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

A STUDY TO DETERMINE ACCEPTANCE AND FAMILY PLANNING PRACTICES AMONG WOMEN IN SIAVONGA DISTRICT

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LIST OF ABBREVIATIONS

CBD	-	Community Based Distributors
CBoH	-	Central Board of Health
CSO	-	Central Statistics Office
DHMT	-	District Health Management Team
DRC	-	Democratic Republic of Congo
EBDs	-	Employee Based Distributors
FP	-	Family Planning
FPLM	-	Family Planning Life Movement
HIV/AIDS	-	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
MCH	-	Maternal and Child Health
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organization
PHC	-	Primary Health Care
PPZA	-	Panned Parenthood Association of Zambia
SDHS	-	South African Demographic and Health Survey
UTH	-	University Teaching Hospital
UN	-	United Nations
ZDHS	-	Zambia Demographic and Health Survey

DECLARATION

I, hereby declare that the work presented in the study for a Bachelor of Science degree in nursing has not been presented either wholly or in part, for any other degree and is not being currently submitted to any other degree.

Signed: ..... **Date:** 04/06/07

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STATEMENT

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

Signed: ..... **Date:** 04/06/07

DEDICATION

This research is dedicated to my beloved late husband Mr. Taxon Kadantu.

To my children, Kacho, Tamasi, Muwaso and Musia Kadantu for their love and moral support which they rendered during my BSC Nursing Studies.

ABSTRACT

The study was conducted in Kariba, Matua and Lusitu rural health centre catchment areas in Siavonga District. The objective of the study was to determine acceptance and family planning practices among women in Siavonga District and to make recommendations to the relevant authorities.
Acceptance of contraceptives by women is a world wide controversy.
Literature review focused on knowledge and acceptance of family planning practices on Global, Regional and National perspectives.

A none interventional descriptive design which employs a quantitative approach was used. The study setting was in matua, Kariba and Lusitu Rural Health centre catchment areas in Siavonga District. A multi- stage sampling technique was used to select the number of units which constituted a study sample of 50 respondents and these were aged 15 – 49 years. An interview schedule was used to collect data. A pilot study was conducted before the main study and necessary adjustments were made to the research instrument.
Data was analyzed manually using a scientific calculator. Data was presented in the form of frequency tables and pie charts. Cross tabulations were used to determine special relationships between variables.

The study revealed that out of the respondents who were using contraceptives, 90% obtained contraceptives, from health facilities 64% from the Chemist, 24% from friends and 22% obtained their contraceptives from the retail shops . Results indicated that health facilities were the largest suppliers of contraceptives followed by the Chemists.

The findings revealed that the respondents who were not using contraceptives sited various reasons such as traditional beliefs 20%, not married 16%, partner did not approve 10% and lack of knowledge on the existence of contraceptives 10%. Only 2% of the respondents sited side effects as a reason for not using

contraceptives .This clearly indicates the need for family planning providers to provide IEC to communities on the benefits of family planning. Where possible they could use community groups to expel the mynths about family planning methods.

The respondents were asked whether tradition allowed them to use modern family planning or not. Half of the respondents (50%) stated that tradition allowed them to use modern family planning and 32% said that tradition did not allow the use of modern family planning. Eighteen percent of the respondents did not respond. The study further revealed that only 2% of the respondents were using traditional family planning. This is in line with ZDHS (2001 - 2002) whose data showed that modern family planning methods were widely used than traditional methods.

The findings revealed that majority of the respondents (54%) said that religion allowed them to use family planning methods, 26% of the respondents did not respond while 20% of the respondents said that religion did not allow them to use family planning methods. Out of 20% of the respondents who said that religion did not allow them to use family planning methods, 12% said that it was spiritually wrong to use family planning while 8% said that it was God's teaching that people should multiply. This is in line with the study conducted by Parthenon (2004 : 94-95) on attitudes of men and women on contraception which stated that culture and religious beliefs were barriers to use of medical methods of family planning.

Study findings revealed that 54% of the respondents indicated that their spouses supported the use of family planning while 22% said that their spouses did not support the idea. This is in line with a study conducted by Ringheim (2005)
In Himachal Pradesh on awareness among women towards aspects of family planning which indicated that globally, men have not shared equally with women the responsibility of fertility regulation. The study further explained that the use

of contraceptives is regarded as being the wives' responsibility. The study further stated that while family planning efforts have been directed almost exclusively towards women, lack of male involvement also could prevent women from using contraceptive methods.

The study results indicated that almost all the respondents (91%) who did not use contraceptives consistently had no support from their spouses. Only 11% of the respondents whose spouses approved the use of family planning methods used contraceptives. This is in line with a study conducted by Watkins (1997) which indicated that men disapprove of family planning and that the reasons for their opposition to family planning are remarkably of cultural settings in Africa. From the study findings it could be deduced that inconsistent use and none use of family planning could have had attributed to lack of support by the spouses for family planning. Men were likely to give reasons such as lack of knowledge and that it is the responsibility of their partners to avoid pregnancy, (Zeko et al 1999:2).

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a developing Country located in the southern part of sub- Saharan Africa Region. It covers an area of 752, 612 square kilometers (about 2.5% of Africa) and it is 1,300 meters above the sea level.

The country is landlocked and it shares boundaries with the Democratic Republic of Congo and Tanzania in the North, Malawi and Mozambique in the East, Zimbabwe and Botswana in the south, Namibia in the south-west and Angola in the west.

Zambia lies between 8 and 18 degrees south latitude and between 20 and 35 degrees east latitude. The country has a tropical climate and vegetation with three distinct seasons: The cool dry winter season from May to August, a hot dry season during September and October and warm wet season from November to April, (CSO, 2003:1).

According to the 2000 census, the population of Zambia is estimated at 10,285,631. Of the total, 5, 070, 891 are males while 5, 214, 740 are females. 22% of females are in child bearing age. The growth rate in 1990 and 2000 was 2.9% per annum. During the 1990- 2000 intercensal period, the growth rates varied by province, changing from 1.3% in Copperbelt province to 1.4% in Northern Province. The 1980, 1990 and 2000 National Censuses reported total population of 5.7 million, 7.8 million and 10.3 million people respectively. This indicates that Zambia's population has been increasing at an alarming rate (CSO, 2003).
For administrative purposes the country is divided into nine provinces each with its respective provincial headquarters. The provinces are: Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, Northwestern, Western and Southern. Lusaka and copperbelt provinces are predominantly urban while the remaining provinces are predominantly rural and 4 of the 10 Zambians live in urban areas. The provinces are further divided into 72 Districts (CSO 2003).

The economic situation in Zambia is described as one of the early improvements in immediate independence period followed by a period of stagnation in the 1970s and early1980 and declined from late 1980 to the present. Sharp decline in copper prices and sharp increase in oil prices attributed to the country's economic deterioration. Poverty levels are currently high. In 1993, 83% of the population was living below the poverty datum line , an increase from 69% in 1991. In 1998, 73% of the population was below the poverty datum line while 58% of the total population was considered to be extremely poor, 15% were moderately poor and only 27% were considered to be above the poverty datum line, CSO (2003:2). National economic problems coupled with illiteracy have a direct impact in the health status of women and children since they are considered to be vulnerable.

"Family planning is a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitude and responsible decisions by individuals and couples in order to promote the health and welfare of the family, group and thus contribute effectively to the social development of a country, Basavathappa (2003:319).

There were no organized family planning services available throughout the country before independence. Family planning services were only provided along the line of rail to white settlers.

In 1970 Family Planning and Welfare Association of Zambia was formed in order to provide family planning services in the country. The formation of this association was prompted by high infant and maternal mortality caused by illegal abortions. This association was registered as "Family Planning and Welfare Association of Zambia" but later changed its name to Planned Parenthood Association of Zambia. In the Ministry of Health, family planning services became well established when they were integrated into maternal and child health services in 1973. Family planning services were intensified by the formation of family planning health unit at the Ministry of Health (MoH) in 1980 and by the introduction of family planning in- service training in order to increase the number of family planning providers. In 1989 family planning policy was developed which provided guidelines in all issues related to family planning.

In 1987 when safe motherhood initiative was launched to address the problem of high neonatal and maternal mortality, the emphasis was on safe motherhood components and family planning. Since the introduction of Reproductive Health Services in Central Board of Health (CBoH) now shifted to Ministry of Health after disolution of CBoH its focus has been to broaden the approach of Maternal and Child Health (MCH) and family planning to address people's health needs from birth to beyond reproductive life years for both men and women (Ngoma, 2005)

The main objective of integrated family planning into maternal and child health services was to make these services available, accessible and affordable to all families.

Family planning services are being offered through family planning health unit of the ministry (MoH) and these have been filtered to all health institutions in the country. These health institutions include both Governmental and non-Governmental sectors. Family planning services are provided by trained service providers both professional (nurses, doctors) and non professional (Community Based Distributors and Employee Based Distributors (CBD and EBDs). The services are offered in hospitals, health centres, clinics, work places and in people's homes.

The Non-Governmental Organizations work closely with the MoH in providing family planning services through the health centres.

The Non-Governmental sectors include:

- Planned Parenthood Association of Zambia (PPAZ)
- Family Planning Life Movement of Zambia (FLMZ)
- Care international
- Churches such as Makeni Ecumenical Centre, Seventh Day Adventist Church and Lutheran World Federation.

In Siavonga District, family planning services are offered at all static clinics and during MCH outreach services in areas which are 12 kilometers and above in order to encourage women to access family planning services.

Family planning is a key strategy in preventing unwanted pregnancies, sexually transmitted diseases including Human Immuno Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and improving family wellbeing. It begins with self understanding of one's own needs after thinking about one's situation. This implies that an individual may obtain knowledge about family planning through person to person discussions, counseling and through mass media messages and may decide to make an informed choice after matching family planning methods with her/his own needs.

Family planning providers can be proud of their work because family planning helps everyone. Family planning improves family wellbeing. Couples with fewer children are better able to provide them with enough food, clothing, housing and schooling. Family planning helps women protect themselves from unwanted pregnancies. As a result many women's lives have been saved from high risk pregnancies and unsafe abortions. Family planning saves the lives of children by helping women space their births Harcher Rinehart et al (1998: 2-10. Family planning enables couples to have children when they need them and to have the required number of children which they can manage or afford to take care of.

In an effort to promote family planning in Zambia, International Organizations such as World Health Organization, National Agencies and Non-Governmental Organizations (NGOs) such as Planned Parenthood Association of Zambia (PPAZ) and Family Life Movement of Zambia have taken up the challenge to promote reproductive health of women in Zambia through policies such as the safe motherhood (1987), the reproductive Health (1996) which have been adopted and implemented in Zambia (Wina: 1999:2).
The reproductive health/Family Planning needs of the youth have also been take into consideration in a published family planning in reproductive health policy framework strategy guidelines. The Policy states that "Men and women of reproductive age shall be eligible for using family planning methods without the consent of their spouses, parents or relatives,"

Ministry of Health/Central Board of Health (1997). The policy legalized all the people who are in reproductive age (15 to 49 years of age) access to contraceptives. This includes the youth. This was done in order to promote family planning in Zambia. The Government through the Ministry of Health has also addressed family planning needs of the youth among other health services by launching Youth Friendly Health Services in 1994. Initially the services were being provided at District Health Management Team (DHMT) pilot sites in Kalingalinga, Chawama and Chilenje but they later extended to all (DHMTs) in Zambia. Planned Parenthood Association of Zambia (PPAZ) Family Planning clinic (the Rachel Lumpa Memorial Health Center) too, has been providing similar services since August 1997 (PPAZ Annual Report,1997).

In April 1980 the Zambian Government adopted Primary Health Care (PHC) which was to be used as a vehicle for efficient implementation of Health Reforms. Maternal and child Health care including family planning is one of the components of health care. The Primary Health Care Programme aims among other things at paying attention to the rural and peri-Urban areas where the health needs of the people are greatest, with particular emphasis placed on maternal and child health care, family planning, control of communicable diseases including sexually transmitted infections and HIV/AIDS (CSO, 2003:4).

The Zambian Government through the Ministry of Health integrated family planning in 1983 into the maternal and child health services in order to make these services available, accessible and affordable to all families.

Through Health Reforms Programme, the Government of Zambia has committed itself to financing a basic health care package of cost-effective health care services. The package has six major health thrusts, reproductive health care service. The package has six major health trusts; reproductive health is one of them. Among the set targets by the Government to improve the health of the population which were to be achieved by the year 2000 were:

- To increase accessibility to and acceptability of family planning services and appropriate use of information in order to increase family planning use.

- To reduce the incidence of sexually transmitted infections (STIs), Acquired Immune Deficiency Syndrome (AIDS) and reproductive tract infections among other diseases.
- To reduce the incidence of induced abortions in order to reduce maternal complications and death (CSO, 2003:4).

1.1.1 HEALTH CARE SYSTEM IN ZAMBIA

Health care services are mainly provided by the Government through the ministry of Health. Other care providers are the non-Governmental Organizations (NGOs).

Health services are delivered at Central Hospitals (3rd level), Provincial Hospitals (2nd level); District Hospitals (1st level); Health centres and Health Posts. The health services delivery is based on the national health sector vision which is to provide Zambians with equity of access to cost-effective quality health services as close to the family as possible, MoH (1991). In order to fulfill its vision, in 1991 the Zambian Government through the Ministry of Health began a process of decentralization of the health care system in which new roles and responsibilities for various levels of the health care system were defined. New structures have been formed through the establishment of various committees and boards. The focus of the health reforms was to decentralize responsibilities for service provision with the districts as the focal point for integrating health care. The overall goal is to provide equitable access to cost-effective quality health care as close to the family as possible.

1.2 STATEMENT OF A PROBLEM

Although family planning services were integrated in Maternal and Child Health care services way back in 1973, there has been a slow decline in fertility level for instance, from 6.5 births per woman in 1992 to 6.1 in 1996 to the current level of 5.9 births per woman. Despite the decline in fertility Zambia remains one of the highest in fertility levels in Sub-Saharan Africa (CSO 2003 xxi).

There has also been an increase in contraceptive use in Zambia over the past decade from 26% in 1992 to 34% in 2001 – 2002, but almost one in three currently married women still have an unmet need for family planning (CSO, 2003). If the unmet need for family planning of all currently married women were met, the contraceptive prevalence rate in Zambia would increase from 34% to 36% (CSO, 2003). According to the statistical information stated above it is quite clear that under utilization of family planning is present country wide.

