THE EFFECTIVENESS OF MUKONCHI RURAL HEALTH CENTRE OF KAPIRI MPOSHI DISTRICT IN PROVIDING REPRODUCTIVE HEALTH INFORMATION TO WOMEN OF REPRODUCTIVE AGE: A CASE STUDY OF ZAMBIAN COMPOUND OF MUKONCHI IN CENTRAL PROVINCE

By

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A dissertation submitted to the University of Zambia in partial fulfilment of the requirement for the degree of the Master of Communication for Development offered by the Department of Mass Communication, School of Humanities and Social Science

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Lusaka2013

Declaration

I, Susan Musonda declare that this dissertation:

(a) Represents my own work;

(b) Has not been previously submitted for a degree at this or any other university; and

(c) Does not incorporate any published work or material from another dissertation.

Signed: _____

Date: _____

Ownership

Approval

This dissertation of Susan Musonda is approved as fulfilling the partial requirements for the award of the degree of Master of Communication for Development by the University of Zambia

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Abstract

This report is based Clinic of Kapiri Mposhi District: A case on the result of the authors' attachment to Mukonchi Rural Health study of Zambian Compound of Mukonchi. The overall objective was to find out the effectiveness of Munkonchi Rural Health Centre in providing reproductive health information to women of age. The research and writing of this report was the final phase of the partial fulfilment of the requirements for the Master of Communication for Development degree at the University of Zambia.

The aim of the study was to establish women's awareness of the existence of reproductive health information at Mukonchi clinic; furthermore to determine if females access information from the clinic and also to find out if the mode of information provision by the clinic was effective. The other aim was to determine the attitudes of women towards reproductive health information. Furthermore the aim was to see how cooperative and encouraging men (husbands) were in assisting women to access reproductive health information.

The methodology that was used in the study consisted of the use of systematic random sampling in picking respondents to the questionnaires. This was done to make sure that all categories in terms of reproductive women and their spouses was proportionately represented. In-depth interview, focus group discussion, observations and use of secondary data were some of the sources of information. Quantitative data was analysed using Statistical Package of Social sciences (SPSS).

The findings of the study showed that Mukonchi Rural Health centre uses different approaches to communicate to the women of age which ranges from weekly health educational programmes, drama groups, involvement of the church and the neighbourhood health committee members. The major challenge faced by the clinic in disseminating information to women of age is that

most women in the area have very low education levels. The other challenge faced by the clinic is that there is so much dependence on just one method of information dissemination. The weekly health education programmes stood out to be the most effective way of information dissemination. However, this method needs to be supplemented by other methods to enhance its effectiveness.

Finally the observations and recommendations have been made in order to improve the communication pattern among women and men of reproductive age to increase the adoption rate which would result in proper utilisation of these reproductive health services.

Dedication

To my beloved family: My husband Maurice Musambi, my children Mapalo, Bukata (Joshua) and Malumbo. I also dedicate this paper to my niece Zoe Musonda for being there for me during this period.

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My special thanks go to the Almighty God for giving me the opportunity and the grace to do a Masters Degree in Communication for Development.

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Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
CBOH:	Central board of Health
CE:	Classified Employee
CBD:	Community Based Distributions
CSO:	Central Statistical Office
FHI:	Family Health International
FGD:	Focus Group Discussion
HIV:	Human Immune Virus
ICPD:	International conference on population and Development
IEC:	Information Education Communication
NGO:	Non Governmental Organisations
PHC:	Primary Health Care
RHCS:	Reproductive Health Commodity Security
RHI:	Reproductive Health Information
SPSS:	Statistical Package for Social Sciences
STD:	Sexually Transmitted Diseases
STI:	Sexually Transmitted Infections
VCT:	Voluntary Counselling and Testing
WHO:	World Health Organisation
ZDHS:	Zambia Demographic Health Survey

CHAPTER ONE: INTRODUCTION

1. Introduction

This is a report on the attachment and research that was carried out on the effectiveness of Mukonchi Rural Health Centre of Kapiri-Mposhi District in providing reproductive health information to women of reproductive age: A case study of Zambian compound of Mukonchi. The research was carried out in Mukonchi, Kapiri District of Central Province of Zambia. For this research to be a success on the subject at hand men were also involved to see how cooperative they are in supporting their spouses in reproductive health information.

The report has seven chapters. Chapter one covers the introduction and background of the report. It discusses the introduction on reproductive health information, presents the situational context of the Zambian population, the background information, description of the study area, statement of the problem, rationale of the study and the objective of the study.

Chapter two discusses the methodology that was used to come up with the report. It includes the Research questions and Quantitative and Qualitative Methods that were used. It also includes the sampling procedure, survey method, data analysis, ethical considerations and the limitations of the research.

Chapter three contains the conceptual and theoretical framework used in the report. It is here that the main concepts are defined and how they have been applied in the report.

Chapter four, deals with literature review that is related to the research. It highlights the worlds view, the African view and the Zambian view. This is to ensure that enough details are obtained and no replication of the same academic work done previously.

Chapter five consists of data analysis and findings of the research. Chapter six is the discussion on the findings, while chapter seven is a combination of the conclusion and recommendations to the study. The last section contains references and appendices to the report.

The framework of the World Health Organization (WHO) defines health as a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 2008, p.3).

Reproductive Health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (http://www.who.int/topics/reproductive_health/en/ -accessed on 12/02 /2012).

According to the International Conference on Population and Development (2004, p. 13), reproductive health is defined as "a state of complete physical, mental and social well being of an individual and not merely the absence of disease or infirmity, in all matters of reproductive system and its functions and process". For the people of the society to maintain their reproductive health, they need reproductive health information. When the planners have information on reproductive health they can plan on how best to prevent certain diseases, which are reproductive health related. The same applies to the health workers in the health centres; they need reproductive health information to teach people on the prevalence of reproductive related

diseases. In addition, when the public is knowledgeable on the reproductive health, they can even change their way of living, which can bring out improvement in their health.

Worldwide, many youths have had sexual intercourse and are at risk of sexually transmitted infections (STIs), including HIV, or unintended pregnancy. Research based reproductive health programs can provide youths with the information, support, and services they need to make responsible decisions about their sexual health.

A number of strategies have been developed to address issues related to women's reproductive health issues in Zambia. One of the key strategies at national level is to ensure that the breadth of issues covered is consistent with the elements agreed to by the International Conference on Population and Development (ICPD, 1994, p.63), which encompass a state of complete physical, mental and social wellbeing. Zambia is committed to increasing national budgetary expenditure on health from 11% to 15% by 2015 with a focus on women and children's health; and to strengthen access to family planning - increasing contraceptive prevalence from 33% to 58% in order to reduce unwanted pregnancies and abortions, especially among adolescent girls. Zambia intends to scale-up the implementation of integrated community case management of common diseases for women and children in order to bring health services closer to families and communities to ensure prompt care and treatment (www.everywomaneverychild.org/.../310-ensuring-universal-accessed on- 12/02/2013).

For any country to perform well in the health sector, it must embrace the utilization of health information and communication. This is because the health sector is the back bone of any country. Reproductive health information encompasses many things such as family planning, sexual activities, and sexually transmitted infections, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, Maternal Child Health Care, Safe Motherhood and so

on. For these things to be known in the communities information has to be communicated. When information is communicated, the people in these areas can improve their way of living. Lack of reproductive health information has an adverse effect on any population. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of reproductive health information regulations of their choice. Additionally, this information provides the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having healthy infant. (http://www.safaids.net/files/Situational-Analysis-on-Sexual, accessed on 05/11/2012).

Reproductive rights are central to human rights, especially the rights of women. They derive from the recognition of the basic rights of all individuals and couples to make decisions about reproduction free of discrimination, coercion or violence. They include the right to a high standard of health and the right to determine the number, timing, and spacing of children. They comprise the right to safe childbearing, and the right of individuals to protect themselves from HIV and Sexually Transmitted Diseases (UNFPA 2005, p. 18).

The government of Zambia through the Ministry of Health is committed to improving the reproductive health of women, men and adolescents aiming at improving child survival and provides a quality life for men and women. When the public is knowledgeable on the reproductive health, they can even change their way of living, which can bring out improvement in their health. Reproductive health information is useful in evaluating the reproductive health programmes, which are introduced at the health centres by going through the statistics that are collected. Therefore, it can be concluded that information is very helpful in the health sector and in particular reproductive health (Klaassen 2005, p. 24).

Reproductive Health is a crucial part of general health. Not only is it a reflection of health during adolescence and adulthood, it also sets the stage for good health beyond the reproductive years for both women and men that have pronounced inter-generational effects. The health of the newborn child largely depends on the mother's health status and of the previous access to health care, besides support from their spouses.

Information is indispensable in almost everything human beings endeavour to do and without information people cannot progress or lead a healthy life in society. The same applies to the strategic sectors of government such as health, education, economic and environmental. For these sectors to contribute to national development they need to utilize information to the maximum.

Population growth has become an increasingly important issue for Zambia. Hence the need for this research was to look at the necessity of the utilisation of reproduction health information and communication to the women using the case study of Mukonchi clinic of Mukonchi area in Kapiri District.

