who recalled six media sources of family planning messages were 11 times likely to use modern contraceptive methods. Those who recalled one media source were twice likely to use modern methods of contraceptive than women who have never been exposed to the media. It was also discovered that women who recalled media source were 30 times likely to discuss family planning with their husband and had visited the health facility 19 times and were currently using family planning than those who were not exposed to the media.



In this study, family planning campaigns have been shown to increase contraceptive use. Multiple media sources of information on contraception seem to reinforce one another and extend the reach of family planning campaign. Complementary messages may help to create an environment where practice of contraception can be perceived as an acceptable social norm. Varied media should continue to be used to promote family planning and other reproductive health issues.

However, the study did not indicate the type of media to which more women were exposed to and also needed to determine how to meet women's information needs most efficiently and how to provide continuous flow of information that is lively and interesting. Contraceptive use often entails a lengthy process of information seeking and continued use requires regular reinforcement and renewed commitment. Thus scattered family planning messages and short-lived campaigns are unlikely to provide adequate support to current or prospective contraceptive users.

Family planning programmes have endorsed the principle of informed choice as a way of ensuring that clients select a method that best meets their needs. In view of this principle, Kim, et al (1998) conducted a study in Kenya to determine how and whether family planning clients make informed choices and decisions. About 176 counselling interaction between female planning clients and family planning providers at 25 service delivery points were audio taped and analysed to identify key counselling behaviours and assess the completeness of the information provided to clients.

The results showed that providers collected information about new client's marital and reproductive history in 60% of the counselling sessions. Women were asked about their childbearing intentions only in 17% of the sessions. In 55% of the sessions, with old acceptors, providers asked about any problems with the current method and raised issues of switching to another method in 27% of these sessions, while asked clients about continuing reproduction in 17% of the sessions.

Providers discussed four methods of contraception with new clients and typically discussed fewer than two with continuing clients. Providers also seldom discussed contraceptive methods to clients' reproductive intentions,

prior knowledge of family planning, contraceptive references, personal circumstances or health risks. However, they emphasised on women's right to make a final decision as to method choice, and rarely assisted women in fully weighing alternatives or ascertained that they understood completely the personal implications of their choice.

The study suggests that family planning providers have a major role in enhancing the quality of woman's contraceptive decision making by playing a more active role in the process. By relating contraceptive information to a woman's personal circumstances and by assisting women in considering their options, providers can use counselling sessions to help women make informed and thoughtful choices about a critical reproductive health issue.

However, the analysis of this study was based on only spoken information and thus unable to give a complete picture of how clients and providers approach the decision making process. It is possible that providers made a silent assessment of new clients to identify important factors when selecting a contraceptive method by simply looking at the new client. For instance, if she is holding an infant. In addition, when counselling continuing clients, providers may rely on clinic records or personal knowledge for this information. The study also excludes the outside influences on the client's decision such as information and advice gathered from friends and relatives or previous visits with a provider.

## **2.4 NATIONAL PERSPECTIVE**

A number of studies have been conducted in Zambia on the knowledge and practices of family planning and factors that influence the use of family planning among women.

In Zambia, it has been estimated that 18,000 criminal abortions are performed every year. Only 1,000 therapeutic abortions are conducted by qualified personnel despite the legalisation of abortion under the 1972 Termination of Pregnancy Act which most health care providers and women are not widely aware of it.

The majority of criminal abortions are unsafe and poorly performed and continue to count for a high proportion of maternal mortality as shown by M'hango, et al (1986).

In a study conducted by Susu, et al (1996) at UTH by the School of Midwifery and Department of Obstetrics and Gynaecology to determine family planning practices before and after childbirth in Lusaka.

A total of 408 randomly selected normally delivered women who had given birth to health infants from postnatal ward at UTH were interviewed. Family planning practices before and after delivery were investigated among 376 of these women. The interviews were conducted in their homes or at the postnatal clinic at UTH at the end of puerperium, while 32 women mainly primiparae were lost to follow up. The results reviewed that 34% of the women had used a family planning method before the present child and 90% had used modern methods. It was also found that women with eight or more years of education used modern contraceptive methods more often than those with less education. It was also discovered that in one year of delivery, 64% of these women were using modern or tradition family planning methods and mainly Lactational Amenorrhea. Those who did not use any method (39%) indicated that their husbands disapproved contraceptive use.

The same study results also revealed that 56% of the teenagers had no knowledge of family planning and 84% of single teenagers had not used contraceptives before. The study results also suggest that teenagers and singles mothers need a special focus in family planning services and development of family planning programmes. In this study, it was recommended that there was need for more research studies to be conducted which focus on views of men on contraceptive use.

Biddlecom and Papohunda did another study in 1998 in urban setting in Zambia. The aim of the study was to examine women's convert use of contraceptives. Three questions were addressed – How is convert use to be measured? How prevalent is it and the factors that underline convert use.

Results from this study showed that women convert use of contraceptive was between 6-20% of all current contraceptive use and convert use was more

where contraceptive prevalence was low. This study did not indicate the reasons for covert use, which could be due to the husband's disapproval or just felt that their husbands will disapprove. However, difficult spouse communication is the strongest determinant of covert use. These results suggest that women using contraceptives secretly need confidential services and reinforcement from family planning providers.

A similar study was conducted in 14 townships in Ndola. The study focused on 1229 women who wanted to delay pregnancy or wanting to stop having children. The results of the study showed that 37% of the women were using the pill, 25% the injectable and 39% were on natural family method and 7% used other methods. In the same study the women were asked whether they would use a method covertly and 57% of the women said that they would secretly use a method if their husband disapproved, 20% indicated that they would not use a method without their husband's knowledge but they would try to persuade their spouse to practice contraception, 16% said they would not use a method and 7% indicated that they would openly use a method even if their husbands disapproved.

The quality of spouse communication and woman's perception of her husband's attitude towards family planning has an impact on woman's family planning behaviour. Open use of contraception in the face of husband's disapproval can result into serious family disputes. The involvement of men in policy and programme circles of family planning should not override the essential right to privacy for women seeking family planning services.

In 1996, Chipoma, et al conducted a study to determine characteristics of contraception acceptors in Lusaka in which 2,912 client records were reviewed in 22 randomly selected clinics in Lusaka. The purpose of the study was to assist the Government and local family planning associations in targeting future efforts to extend services to underserved populations. The study results showed that the newly enrolled acceptors had a medium age of 24 and parity of three. The majorities were married, had some secondary education, while others were unemployed housewives and were breastfeeding

at the time of first visit. Nearly  $\frac{1}{2}$  of the acceptors had used contraceptives before,  $\frac{3}{4}$  had received pills when they enrolled, and they had returned to the clinic about 3 times during the first year. But, it was discovered that only 24% of the acceptors were still active after 12 months later. The study also intends to examine trends in age, parity and education of contraceptive users over a 10-year period.

This study suggests some very important factors that determine the knowledge and practices of family planning such as parity, age, education, marital status and that the need for child spacing is higher than stopping childbearing. The above mentioned study should have also compared the characteristics of the urban and rural areas of Lusaka to examine any similarities or differences so that each segment of women are served according to their needs.

The more recent (EDGS) conducted by Nsemukila, et al (2000) in conjunction with WHO showed that approximately 96% of women knew one method of contraception and only 19% were using some kind of contraception.

This study also revealed that more women in the urban (28%) were using contraception compared to rural women (13%). Women from the Copperbelt and Lusaka Provinces used contraception most (33% and 29% respectively), women from Northwestern and Western Provinces use contraception less at 5% and 9% respectively. The results also showed that 30% of the women who used contraceptives had reached grade 10-12 and were aged between 25-29 years.

This study suggests that despite the high level of family planning awareness, there is a very big gap with the practice of family planning. This gap could be due to non-availability, inaccessible and unaffordable family planning methods. If modern family planning methods were made accessible and available to all women in Zambia, modern family planning practices is likely to increase from the current rate.

## **CONCLUSION**

The literature reviewed has shown that there are many factors that influence women's knowledge and practices of family planning. Most researchers have cited age, education, socioeconomic status, marital status, and commitment to implementation of family planning programmes, religion, media and the quality of family planning services offered.

Some researches have showed the discrepancy that exists between family planning awareness and use, while others have made suggestions on the integration of cost-effective methods like NFP.

Women empowerment remains a critical issue in their knowledge and practices of family planning. This will enable them make decisions about their reproductive life. Family planning services and programmes should include ways of empowering women to know their rights in deciding the use and method of contraception.

# **CHAPTER THREE**

## **3.0 RESEARCH METHODOLOGY**

### **3.1 RESEARCH DESIGN**

A research design is a scheme of action (framework) for answering the research question or problem (Treece and Treece, 1986).

After formulating the specific problem thoroughly and reviewing relevant literature, the researcher thinks through the steps to produce a workable strategy – the research design. It contains all the important information related to strategy and describes the instruments.

To achieve this main objective, a non-interventional descriptive, exploratory study design was used which was both qualitative and quantitative.

A descriptive study involves the systematic collection and presentation of data to describe or define characteristics of a phenomena or person as they naturally occur (Polit and Hungler, 1995).

This research design was found appropriate by the researcher for the following reasons:

- It is less costly and time consuming
- It involves getting information directly from respondents in their natural environment, which eliminates the subjection of respondents to unpleasant conditions; hence cooperation of the subjects will be more easily obtained.

This study was quantitative because data was be quantified in numerical values and percentages. This enables the researcher to make statistical inferences. The study was also qualitative because it endeavored to determine

knowledge and practices of family planning among women. It also attempted to identify various possible factors associated with this particular problem, a subject of major concern in the study.

### **3.2 RESEARCH SETTING**

This study was conducted in Mufulira, a mining town on the Copperbelt. Mufulira District has urban and peri-urban areas.

The district has a projected population of 218,949 at a growth rate of 3.5% for 1999, CSO estimation, while the Council head count is 341,440 in 1997.

The district is served by 24 health facilities, both public and private. All the health facilities are offering family planning services.

The researcher had chosen Mufulira district for the study because she is an employee of MOH working in the district. It was also be less expensive as the research funding from the sponsors is questionable.

### **3.3 STUDY POPULATION**

A study population is an aggregate or totality of all subjects, objects or members that conform to a designated set of specification (Polit and Hungler, 1995).

The study population comprised of women in the childbearing age (15-49) who are living in both urban and peri-urban areas of Mufulira district. The study population is approximately 56,926 (26% of the total population of Mufulira)

### **3.4 SAMPLING METHOD**

Simple random sampling method was used for selection of the health facilities in which the study was conducted. A list of 24 health facilities in the district was made, and then a lottery method was be used to pick eight (8) health centres in which the research was conducted.



The respondents from the randomly selected health facilities were selected by convenience method. Ten women were picked for both interviews and Focus Group Discussion (FGD) at each health facility. The FDGs were conducted at two health facilities where interviews were not conducted.

The researcher has chose this method because:

- It is very simple
- All women will had an equal chance of being included in the study and eliminate biases.
- It also enabled the researcher to make generalisation of the findings

### **3.5 SAMPLE SIZE**

A sample size is a subset of a population selected to participate in the research study (Polit and Hungler, 1995).

The sample size comprised of eighty (80) women attending family planning clinic. Sixty women out of eighty were interviewed and remaining twenty (20) were selected for FDGs. The 80 women were selected using convenient method in 8 randomly selected health facilities.