Zambia has the highest maternal mortality in the sub-region. The maternal mortality rate for Zambia is estimated at 729/100, 000 live births and infant mortality is reported to be at 95 per 1000 live births, (CSO, 2003:8). Perhaps if family planning services were fully utilized most of maternal and infant deaths would have been reduced.

The objectives of National Family Planning Policy adopted in 1979 were:

- To ensure that all couples and individuals have the basic rights to decide freely on the number of children they should have and when they should have them and they should be responsible for their care and their education.
- To initiate, improve and sustain measures to arrive at slowing down the Nation's high population growth rate.

The Family Planning Programme in Zambia has strived to achieve the above stated objectives but despite efforts to create awareness among couples and individuals on the benefits of family planning and dynamics of adverse effects of rapid population growth, there is low utilization of family planning services among women.

The Zambia Demographic and Health Survey (2003) shows that knowledge about contraceptive methods is almost universal in Zambia, with 98% of all women and men knowing at least one method of contraception. Modern methods are more widely known than

traditional methods. The data also shows that 98% of all women know of a modern method compared to 72% who know a traditional one. Among modern methods, the male condom is the most commonly known (94%) closely followed by the pill (93%). Emergency contraception is the least known, reported by a percent of all women. Withdrawal is the most commonly know traditional method (56%). The most commonly known modern methods of family planning among currently married women are the pill and the male condom (CSO, 2003:69). The above statistics show that there is high level of knowledge of family planning methods by both men and women in general. Despite high knowledge of family planning methods the acceptance and utilization of family planning services is still low among women in Siavonga District. A review of hospital and health centre records indicates that family planning under-utilization is still a major problem in Siavonga, See the table below.

The table below indicates a decline in the number of new family planning acceptors from 2004 to 2005 with a discrepancy of 326.

Table 1.2.1

NEW FAMILY PLANNING ACCEPTORS (2004 – 2005)

YEAR	PERIOD	NEW FP ACCEPTORS	YEAR	NEW FP ACCEPTORS
2004	January to March	474	2005	480
	April to June	446		400
	July to September	426		360
		501		281
	TOTAL NUMBER PER YEAR	1847		1521

Source of data
Siavonga annual report (2004-2005).

The table indicates that this problem affects the whole district. This problem requires urgent attention by all concerned stakeholders because the benefits of family planning services can not be over emphasized. The effects of under-utilization of family planning services lead to:

- Unwanted pregnancies

- Unsafe abortion
- Increase in morbidity and mortality of affected women
- Increase in population
- High illiteracy levels
- Increase in poverty

Therefore, this study sets out to investigate acceptance and family planning practice among women in Siavonga district with a view of making recommendations to the relevant authorities on how women could be encouraged to utilize family planning services.

1.3 FACTORS CONTRIBUTING TO ACCEPTANCE AND PRACTICE OF FAMILY PLANNING IN SIAVONGA DISTRICT

There are several factors that influence acceptance and family planning by women and men. These are:

1.3.1 **Socio-cultural and economic factors:**

1. Traditional beliefs

Traditionally it is a taboo to discuss sexual issues publicly and with the people you are not familiar with especially with people of the opposite sex and different age groups. Individuals who are rooted in traditions are less likely to utilize family planning services.

Another reason could be that some traditions for example the Tonga traditional people believe in having many children who should assist with field work and to contribute to the family wealth through charging of dowry price in terms of animals (cows) on the side of girl children. Therefore, they cannot use family planning for fear of being delayed.

2. Knowledge deficit related to family planning

Women will not know about family planning benefits. Lack of knowledge about family planning can lead to a woman producing children without spacing them. This will have a negative effect on the health of the woman and of the children. It will cause poor health on the woman due to frequent pregnancies and child bearing process. Children may also suffer from malnutrition because of premature weaning at an early age when the child is not able to feed himself/herself adequately while the mother may be giving more attention to the new born baby.

3. Cultural beliefs

In many cultures, contraception is resisted by women, men, family members and the community at large. Most societies believe in having many children because this is regarded as a source of parental support when parents grow old. Children are also regarded as a sign of wealth. Some clients prefer to use traditional methods of family planning than modern methods due to fear of side effects.

4. Age

Women who have reached menopause can not see the need for utilizing family planning methods. Young women engage in sexual activities and marry early. As a result, they need to practice family planning but if they lack knowledge, they will not know the benefits of family planning. Usually young women lack knowledge on family planning.

5. Family planning decision

Inability of women to make decisions regarding reproductive health issues can affect their acceptance and practice of family planning. In most cases in societies it is the husbands and in-laws who make decisions concerning reproductive health or use of contraceptives. Many women want to use family planning methods but they think that their husbands will object. In such cases, methods that can be used without knowledge of husbands should be encouraged.

6. Community support

Lack of community support for family planning can lead to non acceptance and use of family planning services. Educating both clients and local leaders can improve attitudes towards family planning and child spacing. Involving community leaders can also help gain confidence of the local population in contraceptive methods.

7. Educational level

The educational level of an individual may have a bearing on family planning acceptance. Highly educated people are likely to utilize family planning services because they easily understand the need for family planning and they are able to read various literatures on family planning and its benefits compared to the individuals with low education level who may find it difficult to understand the need for acceptance and utilization of family planning.

8. Fear of being labelled as promiscuous

Women and men especially the young ones may be discouraged from accessing contraceptives for fear of being labelled as promiscuous because of misconceptions that when you are on contraceptives you may indulge in sexual activities with any man since you are protected from becoming pregnant. The non approval of extra marital sex by most societies also discourages unmarried men and women from utilizing family planning methods.

9. Lack of confidence in health care providers

High contraceptive failure rate caused by inadequate health education by family planning providers can make clients lose confidence in them.

1.3.2 Health related factors:

1. Distance from the health facility.

Distance from the health facility may prevent women and men from traveling for long hours to the health facility for family planning. Providing outreach services in far places can encourage women and men to access and utilize contraceptives.

2. Staff attitude

Poor staff attitude such as shouting at clients may discourage them from accessing family planning methods at any health facility.

3. Lack of privacy

Unnecessary exposure of clients may discourage them from attending family planning clinics.

4. Shortage of staff

Staff shortage may contribute to low family planning utilization. There may be only one or no qualified staff to run family planning clinics at the nearest health facility.

5. Inadequate information education and communication related to family Planning

Inadequate IEC on family planning may make some clients unable to understand the importance of family planning.

6. Long waiting time at the health facility

Long waiting time could be due to staff shortage or lack of adequate knowledge on family planning by the staff who may take long in attending to each client. Long waiting time in the lines discourages clients from going back to health facilities for family planning.

7. Inconvenient opening hours

Inconvenient opening hours keep clients waiting for some time before the clinic is opened. This may discourage some clients from coming back for family planning.

8. Inadequate supervision

Inadequate supervision of health care personnel may lead to provision of poor quality care to clients. Staff members who receive the support and guidance from supervisors become highly motivated to work.

9. Inadequate staff training in family planning

Untrained staff in family planning methods will not adequately give IEC to clients on family planning methods, side effects and its management.

Untrained staff may lack new information on family planning and technical skills.

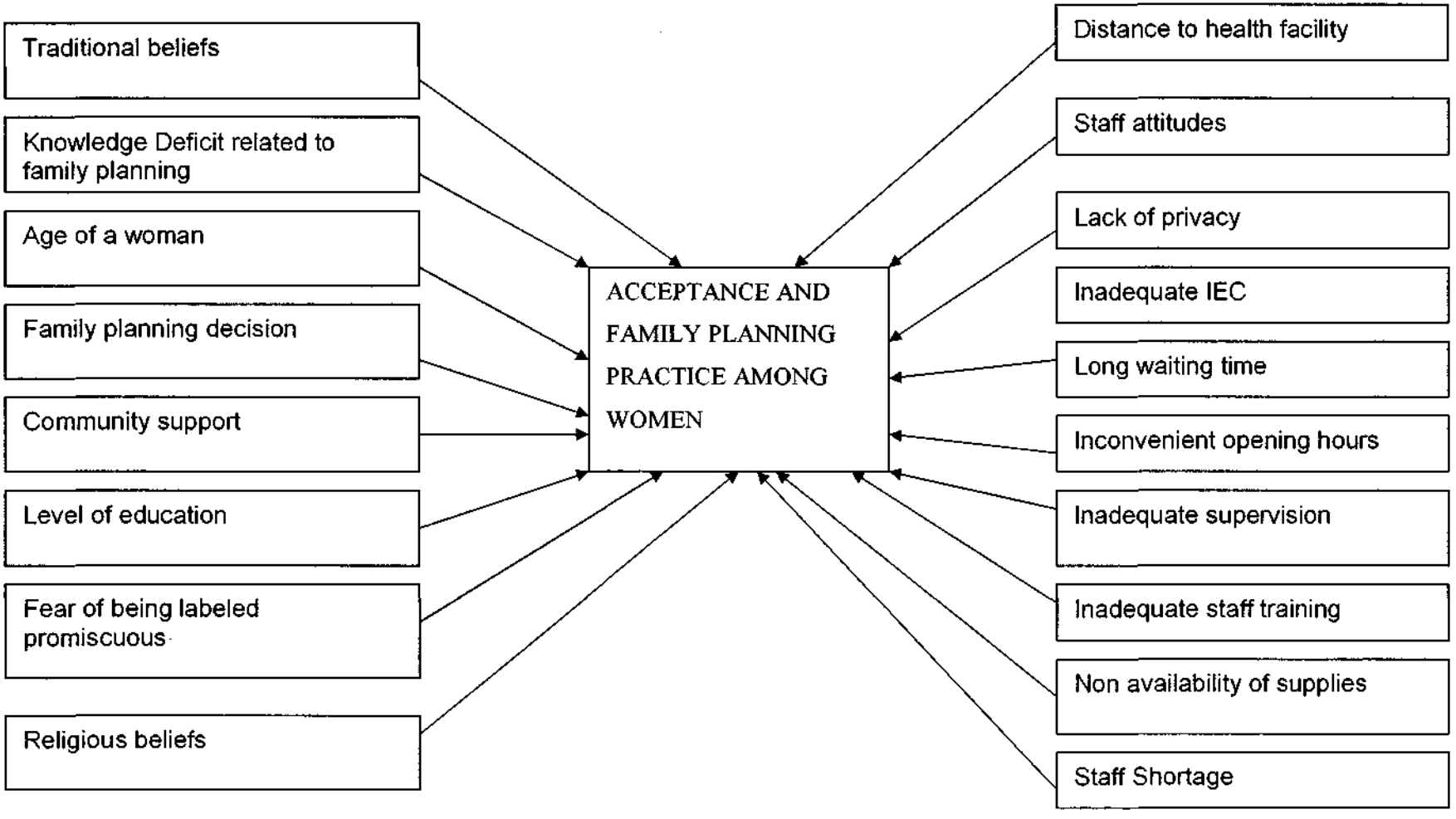
10. Availability of supplies

Shortage of contraceptive supplies may affect provision of quality services and this can make mothers shun the health facilities.

1.4 **SOCIO- CULTURE AND ECONOMIC FACTORS**

FIGURE 1: DIAGRAM OF ANALYSIS OF FACTORS INFLUENCING ACCEPTANCE AND FAMILY PLANNING AMONG WOMEN IN SIAVONGA

STAFF RELATED FAC



1.5 JUSTIFICATION OF THE STUDY

The purpose of this study is to determine acceptance and family planning practices among women in Siavonga District and to make recommendations to relevant authorities on the findings.

Siavonga Annual Action plan for 2004-2005 indicates a discrepancy in new family planning acceptors of 326. This statistics involve many parts of the district. In view of the above therefore, it is imperative that we conduct a study to determine acceptance and family planning practices among women in Siavonga District with a view to developing educational programmes that motivate and increase acceptance of family planning practices among women in Siavonga District.

The importance of family planning can not be over emphasized, Family planning saves lives. It is hoped that the study results will benefit clients, nurses and other health care professionals, the policy making body (MoH), Non-Governmental Organizations(NGOs) and other organizations involved in the provision of family planning services who could use the findings to design effective strategies to motivate women to use family planning services.

1.6 STUDY OBJECTIVES

1.6.1 GENERAL OBJECTIVES

To determine the level of acceptance of family planning practices among women in Siavonga district and to make recommendations on the findings.

1.6.2 SPECIFIC OBJECTIVES

1. To determine women's level of family planning acceptance in Siavonga District.
2. To establish contraceptive knowledge among women in Siavonga District.
3. To determine family planning practices among women in Siavonga District.
4. To make recommendations to relevant authorities on the study findings.

1.7 HYPOTHESIS

- Level of education influences acceptance of family planning method
- Traditional beliefs determine acceptance and practice of family planning methods.

1.8 VARIABLES

Dependent variable

This is a variable that can be caused or affected by the independent variable. It is the core problem. In this study the dependant variables are:

- Acceptance
- Practice

Independent variable

An independent variable is a variable which stands alone and it is not dependent on any other. It is the causer of the problem. Independent variables in this study are:

- Knowledge
- Accessibility
- Distance
- Level of education

TABLE 2: 1.8.1

INDICATORS AND CUT OFF POINTS

INDEPENDENT VARIABLE	INDICATORS	CUT OFF POINTS
1. Knowledge	High	Correctly defines contraceptive method at least three types of contraceptives and one source of contraceptives.
	Average	Correctly defines contraceptive, mention at least two types of contraceptives and one source of contraceptives.
	Low	Inadequately defines contraceptive, mentions only one contraceptive.
2. Accessibility	High	Possibility to obtain contraceptives from three or more sources,
	Average	Possibility to obtain contraceptives from at least two sources
	Low	Probability of obtaining contraceptives from only one source.
3. Practices	Very good	College or University
	Bad	No education
4. Acceptance of contraceptives	High	Approves and uses contraceptive methods regularly.
	Low	Does not approve the use of any contraceptive method.
5. Practice	High	Consistent use of family planning methods for example use of a condom with each sexual act
	Low	Irregular use of family planning methods

1.9 OPERATIONAL DEFINITIONS

Accessibility – The ability to obtain contraceptives.

Contraceptive – A method used to prevent pregnancy and sexually transmitted infections including HIV/AIDS.

Consistent – Continuous use of contraceptives except when pregnant.

Contraceptive usage – Use of contraceptives at each sexual intercourse.

Knowledge – Ability to define the term contraceptive correctly.