The main area of interest in this study was the role of effective communication in the health sector, in reproductive health from the service provider to the consumer. Due to the broadness of the subject under discussion, this research was looking at some of the reproductive health problems such as family planning and safe motherhood that are prevalent in Zambian Compound of Mukonchi area in Kapiri Mposhi District of the Central Province.

1.1. Present Situation

Zambia's population has increased rapidly over the last 30 years. The population which was 3.5 million in 1963 increased to 4.1 million in 1969, 5.7 million in 1980 and 7.8 million in 1990.

In1998 Zambia's population was estimated to be 10.2 million, it rose to13,046,508 according to the 2010 population census results (http://www .zambian-economist.com/2011/01/zambia-2010-census accessed on 18/09/2012).

At the current rate, the Zambian population is expected to double in 25 years. The 2007 Zambia Demographics Health Survey (ZDHS) estimates that 50 percent of the total population is aged less than 15 years and 3 percent is aged 65 years and over. The regional distribution of the population shows that 61 percent (7,978,274) lives in rural areas, while 39 percent (5,068,234) lives in urban areas. Copperbelt and Lusaka are the most densely populated provinces with almost 25 percent of Zambia's total population living in these two regions (CSO2011 report, p. 15).

The reproductive rate's situation in Zambia has remained relatively high and it is likely to remain so for sometime unless concrete reproductive health interventions are undertaken. The total reproductive rate represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific reproductive rates. The total reproductive rates were estimated at 6.5 and 6.1 in 1992 and 1996 respectively. The reproductive rate (that is the total births per woman) in Zambia was last reported at 6.26 in 2010, according to a World Bank report published in 2012. The ZDHS 2007 reported reproductive rate in Zambia remained high over the last 15 years. The report suggests that rural women have three more children per woman than urban women (7.5 and 4.3 children, respectively):- (http://www.tradingeconomics.com/zambia/reproductive-rate-total-births-per-woman-wb-data.html accessed on 18/09/2012).

In recent years, Zambia has made progress in some key areas of sexual reproduction and health. For instance, the maternal mortality rate declined from 729 per 100,000 live births in 2002 to 591 per 100 000 live births in 2007. Under five mortality rates have also declined over time, from

168 per 1000 live births in 2002 to 119 in 2007, while infant mortality rates fell from 95 to 70 per 1000 live births over the same period (MoFNP, 2011, p. 43).

Data from the ZDHS 2007 suggest that access to antenatal care in Zambia is very high, with 94% of women receiving antenatal care from a skilled provider during their last pregnancy. For example, in urban areas, 99% of women accessed antenatal care services for their most recent live births, compared to 91% in rural areas; moreover 99% of women who are literate accessed antenatal care services compared to 88% to illiterate women. Despite achievements in providing antenatal services and satisfying unmet needs for family planning, skilled birth attendance has remained low in Zambia with high urban-rural differentials (CSO et al., 2009, p 16).

The ZDHS 2007 reports that 97.8% of women with education had their delivery attended by a skilled attendant. Admittedly, this correlates highly with literate women, but a more educated woman is more likely to seek and have the resources to be attended to by skilled personnel during delivery. Nevertheless, inadequate number of skilled personnel to attend to births is an obvious factor constraining reduction of maternal deaths. This is much more of a problem for rural areas. 30.8% and 31.7% of women giving birth in rural areas were attended to by a traditional birth attendant or a relative, respectively (MDG progress report 2011, p.34).
The challenge of reducing maternal mortality has been reduced by area-based efforts to improve access to care of obstetric emergencies. Improving coverage of quality skilled attendance at birth has increasingly been emphasized. Post-abortion care, better reproductive health services for adolescents, and improved family planning care are important ingredients in maternal mortality reduction. Maternal mortality reduction today is being promoted by using a human's rights approach (Williams and Wilkins 2000, p.513).

Globally, the total number of maternal deaths decreased from 543 000 in 1990 to 287 000 in 2010. Likewise, the global maternal mortality ratio (MMR) declined from 400 maternal deaths

per 100 000 live births in 1990 to 210 in 2010, representing an average annual decline of 3.1 per cent (http://www.unfpa.org/public/home/publications/pid/10728-assesed on 10/08/2012).

The life expectancy in 1980 was 50.4 years for males and 52.5 years for females. In 1996, it was 46.2 years for males and 44.7 for female's .The life expectancy at birth had further declined to about 37 years in 1998. In 2007, it was 45 years for males and 47 years for females. Life expectancy in Zambia is currently at total population: 52.57 years, male: 51.35 years, female (http//www.who.int/countries/zam/en assessed on 15/09/2012).

Zambia recently carried out a situation analysis on reproductive health services for the adolescents and young people in the country, which identified the gaps, such as high teenage pregnancies, inadequate access to Reproductive Health Services and information. A strategy to address the gaps identified is being developed. The Government's health vision is to provide health services as close to the family as possible, and has since embarked on building infrastructure and strengthening health systems, including capacity building and training for the provision of long term family planning methods alongside strengthening commodity security, especially for rural populations. To ensure a steady and adequate flow of reproductive health commodities, including family planning, the government has set up a Reproductive Health Commodity Security (RHCS) Committee, comprising officials from the Ministry of Health, Ministry of Finance and National Planning, NGOs and Cooperating Partners, including United Nations Family Planning Agency (UNFPA). Zambia has also embarked on the use of community based agents such as Safe Motherhood Action Groups to provide information on the importance of pregnant women delivering in health facilities and utilization of family planning services. In some rural areas, family planning services are distributed through Community Based Distributors (CBDs) in line with the framework of Family Planning Policy and Guidelines

(http://www.un.org/esa/population/cpd/cpd2011/countrystatements agendaitem4/ zambia.pdf, accessed on 5/11/2012).

1.2. Background Information

Access to health facilities and reproductive health information is a priority on the Zambia development agenda as it is highly related to residents' health. The Family Planning Policy Framework, strategies and Guidelines have been developed and provide support and guidance in planning and implementation of the family planning component of the reproductive health programmes. Family planning has contributed to the empowerment of women and men as it helps to control their reproductive health, enabling them to decide when and how many pregnancies one could have. Modern family planning use has increased gradually from 8.9 percent of married women of reproductive age in 1992 to 26.5 percent in 2007. More effort and support is required to increase access and use of family planning services, especially among women of age in rural areas in order to reduce the high unmet need of contraceptives (CSO Report, 1998, p.112).

Providing adequate information, education and communication on women's reproductive health can remove some of the constraints facing women in reproductive health issues. There is need for awareness and sensitization for both men and women on the issue of women's control of their own body and sexuality. Adequate gender sensitization and training need to be provided to health workers in order to allow women of age to getthe right information on reproductive health services available. Gender equality and women's empowerment are important in improving reproductive health. Higher levels of autonomy, education, wages, and labour market participation are associated with improved reproductive health outcomes (Reproductive Health at a Glance Zambia, May 2011, p.1).

The dominant paradigm argued that rapid population growth would not only hinder development, but was itself the cause of poverty and underdevelopment. Almost without exception, population policies focused on the need to restrain growth; very little was said about other aspects of population such as changes in structure or in patterns of migration. Given their genesis among the social and economic elites, it is perhaps hardly surprising that the family planning programmes that resulted were based on top-down hierarchical models and that their success was judged in terms of numeric goals and target numbers of family planning (Carla, 2009, p.1).

The three mentioned elements of reproductive information had been identified. The first was the growing strength of the women's movement and their criticism of the over-emphasis on the control of female fertility - and by extension, their sexuality - to the exclusion of their other needs. A second key development was the advent of the HIV and AIDS pandemic. Suddenly it became imperative to respond to the consequences of sexual activity other than pregnancy, in particular sexually transmitted diseases. But perhaps more important, it became possible (and essential) to talk about sex, about sexual relations outside marriage as well as within it, and about the sexuality of young people. A third development that brought a unity was the articulation of the concept of reproductive rights. An interpretation of international human rights treaties in terms of women's health in general and reproductive health in particular gradually gained acceptance during the 1990s. Three rights in particular were identified:-

