CONTRACEPTIVES USE AMONG RURAL MEN AND WOMEN OF KAZUNGULA

DISTRICT

BY

RABECCA LEMBA

THE UNIVERSITY OF ZAMBIA
LUSAKA
2014

Declaration

I, Rebecca Lemba hereby declare that this dissertation represents by own work. The sources of all materials have been acknowledged and the dissertation has not previously been submitted for a degree of this kind.

Signature of Researcher……

Date …….

Approval

This dissertation of Rabecca Lemba has been approved as partial fulfillment of the requirements for the award of the degree of Master of Arts in Gender Studies at the University of Zambia.

Signed: **Date:**

…… ……

…… ……

…… ……

Abstract

This study identified factors influencing contraceptive use among the rural men and women of Kazungula district. Specific objectives included; establishing fertility aspirations in Kazungula district, identifying myths and misconceptions that influence contraceptive use in Kazungula district, and assessing perceptions relating to attitudes of service providers towards men and women who use contraceptive in Kazungula district. Both quantitative and qualitative data were used. Quantitative data was used to collect information for questions which were closed ended through interviewer guided questionnaires, while qualitative information was collected interviews. Findings indicated vast knowledge about contraceptives. However; the gap is still wide between knowledge and use. The findings of this study have been similar to other studies that had almost a similar topic. Culturally, it was revealed that men are more superior to women. Cultural has set it in such a way that women have no freedom of expression on any issues in a home including on their sexuality. In a rural set up like Kazungula district, a man decides whether to allow the wife to use contraceptives or not. Women who feel they can't go without using contraceptives they opt to leave their contraceptive cards at their friend's home, and in some cases, they negotiate with health providers if they could leave their cards at health centers. This is to prevent their husbands from knowing. In a situation where they are discovered, they stand a chance of being divorced.It was revealed in this study that men especially have continued to appreciate having a lot of children despite their economic status. To them having 6 or more children is part of status in society.It was further revealed that attitudes of the health providers have been key in determining whether men and women will or will not use contraceptives. Some respondents complained bitterly that health providers are not always there to give service to the community. In situation where they are present, they tend to work in an unfriendly manner by using disrespectful language. In some cases, volunteers are expected to do most duties. The respondents said that people have less trust in volunteers knowing that they are not professionally trained for the services they offer to the community. The findings of this study suggest that knowledge about contraceptives does not determine use. The government of Zambia and other stakeholders should therefore consider bringing on board intensive measures that are aimed at involving men in promoting the use of contraceptives. The government needs to put up monitoring and evaluation measures for rural health Centres as a supervisory tool.

IN LOVING MEMORY OF MY BELOVED MOTHER, EVANES MUMBA

WE BELIEVE IN GOD'S RESURRECTION POWER

Acknowledgements

I would like to extend my sincere gratitude to Mother for having provided funding towards my study. I would also like to thank my husband, Leo Chitulangoma for exempting me from most house chores to ensure that this work was complete in time. I extend my thanks to my family for their spiritual and moral support.

My unbounded gratitude goes to Dr A. Kapungwe, firstly for encouraging me in my project, patiently seeing me through tedious drafts and redrafting. Special thanks to Dr. Kusanthan for his patience, understanding and his skill to listen, encourage and give direction which was priceless. Thanks to Mr Sakala and Mr.Roy Kalinda for listening and giving useful tips for reading. May I also extend my special gratitude to all respondents as without them the compilation of this document would have not been possible.

Above all I thank my awesome God for every experience during my two years of study. It was not an easy period, the period actually become longer than usual, this required patience and also faith to keep holding on to the bigger picture that was “graduation”. However, despite all the circumstances God made a path in the darkest path of my life. To God be the glory now and forever more.

ACRONYMS

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CHWs Community Health Workers

CSO Central Statistics Office

EBDs Employment Based Distributers (EBDs),

ICPD International Conference on Population and Development

IPPF International Planned Parenthood Association

MCH/FP Maternal and Child Health Family Planning

PoA ICPD Program of Action of the International Conference on Population and Development

PPAZ Planned Parenthood Association of Zambia

TBAs Traditional Birth Attendants

UNFPA United Nations Population reproductive Fund

UTH University Teaching Hospital

ZDHS Zambia Demographic Health Survey

TABLE OF CONTENTS

Contents page

CHAPTER ONE: BACKGROUND

1.1 Introduction

This chapter discusses the background of the study, the statement of the problem, objectives of the study, its significance and the structure of the thesis. It also describes in brief a historical perspective of contraceptives.

1.2 A Historical perspective of contraceptives

Women in the 'bad old days' of the pre-industrial world experienced repeated unwanted pregnancies. The fertility rate was high, not because the women wanted it that way but because they had no control over it, (Segalen, 1986).

Contraceptives have been there since time in memorial, some researchers cite the fourth century while others have recorded its existence from as far as 1500 (McLaren, 1990). Other scholars have presented the coming of contraceptives on the market in two revolutions. The first was the employment by men in the eighteenth and nineteenth centuries of "Coitus Interruptus". This was a period when Segalen claims that, 'people had not even imagined the possibility of influencing the sexual act, which was an act of nature, and it was this change in attitude towards their bodies that constituted a revolution in mentalities'. The second of Segalen's revolution took place in the 1960s with the advent of the pill and legalized abortion. The difference between the two revolutions is that in the second revolution, contraception control was in the hands of the woman and it recorded the first time the responsibility for creating life was given to those who bring it forth, (Segalen, 1986).

Other studies indicate that the history of contraceptive came along with the discovery of the link between intercourse and reproduction. The very first evidence of birth control came from ancient Egypt, where women consumed herbs that were thought to prevent pregnancy. Later, the Greek gynecologist Soranus discovered that women were more fertile on certain days of the month, though it was not until 1930 that researchers were able to pinpoint this cycle exactly. That same decade, the Anglican Church officially sanctioned the use of condoms for married couples, and since then an abundance of different contraception have been introduced and marketed, with varying success, (Segalen, 1986).

In the early 18th century, contraceptives were on the market with initial purpose of regulating fertility (Segalen, 1986). Throughout the centuries and across the globe, various methods of contraception were developed as a way of reducing the likelihood of fertilization.

After this development, feminist played a role in the fight for having contraceptives on the market. To the women, lack of control over their fertility exacerbated gender inequalities. This meant that the coming of contraceptives was a way of improving women's conditions, (Segalen, 1986).

Contraceptives have been there over centuries, in other words, tracing the exact history of contraceptives is not possible. However, it is important to note that restriction of fertility established its benchmark in the eighteenth or nineteenth century under the influence of pioneers. The ideas behind the pioneers were to advocate for measures that would enable one to have control over their bodies by regulating fertility (National Research Council, 1993). This was through the use of contraceptives; their aim was to enhance contraceptive use.

1.3 International Programs on Sexual and Reproductive Rights

Historically, there have been international programs that have been advocating for contraceptive use. Their concentration has been on the theme "Sexual and Reproductive Rights".

Reproductive rights are rooted in international human rights law. The program of Action agreed upon at the ICPD conference in Cairo in 1994 explicitly affirms that reproductive are human rights (UN, 1994). These rights among others include the right to health, reproductive health and family planning; the right to decide the number and spacing of one's children. At national level, there are a number of policy documents that impact on the recognition of and legal protection for reproductive and sexual rights.

At the highest level are international treaties. Countries whose governments sign and ratify a treaty are bound under international law to comply with the provisions of the treaty. Below are examples of treaties that the Zambian government has signed to promote contraceptive use.

1.3.1 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

The convention was launched on the 3rd of September 1981. The convention was ratified by 174 countries. The CEDAW provides the strongest legal protection for women's sexual and reproductive health and sexual rights.

It plainly requires countries that are part of the convention to ensure that women and men have equal access to healthcare services, including family planning services, and to decide on the number and spacing of their children. It includes provisions that require governments to ensure women's equal access to education, including to education on family planning.

The CEDAW committee has urged states to ensure that all women and adolescents have access to safe and affordable methods of contraception, confidential family planning counseling and services, and sexuality education.

1.3.2 Program of Action of the International Conference on Population and Development (PoA ICPD)

The program was implemented by the International Conference on Population and Development (ICPD) in 1994. The PoA was the first international conference document to explicitly affirm the concepts of reproductive and sexual rights (Bergman, 2004). It provided a twenty year plan of action including several time-bound goals for governments to follow in order to ensure that individuals' reproductive rights are fulfilled. It was a major turning point in the development of reproductive rights in that it rejected population policies focusing primarily on reducing fertility, and focused instead on empowering women in meeting their sexual and reproductive health needs as the critical way to bring about demographic change.

The program also set new bench marks to meet the unmet needs for contraceptives, it called upon governments to "ensure that by 2015 all health care and family planning facilities are able to provide directly or through referral, the widest range of safe and effective family planning and contraceptive methods",(ICPD, 2000). Where there is a gap "a gap between contraceptive use and the proportion of individuals expressing a desire to space to space or limit their families," the document calls upon governments to "attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050 (UN,2003).

1.3.3 Beijing Declaration and Platform for Action

The convention was adopted by the Fourth World Conference on Women in Beijing 1995. This was agreed to by 189 countries. The Beijing Declaration and the Platform for Action extends the ICPD by recognizing that the protection of women's reproductive and sexual health rights is essential for their women's ability to participate equally and fully within all spheres of society (UN, 1995). It focuses on governments' obligations to fulfill the right to health by creating the social and economic conditions that enable women to exercise this right. It recognizes for the first time that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health coercion, discrimination and violence" is important (ICPD, 2000). The contents of the declaration included the following;

Declaration

1. We, the Governments participating in the Fourth World Conference on Women,
2. Gathered here in Beijing in September 1995, the year of the fiftieth anniversary of the founding of the United Nations,
3. Determined to advance the goals of equality, development and peace for all women everywhere in the interest of all humanity,
4. Acknowledging the voices of all women everywhere and taking note of the diversity of women and their roles and circumstances, honoring the women who paved the way and inspired by the hope present in the world's youth,
5. Recognize that the status of women has advanced in some important respects in the past decade but that progress has been uneven, inequalities between women and men have persisted and major obstacles remain, with serious consequences for the well-being of all people,
6. Also recognize that this situation is exacerbated by the increasing poverty that is affecting the lives of the majority of the world's people, in particular women and children, with origins in both the national and international domains,
7. Dedicate ourselves unreservedly to addressing these constraints and obstacles and thus enhancing further the advancement and empowerment (United Nations, 1995).

We reaffirm our commitment to:

"The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment;

We are determined to:

Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education

We are determined to:

We hereby adopt and commit ourselves as Governments to implement the following Platform for Action, ensuring that gender perspective are reflected in all our policies and programmes. We urge the United Nations system, regional and international financial institutions, other relevant regional and international institutions and all women and men, as well as non-governmental organizations, with full respect for their autonomy, and all sectors of civil society, in cooperation with Governments, to fully commit themselves and contribute to the implementation of this Platform for Action", (UN conference on Women: http: genderlinks.org.za)

During these conventions they were a number of issues arising as to how they would enhance contraceptive use, especially after the development of HIV and AIDS. Following this development, it was realized that the involvement of men in family planning would increase contraceptive use. This was because historically men have been decision makers, who also have control over women's sexuality.