Termination of pregnancy/abortion – Discontinuation of a pregnancy.

Attitude – People's feelings towards contraceptive acceptance and use.

Family planning – Process of limiting or spacing the children being born.

Educational level – The level of education attained.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Family Planning has become highly important on the agenda worldwide especially in developing countries including Zambia. This is because family planning awareness promotes its use thereby reducing the number of unwanted pregnancies which eventually results into abortions and maternal deaths.

The importance of family planning was reinforced at United Nations International Conference in Geneva on population in 1984 were all governments were urged to support family planning as a health measure in maternal and child health programmes in order to reduce on population, maternal deaths and promote women's and children's health. At the same conference it was suggested that the programmes should include the ways of making women understand the importance of acceptance and family planning practices.

This literature review will focus on published and none-published research studies that have been conducted globally, Regionally and Locally. The purpose of literature review is to serve as a source for research ideas, orientation of the researcher to what is already know, provision of a conceptual context and a perspective on the problem necessary for interpreting the results of the researcher's study, (Polit F. and Hungler P. 1995).

2.2 GLOBAL PERSPECTIVE

The World Survey conducted by the United Nations on the levels and trends of contraceptive use in 1999 revealed that in most developed countries fertility reached low levels before modern contraceptives were invented but in most developing countries contraception did not become wide spread until modern methods were available. These methods intended to be preferred by new users from the start.

In some of the developed countries particularly in Eastern and Southern Europe, earlier patterns of fertility control chiefly based on withdrawal persisted at least through the 1970s.

The survey further revealed that Bulgaria and Romania used the same methods. In the same survey it was also indicated that "traditional methods are heavily predominant in sub-Saharan African countries". During the same survey it was discovered that in six countries all located in Eastern and Southern Europe, 40% or more couples employ traditional method of family planning. In addition, the survey data for the area around Athens indicated over 40% prevalence of traditional methods in 1983. The highest prevalence levels of traditional methods of family planning in developing world are seen in Lebanon, Mauritius and Turkey (28% to 30% couples), Malaysia, Peru, the Philippines and Srilanka (UN, 1999: 17-19).

The use of contraceptives is regarded as being the wife's responsibility (Ringheim, 2005). In a study on awareness among women towards aspects of family planning in Himachal Pradesh it was reported that globally, men have not shared equally with women the responsibility of fertility regulation. While family planning efforts have been directed almost exclusively towards women, lack of male involvement also reflects the United options available for women.

A similar study by Sinha etal (2001) revealed that the husbands' unwillingness for contraception and improper use of condoms were responsible for one third of all unwanted pregnancies. Further findings indicated that women were the main adaptors of contraceptives where as men played fewer roles. Oral pills were the most well known and most used among 33% of women followed by loop (30%). Apart from vasectomy and usage of condoms both of which are un acceptable to most men, all contraceptive methods are for use by women. Comparison of the findings reported from Himachal Pradesh for people using any of the family planning methods, (67%) and data available from National Family Health Survey (48.2%) indicated that exposure to electronic mass media (Radio and Television) has a large and positive effect on the current contraceptive use and intended future use of contraception (Kamla-Raj, 2005:249 to 250).

Sexual activity is common among youths aged 15-24 years in Latin. The young Adults Reproductive Health Survey on sexual prevalence and use of contraceptives conducted in Latin America and Caribbean sea among 24 years of age revealed that contraceptives are not used by most couples the first time they have premarital sexual intercourse. The reasons sited most often by young women in the survey for not using contraception were lack of knowledge on contraception and not expecting to have sexual intercourse. Men are likely to give reasons such as lack of knowledge and that it is the responsibility of their partners to avoid pregnancy (Zeko etal: 1999: 2). In Jamaica sexual activity among adolescents is very high. 40% of Jamaican women have been pregnant before the age of 20 (Eggleston etal, 1999: 78, 80).

Young people have not been included in the family planning revolution in many developing countries. Few countries provide reproductive health and family planning services freely to the youths; many people view the provision of family planning services to youths as encouraging promiscuity.

According to Enlikar, (2004) and Eggleston etal (1999), adolescents engage in premarital sex with insufficient knowledge of reproduction and family planning and that only small proportions use contraceptives especially condoms. Eggleston etal (1999) were of the view that condom and pills were appropriate methods for young people and they discussed that these contraceptives were available from Doctors, Health Centres and Pharmacies.

Shortages of contraceptives have become a World's concern as they contribute to non accessibility of contraceptives in health facilities. Contraceptive security was the subject of discussion at the International meeting held in Istanbul in May 2001. It was discussed that contraceptive security was like food security. The meeting indicated that there should be adequate supply and choice of contraceptives and condoms for every person who needs them whether for family planning or for disease prevention. At the same International meeting it was concluded that contraceptives were life saving devices to many people in less

developed countries where thousands of people become infected with HIV and where the life time risk of maternal mortality was as high as one in 7 women (Spring, 2002: 16).

In another development, a report on contraceptive demand by the United Nations in 2002 indicated that almost 10 million sub-Saharan African women use family planning methods 3 times this number or 29 million women have unmet need for family planning services. Unmet needs includes married women of reproductive health who fecund and who desire either to increase or delay child bearing but are not currently using contraception.

The same report indicated that many unmarried women (widows, divorcees and young unmarried women) also need contraception. It is also estimated that the unmet need is likely to grow for to reasons; Populations are growing and women of reproductive age make an increasingly high proportion of these populations and that a growing proportion of women will desire to use contraception. According to UNFPA 2004 projections, by the year 2015, the number of women in their child bearing years is expected to increase by more than a fifth to 1.6 billion. This increase along with expected growth in the rate of contraceptive use will boost total demand for contraceptive supply by approximated 40%.

2.3 REGIONAL PERSPECTIVES

The high demand for contraceptives and contraceptive shortages has contributed to low utilization of family planning in most of the sub-Saharan countries. In South Africa, a study carried out by Spring (2002: 15-16) on prevalence of contraceptives revealed that there is increasing demand for contraceptives with the service expansion in rural areas. The study further showed that the possible shortages of contraceptives have made the United States Aid funding on Reproductive health and family planning services stagnant. Expenditure data on contraceptives show that the gains made in contraceptive prevalence may suffer in the coming years, because the Government may not continue to sustain family planning programme expansion and services.

The contraceptives on high demand are oral pill, injectables and sterilization. The ZDHS (1999) documented that both family planning and HIV/AIDS prevention is estimated to be very low, (2.3%). The survey revealed that centrally to the situation in other countries in sub-Saharan Africa, women in South Africa demand for family planning services on their own. Family planning in Southern Africa is user driven and not a Government driven programme. The reason given in the survey could be due to staff shortages, Shortages of commodities, equipment and other related things which South Africa is experiencing.

Where ever services exist, women are constrained for using family planning methods by cultural mores or pressure to rebuild the nations. A study conducted by Pandey (2005) on awareness and knowledge regarding family planning methods in Naggar and Kulu Districts in Himachal Pradesh revealed that there is a close association between family planning knowledge, attitude and behaviour. It also indicated that proper awareness of adequate means of family planning, it's effectiveness and adequate source of information exercised positive impact on developing favorable attitudes which motivate females to adopt family planning behaviour. The study further revealed that the institution of marriage defines and circumscribes the life of a woman as a mother and a house maker; Thus it is fairly common for both men and women to discuss family planning.

Lack of time, education and awareness are deep rooted constraints for women to perform their multidimensional role. In another study it was observed that 67.3% of women were in the age group of 18 to 25 years and had their first child at the same age (Kamla-Raj, 2005:24).

A similar study conducted by Kaur and Pattanaik (1999: 249-250) indicated that literacy in general and female literacy in particular exerted a strong influence on contraceptive use. Higher literacy promoted declines in fertility and child mortality.

Awareness plays an important role in motivating females to have a favorable attitude towards family planning behaviour. In the present study, majority of women knew about birth control measures and were using different types of

contraceptive methods. The majority of respondents were aware about the mechanical method of family planning (loop and condom) followed by chemical methods. The reason might be that the respondents were influenced by the effect of mass media (Television and Radio). Awareness about the natural method was low due to lack of open discussions about family planning matters at home.

A study conducted in South East Anatolia to evaluate contraceptive use by women of reproductive age by Parthenon (2004: 78-79) revealed that 48% of ever-married women of reproductive age had never used any method of family planning, 37.4 % were currently using family planning methods, 14.4% had used family planning methods in the past. The study showed that educational level, knowledge of Turkish type of residence and total number of living children were the main variables that affected the use of family planning methods. It also indicated that family planning in the region was not at the expected level. In order to reduce the barriers to family planning in developing countries, obtainable, acceptable and integrated Health services must be provided. It was observed that knowledge on contraceptive use should include the right of women and men to obtain information about reliable, efficient methods of contraceptives suitable to their budgets and attainable family planning methods in order to organize their fecundity and prevent unwanted pregnancies and their physical, psychological and social health risks.

In some countries, acceptance of family planning practices may be accurate by certain factors. A research conducted on attitudes of women and men on contraception in Umraniye District of Istanbul by Parthenon (2004) revealed that most people who attended the focus groups in the study were against having too many children due to their economic constraints as the influencing factor for limiting the number of children. Urbanization seems to have a strong influence on people's knowledge and attitudes about contraception. In this study, culture influenced selection of type of contraceptive methods. Culture and religious beliefs were barriers to use of medical methods and advocated for withdrawal methods (Parthenon 2004:94-95).

A similar study conducted in Nail urban by Castle etal (1999: 232-234) revealed that the nature of marriage in much of sub-Saharan Africa is much that conjugal ties are often weak and that a clear hierarchy exists where a married woman is subject to both her husband and her in- laws. A woman whose husband opposes contraceptive use may be obliged to keep her use of contraceptives hidden from her husband's relatives too who may equally disapprove Watkins (1997) reported that Kenyan women confirmed in interview that their parents in law are often opposed to family planning because they want their sons to have many children. Reasons for men's opposition to family planning are remarkably consistent across a variety of cultural settings in Africa. Watkins (1997) discovered that in Kenya family planning is perceived to encourage infidelity among wives. Husbands think that their control over their spouses would be weakened in the sexual and domestic areas where women practice contraception. It was further reported that family planning conflicts with men's interest in rearing large numbers of children to compensate for the cattle given as bride wealth at marriage. Watkins also discovered that gender differences are found in reproductive preferences in West Africa. Husbands generally want to have more children and want to have them sooner than their wives do. In other societies God or destiny is thought to pre-determine the number of children a couple has and seeking for change of what such powerful forces have ascribed is considered irrelevant or pointless.

2.4 ZAMBIAN PERSPECTIVES

Zambia Demographic and Health Survey (ZDHA 2001-2002) shows that knowledge of any contraceptive method is almost universal in Zambia with 98% of all women and men knowing at least one method of contraception. The data shows that modern methods are more widely known than traditional methods. 98% method compared to 72% who know of traditional methods. Among modern methods male condom is the most commonly known (94%) followed by the pill 93%. Emergency contraception is the least known (9%) of all women. Withdrawal method is the most commonly known among traditional methods (56%).

The survey showed that contraceptive knowledge is lower among unmarried women who have not had sex than among those who initiated sexual activity. Male condom is the most commonly known method followed by the pills regardless of their sexual activity status. The proportion of those who know of injectable has risen steeply from 53% in 1996 to 82% in 2001-2001.
The same survey indicated that mass media messages such Radio, Television and news papers or Magazines are potential media for disseminating of family planning messages. According to the same Zambia Demographic and Health Survey, the sources of family planning message for 46% of women and 57% of men was the radio. One in four women and one in three women saw a family planning message on television in the 12 months preceding the survey. Newspapers and magazine are the least common sources of family planning messages for both women (16%) and men (28%). Half of the women and almost 2 in 5 men were not exposed to a family planning message through radio, television, newspapers or magazines.

During the survey it was discovered that exposure to family planning message is more common among men than women in urban areas than in rural areas and increases with increasing level of education. Among the provinces, respondents in Lusaka and Copperbelt have higher exposure to family planning messages on television than people in other provinces, with Luapula province being the lowest. Men and women in urban areas are more likely to listen to or watch specific radio and television show on family planning and HIV/AIDS than those in rural areas. The survey shows that 42% of women and 50% of men listen to the radio programmes "life line" in urban areas compared to 15% of women and 25% of men in rural areas (CSO, 2003: 69-85).

