

**A STUDY TO DETERMINE KNOWLEDGE AND
PRACTICES OF FAMILY PLANNING
AMONG WOMEN OF NANGOMA
MUMBWA DISTRICT**

BY

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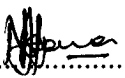
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DECLARATION

I hereby declare that this work presented in this study for the degree of Bachelor of Science in Nursing has not been presented wholly or in part for any other degree or is not being currently submitted for any other degree.

Signed: 

CANDIDATE

Approved By:  Dec '96

SUPERVISING LECTURER

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the paper and in the references.

Signed: Alma

DEDICATION

To my loving and caring husband Oliver Hazemba,
my children Chilobe and Malonga, my parents
Mr and Mrs Ngoma.

"For all things I have the strength by
virtue of him who imparts power
to me"

(Phillipians 4:13)

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ABSTRACT

OBJECTIVE

The aim of the study was to determine knowledge and use of Family Planning among women of Nangoma in Mumbwa District.

DESIGN

A descriptive study was conducted using a structured interview schedule.

SETTING

The study was conducted at Nangoma Mission Health Centre in Mumbwa District. The centre caters for a population of 34,000, majority are women and children.

SUBJECTS

Respondents were women in the reproductive age range of 15-45 years who consented to the interview.

RESULTS

The results show that 44% of women desire to have between 5 and 9 children. 50% of women interviewed have no knowledge on how to regulate the desired number of children.

50% of women have no idea about family planning. Only 18% have practiced family planning before. Out of 82% of the women who have never practiced family planning before 56% attributed it to lack of adequate information and 26% fear complications.

The researcher attributed the low levels of knowledge to source of family planning information. 30% of the women heard about family planning from friends and family members, 44% had no source at all and only 26% were taught by health workers.

CONCLUSION

The findings of this study show that the majority of women lack adequate information on family planning. This has led to non-utilization of the available family planning methods.

1.0 INTRODUCTION

1.1. BACKGROUND INFORMATION

The link between family planning and the health of women has been recognised by many researchers for many decades. The knowledge of this link has been used to initiate and improve family planning programmes. Family planning is the process by which families, couples or individuals decide how they will regulate their reproduction and take necessary action to do so.¹ Family planning aims include control of birth rate in line with the economic capabilities of bringing up the child, education, job opportunities and not merely the amount of arable land.² Family Planning is a voluntary decision. Any attempt to limit people's choice must be considered unethical and ultimately harmful to the community.

It is universally accepted that Family Planning services are essential to promote birth spacing, and to reduce both maternal and infant mortality rate. It has been estimated that if family planning services were more widely available, up to 42% of maternal deaths could be averted in developing countries. The world fertility survey showed that use of family planning varied widely from 69% South East Asia to 11% Africa.³ The survey revealed that approximately 300 million couples in the reproductive age range were not using methods of contraception. These figures indicate a significant unmet need for family planning.

Apparently, modern family planning services have not been readily accepted by many people and have been faced with apathy among intended users. In 1990 the United Nations Population Fund (UNFPA) estimated that the fertility rate among women in developing countries was 3.8 births per woman and that contraception use was 51%.⁴ In Zambia the population growth rate which is at 3.7% per annum has become an important problem in economic and social development and the government has established policies to try and slow down the rate of population increase. The main targets of National Population Policy are:-

1. To reduce population growth rate from 3.7 per annum by the year 2000 and 2.5 by the year 2015.
2. To reduce the total fertility rate from 7.2 at present to 6 by the year 2000 and 4 by the year 2015.
3. To reduce the infant mortality rate from 107/1000 live births to 65/1000 live births by the year 2000 and 50/1000 by 2015; and
4. To make family planning services available by at least 30% of all adults in need of such services by the year 2000.⁵

The strategies for implementing Zambia National Population Policy emphasises on voluntary acceptance of family planning methods in accordance with fundamental human rights. The government has established ways of achieving the targets of the national population policy. They include some of the following.

1. Formulation of Family Planning Programmes
2. Promoting awareness among all the people of Zambia about the national population dynamics and of the adverse effects of rapid population growth.
3. Intensifying Primary Health Care programmes (PHC) especially Maternal and Child Health (MCH) so as to reduce the levels of infant, child and maternal mortality.
4. Expansion of family life education to schools and prepare young ones for parenthood.
5. Training the national experts in health, family planning, statistics, education and other related areas.⁵

In 1979 the government initiated training programmes for health workers in order to equip them with family health issues. The government priority was to make family planning services available, accessible, affordable by 30% by the year 2000. The services are available to all regardless of their social status.⁶ This is very important because lack of family planning services has adverse effects on the family as a whole. At any given time a woman is either nursing a small baby or she is pregnant. This puts increasing pressure

on the bread winner who has to fend for a large family.

The task of providing family planning services has been a responsibility of the government and non governmental organisations (NGOs). The later include Family Life Movement of Zambia (FLMZ 1981); Planned Parenthood of Zambia PPAZ 1972); Makeni Ecumenical Centre; Pharmaceutical Society of Zambia; United Nations Population Fund (UNFPA) all of whom share common goals on family planning.

Nangoma is located 110km from Lusaka along Lusaka Mongu road. The people of Nangoma access professional health care from Nangoma Mission Rural Health Centre established in 1987 and started operating in 1993. The centre is run by Roman Catholic Jesuits who promote Natural Family Planning (NFP) methods. The Jesuits find the artificial family planning methods unacceptable.

Lack of education is a hinderance to utilization of family planning services. Maldin (1979) stated that "Lack of familiarity with the characteristics of a product, how it will be used, what the associated side effects are, are barriers to the adoption of all new products including contraceptives."⁶ Knowledge of where to get the services is another important issue that can influence contraceptive use. Women of Nangoma are supposed to get artificial family planning methods from Mumbwa District Hospital, Zambia Airforce clinic and Kapyanga Rural Health Centre. It takes a well informed woman to walk long distances to get contraceptives.

Edmand's study of low income families and their utilization of family planning services found out that most people desired a limited number of children, but that there was a wide disparity between the desire to limit family size and the knowledge to do so.⁷ This shows how important knowledge is on family planning. Women, therefore have the right

to all relevant information on family planning aspects in order for them to appreciate its benefits and importance.

Wide spread and intelligent fertility control can contribute to the realisation of national goals and policies. All Zambians, regardless of their ethnic background and socio-economic status should participate in population control. This study therefore, strives to determine how much knowledge the women of Nangoma have on family planning in order for them to participate in population control and improvement of their own health status.