1.4 Male Involvement in Family Planning

Historically, Family Planning focused on addressing women's needs. The 1990s, brought with it keen interest in men's participation in Reproductive Health, mainly as a consequence of the HIV and AIDS occurrence. The importance of men's role in reproductive health was emphasized during the 1994 International Conference on Population and Development (ICPD) (UNFPA, 1994).

The 1995 United Nations Fourth conference on Women in Beijing also recognized the importance of encouraging men to take positive steps to achieving gender equality and better

reproductive health. So far programs that have focused on men have endeavored to meet their needs by encouraging them to become active users of methods of contraceptive (Ibid).

According to Mbizvo and Bassett (1996), the effect of family planning programs in African Societies has been weakened mainly because of their failure to incorporate men who are major decision makers in a household. The issue of gender equality is critical in women's family practice. Gender inequalities in sexual relationships in most Sub Saharan Africa (SSA) result from women's low socio-economic status, which makes it the more important to include men in reproductive health programs.

Women in SSA have a subordinate position in relation to men at household and community level and men often control decisions in productive and reproductive issues (Nzioka, 2000).

Literature has indicated low contraceptive in Africa, the justification for this is that men have not been involved. According to Mbizvo and Bassett (1996), they argue that the effect of family planning programs in African Societies have been weakened mainly because of their failure to incorporate men who are major decision makers in households. Women in SSA have a subordinate position in relation to men at household and community level and men often control decisions in productive and reproductive issues (Ibid).

Men's control over women's reproductive behavior translates itself into low contraception use. According to Barnett (1999), women have often said they would like to use contraceptives, but more often they fear being chased or beaten by their husbands who would brand them as prostitutes. In a desperate situation, these women resort to using methods such as injectable which are easier to keep as a secret.

Gender roles in societies make women less able to have control over their sexuality decisions. It has been therefore, in the hands of men to determine the nature and timing of sex. "The belief is that sexual behavior is intended for men who can have as many partners as they like and can have sex on demand from partner", (Mindolo Ecumenical Foundation, 2010).

It is now possible to learn from the above literature that worldwide, a number of programs have been initiated to increase contraceptive use by bringing out the rights of men and women to regulate their fertility. These programs such as Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which entered into force in 1989 (UN, 1979), the Program of Action of the International Conference on Population and Development (ICPD) held in 1994 (UN, 1994), and the Beijing platform Plan of Action

which was established in 1995, (UN conference on Women: http: genderlinks.org.za) to mention but a few.

It is important to note that Zambia has been a signatory to these instruments. Therefore the country has put up measures for the people of Zambia to regulate their fertility by the use contraceptive. These measures include; the adoption of an explicit National Population Policy as an integral component of its Fourth National Development Plan (1989-1993) (MoH, 1997), and the integrated approach which was adopted to reform the health sector in line with recommendations from the ICPD program of Action, such as the Social Marketing Programs (UNFPA, 1995). Besides, there are a number of organizations that have been in existence for over 15 years with emphasis on advocating for contraceptive use, giving contraceptives to the community at no cost and making sure that they accessible. Examples would be Planned Parenthood Association of Zambia (PPAZ); it has been in operation since 1972, Society for Family Health (SFH), which has also been in operation since in 1992.

It is against this background that changes begun to take place. The year 1990 brought with it keen interest in men's participation in reproductive health, mainly as a consequence of the HIV and AIDS occurrence. Men where then brought on board. The importance of men's role in reproductive health was emphasized in the year 1994 during the International Conference on Population and Development (ICPD) (UNFPA, 1994).

Studies have shown that the involvement of men in reproductive health can result in increased contraceptive, continuation and effective use of methods (Wang *et al*, 1998).

Literature worldwide indicate that a number of programs have been initiated to increase contraceptive use by bringing out the rights of men and women to regulate their fertility, making sure that contraceptives are accessible to mention but a few (genderlinks.org.za). This is seen through the above mentioned treaties.

1.5 Statement of the Problem

As indicated above, Zambia has been a signatory of many instruments. In order to implement these treaties, the country has put up measures for the people to regulate their fertility through the use of contraceptives such as the integrated approach which was adopted to reform the health sector in line with recommendations from the ICPD program of Action, (UNFPA, 1995). Besides, there are a number of organizations that have been in existence for over 15

years advocating for contraceptive use and in some instances giving out contraceptives to the community for example Planned Parenthood Association of Zambia (PPAZ) which has been in operation since 1972.

Zambia has yet another USAID funded project called Zambia Social Marketing project whose mandates is to see to it that there is increased contraceptive use. It advocates seriously for the acceptance of condom use and talk in different institutions.

The current situation today is that there are both international and local efforts to increase contraceptive uptake in many parts of the world. Contraceptive use is low in most parts of the world especially in rural areas. As indicated above, there are measures that have been developed at both international and national level to encourage the uptake of contraceptive. However, each year women around the world experience 75 million unwanted pregnancies because contraceptives are not used (Sadik, 1997). Contraceptive use is not only low in Africa, but also in Zambia (MoH, 1997).

This can be seen through the high fertility rates. Zambia's Population Policy (2007) indicates that fertility is very high with a fertility rate of 5.9 percent and a growth rate of 2.4 percent, (Bongaarts, 1990). Besides, the situation worsens in the rural areas for example, during the 2007 ZDHS, the fertility rate rose to 7.5 % from 6.9% in 2002. The comparatively high levels of fertility are a source of concern in the light of the relatively low levels of contraceptive use in this country.

Despite the measures that have been implemented to encourage contraceptive uptake, its use has remained low especially among the rural men and women in some parts of the world (Magadi, 2001). During the ZDHS (2007), Zambia recorded 60 percent of men and women not using contraceptive despite widespread knowledge and awareness which is almost universal. The survey indicated that only 30% of the women in the reproductive age group (15-49) were using contraceptives (ZDHS (2007). "The figure further reduced among men", (Muzyamba, 2006). The major concern is the gap between contraceptive awareness and knowledge (98 percent) and uses (41 percent).

1.6 General Objective:

The general objective of this study was to investigate contraceptive use among rural men and women of Kazungula district

Specific Objectives

- To assess awareness of contraceptives in the study area
- To determine fertility aspirations in the study area
- To identify myths and misconceptions influencing contraceptive use in Kazungula district
- To assess perceptions relating to attitudes of service providers towards men and women of Kazungula district who access contraceptives
- To recommend possible measures of increasing contraceptive ways among the men and women of Kazungula district

1.7 Research Questions

Main Questions

What are the factors influencing contraceptive use among rural men and women of Kazungula district?

Specific Questions

- To what extent are the people in the study aware about contraceptive use
- What are the fertility aspirations in the study area?
- What are the myths and misconceptions surrounding contraceptive use in the study area?
- What are the perceptions relating to attitudes of service providers towards rural men and women in rural Kazungula district when accessing contraceptives?
- What measures can increase contraceptive use among rural men and women of rural Kazungula district?

1.8 Significance of Study

A number of studies on contraception use have found variations in contraceptive use in different regions. Freedman (1987) suggested that any country with regions that are differentiated on ethnic grounds should expect differentials in reproductive and contraceptive behavior. Of the studies that have been done on contraception most of these have been at national level.

In Zambia, the ZDHS provides aggregated data at national level, which is a collection of general information. This information may not be helpful at district level because it does not specify which information is for which district. Besides, there is no trace of such a study at district level despite this information being important at district level for planning and implementation. The study will therefore bring out specific data not provided by ZDHS.

The findings of the study may be useful to government and partner organizations like PPAZ in implementing recommendations as measures to increase contraceptive use among the rural men and women in Kazungula district.

1.9 Limitations of the Study

The findings of this study may not be generalized as culture may differ from province to province and tribe to tribe.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter defines contraception, outlines briefly the types of contraceptives and further reviews studies on this topic with almost similar objectives. In this chapter, one will understand that low contraceptive use is related to high levels of fertility. This will further high light the effect of high fertility levels in a country hit by high poverty levels. The literature review takes different angles as it approaches the topic. It concludes by discussing the possible factors influencing contraceptive use especially among the rural people.

2.1 Contraception

Contraception is the performance of sexual intercourse with the deliberate intention of rendering infertile an act which could be fertile (Ashley *et al.*, 1997). Birth control is a term that describes things that stop a woman or girl from becoming pregnant, also known as contraception. Birth control can mean a wide range of things. Contraceptives are therefore, used to reduce the chances of women or girls becoming pregnant.

2.2 Types of contraceptive methods

There are different types of contraceptive methods for both men and women. These include; the combined pill, Mini pill, IUD, Male condom, Female condom, Diaphragm, Spermicides, Natural Family Planning, Male sterilization, Emergency contraception and Exclusive breast feeding. These are some of the methods available in Zambia (MoH, 1997).

2.3 World Contraceptive Revolution in the Developing World

Over the past 25 years, the world has experienced a contraceptive revolution (Donaldson and Tsui, 1990). Contraceptive prevalence which is the percentage of women in the reproductive age group, married or living in union, that use some type of contraceptive has risen from less than 10 percent around 1990 to 55 percent from late 1980 to early 1990, (Bongaarts, 1990). Most studies around the world on contraceptive use have indicated that in most areas of the

world especially in the rural areas contraceptive use is low (Population Reference Bureau, 1992; Neitzel, 1996; Magadi, 2001).

2.4 Africa - Prevalence of contraception

Most countries in Africa are less developed and yet they have a record of high birth rates. Among the factors that have contributed to sustained high fertility in Africa are large percentages of the population living in rural areas, low levels of socio-economic development, high rates of infant and child mortality, and patterns of social organization deeply ingrained in cultural values that maintain the demand for large families. Moreover until recently, the majority of the African government expressed little support for "population control," as enunciated at the World Population Conference in Bucharest in 1974; their position then was that "development is the best contraceptive" (Donaldson and Tsui, 1990).

African governments questioned the motivation of western nations concerned with limiting the population growth of African nations, and they viewed foreign assistance for population control programs as a poor use of resources, given the other development needs of these countries.

The African approach to contraceptive is a problem. Where knowledge of contraceptive is widespread, actual use is relatively low. The prevalence of Contraceptive use in Africa has been 13 percent, (Population Reference Bureau, 1992; United Nations, 1993). However, the most recent document indicates that Africa's contraceptive use is at 25 percent (Macmillan Reference USA, 2003) and, this too is not good enough.

Most studies in Africa have indicated that contraceptive use in Africa is low, especially in the rural areas, (Macmillan Reference USA, 2003). Only a few countries like South Africa has recorded high contraceptive use among the rural people.

2.5 Zambian and Contraceptives

Zambia has had measures and programs developed with the initiative of increasing contraceptive use. In 1989, the Government of the Republic of Zambia adopted an explicit National Population Policy as an integral component of its fourth National Development Plan (1989-1993) (MOH&CBH 1997).

The overall goal of this policy was to improve the standard of living and quality of life of all Zambians. Its objectives among others included, initiating and sustaining measures aimed at slowing the nation's high population growth rate. This could only be achieved through the promotion of contraceptive use.

In the year 1990, Zambia adopted a population policy, which had targets such as making family planning services available, accessible, and affordable by at least 30 percent of all adults in need of such services by the year 2000, (Zambia's National Population Policy, 1990).