### **3.6 DATA COLLECTION, TOOLS AND TECHNIQUES**

The researcher was responsible for data collection. The researcher trained one research assistant on data collection to ensure speedy data collection from respondents and due to limited time in which the research was to be conducted.

Data collection was conducted between 6<sup>th</sup> - 30<sup>th</sup> August 2001 in all the eight randomly selected health facilities.

A mix of data collection methods was used. The advantages of using a combination of method is that the information collected in different methods complemented each other in analysing the characteristics of contraceptive acceptors; miximised the quality of data collected and reduced bias.

Two data collection tools were used to collect data and these were:

- A structured interview
- Focus Group Discussion

### **3.6.1 STRUCTURED INTERVIEW**

The researcher conducted interviews, and collected information directly (face to face) from respondents using a structured interview schedule. An interview schedule was designed to solicit information and it had both closed and open-ended questions. Open-ended questions gave the researcher an opportunity to explore and clarify issues.

The interview schedule also acted as a guide on what type of questions to ask in order to obtain information on required variables of the study.

The questions were written in English, but were translated into Bemba during the interviews, this being the commonly spoken language in Mufulira.

Women were interviewed in a private place to ensure privacy and anonymity were assured and granted to all respondents.

The researcher chose the interview schedule for the following reasons:

- Respondents included literate and illiterate women
- Misunderstandings were corrected there and then
- Clarification of questions and answers were done by rephrasing questions while retaining the same meaning.
- It was easy to administer considering the limited time of conducting the study.
- Analysis and interpretation of data will be easily accomplished.

However, interview schedule has some limitations, which includes the following:

- It is expensive in terms of printing the interview schedules for each respondent.
- It is time consuming for the interviewer when conducting the interview
- Training is needed for the research assistant

### **3.6.2 FOCUS GROUP DISCUSSION (FGD)**

This is an in-depth interview with a small number of people. The researcher chose FDG as a method of collecting in-depth information from women on knowledge and practices of family planning.

The information that was be collected from FGDs complemented that which was obtained from the interviews.

Questions were formulated to act as a guide, and were translated in Bemba during FGDs. This method was chosen for the following advantages:

- Data collection was fast
- Allowed for clarification of questions
- Respondents were able to express themselves freely in their language
- It allowed the researcher to probe and be able to get richer information.

However, it may be difficult to collect sensitive information from individuals in a group.

### **3.7 DATA HANDLING AND STORAGE**

The researcher numbered all the questionnaires prior to fieldwork. All completed questionnaires were edited in the field to ensure that they had been completed correctly. The completed questionnaires were kept separately in a labeled envelope. The researcher was responsible for the completed questionnaires.

### **3.8 ETHICAL CONSIDERATIONS**

The researcher wrote a letter (Appendix 4) to the (DHO) for Mufulira District Health Management Board (MDHB) for permission to carry out the research in their district. This was done in recognition of their authority and gained their support and cooperation during the study. Written consent from MDHB was received (See Appendix 5). The researcher obtained a verbal consent from all the respondents after a brief explanation on the nature and purpose of the study.

A unique identifier number on the interview schedule identified each respondent. The respondents were assured of confidentiality and anonymity, while privacy was put into consideration when collecting information.

### **3.9 PILOT STUDY**

A pilot study is a small scale or trial run conducted in preparation for the actual study on a limited number of subjects with same characteristics (Pilot and Hungler, 1995).

The researcher conducted a pilot study at Chilenje Family Planning Clinic. The sample comprised of 10 women who were randomly selected for interviews. The researcher conducted a pilot study in order to investigate the feasibility of the proposed study and detect any possible flaws on the data collecting tools.

The pilot study also enabled the researcher to estimate the possible time to administer the tool. After the pilot study, the researcher revised the format and presentation of the questions in the interview schedule; the respondents understanding of the questions was tested and changes were made where necessary.

## **CHAPTER FOUR**

### **4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS**

#### **4.1 DATA ANALYSIS**

The raw data that was collected was sorted out and then grouped into categories. The questionnaires were edited for completeness, uniformity, accuracy and consistency, and then data will be coded.

The responses from closed-ended questions were entered on the master sheet, while responses from open-ended questions and FGD were categorised in different groups and then coded.

The analysis of data was done manually using a scientific calculator.

#### **4.2 STASTICAL ANALYSIS AND PRESENTATION OF FINDINGS**

The findings of the study are presented in frequency tables, percentages, cross tabulation, bar graphs and pie charts.

The use of graphs and bar charts in the presentation of the findings will make the work presentable and easily understood by the readers of the research study.

The frequency tables will summarise the results of the study in a way that will enable readers to be able to understand the findings of the research study.

Cross tabulation of the variables will help to show clearly the relationship between variables and then the researcher will be able to draw meaningful inferences.

**TABLE 1:**  
**RESPONDENTS DEMOGRAPHIC CHARACTERISTICS**

DEMOGRAPHIC CHARACTERISTICS		FREQUENCY	PERCENT
AGE GROUP	15 - 24 years	25	41.6%
	25 - 34 years	22	36.6%
	35 - 44 years	13	21.6
	TOTAL	60	100%
MARITAL STATUS	Single	1	1.6%
	Married	58	96.6%
	Window	1	1.6
	TOTAL	60	100%
PARITY	1- 3 Children	32	53.3%
	4 - 6 Children	25	41.6%
	7 - 9 Children	3	5%
	TOTAL	60	100%
TRIBE	Bemba	30	50%
	Lamba	1	1.6%
	Tonga	3	5%
	Nyanja	11	18.3%
	Others	15	25%
	TOTAL	60	100%
RELIGION	Catholics	20	33.3%
	UCZ	7	11.6%
	SDA	6	10%
	Pentecostals	10	16.6%
	Others	17	28.3%
	TOTAL	60	100%
EDUCATION LEVEL	Basic School	49	81.6%
	High School	10	16.6%
	Post High School	1	1.6%
	TOTAL	60%	100%
EMPLOYMENT STATUS	Unemployed	38	63.3%
	Formal employment	6	10%
	Informal employment	16	26.6%
	TOTAL	60	100%

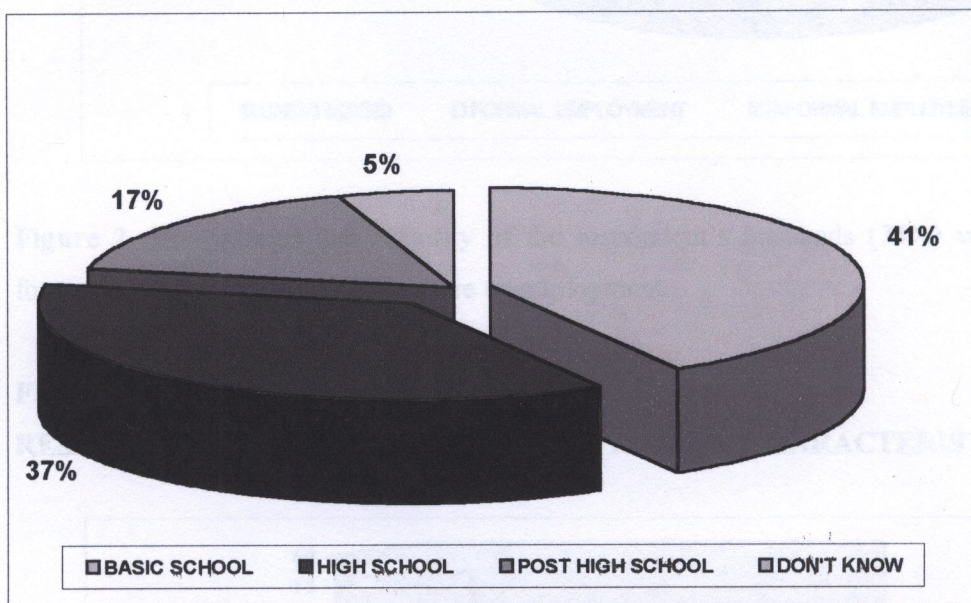
FIGURE 1:

## RESPONDENTS SPOUSE' EDUCATIONAL CHARACTERISTICS

Table 1 shows that most of the respondents (41.6%) were aged between 15 - 24 years. The majority (96.6%) was married and had 1 - 3 children (53.3%). Most respondents (81.6%) had only attained basic school and were unemployed (63.3%). The majorities (98.3%) were Christians and 50% were Bemba speaking.

FIGURE 1:

## REPOENDENTS SPOUSE' EDUCATIONAL CHARACTERISTICS



**Figure 1** describes the respondent's husband's educational characteristics. Most respondents' husbands (41 %) had attained only basic school, 37% had attained high school, only 17% had reached post high school, and 5% didn't know their husbands' level of education.

Figure 1 demonstrates that the majority of the respondents 36 (60%) had monthly income below poverty datum line.



**FIGURE 2:**  
**RESPONDENTS SPOUSE' EMPLOYMENT CHARACTERISTICS**

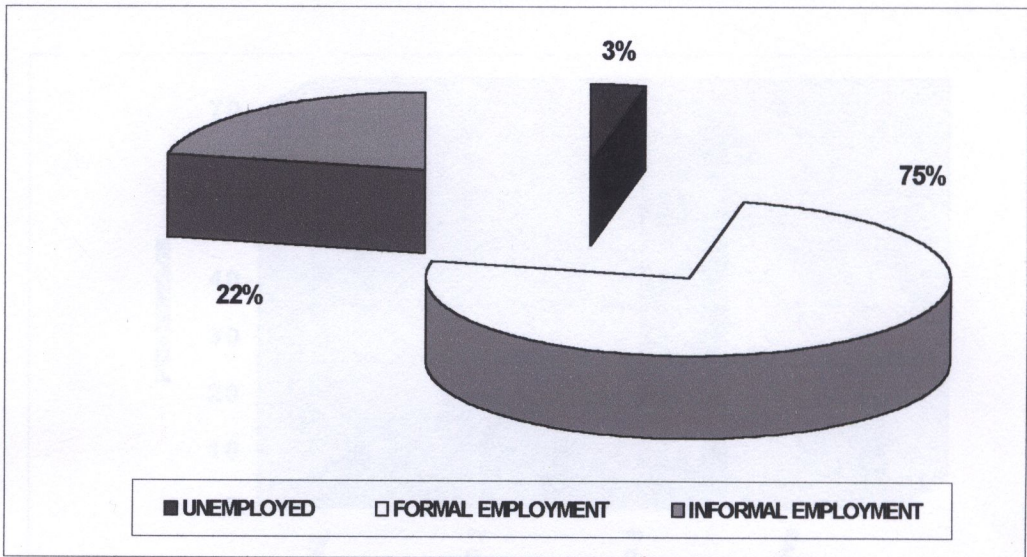


Figure 2 demonstrates that majority of the respondent’s husbands (75%) were in formal employment and only 3% were unemployment.