1.2 **STATEMENT OF THE PROBLEM**

Zambia is one of the world's developing countries that has a population that grows at an alarming rate of 3.7%. At independence in 1964, Zambia's population was at 4.0 million. Twenty six years later, it grew to 8.4 million.⁸ Despite this population growth, family planning services are still underutilized according to available literature.

Unlike in rural areas, women in the urban areas have access to family planning services because they are available in all urban clinics. In Lusaka Urban for instance, there are twelve (12) clinics other than University Teaching Hospital (UTH) that offer Family Planning services. Monde Luhanga conducted a study in 1990 on "why women fail to utilize family planning services in Lusaka Urban".⁹ She concluded that despite their availability, Family Planning services were still underutilized because women lacked adequate knowledge about their existence and utilization.

Knowledge of family planning and the availability of the service are both important to ensure optimum use of contraception. This study strives to determine how much knowledge the women of Nangoma have on Family Planning aspects in order for them to participate in population control.

Nangoma Rural Health Centre caters for a population of 34,000, majority are women and children.

Natural Family Planning (NFP) are the only methods promoted and provided at the centre. These methods need to be properly taught, learnt and implemented. The service is however inconsistent because there is only one teacher or counsellor who is based at Mumbwa District Hospital. This has led to poor follow up of users causing an increase in failure rates. Since artificial family planning methods are not offered it is questionable as to how much knowledge the women of Nangoma have on Family Planning methods for them to practice.

When family planning methods fail or are not utilized women and children suffer most. Frequent and unplanned pregnancies may place a great strain upon the mother's health and vitality especially for those on marginal incomes or with already ill health. According to results from 1976 National Survey of Family Growth, an estimated 8.1 million or 12% of a total of 67.8 million live births occurring to mothers were unwanted in the United States of America.¹ When there are too many children in a home the few resources may not be adequate to share. This leads to malnutrition and lack of education for the children. The father on the other hand is confronted with a problem of providing for a large family. The community and the nation at large are confronted with a possible population explosion. The few socio-economic and other resources cannot cope with such a situation.

It has been observed that the fertility rate among women of Nangoma is high although it is claimed that they attend natural family planning clinic. It has also been noted that these women do not utilize the nearest health centres where they offer all the family planning methods. The researcher alludes to the following contributing factors to this problem.

Socio-cultural beliefs like religious background and upbringing influence acceptance of information on artificial family planning methods. For example when a woman strongly believes that preventing pregnancy by use of artificial family planning methods is sin it is difficult to convince her other wise.

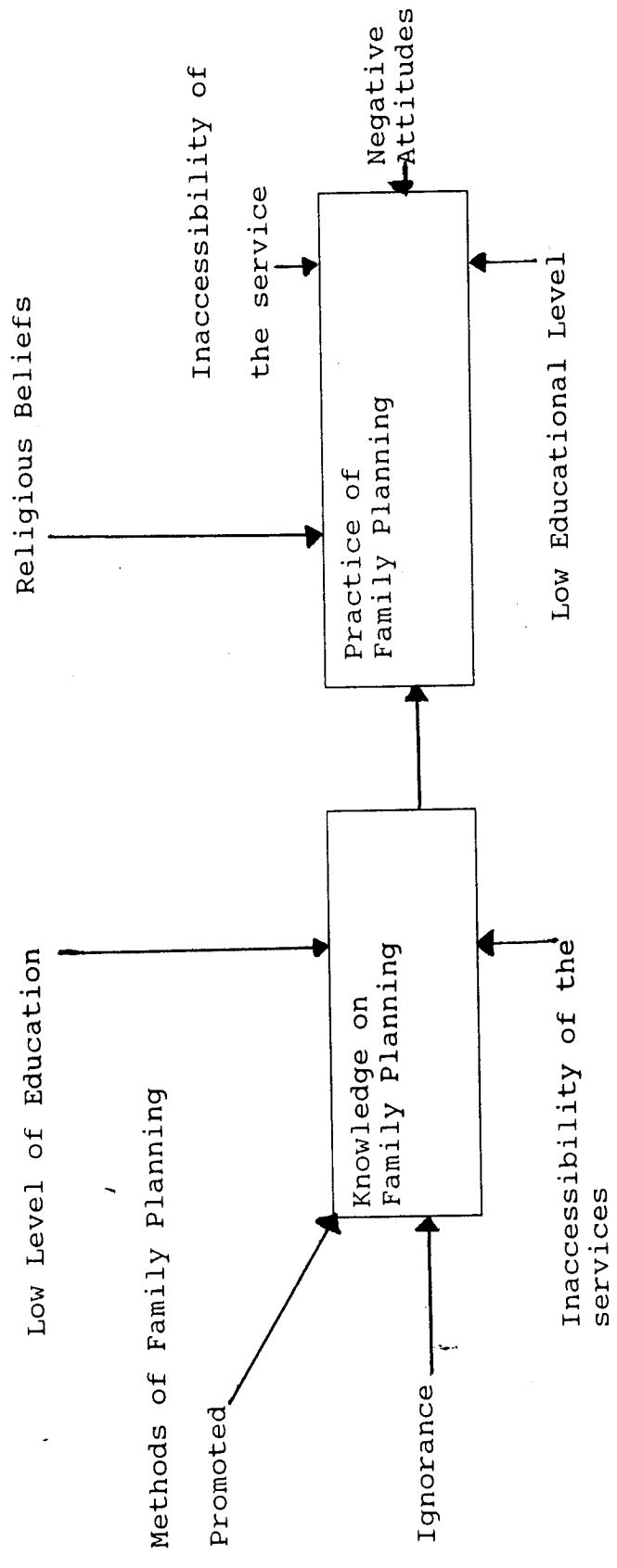
Educational level plays an important role in acceptability and utilization of family planning methods. The more educated a woman is the more perceptive she becomes to health messages. If women of Nangoma were more enlightened they would be able to appreciate the benefits of other forms of family planning. Some woman on the other hand have acquired basic education but are ignorant about family planning issues and this makes it difficult for them to make a choice.

Members of the health team do not conduct outreach activities on a regular basis where family planning services could be integrated with children's clinic and antenatal clinic. Various methods of family planning could be introduced to women during clinic sessions for them to make a choice.

The findings of this study may help to institute programmes to effectively disseminate information on family planning among women of Nangoma. The results may also help to reinforce the already existing programmes to increase their activities. Such programmes include health education campaign; training of Traditional Birth Attendant (TBA), training of Community Health Workers (CHW) and outreach programmes. Mumbwa District management team together with the catholic community may work hand in hand to train more natural family planning (NFP) advisors to ensure effective education and follow up of users. This will reduce failure rates among women who make use of natural family planning methods. A reduction in failure rates will lead to manageable family sizes and a reduction in the population growth rate.