Following the adoption of this policy, a comprehensive National Family Planning Program and National Population program was prepared for the period 1992-2000. In order to achieve the policy objectives some strategies were developed which included the following;

Providing IEC materials on the advantages of small family size for the individual and the nation and training various levels of health providers

Many of the health aspects of reproduction have been dealt with through the public health approaches of maternal and child birth and family planning (MCH)/ FP). Over the past few years, however, important socio-demographic changes have taken place, that have rendered MCH/FP approach to meet all the current concerns in this aspect of health. For example, family planning has been accepted (Zambia's National Population Policy, 1990).

The demographic factors and other emerging issues such as rapid urbanization, gender concerns, brain drain, and HIV and AIDS started unfolding in the 1990s, thereby constituting major obstacles to ensuring improved quality of life for Zambian's population. In an effort to address these issues, the process of revising the population policy started in December 1996, and was based on issues adopted by the 1994 Cairo International Conference on Population and Development (ICPD). The new objectives of the policy took into account the concerns regarding HIV and AIDS, poverty, reproductive health and a global perspective on population and development. The policy was finally revised in 2007 with a vision to improve the quality of life for the people through the achievement of improved population trends with socio-economic development. Some of the objectives included;

- Reduce the high level of fertility, particularly adolescent fertility
- Improve sexual and reproductive health (including family planning) so as to encourage manageable family size (MoH, 1997).

With this background, it has been established that there are a number of programs with different objectives pointing to the importance of contraceptive use. As indicated above it is clear that the Zambian people are aware and knowledgeable about contraceptives. However, the question still remains why the gap between contraceptive knowledge and use?

Contraceptive awareness and knowledge of any contraceptive method is almost universal, with 97 percent of women and 99 percent of men knowing at least one method of contraception. Modern methods are more widely known than traditional methods; 97 percent of all women know of a modern method, compared with 68 per cent who know of a traditional method. Among the modern methods, the emergency pill is the least known, with a representation of 9 percent of all women. The condom and the pill are the most known and where reported at 92 per cent for both. With the traditional methods, the withdrawal methods is the most known among women (59 percent).

A larger proportion of men (99 percent) know a modern method than a tradition method (71 percent). The most commonly known is the male condom (98 per cent). Similar to women, the most commonly known among the traditional method is the withdrawal (61 per cent). Furthermore, it is worth noting that men are half as likely as women to know of implants.

Use of contraceptive methods among women has remained minimal for the past number of years, although there have been improvements, the improvements are minimal, 70 percent of the women in Zambia are not using contraceptives (ZDHS, 2007).

Below is a table (table 2.1) showing trend in fertility rate from 1992-2007 (ZDHS, 2007).

Table 2.1: Trends in fertility rate from 1992-2007

Year	Total Fertility Rates (%)	Rural women cases (%)	Urban women cases (%)
1992	12.9	7.1	5.8
1996	12	6.9	5.1
2002	11.2	6.9	4.3
2007	11.8	7.5	4.3

Source: ZDHS, 2007

2.6 Development of Family planning in Zambia

According to Van den Bourne et al (1996), modern family planning services were on the market in Zambia in the early 1960s. They were offered on a small scale in a few urban areas. The health services were limited and characterized by restrictions. Consequently use of modern methods among the indigenous people was very low although some anthological literature suggests that fertility regulation existed, for example the use of breast feeding and post-partum sexual abstinence primarily for child spacing among some ethnic groups. The MoH played a relatively small role during this time and did not actively offer Family planning services until 1969 when the first maternal and child Health (MCH) unit was established at the University Teaching Hospital (UTH) in Lusaka. Family planning services were later incorporated and the unit was now renamed as Maternal and Child Health Family Planning (MCH/FP). MCH/FP was eventually established in every public health institution in the country. Family planning services were then provided for free (Ald, 1984).

Today's Family planning environment in Zambia owes much of its growth to the effort of Planned Parenthood Association of Zambia (PPAZ), which played a key role in laying the ground for future work. It was established in 1972 as the Family Planning Welfare Association of Zambia (FPWAZ). Most of its early programs focused on awareness creation (PPAZ). The association later changed its name to PPAZ and became affiliated to the parent body, International Planned Parenthood Association (IPPF), (Mutambo, 1990).

In the early years of contraceptives on the market in this country, there was considerable opposition to family planning. Service providers were often harassed if they gave out methods without the consent of client's spouses. Single women were denied family planning services.

During the early ages of development, family planning suffered negative publicity from some politicians. For instance, through the 1970s the women's league of the ruling party (UNIP) campaigned actively against Family Planning (Van Den Bourne, 1996). In some cases, Family Planning literature on contraceptives were confiscated and burned by anti-family planning campaigners. Such altitudes stemmed from traditions of most ethnic groups in Zambia which advocate high fertility.

Zambia became enlightened on the consequences of population growth largely resulting from the Global Conference on Population held in Mexico in 1984. The government began to

recognize the need to shift from pro-natalist to address family planning issues in a more pragmatic way (UNFPA, 1995). The adoption of an explicit national population policy in 1989, which aimed at slowing the rate of population growth, attached some importance to the role of family planning in achieving the goal. The aim of the population policy included; 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 education, information and means to choose in order to enhance the health of families and individuals (Ministry of Finance and Economic Development, 1994:14).

Prior to the health reforms, family planning service provision in Zambia followed vertical program approach (Syawmpi, *et al.*, 2003). The integrated approach was adopted in Health Sector Reform program in line with recommendation from the ICPD program of Action (UNFPA, 1995). The vertical approach is where a program has a single purpose of providing services, in this case family planning services, while the integrated approach involves the provision of a constellation of different reproductive health services at the same time, (Stewart, *et al.*, 2003).

Even though the government had begun offering family planning services in their health institutions for free, a review of the family planning before the introduction of the Health Sexual and Reproductive program, it was clear that service provision was still dominant in the private sector, who sometimes charged for their services and had limited geographical coverage. The lack of political will in providing family planning services had various effects although Zambia had been a site for clinical and introductory trials for various contraceptive methods since 1990 The impact of these initiatives remained very low.

In Zambia, the government is the largest provider of health and family planning service although the 1996 ZDHS shows that 50 per cent of the user relied on non-clinic based services. In the (CSO [Zambia] 2003) survey, 61 per cent of contraceptive users relied on public sector sources. The government has also facilitated the widening of the network of service provision to include Employment Based Distributers (EBDs), Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) and selling of condoms in shops as a way of meeting the goal of providing services as close to the community as possible.

Despite the above measures most studies on contraceptive situation analysis have indicated that the rural areas have been disadvantaged. Chinganya, (1998) observed that while facilities in urban areas offered family planning services on daily basis in rural areas family planning

services were offered one day a week. This restrictive access to contraceptives in rural areas has implications for contraceptive use considering that rural residents mostly rely on government facilities and most women have to walk long distances to the facility.

The Zambia government has not so far made deliberate efforts to encourage the private sector to establish health services in rural areas. This could contribute to increased access to services in these areas. In Zambia urban women are better served than their rural counter parts and this is because urban areas have a concentration of family planning and related services.

Previously family planning service provision in government facilities was restricted to designated days and times. In trying to make services as widely accessible to the community as possible, the family planning policy guideline proposed that services be provided round the clock, the "supermarket approach", in all facilities as a way to increase accessibility contraceptives.

Today contraceptives can be accessed from shops and some NGOs like the New Start Centre, PPAZ to mention a few. However, use is still slow.

2.7 Factors influencing contraceptive use

2.7.1 Overall view

According to Jain (1989), factors that affect couples or individual family size or their desire to do something are known as demand factors. The demand factors at the individual and societal level include; socio-economic, demographic and socio-cultural factors. These generate the demand for contraceptive use. Factors such as education, residence, region and age are associated with the likelihood of using modern contraception, (Magadi, 2001). For instance a place of residence may account for differences in contraceptive use largely due to the characteristics of the area. Urban areas are usually associated with better education and access to social services which may influence contraceptive adoption.

Cultural factors such as sex and fertility preferences may also affect the use of contraceptives. In a multi ethnic culture like Zambia, differences in contraceptive use are expected since traditional beliefs and practices differ from one ethnic and lineage group to another. These influence reproductive and contraceptive behavior as suggested by the cultural hypothesis which suggests that differences in reproductive health and contraceptive behavior may be due

to values and customs which differ from one ethnic group to another (Murty and Devos, 1994).

Zambia has both the matrilineal and patrilineal line of descent among its 73 ethnic groups. It is then expected that ethnic groups of the same lineage descent would have homogeneity in their regulation of fertility. The beliefs and practices of the various ethnic groups on fertility aspirations, sex preference, for instance may hinder or facilitate contraceptive use.

A number of studies on contraception use have found variations in contraceptive use in different regions. Freedman (1987) suggests that any country with regions that are differentiated on ethnic grounds should expect differentials in reproductive and contraceptive behavior. Ominde and Ayiemba (2003) proposed that region of residence may be a stand-in for ethnic or cultural influences that are related to contraceptive adoption.

This is related to the cultural hypothesis that was earlier mentioned. Regional residence in Zambia is influenced by ethnicity largely as a result of historical movements of the ethnic groups (Bertrand, *et al.*, 1996).

2.7.2 Education (Economic)

Economic factors are factors that affect contraceptive use from demand side point of view. The relationship between education and contraceptive use has been well documented. A number of researchers have found that the more educated one is the more they are likely to use contraceptives (Kaufman, 1998, Machini, 1998).

Female education influences contraceptive use in the following ways, when one has greater knowledge they tend to have access to modern methods, and when they go into marriage late, they are exposed to new ideas on small family size to mentions but a few (Hall, 1996). However, increases in education are not always preconditions that contraceptive use will increase as some studies have demonstrated, (Zlidar, *et al.*, 2000). In some studies, contraceptive use has been uniform regardless of education attainment, for example in the Chinese government, (Poston, 1986; Boaching and Zhenmig, 2003).

Some studies have also indicated that there is a relationship between contraceptive use and the place of residence; rural areas have comparatively lower levels of use than urban. (Curtis and Neltzel, 1996). The argument is that contraceptives are usually accessible and there is a wide variety in the urban areas. A study by Moreno (1993) based on DHS data from Latin

America, Asian and North African countries found that levels of contraceptive use among rural women were lower than those of the urban counter parts in all the countries except for Jamaica with a prevalence rate of 62 per cent where urban and rural areas were equal.

2.7.3 Demographic factors

Factors such as age, marital status, and desire for more children, and spousal approval of family planning fall under demographic factors. Studies have shown that contraceptive use is low among women in their teens and rise to its peak among women in their twenties, thereafter declines as the women grow older (Curtis and Neitzel, 1996, Magadi, 2001). Generally levels of contraceptive use are observed to be higher among unmarried women than married women. This is due to the fear of being suspected to be infertile and the fear of being divorced for one who is married, much consideration is after they have had children (Mensch, *et al.*, 1998). "Past studies have also indicated that women tend not to use contraceptives by birth of the first child", (Nsemukila, *et al.*, 1999). This is because of the misconceptions about the effects of modern methods such as pills and IUDs or injections on fertility; these are partly to blame for the lower levels of contraceptive use by birth (Agha, 1997).

Most couples in African communities do not hold discussions on reproduction issues. A study in Zambia by Mahler (1999) found that difficulty in communication with the spouse about family planning hindered women's contraceptive use. It is has also been established that couples who discuss family size and family planning issues have higher levels of contraception continuation and effective use of methods (Becker, 1996).