**FIGURE 3:**  
**RESPONDENTS MONTHLY HOUSEHOLD INCOME CHARACTERISTICS**

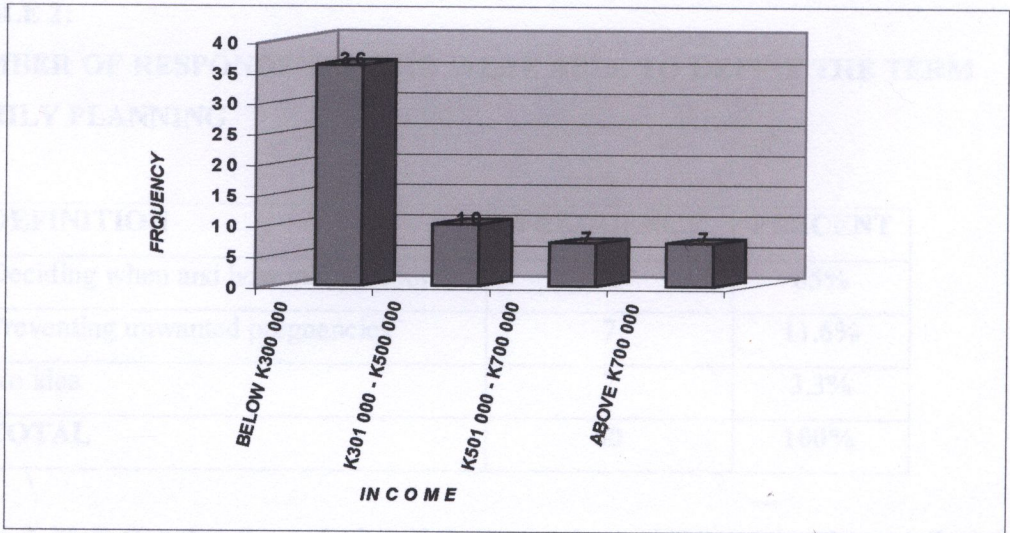


Figure 3 demonstrates that the majority of the respondents 36 (60%) had monthly income below poverty datum line.



FIGURE 3:

**FIGURE 4:**  
**RESPONDENTS AWARENESS OF FAMILY PLANNING METHODS**

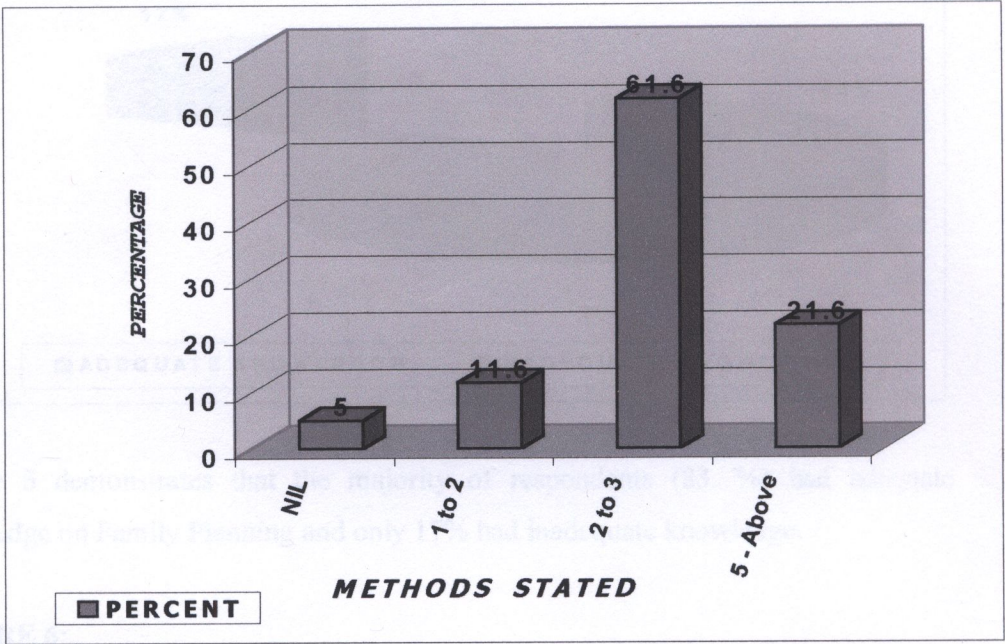


FIGURE 4:

RESPONDENTS FAMILY PLANNING KNOWLEDGE, SOURCE OF INFORMATION

**Figure 4** demonstrates that Majority (94.8%) of the respondents were aware of family planning and able to state at least one method of family planning.

**TABLE 2:**  
**NUMBER OF RESPONDENTS WHO WERE ABLE TO DEFINE THE TERM**  
**FAMILY PLANNING**

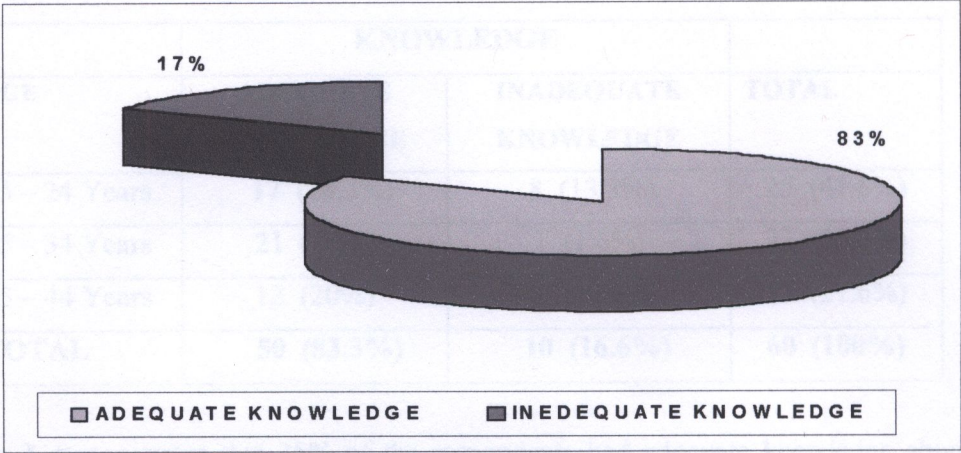
DEFINITION	FREQUENCY	PERCENT
Deciding when and how many children	51	85%
Preventing unwanted pregnancies	7	11.6%
No idea	2	3.3%
TOTAL	60	100%

Figure 6 shows that most respondents (25) had Health Care Providers as source of

**Table 2** illustrates that the majority of the respondents (85%) were able to define family planning correctly and only 3.3% had no idea

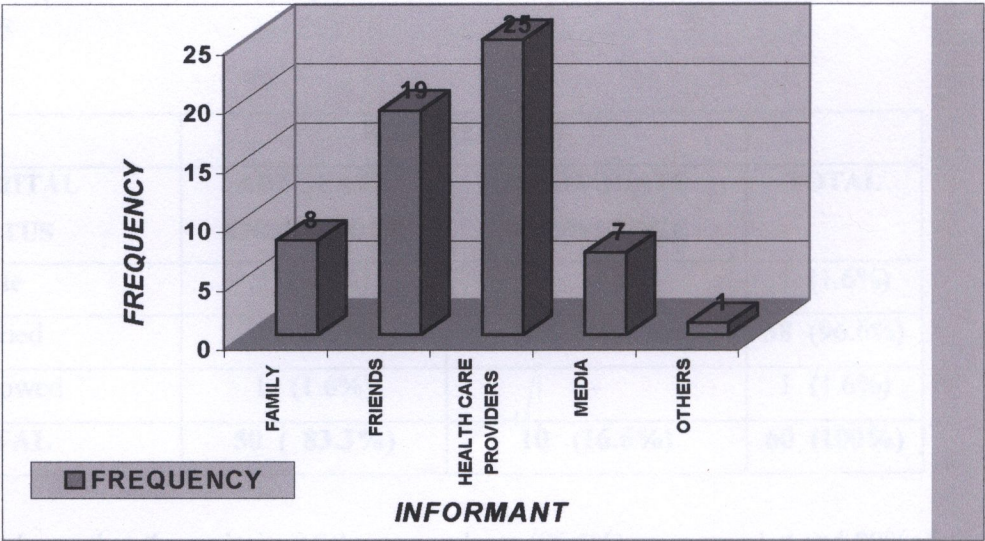


**FIGURE 5:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING**



**Figure 5** demonstrates that the majority of respondents (83. %) had adequate knowledge on Family Planning and only 17% had inadequate knowledge.

**FIGURE 6:**  
**RESPONDENTS FAMILY PLANNING SOURCE OF INFORMATION**



**Figure 6** shows that most respondents' (25) had Health Care Providers a source of information, 19 had friends, 8 had family members, 7 had the media and 1 had other sources of information

**TABLE 3:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY AGE**

	KNOWLEDGE		
AGE	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
15 – 24 Years	17 (28.3%)	8 (13.3%)	25 (41.6%)
25 – 34 Years	21 (35%)	1 (1.6%)	22 (36.6%)
35 – 44 Years	12 (20%)	1 (1.6%)	13 (21.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 3** demonstrates that 35% of the respondents had adequate knowledge about family planning and were aged between 25 – 34years. Most respondents (13.3%) who had in adequate knowledge were aged between 15 – 24 years.

**TABLE 4:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY MARITAL STATUS**

	KNOWLEDGE		
MARITAL STATUS	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
Single	1 (1.6%)	-	1 (1.6%)
Married	48 (80%)	10 (16.6%)	58 (96.6%)
Widowed	1 (1.6%)	-	1 (1.6%)
<b>TOTAL</b>	<b>50 ( 83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 4** shows that the majority of the respondents (96.6%) were married and 80%of them had adequate knowledge about family planning.

**TABLE 5:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PNLANNING BY THEIR INFORMANT**

	KNOWLEDGE		
RELIGION	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
Catholics	17 (28.3%)	3 (5%)	2 0 (33.3%)
UCZ	6 (10%)	1 (1.6%)	7 (11.6%)
SDA	5 (8.3%)	1 (1.6%)	6 (10%)
PENTECOSTALS	7 (11.6%)	3 (5%)	10 (16.6%)
OTHERS	15 (25%)	2 (3.3%)	17 (28.3%)
TOTAL	50 (83.3%)	10 (16.6%)	60 (100%)

**Table 5** demonstrates that most of the respondents (33.3%) were Catholics, and 28.3% of them had adequate knowledge of family planning.

**TABLE 6:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY PARITY**

	KNOWLEDGE		
PARITY	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
1 - 3	22 (36.6%)	10 (16.6%)	32 (53.3%)
4 - 6	25 (41.6%)	-	25 (41.6%)
7 - 9	3 (5%)	-	3 (5%)
TOTAL	50 (83.3%)	10 (16.6%)	60 (100%)

**Table 6** illustrates that all the respondents (41.6%) who had 4 – 6 children and 5% who had 7 – 9 children had adequate knowledge about family planning, while all the respondents (16.6%) who had inadequate knowledge about family planning had 1 – 3 children.

**TABLE 7:**  
**RESPONDEN KNOWLEDGE OF FAMILY PLANNING BY EDUCATIONAL LEVEL**

	KNOWLEDGE		
EDUCATIONAL LEVEL	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
Basic School	39 (65%)	10 (16.6%)	49 (81.6%)
High School	10 (16.6%)	-	10 (16.6%)
Post High School	1 (1.6%)	-	1 (6.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 7** demonstrates that all the respondents (16.6%) who had attained high school and post high school (1.6%) had adequate knowledge about family planning. Respondents (5%) who had inadequate knowledge of family planning had only attained basic school.

**TABLE 8:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY EMPLOYMENT STATUS**

	KNOWLEDGE		
EMPLOYMENT STATUS	ADEQUATE KNOWLEDGE	INEDEQUATE KNOWLEDGE	TOTAL
Unemployed	30 (50%)	8 (13.3%)	38 (63.3%)
Formal	6 (10%)	-	6 (10%)
Informal	14 (2.3%)	2 (3.3%)	16 (26.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 8** indicates that 10% of the respondents were in formal employment had adequate knowledge about family planning, while 13.3% of respondents who had inadequate knowledge about family planning were unemployed.