DIAGRAM SHOWING POSSIBLE CONTRIBUTING FACTORS TO ACQUISITION OF

KNOWLEDGE AND PRACTICE OF FAMILY PLANNING



1.3 **OBJECTIVES**

GENERAL

1. To determine knowledge and use of family planning among women of Nangoma.

SPECIFIC

1. To find out whether women know family planning
2. To assess whether women know about the availability of family planning services.
3. To assess utilization of the available family planning services
4. To assess whether women know the benefits of family planning.
5. To determine the inhibiting factors to family planning utilization.

1.4 **STATEMENT OF HYPOTHESES**

1. Knowledge of family planning determines utilization of family planning methods.
2. Level of education determines acquisition of knowledge on family planning and utilization.
3. Adequate knowledge on family planning is dependent on the source.

5. **DEFINITION OF TERMS**

1. **Family Planning** is the process by which families, couples, or sometimes individuals decide how they will regulate their reproductive health and take necessary action to do so.

2. **Family Planning Service**

Any service provided for the purpose of family planning as defined by WHO.

3. **Natural Family Planning**

Natural Family Planning is a way of life freely chosen by a couple who decide to achieve or avoid pregnancy through selective intercourse as appropriate during the fertile and infertile phases of their fertility cycle.¹⁰

4. **Contraception**

Way of preventing pregnancy by methods other than abstinence.

5. **Knowledge**

Awareness of something.

CHAPTER TWO

2.1 LITERATURE REVIEW

Uncontrolled growth of the population has been recognised as an important and world wide problem with serious social, health and economic implications. In the third world, population control maybe required for survival. The growing number of the people to be fed and provided with other basic necessities may outrun a country's production capabilities, or exceed the amount that could be met with substantial international aid. Poverty, short life span, lack of employment, sub standard health and low levels of energy are the usual accompaniments of serious over populations.¹

Superficially this may seem to have an effect on WOMEN, but the truth of the matter is that even MEN are because they have to fend for a large family. Family Planning is the first line strategy to reduce unwanted pregnancies. Family Planning is having children at the time the family wants them. The aims of family planning include control of birth rate in line with family and community's economic capabilities of child upbringing and offering education, job opportunities and not merely the amount of arable land.²

Family Planning Programmes must therefore be accessible to all women regardless of their marital status and socio-economic status.

The link between Family Planning and the Health of women has been recognised by many researchers for many decades.

Studies that have been done show that there is no doubt that the world is in a transition socially and demographically. We are on the way to creating a world in which mankind's success in reducing death rates is matched by a move towards fewer, healthier planned births.¹¹

"such a world will be one in which women everywhere have a right to control their fertility."¹¹

The world is also going to be one in which reproductive health will be a matter of universal care and concern. Hopefully it will be a world where the commitment to future generations will be matched by the concern that all children are wanted, as seen by the government's support for Family Planning Programmes.

In reality the challenges of population control are even greater since most of those practising contraception in the developing world are not well served with a choice of the most suitable and reliable methods. The concept of family planning is an old one. It has been used in traditional society through traditional methods.

The methods used include coitus interruptus, Rhythm, abstinence where a women who had just given birth went away to live with her parents for as long as two years, and breast feeding.¹²

Pregnancy related deaths, which kill at least 202/100,000 live births women each year in Zambia, have been neglected because those who suffer from them are in actual fact neglected people. They are people with least power and influence over public resources expenditure. These are the poor, rural peasants and above all WOMEN.¹¹ Pregnancy related deaths can be reduced by Family Planning. The women who need it most are either ignorant about it or cannot access the services. The risks of not accessing family planning services can be viewed as a chain ranging from adolescent pregnancy, maternal depletion from closely spaced pregnancies, the burden of heavy physical labour in the reproductive period, the renewed risk of child bearing after age 35 and worse after 40, and throughout these years the ghastly dangers of illegal abortions to which women may be driven in sheer desperation. All these are links from which only menopause or the grave offer the hope of escape HOPE THAT COULD BE REALISED BY FAMILY PLANNING.¹¹ All women regardless of their nationality, creed, religion, socio-economic status suffer the same problems related to child bearing.

In Zambia the population has been growing alarmingly at the rate of 3.7% per year. This rapid population growth rate has had an adverse effect on the socio-

economic activity of this young nation with most of its real economic growth at 0.6% per year.¹⁴

Under no circumstances is a healthy economic development possible when there is a big gap between the rate of population and economic growth. Where possible the two rates should be equal or even better still the economic growth should surpass population growth. When economic growth is not favourable women suffer most because they cannot cope with repeated pregnancies and low nutritional levels. All these problems could be reduced by proper utilization of family planning services by all women in the reproductive age group. Lack of Family Planning has already depleted the available resources in the communities such as, schools and recreational facilities and will continue to do so if the present yearly birth rate of 3.7% is not controlled.¹³

The International Planned Parenthood Federation (IPPF) believe it is a fundamental human right for people to receive family planning advice in order for them to have the number of children they want, bearing in mind their responsibility to the community in which they live and to society as a whole.

In an attempt to control fertility, health authorities are trying to determine reasons

affecting the achievement of the aim of family planning which is to assist families to have children at the time that they want them. Studies have been conducted to determine attitudes towards family planning. One such study was done in California on the attitudes of married students towards over population and family planning by Darney (1970). The findings revealed that subjects had a positive attitude towards family planning, an indication that family planning is a desire of most women.

Religious denomination influence the choice of family planning methods. Most religions agree that family planning is necessary, good and proper, indeed under certain circumstances there is an obligation to plan the number of children in family. Roman Catholics for instance agree with the idea of family planning, although they find only certain methods acceptable. However, McDonald (1982) does not subscribe to this idea. She found religious beliefs to have little effect on the use of family planning among women in Zimbabwe.¹⁵

Social economic status is another factor that may affect utilization of family planning services. Families with low or no income at all face a lot of financial problems not to mention undernourishment.

Information is power. It is perhaps the most powerful tool available to people, one that opens up new possibilities for the exercise of both rights and responsibilities.