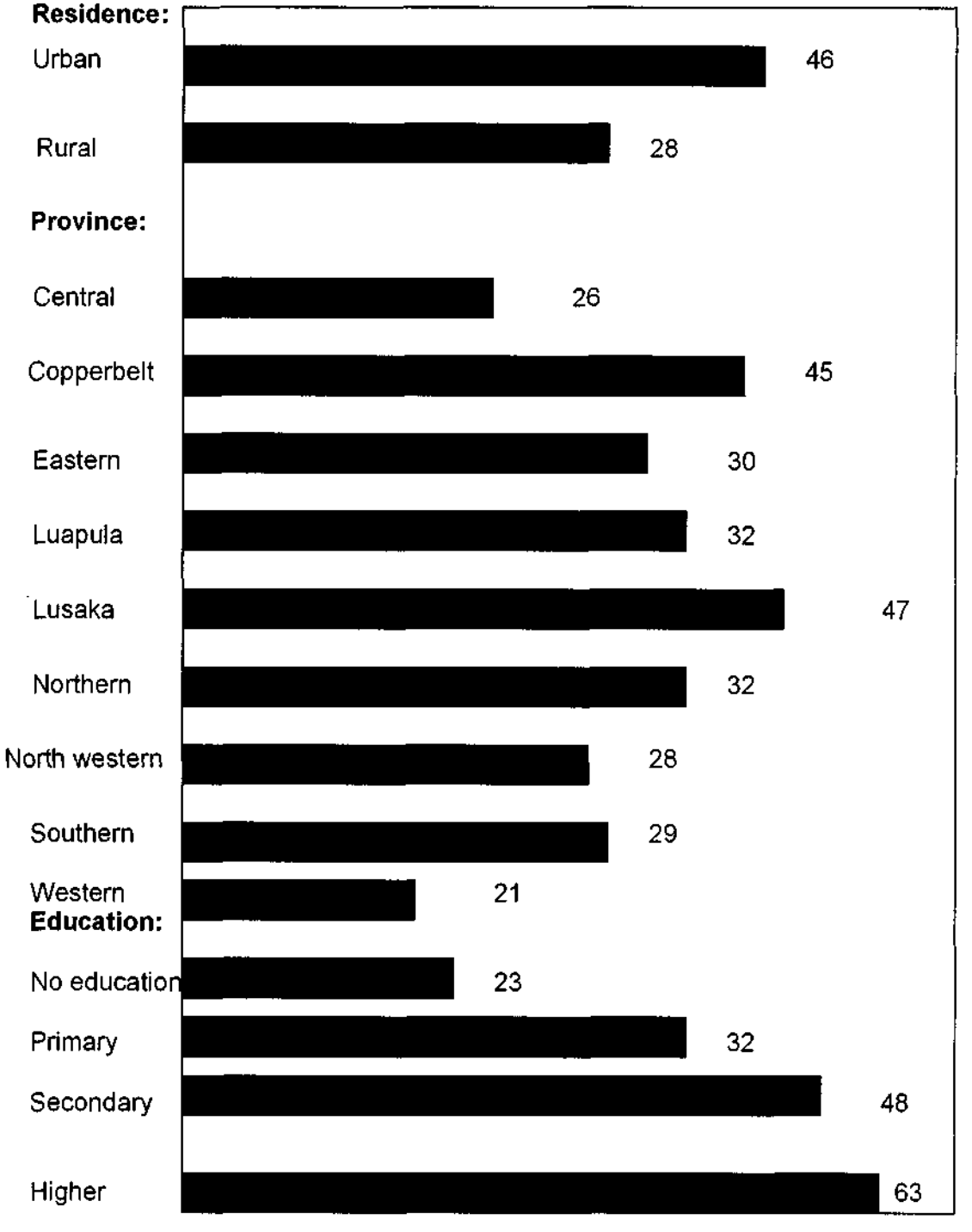
During the ZDHS 2001-2002 it was also revealed that 60% of women reported having used a method of contraception at some time. 42% used a modern method and 34% used a traditional method. Of the modern methods, the pill (28%) is the most common method followed by the male condom (21%). Implant and IUD are the least used methods with least than 1% reporting to have used either method. Of the traditional method, withdrawal is the most commonly used

method (23%) while rhythim /natural family planning is the least commonly used method used by women.

On current use of contraceptive methods the survey showed that one in four women are currently using any contraceptive method. The survey showed that the use of any contraceptive method increases with age, reaching its peak at age group 30-34 (38%). 17% of women use modern family planning while 8% are using traditional methods. The pill is the most commonly used method 8% and the IUD, implant, female condom, Diaphragm/foam/jelly being the least used modern methods. (less than 1%) of traditional methods, withdrawal is the most commonly used (3%). The sexually active unmarried women use a modern contraceptive method (29%) than currently married women (23%) (CSO, 2003: 71-75). According to the ZDHS (2001-2002), the level of current use of contraceptive methods is one of the indicated most frequently used method to access the success of family planning programmes.

The Diagram below shows that women in urban areas were more likely to use contraceptive methods (40%) than their rural counterparts (28%). The most urbanized provinces such as Copperbelt (45%) and Lusaka (47%) have the highest proportions of women currently using contraception. Western province is the lowest (21%). The diagram shows that women with secondary education or higher are 2 to 3 times likely to use contraception as women with no education (CSO, 2003: 76).

FIGURE 2: 2.4 Current use of any contraceptive methods among currently married women aged 15-49 years by background characteristic.



Z.D.H.S (2001 – 2002: 77)

Sources of supply.

During the survey, women who were interviewed mentioned various sources of contraceptive supply such as Government health facilities, private hospitals, clinics and surgeries, mission health facilities, pharmacies and work place.

Intention to use family planning is an important indicator of the potential demand for services. At the time of the survey it was discovered that there has been an increase in the percentage of women none users who intend to use family planning and those who do not intend to use it at all. The main reasons for not intending to use any contraception in the future being fertility related (63%) followed by method related reasons (18%).

Apart from perceived lack of need due to the above reasons, the most important reason by women is fear of side effects. Men are also more likely to be opposed to using contraception on the basis of religious prohibition or the desire to have more children.

The Lusaka impact study conducted in Lusaka clinics on changes in contraceptives revealed that users and none users who are given more information are more likely to accept and continue using contraception than those who receive inadequate or incorrect information (CSO, 2004: 22). In the reviewed literature, none of the studies has encouraged women to use modern contraceptives.

All the studies have sited reasons for women not using contraceptives but no recommendations or steps have been taken to improve acceptance and family planning practices among women. The difference between these studies and my proposed study is that I intend to discover reasons for women not accepting and practicing family planning methods and make recommendations for improvement in acceptance and family planning practice among women to relevant authorities.

2.5 CONCLUSION

From the literature reviewed, it is evident that acceptance of family planning practices is high is some countries and low in others. Various factors have been sited as contributing to low utilization of contraceptives such as; Level of education, traditional and religious beliefs, fear of side effects, location, source of supply and distance from sources of supply including inadequate health education. The literature also revealed that youths are denied access to both information and contraceptives. It is also evident that most women and youths are sexually active and hence they are at risk of unplanned pregnancies unless they are afforded access to information on family planning methods. If users are given more information on family planning practices they would be more likely to accept and continue contraception than those who receive inadequate or incorrect information about family planning practices.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research Methodology refers to the steps, procedures and strategies for gathering and analyzing data in a research investigation (Polit and Hungler,1995). It encompasses the development, testing and evaluation of research instruments to be used in a study.

3.2 RESEARCH DESIGN

Research design refers to the researcher's overall plan for obtaining answers to the research questions or for testing a research hypothesis (Polit and Hungler, 1995). A research design includes research setting, assumptions, relationship between variables, limitations, sample and sampling procedures, instrument to be used and the method for data analysis, (Likwa 2006). The purpose of this study is to determine levels of acceptance of family planning practices among women in Siavonga District and to make recommendations on the findings to the relevant authorities.

A none interventional descriptive design which employs a quantitative approach was used. The researcher collected data to describe or define characteristics of a phenomenon or person as they naturally occurred. It involved a systematic collection, analysis, interpretation and presentation of data to give a clear picture with regard to the levels of acceptance and family planning practices among women of Siavonga District. The selected research design was found to be appropriate because it enabled the researcher to collect accurate data about women of Siavonga District aged 15 to 49 years in 3 health centre catchment areas and to have the insight into the situation. The design has been chosen because of its high degree of representativeness as the sample was randomly selected. Another reason for choosing this design was that the study raised fewer ethical issues as respondents were not subjected to unpleasant conditions such as in experiments.

3.3 RESEARCH SETTING

Research setting is the physical location and condition in which data collection takes place in a study (Polit and Hungler, 1995). This study was conducted at three health centre catchment areas in Siavonga District in Southern Province. This study setting was chosen because it was representative of the whole district.

Siavonga is one of the 9 Gwembe Valley Districts that form Southern Province. It is approximately 195 kilometers Southeast of the University Teaching Hospital (UTH), Zambia's only 3rd level hospital in the capital city – Lusaka. Siavonga shares boundaries with the Republic of Zimbabwe in the south, Mazabuka district in the Northwest and Kafue District in the northeast. The District has an estimated surface area of 3600 kilometers of which 560 kilometers are covered by Lake Kariba (the largest man made lake in Africa and one of the seven wonders in the World). Siavonga District has an estimated population of 70081 people out of whom 80 percent live along the lake shores and along the 3 main rivers namely Kafue River, Zambezi river and Lusitu river. 30 percent of the people live in the inland and in Siavonga and Chirundu settlements CSO (2000). The land is hilly and rocky. The climate is warm throughout the year with temperatures ranging between 15 and 40 degrees Celsius in October and November. The rain season is short, lasting from around Mid November to Mid March. Heavy down pours occur at times but due to the hilly nature of the terrain, most of the rain water is lost in the lake leaving little water for both human and animal consumption. This explains as to why most of the people stay scattered along Kariba Lake shores and along the main rivers very far from the health facilities. This makes it very difficult for them to access health services.

Farming is not well established in Siavonga District due to drought spells. Subsistent farmers grow drought resistant crops such as cotton and millet. There are few peasant farmers who grow Maize and Vegetables while bananas are grown on large scale along the rivers and Kariba Lake shores.

The population is concentrated along the lake shore of Kariba Dam and along the lower Zambezi River where fishing industry is in abundance. The district experiences an influx of fish mongers and fish traders during the open fishing season (March to November) every year. There is a lot of promiscuity among fish farmers, fish mongers and fish traders in the area. This trend has contributed to the increase in unsafe abortions, maternal deaths, increase in population and high prevalence of HIV/AIDS and other sexually transmitted diseases in the Districts, Siavonga District Action Plan (2006-2008). Being a Rural District, Siavonga has very bad road infrastructure. There is only one tar marked road which links the District to the capital city of Lusaka. As for rural areas, only trucks reach there because of bad roads. These roads become impassable during rain season, cutting off five of the rural health centres from the District Health Office. This makes it difficult for the community to access health facilities and services because drugs and other supplies could not be taken to these health centres during this period. This has contributed to the increase in unwanted pregnancies, unsafe abortions, maternal mortality and other diseases in the District (Siavonga District Action Plan, 2006-2008).

There are two main ethnic groups in the district. The Tonga who are the majority occupy a wider area while Gobas are confined to the Eastern side of the district. There is a mixture of languages in Siavonga and Chirundu urban settlements because of workers who have settled in these areas and being border areas there is an influx of people passing through these towns to Zimbabwe, South Africa and back to Zambia. Siavonga is a tourist town and this has also contributed to mixtures of languages such as English, Bemba, Nyanja and other languages apart from the immigrants who have gone to settle there.

There are three basic schools, one high school, several community schools and nursery schools in the area. Literacy is low in the area due to high failure rate. Education is crucial to better understanding of health needs especially family planning. The district hospital is one kilometer away from the District Health Office. It offers first level health services. The hospital has an affiliated health centre which offers out patient services and there is maternal and child health department

where various Primary Health Care activities are carried out including family planning offered on supermarket basis. Primary health care services are offered in all nine health centres in the district despite critical staff shortages which the District is experiencing like any other district which is mainly attributed to brain drain and refusal by trained staff to serve in rural health centres with impassable roads.

The main health problems in the area are; early marriages as a result of poverty so that the girl can be taken care of by the husband, increase in child bearing attributed to cultural demand for more cows from female children as dowry price, early onset of sexual activities in boys and girls due to high dropout rate from school which is attributed to high failure rate. Early engagement in sexual activities lead to unwanted pregnancies and unsafe abortions including maternal deaths.

3.4 STUDY POPULATION

A study population is basically the universe of units from which the sample is to be selected (Bryman, 2001). It consists of the total group of people or objects meeting the desired set of criteria of the interest of the research. The study population will consist of women aged 15 to 49 years. This group comprises of the youth and women of child bearing age. This population consists of 22 percent of the total. District population of 70081,(CSO, 2000). This study population was selected because it was the population which is involved in family planning. That study population is directly affected and predisposed to unwanted pregnancies, abortions and their complications.

3.5 SAMPLE SELECTION

Sample selection is a process of selecting a portion of the population for the study to represent the whole population Bryman (2001). A multi-stage sampling is a sampling of stage that proceeds from large to smaller sampling units (e.g. from states to nursing schools, to faculty members (Polit and Hungler, 1995). Multi-stage sampling technique was used to select the number of units which constituted the study sample of 50 respondents. Three health centres were selected by using

simple random sampling technique. This involved listing of the names of all nine health centres, each on a separate piece of paper. Pieces of papers were folded separately and put in a closed box. The box was shaken vigorously and an independent person was asked to pick one piece of paper at a time from the box with her eyes closed after each shake and up to three papers were picked from the box. The names of the health centres on picked papers represented all health centre catchment areas in the District.

Six villages in the selected health centre catchment areas were randomly selected using the rotary method. Then 50 women from the selected villages were selected using simple random sampling method. Simple random sampling procedure ensured that each unit of the sample was chosen on the basis of chance. All units of the study had an equal or at least a known chance of being included in the sample.

3.6 SAMPLE SIZE

Sample size is the number of the subjects which constitutes the study sample, (Bryman, 2001). According to Bryman the decision about sample size represents a compromise between constraints of the time and cost, the need for precession and variety of considerations. A sample of 50 respondents was selected from the population of 1540 women aged 15 to 49 y ears.

3.7 DATA COLLECTION TOOLS

A data collection tool refers to an instrument or equipment used to gather information (Polit and Hungler, 1995). It may take the form of questionnaire or interview schedule, mechanical device, checklist or some other types of tools for eliciting information.

In this study, the researcher used the semi- structured interview schedule to collect data from women aged 15 to 49 years. An interview schedule is similar to a structured questionnaire. Sometimes it is called a standardized interview. It entails the administration of an interview schedule by interviewer. The aim is for all interviews to be given exactly the same context of questionnaire

(Bryman, 2001). The questions in an interview schedule were preset and did not provide for further clarification or pursuing of the respondents' answers.

The semi-interview schedule was thought to be appropriate for the study because most of the women in Siavonga were illiterate. It enabled the literate and the illiterate to take part or to participate in the study. Another reason was that the interview schedule allowed for a higher response rate than the self-administered questionnaires. The tool also allowed the interviewer to clarify questions in order to reduce ambiguity. The instrument selected was based on the theoretical framework selected for the study.

3.7.1. THE ANTICIPATED DISADVANTAGES OF INTERVIEWS

1. The presence of the interviewer can influence responses.
2. Information may be less complete than information gained through observation.
3. Unstructured interview is difficult to analyze.
4. Important information may be missed because spontaneous remarks by respondents are not usually recorded in unstructured interviews.
5. Training programmes are needed for interviews. This can be expensive.
6. The interviewers may misinterpret none-verbal behaviour.
7. Interviews are time consuming and expensive.
8. Arrangements for interviews may be difficult to make.

The researcher will minimize the disadvantages of the interview by:

1. Introducing herself to the interviewee.
2. The researcher will explain the nature and the purpose of the research topic.
3. The researcher will create a conducive atmosphere in which the interviewee can express herself freely. The researcher ensured confidentiality and informed the interviewees that their frank opinions were needed.

4. The researcher was joting down important points from the interviewees' spontaneous remarks in the space provided for any other information in the interview schedule.
5. The researcher avoided emotional leading questions and never showed surprise at any answer the respondent gave.
6. The researcher spent only 45 minutes on interviewing each respondent.

