1. INTRODUCTION.

1.1 BACKGROUND

Rapid population growth in the developing nations emerged as a social problem of magnitude only after World War II. It was generally recognized as such within a decade or so and was being addressed on a broad international scale within another decade.

Family planning activities in almost every country were initiated by volunteer groups, usually doctors or women’s organizations. The early efforts were undertaken to provide a service perceived as needed rather than to affect the rate of population growth. The services were usually rendered by clinics run by the voluntary organizations, and little use was made of mass communication or motivational activities. In an efforts to advance the practice of family planning one of the most obvious ideas was to integrate it with the prevailing system of health care and a number of rather complex experiments were mounted to test this combination (Fisher, 1991).

Family planning, traditionally, has been practiced throughout the world since time immemorial. In Zambia, family planning services had for a long time not been given national attentions. It was not until 1984 when the conference identified three major rationales which account for family planning expansion (Ewaran, 2002).

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 rational was the demographic rationale as family planning emerged in response to concerns about negative effect of the population growth in social economical development. The
objective for this was to reduce birth rate. Family planning delays pregnancy until the most convenient and appropriate time (WHO, 1999).

To uphold the two major rationales, the United Nations conference urged all governments to support family planning as a health measure in maternal child health programmes as a way of reducing birth occurring too (WHO, 2000).

On the one hand, most family planning workers are motivated by a wish to help individuals choose safe and acceptable means to space or limit pregnancies. On the other hand, fears about raped population growth are a powerful level for dislodging the funds for family planning programmes and this has led some managers to feel that their real priority is to reduce fertility.

Many programmes have been caught between these two conflicting mandates, often the demographic imperative and the funds that weightier where this has happened. Family planning programmes have often come to emphasize quantity over quality coverage over individual needs. The same influence can be seen in the criteria commonly used for measuring the effectiveness of such programmes acceptance rates compel years of protection or even proportion of women using long term method family planning (Fisher, 1991).

At the heart of these conflicting pressures is the lack of a clear distinction between wanted and unwanted fertility and a corresponding confusion about what family planning can and cannot do. Social and economic change can cause people to space
birth or to have fewer children. Family planning programmes can permit the safe exercise of such choices (Fisher, 1991).

The main job of family planning programmes is therefore not to promote smaller families per se but to meet existing demand with services that are respectful and competent. When this is accepted as the unambiguous mandate, the quality of services being offered and their responsiveness to individuals requirement.

1.2 STATEMENT OF THE PROBLEM

Despite the introduction of modern family planning methods, it has been found that there is a high level of pregnancies and child bearing among women (DHS, 1996). Hence, this study investigated on the effect of community education in the utilization of modern family planning methods among women.

1.3 PURPOSE OF THE STUDY

The purpose of the study is to determine the effect of community education in the utilization of modern family planning among women. The study, therefore, investigated the extent to which women have adopted modern family planning in the community.

1.4 OBJECTIVE OF THE STUDY

The general objective of the study was;

(i) To find out the effect of community education in the utilization of modern family planning among women.
SPECIFIC OBJECTIVES

(i) To investigate whether community education influence the utilization of family planning.

(ii) To investigate changes and adoption rate of women participating in the utilization of modern family planning.

(iii) To determine women attitude towards modern family planning.

(iv) To determine the knowledge level of women towards family planning.

1.5 SIGNIFICANCE OF THE STUDY

The significance of the study is that was to inform and give alternative solutions to the problem of high levels of pregnancies among women.

1.6 ASSUMPTION OF THE STUDY.

The assumption of the study was that the desire for many children by couples contributed to less usage of Family planning methods/ samples, traditional beliefs and religious beliefs because of lack of knowledge about family planning which hinders women from participating in Family Planning services.

1.7 LIMITATION OF THE STUDY

The scope of the study was limited to a number of factors. The researcher had wished to cover more communities as a way of collecting more information. However due to lack of resources such as time, funds and transport, only one community will be covered.
1.8 DEFINITION OF TERMS

Population: The number of people in which the study was carried (CSO, 2000).

Knowledge: Facts, feelings or experience knowledge by women about family.

Women: Female in child bearing age 15 to 49 years (WHO, 2000).

Attitude: The way the client / health care provider perceive family planning (WHO, 2001).

Practice: clients should look forward to the next visit and understanding the reason for continued monitoring (Stein, 1997).

Unplanned birth: giving birth to children without planning (Ewaran, 2002).

Family Planning: the process by which families’ couple or individuals decide how they regulate their reproduction and take necessary measures to do so (MOH, 1999).