"Information is the key to understanding and coping with change. It is the basis for enhanced self awareness, empowering individuals to exert more control of their own lives."¹⁶

Information, Education and Communication (IEC) on family planing opens up the minds of not only women but men as well. The goals of IEC include:-

- i. "To enhance the ability of couples and individuals to exercise their basic right to decide freely and reasonably on the number and spacing of their children."
- ii. "To raise awareness and understanding about the relevance of population related issues to all levels of decision making whether personal, national or international."¹⁷

Access to family planning information is empowering and enables individuals to better understand and participate more effectively in the decision making process in their families. Some men often want to have bigger families than women do yet it is women's health that is put at risk by mistimed and unwanted pregnancies. Recent research in Nigeria shows that decision to have another child is more often than not made by the man rather than by the woman.¹⁸ Sometimes couples may come under pressure from the husband's mother or other female relatives into starting or increasing their family.

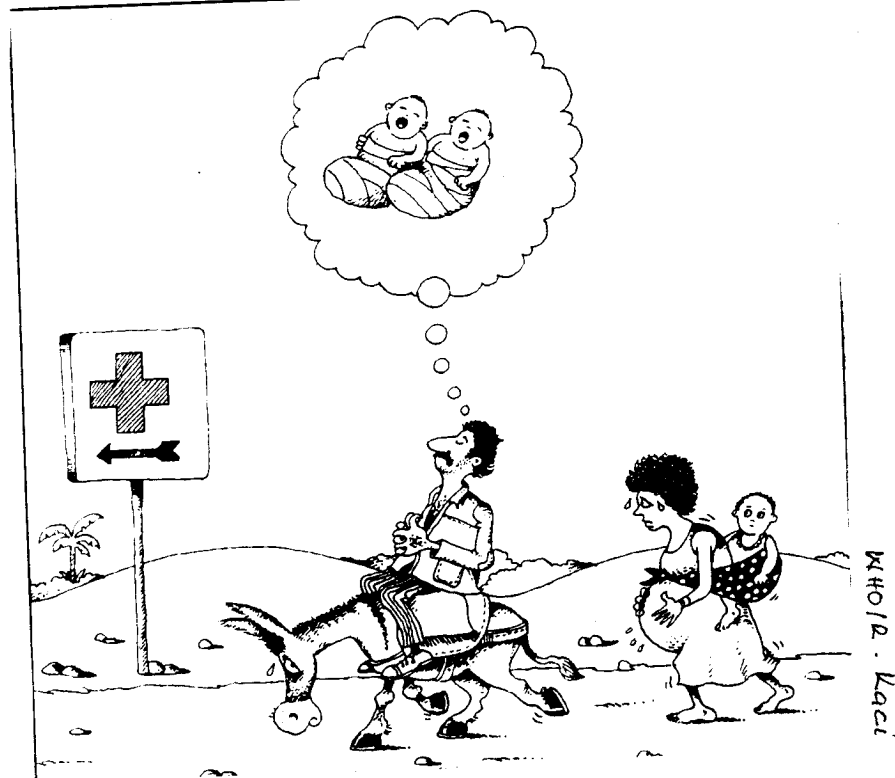


Figure 1

Who decides the family size

Adequate knowledge of the available contraceptive methods ensures better acceptability, continuity and satisfaction and lower failure rates of those methods. A study conducted in 1993 in Brussels among 114 women attending three family planning clinics revealed that many had misconceptions on family planning, believed in false rumours and had considerable insufficient knowledge on various family planning methods.¹⁹ Another study conducted in Cambodia by Kulig J.C in 1995 on "Family Planing knowledge and use" revealed that women lacked knowledge on Family Planning methods, their usage and side effects.²⁰

In order to increase women's ability to correctly use family planning methods, so as to lower unwanted pregnancies, efforts should be made by Health Practitioners as well as by mass media and teaching institutions to disseminate information on Family Planning.

In Zambia Family Planning has been a national priority since 1989, when the effects of economic decline and the rising population prompted government action. Lately people are starting to recognise the health benefits of child spacing and feel the economic pressure of a large family. It has been recognised that there has been a significant gap between awareness and use of family planning which calls for more studies to be conducted on knowledge, attitudes and practices to understand why people are under utilizing the existing services.

In institutions where artificial family planning methods are not promoted (mission hospitals) adequate knowledge on the existing methods is important. Successful incorporation of Natural Family Planning within Zambia's service delivery programme is necessary but will require fundamental changes in the way such services are offered. First 'knowledge' and responsibility for training should be for all health workers unlike the present monopoly of the selected few. This is because Natural Family Planning calls for adequate dissemination of information and follow up of users. This is to ensure reduced failure rates. Women should access family planning services, which will increase utilization and subsequently reduce poverty and improve health of individuals especially women.

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

A descriptive study was used in this research. Data was systematically collected and presented in order to give a clear picture of the factors that determine knowledge and use of family planning by women of Nangoma in Mumbwa District. The study was qualitative in that data collected was quantified in numerical values and percentages for easy interpretation and making inferences.

3.2 RESEARCH SETTING

The study was conducted in Nangoma from 29th July to 2nd August 1996. Nangoma has a population of approximately 34,000 people, the majority are women and children. The centre is located 110 kilometres along Lusaka - Mongu road. the majority of women have attained primary education and a few have secondary education. The researcher chose Nangoma because it offers an ideal rural setting.

3.3 **STUDY POPULATION**

The study population comprised of women in the reproductive age range of 15-45 years living within 16km radius to Nangoma mission Health Centre. The sample was chosen from women who had been attending children's clinic from July 1995 to January 1996, whose children were aged between few weeks and two (2) years. These women were ideal because they were expected to be knowledgeable on family planning issues and practices seeing that their children still needed their attention. The total study population was 428.

3.4 **SAMPLE SIZE**

The total number of women that had been attending children's clinic was 428 according to the clinic register. 95 attended the clinic between the 29th of July and 2nd August 1996, out of whom 50 (22.2%) were interviewed.

3.5 **SAMPLING METHOD**

All the women attending children's clinic were asked to pick a number randomly from a box. Those that picked numbers from one (1) to fifty (50) were interviewed. This gave each subject a chance of 1:2 of being included in the sample.

This method was used to reduce bias. It also ensured accessibility to the study population based on feasibility on time, and costs.

3.6 **DATA COLLECTION TECHNIQUE**

Data was collected using a structured interview schedule. Face to face interviews were conducted because of various reasons. Some of which are the following:

- i. Structured interviews use a script and set questions for the interview.
- ii. The interviewer is allowed to clarify the questions or answers and device individualised probes.
- iii. Women who cannot read and write could still be interviewed.
- iv. The researcher has an opportunity to read non verbal messages.
- v. Structural interviews are a relatively simple method of obtaining data.
- vi. Analysis and interpretation of data can be easily accomplished.