**TABLE 9:****RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY MONTHLY INCOME**

	<b>KNOWLEDGE</b>		
<b>INCOME</b>	<b>ADEQUATE KNOWLEDGE</b>	<b>INADEQUATE KNOWLEDGE</b>	<b>TOTAL</b>
Below K300 000	27 (40%)	9 (15%)	36 (60%)
301 - K500 000	9 (15%)	1 (1.6%)	10 (16.6%)
501 - K700 000	7 (11.6%)	-	7 (11.6%)
701 - Above	7 (11.6%)	-	7 (11.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 9** demonstrates that 23.2% of the respondents had an income above K500 000 had adequate knowledge about family planning. 15% of those who had inadequate knowledge had an income below K300 000.

**TABLE 10:****RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY THE SOURCE OF INFORMATION**

	<b>KNOWLEDGE</b>		
<b>INFORMANT</b>	<b>ADEQUATE KNOWLEDGE</b>	<b>INADEQUATE KNOWLEDGE</b>	<b>TOTAL</b>
Family	7 (11.6%)	1 (1.6%)	8 (13.3%)
Friends	16 (26.6%)	3 (5%)	19 (31.6%)
Health Care Provider	20 (33.3%)	5 (8.3%)	25 (41.6%)
Media	6 (10%)	1 (1.6%)	7 (11.6%)
Others	1 (1.6%)	-	1 (1.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

**Table 10** indicates that most respondents (41.6%) had Health Care Providers as their source of information on family planning and 33.3% of them had adequate knowledge of family planning, while 8.3% had inadequate knowledge about family planning.

**TABLE 11:**  
**KNOWLEDGE BY SPOUSE' EDUCATIONAL LEVEL**

	KNOWLEDGE		
SPOUSE' LEVEL OF EDUCATION	ADEQUATE KNOWLEDGE	INADEQUATE KNOWLEDGE	TOTAL
Basic School	17 (28.3%)	8 (13.3%)	25 (41.6%)
High School	21 (35%)	1 (1.6%)	22 (36.6%)
Post High School	10 (16.6%)	-	10 (16.6%)
Don't know	2 (3.3%)	1 (1.6%)	3 (5%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

Table 11 demonstrates that 16.6% of the respondents whose husbands had reached post high school had adequate knowledge about family planning. 13% of those who adequate knowledge about family planning had their husbands attained only basic school.

**TABLE 12:**  
**RESPONDENTS FAMILY PLANNING KNOWLEDGE BY SPOUSE' EMPLOYMENT**

	KNOWLEDGE		
SPOUSE EMPLOYMENT	ADEQUATE KNOWLEDGE	INEDEQUATE KNOWLEDGE	TOTAL
Unemployed	2 (3.3%)	-	2 (3.3%)
Formal	39 (65%)	6 (10%)	45 (75%)
Informal	9 (15%)	4 (6.6%)	13 (21.6%)
<b>TOTAL</b>	<b>50 (83.3%)</b>	<b>10 (16.6%)</b>	<b>60 (100%)</b>

Table 12 demonstrates that 65% of the respondents whose husbands were in formal employment had adequate knowledge about family planning and 10% whose husbands were in formal employment had inadequate knowledge.

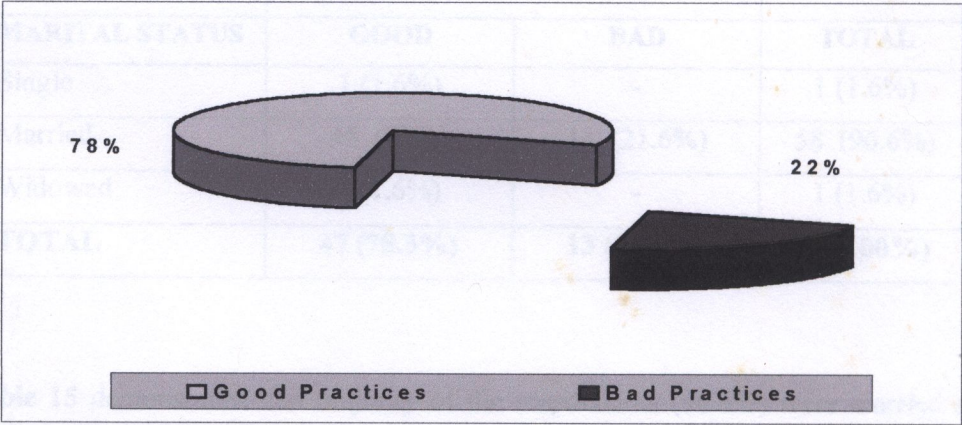


**TABLE 13: RESPONSES ON THE DISADVANTAGES OF PRACTICING FAMILY PLANNING**

DISADVANTAGE CATEGORIES	FREQUENCY	TOTAL
Causes cancer of Breasts and Uterus	15	25%
Causes Infertility	10	16.6%
Causes congenital malformation of babies	2	3.3%
Causes ovarian cysts and fibroids	2	3.3%
Other disadvantages	9	15%
No disadvantages	20	33.3%
<b>TOTAL</b>	<b>60</b>	<b>100%</b>

**Table 13** shows that 33.3% of the respondents stated no disadvantages in practicing family planning. 25% stated that family planning causes cancer of the breasts and uterus and 16.6% stated that it causes infertility. 15% said that family planning stated other disadvantages, and 3.3% stated that it causes cysts, fibroids and congenital malformations.

**FIGURE 7: RESPONDENTS FAMILY PLANNING**



**Figure 7** illustrates that the majority respondents (78%) were practicing family planning and 22% were not practicing family planning



**TABLE 14:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY AGE**

	PRACTICES		
AGE	GOOD	BAD	TOTAL
15 – 24 Years	16 (26.6%)	9 (15%)	25 (41.6%)
25 – 34 Years	19 (31.6%)	3 (5%)	22 (36.6%)
35 – 44Years	12 (20%)	1 (1.6%)	13 (21.6%)
<b>TOTAL</b>	<b>47 (78.3)</b>	<b>13 (21.6%)</b>	<b>60 (100%)</b>

**Table 14** demonstrates that most respondents (31.6%) practicing family planning were aged between 25 – 34 years. 15% of the respondents who were not practicing family planning were in the age group between 15 –24 years.

**TABLE 15:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY MARITAL STATUS**

	PRACTICES		
MARITAL STATUS	GOOD	BAD	TOTAL
Single	1 (1.6%)	-	1 (1.6%)
Married	45 (75%)	13 (21.6%)	58 (96.6%)
Widowed	1 (1.6%)	-	1 (1.6%)
<b>TOTAL</b>	<b>47 (78.3%)</b>	<b>13 (21.6%)</b>	<b>60 (100%)</b>

**Table 15** demonstrates that majority of the respondents (96.6%) were married and 75% were practicing family planning while 21.6% were not.

**TABLE 16:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY PARITY**

	PRACTICES		
PARITY	GOOD	BAD	TOTAL
1 - 3	23 (38.3%)	9 (15%)	32 (53.3%)
4 - 6	21 (35%)	4 (6.6%)	25 (41.6%)
7 - 9	3 (5%)	-	3 (5%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

**Table 16** demonstrates that respondents who had 7 – 9 children (5%) were practicing family planning, 15% of the respondents who had 1 – 3 children were not practicing family planning, and 6.6% with 4 - 6 children were also not practicing family planning.

**TABLE 17:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY RELIGION**

	PRACTICES		
RELIGION	GOOD	BAD	TOTAL
Catholics	15 (8.3%)	5 (8.3%)	20 (33.3%)
UCZ	7 (11.6%)	-	7 (11.6%)
SDA	5 (8.3%)	1 (1.6%)	6 (10%)
Pentecostals	8 (13.3%)	2 (3.3%)	10 (16.6%)
Others	12 (20%)	5 (8.3%)	17 (28.3%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

**Table 17** shows that the majority of the respondents (33.3%) were Catholics and 25% of them were practicing, 8.3% of the Catholics were still not practicing family. All the UCZ members were practicing family.

**TABLE 18:**  
**RESPONDENTS FAMILY PRACTICES BY THE LEVEL OF EDUCATION**

	PRACTICES		
EDUCATIONAL LEVEL	GOOD	BAD	TOTAL
Basic School	36 ( 60%)	13 (21.6%)	49 (81.6%)
High School	10 (16.6%)	-	10 (16.6%)
Post High School	1 (1.6%)	-	1 (1.6%)
<b>TOTAL</b>	<b>47 (78.3%)</b>	<b>13 (21.6%)</b>	<b>60 (100%)</b>

**Table 18:** demonstrates that 60% of the respondents who were practicing family planning had attained basic education and were practicing family planning, while 21.6% were still not. All respondents (16.6%) with high school and post high school (1.6%) were practicing family planning.

**TABLE 19:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY EMPLOYMENT STATUS**

	PRACTICES		
EMPLOYMENT STATUS	GOOD	BAD	TOTAL
Unemployed	27 (45%)	11 (18.3%)	38 (63.3%)
Formal	6 (10%)	-	6 (10%)
Informal	14 (23.3%)	2 (3.3%)	16 (26.6%)
<b>TOTAL</b>	<b>47 (78.8%)</b>	<b>13 (21.6%)</b>	<b>60 (100%)</b>

**Table 19** indicates that 45% of the respondents were unemployed and were practicing family planning. 18.3% of those who were unemployed were not practicing family planning.

TABLE 21:

**TABLE 20:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY SPOUSE**  
**EDUCATIONAL LEVEL**

SPOUSE'S LEVEL OF ADUCATION	PRACTICES		TOTAL
	GOOD	BAD	
Basic School	16 (26.6%)	9 (15%)	25 (41.6%)
High School	19 (31.6%)	3 (5%)	22 (36.6%)
Post High School	10 (16.6%)	-	10 (16.6%)
Don't Know	2 (3.3%)	1 (1.6%)	3 (5%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

Table 20 demonstrates that all the respondents (16.6%) whose spouses had attained high school were using family planning. 15% of respondents spouses had basic school were not using family planning.

TABLE 22:

**FIGURE 8:**  
**FAMILY PLANNING PRACTICES BY SPOUSE'S EMPLOYMENT STATUS**

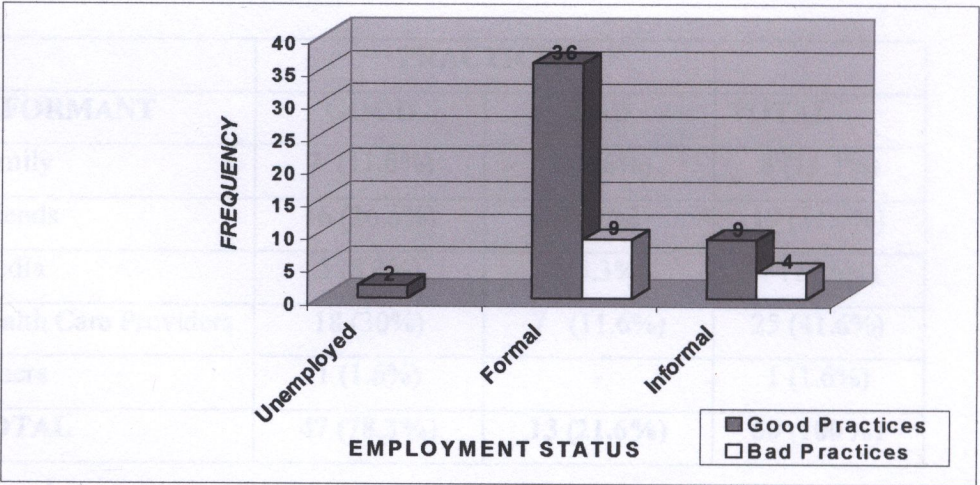


Figure 8 demonstrates that the respondents (36) 60% whose spouses were in formal employment were practicing family planning, and 9 (15%) whose spouses were in formal employment were still not using family planning.