2.7.4 Fertility Aspirations

Fertility Regulation in African context has been for child spacing rather than limiting births. Sex was restricted to married people and was usually for the purpose of procreation, similar to Thomas Malthus Theory on population growth (Wrong, 1965). Traditional methods on regulating fertility include periodic and total abstinence, breastfeeding, herbs and strings (worn around the waist) (Nsemukila, *et al.*, 1999). Some of these methods were used to observe taboos and restrictions imposed by society which consequently resulted in spacing births.

Cultural reasoning foster high fertility and contribute tremendously to low use of family planning methods in most African societies.

Women's contraceptive behavior has been influenced by cultural norms and practices such as early and universal marriage, high fertility aspiration, son preference and spousal and familial opposition to family planning. The findings of the study in Naviongo, Northern Western of Ghana found that women who chose to use contraceptives faced the risk of becoming ostracized by their spouse's reactions, relatives and societies (Bawal,et al., 1999). Such reactions sometimes compel women to practice contraception secretly as found in a study in Mali (Castle, et al., 1999).

Another study in Zimbabwe by Francis-chizororo, et al., (1998), found that mothers in law and husbands wanted their daughters to have many children to extend the family line and thus opposed the use of contraceptives until at least after two or three children.

High fertility rates also result from children preference. Strong preferences for female children have been documented among the matrilineage. A researcher observed that female children were preferred among the Gweembe Tonga because they also bring wealth to the family through dowry which is mainly in form of cattle, so a man with many sons is disadvantaged (Clark, et al., 1995).

2.7.5 Myths and Misconceptions

It has been realized that for family planning programmes to be successful, there is need to consider the social context in which decisions on family planning operate (Bulatao, 1989). Cultural orientation may encourage or discourage women from using contraceptives. Many studies have found that the cultural orientations are more of an obstacle to women's use of modern contraceptive methods.

Myths and misconception have had their own effect on contraceptive use. They have been a barrier to the adoption of modern contraception. While it is clear that awareness creation could drive out misconception, sometimes these misconceptions are deeply embedded in the people's culture. A study in rural Tanzania found out that women were not comfortable in using injectables because it disturbed their monthly period which is regarded as a sacred thing in some societies (Makundi, 2000).

Myths and misconceptions have a major influence on the type of methods that woman in particular communities. This is why as indicated above determinant of contraceptives can vary from community to community, and society to society. Gweembe is one example where a daughter is preferred to a son, this is because at a time of marriage, the bride price will come through in form of cows to the girl's family. There are common myths that influence contraceptive use in rural areas such as; Wearing a condom is like having sex with a sweet rapper, protection is a woman's responsibility, a condom can get stuck in a woman's body, the first time a girl has sex she cannot fall pregnant, more children the stronger the woman, contraceptives are for prostitutes, no sexual satisfaction when you use condoms, you would never have a child when you use pills or injections to mention but a few methods (WHO, 2006).

2.7.6 Health Providers Attitudes

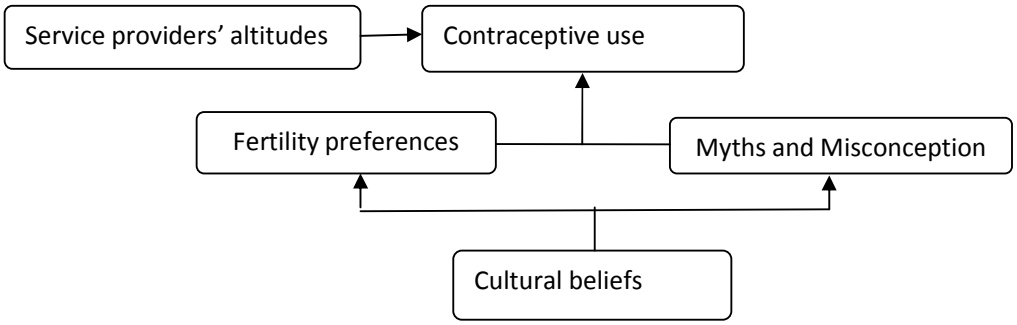
The populations of countries ravaged by the AIDS epidemic are now painfully aware that children born to mothers infected with Human Immunodeficiency Virus (HlV) may be infected themselves.

Whereas medical personnel advice against pregnancy for women who are HIV positive (to avoid hastening the onset of symptoms), this advice may be meaningless to women who measure their own personal worth by their contribution to continuing the lineage.

It is been hypothesized that the quality of care strongly influences contraceptive behavior, besides availability of infrastructure, equipment, supplies and trained staff play an important role. As indicated by Kwan (1994) client satisfaction and acceptance of services largely depend on the altitude and the competence of service providers.

Another study by Banda (2002), indicated that attitudes of health provider's attitudes towards the adolescents impede contraceptive use. This could be the case in the rural areas of Kazungula district. Another study by Ngoni (1997) indicated that men were not able to use contraceptives because of the altitudes of the female nurses who portrayed a picture that contraceptives were a woman's issue.

2.8 Theoretical Framework



The above theoretical framework has shown both supply and demand factors that affect contraceptive use. The following factors have remained the focus of the study; myths and misconception, attitudes of service providers, and fertility preferences.

It is becoming recognized that for family planning programmes to be successful, there is need to consider the social context in which decisions on family planning operate (Bulatao, 1989). Cultural orientation may encourage or discourage women from using contraceptives. Many studies have found that the cultural orientations are more of an obstacle to women's use of modern contraceptive methods.

Cultural beliefs and practices also have a major influence on the type of methods that women in particular communities use.

The supply factors that affect the delivery of family planning services have been observed to be important in determining contraceptive use. One important aspect is the quality of service provided. Elements of quality of care include; choice of contraceptive method, information given to clients, provider competence, client provider relations and follow up mechanism. In the theoretical framework used service delivery factor; altitude of service providers is what was considered for this study.

Supply factors too influence contraceptive use. Supply factors entail the entire service delivery mechanism from external donor assistance to the actual delivery to the client. If supply factors are not functioning properly, delivery of services will be affected and this may in the end affect contraceptive use. Government policies on family planning use and the types of methods allowed in the country influence the supply environment (Benaya, 2004).

As reviewed above, literature has proved that in most countries, the attitude of the service providers in the rural areas is compromised thus low uptake of contraceptives. However, a

few countries have managed to have a quality service both in urban and rural areas. In South Africa for example, the prevalence of contraceptive use in rural areas was higher than in urban. The situation in Zambia is that fertility rates and illiteracy levels are higher in rural areas, short interval births, early marriages and poverty levels are higher in the rural areas.

There is need to promote equitable development as the notion of the country remains, One Zambia, One Nation.

This study aimed at establishing factors that are influencing contraceptive use from both the supply and demand side in the villages of Kazungula district.

CHAPTER THREE- METHODOLOGY

3.0 Introduction

This chapter outlines the research methodology that was employed in this study. The chapter looks at the research design under which the type of research, the target population, and sampling design are discussed. The chapter further explains the research instruments that were used, research process, data analysis process, limitations of the study and ethical considerations.

3.1 Study design

Cooper and Schindler (2003) contend that, 'research design is the plan and structure of investigation so conceived as to obtain answers to research questions.' Coldwell and Herbst (2004) observe that a research design is 'the strategy for the study and the plan by which the strategy is to be carried out.'

The study used a descriptive design that was the reason why questions were designed in a way to collect information as the situation was at the time of the study. The study was conducted between December 2011 and February 2012 in Kazungula District of southern province. The project considered men and women who had been involved in sexual activities within the reproductive age group. The study was undertaken to establish factors influencing contraceptives use in Kazungula district as was at time of study. Data was collected using both quantitative and qualitative methods.

3.2 The study population

The study population included both men and women (married and unmarried) of the reproductive age group (15-49 years) in Kazungula district. This was on the condition that they have at least one child.

3.3 Study sample size

Simple random sampling was used in the selection of respondents. This method was chosen because all houses in this community had an equal and independent chance of being selected as a member of the sample. The research site was Kazungula district were chief Mukuni willingly worked with the researcher. The chief was flexible and also facilitated in making sure that people where readily available especially in the health centres. The study sample size was 137. The sample size took into account available time and financial resources. The sample was broken down as follows.

Age and sex of respondents

Table 3.1: Age and sex of respondents

Age of the respondents								
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Female	5	25	16	12	10	4	4	76
Male	0	8	19	19	6	5	4	61
Total	5	33	35	31	16	9	8	137

Source: Field Data (2012)

3.4 Inclusion Criteria

The participants must have resided in Kazungula for over two years whether married and unmarried men and women of the reproductive age group (15-49) and had at least a child were eligible for the Study.

3.5 Exclusion Criteria

Below the age of 15 and above 49 with an exclusion of males and females that did not have a child. This also included those that had not stayed over two years in Kazungula district.

3.6 Sampling techniques

Systematic Random sampling at an interval of 3 was used in selecting households where female key respondents were picked from. The same system was used for men but at an interval of 4. However, in homes were men were not there, females were selected.

3.7 Data Collection

After giving written or oral informed consent, men and women were interviewed by trained male and females. Interviews wereconducted on one to one.

Data was collected through interviewer administered questionnaires with both open and closed ended questions. A total number of 137 individuals were interviewed. Eligible women and women were successfully interviewed in every third household selected, in the case of men and in every fourth household selected, a man was interviewed. Data was collected within a period of two months, November and December 2011.

3.8 Quality Control Checks

During data collection, at the end of each day, the researcher would go through the filled in questionnaires. This was to ensure that all the information was properly collected and recorded. Information was checked for completeness and internal consistency. This was to make sure that there was collection of quality data.

3.9 Pre-testing

Pre-testing of the study instruments was done before the main study. All unclear questions where reformulated and those questions found to be irrelevant were removed. The final key respondent questionnaire was now divided into four sections. These included; Respondent Background Information; Family Planning Methods; Service Provision and Availability and finally Cultural practices.

3.10 Data Analysis

A questionnaire involving both closed-and-open-ended questions was used to collect both quantitative and qualitative data. It was designed to capture socio-demographic variables such as age, educational level, marital status and number of children. Questions on fertility preference, knowledge, attitude and practice of family planning were included.

After collection of data, it was entered on SPSS software package for processing and analysis. Data was analyzed using SPSS (quantitative) and the Narrative Method (qualitative). Tables will be used in the next chapter for the interpretation of the findings.

3.11 Ethical Consideration

Before conducting the study, permission to carry it out was sought from the Research Ethics Committee of the University of Zambia. An authorization letter was also given from Ministry of Health to conduct this research in Kazungula district. Informed consent was obtained from the participants before recruiting them into the study. Confidentiality was maintained, and their names and study numbers were unlinked.

Justice, Respect and Beneficence for respondents were adhered to and ethical approval was taken to indemnify the study. Before conducting the study, permission to carry it out was sought from the Research

4. CHAPTER FOUR: DISCUSSION OF FINDINGS

4.0 Introduction

In this chapter analysis of data and discussion of findings from each item in the research instrument are carried out. The findings of the study are presented in form of figures, tables and comments. The chapter starts by giving a description of socio-demographic characteristics of respondents through a table.