3.7 **ETHICAL CONSIDERATIONS**

In order to conduct the study in Nangoma the researcher sought for permission from Father Rozman who is Incharge of the Mission Health Centre.

The purpose and nature of the study was explained as well as how the findings were to be used.

Prior to the interview the respondents were asked as to whether they would accept to be interviewed or not and were assured of confidentiality.

3.8 **PILOT STUDY**

A pilot study was conducted in Mtendere compound to pretest and assess the validity of the data collection tool. Ten (10) subjects were selected for the study so as to be able to assess the reactions of the respondents to the research procedure. Time needed for the study was estimated. Feasibility of the sampling procedure was assessed as well as the appropriateness of the format of the questionnaire.

A few amendments were made to the questionnaire and four (4) questions were omitted because of their unsuitability to the study. Two (2) more questions were instead included.

CHAPTER FOUR

4.0 DATE ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Following collection of data from Nangoma each questionnaire was checked for accuracy and completeness. Data from open ended questions were categorised and then coded. Then data was put on a data master sheet for easy analysis manually. This made it easy to draw frequency and cross tabulations for conclusions on the variables and objectives of the study.

4.2 **PRESENTATION OF FINDINGS**

TABLE I

n = 50

RESPONDENTS' AGE GROUPS

AGE GROUP	RESPONDENTS
15-19	11 (22%)
20-24	20 (40%)
25-29	6 (12%)
30-34	7 (14%)
35-39	4 (8%)
40-44	2 (4%)
TOTAL	50 (100%)

Table I shows that the majority of the respondents (40%) were aged between 20-24 years, 8% between 35-39 and 4% between 40-44 years.

Mean age = 24.9 years

TABLE II

n = 50

RESPONDENTS' MARITAL STATUS

MARITAL STATUS	RESPONDENTS
SINGLE	8 (16%)
MARRIED	41 (82%)
DIVORCED	1 (2%)
TOTAL	50 (100%)

Table II shows that 82% were married and 16% were single

TABLE III

RESPONDENTS' RELIGIOUS AFFILIATION

RELIGION	FREQUENCY/PERCENTAGE
NEW APOSTOLIC	23 (46%)
ROMAN CATHOLIC	13 (26%)
SEVENTH DAY ADVENTIST	14 (28%)
TOTAL	50 (100%)

Table III shows that only 26% of respondents are Catholics with the majority being New Apostolic (46%)

Table IV

n = 50

RESPONDENTS' LEVEL OF EDUCATION

EDUCATIONAL LEVEL	FREQUENCY/PERCENTAGE
NONE	3 (6%)
PRIMARY	32 (64%)
SECONDARY	15 (30%)
TOTAL	50 (100%)

Table IV shows that 6% have never been to school, 64% have primary education 30% have secondary education.

TABLE V

RESPONDENTS' NUMBER OF PREGNANCIES

NUMBER OF PREGNANCY	FREQUENCY/PERCENTAGE
1-5	42 (84%)
6-10	6 (12%)
11-15	2 (4%)
TOTAL	50 (100%)

Table V shows that 84% have had between 1-5 pregnancies, 12% between 6-10 and 4%, 11-15 pregnancies.

n = 50

RESPONDENTS' DESIRED NUMBER OF CHILDREN

DESIRED NUMBER OF CHILDREN	FREQUENCY/PERCENTAGE
	14 (28%)
	22 (44%)
14	14 (28%)
TOTAL	50 (100%)

As regards the desired number of children Table VI shows that 44% desire to have between 5 and 9 children.

TABLE VII

RESPONDENTS' KNOWLEDGE ON HOW TO REGULATE THE NUMBER OF CHILDREN

HOW TO REGULATE THE NUMBER OF CHILDREN	FREQUENCY/PERCENTAGE
USE OF FAMILY PLANNING	16 (32%)
CONSULTING HEALTH WORKERS	3 (6%)
ABSTINENCE	2 (4%)
USE OF TRADITIONAL MEDICINE	4 (8%)
NO IDEA	25 (50%)
TOTALS	50 (100%)

Table VII shows that 50% of the respondents had no idea on how to regulate number of children and 32% said they would

TABLE VIII

RESPONDENTS' KNOWLEDGE OF FAMILY PLANNING

DEFINITION OF FAMILY PLANNING	FREQUENCY/PERCENTAGE
WAY OF HAVING CHILDREN ONE CAN SUPPORT	8 (16%)
CHILD SPACING	17 (34%)
NO IDEA	25 (50%)
TOTAL	50 (100%)

Table VIII shows that 50% of the respondents could not define Family Planning.

TABLE VIII

RESPONDENTS' KNOWLEDGE OF FAMILY PLANNING

DEFINITION OF FAMILY PLANNING	FREQUENCY/PERCENTAGE
WAY OF HAVING CHILDREN ONE CAN SUPPORT	8 (16%)
CHILD SPACING	17 (34%)
NO IDEA	25 (50%)
TOTAL	50 (100%)

Table VIII shows that 50% of the respondents could not define Family Planning.

TABLE IX

RESPONDENTS SOURCE OF FAMILY PLANNING INFORMATION

SOURCE OF INFORMATION	FREQUENCY/PERCENTAGE
FRIENDS	8 (16%)
FAMILY	7 (14%)
HEALTH WORKERS	13 (26%)
NONE	22 (44%)
TOTAL	50 (100%)

Table IX shows that the majority (44%) of the respondents had no source of information on Family Planning. Only 26% had health workers as sources of family planning information while 30% got it from family members and friends.

TABLE X

RESPONDENTS' FAMILY PLANNING UTILIZATION

PRACTICE OF FAMILY PLANNING	FREQUENCY/PERCENTAGE
YES	9 (18%)
NO	41 (82%)
TOTALS	50 (100%)

Table X shows that only 18% of the respondents have used Family Planning methods before and 82% have never.

TABLE XI

**RESPONDENTS' REASONS FOR NON UTILIZATION OF
FAMILY PLANNING SERVICES**

REASONS	FREQUENCIES/PERCENTAGE
LACK OF ADEQUATE INFORMATION	28 (56%)
FEAR OF DEVELOPING COMPLICATIONS	10 (20%)
USE TRADITIONAL METHODS	3 (6%)
TOTALS	41 (82%)

As regards reasons for non utilization of Family Planning services Table XI shows that 56% lack adequate information about its availability, 20% fear complications and 6% use traditional family planning methods.

TABLE XII

**RESPONDENTS' KNOWLEDGE ON THE AVAILABILITY OF
FAMILY PLANNING SERVICES**

RESPONSES	FREQUENCIES/PERCENTAGE
YES	16 (32%)
NO	34 (68%)
TOTAL	50 (100%)

Table XII shows that 68% of the women do not know about the availability of family planning services and 32% do.