Contraception: methods and practices used to prevent or delay pregnancy (MOH, 1999).

Family Planning Services: Any type of service provided to the women for the purpose of family planning as defined by World Health Organization (WHO, 2002).
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The memories of the women you talk to may be clouded by what they remember or were told, and not necessarily informed by what actually happened. You can start by telling these mothers that there is new evidence that indicates that early marriage and childbearing is detrimental to the health of women and children.

The major concern of this study is to determine the effect of community education in the utilization of modern family planning among women. In this chapter, literature review will be discussed in relation to factors of awareness, knowledge accessibility and attitudes towards modern family planning.

Community Education is a process designed to enrich the lives of individuals and groups by engaging with people living within a geographical area, or sharing a common interest, to develop voluntarily a range of learning, action and reflection opportunities, determined by their personal, social, economic and political needs (Ewaran, 2002).

We can approach community education as education for community with community. It is also a process of becoming part of an existing social network in order to encourage dialogue and learning. Community is not just the place or context in which education is to occur. Fostering community is also a central concern. Community education in its stronger sense has parallels in the tradition community organization (Ceve, 1990).
Mubanga (2000), started that family planning is planning and how many children to have and how to prevent unintended pregnancies. It covers areas as varied as when and why to get pregnant, the number of children that are wanted, what to do when an unintended pregnancy occurs, and the types of family planning methods to use to delay, space, or avoid a pregnancy (modern contraceptives as well as traditional methods). Family planning is the planning of when to have children, and the use of birth control and other techniques to implement such plans. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management (Fisher, 1991).

Family planning is sometimes used as a synonym for the use of birth control, though it often includes more. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy. Family planning services are defined as educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved (MoH, 19991).

Family planning was more pronounced in 1916 when Margaret Sager opened the first family planning clinic in United States of America (USA). Although the introduction of family planning was accepted in some parts of the world it still received opposition on moral, religious political and cultural grounds. The introduction and adoption of a National population policy in 1989, and the National Family planning policy later in 1997, encouraged the provision of family services in Zambia by both the government and private providers.
Family planning is a component of reproductive health and has been included in the essential health care package in the health reforms. It is recognized as having a larger impact on the well-being of individuals and family as well as the social economic situation of a country. It is also about enabling people to have safe and fulfilling sexual relationships and to decide if and when to have children. Family planning also reduces the bad outcomes of pregnancy that include maternal deaths, abortion complications and miscarriages (Stein, 1997).

### 2.2 Methods of Family Planning

There are two types of family planning methods. These are traditional and modern family planning methods. Traditional methods include abstinence and withdrawal whereas modern includes condoms, oral contraceptive such as Microgynon, Norplant, intrauterine devices, and vasectomy (Chinguya, 1998).

Modern Family planning has been a sensitive issue in the African society. Some of the religious groups have shown interest in instituting birth control measures either through modern family planning method or natural methods of family planning. Since then family planning methods have been widely distributed and used in Zambia (MOH, 1997).

Different methods of birth control have varying characteristics. Condoms, for example, are the only methods that provide significant protection from sexually transmitted diseases. Spermicide may be used alone, or in combination with a physical barrier.

There are various delivery methods for hormonal contraception. Forms of synthetic oestrogens and progestins (synthetic progestogens) combinations commonly used
include the combined oral contraceptive pill ("The Pill"), the Patch, and the contraceptive vaginal ring ("NuvaRing"). A monthly injectable form, Lunelle, is not currently available for sale in the United States (Halpern, 1996).

The most effective methods in typical use are those that do not depend upon regular user action. Surgical sterilization, Depo-Provera, implants, and intrauterine devices (IUDs) all have first-year failure rates of less than one percent for perfect use. In reality, however, perfect use may not be the case, but still, sterilization, implants, and IUDs also have typical failure rates under one percent. The typical failure rate of Depo-Provera is disagreed upon, with figures ranging from less than one percent up to three percent (Fisher, 1991).