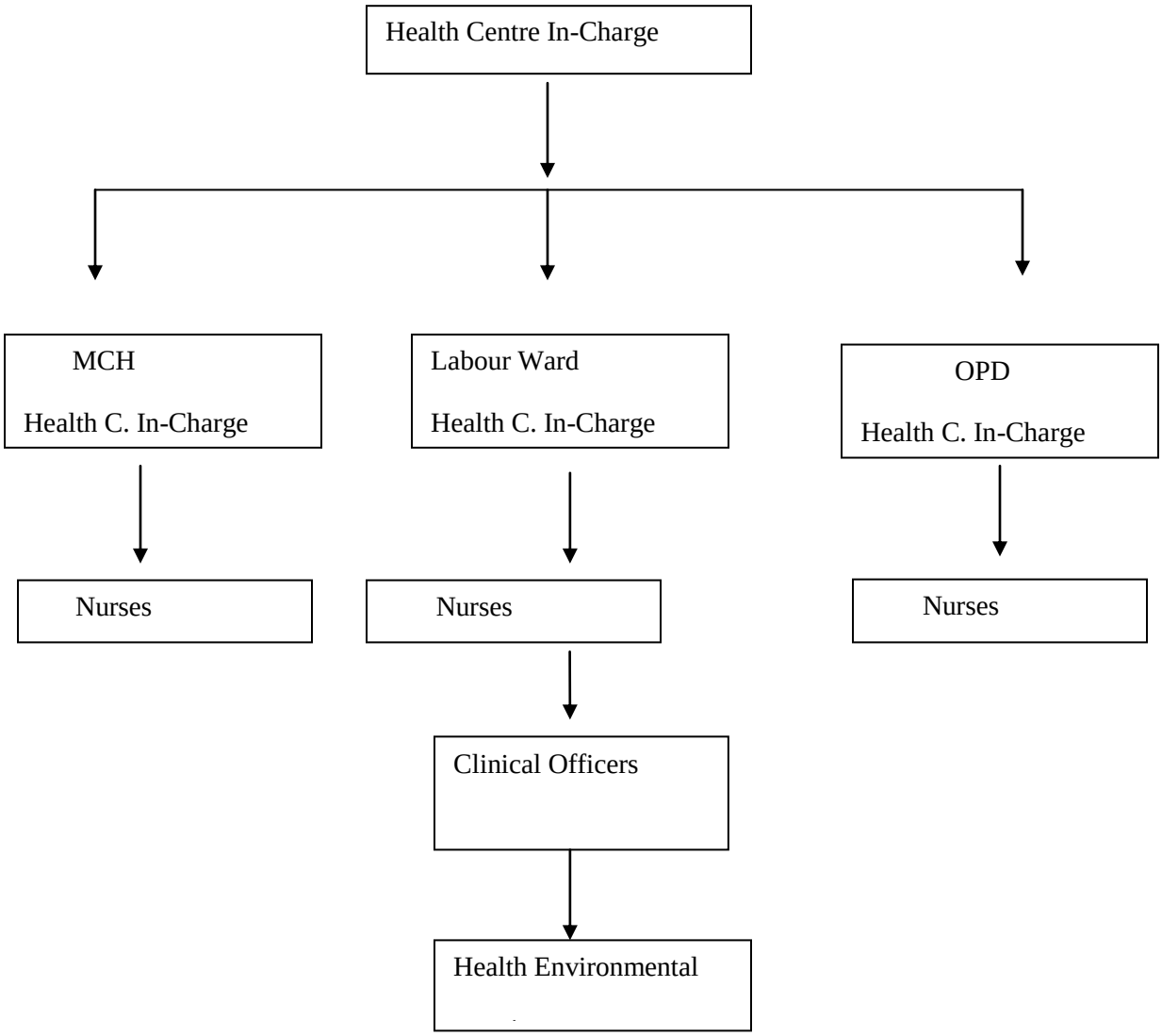
- the right of couples and individuals to decide freely and responsibly the number and spacing of children and to have the information and means to do so;
- the right to attain the highest standard of sexual and reproductive health;
- and, the right to make decisions free of discrimination, coercion or violence (http://www.who.int/bulletin/volumes/88/7/09-063412/en/index.htm-WBI Reproductive Health and Health reform; Background paper on reproductive health, p. 16 accessed on 06/11/2012).

1.3. Description of the Area

The study area, Mukonchi, encompasses a description of a rural area in Central Province, KapiriMposhi District. The area is sparsely populated with the rural majority being women of reproductive age. The Health Centre is in the Eastern Zone of Kapiri Mposhi District. The Centre borders with Kafinda and Chishinka in the East, Chibwe in the West, Lunchu B in the North while Kampumba borders in the South. The nearest referral Centre is Kabwe General Hospital in Kabwe District, which is accessible by a 54Km gravel road. The Health Centre's population was at 19, 512 and women of childbearing age were 4,743(15-49 years) (Kapiri District Health Centre Annual Report, 2011, p.6).

The organisation structure of Mukonchi Clinic comprises the head of the clinic is the Health In-Charge under whom fall three Departments. These are Maternal Child Health Care, Labour Ward and Out Patient department. The Maternal Child Health Care Department is the one which has incorporated the Reproductive Health Section. The organisation structure for Mukonchi health rural Clinic is as summarized on the next page.

Mukonchi Rural Health Centre Organisation Structure



1.4. Statement of the Problem

Women of Mukonchi in Kapiri District are facing a lot of problems with diseases that are of reproductive health nature. Most of them have many children while some are infected with HIV, AIDS, and Sexually Transmitted Infections. Women also tend to be married off early at tender ages normally less than sixteen years of age which results in exposing them to complications of pregnancies. The end result is high maternal and child mortality. In addition, they have limited access to reproductive health information and family planning programmes.

According to Kapiri District Hospital quarterly health report (2010, p. 14) only 34% women of childbearing age of Mukonchi are on family planning programme. When women in a given population are not using family planning methods there is likelihood of it to result in overcrowding of the place which would become a health hazard to the community thus may result in getting infected with various diseases such diarrhoea, cholera, dysentery and other related diseases . Furthermore, Kapiri District Hospital quarterly report (2010: p.15) reveals that the STIs prevalence rates stands at 52% in Mukonchi, this also means that there would be a lot of deaths as a result of STIs and the community would lose women who are productive. Arising from this situation, one would deduce that the HIV and AIDS prevalence rate is also likely to be high because where STIs prevalence rate is high; cases of HIV and AIDS are also recorded. As Ford Foundation (1996, p.17) puts it that STI prevalence rate can act as an indicator for the magnitude of HIV and AIDS where data is not available. The consequence of HIV and AIDS is that the community would have unhealthy people who will contribute less to the development of any given community coupled with high mortality rates directly because of the disease and also indirectly due to HIV induced and related diseases such as tuberculosis and cancer to name but a few.

One of the major problems to women of age in Mukonchi is lack of adequate information; as access to information is not easy. Remember that information is power. Therefore, lack of

information by women of age in Mukonchi area leads to life haemorrhage. Due to cultural phenomena, the rate of adoption is very slow in terms of reproductive health information such as family planning, STI's and HIV and AIDS. From this it can be drawn that these problems are experienced because the people in this area lack reproductive health information. Lucas (1994, p. 85) also holds that when women have a negative attitude towards contraception the consequence is high fertility and unwanted pregnancies which may sometimes end up in termination. The consequence of this problem is that there will be high maternal deaths and infant mortality rate because women are not using family planning.

1.5. Rationale of the Study

Vivian (2007, p.3) asserted that people form opinions from the information and interpretation to which they are exposed, meaning that information has an element of persuasion. Information also binds communities together by giving messages that become a shared experience. It is often stated that information is power, hence if women are given necessary information then there would be empowerment with good knowledge about reproductive health.

This research is intended to contribute to greater understanding and appreciation of how different information dissemination strategies can assist to facilitate efficiency in the provision and dissemination of reproductive health information.

Reproductive health problems remain the leading cause of ill health and death for women of age worldwide and Zambia inclusive (Lucas, 1994, p. 56). Impoverished women, especially those living in developing countries like Zambia suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence and other problems related to their reproductive system and sexual

behaviour. Access to information is essential in communication because without it there would be difficulties to communicate and increase adoption rates (http://www.unfpa.org/rh/index.htm, accessed on 7/11/2012).

The significance of this study is that the findings would be beneficial to the community development committees and would be helpful to policy makers and other stakeholders involved in the dissemination of reproductive health information and other health services. The study was carried out because very little has been written on the effectiveness of clinic centres in providing reproductive health information in Zambia and there is nothing written about the Mukonchi Rural Health Clinic.

The findings of this research would be contributing to the existing body of knowledge. The findings also would help to improve the current situation at Mukonchi health clinic and the community it serves. The research findings would bring positive adjustment to the way Mukonchi Health clinic disseminates information to women of age and their spouses and will help to change the perceptions of the females and their spouses in the surrounding communities.

1.6.General Objectives

To access the effectiveness of Mukonchi Rural Health Centre in providing Reproductive Health Information to reproductive women of age at Zambian Compound in Kapiri Mposhi.

1.6.1. Specific Objectives

- To establish the socio economic and demographic status of women of reproductive age at Zambian Compound of Mukonchi.

- To determine the knowledge, attitude, practices and beliefs in reproductive women of age on reproductive health issues of Zambian Compound of Mukonchi.
- To establish women's awareness of the existence of the reproductive health information at Mukonchi Rural Health Centre of Mukonchi.
- To establish the average number of visits by reproductive women of age per week for family planning services at Mukonchi Rural Health Centre.
- To find out if the mode of information provided by the Mukonchi Rural Health Centre is effective.
- To find out if and how women access reproductive health information from the Mukonchi Rural Health Centre.
- To find out the effectiveness of the methods used by Mukonchi Rural Health Centre to disseminate information of reproductive health.
- To find out how cooperative and encouraging the men (husbands) are in assisting women to access reproductive health information.