4.1 Socio-Demographic Characteristics of Respondents

Below is Table 1 giving a summary of the socio-demographic characteristics of the respondents. Socio-demographic variables are important factors influencing individual's decisions on contraception and fertility. Results in Table 1 indicate that the majority of study participants were (nearly half) aged between 20-34 years. However, substantial proportions of respondents (41%) were above 30 years. There have been early marriages in rural Africa and this study indicates that a sizeable number of study participants who were in the youngest age group reported having had children and hence the need for modern contraceptives. Early marriages and lack of awareness on contraceptives have led to high dropouts in schools. The sample size included both males and females. The Females represented 55.5% of the sample.The largest age group in the sample was between 25 and 29 which accounted for 25.5% of the sample size. The second largest was in the age group of 20-24 and this represented 33 (24.1%) of the sample size. The lowest represented age group in the sample was between 15 and 19 at 5 (3.6%).

Table 1 Socio-demographic characteristics of respondents

CHARACTERISTIC	FREQUENCY	PERCENTAGE
SEX		
Female	76	55.5
Male	61	44.5
AGE		
15-19	5	3.6
20-24	33	24.1
25-29	35	25.5
30-34	31	22.6
35-39	16	11.7
40-44	9	6.6
45-49	8	5.8
EDUCATION		
None	2	1.5
Primary	30	21.9
Secondary	88	64.2
Tertiary	17	12.4
Marital Status		
Married	76	55.5
Single	53	38.7
Divorced	6	4.4
Widowed	2	1.5
TOTAL	137	100

Source: Field Data (2012)

4.2 Awareness levels

There have been efforts to both increase contraceptive awareness and use. This has been at both global and national level. The Beijing Declaration and Platform for Action was one amongst many initiatives.

The study findings revealed generally high levels of awareness of contraceptive methods among male and female study participants. Many men and women during the interview could mention atleast two modern methods**.** The most known contraceptive method was the male condom at 100 percent, followed by the injection (96.4 %), pill (92%), female condom (81.8%), and withdrawal (73.6%). The least known was the diapghram as shown in Table 2.

Table 2 - Awareness by contraceptive method

Method	Frequency	Percent
Female Sterilization	43	31.4
Male Sterilization	37	27
Pill	126	92.0
Loop	61	44.5
Injection	132	96.4
Implants	51	37.2
Male Condoms	137	100.0
Female Condoms	112	81.8
Diaphragm	0	0.0
Lactational Amenorhea	14	10.2
Rhythm	77	56.2
Withdrawal	109	79.6
Emergency pill	31	20.4
Standard day Method	91	66.4

Participants were asked about their source of information on family planning to determine their sources of information; this is elaborated further in Table 3 below. The popular sources among the women include the health facility, friends and elders while among men common sources include elders (grandparents in particular) and the radio.This also explains that men and women have different sources of information and these sources may not strike a balance in the level of understanding because myths and misconceptions are still there.

Table 3 Men and women's sources of contraceptive methods information

Women only	**Both sexes**	**Men only**
Safe motherhood clubs, under -5 clinic posts	Friends, Health Facility, Television, Hospital, School, Elders, Seminars/workshops, Parents, PPAZ, Radio	Bars, Newspapers, Magazines, Church, Outreach activities, Spouses, the Red Cross and the Neighbourhood Health Committee

Generally there is so much information on the market about contraceptives. Organizations such as the United Nations Population reproductive Fund (UNFPA) have been involved in information dissemination and distributing contraceptives (UNFPA, 1996). The organization became actively involved in Zambia in 1972, and in 1984 the first country program was established. Important achievements emanating from this cooperation relating to family planning provision including the 1989 National Population Policy, the 1980, 1990 and 2000 were recorded. The fund had a provision for censuses support for the national family planning which was done. There were advances in the field of population and reproductive health. The major focus of UNFPA's support of family planning in Zambia has been towards building national capacity through training and strengthening national institution and reproductive health care services. UNFPA supported the contraceptive Needs Assessment study and has also supported the production of the family planning policy guidelines jointly with World Health Organization. It further proposed to assist in creating demand for reproductive and family planning services among men, women and adolescents as well as making the services more accessible to underserved groups (UNFPA, 1996).

Table 4 reveals that most men used male condoms (41.8%) at first sex and most women used the combined pill (21.8%). The least used method among women was the injections (1.8%). Table 4 below has shown further by indicating what percentages men and women used a specific method at first sex.

Table 4 Use of Contraceptives at first sex by method

Method	Frequency	Male f	Percent	Female f	Percent
Combined pill	21	8	14.5	12	21.8
Mini pill	1	0	0	2	3.6
Male Condom	30	23	41.8	7	12.7
Female Condom	2	0	0	2	3.6
Injectables	1	0	0	1	1.8
Total	55	31	56.3	24	43.6

Source: Field Data (2012)

4.3 Contraceptive Use and Education Attainment

Table 5 below reveals there were more females (58%) compared to men (42%) who had used a contraceptive method at first sex by level of education. A number of researchers have found that the more educated one is the more they are likely to use contraceptives (Kaufman, 1998, Mancini, 1998). Table 5 also shows that there were more Education did not have so much influence on men's decision on the use of contraceptives. However, this was not the case for women. Some studies have had similar findings. This was so because culture has been so much rooted in the minds of people, and they believed in having a lot of children, and that child bearing kept their marriages running, especially among men.

Table 5- Level of Education by Contraceptive use at first sex

Level of Education	Male	Female	Contraceptive Use at first sex
None	0%	0%	0%
Primary	11%	11%	22%
Secondary	20%	31%	51%
Tertiary	11%	16.4%	22.4%
Total	42%	58%	100%

Source: Field Data (2012)

Education is not always a precondition for contraceptive use as some studies have demonstrated, (Zlidar el al., 2000). In some studies, contraceptive use has been uniform regardless of education attainment, for example in the Chinese government, (Poston, 1986; Boaching and Zhenmig, 2003).

Female education influences contraceptive use in many ways, when one has greater knowledge one tends to have access to modern methods of contraception, and they have the ability to choose when they go into marriage. They are quite exposed to new ideas of having a small family size (Hall, 1996). Increased participation of women in schooling and the labour market raises the economic value of their time, which increases the opportunity cost of raising children (Guilkey, 1998) confirms that women's education is associated with smaller desired family sizes across the world. The longer a woman stays in school, the longer

they defer giving birth to their first child. This lowers the chances of giving birth to many children. Moreover with more education and exposure, women acquire more information about their bodies and are more able to process that information to their advantage (Vavrus and Larsen, 2003; Singh, 1990). The positive impact of women's education on their autonomy, leading to later marriages, increased use of contraceptives and lower fertility as discussed by Mason (1986). In this study it was observed that the link between women's education and fertility is much stronger than that of the husband's (Ainsworth et al., 1995).Table 5 also confirms that contraceptive use is high among females compared to men**.**

4.4 Current use of contraceptives

Table 6 shows methods of contraceptives respondents were using at the time of the study. It shows that 15.3% of the respondents were using the combined pill and 13.1 % were using male condoms, 13.1% were using injectable. These were the most common methods used by both men and women. The least used method was the mini pill at 0.7%. Table 6 further indicates that more women 57.9% than men 26.2% were using a contraceptive method with their partners at the time of the study.

Table 6 Current use of contraceptives

Method	**Female**	**Male**	**Total**
Combined pill	17(12%)	4(2.9%)	21(15.3%)
mini pill	1(0.7%)	0 (0%)	1(0.7%)
IUD	2(1.4%)	0(0%)	2(1.4%)
Male Condom	7 (5.1%)	11(8%)	18(13.1%)
Injectables	17(12.4%)	1(0.7%)	18(13.1%)
none	32 (23%)	45(32.8%)	77(56.2%)
Total	76(55.5%)	61(44.5%)	137(100)

Source: Field Data (2012)

Table 7 shows that contraceptive use was high among those aged between 20-24 (40%) and it kept reducing as age increased. This may imply that contraceptives methods are mainly used among the younger people.

Table 7 Age by contraceptive use at time of study

Age	Combined pill	mini pill	IUD	Male Condom	Injectables	Total	Percent
15-19 years old	0	0	0	0	0	0	0
20-24 years old	13	0	1	5	5	24	40
25- 29 years old	6	1	0	8	5	20	33.3
30-34 years old	1	0	0	5	5	11	18.3
35-39 years old	1	0	0	0	2	3	5
40-44 years old	0	0	0	0	1	1	1.7
45-49 years old	0	0	1	0	0	1	1.7
Total	21	1	2	18	18	60	100

Source: Field Data (2012)

Table 8 shows contraceptive use by marital status at the time of the study. The study findings revealed that contraceptive use was high among singles (46.7%) compared to the married (41.7%). Contraceptive use was lowest among the widowed. Table 8 has broken it further that capturing all contraceptive methods that where mentioned by respondents. Through marital status, Table 8 which is below shows what percentage of the Married, Single, Divorced, Widowed used a method.

Table 8 Contraceptive method by marital status at time of study

Contraceptive method	Married	Single	Divorced	Widowed	Total
Combined pill	6(4.3%)	15(11%)	0(0%)	0(0%)	21(15.3)
Mini pill	0(0%)	1(0.7%)	0(0%)	0(0%)	1(0.7%)
IUD	1(0.7%)	0(0%)	0(0%)	1(0.7%)	2(1.4%)
Male condom	6(4.3%)	12(8.8%)	0(0%)	0(0%)	18(13.1%)
Injectables	12(8.8%)	0(0%)	4(6.7%)	2 (1.4%)	18(13.1%)
Total	25(18.2)	28(20.4%)	4(2.9%)	3(2%)	60(44%)

Source: Field Data (2012)

4.5 Fertility Desires

Table 9 shows frequencies of desired number of children by sex. The majority (35.8%) of the women desired having between 3 and 5 children while the majority men (49.9%) desired having between 7 and 9 children.

Table 9- Fertility desires by sex

Desired number of children	No of respondants	Female	Male
less than 3	3(2.2%)	3(3.9%)	0
between 3 and 5	6(4.4%)	0	6(9.8%)
between 5 and 7	37(27%)	16(21.1%)	21(34.4%)
between 7 and 9	42(30%)	12(15.8%)	30(49.2%)
more than 9	49(35.8)	45(59.2%)	4(6.6%)
Total	137(100%)	76(100%)	61(100%)

Source: Field Data (2012)

It was revealed in this study that some men and women had high fertility aspirations and desire to have large families. This was noted among men and women of different ethnic and lineage background. Their reasons included expectation of future child loss, high infant mortality, prestige and having children as investment for the future. However, there were some men and women who acknowledged that having fewer children was better than having men children in the present economic conditions.

The study revealed that the desire for fewer children usually expressed a rise in contraceptive use. The fact that fertility aspirations were high among men in this study as can be seen in Table 8 give a better explanation why contraceptive use was low in the study area. Having children of at least more than 5 was highly appreciated. High fertility aspiration has become like a cultural norm in today's society, were women with a number of children are more respected. This has led to a situation where women's experience with contraceptives is been determined by society's expectations of their multiple roles as wives, mothers and members of their community.

4.6 Myths, Misconceptions and Traditional beliefs

Myths and Misconceptions were key in the findings of this study. Some of these included the following;

- ***"Contraceptives are for prostitutes"***

It was observed that there is a negative attitude that men and women have towards contraceptive usage. It was viewed that contraceptives promote promiscuity. A study by Kigondu (1995) had similar findings. Contraceptives were associated with prostitution and adultery and most married men only accepted using contraceptives (condoms) outside marriage.

However, men and women have been vigilant in encouraging fidelity. They speak about fears and risks associated with contraceptives, prevalence and the consequences of HIV and AIDS infection. This actually works on someone's psychology as they speak about risks one may encounter in using contraceptives, this leaves the community with fears, which persuades them to go for "safer natural methods". In a way this promotes non-use. Zulu and Chepngeno, (2003) also made similar observations in a study conducted in Malawi.