**TABLE 21:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY INCOME**

	PRACTICES		
INCOME	GOOD	BAD	TOTAL
Below K300 000	28 (46.6%)	8 (13.3%)	36 (60%)
301 – K500 000	7 (11.6%)	3 (5%)	10 (21.6%)
501 – K700 000	5 (8.3%)	2 (3.3%)	7 (11.6%)
Above K700 000	7 (11.6%)	-	7 (11.6%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

**Table 21** demonstrates that 46.6% of the respondents whose income was below K300 000 were practicing family planning followed by those earning between 301–500 000 per month (16.6%) and those who earn K701 000 and above. 13% of respondents with an income below K300 000 still do not use family planning.

**TABLE 22:**  
**RESPONDENTS FAMILY PLANNINGPRACTICES BY THE SOURCE OF INFORMATON**

	PRACTICES		
INFORMANT	GOOD	BAD	TOTAL
Family	7 (11.6%)	1 (1.6%)	8 (13.3%)
Friends	16 (26.6%)	3 (5%)	19 (31.6%)
Media	5 (8.3%)	2(3.3%)	7 (11.6%)
Health Care Providers	18 (30%)	7 (11.6%)	25 (41.6%)
Others	1 (1.6%)	-	1 (1.6%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

**Table 22** indicates that most of the respondents (30%) who were practicing family had Health Care Providers as their source of information. 11.6% of the respondents who had Health Care Providers as their source of information were still not using family planning.

**TABLE 23:**  
**RESPONDENTS FAMILY PLANNING PRACTICES BY METHODS STATED**

	PRACTICES		
METHODS STATED	GOOD	BAD	TOTAL
Nil	-	3 (5%)	3 (5%)
1 - 2	3 (5%)	4 (6.6%)	7 (11.6%)
3 - 4	31 (53.3%)	6 (10%)	37 (61.6%)
5 - Above	13 (21.6%)	-	13 (21.6%)
TOTAL	47 (78.3%)	13 (21.6%)	60 (100%)

Table 23 demonstrates that 21.6% of the respondents who knew five (5) and above methods of family planning were practicing family planning. All the respondents (5%) who didn't know any family planning method were not using any method.

**TABLE 24:**  
**RESPONDENTS RESPONSES ON WHO DECIDED FOR THEM TO PRACTICE FAMILY PLANNING**

DECISION MAKER	FREQUENCY	TOTAL
Myself	30	50%
Couple	4	6.6%
Husband	22	36.6%
Health Care Provider	3	5%
Friends	1	1.6%
TOTAL	60	100%

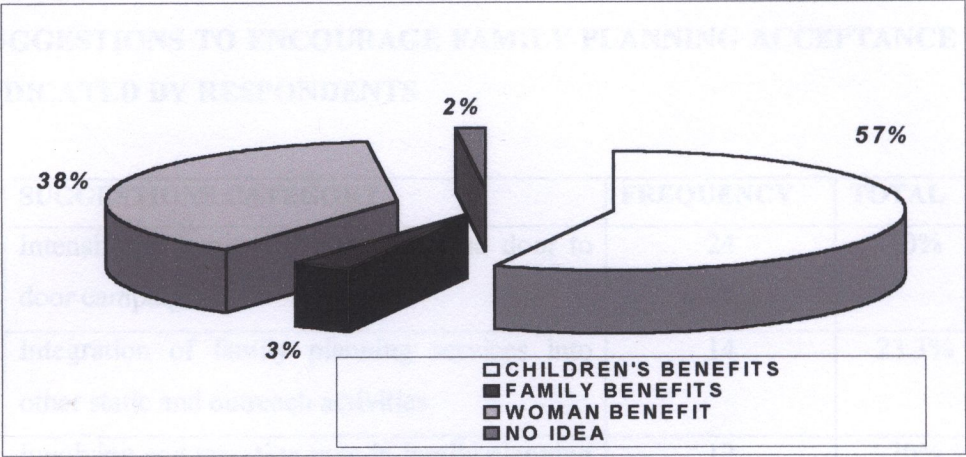
Table 24 demonstrates that 50% of the respondents made their decisions to practice family planning, 36.6% had their husbands, 6.6% made the decision as a couple, 5% had Health Care Providers and 1.6% had friends or family members decided for them to practice.



Figure 10 demonstrates that 75% of the respondents who had adequate knowledge on

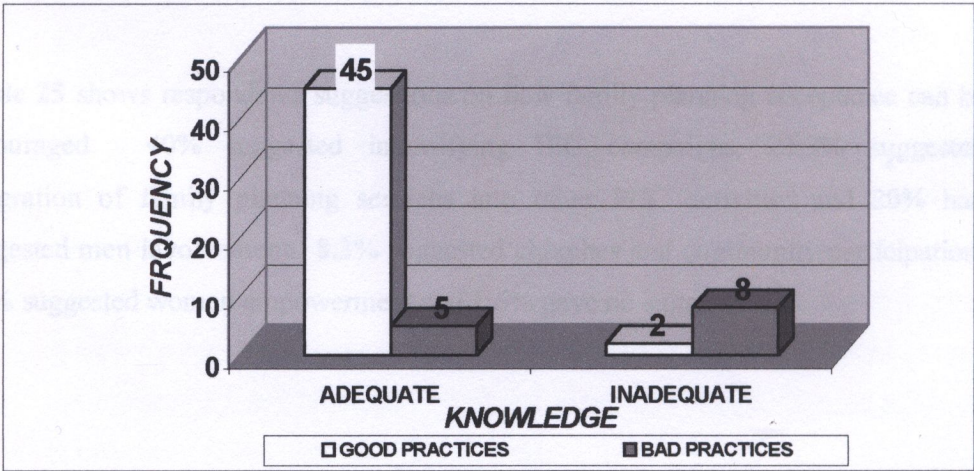
**FIGURE 9:**  
**RESPONDENTS RESPONSES ON THE BENEFITS OF PRACTICING**  
**FAMILY PLANNING**

TABLE 25:  
SUGGESTIONS TO ENCOURAGE FAMILY PLANNING ACCEPTANCE AS  
INDICATED BY RESPONDENTS



**Figure 9** demonstrates that 57 % of the respondents stated children's benefits in practicing family planning, while 38.3% gave woman's benefits, 3.3% stated family benefits and 1.6% had no idea of the benefits of practicing family planning

**FIGURE 10:**  
**RESPONDENTS KNOWLEDGE OF FAMILY PLANNING BY THEIR**  
**PRACTICES OF FAMILY PLANNING**



**Figure 10** demonstrates that 75% of the respondents who had adequate knowledge on family planning and 13.3% who had inadequate knowledge on family planning were not practicing family planning.

**TABLE 25:**  
**SUGGESTIONS TO ENCOURAGE FAMILY PLANNING ACCEPTANCE AS INDICATED BY RESPONDENTS**

SUGGESTIONS CATEGORY	FREQUENCY	TOTAL
Intensifying family planning IEC and door to door campaigns	24	40%
Integration of family planning services into other static and outreach activities	14	23.3%
Involving and targeting men in family planning services	12	20%
Empowering women to know their rights in making family planning decisions	4	6.6%
Involving the churches and community in family planning services	5	8.3%
No suggestions	1	1.6%
<b>TOTAL</b>	<b>60</b>	<b>100%</b>

**Table 25** shows respondents suggestions on how family planning acceptance can be encouraged. 40% suggested intensifying IEC campaigns, 23.3% suggested integration of family planning services into other PHC activities and 20% had suggested men involvement. 8.3% suggested churches and community participation, 6.6% suggested women empowerment and 1.6% gave no suggestions.



## **CHAPTER FIVE**

### **5.0 DISCUSSION AND INTERPRETATION OF FINDINGS**

The research study was done to determine the knowledge and practices of family planning among women. The researcher was prompted to do this study by the reducing number of women accepting family planning and the increasing number of maternal and infant mortality and morbidity.

The sample consisted of eighty (80) women who were conveniently selected for interviews and FGDs. Sixty (60) were selected for interviews in six (6) randomly selected health centres and twenty (20) were selected for FGDs in two health centres selected by replacement in both urban and peri-urban areas of Mufulira District.

The health centres selected for interviews were Kamuchanga District Hospital, Malcom Watson Hospital, Clinics 7, Butondo, Kamuchanga clinic and Clinic 5. The health centres selected for FGDs were Kansuswa and Kamuchanga clinic.

The study found some significant information on knowledge, practices, views, opinions, perceptions, and beliefs about family and the factors that influence them.

### **5.1 CHARACTERISTICS OF THE SAMPLE**

The study subjects were women in the childbearing age (15 – 49 years) and most were aged between 15 – 24 years (41.6%). The majority (96.6%) of the respondents were married and had between 1 – 3 children (53.3%). This could be attributed to the fact that marriage is universal in Zambia and women marry at an early age. By the age of 17, nearly one third (1/3) of women had already had a first child, and by the age of 19, the proportion of child bearing increases to two thirds (2/3) (Nsemukila, et al, 1998).

The majority of the respondents (81.6%) had basic education and were unemployed (63.3%). It is most likely that low educational level could affect the respondents' level of understanding certain aspects of family planning.

Their low educational level could be the reason for their unemployment. The majority of the respondents (98.3%) were Christians from various religious denominations (Table 1, page 41).

Most of the respondents' spouses (41.6%) had attained basic education (Figure 1, page 42) and the majority (75%) were in formal employment (Figure 2, page 43). It is most likely that the low educational level of the spouses could affect the acceptance and practice of family planning.

Majority of the respondents (60%) had monthly household income below K300 000 (Figure 3, page 43). This could be attributed to the respondents spouses low educational level and that most women were unemployed (63.3%).

## **5.2 WOMEN'S KNOWLEDGE OF FAMILY PLANNING**

Section B of the questionnaire had both closed and open-ended questions that aided in determine the basic knowledge that women had about family planning.

The findings showed that all the respondents had heard of family planning and that the majorities (94.8%) were able to mention at least one method of family planning (Figure 4, page 44).

Similar were the findings for FGDs where all the respondents acknowledged having heard about family planning. When asked to define family planning, the majority (85%) women defined it as a method or way of deciding the number of children and when to have them and only 3% had no idea (Table 2, page 44). Some of the participants in the FGDs said that it was a way of stopping having children and gave an example of sterilisation.

The findings further showed that 83.3% women had adequate knowledge on family planning and 16.6% had inadequate knowledge. (Figure 5, page 45). These findings confirm the ZDHS findings that stated that knowledge on family planning is almost universal and revealed increased knowledge. For instance in 1992 ZDHS 90% women could mention at least one method regardless of their age. The percentage increased to 92% in 1996 and 96% in

2000 (EDGS). Similarly, Schwartz, et al (1999) in Zimbabwe also found out that 96.2% women knew at least one modern method of family planning and in India by Kummar, et al (1999) where 96% of women knew at least one modern method.