CHAPTER TWO : METHODOLOGY

2. Introduction

This chapter discusses the methodology the researcher used in the research. It contains the main questions which were asked during data collection. The chapter further discusses ways of gathering the data and sampling procedures which were employed during the research. The study methodology was structured under the following sub-headings: Research Questions, Methods of Data Collection, Quantitative Survey, and Qualitative survey, Data Collection, Sampling Procedure, Data Analysis, Ethical Considerations and Limitations of the study. The researcher administered 100 questionnaires for women and other 100 for men. The questionnaires were randomly administered to a sample of reproductive women and men of Zambian Compound of Mukonchi.

2.1. Research Questions

The following are the main questions which were used during the research:

- How is the socio economic and demographic status for women of reproductive age in Mukonchi?
- What are the knowledge, attitudes, practices and beliefs among reproductive women of age in Mukonchi area?
- What are the communications strategies which are used by Mukonchi Health Clinic and its agencies to communicate with women of age and their spouses?
- What are the communication challenges being faced by implementers of reproductive health services in Munkonchi area?
- Which effective communication strategies can assist to disseminate reproductive health information effectively to reproductive women of age of Mukonchi?
- How are the men involved in reproductive health services?

2.2 Research Design

Research design is considered as a "blueprint" for research, dealing with at least four problems: which questions to study, which data are relevant, what data to collect, and how to analyze the results. The best design depends on the research question as well as the orientation of the researcher. A research design deals with a logical problem and not a logistical problem (Yin, 1989, p. 29). Before a builder or architect can develop a work plan or order materials they must first establish the type of building required, its uses and the needs of the occupants. The work plan flows from this. Similarly, in social research the issues of sampling, method of data collection (e.g. questionnaire, observation, and document analysis), and design of questions are all subsidiary to the matter of what evidence needs to be collected.

Therefore a good research needs a design or a structure before data collection or analysis can commence. A research design is not just a work plan. A work plan details what has to be done to complete the project but the work plan will flow from the project's research design. The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible. Obtaining relevant evidence entails specifying the type of evidence needed to answer the research question, to test a theory, to evaluate a program or to accurately describe some phenomenon.

2.2.1. Tools and approaches used to collect data

In order to gain a comprehensive understanding of the relevance of Reproductive Health Information to women of age of Munkochi, the researcher had to ensure that as much data as possible was collected by using both quantitative and qualitative survey. The mix methodology was aimed at improving research validity of psychological trials based on the fact that any method employed has its own limitations and biases that would be reduced by the use of two multiple approaches (Cresswell 2000, p.137).

Using this approach, it was possible to get acquaintance with the attitude of women of age in Mukonchi, the perception of their spouses (partners/husbands) and also gain an insight view into possible communicative and participatory strategic interventions to address the effects. Due to the triangulation of the study the following approaches were undertaken.

- Focus group discussions.
- In-depth interviews
- Observation Method (Attending scheduled local programmes and meetings).
- Use of structured questionnaires.
- Use of documentary data.

2.2.2. Quantitative Survey

Quantitative Research method is applied as a research tool. Quantitative Research applies statistics as a means of capturing and dealing with large numbers, classifying the numbers and making statements about their meaning. A whole number of techniques' are based on use of descriptive statistics. Quantitative experiments are useful for testing the results gained by a series of qualitative experiments, leading to a final answer and narrowing down of possible directions for follow up research to take.

The researcher choose the quantitative survey as one of the methods of conducting research because it enabled different types of techniques from those of qualitative methods that relies more on interviews, observations, small numbers of questionnaires, focus groups, subjective reports and case studies but for quantitative method there was much more focus on the collection and analysis of numerical data and statistics. Quantitative research allowed the researcher to go through a process which is recognised and accepted by the social science community (Miles &Huberman, 1994, p. 40).

The structured questions addressed the following:-.

- Vital personal information on persons interviewed
- Social, economic and demographic status of persons interviewed
- Level of awareness on reproductive health issues
- Reproductive Health Services available at the health centre
- Availability of health education services on Reproductive Health
- Traditional beliefs on Reproductive Health
- Knowledge, attitudes and practices among reproductive women of age on reproductive health issues
- How you learnt about reproductive health issues
- Where you learnt reproductive health issues
- Benefits of reproductive health information
- Modes of information provision by the Mukonchi Rural Health Centre to women of age of Zambian compound of Mukonchi

- Male involvement and how supportive they are to their spouses in reproductive health issues

2.2.3. Qualitative Survey

The researcher used the Qualitative methods because it produces information only on the particular cases studied and any more general conclusions are only hypotheses. The Researcher used qualitative research because it was able to examine, analyse and interpret observations for the purposes of discovering underlying meanings and patterns of relationships, including classification of types of phenomena and entities, in a manner that does not involve mathematics models (http://www.gifted.uconn.edu/siegle/research/Qualitative/qualquan.htm-accessed on 16/02/2013).

The qualitative research allowed the researcher to be involved; it made the researcher gain an inside view of the field under study. In qualitative survey, description played an important role of suggestions, possible relationship causes, effects and dynamic processes that the researcher under took on this study (Miles &Huberman, 1994, p. 40).

In qualitative research the researcher was not able to use statistics but rather a more descriptive, narrative style, thus, allowed a benefit to the subject under study (Maxi, 1999, p. 56).

(i) Focus Group Discussions

In this approach the following methods were used for data collection:

Figure 1. The Researcher with Focus Group Participants

Focus Group discussions were held with reproductive women of age and their spouses of Zambian Compound who attended the Health visits at Mukonchi Rural Health Centre, as shown in figure 1.

The researcher acted as a facilitator to ensure that the discussion was on course and research intentions were brought out. An audio tape recorder was used to record the discussions.

(ii) In-Depth Interview

This is another method of data collection that was used. Consent was sought from all respondents and confidentiality guaranteed. This was done in order not just to get answers, but also to understand people's feelings, experiences and meanings they attach to their experiences of their reality of being studied (Seideman 1991, pp.77-81).

Semi structured in-depth interviews were conducted with women of age, men, opinion leaders, members of the neighbourhood health committee and staff from the Health Centre.

The advantage of this method was that it enabled the researcher to view the situation without artificiality that sometimes accompanies experiments. These methods also provided the possibility of deeper understanding of the phenomenon by finding out more information than expected.

(iii) Sampling Procedure

Study Area

The study was carried out in Zambian compound in Mukonchi of Kapiri District of Central Province. Mukonchi has a population of 22,479 while Zambian Compound has a total population of 5,000. The reason why the researcher chose Zambian compound is because the health information system is located in the same area. The target population was selected from Zambian compound because it is the one which has been identified to have the problem already stated. Also the findings are representative to Mukonchi health clinic and are applicable to any health information system providing information to a community of similar characteristics.

The category of women of age and their husbands from the Zambian Compound of Mukonchi of KapiriMposhi district was covered (Mukonchi health Report, pp. 16).

Type of Study

This research adopted a non-experimental design because it was undertaken in uncontrolled and natural setting of the environment. The study was descriptive since it involved systematic collection and presentation of data. Furthermore, the findings have been generalized to the entire population of Munkonchi clinic.

Target population

The target population included women of reproductive age and their husbands between 15-49 years from Zambian compound. A female or male household head was interviewed, in a situation where a household head was not found any woman or man of reproductive age was interviewed.

2.3.1. Systematic Random Sampling and Procedure

The researcher used Systematic Random Sampling to select population sample size of two hundred (200) out of 5000 population of Zambian Compound of which one hundred were administered to women and the other hundred to the men so as to see also how men participate in helping their women in reproduction health information.

Systematic Random sampling was used; the researcher picked every 8^{th} count starting from number 5. Systematic sampling is a random sampling technique which is frequently chosen by researchers for its simplicity and its periodic quality. The procedure involved was systematic random sampling and it was done manually (http://sociology.about.com/od/Types-of-Samples/a/Systematic-Sample.htm, accessed on 16/02/2013).

2.4. Data Collection

2.4.1. Physical Observation

The researcher spent two months in Mukonchi district observing and participating in the clinic's day to day activities. The method used thorough systematic and unbiased noting down what the researcher sees. The aim was to capture relevant data that would be used to quantify the study findings.

Figure 2. The researcher during the Anti-natal class Observation

2.4.1.2. Questionnaires

The questionnaire method was used because it involves personal contact with the respondents, chance was given to express views in their own words as they ticked or filled in the questionnaire. Open and closed ended questions were used in the questionnaire. The researcher had separate questions for both women and men but carrying similar information or message.

2.4.1.3. *In-Depth Interviews*

In-depth interviews were employed in data gathering. This was another method of data collection that was used. Semi structured in-depth interviews were conducted with Opinion Leaders, staff from the Health Centre, the Clergyman from Mukonchi Catholic Church, the Chairman of Zambian Compound and the Ward Counsellor from Mukonchi Ward.

Figure 3. The researcher interviewing the Ward Councillor

The advantage of this method was to enable the researcher to view the situation without artificiality that sometimes accompanies experiments. The in-depth interview methods provided a deeper understanding of the phenomenon by finding out more information than expected.

This method was targeted at the opinion leaders in the community and neighbourhood health committee members.