3.8. DATA COLLECTION TECHNIQUE

A data collection technique is a process that allows to systematically collect information about objects of the study (that is people, objects and phenomena) and the setting in which they occur(Polit and Hungler,1995).

The researcher used interview technique (face to face interview) to collect data from women aged 15 to 49 years in 6 selected villages.
Interviews were conducted by the researcher in a natural setting in the selected villages. Permission was sought from the respondents before conducting the interviews. The respondents were asked to provide a quiet environment for privacy and confidentiality. The researcher explained the purpose of the session and the interviewee was assured of confidentiality, privacy and anonymity by using serial numbers on the semi interview schedule. The respondents were informed that they were free to withdraw from the study or not to join the study if they choose to do so.

The interviewees were interviewed one at a time to maintain privacy and confidentiality. The interview schedule was filled in by the researcher as the responses were given in the form in which they were given in order to avoid altering their meaning. At the end of the interview, the researcher thanked the respondents and reassured them that the collected information would be kept in a locked cupboard.

3.9. PILOT STUDY

A Pilot Study is a small scale version of trial done in preparation for a major study. Pilot study is conducted to ensure that survey questions operate well and it has a role in ensuring that the research instruments as a whole function well (Bryman, 2001).

A pilot study was conducted on 30th August at Game Village in Siavonga. The researcher selected five women aged 15 to 49 years using random sampling method. An interview schedule was used to collect data. This study setting was chosen for pilot study because it was similar to the study area and it had similar characteristics to the actual study population. The purpose of the pilot study was to test the validity and reliability of data collection instruments in order to detect some unseen problems.

The researcher intended to assess the appropriateness and clarity of questions. Data was collected and analyzed manually and necessary adjustments were made to the instruments before embarking on conducting the main research.

3.10. VALIDITY

Validity refers to the issue of whether an indicator or set of indicators that is deviced to gauge a concept really measures that concept (Bryman, 2001). It is the degree to which an instrument measures what it is intended to measure. The validity of the research instrument was measured by ensuring that all the variables of the study were included in the interview schedule by making questions simple, brief and concise and by conducting a pilot study to ensure validity of the study instruments. The researcher and experts in the field of research went through the research tool to ensure no important item was missed out. The collected data was analyzed, interpreted and presented as aggregate results of the study.

3.11. RELIABILITY

Reliability refers to the consistency of a measure of a concept (Bryman, 2001). It is the dependability and degree of consistency with which the instrument

measures the attribute it is designed to measure. Reliability was obtained by ensuring that the tool was tested before the main study was conducted.
The study was used as a baseline data and the same questionnaires were administered and used throughout the study.

3.12 ETHICAL CONSIDERATION

There was need to consider whether our research procedures were likely to cause any physical or emotional harm to our study population, Likwa N. (2006). Written permission was sought from Siavonga Health Management Team and the In-charge of the Health Centre Catchment areas where the study was conducted. (See Appendix 2). Verbal and signed consent were obtained from each respondent before conducting the interviews. Respondents were informed of the freedom to withdraw or refuse to participate in the study at any time they wished to do so. They were interviewed in the language they understood better and they were treated with respect.

3.13 PLAN FOR DATA COLLECTION

Data collection is the gathering of information needed to address a research problem (Bryman, 2001). Data was collected over a 4 weeks period in the month of September, 2006 from three health centre catchment areas. Data was collected by the researcher.

3.14 PLAN FOR DATA ANALYSIS AND PRESENTATION OF FINDINGS

Data analysis is the systematic organization and synthesis of research data and testing of research hypothesis using those data, Polit etal (1999).
Collected data is raw data because it has little practical value as it stands. The collected information must be processed and analyzed for it to be meaningful. All interview schedules were checked for completeness, consistency in responses and accuracy. This was done while in the field.

Data collected from respondents was entered on a data master sheet. It was sorted out and categorized as well as coding. A code book was developed

which was an outline that explained what each research question was, the values associated with each question and the numerical value representing each question and the values assigned to it. Data from the data master-sheet was presented in form of cross tabulation figures and it was summarised using frequencies and percentages according to the sequences of questions on the interview schedule questionnaire. These tables summarised the results to enable researchers to follow and understand the researcher's intentions and buildings of the study.

3 .15 PLAN FOR DISSEMINATION AND UTILISATION OF FINDINGS.

After data analysis, the researcher wrote a research report. The purpose of research report was to communicate the findings to the public. A copy was submitted to each of the following departments: Post Basic Nursing Department, University of Zambia Medical Library, Programme and policy decision makers such as the Ministry of Health, Siavonga Health Management Team and the health centre In-charge of catchment areas where research will be conducted.

CHAPTER 4

4.0 DATA ANALYSIS AND PRESENTATION OF THE FINDINGS

4.1 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data and the testing of research hypotheses using those data (Polit and Hungler, 2001).

The raw data that was collected was sorted out and grouped into categories. The questionnaires were edited for completeness, uniformity, accuracy and consistency and it was coded. The responses from closed ended questions were entered on the data master sheet while responses from open ended questions were categorized according to major themes and coded. Data was analyzed manually by single counting and use of a scientific calculator

4.2 PRESENTATION OF THE FINDINGS

The findings of the study have been presented in frequency tables, percentages and pie charts. The frequency tables summarized the results of the study to enable the readers to understand the findings of the research study. Cross tabulations of variables have helped to show clearly the relationship between variables. The findings from the study were presented according to the sequence of questions and sections in the questionnaire.

SECTION A

All the respondents were females

TABLE 1: AGE IN YEARS (n = 50)

AGE IN YEARS	FREQUENCY	%
15-20	9	18
21 - 35	28	56
36-49	13	26
TOTAL	**50**	**100**

Majority of the respondents (56%) were between 21 - 35 years. 36% of the respondents were aged 36 - 49 years, 18% of the respondents were between the ages of 15 - 20 years.

TABLE 2: MARITAL STATUS (n = 50)

MARITAL STATUS	FREQUENCY	%
Single	10	20
Married	36	72
Widowed	3	6
Divorced	1	2
TOTAL	**50**	**100**

Majority of the respondents 72% were married while 20% were single.

TABLE 3: LEVEL OF EDUCATION (n = 50)

LEVEL OF EDUCATION	FREQUENCY	%
None	16	32
Grade 1- 7	23	46
Grade 8- 9	4	8
Grade 10 - 12	7	14
TOTAL	**50**	**100**

46% of the respondents were in the range of grade 1 - 7. 32% had not been to school, 14% had reached grade 10 - 12 while 8% were in grades 8- 9.

TABLE 4: SOURCE OF LIVELIHOOD (n = 50)

SOURCE OF LIVELIHOOD	FREQUENCY	%
Peasant farming	32	64
Business	12	24
Employed	6	12
TOTAL	**50**	**100**

More than half (64%) of the respondents were peasant farmers, 20% were engaged in small scale business while 12% were in full employment.

TABLE 5: TRIBE (n = 50)

TRIBE	FREQUENCY	%
Tonga	39	78
Goba	9	18
Other	2	4
TOTAL	**50**	**100**

More than three quarters (78%) of the respondents were Tongas while 18% were Gobas, 4% belonged to other tribes.

SECTION B: KNOWLEDGE ON CONTRACEPTIVES

TABLE 6: HAVING HEARD OF CONTRACEPTIVES (n = 50)

HEARD OF CONTRACEPTIVES	FREQUENCY	%
Yes	45	90
No	5	10
TOTAL	**50**	**100**

Most of the respondents (90%) had heard about contraceptives while 10% had never heard about contraceptives.

TABLE 7: SOURCES OF INFORMATION ON CONTRACEPTIVES

(n = 50)

SOURCE OF INFORMATION	FREQUENCY	%
Electronic Media	4	8
Relatives	4	8
Friends- _	11	22
Health Worker	26	52
Never heard	5	10
TOTAL	**50**	**100**

Most of the respondents (52%) had heard about contraceptives from a health worker, 22% had heard from friends, 8% had heard from relatives. 10% of the respondents had never heard of contraceptives.

FIGURES 3:SOURCES OF INFORMATION ON CONTRACEPTIVES (n =50)

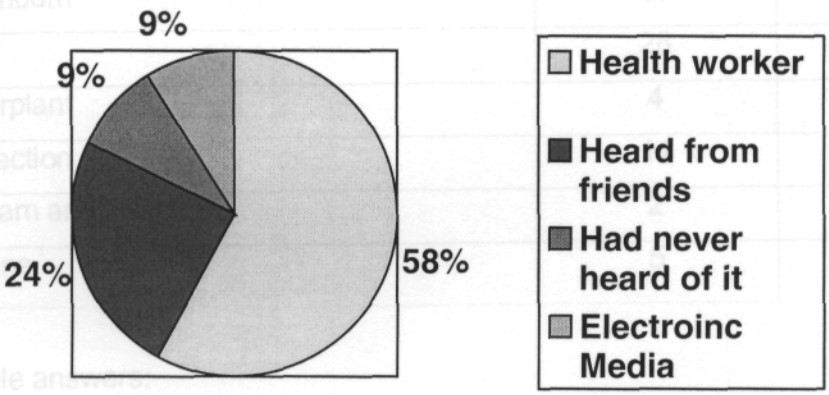


Figure 3 illustrates the major source of information on contraceptives being a health worker (58%), 24% of the respondents had heard about contraceptives from friends, 9% had never heard of contraceptives while electronic media had been a source of information for 9% of the respondents.

TABLE 8: DEFINITION OF CONTRACEPTIVES (n = 50)

WHAT ARE CONTRACEPTIVES?	FREQUENCY	%
Methods to prevent pregnancy	35	70
Methods to prevent STIs	2	4
Methods to prevent HIV/AIDS	3	6
Methods to prevent HIV/AIDS, STIs, Pregnancy	5	10
Do not know	5	10
TOTAL	**50**	**100**

Multiple answers:

Most of the respondents (70%) defined the contraceptives as methods used to prevent pregnancy. 10% defined contraceptives as methods used to prevent HIV/AIDS, STIs and pregnancy.

TABLE 9: KNOWLEDGE ON CONTRACEPTIVES (n = 50)

KNOWLEDGE ON CONTRACEPTIVES	FREQUENCY	%
Condom	33	66
Pill	28	56
Norplant	4	8
Injection	14	28
Foam and Jelly	2	4
None	5	10

Multiple answers:

Majority of the clients mentioned condom (66%) as a method of contraceptives 56% of the respondents mentioned the pill while 28% mentioned injections. 10% did not mention any contraceptive method.

SECTION C: ACCEPTANCE/PRACTICE OF FAMILY PLANNING

TABLE 10: USE OF CONTRACEPTIVES (n = 50)

USE OF CONTRACEPTIVES	FREQUENCY	%
Yes	12	24
No	38	76
No response	5	10

Multiple answers.

76% of the respondents had never used any family planning methods before.

TABLE 11: MODERN FAMILY PLANNING METHODS BEING USED (n = 12)

METHOD BEING USED	FREQUENCY	%
Microgynon	5	10
Condom	1	2
Safe plan	1	2
Noreste rate	**5**	**10**
TOTAL	**12**	**24**

Out of 24% of the respondents who were using modern family planning methods, 10% were on microgynon and another 10% were on noresterate

TABLE 12: SIDE EFFECTS OF FAMILY PLANNING METHODS BEING USED (n = 12)

SIDE EFFECTS OF FAMILY PLANNING USED	FREQUENCY	%
Yes	5	10
No	7	14
TOTAL	**12**	**24**

Out of 24% of respondents on modern family planning methods, 10% experienced side effects while 14% did not.

TABLE 13: SIDE EFFECTS OF CONTRACEPTIVES EXPERIENCED BY THE RESPONDENTS (n = 12)

SIDE EFFECTS	FREQUENCY	%
Heavy menses	1	2
Loss of appetite	2	4
Nausea	1	2
Irregular periods	1	2
TOTAL	**10**	**20**

Only 4 of the respondents who were using contraceptives experienced loss of appetite, 2% experienced nausea and another 2% had irregular periods.

TABLE 14: CONSISTENT USE OF FAMILY PLANNING METHODS (n = 39)

CONSISTENT USE OF FAMILY PLANNING	FREQUENCY	%
Yes	3	6
No	36	72
TOTAL	**39**	**78**

Most of the respondents (72%) did not use family planning methods consistently.

TABLE 15: REASONS FOR USING CONTRACEPTIVE (n = 12)

REASONS FOR USING CONTRACEPTIVES	FREQUENCY	%
To prevent pregnancy	10	20
Protection from HIV/AIDS	2	4
TOTAL	**12**	**24**

Out of 24% of the respondents who were using contraceptives 20% said that they used contraceptives to prevent pregnancy.

TABLE 16: REASONS FOR NOT USING CONTRACEPTIVES (n = 38)

REASONS FOR NOT USING CONTRACEPTIVES	FREQUENCY	%
Not married	8	16
Not sexually active	1	2
Religious beliefs	5	10
Partner can't allow	6	12
Traditional beliefs	10	20
Lack of knowledge	5	10
Fear of promiscuity label	2	4
Fear of side effects	1	2
TOTAL	**38**	**76**

20% of the respondents sited traditional beliefs as the reasons for not using contraceptives, 16% of the respondents stated that they were single, 12 said that their partners did not allow contraceptive use while 10% of the respondents had no knowledge of the existence of contraceptives.

SECTION D: TRADITIONAL AND RELIGIOUS BELIEFS

TABLE 17: TRADITIONAL BELIEFS ON FAMILY PLANNING (N=50)

TRADITIONAL BELIEFS ON FAMILY PLANNING 50)TRADITIONAL BELIEFS	FREQUENCY	%
Yes	25	50
No	16	32
No response	9	18
TOTAL	**50**	**100**

50% of the respondents said that tradition allowed the use of family planning, 32% said tradition did not allow the use of family planning.

TABLE 18: USE OF TRADITIONAL FAMILY PLANNING (n = 25)

TRADITIONAL FAMILY PLANNING	FREQUENCY	%
Yes	1	2
No	24	48
TOTAL	**25**	**50**

48% of the respondents did not use traditional family planning methods. Only 2% used traditional family planning method.

TABLE 19: RELIGIOUS BELIEFS ON USE OF FAMILY PLANNING (n = 50)

BELIEFS	FREQUENCY	%
Yes	27	54
No	10	20
No response	13	26
TOTAL	**50**	**100**

54% of the respondents said that religion allowed the use of family planning methods, 26% of the respondents did not respond while 20% said that religion did not allow the use of family planning methods.