TABLE XIII

**RESPONDENTS' KNOWLEDGE OF THE AVAILABLE FAMILY
PLANNING METHODS**

FAMILY PLANNING METHOD	FREQUENCIES/PERCENTAGE
NATURAL FAMILY PLANNING METHOD	3 (6%)
NO IDEA	47 (94%)
TOTAL	50 (100%)

Table XIII shows that 6% of the respondents knew that Natural Family Planning method are offered at the centre while 94% had no idea at all.

TABLE XIV

**REASONS FOR NON UTILIZATION OF NATURAL FAMILY PLANNING
METHODS**

REASONS	FREQUENCY/PERCENTAGE
LACK OF INFORMATION	2 (4%)
DIFFICULT TO LEARN AND LACK OF FOLLOW UP	1 (2%)
TOTAL	3 (6%)

Table XIV shows that 4% of the respondents lacked adequate information on Natural Family Planning methods while 2% said it is difficult to learn and lack of follow up.

TABLE XV

RESPONDENTS' FAMILY PLANNING METHODS USED

FAMILY PLANNING METHOD	FREQUENCY/PERCENTAGE
CONTRACEPTIVE PILLS	4 (8%)
CONDOM	2 (4%)
TRADITIONAL MEDICINE	3 (6%)
NATURAL FAMILY PLANNING METHODS	NIL
TOTALS	9 (18%)

Table XV shows that out of 18% of the respondents that have practiced family planning before 8% used contraceptive pills, 4% condoms and 6% traditional methods. None of them used Natural Family Planning which is promoted at the centre.

TABLE XVI

RESPONDENTS' EDUCATIONAL LEVEL IN RELATION TO
FAMILY PLANNING PRACTICE

EDUCATIONAL LEVEL	FREQUENCIES/ %	PRACTICE	NON-PRACTICE
NONE	3 (6%)	NIL	3 (6%)
PRIMARY	32 (64%)	2 (4%)	30 (60%)
SECONDARY	15 (30%)	7 (14%)	8 (16%)
TOTAL	50 (100%)	9 (18%)	41 (82%)

Table XVI shows that out of the 6% of the respondents that have never been to school none of them has practiced family planning before. 64% of those that have attained primary education only 4% have practiced family planning. Those that have attained secondary education 16% have practiced Family Planning before.

TABLE XVII

RESPONDENTS' KNOWLEDGE OF FAMILY PLANNING IN
RELATION TO PRACTICE

KNOWLEDGE OF FAMILY PLANNING	FREQUENCIES/ PERCENTAGE	PRACTICE	NON-USAGE
CHILD SPACING	17 (34%)	7 (14%)	10 (20%)
HAVING CHILDREN ONE CAN SUPPORT	8 (16%)	2 (4%)	6 (12%)
NO IDEA	25 (50%)	NIL	25 (50%)
TOTAL	50 (100%)	9 (18%)	41 (82%)

Table XVII shows that the respondents who lacked knowledge of family planning have never practiced family planning.

TABLE XVIII

RESPONDENTS' KNOWLEDGE ON FAMILY PLANNING**IN RELATION TO SOURCE OF INFORMATION**

SOURCE	FREQUENCIES/ PERCENTAGE	CHILD SPACING	HAVING A NUMBER OF CHILDREN ONE CAN SUPPORT	NO IDEA
FRIENDS	8 (16%)	4 (8%)	NIL	4 (8%)
FAMILY	7 (14%)	1 (2%)	5 (10%)	1 (2%)
HEALTH WORKER	13 (26%)	10 (20%)	3 (6%)	NIL
NONE	22 (44%)	2 (4%)	NIL	20 (40%)
TOTAL	50 (100%)	17 (34%)	8 (16%)	25 (50%)

Table XVIII shows that none of the 26% of the respondents who got their family planning information from health workers lacked knowledge on Family Planning. As for the 44% who have never heard of family planning before none of them could explain what it is.

TABLE XIX

RESPONDENTS' KNOWLEDGE OF FAMILY PLANNING
IN RELATION TO LEVEL OF EDUCATION

LEVEL OF EDUCATION	FREQUENCY/ PERCENTAGE	CHILD SPACING	HAVING A <u>NO.</u> OF CHILDREN ONE CAN SUPPORT	NO IDEA
NONE	3 (6%)	2 (4%)	NIL	1 (2%)
PRIMARY	32 (64%)	10 (20%)	5 (10%)	17 (34%)
SECONDAR Y	15 (30%)	5 (10%)	3 (6%)	7 (14%)
TOTAL	50 (100%)	17 (34%)	8 (16%)	25 (50%)

Table XIX shows that 16% of the respondents who have secondary education know family planning. 34% of those with primary education do not know family planning.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The results of this study are based on the analysis of responses from fifty (50) women who were included in the sample. The aim of the study was to determine knowledge and practice of Family Planning among women of Nangoma in Mumbwa District. The study was of concern because family planning saves lives in four (4) ways which are, delay of the first birth, spacing of births by at least two (2) years, avoiding too many pregnancies and stop births on time.¹⁷

5.2 DISCUSSION OF FINDINGS

All the respondents were women in the age group of 15-45 years. Table 1 shows that the majority of the respondents were aged between 20-24 (40%). This indicates that the majority of the respondents were in the prime age group for child bearing. These women are in a vulnerable group in that they are young thus the need for provision of family planning services in the area for them to participate in population control.

The majority of the respondents (82%) were married. In many Zambian cultures marriage is valued as a source of pride for couples with girl children. This explains why a bigger percentage of women are married according to Table II.

Table III shows that 26% of the respondents are Catholics and 74% belong to New Apostolic and Seventh Day Adventist Churches. These results show that Natural Family Planning has been imposed on a larger community who are non Catholics. This is not in line with the United Nations Charter which states that Family Planning is a Human right that should be extended to all couples and individuals. This Charter was ratified by the Zambian government. All service delivery facilities receiving government funding should therefore be encouraged to respect national policies that entitle citizens to basic health care services, including family planning.

Table IV shows that 30% of the women interviewed have secondary education, 64% primary and 6% have no education. The more educated a woman is the more perceptive she becomes to health related issues. Therefore more investment in education of girls and women is the key to enhancing their status and is critical to development process. An educated woman is better able to participate in community development and more likely to make decisions about marriage and child bearing.

According to Table XIX out of 6% of the respondents who have had no form of education 2% have no idea of what family planning is, 4% though knew that Family Planning is child spacing.