Other methods contain only a progestin (a synthetic progestogen). These include the progesterone only pill (the POP or 'minipill'), the injectables Depo-Provera (a depot formulation of medroxyprogesterone acetate given as an intramuscular injection every three months) and Noristerat (Norethindrone acetate given as an intramuscular injection every 8 weeks), and contraceptive implants. The progestin-only pill must be taken at more precisely remembered times each day than combined pills. The first contraceptive implant, Norplant, has been removed from the market in the United States but is still used in many other countries. A single-rod implant called Implanon is approved in the United States. The various progestin-only methods may cause irregular bleeding during use. Ormeloxifene (Centchroman) is a selective estrogen receptor modulator, or SERM. It causes ovulation to occur asynchronously with the formation of the uterine lining, preventing implantation of a zygote. It has been widely available as a birth control
method in India since the early 1990s, marketed under the trade name Saheli. Centchroman is legally available only in India (Halppern, 1991)

Reaching women and their partners who have a stated need is the first step in reducing unplanned pregnancies. While ensuring access to family planning services is one dimension of this challenge (services close to home, variety of methods, congenial setting, low cost, few barriers to eligibility), women and their partners also need information and they need to be encouraged to discuss family planning. Strengthening family planning and behavior change programs is crucial. Within the health system, taking advantage of every opportunity to integrate family planning into other health services (maternal and child health, HIV/AIDS services) is another essential step, with the integration focus on (MOH,1999).

2.3 Barriers in getting family planning

Eswaran (2002), said that lack of information, fear of side effects, geographical, social, and economic reasons that prevent women from obtaining and using family planning methods. Other studies in sub-Saharan Africa reveal that nurses’ attempts to stigmatize teenage sexuality, their scolding and harsh treatment of adolescent girls, and their unwillingness to acknowledge adolescents as contraceptive users, also undermine the effective use of contraception by girls. Youth need better information on reproductive physiology and sexual health, and detailed information on contraception. They also need youth-friendly services and providers who are open and willing to serve youth with respect as clients.
Providing family planning information to women is a form of empowerment through participation in various reproductive health activities. Feminism such as Stein claims that human relations should be based on women’s values of nurturance and solidarity, shared and communal child care. Women’s participation in decision making and priority setting (Stein, 1997). Eswaran (2002) agrees with this feminists view in that couples must decide on family planning methods so that together they can have the number of children they wish to have and when to have no missed good opportunities. In family planning Saves Lives, we present a lot of evidence about the health benefits of family planning for birth spacing, HIV prevention, and reducing abortion rates. As you point out, there is also the financial/economic case to be made, too. Costs associated with raising children today health care, education and food.

Eswaran (2002:40) further stated, “I agree with the policy which allows women to freely participate in family planning activity even when men have not consented because reproductive health was declared a human right at the 1995 Beijing conference”. In Zambia, family planning participation rate (s) also depends on one’s educational level. Generally, the higher the educational level, the higher the participation rate. This was evident in the study which was conducted by Gaiosie etal (1993) on the relationship between education and family planning prevalence. The findings of his study revealed that those who had primary education (12.8%) secondary education (27 %) or higher education (58%) have contraceptive prevalence rates above the national average.

Although family planning services are very important to both males and females, the female have been major participants ever since their inception. Most of the studies that
have been conducted in the third world have focused on women. Even the family planning programs are designed almost exclusively for women. As a result, men have found themselves secluded and have conveniently accepted the situation. A good example is the integration of maternal child health services and family planning services, which are meant to service children and women only (MOH, 1999).

John Hopkins (2001), report on contraceptive, states that an estimated 55% of married women in the developing world are using some sort of contraception and 50% are using modern methods on controls. In 1990, an estimated 41% of married women in developing countries were using contraceptives. In the 38 developing countries survey, by side-bars 2002 indicates that fertility has fallen by an average fertility has been falling. Results from 1990 surveys suggest that the peace of decline has been slowing compared with fertility declines in the 1970s, and 1980s. Many factors help to explain why the pace of fertility decline appears to be slowing due to economic and social changes and new reproductive attitudes (Melba, 2000). At the same time infant and child mortality is falling in response to better public health measures in which family planning is a component (Mubanga, 2000).

The question many people would want to ask is, why family planning planned parenthood global partner reports that family planning is a basic right and it is something people want world-wide the report further says that 150 million married women already indicates a desire to plan their families, but lack access to family planning, which includes information, health. The other reason is the large number of young people entering their reproductive years. Three billion of the six billion people alive today are under age 25 (Winfrey, 1997).
2.4 Advantages of family planning.

By spacing births, family planning lowers mortality among both women and children, just by increasing the time between births or the age of first motherhood.

(i) Family planning can reduce infant and child mortality by up to 25% (Ubangi, 1999). Family planning can help reduce both abortions and deaths from usage abortion; the recent experience of Russian and several eastern European countries provides evidence that increased use of family planning reduces reliance on abortion global partners.