2.5. Data Analysis

Data was analysed through the use of Statistical Package for Social Sciences (SPSS) software for data entry and analysis. This programme was used as it helped to obtain frequencies, percentages and charts in an accurate and faster way for easy interpretation.

2.6. Ethical Considerations

Due to the sensitivity of the topic, the respondents were assured that information which they were giving was treated with the highest confidentiality as the study is purely academic.

Furthermore, notification was made to the Mukonchi clinic health management board since the information which was collected concerns them.

2.7. Limitation of the Research

It is important to note that there were some limitations in the process of gathering data for the research. It is also important to mention that a good number of respondents to the questionnaires were unable to read and understand English. In such circumstances the data collector had to translate questions into a locally used language to enable the respondent understand and respond appropriately. This was risky as translation into a local language may not carry the accurate meaning thereby leading to inappropriate responses.

The research was conducted outside Lusaka specifically rural area of Central Province which was far away which made it costly thus needed proper financial support.

CHAPTER THREE: CONCEPTUAL AND THEORETICAL FRAMEWORK

3. Introduction

This chapter looks at the main concepts and theories the researcher used in this study; Communication, Family Planning, Safe Motherhood and Health Promotion. These have been identified as the key concepts in this research document.

3.1. Communication Defined

Many definitions have been made regarding the term communication. These attempts by various scholars to give a definition of the term have landed in a predicament because there is no single approach to the study of communication (Madondo, 2002, p.36). Some scholars have defined communication as a symbolic social process, which occurs when there is an idea in response to something, which has been seen or heard (Wimmer and Dominic, 1997, p.134).

Communication as been defined by other scholars as any act by which one person gives to or receives information from one person about that person's needs, desires, perceptions, knowledge, or affective states. Communication may be intentional or unintentional, may involve conventional or unconventional signals, may take linguistic or non-linguistic forms, and may occur through spoken or other modes (http://www.unm.edu/~devalenz/handouts/defcomm.html accessed on 28/10/2012).

Others have defined communication as that which takes place when one individual, a sender, displays, transmits or otherwise directs a set of symbols to another individual, a receiver, with the aim of changing something, either something the receiver is doing (or not doing) or changing his or her world view. This set of symbols is typically described as a message (Shirley et al., 1994, p. 43).

McQuail (1994, p.492) says, "the term communication has many meanings and definitions but the central idea is of a process of increased commonality or sharing between participants on the basis of sending and receiving messages."

Miller (1996, p.7) observed that communication has its central interest in behavioural situations in which a source transmits a message to a receiver with conscious intent to affect the latter's behaviour. According to Tubbs (2008, p.7), communication is the process by which participants create and share information with one another for mutual understanding. Similarly Rodgers (2003, p.35) refers to communication as a process by which participants create and share information with one another for mutual understanding.

In this study communication is applied in the sense that for the information to be disseminated effectively to the reproductive women of age communication has to be used, in this case the health providers must communicate effectively to these women of age in Mukonchi area.

3.2.1. Types of Communication

There are several types of communication. However, the most notable communication contexts include:

3.1.1.1. Small Group Communication

Small group communication is, of course, the communication that is carried out within a small group. A small group is generally defined as a group that consists of at least three members or a maximum of around twelve to fifteen members. A group that has just two members or more than fifteen members would not come in the category of a small group. A small group may be a professional group, an educational group or a social group. The members belonging to it will have a common bond or interest or goal that brings them together. Even though the numbers of

members are less in a small group, effective communication between them is still important (http://www.buzzle.com/articles/small-group-communication-effective-team-communication.html, accessed on 22/02/2013).

This type of communication is in line with the study in that during the focus group discussions it helped the researcher to communicate with the participants fully since the group had a common interest.

3.1.1.2. Organisational Communication

This is communication within an organization or between organizations. Effective communication in the workplace is essential to the delivery of successful organisational strategy and change, employee commitment, and ultimately competitive advantage. An organisation's ability to engage stakeholders through excellent communication strategy and action is an essential skill. Without it the chances of organisations ever achieving their strategic objectives are reduced. Organisational Communication offers practical tools, techniques and a model for developing a communications strategy (Tubbs et al., 2008, pp. 19 – 22).

Organisational communication is in line with the study in that it will be able to show how Mukonchi rural health centre offers practical tools, techniques and how they work as an organisation in disseminating information to women of age and their spouses.

3.1.1.3. Interviewing

The context is defined as communication transaction and it emphasizes questions and answers with a view of extracting the required information (Tubbs et al., 2008, p.15). During the in-depth interviews, focus group discussion and when administering questionnaires the researcher used this type of communication.

3.1.1.4. Participatory Communication

It is defined as the type of communication in which all the interlocutors are free and have equal access to the means to express their view points, feelings and experiences. Therefore, it implies people's involvement in all forms of communication; be it inter-personal, mass media, team communication and cultural communication (Shirley et al., 1994, p.43).

During the focus group discussion the researcher was able to use this type of communication. Besides, the Mukonchi Rural health Centre uses participatory communication during the weekly health education programmes. The women participate fully by engaging them in a discussion.

Participatory communication is an essential component in development. The notion of participatory communication signifies a pragmatic concept that presupposes a basic commitment on mutuality and respect for one another (Freire 1978, p.81).

3.1.1.5. Communication for Development

Communication for development implies the use of a communication process, techniques and strategies in promoting development ideas to raise peoples' awareness of their own situation and

the options they have at their disposal for activities involving change, as well as helping to resolve social conflicts and working together to reach a consensus (IIboudo, 2002, p. 17).

The aim communication for development is to facilitate mutual understanding and consensus for action among stakeholders during every step of the process to ensure success and sustainability of the development effort. It seeks to integrate people's culture, attitudes, knowledge, practices, perceptions, needs and problems in the implementation of projects and programmes to guarantee that they are effective and relevant (Mefalopulos and Moetsabi 1999, p. 55). For proper development to take place there is need to empower women and men in reproductive health information.

3.1.2 Importance of Communication

According to Infant et al. (1997, p. 23), it is important to communicate because it helps create cooperation and interaction with one another, acquire information and entertainment. He adds that communication is important because without it development would not be possible. Even to be aware that development has occurred; one should be able to communicate within self (intra personal) and with others. In line with this research, communication was played throughout the research because for data to be collected fully there was full use of communication.

3.1.3 Family Planning

The term family planning is sometimes used interchangeably with the term birth control, although there are some differences between the two terms. While birth control is something anybody can use to prevent pregnancy, family planning is seen as something monogamous couples use to temporarily delay pregnancy. In this way, it is seen as a method to plan, rather than prevent, children. This method has been seen as responsible choice for couples who are not

ready to have children in the present but may want to in future (http://www.wisegeek.com/what-is-family-planning.htm, accessed on 10/12/2012).

Family planning includes all methods of birth control, from the pill to condoms, Intrauterine Devices (IUD), injectable hormonal contraceptives, and diaphragms, caps and spermicidal. Depending on the area, it may also refer to methods used to terminate a pregnancy or possible pregnancy, such as abortion and emergency contraception. It may also refer to surgical sterilization methods, including vasectomies and tubal ligation; and to non-surgical methods of sterilization (Seats, 2000, p. 26).

Family planning is also the term preferred by religious couples who do not approve of using artificial birth control methods to prevent pregnancy. In this case, the term refers exclusively to techniques such as temporary abstinence, the withdrawal method, or the rhythm method, in which no outside interference is used. While family planning clinics do not favour any method over others, they are usually able to accommodate most preferences and beliefs (Walleys, 2001, p.37).

A lack of cultural sensitivity and poor treatment can discourage women from accessing services even where available. Women have cited a variety of abusive behaviours as reasons for choosing the more perilous routes of home birth. Among them: offensive and demeaning language on the part of health care personnel, ridicule in the form of mockery concerning a woman's clothing, smell, hygiene, cries of pain, or the desire to remain clothed while giving birth (http://www.unfpa.org/rh/planning.htm -accessed on 12/08/2012).

3.1.4. Safe Motherhood

Safe motherhood refers to physical safety - ensuring that both mother and infant survive the pregnancy and delivery (http://notenoughgood.com/2012/02/redefining-safe-motherhood/ accessed on 11/10/2012). However, as the move goes towards a more human rights- based understanding of maternal health, the concept of safe motherhood is expanded past the basic health care needs of women. Instead, safe motherhood now encompasses various areas within the human rights realm; women not only have the right to appropriate and timely medical treatment, but also treatment that respects a woman's dignity and choices (http://notenoughgood.com/2012/02/redefining-safe-motherhood/ accessed on 11/10/2012).

Safe Motherhood has evolved from a neglected component in maternal and child health programs to an essential and integrated element of women's sexual and reproductive health (The Safe motherhood initiative, 2005, p.8).

3.1.5. Health Promotion

Health Promotion is a general term which covers all health issues and includes all methods including improvements in services, promotion of healthy public policy and education/communication components of health promotion. Health Education specifically refers to the education/communication components of health promotion. Also used for health education has been the term 'information, education and communication' usually abbreviated to IEC- and another term communication support (www.jhonhubley.co.uk-accessed on 12/10/2012). Health Education messages are developed based on knowledge, attitude and practices (KAP). Messages

will need to be tailored for cultural acceptability, literacy levels, available infrastructure and for their specific target audience (Kailyaperul et al., 2003, p.14).