Out of 64% that have attained primary education 30% know that Family Planning is child spacing, 10% said it is having a number of children one can support while 34% had no idea at all. Out of 30% of the respondents who have attained secondary education 10% knew that family planning is child spacing, 6% said it is having a number of children one can support and 14% had no idea. What should be born in mind is the fact that both, high levels of education and GOOD ACCESS to reproductive health services translate into both lower infant mortality and lower fertility rate.

Table XVI shows a relationship between level of education and use of family planning. Out of 6% of the respondents that have never been to school non of them practiced family planning. 64% of those that have attained primary education 4% have used family planning and 60% have never practiced. Out of 30% that have attained secondary education 14% have used family planning methods and 16% have never used family planning methods before. This also confirms the fact that high levels of education are as essential as availability of the services.

Table VI shows that the majority (44%) of women desire to have between 5-9 children, but Table VII shows that 50% had no idea of how they were going to ensure that they maintain the number of children indicated and only 6% mentioned that they would consult health workers for advice while 32% said

they would use family planning but expressed disappointment on the fact that artificial planning methods were inaccessible. Women's desires have therefore been ignored because they are not able to fulfil them.

According to the Zambia Demographic Health Survey (ZHDS) 1992 conducted by the Central Statistics Office in conjunction with the University of Zambia (UNZA) it was established that knowledge is a precondition for proper or higher utilization of any given service. Table VIII indicates that 16% of the respondents know that family planning is having the number of children one can support, 34% know that it is child spacing but 50% of the respondents have no idea. The findings of ZHDS show that 90% of Zambian women have heard about family planning. Yes, women could have heard about family planning but could not have fully understood the issue, as indicated by the results of this study. The findings in Table IX which show that 16% heard about family planning from friends, 14% heard from family members, 44% have never heard from anybody and only 26% heard from health workers.

From the researcher's experience information on family planning from friends and family members is not always reliable. Most of it is misleading as shown by the respondents' reasons for non utilization of family planning methods in Table XI. 56% said it was due to lack of information on family planning while 20% fear

complications like developing cancers and failure to conceive after discontinuation of the methods particularly oral contraceptive pills. This is in agreement with the study conducted in Brussels in 1993 among hundred and fourteen (114) women attending three (3) family planning clinics, which revealed that many had misconceptions on family planning, believed in false rumours and had considerable insufficient knowledge on various family planning methods. No such information could come from well trained health workers.

Table X shows that 18% of the respondents have used a form of Family Planning methods before and 82% have never used family planning methods before. These results are alarming because if no action is taken those women not practising family planning will contribute to population explosion. Family Planning services should be accessible and acceptable by the community. The researcher perceived that there is lack of adequate education on family planning to equip women with adequate information on the services and choose the methods they want themselves. For instance Table XII shows that 68% of the respondents do not know about the availability of family planning services at Nangoma Mission Health Centre. The 32% who knew about its availability were also not sure of the methods offered. Despite the Hospital policy of offering only Natural Family Planning (NFP) the results show that only 6% of the respondents knew of its availability and 94% had no idea at all (Table XIII).

According to Table X the 82% of the respondents who do not practice family planning, 76% indicated that there was lack of information about its availability and 6% said it was difficult to use Natural Family Planning because of inadequate information and poor follow up of users by health workers. This is true because the Natural Family Planning specialist is based at Mumbwa District Hospital and conducts her clinic once a month which makes follow up of users difficult, thus increasing the failure rate. Inadequate information about Natural Family Planning methods is very unsafe. As indicated before information is the most powerful tool available to people, one that opens up new possibilities to exercise both rights and responsibilities.

When women are not well informed about family planning even the utilization of the service will be affected. Table XVII shows that out of 34% of women who said that family planning is child spacing, 14% have used family planning before, 16% who said it is having a number of children one can support only 4% had used family planning before. However, none of the 50% of respondents who have never heard about family planning have practiced. These findings confirm what Maldin (1979) stated "Lack of familiarity with the characteristics of a product, how it will be used, what the associated side effects are, are barriers to the adoption of all new products including contraceptives.⁶ "It is difficult for women to make a firm decision on use of Family Planning if they are not well informed.

The National Population policy aims at enabling the citizens of Zambia to bear a number of children they are able to raise, educate, and provide equal opportunities to lead a healthy life, at the same time to control the population growth within the limited national resources.

The source of information should be accessible to avoid ambiguity because information empowers and enables women to better understand and participate in decision making.

The source of information on family planning also determines its accuracy and adequacy. Table XVIII shows that 26% of women who obtained family planning information from health workers 26% knew that family planning is child spacing and having the number of children one can support adequately. As for those who heard from friends the results show that 4% knew what it is and 4% had no idea at all.

The government, therefore should ensure that all health workers are equipped with information on different types of family planning methods. Health Workers should subsequently educate Traditional Birth Attendants (TBAs) and Community Health Workers on family planning, its benefits and adverse effects to individuals, families, the community and the nation as a whole.

For example, all the health workers at Nangoma Health Centre regardless of their qualifications should be taught about all family planning methods with emphasis being placed on Natural Family Planning so that women who attend the clinics can access information. To depend on one family health nurse from Mumbwa is unrealistic and a violation of women's rights to decide for themselves on family planning issues.

Adequate knowledge on the available family planning method ensures better acceptability, continuity and satisfaction and lower failure rates of those methods. Table XIII shows that only 6% of the respondents knew about the availability of natural family planning methods and, that means the remaining 94% should concern the providers.

The major findings of this study are that the majority of women lack adequate knowledge on family planning. This has subsequently led to non utilization of the available family planning methods. Inaccessibility of family planning services makes it difficult for the rural women to participate in population control which is a major goal of the Zambian Government as indicated in the national population policy. This, therefore calls for the government action to ensure adequate coverage of Family Planning Programmes for women especially in the rural areas.

5.3 **IMPLICATIONS ON THE HEALTH SYSTEM**

Zambia's National Reproductive Health Programme is based on the recognition that access and information are basic rights of individuals and couples, and that Family Planning is an important tool in improving Maternal and Child Health (MCH) and the quality of life of the family. With such low levels of knowledge and usage of family planning the researcher is inclined to think that the dissemination of family planning services leaves much to be desired.

The findings of the study spell a great need for the service providers to intensify family planning campaign and provide comprehensive education on family planning issues in the rural areas.