(ii) Family planning strengthens the health of both the mother and the baby; the longer the child breast feeds from the mother the healthier the child would be. Therefore family planning reduces the chances of a child dying at an early age. When women fertility is not controlled there is likelihood that the mother will die from maternal problems caused by complication of short interval, early pregnancies, and late pregnancies (Nsemukila, 1998).

(iii) Family planning plays a critical role in avoiding short interval pregnancies or late pregnancies which may cause material mortality, birth interval means the period of time between successive live births. The 2001-2002 D.H.S research shows that births born too soon after the previous birth are at an increased risk of dying. Particularly when the interval between births is less than 36 months, population growth is caused by total fertility rate (TFR) which is defined as the total number of births a woman would have by the end of the child bearing period.

(iv) Family planning practices also depend on one’s traditional beliefs. In the study by the ZDHS (1992) it was revealed that despite the fact that the culture has supported
the notion of child spacing for generations, modern family, modern family planning has not been inversely accepted. About 80 percent of married women who are aware of a contraceptive method approve of family planning. This means that about one of five disapprove. This may be caused by a number of perceived or real disadvantages of family planning.

2.5 Disadvantages of family planning.

Some of the disadvantages of modern contraceptives that were mentioned in the Ndola and Lusaka study by the ZDHS (1992) were that;

(i) They have 41.3% bad side effects and that 27.3% cause infertility.

(ii) They encourage prostitution and female promiscuity (3 percent).

(iii) They are unnatural, and their use is against religious doctrines (2 percent), and lastly,

(v) They are unreliable 1.7 percent.

(vi) Condoms and diaphragm sponge possible side effects are irritation or reactions and risk for urinary tract infection.

Marriage is universal in Zambia and is contracted early. The average age of marriage was 19 years in 2000. The age varies with the residence and education of women. The government of Zambia restructured the population policies so as to simultaneously address reproductive health family planning and improvements in socio-economic status of women in line with Beijing conference of 1994 ministry of health 1998 report. In
1994 the ministry of Health changed its policy on family planning provision. The consent requirements from husbands in order to receive family planning services were abolished (M.O.H, 2000).
3.0 CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

This section gives details on methods of research; these include the research design, population, and sample, sampling procedures and data collection methods the study intends to use. A summary of how data has been analysed.

3.2 RESEARCH DESIGN

Borg and Gall (1989) define research design as a process of creating an empirical test to support or refute a knowledge claim. Ghost (1992) states that a research design is an arrangement of condition for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. The study employed a descriptive research design, which is a fact-finding approach. The design also allowed the researcher to conduct in depth open interviews in order to understand the experience particular of a situation. Descriptive in this study include investigation on the knowledge, attitude and practices of women towards modern family planning methods.

Bless (1987) refers quantitative approach to procedures that use numerical values to describe data. Quantitative approach is more formalized in nature as explicitly controlled, with a more carefully defined scope. This approach aims at examining generally accepted explanations of phenomenon and is more and structured and controlled in nature (Collins et al, 2000).
3.3 POPULATION

A population refers to all members of a real or hypothetical set people, object, events, to which one wishes to generalize the results of research (Borg and Gall 1979). There are 576,124 people in Kitwe of which Mindolo has a population of

4.3 SAMPLE SIZE

A sample is a small proportion of the population or a subset of the whole which is to be investigated and whose findings can be generalized to the entire population (1987). A sample is a selected group of elements from entire population that has the same characteristics.

The sample consists of one community and health workers. The researcher adopted a probability designed in which the researcher used simple random sampling. The researcher only took one community. Below is a table to show distribution of questionnaires.

### TABLE 1.0 SHOW THE DISTRIBUTION QUESTIONNAIRES

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<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Mindolo</td>
<td>50</td>
<td>100.0</td>
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<tr>
<td>Total</td>
<td>50</td>
<td>100.0</td>
</tr>
</tbody>
</table>
3.5 SAMPLING PROCEDURES

Collins et al (2009) defines sampling as a process by which as a sample is drawn from a comprehensive list of all units or elements. Sampling refers to the population from which they were chosen.

The researcher used probability methods which involved simple random selection produce to ensure that each unit of the sample is chosen on the basis of chance. Paper written YES and NO were shuffled and each respondent was allowed to pick one piece of paper. Those that picked the YES papers were to answer the questionnaire.

3.6 DATA COLLECTION TECHNIQUES, METHODS AND INSTRUMENTS.

A technique refers to the specific device or means of recording data such as interviews (Merriam and Simpson, 1995). Instruments are the tools used to collect data like interviews guide and questionnaire.