Most of the respondents (41.6%) had health care providers as their source of information about family planning, and those who had friends (Figure 6, page 45) followed these. In the FGDs majority of the participants also mentioned health care providers as their source of information, other mentioned friends and family members and a few had the schools as their sources of information on family planning. This implies that family planning information could be transmitted to the intended target groups by peers other than the health care providers alone.

The majority of the respondent (83.3%) and participants in the FGDs were able to mention more than three methods of contraception. The modern methods mentioned in both groups of FGDs and interviews were oral contraceptives, condoms and injectable, while traditional methods such as strings and beads worn around the waist (Impipi in Bemba) and herbs (to drinks) were common to all the respondents.

Though the majority of women (100%) had heard about family planning and were able to mention at least one method (94.8%) of family planning, define it correctly (85%) and 83.3% had adequate knowledge about family planning, the study revealed a gap between the women's knowledge and acceptance of family planning.

These findings support earlier findings by Nsemukila, et al (1998) and EDGS (2000) where 96% of women had heard about family planning and only 19% were using some kind of contraception. Therefore, a lot still needs to be done to change the women's attitudes towards family planning.

In this study, most of the respondents (35%) who had adequate knowledge about family planning were aged between 25 – 34 years. The majority of those who had inadequate knowledge (13.3%) about family planning were aged between 15 – 24 years (Table 3, page 46). These findings revealed that

there were more middle-aged women (25 – 34 years) who utilised family planning services compared to the younger and the older women. This could be attributed to the fact that family planning is commonly associated with marriage and most women in the younger group (15 – 24 years) could not have been married, while those in the older age group (35 – above) could have stopped having children.

Most of the respondents (80%) who had adequate knowledge about family planning were married (Table 4, page 46). The findings also showed only a small percentage of widows (1.6%) and single women (1.6%) who were knowledgeable about family planning. These findings show a direct association between knowledge of family planning and the marital status has an influence on the women's use of family planning.

In this study, most of the respondents (33.3%) were Catholics and 28.3% of these had adequate knowledge about family planning (Table 5, page 47). There were no direct association between religious denomination and the knowledge about family planning

The study also found that all the respondents (41.6%) who had 4 – 6 children and those who had 7 – 9 children (5%) had adequate knowledge about knowledge about family planning. The respondents (16.6%) who had inadequate knowledge about family planning had 1 – 3 children (Table 6, page 47). The found a positive relationship between parity parity and knowledge about family planning. The knowledge of women who had 4 children and above could be attributed to the information obtained from health care providers on subsequent postnatal clinics and other reproductive health services.

The study also found that all the respondents (16.6%) who had inadequate knowledge had basic education, while all the respondents (16.6%) who had high education and post high school (1.6%) had adequate knowledge about family planning. (Table 7, page 48). This implies that women's information assimilation may be minimal due to low educational level as compared to

those with high educational level. The education of a woman is often used to determine woman's knowledge and usefully reflects her level of empowerment and independence in terms of decision-making. The study found a positive relationship between education and knowledge about family planning as stated in the hypothesis. The knowledge about family planning appears to increase with the level of education. These findings are similar to Mulebwa (1996)'s results which stated that of high educational level are more likely to be knowledgeable about family planning and likely to seek family planning services. These results also support the findings of Halperin (1994) in Chiapas, Mexico.

The findings have also revealed that majority of the respondents (13.3%) who had inadequate knowledge on family planning were unemployed, while the respondents (10%) who had adequate knowledge were in formal employment (Table 8, page 48). The employment status of a woman reflects her educational level and addition her socio – economic status and the likelihood of being knowledgeable about family planning. The showed a strong association between socio-economic indicator of education and employment and knowledge about family planning.

These findings support ZDHS (1996) and EDGS (2000) findings which found that women with high educational level were four (4) times likely to be knowledgeable about family planning than with low educational level, and that the higher the socio-economics status the more likely family planning services are obtained.

The study also found that the respondents (23.2%) who had a monthly income above K500 000.00 had adequate knowledge about family planning and the majority of the respondents (15%) who had inadequate knowledge had an income below K300 000.00 (Table 9, page 49). It is therefore clear those women with high socio-economic status who are educated and employed. (Tables 7, 8, 9) are more knowledgeable about family planning than those with low socio-economic status. These findings support the hypothesis statement

that states that women of high socio-economic status are more likely to be knowledgeable about family planning than women of low socio-economic status. The study results are also in line with ZDHS (1996) and EDGS findings.

In this study the health care providers (41.6%) were the main source of information on family planning and 33.3% of those who had health care providers as their informants had adequate knowledge on family. The study also found that of the 16.6% who had inadequate knowledge on family planning, half (8.3%) had health care providers as their source of information on family planning (Table 10, page 49). These results may indicate that IEC from the health care providers is not making much impact, hence the need to review and change IEC strategies on family planning.

The study also found that most of the respondent (13.3%) who had inadequate knowledge on family of planning had husbands who had attained basic educational level and all the respondents (16.6%) whose husbands had reached high school had adequate knowledge on family planning (Table 11, page 50). The study supports the findings of Nsemukila (1998). For instance, 35.3% of women whose husbands had no education had inadequate knowledge on family planning as compared to 10.7% whose husbands had post secondary education. The likelihood of having knowledge about family planning appears to increase with spouse' educational level.

In this study, it was found out that majority of the respondent (65%) whose husbands were in formal employment had adequate knowledge on family planning and those 10% had inadequate knowledge (Table 12, page). Formal employment is often associated with the educational level and income as indicators of economic status with direct association between spouse employment status and the knowledge on family planning.

In this study, it was also found that most respondents (33.3%) didn't know any disadvantage of using family planning, 25% mentioned that it causes cancer of the breast and uterus, 16.6% mentioned infertility, 15% mentioned other disadvantages and 3.3% mentioned ovarian cysts, fibroids, and congenital

malformation of the babies (boneless) (Table 13, page 51). Similar were the concerns the FGDs participants mentioned as misconceptions on modern family planning methods in their communities. Among the methods alleged to cause the mentioned disadvantages were the oral contraceptives and injectables. The findings were similar to Nsemukila, et al (1998), ZDHS (1992 and 1996) and EDGS (2000) which revealed the same reasons as disadvantages of using family planning. Similarly, Schwatz (1999) in Zimbabwe, which showed, that concerns were both main reasons for discontinuation and postponement of contraceptive use. This implies that the area of increased health concerns need attention among current and potential users.

### **5.3 WOMEN'S PRACTICES OF FAMILY PLANNING**

Section C of the questionnaire contains questions on women's practices of family planning.

In this study, majority of the respondents (78%) were using family planning and 27% were not (Figure 7, page 51). Although a large number of the respondents were practicing family planning, the findings of this study should be generalised with caution because of the small sample. However, most of the FGDs participants confessed that a large number of women in their communities were not using modern family planning methods, but were using traditional methods such as strings and beads worn around the waist. Others took herbs that suppress menstruation until when they wanted to become pregnant. Withdrawal, NFP and Lactation Amenorrhoea were other methods, which were also commonly used. The use of traditional methods of family planning was mentioned in both the interviews and FGDs as a common phenomenon. The 1992 and 1996 ZDHS and other reproductive health studies such as Study of Factors associated with Maternal Mortality in Zambia by Nsemukila, et al (1998) and EDGS (2000) have reported the use of such methods. Despite this knowledge, little has been done in establishing the effectiveness and the safety of some of these methods.

The study found that most respondents (31.6%) who were using family planning were aged between 25-34 years. Those who were not using family planning (15%) were in the age group between 15-24 years (Table 14, page 52). Similar findings were also discovered by Chipoma, et al (1996) who stated that majority of enrolled family planning acceptors had a medium age of 24. These findings imply that teenager and older women are undeserved. The two categories of women are more at risk of pregnancy related complications than the middle aged.

The study also found that majority of the respondents (75%) who were practicing family planning were married and 21.6% were still not practicing family planning. Apparently, the study found that a few (1.6%) and single women (1.6%) (Table 15, page 52). This implies that a woman's marital status had an influence on the use of family planning. The findings support the study findings of Ledward (1998) in South Africa where widows and single women were not regarded kindly if they were found using family planning outside wedlock

The findings also revealed that most of the respondents (38.3%) who were using family planning had 1-3 children (Table 16, page 53). It is most likely that women who practiced family planning wanted to delay pregnancy rather than to stop having children. These findings are in line with Chipoma, et al (1996)'s study, which found majority of the family planning acceptors to be of parity three.

In this study most of the respondents (33.3%) were Catholics and 25% of these were using family planning and 8.3% were still not. The respondents (11.6 %) who were UCZ members were using family planning (Table 17, page 53). The Participants in the FGDs were Christians who belonged to different religious denominations. The majority of women were from Catholic, UCZ and Anglican Churches who knew the teachings of their churches on practice family planning. These three churches advocate for the use of NFP and discourage the use of artificial methods. The women who belonged Pentecostal churches stated that their churches advocate the use of artificial



methods and condemn traditional methods (herbs and wearing of strings and beads). A few women from other religious denominations mentioned that their churches strongly oppose the use of family planning because it was against Gods' will and others expressed ignorance of their churches teaching on family planning.

These findings showed that religious denomination might have an influence on the woman's use of family planning. The result support the study in India by Kummar, et al (1999) which showed increased family planning among the Buddhists and Sikhs (51-63%), then Hindus and Christians (42-48%) and lowest among Muslims (28%). This implies that religious denomination could be used as a strategy for family planning IEC in order to create more awareness and acceptance of family planning.

The study also found that majority of the respondents (81.6%) had attained basic education level and 60% were using family planning. All the respondents who had high (16.6%) and post high school (1.6%) were using family planning. Although the majority the majority of the respondents who had attained basic education level were using family planning services, a few respondents (21.6%) in this group were still not using family planning (Table 18, page 54). These figures show a positive association between the education level and family planning use.

These findings are similar to EDGS (2000) findings, which found that 56% of women who had used contraceptives had reached grade 10-12 and Chipoma, et al (1996) had similar findings. The NFHS (1999) conducted in India also found out that family-planning acceptance was higher among the literate (56%) than the illiterate (34%). Illiteracy still remains a strong predictor of non-acceptance of family planning globally among women of as well as inaccessibility to other health services available.

Majority of the respondents (63.3%) were unemployed, 45% of these were using family planning and 28.3% were not, while the respondents (10%) who were in formal employment were using family planning (Table 19, page 54).

The findings found a positive association between employment status and the use of family planning.

In this study, of the respondents (78.3%) who were using family planning, 31.6% had their spouses attained high school education, while others (16.6%) had their spouses who attained post high school education. 15% of the respondents whose spouses reached basic education level were not family planning (Table 20, page 55). The practices of family planning seem to increase with the level of spouse's education. The study findings were similar with Nsemukila, et al (1998) which showed family planning acceptance rates improved with levels of husbands' education. The findings further revealed that those women whose husbands had primary education were about (4) times more likely to accept family planning than those women whose husbands did not have any schooling.

Majority of the respondents (60%) whose spouses were in formal employment were using family planning and 15% in the same group were still not using family planning (Figure 8, page 55). There did not seem to be a direct association between spouse' employment status and the use of family planning. The findings rather contradicted other studies which associated employment of the spouse and the woman' acceptance of family planning. (Mulebwa, 1996).