The health facilities that do not offer artificial family planning methods should provide effective methods that women could utilize. Given the limited range of modern contraceptive options currently available in Zambia, natural family planning (NFP) could have a significant impact on overall contraceptive use, and in many cases make the difference between use and non-use of any family planning methods.²¹

When Natural Family Planning is well integrated in Family Planning programmes it will help reduce the birth rate which is at 3.7% annually.

There is need to re-educate the health providers in Nangoma on importance of family planning in order for them to make an impact on the community to acquire knowledge on family planning as well as its practice.

The management of Nangoma Mission Health Centre should be encouraged to look at the issue of family planning positively. The imposition of the Catholic view of family planning should be rectified, or the violation of women's right to choose the preferred method will continue.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study sought to determine knowledge and use of family planning among women of Nangoma, Mumbwa District. The results strongly indicate the unmet needs of family planning because the majority of women lack adequate knowledge on family planning.

The hospital policy of only providing Natural Family Planning to the community does not facilitate development. It denies the women their right to choose which would consequently improve the quality of their lives as well as their families'.

6.2 RECOMMENDATIONS

In view of the findings:-

1. There is need for Mumbwa District Health Board in conjunction with Nangoma Mission Hospital management to train more Natural Family Planning specialists to help in effective education on the method and follow up of users.
2. Management at Mumbwa District Health Management Board (MDHMT) should introduce new family planning programmes like Community

Based Distribution Agencies (CBD), Mobile Family Planning Teams and integration of Traditional Birth Attendants (TBAs) and Community Health Workers (CHW) in Family Planning Programmes. This will ensure adequate coverage of the community.

3. Management at MDHMT should reinforce efficient contraceptive supply in other health centres other than Nangoma.
4. All of women of Nangoma should have equal access to all Family Planning methods. For example during children's clinics, Family Planning should also be provided. If this is not possible information on alternative sources of supply of family planning methods should be communicated to the women.
5. Another study to be done at a larger scale.

6.3 **LIMITATIONS OF THE STUDY**

The major limitation of the study was that it was done alongside other courses.

There was little time to increase sample power.

APPENDIX I

TITLE OF STUDY: Study to determine knowledge and use of
Family Planning among women of Nangoma

NUMBER OF QUESTIONNAIRE

PLACE OF INTERVIEW

NAME OF INTERVIEWER

DATE:

INSTRUCTIONS

1. Introduce yourself to the client and explain the purpose of your interview.
2. Assure the client that all information is confidential.
3. Ask questions as phrased, only clarify where necessary without changing the complete meaning of the sentence.
4. Please tick (✓) the right answer and write the comments in the spaces provided.
5. Thank the respondent at the end of the interview.

SECTION I

DEMOGRAPHIC DATA

1. How old are you?
2. What is the name of your village?
3. What is your marital status?
 1. Single ()
 2. Married ()
 3. Divorced ()
 4. Widowed ()
 5. Separated ()
4. What denomination do you belong to?
.....
5. How far did you go in school?
 1. None ()
 2. Primary ()
 3. Secondary ()
 4. College/UNZA ()
 5. Other (specify) ()
6. What do you do for your living?
 1. House wife ()
 2. Self employed ()
 3. Employed ()
 4. Other (specify) ()

14. If No, why not?

.....
.....
.....

15. If yes, what type of Family Planning method did you use?

- 1. Contraceptive pills ()
- 2. Condom ()
- 3. Loop ()
- 4. Traditional methods ()
- 5. Natural Family Planing ()
- 6. N/A ()
- 7. Other (Specify) ()

16. Where did you obtain the family planing service?

- 1. Local market ()
- 2. Clinic/Health Centre ()
- 3. Hospital ()
- 4. Other (Specify)
.....

17. Do they offer family planing service at Nangoma.

- 1. Yes ()
- 2. No ()

18. If yes, what type of methods do they offer?

- 1. Contraceptive pill ()
- 2. Loop ()
- 3. Condom ()
- 4. Natural Family Planning ()
- 5. Traditional ()
- 6. N/A ()
- 7. Other (Specify) ()

19. Do you utilize the Family Planning service at Nangoma Clinic?

1. Yes () 2. No ()

20. If Yes, are you satisfied with the services offered?

1. Yes () 2. No ()

21. If you are not, give reasons.

.....
.....
.....

22. Where else are the Family Planning services offered other than Nangoma?

1. Zambia Airforce ()
2. Kapyanga Clinic ()
3. Mumbwa District Hospital ()
4. Other (specify) ()

.....

23. What are the benefits of Family Planning?

.....
.....

24. What are your recommendations about the provision of Family Planning services in your area.

.....
.....

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THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

25th March, 1996

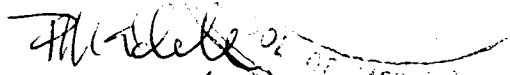
PPAZ
LUSAKA

Dear Sir/Madam,

This is to introduce.....ALICE NGOMA HAZEMBA.....
a Fourth Year BScN student in the School of Medicine, Department of
Post Basic Nursing. This student is carrying out a Research study in
partial fulfillment of the Degree requirement. The name of the Research
Topic is.....TUBERCULOSIS.....
.....

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

Yours faithfully,


Patricia M. Ndele (Mrs)
ACTING HEAD/RESEARCH LECTURER

16th July, 1996

The Executive Director
Kangoma Local Health Centre
MURWA



P. S. S. Lead - Post Basic Nursing

Dear Sir,

re: RESEARCH STUDY AT MURWA

We are fourth year students in the School of Medicine, Department of Post Basic Nursing pursuing a Bachelor of Science Degree.

As part of the fulfilment for a degree programme, we are required to carryout research projects. Our chosen topics of study are on "Knowledge and practices Towards Anaemia in Pregnancy and Knowledge on Family Planning Among women of Kangoma.

We intend to collect data from a randomly selected sample of pregnant and non pregnant women at the Health Centre, Antenatal Clinic between 29th July and 2nd August 1996.

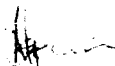
The purpose of this letter is to kindly ask for permission to enable us carryout the projects at your Institution.

Thanking you in anticipation.

Yours faithfully,



Marjory Kasumba Mungo



Alice Ngoma Muzenda

NANGOMA MISSION HOSPITAL

11 SEP 1996

NANGOMA P.O. BOX
MUMBWA

11-9-96

TO WHOM IT MAY CONCERN:

This is to inform you that CHARITY KASUBA SIKAMO and ALICE NGOMA HAZEMBA were given permission to carry out their research study in Nangoma Mission institution from 29-7-96 to 2-8-96. They successfully completed their research and left 2-8-96.

Sincerely yours,

Phiri
Elizabeth Phiri
Acting Administrator