The study used oral interview guide to collect data from health workers and a focus group discussion. The interview guide helped to get information which would not be obtained using the questionnaire. A lot of explanation and clarification were made. The researcher also used a question to collect data from the respondents.

3.7 DATA ANALYSIS

Data analysis refers to the process of using specific procedures to work through data collected (Collins et al, 2002). This involves summarizing and presenting quantitative data using numerical values. The data collected was analyzed using a computer
program Statistical Package for Social Sciences (SPSS). Excel and manual were the 
two programmers had restrictions.

**ETHICAL CONSIDERATION**

The researcher asked for permission from the District Health secretary to carry out a 
research in the selected area. The researcher asked for permission from the 
respondents as a group or individually, the intentions are to create a conducive 
atmosphere and to motivate the respondents to participate freely during the data 
collection exercise. In addition to that, names of participants will not be disclosed.
4.0 CHAPTER FOUR: RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter deals with analysis of the findings of the study. It presents results from the community on a number of aspects of contraception including knowledge of specific contraceptive methods, attitudes and behavior regarding contraceptive use, source of methods, and cost of methods. Information on knowledge of contraception was collected in the study by asking female to name ways or methods by which a couple could delay or avoid pregnancy. Contraceptive methods are grouped into three types in table 2.0. Modern methods include female sterilization, male sterilization, the pill, intrauterine device (IUD), injectables, implants, male condom, diaphragm, foam/jelly, lactation amenorrhea (LAM) and emergency contraception. Traditional methods include the rhythm method (periodic abstinence) and withdrawal.

The study has reviewed that conventional method is more known than natural and traditional method. Below is the table to show percentage.

**TABLE 2.0: SHOWS TYPES OF CONTRACEPTIVE METHODS**

<table>
<thead>
<tr>
<th>Types</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Traditional Methods</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Natural Methods</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>conventional Methods</td>
<td>55</td>
<td>70</td>
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<tr>
<td>Tatol</td>
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<td>100</td>
</tr>
</tbody>
</table>
From the data collected to determine the knowledge levels of women that use modern family planning. It has been seen that 98% of women age 15-45 and above know at least one or more method of contraception. The most commonly known methods are the pill 54%, condoms 18%, and natural 16%, IUC 18% and injectable 37%. Below are the figures to show the knowledge level and age of women.

**FIGURE 1: BAR CHART TO SHOW KNOWLEDGE OF CONTRACEPTIVE**
To determine the use of modern family planning the study has reviewed that modern contraceptive use increases dramatically with women's education level. Half of married women with more than secondary education use modern methods, compared with only 4% of women with no education. Below is the table to show uses of modern family planning.

**FIGURE 3: PIE CHART SHOWS THE USES OF MODERN CONTRACEPTIVE**
The research finding reviews that 4% of respondents did not have formal education, 16% attended primary education, 28% attended secondary education and 18% had crossed over from secondary to college, and 34% have reached university level

FIGURE 4: PIE CHART SHOWS THE EDUCATIONAL LEVEL OF RESPONDENTS

Many respondents had one to two children 48%, the second group of three to four 42, 4% had five children and above and only 6% had no children. The respondents were in the productive age group whose number of children is likely to increase by the end of their reproductive age.
More than half percent of the respondent were married, 62% divorced while 16% were widowed and 14% and 8% were single, indicating that the majority of respondents were potential family planning clients.
In terms of source and information of family planning methods, it has been reviewed 30% of the respondents got their information about family planning from friends, 4% from families, 4% form media and 62% from health centre's. This shows that health centres are the largest source of information because of the many health programmes that women participate in at the health centres.

TABLE 3.3 SHOWS SOURCES OF FAMILY PLANNING

Information on where women obtain their contraceptive is useful for family planning programme managers and implementers for logistic planning. In the 2007 ZDHS, women who reported using a modern contraceptive method at the time of the study was asked where they obtained the methods the last time they acquired. The table below shows that more than two-thirds of current modern method contraceptive users obtained their contraceptive method from the public sector, mostly government health centre's
26%, private medical institutions are the second most common source of contraception
19%, while non-medical sources are the least common 5%.

**COST OF CONTRACEPTIVE**

Women using modern methods of contraceptive were asked how much they paid in total the last time they obtained the method. The study has reviewed that majority of women 71% who use modern contraceptive methods get them for free and 6% could not recall how much they paid for their method. The median cost of all contraceptive methods is 807 kwacha.