3.2.1. Main Theories and Application to the Study

The following were the main theories that were used in the study:

3.2.1.1 Diffusion of Innovation Theory

This was the main theory that was connected to the research. Diffusion of Innovation Theory encompasses very well with everyday life and how this either adopts or eliminates certain elements.

Rogers (2003,.p.5) defined diffusion as the process by which an innovation is communicated through certain channels over time among the members of a social system. Roger's definition contains four elements that are present in the diffusion of innovation process. The four main elements are:

- Innovation: an idea, practice, or object that is perceived as new by an individual to unit of adoption. Rodgers offered the following description of an innovation: "An innovation is an idea, practice or project that is perceived as new by an individual or other unit of adoption"(Rodgers, 2003, p.12).
- Communication channels: these are messages one gets from one individual to another. This communication occurs through channels between sources. Rodgers states that a source is an individual or an institution that originates a message. A channel is the means by which a message gets from the source to the receiver (Rodgers, 2003, p. 204).

- Time : the three time factors are:
    a) Innovation – decision process

b) Relative time with which an innovation is adopted by an individual or group
c) Innovation's rate of adoption.

- Social system: a set of interrelated units that are engaged in joint problem solving to accomplish a common goal (Rodgers 2003, p. 23).

In the diffusion of innovation the communication process between the media and the point of decision-making by the audience passes through many hands. Therefore, the roles of the opinion leaders are of paramount importance.

Rogers (2003, p.5) defines the diffusion as a process in which an innovation is communicated through certain channels over time among members of a social system. Thus it is the spread of a new idea from its source of invention or creation to its ultimate users or adopters. Rogers differentiates the adoption process from the diffusion process in that the diffusion process occurs within society, as a group process as, the mental process through which an individual passes from first hearing about an innovation to final adoption to be effective through channels over some time hence the members of the social system will be able to learn from each other in the community.

The theory is relevant to the research as it provides the reality of how lives of the members of the social system are affected in terms of information flow. The people in positions of authority at the health centre act as innovators while members of the neighbourhood health committee, church elders, chairpersons and counsellors' act as adopters who influence others in the adoption process. It is evident that as opinion leaders in the social system adopt information these have great influence over the members of the community and play a critical role in determining the flow of information in communities. The organizational structure depicts well this trend when information moves from clinic staff to the neighbourhood health committee and community leaders and finally to the grassroots.

The five stages of innovation decision process

Rogers (2003, p.172) described the innovation-decision process as "an information seeking and information processing activity, where an individual is motivated to reduce uncertainty about advantages and disadvantages of an innovation". For Rodgers the innovation-decision process involves five steps: Knowledge, Persuasion, Decision, Implementation and Confirmation.

The knowledge stage: the innovation process starts with the knowledge stage. In this stage an individual learns about the existence of information about the innovation. What, how and why are the critical questions in the knowledge stage. During this phase, the individual attempts to determine what innovation is and how it works (Rodgers, 2003, p. 21).

The Persuasion stage: the persuasion stage occurs when an individual has a negative and positive attitude towards the innovation, but the formation of a favourable or unfavourable attitude towards an innovation does not always lead directly or indirectly to an adoption or rejection (Rodgers, 2003, p.176). While information about an innovation is usually available from outside experts and scientific evaluations, teachers usually seek it from trusted friends and colleagues whose subjective opinions of an innovation are most convincing (Sherry, 1997, p. 70).

The Decision Stage: at the decision stage in the innovation –decision process, the individual chooses to adopt or reject the innovation. While adoption refers to full use of an innovation as the best course of action available, rejection means not to adopt an innovation (Rodgers, 2003, p.177). If an innovation has a partial trial basis, it is usually adopted more quickly, since most individual's first want to try the innovation in their own situation and then come to an adoption decision (Ismail 2006, p.16).

The Implementation Stage: At the implementation stage, an innovation is put into practice. However, an innovation brings in the newness in which some degree of uncertainty is involved in diffusion; thus the implementer may need technical assistance from change agents and others to reduce the degree of uncertainty about the consequences (Ismail, 2006, p.17). Moreover, the innovation-decision process will end since the innovation loses its distinctive quality as the separate identity of new idea disappears (Rodgers, 2003, p. 180). Reinvention usually happens at the implementation stage, so it's an important part of this stage (Ismail, 2006, p. 17). Reinvention is the degree to which an invention is changed or modified by the user in the process of its adoption and implementation (Rodgers, 2003, p.180).

Confirmation Stage: The innovation decision already has been made, but at the confirmation stage the individual looks for support for his or her decision. This decision can be reversed if the individual is exposed to conflicting messages about the innovation (Roders,2003,p189).

However, the individual tends to stay away from these messages and seeks supportive messages that confirm his or her decision; thus attitudes become more crucial at the confirmation stage depending on the support for adoption of the innovation and the attitude of the individual, later adoption, or discontinuance happens during this stage (Ismail 1997, p. 17).

The above description of innovation – decision process illustrates five important points people should be convinced of before the adoption of an innovation. The attributes of innovations include: Relative advantage, Compatibility, Complexity, Trialability and Observability .The innovation-decision process is an uncertainty about the innovation (Rodgers, 2003, p. 232).

Perceptions of these characteristics predict the rate of adoption of innovations (Rodgers, 2003, p. 219).

The rate of adoption is the relative speed with which an innovation is adopted by members of a social system (Rodgers, 2003, p. 221). For instance the number of individuals who adopted an innovation for a period can be measured as the rate of adoption of the innovation.

- Relative advantage to the innovation :– this refers to the degree to which an innovation is perceived as being better than the idea it supersedes (Rodgers,2003, p. 229)
- Compatibility: – this is concerned with the degree to which an innovation is perceived as being consistent with the existing values, past experience and needs of potential adopters. (Rodgers, 2003, p. 15).
- Complexity: – it is defined as the degree to which an innovation is perceived as difficult to understand and use (Rodgers, 2003, p. 15).
- Trialability :– The degree to which an innovation may be experimented with on limited basis(Rodgers,2003,p.16)
- Observability: – The degree to which the results of an innovation are visible to others (Rodgers, 2003, p.16).

Only after going through these stages would the society or individuals adopt the innovation and integrate it into their day-to-day life. The heaviest load in this process lies with the one who is conceived and introduces the innovation to the would-be adopters. This is crucial as the point of departure of the entire process resides at this level.

For adoptable innovations to take place in communities, it's necessary to consider the five stages mentioned and relate them to issues of modern communication that can easily be embraced by

affected communities. The impact of this theory to this study is that members in the social system (reproductive women of age) react differently in the manner information is received, hence some people in the social system (reproductive women of age and are early adopters while others are late adopters. It is very important for the innovators to make sure that reproductive health information for it to be reached effectively, it has to be a process that cannot be done in a short while because it passes through many hands.

3.2.2. The Mult-Step Flow Theory

The second theory the researcher used is the multi-step flow theory because it explains very well how information flows within the organization and its members. In this theory, understanding the identity of the opinion leaders is important. Katz and Lazarsfeld (1955 p.84) and Lowery and Defleur (1995 p.39) identified three dimensions in the lives of an individual that were related to his or her opinion leadership role namely, position in life cycle, socio-economic status and social contacts.

The Diffusion of innovation theory is used as the main theory because it brings a lot of players on board in the communication process. Whereas the Multi Step Flow Theory deals with the exchange of information between the media and the recipients, Diffusion of Innovation Theory deals with the conditions that increase or decrease the likelihood that members of a given society will adopt a new idea, product, or practice.

In the diffusion of innovation the communication process between the media and the point of decision-making by the audience passes through many hands. Therefore, the roles of the opinion leaders are of a paramount importance.

The core-assumption of this theory is that media messages pass through several opinion leaders before reaching the mass audience. There is a flow of influence from both opinion leaders to less attentive actors, but also between opinion leaders to other leaders (Clark 2001, p.14). This kind of opinion sharing occurs in a horizontal fashion between opinion leaders. This creates a flow of influence which extends even further when readers share information with others via media or through the offline interpersonal communication.

The Multi Step-Flow Theory is relevant to the research as it provides the reality of how lives of the members of the social system are affected. The people in positions of authority at the health centre, members of the neighbourhood health committee, church elders, chairpersons and counsellors will act as opinion leaders in relaying information to the community. It is evident that these have great influence over the members of the community and play a critical role in determining the flow of events in communities. The organizational structure depicts well this trend when information move from clinic staff to the neighbourhood health committee and community leaders and finally to the grassroots.

CHAPTER FOUR: LITERATURE REVIEW

4. Introduction

This chapter looks at some of the literature that has been written connected to the study on three levels, namely: the Global perspective, Africa and Zambia. This report begins with a global perspective on Reproductive Health Information, the second part deals with the African perspective on Reproductive Health information and the last part deals with the Zambian Reproductive health information. The purpose is to make sure that this report is original and not a duplicate of what has been done in the past.