- ***"Pills cause infertility"***

Since its approval on May 9, 1960, the pill is among one of the most carefully studied medications in U.S. history. Although women's knowledge has significantly improved since the introduction of the pill, many pill myths still exist. According to research in the British Medical Journal, poor knowledge about the pill accounts for about 20% of unwanted pregnancies. Because many myths are associated with the pill, it is important to improve knowledge, so one can be more educated about their contraceptive choice**.** However, there is NO connection between taking the pill and infertility. Fertility can return almost immediately after stopping the pill, which is why it's important not to miss pills. Some women may face a delay in becoming pregnant after stopping pill use, especially if they had irregular periods before starting it. Women using the pill may experience delayed childbearing until their late 30s, a time when natural fertility has waned, thereby confusing pill use as the cause for not becoming pregnant rather than age. Woman may have always had a fertility problem but was unaware of it because she was not trying to get pregnant.

The study revealed lack of in-depth knowledge on some methods as result of misconceptions of how some methods work and perceived side effects of methods such as pills, sterilization and condoms were commonly among the less educated study participants. The most common misconception noted in this study is that pills cause cancer and infertility. The belief that pills cause infertility is not peculiar to this study as other studies elsewhere have found similar views. For instance, a study on the factors influencing the uptake of contraceptive use in

Malawi, found that women feared getting cancer as a result of the pill (Opportunities and Choices Programme, Fact sheet 14, 2003)

This misconception has been a finding of many studies for example (Benaya 2004). Others even believe that diseases such as cancer can be caused by the combined pill. It was believed that the use of contraceptives is meant for those that have had children before. It was therefore believed to be at owner's risk for a person to decide to use contraceptives before having children.

- ***"The strength of a woman lies in the number of children she bears".***

It is common that most women want to be admired and to remain in their marriages, therefore as a way of promoting child bearing, such a myth is immortalized. It is meant to encourage women to have a lot of children. It was revealed that the only possible way for a woman to keep her marriage was to live by the saying. As a result, most women were denied the right of accessing contraceptives.

This situation was exacerbated by sex preference of parents. There were strong preferences for female children. A researcher observed that female children were preferred among the Gweembe Tonga because they also bring wealth to the family through dowry which was mainly in form of cattle. A man with many sons was disadvantaged (Clark el al., 1995). This was the case in this study, it was revealed from a number of respondents that some men and women still value the female folk compared to the opposite sex for dowry benefits.

Current number of living children was another factor that was significantly associated with current use of modern contraceptives in a study population. Due to preference for large number of children by most of study participants as it has also been the case in other part of Africa. It was seen that women with less children (3 and below) were less likely to be current user of contraceptives compared to those that have already achieved higher number of children (4 and above). This finding implies more education need to be given to the community on the importance of smaller families and hence increased contraceptive uptake. Women participation in household decisions including those related to fertility (i.e., high women autonomy in household matters; gender power balance in household decisions) as well as spousal communication on family planning have been indicated in several studies to be associated with increased likelihood of modern contraceptive use by women (Matthews et al., 2005).

Table 10 indicates that 66 (48.2 %) respondents said that the attitude of the health providers was poor compared to 40.9% said that the attitude of the respondents was good.

Table 10 Perceptions of Respondents towards staff attitudes

Sex	Poor	Good	Fair
Male	34 (44.7%)	33(43.4%)	9(11.2%)
Female	32(54.5%)	23(37.7%)	6(9.8%)
Total	66(48.2%)	56(40.9%)	15(10.9%)

Source: Field Data (2012)

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.0 Discussion of Findings Of factors Influencing Contraceptive Use

"Use of contraceptives in Sub-Sahara Africa is low", (Berer, 2007). In Africa at large, women are expected to prove their fertility before the thought of using any contraceptives. This is because cultural norms expect that married women most especially are supposed to have children if they are to earn respect from society. Women's gender identities and social statuses are tied to motherhood and childlessness is highly stigmatized (Cooper, 2007). It is because of this that most married women feel pressured to have children.

All respondents were aware of at least a method, however only 44% of the respondents were using contraceptives. A number of factors can explain this;

The International Conference on Population and Development, 1994 (ICPD-94) emphasized on a broader context of reproductive health with a centrality on family planning and on the empowerment of couples in deciding their own reproductive health issues in a free but responsive manner. Empowerment of couples on the issues of desired family size and /or number of children can only be generated through effective interaction and communication with each other. However, in a developing country limited communication between spouses set barriers towards a better understanding of the couples themselves and in making a responsible decision towards achieving the desired family size. The Zambian culture renders more power to men over sex in marriage. A woman is to be silent as revealed in this study. As a result this cultural reasoning fosters high fertility and contributes tremendously to low use of family planning methods. Spousal communication has its role on achieving the desired number of children through use of contraceptives.

It was observed that most women's contraceptive behavior was also influenced by practices such as high fertility aspiration, daughter preference and familial opposition to family planning. The findings of a study in Naviongo, Northern Western of Ghana found that women who chose to use contraceptives faced the risk of becoming ostracized by their spouse's reactions, relatives and societies (Bawal, 1999) was the case in this study. Such reactions compelled women to practice contraception secretly. It was observed that in most areas where women are not allowed to use contraceptives go by using the method secretly, this was also a finding in a study conducted in Mali (Castle, 1999).

Most men than women in the areas visited had high fertility aspirations and desire for large families. Research studies reveal that men preferred large family sizes compared to women. This was the finding of this study and it also confirms the findings of Benaya (2004). There was a disparity in the number of children men and women would like to have. This disparity in preferences towards family size led to misunderstandings between couples in deciding whether to use contraceptives or not. Some men of Kazungula district only expected to use contraceptives with outside marriage partners and recommended that their wives should not access any contraceptives. Women who did not want to lose their marriages had gone ahead to keep the words of their husbands.

However, some married women who reported using contraceptives either used injections as their husbands were not informed. This was because they wanted to preserve their marriages. It was revealed that at a point they would be discovered that they use contraceptives; they would be beaten and in some instances divorced.

Women who wanted to have children of less than five, went into what they called "women agreements". The women's agreements involved women agreeing with each other or health providers so that their using of contraceptives would be kept as a secret. This was done by leaving their contraceptive cards at the Health Centre with specific individuals or asking a friend to keep it in their home. Apart from this, women with similar challenges preferred injectables because they were not easily noticeable, hence one would pretend to be barren.

Husband opposition was also noted to be a significant barrier to contraceptive use among women in a study population. Women that reported that their husband approves contraceptives were more likely to be current users of contraceptives compared to the counterpart. Women openly said husbands were an obstacle to modern contraceptives use and other men want their women to give be giving birth all the time. This observation reflect a need for males to be given more education on the importance of family planning in a study population to improve uptake of modern contraceptives, this could be through involvement of males in family planning programs.

It was observed that some respondents in the district did not mind about the spacing between their children as long as they were sure that they would have their next child. To them contraceptive use was unacceptable basing their reasoning on the belief that use of contraceptives caused barrenness. The respondents were however not sure of the specific

methods that would lead to barrenness. They revealed that a woman with such a complication would not be desired for marriage especially in the Tonga culture where men's aspirations for children were high. The situation was that when a woman is married, she becomes a man's ownership. This leaves her with no control over her body. Power was vested so much in the man to even determine the number of children a woman should have.

It was observed that culture has taught women to keep silent on matters relating to sexual intercourse. This has led to poor spousal contraceptive communication in Kazungula. Initiation ceremonies and kitchen parties that are organized for girl carry with them teachings that women are to submit and not to question the man on sexual matters. This means that if a man wants six or more children the woman should not argue with the man. For some wives, having many children stabilizes their marriage. It prevents husbands from marrying additional wives. For husbands, having many children helps them to keep their wives from objecting to their takings. This was the situation in Kazungula district. These findings confirm conventional population, family planning and reproductive health programmes that view high fertility as disempowering for women, and contraceptive use as capable of redressing gender inequality.

In the recent years there has been an increased thrust on family planning campaigns in the country by both government and non- governmental organizations, which included among others, intensification of family planning services in almost all health facilities including those in rural areas as well as rising awareness to the community on the benefits of family planning. Since intensification of these campaigns, scanty information is available on current status of modern contraceptive use in most parts of the country specifically in rural areas as well as factors influencing their use. This information is important for more informed decisions on family planning campaigns in the country

Despite the government efforts, the fertility rate and contraceptive prevalence are still at unacceptable level. Among others, factors that limited contraceptive uptake included myths rumours and misinformation about modern contraceptives.

The narratives reveal that most women had myths and misconceptions regarding the use of contraceptives. For instance, some respondents believed that the use of the pill delayed periods and led to complications during pregnancy, wearing a condom was like having sex with a sweet rapper, protection was a woman's responsibility, the first time a girl would

indulge into sex, she would not fall pregnant, the more children the stronger the woman, contraceptives were for prostitutes, no sexual satisfaction when you use condoms, you would never have a child when you use pills or injections to mention but a few.

According to the study results, myths and misconceptions were in existence and this influenced contraceptive use. Some myths and misconceptions which were given were meant to silence women on sexual matters. This was one of the possible reasons why contraceptive use was low among the women in the sample.

It was observed that the reason why most men use a contraceptive method is because of how culture has empowered them on matters of sex. It is actually up to a man to decide whether to use a contraceptive method or not. Women were not able to negotiate for safer sex because of what they were taught during the initiation ceremony or through girls common talks.

Staffs that are not people oriented discourage clients from accessing contraceptives. Many studies have revealed that service delivery and contraceptive uptake interrelate, (RamaRao, 2003). This was the finding in this study. It was observed that people in Kazungula district were looking for an opportunity to discuss their reproductive health concerns. However, it was realized that they had shortage of staff and so at times they had to depend on community volunteers. This also affected them in that they had no quality time with staff officers. It was also brought to light that the staff in the health centers were loaded with work and this led to a poor flow of communication between the community and staff.

An article based on a longitudinal study in Bangledesh by Koenig, (2003) provided compelling evidence that improvements in quality of care are likely to lead to continued use and greater acceptance of methods.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

All in all, Contraceptives play an important role in the lives of men and woman. The use of contraception save women's lives and improves their health by allowing them to avoid unwanted and poorly timed pregnancies. Contraceptives also save children's lives by allowing parents to delay and adequately space births. When births come too early or less than two years apart, the health of infants and their siblings is endangered. This may increase infant and maternal mortality rates (ZDHS, 2007).

Use of contraceptives helps to 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 (WHO, 1996). At the same time, measures to improve women's status, coupled with access to contraceptives and other key reproductive health services, are likely to result in the most rapid improvements in health and wellbeing. Contraceptives are intended to control fertility thereby giving room to the couples to recover from the previous delivery.

Contraceptives reduce fertility and can help to relieve the pressures that rapidly growing populations place on economic, social, and natural resources. Rapid population growth impedes economic growth and makes it more difficult to achieve improvements in education, health and environmental quality, (CSO, 2007).

The people in the rural areas are less educated, and economically poor. This means that those who are HIV positive (women) are likely to infect their children because most of them breast feed more than six months due to financial limitations. It is important however, that men and women of this country become concerned and start using contraceptive.