TABLE 20: REASONS FOR RELIGIOUS BELIEF ON NONE USE OF FAMILY PLANNING (n = 10)

RELIGIOUS BELIEF	FREQUENCY	%
Spiritually wrong	6	12
To multiply	4	8
TOTAL	**10**	**20**

Out of 20% of the respondents who stated that religion did not allow the use of family planning, 12% of the respondents said that it was spiritually wrong to use family planning while 8% said that it was God's teaching that people should multiply and fill the earth.

TABLE 21: SPOUSE SUPPORT FOR FAMILY PLANNING (n = 50)

SPOUSE'S SUPPORT FOR FAMILY PLANNING	FREQUENCY	%
Yes	27	54
No	11	22
No response	12	24
TOTAL	**50**	**100**

54% of the respondents indicated that their spouses supported the use of family planning, 22% said that their spouses did not support them.

SECTION E: ACCESSIBILITY OF CONTRACEPTIVES

TABLE 22 : DISTANCE TAKEN TO REACH THE HEALTH CENTER (n = 50)

DISTANCE	FREQUENCY	%
Less than 20 minutes	1	2
20 to 30 minutes	13	26
More than 20 minutes	36	72
TOTAL	**50**	**100**

Most of the respondents (72%) stated that they lived more than 30 minutes walking distance to the health centre, 26% said that they took about 20 to 30 minutes to reach the health center.

TABLE 23 : PROVISION OF FAMILY PLANNING CLINICS PER WEEK (n = 50)

FAMILY PLANNING CLINIC PER WEEK	FREQUENCY	%
Twice per week	**20**	**40**
Do not know	**30**	**60**
TOTAL	**50**	**100**

Majority of the respondents (60%) did not know how often family planning services were provided per week, 40% said that family planning clinics were offered twice per week.

TABLE 24: CONVENIENCE OF FAMILY PLANNING SERVICES (n = 24)

CONVENIENCE OF FAMILY PLANNING SERVICES	FREQUENCY	%
Convenient	19	38
Not convenient	5	10
TOTAL	**24**	**48**

Out of the 24 respondents who were using family planning, 38% were of the view that family planning clinic operation hours were convenient while 10% said that family planning clinic operation hours were not convenient.

TABLE 25 : AVAILABILITY OF CONTRACEPTIVE SUPPLY (n = 45)

AVAILABILITY OF CONTRACEPTIVE SUPPLY	FREQUENCY	%
Yes	10	20
No	2	4
No response	33	66
TOTAL	**45**	**90**

Most of the respondents (66%) did not know whether contraceptives were available at the health centre or not, 4% said that the contraceptives were not available while 20% said that they were available.

TABLE 26: REASONS FOR NONE AVAILABILITY OF CONTRACEPTIVES (n = 50)

REASONS FOR NO CONTRACEPTIVES	FREQUENCY	%
Lack of transport	2	4
No response	48	96
TOTAL	**50**	**50**

Majority of the respondents (96%) did not give any reason why contraceptives were not available at the health centre. Only 4% attributed the none availability of contraceptives to lack of transport at the health centres.

TABLE 27: SUGGESTIONS ON HOW FAMILY PLANNING COULD BE IMPROVED (n = 50)

SUGGESTIONS	FREQUENCY	%
Health education	25	50
More family planning posters at clinics	1	2
No response	24	48
TOTAL	**50**	**100**

Half of the respondents (50%) suggested that health education could improve acceptance and family planning while 48% of the respondents did not respond.

TABLE 28: CONTRACEPTIVE KNOWLEDGE IN RELATION TO AGE

CONTRACEPTIVE KNOWLEDGE	AGE IN YEARS 15 - 20	21 - 35	36-49	TOTAL
Huh	2 20%	6 21%	2 17%	10 20%
Average	3 (30%)	10(36%)	4 (33%)	17 (34%)
Low	5 50%	12 43%	6 50%	23 46
TOTAL	**10(20%)**	**28(56%)**	**12(24%)**	**50(100%)**

Most of the respondents (50%) between 15 - 20 years and 50% between 36 - 49 years had low knowledge on contraceptives while 21 % of the respondents between 21 - 35 years had high knowledge on contraceptives.

TABLE 29: KNOWLEDGE OF CONTRACEPTIVES IN RELATION TO SOURCE OF INFORMATION

CONTRACEPTIVE KNOWLEDGE	SOURCE OF INFORMATION					TOTAL
	Electric Media	Print Media	Relatives	Friends	Health workers	
High	1 25%	0 0%	0 0%	0 0%	6 23%	7 14%
Average	1 25%	0 0%	1 25%	4 36%	11 42%	17 34%
Low	2 50%	5 50%	3 75%	7 64%	4 35%	26 52%
TOTAL	**4 (8%)**	**5(10%)**	**4(8%)**	**11**	**26(52%)**	**50(100%)**

Three quarters of the respondents (75%) who had heard about contraceptives from relatives had low knowledge on contraceptives, 25% of the respondents who had heard from the electronic media and 23% of respondents who had heard from health workers about contraceptives had high knowledge on contraceptives.

TABLE 30: KNOWLEDGE ON CONTRACEPTIVES IN RELATION TO USE OF CONTRACEPTIVES

KNOWLEDGE ON CONTRACEPTIVES	USE OF CONTRACEPTIVES		TOTAL
	Using	Not using	
High	5 (41%)	3 (8%)	8 (16%)
Average	3 (25%)	14 (37%)	17 (34%)
Low	4 (33%)	21 (55%)	25 (50%)
Total	**12 (24%)**	**38 (76%)**	**50 (100%)**

Majority of the respondents (55%) who were not using contraceptives had low knowledge on contraceptives while 41 % of the respondents who were using contraceptives had high knowledge on contraceptives.

TABLE 31: USE OF CONTRACEPTIVES IN RELATION TO THE LEVEL OF EDUCATION

USE OF CONTRACEPTIVES	LEVEL OF EDUCATION				TOTAL
	NONE	G1-7	G8-9	G10-12	
Yes	3 (19%)	6 (26%)	0 (0%)	3 (43%)	12 (24%)
No	13(81%)	17(74%)	4(100%)	4 (57%)	38 (76%)
Total	**16(32%)**	**23(46%)**	**4 (8%)**	**7 (14%)**	**50(100%)**

All (100%) of the respondents who were not using contraceptives had attained grade 8 – 9, (81%) of the respondents who were not using contraceptives never went to school and 74% had attained Grade 1 - 7, 43% of the respondents who were using contraceptives had attained Grade 10 - 12.

TABLE 32: USE OF CONTRACEPTIVES IN REELATION TO AGE

USE OF CONTRACEPTIVES	AGE IN YEARS			TOTAL
	15 - 20	21 - 35	36 - 49	
Yes	1(11 %)	8 (29%)	3 (23%)	12 (24%)
No	8 (89%)	20 (71%)	10 (77%)	38 (76%)
Total	**9 (18%)**	**28(56%)**	**13(26%)**	**50(100%)**

Majority of the respondents (89%) who were not using contraceptives were aged between 15 - 20 years and 77% of the respondents who were not using contraceptives were between 36 – 49 years old while 29% of the respondents who were using contraceptives were between 21 - 35 years old.

TABLE 33: USE OF CONTRACEPTIVES IN RELATION TO SOURCE OF INFORMATION

USE OF CONTRACEPTIVE	SOURCE OF INFORMATION					TOTAL
	Electric Media	Print Media	Relatives	Friends	Health workers	
Yes	0(0%)	0(0%)	1 (25%)	0 (0%)	11 (42%)	12 (24%)
No	4(100%)	5(100%)	3 (75%)	11(100%)	15(58%)	23(46%)
TOTAL	**4 (8%)**	**5(10%)**	**4(8%)**	**11(22%)**	**26(52%)**	**50(100%)**

All the respondents (100%) who were not using contraceptives heard about contraceptives from electronic media, print media and friends respectively while 42% of the respondents who were using contraceptives heard about them from health workers.

TABLE 34: USE OF CONTRACEPTIVES IN RELATION TO OCCUPATION

USE OF CONTRACEPTIVES	OCCUPATION			TOTAL
	PEASANT FARMERS	BUSINESS	EMPLOYED	
Yes	8 (25%)	2 (17%)	2 (33%)	12 (24%)
No	24 (75%)	10 (83%)	4 (67%)	38 (76%)
Total	32 (64%)	**12(24%)**	**6(12%)**	**50(100%)**

Majority of the respondents (83%) who were not using contraceptives were engaged in small scale business while 33% of the respondents who were using contraceptives were in full time employment.

TABLE 35: USE OF CONTRACEPTIVES IN RELATION TO SUPPORT FROM THE SPOUSE

USE OF CONTRACEPTIVES	SUPPORT FROM SPOUSE			TOTAL
	YES	No	NOT	
Yes	10 (37%)	0 (0%)	0 (0%)	10 (20%)
No	17 (63%)	11 (100%)	12 (100%)	40 (80%)
Total	**27 (54%)**	**11(22%)**	**12(24%)**	**50(100%)**

All the respondents (100%) who were not using contraceptives had no support from their spouses, respondents who were not using contraceptives (100%) were not sure of support from their spouses, 37% of the respondents who were using contraceptive had support from their spouses.

TABLE 36: USE OF CONTRACEPTIVES IN RELATION TO DISTANCE TO THE HEALTH FACILITY

USE OF CONTRACEPTIVES	DISTANCE TO THE HEALTH FACILITY			TOTAL
	>20 Minutes	20-30 minutes	<30 minutes	
Yes	1 (100%)	4 (31%)	7 (19%)	12 (24%)
No	0 (0%)	9 (69%)	29 (81%)	38 (76%)
Total	**1 (2%)**	**13(26%)**	**36(72%)**	**50(100%)**

All the respondents (100%) who were using contraceptives took less than 20 minutes to reach the health facility while 81 % of the respondents who were not using contraceptives took more than 30 minutes to reach the health facility.

TABLE 37: USE OF CONTRACEPTIVES IN RELATION TO THE AVAILABILITY OF CONTRACEPTIVE SUPPLIES

USE OF CONTRACEPTIVES	AVAILABILITY OF SUPPLIES				TOTAL
	Yes	No	Do not know	No response	
Yes	8 (80%)	2 (100%)	0 (0%)	2 (6%)	12 (24%)
No	2 (20%)	0 (0%)	5 (100%)	31(94%)	38 (76%)
Total	**10(20%)**	**2(4%)**	**5(10%)**	**33(66%)**	**50(100%)**

All the respondents (100%) who were using contraceptives said that contraceptive supplies were not available at the health facility while respondents (100% who were not using contraceptives said that they did not know whether contraceptive supplies were available at the health facility or not.

ABLE 38: CONSISTENT USE OF CONTRACEPTIVES IN RELATION TO SIDE EFFECTS

CONSISTENT USE	SIDE EFFECTS					TOTAL
	Heavy menses	Loss of appetite	Nausea	Irregular Periods	Nil	
Yes	1(100%)	0(0%)	0 (0%)	0 (0%)	2 (4%)	3 (6%)
No	0(0%)	2(100%)	1 (100%)	1(100%)	32(64%)	36(72%)
TOTAL	**1 (2%)**	**2(4°1°)**	**1(2%)**	**1(2%)**	**34(68%)**	**39(78%)**

All the respondents (100%) who used contraceptives consistently experienced heavy menses, respondents who were not using contraceptives consistently (100%) had loss of appetite and another 100% had nausea. Only 4% of the respondents who used contraceptives consistently had no side effects.

TABLE 39: CONSISTENT USE OF CONTRACEPTIVES IN RELATION TO THE DISTANCE FROM THE HEALTH FACILITY

CONSISTENT USE	DISTANCE TO THE HEALTH FACILITY			TOTAL
	>20 Minutes	20-30 minutes	<30 minutes	
Yes	0 (0%)	1 (8%)	2 (6%)	3(6%)
No	1 (100%)	9 (69%)	26 (72%)	36(72%)
Not sure	0 (0%)	3 (23%)	8 (22%)	11 (22%)
Total	**1 (2%)**	**13(26%)**	**36(72%)**	**50(100%)**

All the respondents who were not using contraceptives consistently (100%) were walking for less than 20 minutes from the health facility, 8% of the respondents who were using contraceptives consistently were walking for 20 to 30 minutes to reach the health facility.

TABLE 40: CONSISTENT USE OF CONTRACEPTIVES IN RELATION TO KNOWLEDGE OF CONTRACEPTIVES

CONSISTENT USE	KNOWLEDGE OF CONTRACEPTIVES			TOTAL
	High	Average	Low	
Yes	2 (18%)	0 (0%)	1 (5%)	3(6%)
No	7 (64%)	12 (71%)	17 (77%)	36(72%)
Not sure	2 (18%)	5 (29%)	4 (18%)	11 (22%)
Total	**11 (22%)**	**17(34%)**	**22(44%)**	**60(100%)**

Majority of the respondents (77%) who were not using contraceptives consistently had low knowledge on contraceptives while 18% of the respondents who were using contraceptives consistently had high knowledge on contraceptives.

TABLE 41: CONSISTENT USE OF CONTRACEPTIVES IN RELATION TO SUPPORT FROM THE SPOUSE

CONSISTENT USE		SPOUSE SUPPORT		TOTAL
	Yes	No	Not sure	
Yes	3 (11%)	0 (0%)	0 (0%)	3(6%)
No	15 (56%)	10 (91%)	11 (92%)	36(72%)
Not sure	9 (89%)	1 (9%)	1 (8%)	11 (22%)
Total	**27 (54%)**	**11(22%)**	**12(24%)**	**50(100%)**

Majority of the respondents (92%) who did not use contraceptives consistently were not sure of support from their spouses while 91 % of the respondents who did not use contraceptives had no support from their spouses. Only 11 % of the respondents who used contraceptives consistently ha support from their spouses.

TABLE 42: CONSISTENT USE OF CONTRACEPTIVES IN RELATION TO AGE

CONSISTENT USE		AGE IN YEARS		TOTAL
	15-20	**21-35**	**36-49**	
Yes	0 (0%)	3 (11%)	0 (0%)	3(6%)
No	7 (78%)	20 (71%)	9 (69%)	36(72%)
Not sure	2 (22%)	5 (18%)	4 (31%)	11 (22%)
Total	**9 (18%)**	**28(56%)**	**13(26%)**	**50(100%)**

Majority of the respondents (78%) who were not using contraceptives consistently were between 15 - 20 years and another 71 % were between 21 - 35 years while 11 % of the respondents who were using contraceptives consistently were between 21 - 35 years old.