The services at the supply centers are on average good, this includes health centers and private organization.
The study has reviewed that less than half percent (30%) have tried three types of modern family planning, 38% two types, 26% only one and 6% have tried any method.

**TABLE 3: SHOWS NUMBER OF MODERN FAMILY PLANNING EACH HAVE TRIED**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
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<td>Valid</td>
<td></td>
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<tr>
<td>1</td>
<td>13</td>
<td>26.0</td>
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<tr>
<td>2</td>
<td>19</td>
<td>38.0</td>
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<tr>
<td>3</td>
<td>15</td>
<td>30.0</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>6.0</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100.0</td>
</tr>
</tbody>
</table>
INFORMED CHOICE

Women currently using a modern method of contraceptive were asked whether they were informed about side effects or problems that they might have with the method, what to do if they experienced side effects, and other methods that they could use. This is a measure of the quality of family planning service provision. 75% of contraceptive users were informed of the side effects of the method they used, 73% were informed about what to do if they experienced side effects and 63% were informed of other available methods of contraceptive. About eight in ten women who obtain their current family planning method from public sector facilities were informed about side effects, method related problems, and what to do if they experienced side effects in contrast, around two thirds of women who obtained their method from private medical sector were informed of method-related problem and how to address them should they occur.

FIGURE 8: PIE CHART TO SHOWS WOMEN WITH SIDE EFFECTS.
FUTURE USE OF CONTRACEPTIVE

An important indicator of the changing demand for family planning is the extent to which nonusers plan to use contraceptive methods in the future. Currently married who were not using a contraceptive method at the time of the study were asked about their intention to use family planning in the future. The study has reviewed that 66% of currently married nonusers intend to use a method of contraception in the future, 29% have no intention of using any method in the future, and 5% are unsure of their intentions.

Following the figures given at the clinic, it revealed that 55% of women do not intend to use a method in the future for fertility-related reasons. The second largest category is women who do not intend to use a method for method–related reasons 26%, and the third category comprises women who are not willing to use a method because of respondents or other people’s opposition to the use of contraceptive 11%.
5.0 DISCUSSION OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS.

5.1 DISCUSSION OF THE FINDINGS.

The study investigated on the attitude, knowledge and practice of farmers towards modern family planning among women revealed that 96% of women have knowledge about family planning and 2% of all women age 15-46 and above know at one modern method of family planning and the most commonly know methods are the male condom, pill and injectables.

This shows that 78% knew family planning as a way of preventing unintended pregnancies and how many children the couple wishes to have. Mubanga (2000) said that family planning covers areas as varied as when and why to get pregnant, the number of children that are wanted, what to do when an unintended pregnancy occurs, and the types of family planning methods to use to delay, space, or avoid a pregnancy (modern contraceptives as well as traditional methods). Family planning is the planning of when to have children, and the use of birth control and other techniques to implement such plans. He further said Family planning is sometimes used as a synonym for the use of birth control, though it often includes more. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy.

The study has revealed that the increase in fertility rate is as result of lack of access to family planning, which includes information and health. Parenthood global partner
reports that says that 150 million married women already indicates a desire to plan their families, but lack access to family planning, which includes information, health. The other reason is the large number of young people entering their reproductive years. Three billion of the six billion people alive today are under age 25 (Winfrey, 1997).

The study also revealed that the most known form of contraceptive is the condom because of usage in the fight against HIV/AIDS prevention.

Despite women having knowledge about family planning methods, fertility rate has increased because it varied by residence and by region. Women in urban areas had 4.3 children on average, compared with 7.5 children per women in rural areas. Fertility also varied with mother’s education and economic status. Women who have more than secondary education had an average of 2.4 children while women with no education had almost four times as many children. This shows that fertility increases as the wealth of the respondents’ household decreases. The poorest women in general, had more than twice as many children as women who live in the wealthiest household said by one of the health workers.

In Zambia, family planning participation rate (s) also depends on one’s educational level. Generally, the higher the educational level, the higher the participation rate. This was evident in the study which was conducted by Gaiosie etal (1993) on the relationship between education and family planning prevalence. The findings of his study revealed that those who had primary education (12.8%) secondary education (27 %) or higher education (58%) have contraceptive prevalence rates above the national average.
A study done in India revealed that there was an indirect relation between lack of education and high fertility (Das Gupta and Bhat, 1997). Similarly child bearing begins early in Zambia among women with low education (Zambia baseline health survey report 2000). Almost half of women in Zambia are married by age 18. Age at marriage greatly increases with education, women with more than secondary education get married more than 7 years later than those with no education (DHS Survey, 2010).