Reproductive health information is one of the most important aspects of health. Health allows people to work and allows them to live happily. Protecting and promoting reproductive health care is central to the entire process of poverty reduction and human development. For the country, meeting the reproductive health needs of the poor is an important means to prevent the increase in poverty as they suffer a heavy burden of diseases. This can only be done by providing reproductive health information to the women of age and their spouses specifically at Global, African and National level.

The World Health Organisation (2000, p.73) stated that information and education provide the informed base for making choices. It further stated that information and education are necessary and core components of health promotion, which aims at increasing knowledge and disseminating information related to health. Health information and education should include the

public's perceptions and experiences of health and how it might be sought; knowledge from social sciences and epidemiology on the patterns of health, disease and factors affecting them. It also expressed that health information systems should collect and disseminate the information in the right channel to meet the needs of the community they are serving.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. The WHO definition of reproductive health extends beyond the physical aspects of health to include mental and social well-being. A quality service attempts to capture all aspects of the definition. This means that reproductive health service program must take into account the social context in which women and men live (Silimperi, 2000, p. 12)

Reproductive health, therefore, implies that reproductive women and men are able to have a satisfying and safe sex life. It means that having the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed. Women and men should have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of reproductive health information, which are not against the law. The right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child (ICPD, 2004, p.4).

4.1. Global Perspective on Reproductive Health Information

The 1994 Cairo International Conference on Population and Development (ICPD) marked a turning point for reproductive health. For the first time, reproductive rights were internationally recognised by Governments, as contained in the international human rights documents. The

Programme of Action adopted at the ICPD established the right of men and women to be informed about their reproductive health choices and to have access to the information and services that make good health possible (Reproductive Health Profile, 2003, p.7).

Taking a holistic and life cycle approach to women's health, the Beijing Platform Action proposed five strategic objectives:-

- Increased women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.
- Strengthen preventive measures programmes that promote women's health
- Undertake gender sensitive initiatives that address sexually transmitted diseases, HIV and AIDS, sexual and reproductive health issues.
- Promote research and disseminating information on women's health (ICPD, 1994, p.5).

Global health has improved considerably over the last four decades, but everywhere the reproductive health status of the poor compares unfavourably with that of the more affluent sectors of society. In Africa, one in 26 women of reproductive age dies from a maternal cause, as opposed to one in 9400 in Europe (http://www.who.int/bulletin/volumes/89/4/10-083329/en/index.html, viewed on 5/20/2013).

Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention management and prevention of maternal and peri-natal mortality and morbidity.

On the other hand since 2006, there have been important improvements in the health status of men at global level especially on reproductive health information, including an increase to life expectancy by more than a decade (Klassen, 2006,p. 77).

The following are some of the achievements that have been recorded in terms of men participation in reproductive health information:

- Educating fathers about safer childbirth and discouraging unsafe home deliveries
- Training physicians to involve men in maternity care, which has resulted in more husbands accompanying their wives to antenatal clinics.
- Encouraging men to share domestic chores and parenting responsibilities, which made women more likely to receive prenatal care, to reduce their workloads before giving birth and to deliver under more sanitary conditions (www.unfpa.org/publications/detail.cfm?ID-248filterListType –accessed on 02/11/2012).

Communities can play an important role in building demand for appropriate reproductive health services. For instance, they can mobilize and build awareness at the local level about reproductive health issues. They can organize to pool resources in micro-insurance schemes. individuals. Such efforts can be especially effective and timely as health reform and decentralization is underway in many countries. Innovative and participatory approaches are needed to ensure that reproductive health issues receive adequate attention during this transition (Lucas, 1994, p.57).

At least 200 million women want to use safe and effective family planning methods, but are unable to do so because they lack access to information and services or the support of their husbands and communities. And more than 50 million of the 190 million women who become pregnant each year have abortions. Many of these are clandestine and performed under unsafe conditions (Seats, 2000, p.23).

The need for voluntary family planning is growing fast, and it is estimated that the 'unmet need' will grow by 40 per cent during the next 15 years. But even though it is an economically sound investment, family planning has been losing ground as an international development priority.

Funding is decreasing, and the gap between the need and the available resources is growing. The international community has agreed that reproductive choice is a basic human right. But without access to relevant information and high-quality services, that right cannot be exercised (Seats, 2000, p. 24).

In Indonesia, through the programmes they initiated in the clinics they were able to train peer educators among sex workers of small groups of 5-10 people. During the training sessions, the tools used included flip charts, models of the penis, and special card games as well as role play games. Then influential brothel owners were selected to influence others in the locality by developing 'model brothels'. Also free supplies of condoms for sex were then established and put in place. Before the intervention, only 42% of the women surveyed by volunteers posing as clients refused to have sex without a condom. After the peer education programme the proportion which refused to have sex without a condom increased to more than 90%. This kind of research may have some testing effect were the subjects had an idea that they were being observed hence their behaviour changed. Therefore the findings of this research cannot be that reliable (Quarterly Report 2011, p. 4).

4.2. Perspective on Reproductive Health Information in Africa

The importance of good health and education to a woman's well-being and that of her family and society - cannot be overstated. Without reproductive health and freedom, women cannot fully exercise their fundamental human rights, such as those relating to education and employment. Yet around the world, the right to health, and especially reproductive and sexual health, is far from a reality for many women. According to the World Bank, a full one-third of the illness among women of ages 15- 49 in developing countries is related to pregnancy, childbirth, abortion, reproductive tract infections, and human immunodeficiency virus and acquired immune deficiency syndrome (Hubby, 2000, p. 54).

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and largely preventable suffering and deaths. Many of the women and girls who die each year during pregnancy and childbirth could have been saved by relatively low-cost improvements in reproductive healthcare; yet high levels of maternal mortality persist. The benefits of eliminating the harmful and painful practice of female genital mutilation are easily demonstrated, yet it persists for cultural and traditional reasons. And a large proportion of abortions, some resulting in death and injury, would be avoided if women and men had access to safe, affordable and effective means of contraception (http://www.un.org/ecosocdev/geninfo/women/womrepro.htm, accessed on 20/02/2013).

Women's health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner. Reproductive health is determined not only by the quality and availability of health care, but also by socio-economic development levels, lifestyles and women's position in society. In fact, the International Federation of Gynaecology and Obstetrics asserts that improvements in women's health require state action to correct injustices to women. In its 1994 World Report on Women's Health, the Federation states that women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights (Klassen, 2001, p. 33).

The long-term vision of the reproductive health strategy for the African Region 1998-2007 and beyond is that all the women and men of the region should enjoy, within the next 25 years, an improved quality of life through a significant reduction of maternal and neonatal morbidity and mortality, unwanted pregnancies and sexually transmitted infections and through the elimination of harmful practices and sexual violence. The countries of the region should also promote healthy sexual relationships, responsible parenthood and gender equality (Reproductive Health Profile, 2011, p.4).

The growing interest in the quality of reproductive health services over the last decade has emanated from a concern with the high levels of maternal mortality and morbidity in developing countries. Health professionals and organisations working in the developing world are now actively seeking more effective ways to prevent maternal deaths and improve women's health care (Assessing the Quality of Reproductive Health Services Vol. 17, p 423).

More than half a million women in the developing world die during pregnancy and child birth due to prevalence cases , with over 90% of those in Africa and Asia (www.unicef.org/sowc07/ docs/sow.pdf-assesed on 24/10/2012). Unsafe abortion continues to imperil women's reproductive health in developing countries. According to WHO estimates, 19 million unsafe abortions were carried out in 2000, with Asia, Africa and Latin America accounting for the highest numbers (www.who.int/reproductive -health/publications/unsafe_abortion-accesed on 15/09/2012).

Access to sexual and reproductive health is a key element in the fight against poverty and a necessary condition for the achievement of the Millennium Development Goals set up by the United Nations Agenda for 2015. To move forward to this agenda, the Ministers of Health of the African Union adopted in 2005 a Continental Policy on Sexual and Reproductive Health and Rights, recently strengthened by the Maputo Plan of Action, which set up the main strategies and challenges to be implemented in the next years. Considering it essential to build on partnership and mutual collaboration, a High Level Meeting on Sexual and Reproductive Health Policies in Africa was held in Barcelona from February 27th to March 3rd 2005, promoted by the Spanish Interest Group on Population, Development and Reproductive Health, Metges del Mon, the Spanish International Cooperation Agency and the Catalan Development Cooperation Agency, (http://www.unfpa.org/public/cache/bypass/parliamentarians/pid/3615?newsLId=6929, accessed on 30/03/2013).

Most women today want two, three or four children - fewer than in generations past. The use of modern contraceptive methods, including voluntary sterilization, has increased rapidly over the past 30 years, especially in countries with strong family planning programmes. In less developed regions, contraceptive use approaches 60 per cent of couples.

Most of this increase reflects greater contraceptive use by women. But in many countries, poverty and profound inequalities between men and women limit women's ability to plan their pregnancies. So does lack of access to effective contraceptive protection.