Knowledge of contraceptives was high in a study population. Substantial proportion of women had positive attitude towards contraceptives and hence more room for increasing contraceptive use in a study population, though negative attitude of husbands towards contraceptive on family planning could be a limitation. Regarding contraceptive prevalence

rate, although there was some improvement compared to the past national averages, however, the current figure for prevalence rate is still low when compared to the national target. Likelihood (chances) of being current user of contraceptives by a woman increased with increase in education level, having higher number of living children, spousal communication on contraceptives, woman participation in decisions making regarding fertility in a family, husband approval of contraceptives, good attitudes of service providers and having positive attitudes towards modern contraceptives.

6.2 Recommendations

- There is need for more education on the importance of contraceptive use. Rural areas need to be handled differently from urban areas. Most respondents recommended door to door sensitization.
- The ministry of health needs to put up serious monitoring measures for the health workers in rural areas as some are rarely on duty.
- The ministry of health needs to work closely with the health workers in rural communities to make sure that measures for training them in new contraceptive methods are passed on to them. The reasoning behind this is that the services from NGOs may not be sustainable.
- Contraceptive uptake should be a man and woman issue. Therefore, the chiefs have a better way of influencing their people. There is need for the service providers to work hand in hand with the chiefs in order to bring the men on board so that they feel part and parcel of family planning in a home.
- Increased awareness campaigns, coupled with adequate provision of a large range of methods and services, facilities with adequate trained male and female providers may go a long way in increasing uptake in the visited areas.

  The respondents also called for community sensitization with major concerns of male involvement in use of contraceptives.

References

Agha, .1997. Sexual Activity and Condom Use in Lusaka (Reprint). Research Dicision Working Paper, No 6 Population Services International

Ainsworth, M .1995. The Impact of Female Schooling on Fertility and Contraceptive Use: A Study of Fourteen Sub-Saharan African Countries. Living Standards Measurement study, Working Paper, No.110. World Bank, Washington D.C

Ald, M, R, .1984. A Study About Knowledge, Altitudes and Practice towards Family Planning in Zambia. M.A Thesis, unpolished, Department of Psychology, University of Zambia

Ashley M, & Kelvin D, .1997. Health Care Ethnics. Washington, D.C, Georgetown University Press

Banda, H .2002. Patterns of Sexual Practice, Use and Knowledge of Contraceptive Methods among Adolecents in Lusaka Urban. Lusaka, UNZA

Barnett, B .1999. First Time Users have Diverse Needs. Network, Vol.19, No4

Bawal, A.A., Akweongo, P., Simmons, R and Phillips, J.F .1999. Studies in Family Planning, Women's Fears and Sexual Anxieties: The Impact of Family Planning. Vol. 33. No, pp54-66

Becker, S.1996. Couples and Reproductive Health: 'A Review of Couple Studies'. Studies in Family Planning, Vol.27, No 6 pp 291-306

Benaya, K.W.K .2004. Factors Influencing Contraceptive Use and Method Choice Men and Women in Zambia. PHD Thesis Lusaka, Unza

Berer, M. .2007. Maternal Mortality and Morbidity: is pregnancy getting safer for women? Reproductive Health Matters, 2007; Vol. 15 (30):6-16

Bertrand J.T., Magnani R.J, and Rotenburg .1996. Evaluating Family Planning, with adoptions for Reproductive Health. Chapel Hill, North Carolina, Carolina Population Centre

Boaching and Zhenmig, .2003. China: The Effects of Family Planning on Women's Lives. Family Health International

Bongaarts, J., W, P Mauldin, and Phillips J.F., .1990. The demographic impact of family planning programs. Studies in Family Planning 21 (6). Pp299-310

Bulatao R, .1989. 'Contraceptive Use Framework'. In Asia and the United States.

Castle, S., Konate, M.K, P.R and Martin, S .1999. A Qualitative Study of Landestine Contraceptive Use in Urban Mali. Studies in Family Planning. Vol 30. No.3 pp.231-248

Central Statistics Office [Zambia] .2003. Census of Population and Housing. Lusaka, CSO

Central Statistics Office [Zambia] .2003.. Zambia Demographic Health Survey. Lusaka, CSO

Central Statistics Office [Zambia] .2007. Zambia Demographic Health Survey. Lusaka, CSO

Chinganya, O, Siachitema, K., Sinyangwe, G., Mukuka L., and Alisa, A.K. 1998. Zambia Situation Analysis Study 1997: An Assessment of the Functional and Quality of Reproductive and Child Health Service in Zambia. CSO

Clark, S. Colson, E., Lee, J. and Schhudder, T. 1995. Ten Thousand Tonga: A Longitudinal Anthropological Study from Southern Zambia, 1956-1991. Population Studies, Vol.49, No. 1, pp.95-108.

Coldwell, D. and F. Herbst .2004. Business Research. Cape Town: Juta

Cooper, D. (2007). "Life is still going on": reproductive intentions among HIV positive women and men in South Africa. Journal of Social Science and Medicine, 2007.Vol.65 (2):274-283

Cooper, R. and P.S. Schindler (2003). *Business Research Methods (8th Edition*). Tata McGraw-Hill

Curtis and Neltzel, .1996. Contraceptive Knowledge, Use and Sources. Demographic Health Survey Comparative Studies, No.19. Calverton Maryland

Donaldson, PJ. and Tsui A O, .1990. The International Family Planning Movement. Population Bulletin 45(3) pp1-45

Francis-chizororo M, Wekwete, N and Matchka, M, .1998. Family Influences on Zimbabwe Women's Reproductive Decisions and their Participation in the Wider Society. Research Triangle Park, University of Zimbabwe and Family Health International, USA

Freedman R, .1987. The Contributions of Social Science Research to Population Policy to Family Planning Program Effectiveness. Studies in Family Planning 18(2):57-105

Guilkey, D., G. Angeles and T. Mroz. .1998. The measurement of indirect program impact through the effect of female education on fertility and mortality. Carolina Population Centre, University of North Carolina, Chapel Hill.

Hall, G .1996. Eye on Sub Sahara Africa; Population Policy. Poverty lines No 1, World Bank

Http: genderlinks.org.za-UN conference on Women

http://www.ehow

International Conference on Population and Development Program of Action .2000. Centre for Reproductive Rights, Beijing+5: Assessing reproductive Rights.

Jain A.K .1989. Fertility Reduction and the Quality of Family Planning Services. Studies in Family Planning, Vol. No 1pp 1-16

Kaufman, C E .1998. *Contraceptive Use in South Africa under Apartheid (Determinants and Consequences of fertility)*. Demography, Vol 35, No4: pp. 421-434

Kigondu, S.C, Kirumbi, L., Violet, K. and Mwai, C. 1995. Condom acceptability among high-risk sexually transmitted diseases groups: A case study of the long distance truck drivers and their assistants. Nairobi Kenya: Department of Obstetrics and gynecology, University Nairobi.

Koenig al., .2003. Women's status and domestic violence in rural Bangledesh: individual- and community-level effects. Demorgraph, Vol.40, No. 2, pp. 269-288

Kwan, M.1994. When the client is King. Planned Parenthood Challenges. Public Affairs Department of IIPF, London 1994/2

Macmillan Reference USA, .2003. Health Division. Thomson Learning, Inc.

Magadi, M, Zulu, Ezeh A& Curtis, S, .2001. Contraceptive Use Dynamics in Kenya: Further Analysis of Demographic and Health Survey Data. APHRC and measure evaluation

Mahler, .1999. Contraceptive Method Use among Urban Zambian Women is tied to Communication. International Family planning Perspective's, vol. No2. Pp103-104

Makundi, .2000. Quality of Care and Accessibility of Family Planning services in Tanzania: Providers, clients and Non Users perspectives. Paper presented at the annual meeting of the Population Association of America, Washington, DC, and March pp. 29-39

Mancini, D, .1998. Determinants of Fertility Preferences and Contraceptive Use. Measure Evaluation, USA

Mason, K.O. (1986). The status of women: conceptual and methodological issues in demographic studies. *Sociological Forum*, *Vol.1*, pp. 284-300.

Mathews, Z., Madise, N, Stephenson, R. and Holmes, D.2005. "Modelling for Complex Survey Data: An Application to Child Nutritional Status in Four African Countries.' Paper presented at Population Association of America Annual Conference. Los Angeles, U.S.A

Mbizvo, M.T and Basselt, M.T, .1996. Reproductive Health and AIDS, Prevention in Sub-Saharan Africa. The Case for Increased Male Participation. Health Policy and Planning Vol II, No1 pp.84-92

Mbizvo, M.T and Basselt, M.T. 1996. Reproductive Health and AIDS, Prevention in Sub-Saharan Africa. The Case for Increased Male Participation. Health Policy and Planning Vol II, No1 pp.84-92

McLaren, A, .1990. A History of Contraception. USA, Blackwell

Mensch, B.J, Bruce, J and Greene M.E .1998. The Uncharted Passage: Girls' Adolescents in the Developing World. New York, the Population Council

Mindolo Ecumenical Foundation, .2010. Gender Based Violence Training Manual for the Clergy. Kitwe, Zambia Episcopal Conference

Ministry of Finance and Economic Development, .1994. Zambia's National Population Policy; First Version. Lusaka, MoF

Ministry of Health, .1997. Family Planning in Reproductive Health: Policy Framework, Strategies, Guidelines. Lusaka, MoH

MOH and Central Board of Health Zambia, .1997. HIV and AIDS in Zambia: Background, Projections, impacts and interventions. PCI/ Policy Project, USAID

Moreno L, .1993. Differences by Residence and Education in Contraceptive Failure Rates in Developing Countries. International Family Planning Perspective's, Vol.19 No2, Pp54-71

Murty and Devos, .1994. Ethnic Differences in Contraceptive Use Srilanka in Studies in Family Planning, Vol. 15, No 5, pp222-232

Mutambo, .1990. 'Opposition as a Challenge to Family Planning programs in Zambia'. Paper presented at the fifth Annual International Women's Rights Action Watch Convention; Where Are We? What's next? New York

Muzyamba B, I .2006. Factors Influencing Male Interest in the Use of Family Planning: A comparative Study of Rural and Urban Communities in Monze District of Zambia. MA Dissertation, UNZA

National Research Council, .1993. Factors Affecting Contraceptive Use in Sub-Sahara Africa. Washington D.C, National Academy Press

Ngoni K. B, .1997. A Study to Determine Factors Contributing to the Utilization of Family Planning Services by Kabwe Secondary School Adolescents.MPH. Dissertation, UNZA

Nsemukila, G.B., Phiri D.S., Benaya, W.K and Kitahara, N.1999. A Study of Factors Associated with Maternal Mortality, 1998. Ministry of Health, United Nations Population Fund, Central Board of Health and University of Zambia

Nzioka, .2000. Factors influencing male interest in family planning in Kenya. African Journal of Reproductive Health, Vol. 2, No.2, pp.122-141

Omondi, O and Ayiemba, E .2003. Contraceptive Use Dynamics among Migrant Women in Kenya. African Population Studies, Vol, 18, No.2 pp. 69-90

Opportunities and Choices Reproductive Health Corsium .2003. Barriers to Use of Family Planning Services in Malawi; Findings from Focus Group Discussions: Fact sheet 14; Opportunities and Choices Programme University of Southampton

Population Reference Bureau, .1992. World Population Data Sheet. Washington D.C

Poston, D. L .1986. Patterns of contraceptive Use in China (1986). Studies in Family Planning, Vol. 17 No 5 pp. 217-227

Ramarao S, L, Lacuesta, M., Costello, M., Pango bibay, B and Jones, H. .2003.. The Link Between Quality of Care and Contraceptive Use. International Family Planning Persepectives. Vol. 29, No2, PP 76-83

Sadik, N, .1997. The State of the World Population. New York, UNFPA

Segalen. .1986. Historical of Anthropology of the Family. London, Cambridge Press Stewart,

Singh, S and Wulf, D. 1990. Toadys Adolecent's, Tomorrows's Parents: A portrait of the Americans. New York, Alan Guttmacher Institute.