To aid women make informed choice on family planning adequate formal education is very important according to the study made by Mindolo in Kitwe district reviewed that low education has a direct influence on high fertility rate because of the deserve to have many children as a future security (Mulubwa, 1999).

The research finding reviews that 4% of respondents did not have formal education, 16% attended primary education, 28% attended secondary education and 18% had crossed over from secondary to college, and 34% have reached university level. The D.H.S survey for 2001-2002 on its page 58 indicates that fertility level is high among women with no education or low education.

Use of modern family planning also varies by residence and region. Modern methods are used by 42% of married women in urban areas compared with 28% in rural areas. The other revelation is that modern contraceptive use increases dramatically with women’s education. 50% of married women with more secondary education used modern methods compared with only 4% of women with no education.
In order to address the negative revelation about women not using family planning contraceptives providers must consider intensifying Information Education and Communication IRC programmers designed attitudes, beliefs and perceptions. Eswaran (2002), said that lack of information, fear of side effects, geographical, social, and economic reasons that prevent women from obtaining and using family planning methods. Other studies in sub-Saharan Africa (including Nigeria) reveal that nurses’ attempts to stigmatize teenage sexuality, their scolding and harsh treatment of adolescent girls, and their unwillingness to acknowledge adolescents as contraceptive users, also undermine the effective use of contraception by girls. Youth need better information on reproductive physiology and sexual health, and detailed information on contraception. They also need youth-friendly services and providers who are open and willing to serve youth with respect as clients.

Public institutions such as government hospitals, health centers, and clinics currently provide contraceptives to 26% of current users. Information on where obtain their contraceptives is useful for family planning programme managers and implementers for logistic planning. In the 2007 ZDHs women who reported using a modern contraceptive method at the time of the survey was asked where they obtained the method the last time of the acquired it. Interviewers were instructed to not know exactly in which category the source falls (e.g. government or private, health centre or clinic).

Among the women who were using modern family planning, 68% had experienced side effects of the method used and 32% have not expired side effect. Family planning
clients should be informed about the side effects of the method used, what to do if they experience side effects, and about other methods that could be used.

Some of the disadvantages of modern contraceptives that were mentioned in the Ndola and Lusaka study by the ZDHS (1992) were that; they have 41.3% bad side effects and that 27.3% cause infertility. They encourage prostitution and female promiscuity (3 percent). They are unnatural, and their use is against religious doctrines (2 percent), and lastly, they are unreliable 1.7 percent. Condoms and diaphragm sponge possible side effects are irritation or reactions and risk for urinary tract infection.

Women who were using family planning, only 5% were visited by a field worker who discussed family planning and only 17% of women who visited a health facility discussed family planning with a health worker. Overall, 4 in 5 non users did not discuss family planning with any health worker.

Having discussed with young people, many young people are not hearing family planning messages in the media, 60% of young people age 16-19 had not heard about family planning on the radio, television or in newspaper. This is why more than one-quarter of young women age mothers and an additional 6% are pregnant with their first child. Young women with lower than primary education are more than twice as likely to have started childbearing by age 19 than those who have completed secondary school.

Compels using family planning as a means to control family planning size (that is to stop having children) adopt contraceptive after having a number of children they want. When contraceptive is used to space births couples may start to use family planning earlier
with the intention to delay a possible pregnancy. This may be done before a couple has had their desired number of children.

5.2 CONCLUSION.

In conclusion, the Ministry of Health seeks to increase access contraceptive and also using the media to spread the information easily about family planning. Funding should be made available to health workers to promote community planning message. Information on the level of public exposure to a particular type of media allows policy makers to use the most effective media for various target groups in the population.

Marriage is universal in Zambia and is contracted early. The average age of marriage was 19 years in 2000. The age varies with the residence and education of women. The government of Zambia restructured the population policies so as to simultaneously address reproductive health family planning and improvements in socio-economic status of women in line with Beijing conference of 1994 ministry of health 1998 report. In 1994 the ministry of Health changed its policy on family planning provision. The consent requirements from husbands in order to receive family planning services were abolished (M.O.H, 2000).

Family planning practices also depend on one’s traditional beliefs. In the study by the ZDHS (1992) it was revealed that despite the fact that the culture has supported the notion of child spacing for generations, modern family, modern family planning has not been inversely accepted. About 80 percent of married women who are aware of a contraceptive method approve of family planning. This means that about one of five
disapprove. This may be caused by a number of perceived or real disadvantages of family planning.