TABLE 43: CONSISTENT USE OF CONTRACEPTIVES IN RELTION TO LEVEL OF EDUCATION

CONSISTENT USE		LEVEL	OF		TOTAL
	NONE	**G1-7**	**G8-9**	**G10-12**	
Yes	1 (5%)	0 (0%)	0 (0%)	2 (25%)	3 (6%)
No	15(79%)	14(78%)	2(40%)	5 (62%)	36 (72%)
Not sure	3 (16%)	4 (22%)	3 (60%)	1 (13%)	11 (22%)
Total	**19(38%)**	**18(16%)**	**5 (10%)**	**8 (16%)**	**50(100%)**

Majority of the respondents (79%) who were not using contraceptives consistently had never been to school, 78% of the respondents who were not using contraceptives consistently attained grades 1 - 7. Only 2% of the respondents who were using contraceptives consistently attained grades" 10-12.

CHAPTER FIVE

5.0 DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The main objective of this study was to determine knowledge, acceptance and family planning practices among women in Siavonga District. The researcher was prompted to conduct this study by the discrepancy in the new family planning acceptors of 326 which was indicated in Siavonga Annual Action Plan for 2004 - 2005. This implies that the total number of new family planning acceptors for the year 2004 were 1,847 while in 2005 they were 1,521(Siavonga Annual Action Plan for 2004 – 2005).

Discussion of the findings is based on the responses from 50 randomly selected subjects who participated in this study. The information gathered from the semi-structured questionnaire has been arranged and discussed under the following headings:

- Demographic data
- Knowledge and access to contraceptives
- Family planning practice

5.2 Demographic data

The study sample consisted of 50 women aged 15 - 49 years. Majority of the respondents were aged 21 - 35 years (Table 1 page 41).The mean age of the respondents was 32 years and the age range was15-49 years. Eighteen percent of the respondents were aged between 15 - 20 years. It is quite interesting to note that both the young and older mothers were using family planning services. These groups of women should be encouraged to use family planning as this will improve their wellbeing and that of their children. This is in line with Harcher et al (1998:1-2) who reported that family planning improves family wellbeing and saves the lives of children by helping women space their births.

The study findings further revealed that majority of the respondents (72%) were married and 20% were single (Table 2 page 42). This is because the Zambian society places

more value on marriage. This is in line with the bindings by CSO (2003) which found that 72% of the Zambian population were married.

With regard to educational levels the study bindings showed that 46% of the respondents had attained grade 1- 7, 14% of the respondents had attained grade 10 - 12. There were no were no respondents who reached University or college. (see Table 3 page 42) Despite the availability of 3 basic schools and several community schools in the study population, 32% of the respondents never went to school. This could be due to long distance pupils have to walk to go to school and this could have discouraged them from going to school. The study bindings indicate that majority of the respondents (64%) were peasant farmers. 24% were engaged in small scale business while 12% of the respondents were engaged in full employment (Table 4 page 43). The study further reveals that all the respondents were Christians who belonged to various religious denominations. This was expected because there were various Christian denominations in Zambia apart from that Zambian declared Christian nation by our second Republican President Dr. F.T.J. Chiluba in 1995. The study also revealed that more than three quarters of the respondents were (78%) Tongas while 18% belonged to the Goba tribe and 4% of the respondents belonged to other tribes (Table 5, page 43)

5.3 KNOWLEDGE AND ACCESS TO CONTRACEPTIVES

This section of the questionnaire (Appendix 1) consisted of questions on knowledge and access to contraceptives. This was to assist the researcher in determining basic knowledge and access to contraceptives. In this study respondents were asked whether they had heard about contraceptives. The study findings indicated that almost all the respondents (90%) had heard about contraceptives. Only 10% of the respondents had never heard about contraceptives (Table 6 page 43). This is in line with CSO (2003:3) which indicated that knowledge on contraceptive method is almost universal in Zambia. The source of information is crucial to knowledge on contraceptives. The study revealed that 52% of the respondents had heard about family planning and contraceptives from health workers. 22% had heard from the electronic media and another 8% had heard about family planning from their

relatives (Table 7 page 44). The study also revealed that three quarters of the respondents (75%) who had heard about contraceptives from the relatives had low knowledge about contraceptives. Twenty five percent of the respondents who had heard about contraceptives from the electronic media and 23% of the respondents who had heard from health workers had high knowledge on contraceptives (Table 29 page 55) This could imply that health workers are in contact with women of child bearing age and that they are active in giving information education and communication on family planning as compared to the relatives, friends and electronic media. The high knowledge levels on contraceptives exhibited by the respondents who had heard about contraceptives brown health workers could also be attributed to women's frequent contact with health workers. As women come to the health facilities to obtain health services, they are likely to receive information on family planning. The introduction of supermarket approach especially in maternal and child health department could also have had contributed to most women obtaining information on family planning from health workers as they come for other health services like antenatal clinic, children's clinic and postnatal clinic among other services.

Respondents were asked to define the concept of family planning and majority of the respondents (70%) defined the family planning concept correctly. Only 10% of the respondents could not define the concept and they gave reasons that they had never heard about family planning before (Table 8 page 45). Another 10% of the respondents defined family planning as methods used to prevent pregnancy, HIV/ADS and STIs. It could be assumed that 70% of the respondents who defined family planning concept correctly had prior information on the meaning of family planning. Respondents were also asked to mention any contraceptive methods they knew. It was found that majority of the respondents (66%) mentioned condom as a method of contraceptives. Fifty two percent mentioned the pill, 28% mentioned injections and 10% of the respondents did not mention any contraceptive method (Table 9 page 45). It could be deduced that a condom is the most popular contraceptive know by most respondents followed by a pill. This is in line with ZDHS (2001 - 2003) which indicated that male condom was the most commonly known contraceptive followed by a pill. Lack of knowledge on contraceptives by 10% of the respondents implies that health workers still need to strengthen IEC on contraceptives in order to reach out to these women.

In this study the findings indicated that most of the respondents (72%) lived about 30 minutes walking distance to the health centre. Twenty six percent of the respondents said that they took about 20 to 30 minutes top reach the health facility. (Table 23 page 52) 40% of the respondents indicated that the services were provided twice per week. Majority of the respondents (60%) did not know how often family planning services were offered per week (Table 24, page 52). From the study results, it could be deduced that lack of knowledge on when family planning services are offered can prevent women from accessing family planning services. Perhaps health care professionals are not doing much to sensitize women on this issue hence the need for them to double up their efforts.

Most of the respondents (72%) were not sure of whether family planning services were convenient or not (Table 25 page 53). Twenty eight percent were of the opinion that family planning operation hours were convenient. The study results corresponded with a study conducted by Kamla - Raji (2005:24) which stated that lack of time, education and awareness are deep-rooted constraints for women to perform their multidimensional role which includes family planning. The study results indicated that most of the respondents (76%) did not know whether contraceptives were available at the health centre, 20% of the respondents were of the view that contraceptives were always available at the health centre and 4% of the respondents said that contraceptives were not available at the health centres (Table 26 page 53). The study findings further indicated that only 4% of the respondents attributed the to none availability of contraceptives at the health centres to lack of transport at the health centres. Most of the respondents (96%) did not give any reason for none availability of contraceptives at the health centres (Table 27, page 54). Every facility that provides family planning services must have supplies of all the contraceptives it offers. If it runs out frequently clients may give up on family planning altogether. There is need for health care professional of family planning providers to ensure that contraceptives supplies are available all time.

5.4 FAMILY PLANNING PRACTICE

This section of the questionnaire consisted of questions to aid in determining family planning practice among women in Siavonga District. The study findings revealed that majority of the respondents (76%) had never used any modern contraceptives before. Only 24% of the respondents were using contraceptives (Table 10 page 46). This corresponds with ZDHS (2001 - 2002) which indicated an increase in the percentage of none users of contraceptives because of fear of side effects and territory related reasons. The study also revealed that 55% of the respondents who were not using contraceptives had low knowledge on contraceptives and 41% of the respondents who were using contraceptives had high knowledge (Table 30, page 56).This is in line with the Impact Study conducted in Lusaka Clinics on changes in contraceptives which revealed that the users and none users who were given more information were more likely to accept and continue using contraceptives than those who receive inadequate or incorrect information
(CSO ,2004:22).

The findings of the study further revealed that out of 24% of the respondents who where using modern contraceptive methods, 10% were using microgynon and another10% of the respondents were using noresterate (Table 11, page 46). The study also indicated that 43% of the respondents who reached grade 10 - 12 were using contraceptives while 32% of the respondents who never went to school were not using contraceptives (Table 31, page 56). This is in line with a study conducted by Kauri and Pattanaik (1999:249-250) which revealed that literacy in general and female literacy in particular exerted a strong influence on contraceptive use.

In this study, the findings indicated that out of 24% of the respondents who were using family planning methods, 10% experienced side effects while 14% did not experience any side effects (Table 12, page 47). The side effects which were experienced by the respondents included loss of appetite 4%of nausea 2% and irregular periods 2% (see table13 page 47) The study findings indicated that the side effects experienced by the respondents were minimal. Although the percentage of the women who experienced side effects was small, there is need for health care professionals to manage the women who are experiencing side effects so that they do not stop using contraceptives. The study findings further revealed that the major reasons why respondents were using

contraceptives were to prevent unwanted pregnancies as indicated by 20% of the respondents (Table 15, page 48). This corresponds with a research conducted by Parthenon (2004) in is in Umiraye District of Istanbul on attitudes of women on contraceptives which revealed that most people who attended the focus group discussions in the study were against having too many children due to their economic constraints.

The study revealed that out of the respondents who were using contraceptives, 90% obtained contraceptives, from health facilities 64% from the Chemist, 24% from friends and 22% obtained their contraceptives from the retail shops (Table 16 page 48) Results indicated that health facilities were the largest suppliers of contraceptives followed by the Chemists.

The findings revealed that the respondents who were not using contraceptives sited various reasons such as traditional beliefs 20%, not married 16%, partner did not approve 10% and lack knowledge on the existence of contraceptives. Only 2% of the respondents sited side effects as a reason for not using contraceptives (see Table 17, page 49). This clearly indicates the need for family planning providers to provide IEC to communities on the benefits of family planning. Where possible they could use community groups to expel the myths about family planning methods.

The respondents were asked whether tradition allowed them to use modern family planning or not. Half of the respondents (50%) stated that tradition allowed them to use modern family planning and 32% said that tradition did not allow the use of modern family planning. Eighteen percent of the respondents did not respond (Table 18 page 49). The study further revealed that only 2% of the respondents were using traditional family planning. (Table 19 page 50) This is in line with ZDHS (2001 - 2002) whose data showed that modern family planning methods were widely used than traditional methods.

The findings revealed that majority of the respondents (54%) said that religion allowed them to use family planning methods, 26% of the respondents did not respond while 20% of the respondents said that religion did not allow them to use family planning methods (Table 20 Page 50). Out of 20% of the respondents who said that

religion did not allow them to use family planning methods, 12% said that it was spiritually wrong to use family planning while 8% said that it was God's teaching that people should multiply (Table 21 page 51). This is in line with the study conducted by Parthenon (2004:94 - 95). On attitudes of men and women on contraception which started that culture and religious beliefs were barriers to use of medical methods of family planning.

Study findings revealed that 54% of the respondents indicated that their spouses supported the use of family planning while 22% said that their spouses did not support the idea. This is in line with a study conducted by Ringheim (2005).
In Himacual Pradesu on awareness among women towards aspects of family planning which indicated that globally, men have not shared equally with women the responsibility of fertility regulation. The study further explained that the use of contraceptives is regarded as being the wives' responsibility. The study further stated that while family planning efforts have been directed almost exclusively towards women, lack of male involvement also could prevent women from using contraceptive methods.

The study results indicated that almost all the respondents (91%) who did not use contraceptives consistently had no support from their spouses. Only 11% of the respondents whose spouses approved the use of family planning methods used contraceptives (Table 41 page 61). This is in line with a study conducted by Watkins (1997) which indicated that men disapprove of family planning and that the reasons for their opposition to family planning are remarkably of cultural settings in Africa. From the study findings it could be deduced that inconsistent use and none use of family planning could have had attributed to lack of support by the spouses for family planning. Men were likely to give reasons such as lack of knowledge and that it is the responsibility of their partners to avoid pregnancy, Zeko et al (1999:2).

5.5 IMPLICATIONS ON THE HEALTH CARE SYSTEM

The study results showed that majority of the respondents had heard about family planning (90%). This could lead to more women coming for family planning. Despite having heard about family planning, majority of the respondents were practicing family planning(76%). This may lead to unwanted pregnancies and abortions which will impact on the health of women in child bearing age. Unwanted pregnancies and abortions can lead to increased morbidity and mortality. Therefore, there is need to intensify health education and mass campaigns on the benefits of family planning services so that people can come and access contraceptives to prevent unwanted pregnancies and abortions which may cause strain on the limited resources due to morbidity. According to the study results, health workers were the main source of information on contraceptives 52% followed by friends 22%. There is need for the Ministry of Health and health care providers to exploit other sources for the dissemination of information on contraceptives and their benefits to the rural community.

According to the study results, health centres were the main sources of contraceptives as Indicated by 90% of the respondents. It could be of benefit to the rural community if they were utilizing these health centres. The health workers should conduct outreach activities which should include family planning in order to improve the situation. Mass targeted IEC on benefits of contraceptives and the source of supply should be carried out by health workers so as to attract women to come to the health centres for family planning. The none availability of contraceptives at health centres as reflected by 76% of the respondents who did not know whether the contraceptives were available at the health centres or not. This would lead to inconsistent use of contraceptives and it will result in the increase in contraceptive failure rate and this will bring a negative impact on the health care system in terms of increased complications from unwanted pregnancies, abortions and malnutrition on infants who are not yet ready to be weaned or to feed themselves at a time the mother is expecting or nursing a new baby from unwanted pregnancy. There is need for the Ministry of Health to put strict measures in the health care system to ensure availability of contraceptives in all health facilities for continuity and consistent use of contraceptives in order to minimize contraceptive failure rate mortality and morbidity of women and children.