Stewart, J F.,Stecklov, J.F,. Adewuyi, A. 2003. Family Planning Program Structure and Performance in West Africa, International Family Planning Persepectives. Vol. 25, supplement, pp 522-529

Syawmpi, M. M., Liywali, K.J Mbala, and Syawmpi M. 2003. Country Analysis of Family Planning and HIV and AIDS. Zambia Policy Project

UNFPA, .1994. Program of Action of the International Conference on Population and Development. Cairo, Egypt

UNFPA, .1995. Fast Facts on Maternal Mortality and Mobidity. Geneva

UNFPA, .1995. Fast Facts on Maternal Mortality and Mobidity.Geneva

UNFPA, 1994. Report of the International Conference on Population and Development. New York

United Nations .1979.Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). UN Doc GAOR

United Nations, .1995. Beijing Declaration and the Platform for Action: Fourth World Conference on Women.Beijing China, Sept 4-15, UN Doc. A/CONF, Newyork, United Nations

United Nations, .2003. Centre for Reproductive Health Rights, Bringing Rights to Bear: An Advocates Guide to the UN Treaty Monitoring Bodies on Reproductive and Sexual Rights. Newyork; United Nations

United Nations. .1993. Declaration on the elimination of violence against women. 85th Plenary Meeting, A/RES/48/104. Geneva, Switzerland: United Nations General Assembly

Vavrus, F. and U. Larsen .2003. Girls' education and fertility transition: an analysis of recent trends in Tanzania and Uganda. Economic Development and Cultural Change, Vol. 51(4), pp. 945-76.

Wang, C.C., Viltinghoff,E., Hua WH., and Rong, Z.M., .1998. Reducing Pregnancy and Induced Abortion Rates in China: Family Planning with Husband Participation. America, Journal of Public Health. Vol, 88, No4

Westoff and Bankole A. (1995). Unmet Need: 1990-1994. *DHS Comparative Studies No. 16*.Calverton, Maryland, Macro International

World Health Organisation, .1996.Health Benefits of Family Planning, Geneva

World Health Organisation, .1996. Health Benefits of Family Planning, Geneva

World Health Organisation, .2006. Package for Community Volunteers. HIV Prevention, Treatment, Care, and Support, IFRC, SAFAIDS. Geneva

World Health Organisation, .2006. Package for Community Volunteers. HIV Prevention, Treatment, Care, and Support, IFRC, SAFAIDS

Wrong, .1965. Population and Society. Ramdam House Inc, USA

Zlidar, V.M., Gardner, R. Rutstein, S.O, Morris L, Goldberg Hj and John, K, .2000. New Survey Findings: The reproductive Revolution Continues. Population Reports, Series M No 17. Baltomore, The John Hopkings Blomberg School of Public Health, The information Project

Zulu and Chepngeno, G. .2003. Spousal communication about the risk of contracting HIV/AIDS in rural Malawi. Demographic Research, special collection 1, article 8.

Appendix 1

Time Frame

S/#	Activity	Period
1.	Selection and Approval of Research Topic	January, 2011
2.	Proposal Writing	May- June 2011
3.	Submission of Proposal	June, 2011
4.	Preparation of Research Instruments	July 2011
5.	Pilot Study	July 2011
6.	Review of Pilot Study and Corrections on Research Instruments	July- August 2011
7.	Main Data Collection	September- October 2011
8.	Data Sorting, presentation and analysis	October -December 2011
9.	Presentation of First Draft of Dissertation	January 2012
10.	Corrections and Submission of Second Draft of Dissertation	January 2012
11.	Submission of Final Copies of the Dissertation	October 2013

Appendix 2

Budget

s/#	Item/ Description	Quantity	Cost in Zambian Kwacha
1.	Stationery:		
	a. Toner Cartridge	02	1, 400, 000
	b. Reams of Paper	06	180, 000
	c. Pencils, pens, erasers		100, 000
	d. Photocopying		500, 000
	e. Note Books	06	100, 000
2.	Transport	60 Days	3, 000, 000
3.	Refreshments		1000, 000
4.	Flash disks	5 Respectively	500,000
5.	Contingency @ 10% of Budget		678 000
	Grand Total		ZMK 7,458,000

Key Informant Interview Guide

My name is _____. I 'am from the University of Zambia. We are carrying out a study on family planning to find out what factors influence men and women to use or not to use family planning in rural areas. We are interested in understanding your opinions on what people like yourself feel about family planning and what can be done to improve provision of family planning services for men and women in this community. We feel that talking to people like you can help us find the best practices, opinions and your feelings about these issues can enable us improve health service provision in this community. We would like to assure you that that the information you provide is very important and it will be treated with confidentiality. We will appreciate your participation and would like to find out if you would be willing to be part of the discussion? Would you take some time to answer a few questions? I will start by asking questions about you.

Background information (Section A)

Sex: Male ( ) Female ( )

Q No	Questions	Categories	Codes
Q1	How old are you?	15-19 20-24 25-29 30-34 35-39 40-44 45-49	1 2 3 4 5 6 7
Q2	What is the highest level of your education?	None Primary Secondary Tertiary	1 2 3 4
Q3	What is your marital status?	Currently Married Single	1 2

		Divorced Widowed	3 4
Q4a	Have ever heard of contraceptives?	Yes No (If No End)	1 2
Q4b	How did you get to hear about contraceptive method?		
Q5	Have you ever being involved in a sexual relationship?	Yes No (If No End)	1 2
Q6	Did you use any contraceptive method the first time you had sex?	Yes No	1 2
Q7	If Yes to Q6, what contraceptive method did you use with your first sexual partner?	1 .Combined pill 2. Mini pill 3. IUD 4. Male condom 5. Female condom 6. Diaphragm 7. Spermicides 8. Natural Family Planning 9. Male sterilization 11. Emergency contraception 12. Exclusive breast feeding 13. Other specify_____	1 2 3 4 5 6 7 8 9 10 11 12 13……
Q8	Are you currently using any contraceptive method?	Yes No	1 2
Q9	If yes to Q8, what contraceptive method are you currently using with	1 .Combined pill 2. Mini pill	1 2

	your sexual partner?	3. IUD 4. Male condom 5. Female condom 6. Diaphragm 7. Spermicides 8. Natural Family Planning 9. Male sterilization 11. Emergency contraception 12. Exclusive breast feeding 13. Other specify_____	3 4 5 6 7 8 9 10 11 12 13……

Section B

Family planning methods

I would now like to talk about family planning, the various methods that a couple can use to delay or avoid pregnancy

For methods not mentioned spontaneously, ASK: Have you ever heard of (Method)?

Circle code 1 in this section A for each method mentioned spontaneously. Then proceed down the section, reading the name and description of each method not mentioned spontaneously. Circle code one if method is recognized. Then, for each method with code 1 circled in section A, ask if the individual has ever used that method.

9.	Female Sterilization Women can have an operation to avoid having any more children.	Yes…..1 No……2	Have you ever had an operation to avoid having more children with your partner? Yes……1

			No…….2
10.	Male Sterilization Men can have an operation to avoid having any more children.	Yes…1 No…..2	Have you ever had a sexual partner who had an operation to avoid having any more children? Yes……1 No…….2
11.	PILL Women can take a pill every day to avoid becoming pregnant.	Yes……1 No……2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
12.	IUD Women can have a loop or coil placed inside them by a doctor or nurse.	Yes…….1 No……2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
13.	INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more years.	Yes…….1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
14.	IMPLANTS Women can have a several rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	Yes…….1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
15.	MALE CONDOM Men can put a rubber sheath on their penis before sexual intercourse.	Yes…1 No…..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
16.	FEMALE CONDOM Women can place a plastic sheath in their vagina before sexual intercourse.	Yes……1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
17.	DIAPHRAGM	Yes……1 No…….2	Have you ever used this method with your sexual partner? Yes…….1

			No……..2
18.	LACTATIONAL AMENORRHEA METHOD (LAM) Up to 6 months after childbirth, after birth a woman can use a method that requires she breast feeds frequently, day and night, and that her menstrual periods has not returned.	Yes……1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
19.	Rhythm METHOD Every month that a woman is sexually active she can avoid having sex by not having sexual intercourse on the days of the month she is mostly likely to get pregnant	Yes……1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
20.	WITHDRAWAL Men can be careful and pull out before climax	Yes……1 No……..2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
21.	EMERGENCY CONTRACEPTION As an emergency measure after unprotected sexual intercourse, women can take special pills at any time within five days to prevent pregnancy.	Yes……1 No……2	Have you ever used this method with your sexual partner? Yes…….1 No……..2
22.	Standard Day Method A woman's monthly cycle is monitored using beads to check for the fertile window, which is several days before ovulation and a few hours after.	Yes……1 No……2	Have you ever used this method with your sexual partner? Yes…….1 No……..2

Section C: Service Provision and Availability of Contraceptives

23.	Do you know of a place where you can obtain a method for family planning?	Yes…….1 No……..2	
24.	If yes to Q19, Where is that? Probe to identify each source and circle appropriate code(s) If unable to determine if Hospital, Health centre's or Clinic is public or private medical write the name of the place.	Public sector GOVT. Hospital…….1 GOVT. Health Centre….2 Family Planning Clinic….3 Mobile Clinic……4	

		Other Public…….. Specify Private Medical Sector Private Hospital/Clinic…..5 Mission Hospital/Clinic….6 Pharmacy……7 Private doctor……..…..8 Community Work Place….9 Work place…….10 Mobile clinic……..…11 Fieldworker……12 Other private medical……..13 Other source Shop……..…14 Church…….15 Friend /Relative……...16 Other specify……..…..17	
25.	Have ever experienced a situation where you were unable to access contraceptives? (Probe for details, if yes, ask, what happened)		
26.	If yes to Q21, how long were contraceptives out of stock? (Probe for details: what lead to the shortage? Expensive?)		
27.	Have you ever experienced a contraceptive challenge and no one could help you due to lack of experts? (Probe for details: When? how were you helped?)		
28.	How would you rate the altitude of health providers towards you as you seek contraceptives?	1. Good 2. Fair 3. Poor	
29.	In your view, what would you comment about the availability of contraceptives in this district?		
	Section D: Cultural Beliefs and Practices		

30.	What are the traditional beliefs and practices held in this district concerning fertility regulation?		
31.	Do people in this district practice these traditions? (Probe: what, why, why not)		
32.	What are the common sayings that encourage women and men to have more children? (Probe: Mention them)		
33.	What are tradition methods that are recommended to increase or reduce births?		
34.	Who determines how many children a couple should have?		
35	How many children would you like to have?	Less than 3 Between 3 and 5 Between 5 and 7 Between 7 and 9 More than 9	1 2 3 4 5
35.	What are the possible measures that would increase contraceptive uptake in this district?		

Thanks for your cooperation