The study found that most of the respondents (46.6%) whose monthly house hold income was below K300 000.00 were using family planning and 13.3% with the same income were still not (Table 21, page 56). There seemed to be an increase in the acceptance of family planning as the income increases. The study found a positive association between socioeconomic status and family planning use. Similar were the findings in India by Kumar, et al (1999).

The study also found that 30% of the respondents who were using family planning had health care providers as their source of information and 11.6% in the same group were still not using family planning (Table 22, page 56). These findings imply that IEC by health care providers is not making much

impact in changing women's behaviour on family planning use. There is need to review IEC strategies and programmes on family planning in order for it to be accepted.

In this study, it was found that the respondents (21.6%) who mentioned five (5) and above methods of family planning were using family planning, while all the respondents (5%) who didn't know any family planning method were not using any method (Table 23, page 57). The findings showed a positive association between the knowledge of family planning and the use of family planning. There seemed to be an increase in the number of family planning methods mentioned and the practice of family planning. The more methods of family planning known to a woman the more likely she can practice family planning. The study findings confirm the study hypothesis statement, which states that women who are aware of family planning are more likely to practice family planning than those who lack the knowledge.

The study findings also showed that majority of the respondents (46.2%) who were not practicing family planning didn't know about it, 30.8% had their husbands disapproval, 15.4% stated the need for more children and 7.6% were influenced by misconceptions and beliefs opposed to the practice of family planning. The participants in the FGDs said that the men's role in family planning could not be overemphasized. They added that most women were not practicing family planning because of their husbands' disapproval. Some women mentioned that men disapproved because they regard the practice as against God's will and that it promoted prostitution among women. The majority of the respondents said that their husbands approved their of family planning, a few said that they were using family planning besides their husbands disapproval (covertly) and others mentioned convincing their husbands to avoid family disputes.

These findings imply that the IEC on family planning hasn't reached the intended target and there is need to intensify it to create more awareness for it to be accepted and appreciated. Husbands' disapproval of family planning practice is still a major factor to non-use of family planning by most women. Similar were the findings by Bibblecom, et al (1998) in Ndola.

The study also found that most respondents (50%) made their own decisions to use family planning, 36.6% had their husbands, 6.6% made the decision as a couple, 5% had health care providers and 1.6% had friends (Table 24, page 57). These results imply that the role of men is critical in deciding the family planning use by women and therefore, the need to involve the in family planning. The findings support the earlier discussion where 30.8% had their husbands' disapprove the use of family planning.

The study found that 56.6% women knew the benefits of practicing family planning related to children, 38.3% knew those related to women, 3.3% to the family and 1.6% had no idea (Figure 9, page 58). The majority of women who participated in FGDs said that family planning was good as it helps to limit the family size, prevents unwanted pregnancies, children grow well, helps the women to recover from the stress from previous pregnancy, thus improving her health status. The findings imply that women need to know the benefits of practicing family planning as related to themselves, children, family and the community in order for them to accept it (WHO, 2000).

## **5.4 KNOWLEDGE AND PRACTICES**

The study has found that all the respondents (83.3%) had adequate knowledge about family planning, 75% were practicing family planning, while 16.6% who had inadequate knowledge, 13.3% were not using family planning. Similarly, it is also true to say that all the respondents (78.3%) who were practicing family planning, 75% had adequate knowledge about family planning, and 21.6% who were not practicing family planning, 13.3% had inadequate knowledge about family planning (Figure 10, page 58). The study found a positive association between the knowledge and the practices of family planning. The more knowledgeable a woman is about family planning, the more likely to practice family planning.

In this study, most respondents (40%) suggested intensifying IEC as a means of encouraging family planning acceptance, 23. 3% suggested integration of family planning services onto other PHC activities, 20% suggested to involve men, 8.3% suggested Churches and community participation, 6.6% suggested

women empowerment in decision making on family planning and 1.6% made on suggestions (Table 25, page 59). Same were the ideas of women who participated in FGDs who further sort Government's protection by enacting a Law that will protect women from being divorced or abused by men if they decided to use family planning without their approval. The suggestions made by the respondents are some of the factors that may influence women's knowledge and practices of family planning that need to be addressed by family planning programme implementors in order to make family planning acceptance a reality.

From these findings, all the objectives stated in the study have been met. The findings also prove the hypothesis to be correct.

## **5.5 IMPLICATIONS FOR THE HEALTH CARE SYSTEM**

The study results showed that most women had adequate knowledge (83.3%) about family planning. Despite the knowledge, family planning acceptance is still low. As a result, most of them do not seek family planning services from the health facilities, while some women use the traditional methods such as wearing strings around their waists which may not be effective.

It was evident too from the study that health care providers were the main source of information on family planning, hence forming the basis for the successful implementation of Reproductive Health Services. However, IEC on family planning by the health care providers hasn't made much impact in changing women's behaviour on family planning practice.

There is need to equip health care providers with adequate knowledge and update their communication skills to enable them communicate effectively with clients. There is also need to review IEC strategies and programmes to the level the women can assimilate in order for women to accept family planning. There is need to exploit other sources for the dissemination of family planning information such as peer groups, schools and religious denominations in the light of their teachings to create more awareness of family planning services available for them. This is necessary because unless

health care providers work in collaboration with other stakeholders in intensifying IEC on family planning, acceptance will remain remarkably low.

The study revealed that men's role in family planning cannot be overemphasized. For so long, family planning has been associated with a woman, hence the need to target men in IEC programmes in order to create more awareness of family planning as their decision is crucial in family planning use by women.

The challenges to the health care system is to review IEC strategies and create new ones that are client oriented in the dissemination of information on family planning to men. This can be achieved by use of service clubs such as the Lions and Rotary as well as Churches to strengthen their knowledge base on family planning and positively accept women's practice of family planning. The health care system too, need to revisit the IEC strategies and programmes of family planning services to some disadvantaged priority target groups such as the physically and mentally handicapped, as well as those with major psychiatric disorders in order to achieve the National objectives of family planning programmes and policies

# **CHAPTER SIX**

## **6.0 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS**

### **6.1 CONCLUSION**

The evaluation of knowledge and practices of family planning in Mufulira district was worth undertaking.

The study findings showed that women of Mufulira district (83%) had adequate knowledge about family planning and 94.5% were able to mention at least one modern method of family planning. However, 16.6% had inadequate knowledge, and 21.6% were not using family planning.

Though most respondent had health care providers as their source of information, there seem to be not much impact on the change of women's behaviour on the use of family planning. This implies the need to equip the health care providers with communication skills through problem solving in order to create more awareness.

Unless family planning services are made available, accessible and affordable to all women, the reduction of maternal and infant mortality will not be a reality.

### **6.2 LIMITATIONS OF THE STUDY**

- The major limitations of the study were that, it was done alongside with other courses during the academic year, hence it was conducted within the limitations of time in which to be completed and submitted to UNZA.
- The funding of this study had been another problem, making it impossible to conduct a study on a large scale and hence the sample

size had to be one, which could be managed within the little resources and short time framework. The sample size was just too small to make statistical generalisation on the whole population

- The failure to get extra funding made it impossible for the researcher to collect data from more than two (2) health facilities in the peri-urban areas of the district due to increased cost of public transport.
- The manual data analysis was rather cumbersome and time consuming as the study was conducted alongside with other course.

## **6.3 RECOMMENDATIONS**

On the basis of the findings of this study, the following recommendations have been made for the health centres and MOH /CBOH.

### **6.3.1 HEALTH CENTRES**

1. The health care providers need to be re-oriented to the new family planning trends in order to equip them with the skills and knowledge in the provision of family planning services. This could be achieved by making deliberate policy to retrain family planning providers by organising reorientation workshops over a period of time.
2. Health care providers need to be retrained in communication skills for them to be accurate and effective communicators. This could be done through in-service training in conjunction with family planning re-orientation workshops and seminars.
3. The health care providers and policy makers need to review the IEC strategies and programmes in the provision of family planning services. This could be done through peer educators, drama and songs in addition to those currently being used.



### **6.3.2 MINISTRY OF HEALTH/CENTRAL BOARD OF HEALTH**

1. Positive and deliberate strategies need to be developed to increase men's involvement in the family planning services. This could be achieved through the use of men dominated organisations such as Service clubs (Lions and Rotary), football clubs and drinking places for the dissemination of IEC.
2. A community based research need to be done on a larger scale to determine the effectiveness and the safety of some of the traditional family planning methods used by women.
3. The Government needs to enact a Law to protect women from any forms of abuse from the public, family or spouse on account of using family planning without their approval.
4. The MOH need to work in closer collaboration with other stakeholders such as Churches Mother bodies, Christian Health Institutions (CHIs), NGOs, Schools and the community at large in creating family planning awareness. This could be achieved by requesting their inputs in policy formulation and programme implementation of family planning through workshops and seminars.
5. NFP has been overshadowed by modern methods for a long time, while most health care providers can not comfortably counsel women on this method. The MOH need to work in collaboration with religious organisations as well as NGOs like Family Life Movement of Zambia which advocate for this method to re-orient family planning providers and community Volunteers on NFP. This could promote men's involvement in family planning.

## REFERENCES

1. Biddlecom, A.E., et al (1998), Convert Contraceptive Use, Prevalence Motivation and Consequences, Institute of Social Research, Michigan.
2. Biddlecom, A. E., et al (1998), A survey on Convert Method Use among Zambian women is tied to poor spousal communication on contraceptive, Ndola.
3. Chipoma R. B., et al (1987), Contraceptive Acceptors in Lusaka, Zambia, Characteristic of Lusaka.
4. CBOH (1997), Integrated Technical Guidelines for Frontline Health Workers, CBOH, Lusaka.
5. CSO/MOH (2000), The End of Decade Goal Survey, CSO, Lusaka
6. CSO (1997), Zambia Demographic Health Survey 1996, CSO/MOH, Micro International Inc., Calverton, Maryland.
7. Fisher, E. J., et al (1991), Handbook for Family Planning Operations Research Design, The Population Council, New York.
8. Gaise, K., et al (1993), Zambia Demographic Health Survey, 1992, UNZA/CSO, Micro International Inc. Maryland.
9. Gray, R.H., et al (1993), Evaluation of Natural Family Planning Programmes in Liberia and Zambia, Johns Hopkins University, School of Hygiene, Baltimore, Maryland.
10. Halperin D., et al (1996), Strategic Approach to Contraceptive Introduction, Chiapas, Mexico
11. Jato, J. M., et al (1996), A Study of Impact of Mass Media on Family Planning Promotion in Tanzania, Dar es Salaam
12. Kim, Y. M., et al (1998), Informed Choice and decision making in Family Counselling in Kenya, International Perspective, volume 24, number 1, New York.
13. Kummar, A. P., et al (1999), A National Family Health Survey in India, Alan Cuttermacher Publications, Bombay.
14. Lee K., et al (1998), Family Planning Policies and Programmes in Eight low income Countries; A comparative policy analysis, London, School of Hygiene and Tropical Medicine Health Policy Unit, London.
15. Ledward, R. R., (1986), A Handbook for Obstetrics and Gynaecology, Utilisation of maternity Services, Wright, Bristol.