5.6 CONCLUSION

The purpose of the study was to determine acceptance and family planning practices among women in Siavonga District. Study findings revealed that almost all women had heard about family planning (90%) and had adequate knowledge on family planning 70%. The study results showed that only 76% of the respondents practiced family planning. Illiteracy could have contributed to none acceptance of family planning with 32% of the respondents not having been to school. The study findings further revealed that 76% of the respondents had never used family planning before, The study results further showed that almost all the respondents (91%) who did not use contraceptives consistently had no support from their spouses. This indicates that support by the spouses is crucial to acceptance/ practice of family planning. Half of the respondents (50%) state that tradition allowed them to use contraceptives while 54% of the respondents were of the view that religious allowed the use of contraceptives. The study finding received that more than half (72%) of the respondents lived about 30 minutes walking distance to the health centre. The study showed that (60%) of the respondents did not know how often family planning services were provided per week.

The study findings revealed that more than half (72%) of the respondents were not sure of whether family planning service operation hours were convenient or not.

The study further indicated that more than three quarters of the respondents(76%) did not know whether contraceptives were available at all times at the health centres or not. It was also revealed that almost all the respondents (96%) did not give any reason for none availability of contraceptives at the health centres.

5.7 Recommendations

Based on the conclusion, the following recommendations are supposed to enhance the sustained practice of family planning by women in Siavonga District.

5.7.1 To the Ministry of Health

The Ministry should put strict measures in place to ensure availability of contraceptives in the rural community especially Siavonga in order to promote consistent use of contraceptives, reduce time, contraceptive rate and reduce morbidity and mortality which may arise from complications of unwanted pregnancies and abortions. The Ministry of Health should lobby for improvement of conditions in rural areas such as good infrastructure and rural hardship allowance among other incentives in order to attract qualified health care providers
especially midwives to stay in rural areas and save the people.

5.7.2 To the District Health Office

It is recommended that the District Director and the Maternal and Child Health programme officer should ensure adequate supply of contraceptives to the health centres and should allocate enough funds for MCH activities which support family planning.

The MCH co-ordinator should conduct supervisory visits apart from the main supervisory visits done by the DH M T.

In order to ensure availability of contraceptives at heath centres, He/she should increase the ordering of contraceptives by giving the actual population of women of child bearing age in the District.

- The MCH co-ordinator should also arrange and co-ordinate mass campaigns on the benefits of family planning especially in rural areas once per month in addition to daily health education given by health workers on family planning in order to encourage women to come for family planning.

- He/she should supply all the health facilities with posters on family planning written in local languages as one of the methods of attracting women to come for family planning.

5.7.3 Health centre staff

- Health centre staff should take keen interest in finding out why women do not come for family planning.
- They should intensify health education on the benefits of family planning.
- Health centre staff should conduct outreach activities to take family planning services as close to people who live far away from health facilities as possible in order to encourage people to accept and practice family planning. This will also improve consistent use of contraceptives.
- The health centre staff should involve the spouses in dissemination of information on family planning benefits in order to encourage them to support their spouses with regard to family planning matters.

Health centre staff should involve traditional leaders such as chiefs, village headmen and they should work hand in hand with neighborhood health committees, community health workers and ward councilors among others in order to encourage people to accept and use family planning.

■ Health centre staff together with MCH co-ordinator and the District Director should involve stake holders such as head masters, church leaders, and non governmental organisations in setting strategies which can encourage women to practice family planning.

5.7.4 DISSEMINATION AND UTILIZATION OF THE FINDINGS.

After data analysis, the researcher wrote a research report. The purpose of the research report was to communicate the findings to the public. A copy was submitted to each of the following departments: Post basic nursing department, University of Zambia medical library, Programme and policy decision makers such as the Ministry of health, Siavonga Health Management team and the Health Centre in-charge of catchment areas where research was conducted.

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7.0 APPENDICES

APPENDIX 1: STRUCTURED INTERVUEW SCHEDULE

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

STRUCTURED INTERVIEW SCHEDULE FOR WOMEN AGED 15 TO 49 YEARS IN SIAVONGA DISTRICT

TOPIC: A STUDY TO DETERMINE ACCEPTANCE AND FAMILY PLANNING PRACTICES AMONG WOMEN IN SIAVONGA

DATE OF INTERVIEW.....
PLACE OF INTERVIEW.....
NAME OF INTERVIEWER.....
SERIAL NUMBER OF THE INTERVIIEWEE.....
NAME OF THE VILLAGE.....

INTRODUCTION TO THE INTERVIEWER

1. Introduce yourself to the interviewee(s)
2. Explain the purpose of the interview
3. Get verbal consent from the interviewee before conducting the interview.
4. Assure the interviewee of confidentiality and anonymity.
5. Do not write the name of the respondent on the interview schedule to ensure anonymity.

For office use only

SECTION A

DEMOGRAPHIC DATA

1. Sex

    a. Male ☐

    b. Female ☐ ☐

2. Age on last birthday

    a. 15-20 ☐

    b. 21-35 ☐

    c. 36-49 ☐ ☐

3. What is your marital status?

    a. Single ☐

    b. Married ☐

    c. Staying together ☐

    d. Widowed ☐

    e. Divorced ☐

    f. Separated ☐ ☐

What is your level of education?

    g. None ☐

    h. Grade 1-7 ☐

    i. Grade 8-9 ☐

    j. Grade 10-12 ☐

    k. College ☐

    l. University ☐ ☐

6, What is your religion?

a. Christianity ☐

b. Moslem ☐

c. Hindu ☐

d. Others (please specify): .....

7. What is your tribe? ..... ☐

8. What is your professional attainment? ..... ☐

SECTION B

KNOWLEDGE ON CONTRACEPTIVES

9. Have you ever heard of contraceptives? ☐

a. Yes ☐

b. No ☐

c. No response ☐

10. If your answer to question 9 is yes, from whom? ☐

a. Parents ☐

b. Mass media ☐

c. Electronic media ☐

d. Print media ☐

e. Relatives ☐

f. Friends ☐

g. Others (specify) .....

11. What do you understand by the term contraceptives? ☐

a. Methods used to prevent pregnancy ☐

b. Method used to prevent STIs ☐

c. Method used to prevent HIV/AIDS ☐

d. Method used to prevent HIV/AIDS/STIs ☐

12. Mention any modern contraceptives that you know ☐

a. Condom ☐

b. Pill ☐

c. Norplant/ Implant ☐

d. Injection ☐

e. Loop ☐

f. IUD ☐

g. Foams and jelly ☐

h. None ☐

SECTION C

ACCEPTANCE/ PRACTICE OF FAMILY PLANNING

13. Have you ever used any family planning method? ☐

a. Yes ☐

b. No ☐

c. No response ☐

14. If the answer to question 13 is yes, mention the modern method of contraceptives you are using..... ☐

15. Do you have any problems with the planning method you are using? ☐

a. Yes ☐

b. No ☐

c. Do not know ☐

16. If yes describe the problems you are experiencing..... ☐

.....

.....

.....

17. Do you use family planning method at each sexual intercourse? ☐

a. Yes ☐

b. No ☐

c. No response ☐

18. What are your reasons for using contraceptives? ☐

a. To prevent unwanted pregnancy ☐

b. For protection from sexual transmitted infection (STIs) ☐

c. For protection from Human Immune Virus/ Acquired Immune Deficiency Syndrome ☐

d. Others (specify) .....

19. Where do you obtain the contraceptives from? ☐

a. Clinic ☐

b. Chemist ☐

c. Shops ☐

d. Friends ☐

e. Others (specify) .....

20. If the answer to question 13 is no what are your reasons for not using contraceptives? ☐

a. Not married ☐

b. Not sexually active ☐

c. Religious belief ☐

d. Partner does not allow contraceptive use ☐

e. Traditional belief ☐

f. Fear of being labeled as promiscuous ☐

g. Lack of knowledge about existence of contraceptives ☐

h. Others (Please specially)

.....

.....

SCETION D

TRADITIONAL AND RELIGIOUS BELIEFS

21. Does your tradition allow the use of condoms?

    a. Yes ☐
    b. No ☐
    c. No response ☐

22. If your answer to the question above is yes, are you using traditional family planning method?

    a. Yes ☐
    b. No ☐
    c. No response ☐

23. If the answer to question 22 is yes, what are your reasons for using traditional family planning methods?

    a. Long waiting hours at the health centre ☐
    b. Staff attitudes ☐
    c. Lack of privacy ☐
    d. Distance to the health facility ☐

24. Does your religion allow the use of any family planning method?

    a. yes ☐
    b. No ☐
    c. No response ☐

25. If the answer to question 24 in no, explain why.

    .....
    .....

26. Does your spouse support the use of family planning?

    a. Yes ☐
    b. No ☐
    c. Don't know ☐

SECTION E
ACCESSIBILIYT TO CONTRACEPTIVES

27. How long does it take you to get the nearest clinic?

a. Less than 20 minutes ☐

b. 20 to 30 minutes ☐

c. More than 30 minutes ☐

d. Do not know ☐

28. How often does the clinic provide family planning services?

a. Once a week ☐

b. Twice per week ☐

c. Daily ☐

d. Do not knows ☐

29. How convenient are the operation hour at the clinic?

a. Very convenient ☐

b. Convenient ☐

c. Not convenient ☐

d. Do not know ☐

30. Are all the contraceptives available at your nearest clinic?

a. Yes ☐

b. No ☐

c. No response ☐

31. If the answer in no, explain why? .....
.....

32. How can acceptance and family planning practices be improved in you areas?
.....

Thank you for your cooperation

APPENDIX 2 AND 3

All correspondence should be
Addressed to the District Director of Health
Telefax: +260 1 511077

In reply please quote

No.....

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

DISTRICT HEALTH OFFICE
P.O BOX 16
SIAVONGA.

30th March 2007

UNIVERSITY OF ZAMBIA
DEPT. OF POST
BASIC NURSING
SCHOOL OF MEDICINE
Received
Mudele
Actg HOD

University of Zambia
Post Basic Nursing
P.O. 50110
LUSAKA

Dear Sir

RE: RESEARCH WORK – MABLE CHONGO KADANTU

The above mentioned conducted research work at Kariba, Matua and Lusitu Rural Health Centre Catchment Areas.
During the period starting from 1st September 2006 to 30th September 2006.
However, her introduction letters from your institution have been misplaced, a development which we regret and wish to apologise on her behalf.

Kindly take this letter as an official confirmation of her having done the said research with our permission.

Yours in Community Service

Dr. E. Kunka
Ag. DISTRICT DIRECTOR OF HEALTH

APPENDIX 4 : WORK PLAN

WOULD SCHEDULE

TASK TO BE PERFORMED	DATE	PERSONNEL ASSIGNED TO TASK	PERSON DAYS REQUIRED
Finalize research proposal	Week 1 – 9 1st June – 7th Aug 2006	Investigator and research supervisor	68 days
Clearance from researched ethics committee	Week 10 – 13 8th – 29th August 2006	Research supervisor and principal investigator	22 days
Pilot study	Week 14 30th – 31st Aug 2006	Principal investigator	2 days
Data collection	Week 15 – 19 4th September to 6th October 2006	Principal Investigator	33 days
Data analysis	Week 21 – 25 20th October to 24th November 2006	Principal Investigator	29 days
Report writing and submission	Week 26 – 28 27th November to 18th December 2006	Principal Investigator	22 days
Dissemination of findings	Week 29 19th – 26th December 2006	Principal Investigator	7 day
Monitoring and evaluation	Continuous	Principal Investigator and Research Supervisor	continuous

APPENDIX 5: GANTT CHART

	MONTHS			**2006**						**2007**
Task to be Performed	June	July	August	Sept	October	Nov	Dec	January	Feb	
Finalizing research Proposal		X	X							
Permission to conduct study			X							
Pilot study			X							
Data collection				X						
Data analysis						X				
Report writing							X			
Submission of final report								X		
Monitoring and evaluation									X	X

APPENDIX 6

RESEARCH *BUDGET*

ITEM	UNIT COST	TOTAL
FIELD WORK AND TRAVEL EXPENSES	**K**	**K N**
Lunch allowance for the researcher	50, 000.00 per day x 14 days	700, 000.00
Transport for the researcher	60, 000.00 per day x 33	1, 980, 000.00
SUB TOTAL		**2, 680, 000.00**
Secretarial services: Typing and editing	2, 500.00 per page x 100 pages	250, 000.00
Photocopying	200 per page x 100 pages	20, 000.00
Stationary	20, 000.00 per ream x 4 reams	80, 000.00
Pens	1, 000.00 per pen x 6 pens	6, 000.00
Pencils	500.00 per pencils x 5 pencils	2, 500.00
Eraser	5, 000.00 per box x 1 box	5, 000.00
Correction pen	18, 000.00 per pen x 2 pens	36, 000.00
Ruler	2, 000.00 per ruler x 1 ruler	2000.00
SUB TOTAL		**401, 500.00**
Folders	20, 000.00 per folder x 2 folders	40, 000.00
Flush disc	200, 000.00 per flush disc x 1	200, 000.00
Flip chart	60, 000.00 per flip chart x 1	60, 000.00
Markers	5, 000.00 per marker x 3 markers	15, 000.00
Perforator	20, 000 per perforator x 1	20, 000.00
Stapler (heavy duty)	50, 000.00 per stapler x 1 stapler	50, 000.00
Spiral binder	2, 000.00 per spiral binder x 7	14, 000.00
Scientific Calculator	100, 000.00 per calculator x 1	100, 000.00
SUB TOTAL		**519, 000.00**
Miscellaneous expenses 10% of total budget		246, 050.00
GRAND TOTAL		**4, 345, 550.00**

JUSTIFICATION OF THE BUDGET

In order to carry out the study effectively and professionally, I will need funds for operational, administrative and secretarial services as stated.

STATIONERY

Stationery will be needed to carry out the study. This include: typing, reams of paper for writing and for printing research proposals and questionnaires, pens for writing, rubber for erasing mistakes, flip chart for data analysis, makers for use on the flip chart, files for filing documents to keep information, ruler for drawing lines on the flip chart and on papers, heavy duty stapler for stapling documents, spiral binder for binding the research proposal, scientific calculator for use during data collection and data analysis, perforator for making holes in the documents before filing them in the files. Pencils for use when writing temporal work, correcting pen for correcting mistakes, flush disc for storing typed research before making final printed copy.

PERSONNEL

The researcher will need money for transport to travel to and from the research site. Lunch allowance will be needed during data collection for the researcher.

CONTINGENCY

10% of the total amount of the budget will be added to the total amount of the budget for inflation as well as for expenses during the study.