5.3 RECOMMENDATION

From the data collected it has been seen that 70% of women taking modern contraceptive face a lot of problems. To improve or increase the service that the ministry can offer to the women and overcome some other constraints, the following measures should be taken.

- There must be special programmes on family planning for church organization and other resistant groups, programmes such as debate, discussions and dialogue.
- Separate family planning programmes from mother child health (M.C.H) services.
- Include family planning messages in traditional ceremonies for girls and boys and during kitchen parties.
- Encourage peer group system within the community in which women can exchange and encourage each other to use contraceptives.
- Stimulate women participation in family planning through various developmental activities.
- There is urgent need to produce materials in local language on family planning contraceptives, make full use of the recent established community radio station to disseminate family planning information and to dispel myth and rumours about contraceptives.
• Encourage community health workers to include family planning messages in their health activities in their communities.
REFERENCES


Government of Zambia (2001-2002 ). Demographic and Health Survey Government of Zambia

Focus Group Discussion Guide for Participants

1. Discuss all known female methods of family planning highlighting most effective ones?
2. What factors affect the use of modern female family planning method?
3. What are the benefits of modern family planning?
4. Which female planning methods are used by your community?
5. What are your feelings towards the use of modern female family planning?
Interview Guide for Health Care Providers
The information is for academic purposes only and will be treated with strict confidence
1. Do you offer counseling services to your clients for modern family planning method?
2. If yes, what are the main issues, which affect the utilization of modern family planning method?
3. How are you encouraging the use of modern family planning method?
4. What method of information dissemination do you use on your clinic on modern family planning method?
5. What are the attitudes of your clients towards modern family planning method?
6. Are your clients affected by the traditional and cultural beliefs on the use of modern female planning?
QUESTIONNAIRE FOR PARTICIPANTS

I’m a student at the University of Zambia, pursing a degree in Adult Education. I’m conducting a research on the knowledge, Attitude and use of family planning methods among women of Mindolo community in Kitwe. The information you will provide, will be strictly confidential and used for academic purposes only.

INSTRUCTIONS

1. Kindly answer all questions in this questionnaire to the best of your knowledge.
2. Please tick ( ) the right answer.
SECTION 1 : PERSONAL DETAILS

1. Name of the community:-----------------------------

2. What is your age?
   a) 15 -24 years   ( )
   b) 25-34 years   ( )
   c) 35-44 years   ( )
   d) 45  and above

3. What is your marital status?
   a) Single   ( )
   b) Married   ( )
   c) Divorced   ( )
   d) Widow   ( )

4. What is your education level?
   a) never attended school   ( )
   b) primary   ( )
   c) Secondary   ( )
   d) College   ( )
   e) University   ( )

5. What is your occupation?
   a) Student   ( )
   b) House wife   ( )
c) Employed (   )

d) Self-employed (   )

6. How many children do you have?

a) No child (   )

b) 1-2 children (   )

c) 3-4 children (   )

d) 5 and above (   )

7. What is the age difference between the last 2 children?

a) 0-12 months (   )

b) 13 -24 months (   )

c) 25 months and above (   )

SECTON B: knowledge and Attitude about family planning.

8. Have you ever head of family planning?

a) Yes (   )

b) No (   )

9. If ‘yes’ where did you get the information about family planning?

a) friends (   )

b) Family (   )

c) media (   )

d) health centre’s (   )
10. Which family planning method do you know?
   a) Traditional method
   b) Natural method
   c) Conventional Method

11. Do you get assistance from health workers?
   (a) Yes
   (b) No

12. If your answer is ‘yes’ in (11) how would you rate the services?
   a) Very good
   b) Good
   c) Poor
   d) Very poor

13. Do you get the contraceptive supplies each time you need them?
   a) Yes
   b) No

14. If ‘yes’ to question 15, what type of contraceptive would you prefer?
   a) Pill
   b) I.U.C.D
   c) Condoms
   d) Traditional
15. Do you use any modern family planning method?
   a) Yes  (   )
   b) No   (   )

16. Have you ever had any problems with modern family planning methods?
   a) Yes  (   )
   b) No   (   )

17. If ‘yes” was the problem related to
   a) The failure of the method  (   )
   b) Did the experience due to physical problem (   )
   c) Any other, specify  (   )

18. How many other modern method have you tried?
   a) 1  (   )
   b) 2  (   )
   C) 3  (   )
   d) 4 and above  (   )

THANK YOU FOR YOUR COOPERATION.