16. M'hango A.C., et al (1984) **Reproductive Mortality in Lusaka Zambia 1982-83, Studies in Family Planning**, Lusaka.
17. Mwandila. W., (1996), **A paper on Abortion presented at Zambia Information Services Workshop for Editors on 30<sup>th</sup> May 1996**, UTH, Lusaka.
18. MOH/CBOH, (1997), **Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines**, MOH/CBOH, Lusaka.
19. MOH, (1997), **Reproductive Health Policies, Strategies and Guidelines**, MOH, Lusaka.
20. MOH, (1997), **Safe Motherhood Policy, Strategies and Guidelines**, MOH, Lusaka.
21. MOH, (1996), **Zambia Safe Motherhood Needs Assessment and Guidelines**, MOH, Lusaka.
22. MOF, (1997), **Zambia National Population Policy** (Draft), MOF and Economic Development, Lusaka.
23. Mulebwa A. (1996), **A study of Factors contributing to Under Utilisation of Family Planning Among Women of Mine townships in Mufulira**, unpublished paper, Lusaka.
24. Nazar, L. B., et al (1999), **Education and Non-use of Contraceptive among poor women in Chiapas, Mexico**, International Family Planning Perspectives; volume 25, number 3, New York.
25. Nsemukila B.G., (1998), **A study of Factors Associated with Maternal Mortality in Zambia**, MOH, Lusaka.
26. Polit, D. F. and Hungler, P. B., (1995), **Essentials of Nursing Research, Methods and Applications**, Lippincott Company, Philadelphia
27. Schwartz, U., et al (1999), **Knowledge and practices of family planning in Zimbabwe**, Department of Community Medicine, University of Zimbabwe, Harare.
28. Susu, B., et al (1996), **Family planning Practices Before and After Childbirth in Zambia**, School of Nursing and Midwifery, Department of Obstetrics and Gynaecology, UTH, Lusaka.
29. Treece, E. W. and Treece J. W., (1948), **Elements of Research in Nursing**, Mosby Company, London.

30. UNICEF, (2000), **Our Children at End Decade, A Report on Zambia's progress towards the World Summit for Children Goals (Draft 3)**, United Nations, New York.
31. WHO, (1995), **An Assessment of the Need for Contraceptive Introduction in Zambia, Family Planning Options**, WHO, Geneva.
32. WHO, (1996), **Health Benefits of Family Planning**, WHO, Geneva.
33. WHO, (1996), **Improving Access to Quality Care in Family Planning, Medical Eligibility Criteria for Contraceptive Use**, WHO, Geneva.
34. WHO, (2000), **Reproductive Health Research at WHO; A new Beginning, Biennel Report 1998-1999**, WHO, Geneva.

## Appendix 1

### INTERVIEW SCHEDULE

**TOPIC:** A STUDY TO DETERMINE KNOWLEDGE AND PRACTICES  
OF FAMILY PLANNING AMONG WOMEN IN MUFULIRA  
DISTRICT

**CONFIDENTIAL**

**IDENTIFIER No:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**HEALTH FACILITY No:** \_\_\_\_\_

#### ***INSTRUCTIONS TO THE RESEARCH ASSISTANT***

1. Introduce yourself to the respondents before starting the interview
2. Explain the purpose of the interview and ask for permission to interview the participant
3. Participants should not be forced to be interviewed
4. Do not write respondent's names on the interview schedule
5. Assure confidentiality and all information should be kept confidential
6. Write responses in the spaces provided
7. Please ask all questions
8. Thank the respondents at the end of each interview

SECTION A: DEMOGRAPHIC CHARACTERISTICS

QUESTIONS

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1. How old are you?

1. 15 – 24 years
2. 25 – 34 years
3. 35 – 44 years
4. 45 and above

2. What is your marital status?

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

3. What is your tribe?

1. Bemba
2. Lamba
3. Lozi
4. Tonga
5. Nyanja
6. Other (specify)

4. What is your religion?

- 1. Catholic ☐
- 2. UCZ ☐
- 3. Anglican ☐
- 4. Pentecostal ☐
- 5. Others (specify) \_\_\_\_\_

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☐

5. What is your highest education level?

- 1. Never been to School ☐
- 2. Basic education ☐
- 3. High secondary education ☐
- 4. College ☐
- 5. University ☐
- 6. Any other (specify) \_\_\_\_\_

☐

6. What is your spouse's highest level of education?

- 1. Never been to school ☐
- 2. Basic education ☐
- 3. High secondary education ☐
- 4. College ☐
- 5. University ☐
- 6. Don't know ☐
- 7. Any other (specify) \_\_\_\_\_

☐

7. What is your occupation?

- 1. Unemployed ☐
- 2. Formal employment ☐
- 3. Informal employment ☐

☐

8. What is your spouse's occupation

For official use only

1. Unemployed

2. Formal employment

3. Informal employment

9. What is monthly household income?

1. Below K300, 000.00

2. K301, 000 – K500, 000.00

3. K501, 000 – K 700,000.00

4. Above K700, 000.00

**SECTION B: KNOWLEDGE OF MOTHERS TOWARDS  
FAMILY PLANNING**

10. How many children do you have?

1. 1 - 3

2. 4 - 6

3. 7 - 9

4. 10 and above

11. How old is your last child?

1. 0 - 11 months

2. 12 - 23 months

3. 24 - 35 months

4. 36 - 47 months

5. 48 - 59 months



12. What is the interval between your children?

1.

Less than 1 year
2.

1 – 2 years
3.

2 – 3 years
4.

3 – 4 years

13. Do you plan to have more children?

1.

Yes
2.

No

14. Explain your answer in question 13.

15. How many children would like to have?

1.

1 - 3
2.

4 - 6
3.

7 - 9
4.

10 and above

16. What are your reasons for the answer in questions 15.

17. Have you ever heard of family planning?

1.

Yes
2.

No

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18. If your answer in 17 yes who was your informant?

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1. Family
2. Friends
3. Health care provider
4. Media
5. Any other (specify)

19. What do you understand by family planning?

20. Do you know any method of family planning?

1. Yes
2. No

21. If your answer to question 20 is Yes, state the methods of family planning you know?

1.
2.
3.
4.

### SECTION C: PRACTICES OF FAMILY PLANNING

22. Have you ever used any method of family planning?

1. Yes
2. No

23. If yes to question 22, which methods have you used?

1. Oral contraceptive
2. Injection
3. Condoms
4. Traditional
5. Natural
6. Any other (specify)

24. If no to question 22, what are the reasons for not using any family planning?

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- 1. Didn't know about it
- 2. Want to have more children
- 3. Religious and traditional beliefs
- 4. Husband disapproval
- 5. Any other (specify)

25. Are you currently on any method of family planning?

- 1. Yes
- 2. No

26. If yes to question 25, which method are you using?

- 1. Oral contraceptive
- 2. Injection
- 3. Condoms
- 4. Loop
- 5. Natural
- 6. Traditional
- 7. Any other (specify)

27. Whose decision was it that you use a family planning method?

- 1. Myself
- 2. Spouse
- 3. Couple
- 4. Health care provider
- 5. Family/friends
- 6. Partner
- 7. Any other (specify)

28. Do you discuss family planning with your spouse/partner?

1. Yes

☐

2. No

☐

29. Is your spouse/partner in favour of family planning?

1. Yes

☐

2. No

☐

3. Not applicable

☐

30. Are you in favour of family planning?

1. Strongly in favour

☐

2. In favour

☐

3. Not in favour

☐

4. Strongly not in favour

☐

31. What do you think are the benefits of family planning?

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32. What do you think are the disadvantages of family planning?

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33. What suggestions would you like to make in order to encourage Women accept family planning?

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**THANK YOU FOR PARTICIPATING IN THE STUDY**

## **Appendix 2**

### **FOCUS GROUP DISCUSSION**

#### **AIM**

To obtain in-depth information from women on the knowledge and practices of family planning

1. Have you ever heard of family planning? What is it?
2. Do women use family planning in your communities? Why?
3. What methods are used and who decides on them?
4. What are your views about family planning?
5. What are the benefits of family planning?
6. Where do you go for your family planning services?
7. Do you think the services that are offered at the health facility adequate?
8. Do men have a role in family planning? If yes, what are their roles? If not why?
9. What are some of the religious and traditional beliefs regarding family planning in your community?
10. Give suggestions in order to encourage women to accept family planning.

***THANK YOU FOR PARTICIPATING IN THE STUDY***

## Appendix 3



**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF POST BASIC NURSING**

Telephone: 252453  
Telegrams: UNZA, LUSAKA  
Telex: UNZALUZA 44370  
Fax: +260-1-250753  
E-mail: [pbnu@coppernet.zm](mailto:pbnu@coppernet.zm)

P.O. Box 50110  
Lusaka, Zambia

16<sup>th</sup> May 2001


Dear sir/Madam,

This serves to introduce Mr/Mrs/Ms. MARGARET MPINDU  
a Fourth Year BSC (Nursing) student in the Department of Post Basic Nursing,  
School of Medicine, University of Zambia. The student is undertaking a  
Research Study in partial fulfilment of the above mentioned degree.

The Research Topic for study is TO DETERMINE THE KNOWLEDGE  
AND PRACTICES OF FAMILY PLANNING AMONG  
WOMEN IN MUFUNDI DISTRICT

We shall be most grateful if you could access the student to information on the  
subject or clients and any other assistance the student may require.

Yours faithfully

  
C.M. Ngoma (Mrs.)  
COURSE CO-ORDINATOR  
DEPARTMENT OF POST BASIC NURSING

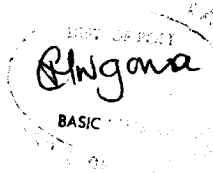
## Appendix 4

The University of Zambia  
School of Medicine  
Department of Post Basic Nursing  
P.O.Box 50110  
LUSAKA

18 th July, 2001

The District Director of Health  
Mufulira District Health Management Board  
P.O. Box 40050  
MUFULIRA

u.s.f. The Head of Department  
School of Medicine  
Department of Post Basic Nursing  
P.O.Box 50110  
LUSAKA



Dear Sir,

**RE: PERMISSION TO CONDUCT A RESEARCH STUDY**

I am a fourth (4) year student pursing a degree course in Nursing at the University of Zambia, School of Medicine.

As part of the requirements of the degree programme in Nursing, I am required to submit a research study in a chosen topic. The title of the topic is "A Study to Determine the Knowledge and Practices of Family Planning among women in Mufulira District". The target population will be women in the reproductive age (15-49years).

It is in this respect that I am asking for permission to conduct the research in your district.

Your assistance and cooperation will be highly appreciated.

Thapking you in anticipation.

Yours faithfully,

**Mpundu Margaret**

## Appendix 5

Barclays Bank Chambers  
1st Floor  
Butaka Street  
P.O. Box 40055  
MUFULIRA  
  
Phone: 412886, 412636  
Fax: 410088  
E-mail: mukimw@zamnet.zm



REPUBLIC OF ZAMBIA

### MINISTRY OF HEALTH MUFULIRA DISTRICT HEALTH MANAGEMENT BOARD

*In reply please quote*

No. ....

*All correspondence to be addressed  
to District Director of Health*

07/08/01

Ms Margaret Mpundu  
Mufulira District Health Management Board  
P O Box 40055  
**MUFULIRA**

Dear Margaret Mpundu

#### **RE: PERMISSION TO CONDUCT A RESEARCH STUDY**

Kindly refer to the above subject.

I am glad to inform you that permission to undertake the said study is granted and you can start as soon as you are ready.

Wishing you the best in the research.

Yours sincerely

**DR MUKUPA**  
**ACTING/DISTRICT DIRECTOR OF HEALTH**

CC Acting/Manager Planning and Development

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