Differing patterns of contraceptive use may not reflect women's personal preferences as much as political and economic decisions made by governments to emphasize certain methods, the attitudes of medical professionals, cost, the limited range of methods offered in some countries or an uneven availability of contraceptive supplies (Guard and Ambre, 2002, p. 28).

Research which was carried out by World Health Organisation in 2011 found that lack of information utilization, limited access of service and lack of awareness on reproductive information, results in unwanted pregnancy and abortions. It also reported that lack of information is the most important factor in the least developed countries which was causing increase in the maternal and reproductive diseases. It further noticed that the attitude of the people was also the result of low utilization of health facilities. This means that even the information which was provided by the health centres could not be appreciated because they had a negative attitude towards reproductive health information (http://www.who.int/reproductivehealth/publications/general/lancet_4.pdf, accessed on 30/03/2013)

The Family Planning Association of Kenya (2001, p.12), provided the reproductive Health information to people by involving the Health centres where they disseminated information using the reference materials, Drama, Peer educators, News paper posting and music festivals. This

information was provided through static clinic services for family planning and reproductive health was geared to meet the needs of the people of low economic status especially women. After they evaluated in the districts they provided information, it was discovered that there was an increase in the prevalence of contraceptive use from 17.6% in 1995 to 26.4% in 2007and the reproductive diseases reduced tremendously. The method which the people recognized as the most effective method of all the methods of information provision is peer education.

Hubley (2004, p. 28) reported on the Soap opera Twende Wakati (lets go with the times) that was broadcast in Kiswahili in Tanzania twice a week for 30 minutes over a 6-year period that reproductive health information specifically on HIV and AIDS and Sexually Transmitted Diseases were incorporated in the play. After some time an evaluation was done and this was found that the programme was listened to by more than half of the target population and that there was a decrease in the reported number of sexual contacts in districts receiving the broadcasting compared to those who did not receive them. The finding of this research may be questioned in that the behaviour of the people changed due to some other factors and not the broadcasting. It may be due to maturation effect that people change with time and it may be that it was time for them to change.

Information on health can be disseminated by combining mass media and entertainment. It is an effective way because people will be following entertainment and on the other hand they will learn health issues. Silimperi (2002, p.15) carried out a research in Ilorin, Ibadan and Enugu cities in Nigeria. Family planning and sexually transmitted diseases dramas were included in the popular television entertainment shows in a three years campaign. Also four radio spots were broadcast 169 times; five television spots were broadcast 110 times; two newspaper advertisements were published for six weeks; and 1500 copies were displayed. It was estimated

that half of the population had watched and listened to the programmes. After an evaluation it was discovered that clinic clients increased in all cities by two to three times.

Walley and Wright (2008, p. 55) Carried out a research in Gambia where a campaign consisted of 30-seconds drama radio spots and a 39- episode drama was done by the health institution. Also messages were designed to convey that Islam supports the use of modern contraception, that the modern methods are safe, that family planning service providers are knowledgeable and caring, and that couples should discuss family planning. An evaluation found that people who had heard the serial drama could name significantly more contraceptive methods and were significantly more positive about family planning; and were also likely to use modern methods than those who had not heard the drama. It was also found that they were more knowledgeable on the STIs and HIV and AIDS.

Guard and Ambre in 2002 collected information from the health centres to design a programme and supporting materials, including leaflets. Then a survey of knowledge, attitude and practice was carried out. Groups of 30 community educators were recruited from each health centre in Moyo district of Gambia and were trained to conduct information sessions at the health centres. During the five months of information campaign an estimated 50000 people attended the health centres based information session and 4500 pamphlets and 40000 condoms were distributed. A survey found that knowledge about condoms and reported use had increased in the programme areas. It was also discovered that the attitude of people towards condom use became positive. The number of STDs cases reduced at the health centres where they provided health information (Guard and Ambre, 2002, p.55).

Riley (2003, p.71) undertook the research in developing countries on the effectiveness of health workers in providing health information for change. In the first place he observed that health workers at the district level were responsible for collection, recording and disseminating timely

data. He also observed that in some countries the degree of analysis and the use of information are also expected at district level. What was discovered after the evaluation was that even when the health workers are properly trained and have access to the tools needed to record, analyze and report they could not disseminate information to meet the needs of the people they are serving. It was also found that workers had low motivation and this affected them in the provision of health information to their clients. It was also found that the health systems in developing countries experienced operational problems.

Seats (2000, p, 22) carried out a research and found that females in squatter settlements were not knowledgeable about reproductive health. This is because the peer educators lacked information and confidence to communicate to females on issues of sexuality and contraception. Most of the peer educators were not well trained to disseminate information to the community effectively. This contributes to females in the areas of poor socio-economic status to face a lot of reproductive health problems because they do not receive adequate reproductive health information. In order to solve reproductive health problems it is not just a matter of disseminating information but it is by providing timely, appropriate and accurate information.

4.3. National Level

A number of strategies have been developed to address issues related to women's reproductive health issues in Zambia. One of the key strategies at national level is to ensure that the breadth of issues covered is consistent with the elements agreed to by the International Conference on Population and Development (ICPD, 1994, p.63), which encompass a state of complete physical, mental, social well being Zambia is committed to increasing national budgetary expenditure on health from 11% to 15% by 2015 with a focus on women and children's health; and to strengthen access to family planning - increasing contraceptive prevalence from 33% to 58% in order to reduce unwanted pregnancies and abortions, especially among adolescent girls. Zambia will

scale-up the implementation of integrated community case management of common diseases for women and children, to bring health services closer to families and communities to ensure prompt care and treatment (www.everywomaneverychild.org/.../310-ensuring-universal-accessed on- 12/02/2013).

Since 1992 the Zambian Government has been implementing significant health sector reforms, aimed at strengthening health service delivery in order to improve the health status of the Zambians. The reforms has yielded significant results of strengthened health systems, improved access to health care and improved health outcomes as reported in the 2007 Zambia Demographic Health Survey (National Health Strategic Plan, 2011-2015, p. 84).

Major challenges however remain relating to deteriorating indicators in the high unmet need and poor utilization of reproductive health services .These, coupled with national commitments to achieve the Millennium Development Goals (2001) targets especially MDG 4 (four) to reduce child mortality and MDG 5 (five) to reduce child mortality by 2015, necessitate the need for fundamental changes in the area of sexual and reproductive health (Reproductive Health Communication, 2010-2012, p. 4).

The Zambia Association of Gynaecologists and obstetricians observed with dismay the low use of family planning services among women. Addressing women at Lusaka's Mulungushi International Conference Centre in July 2012 the Association President Dr. Mutima Muyuni said women have the information on the methods of family planning but its usage was low. Dr. Muyuni said knowledge about the family is high as about 98% of women in Zambia knew about it but wondered why the services are shunned away.

However the meeting also revealed the unavailability of formal medical abortion services which were not accessible to the majority of women in the country. This was concluded from the high mortality rate as a result of unsafe abortion. The high mortality rate from unsafe abortions is a clear indication that abortion services are not readily available. It was discussed in the meeting that no woman should die because of lack of access to reproductive health information which includes safe abortion services. The government of Zambia disclosed that it will continue to promote access to voluntary family planning services, access to pre- and antenatal care, skilled attendance at all births in order to prevent maternal deaths and reduce complications during child bearing (Muyuni, 2012,p. 6).

There is a big number of pregnant mothers especially in developing countries including Zambia who die due to poor access to health services including access to abortion services. It was further charged that there is currently no comprehensive treatment of complication of unsafe abortion services. The Finance Minister Alexander Chikwanda on the eve of the World Population day which falls on 11th July each year disclosed that government will continue to promote access to voluntary family planning services, access to pre and antenatal care, skilled attendance at all births in order to prevent maternal deaths and reduce complications during child bearing. It was further said that a number of pregnant mothers especially in the developing countries including Zambia die due to poor access to health services that women suffer disproportionately from un-attended pregnancies and maternal deaths. Chikwanda observed that Zambia still has a lot of challenges in the provision of reproductive health information services, sexually transmission infections, HIV and AIDS, Gender Based violence and other challenges resulted to reproductive health. And the first lady Dr. Christene Kaseba Sata in her key note address to the Marie Stopes –organized pre-conference at the Royal College of Obstetricians and Gynaecology in London, United Kingdom (UK) emphasized that family planning particularly for women still has a lot of challenges related to reproductive health. On the 11th July 2012, the government further stated

that need to emphasize on family planning particularly for women and youths who were more disadvantaged groups when it comes to choices over reproductive rights (Muyuni, 2012, p. 4).

In 1991 the Government of Zambia embarked on radical health reforms process that has been dedicated to providing Zambians with equity of access to cost effective quality health care as close to the family as possible. Despite this vision the government still faces a number of challenges. Although information education and communication (IEC) has been acknowledged as important in reproductive health by many health workers, there has been a sporadic IEC activity with little or no systematic documentation or evaluation of activities that exists. Limited information exists at the National level on IEC campaign design, areas of operations and the audiences for which messages and materials were developed (Health Reform in Zambia, 1997, p.33).

The Zambia Demographic and Health Survey is a survey designed to collect data on reproductive, maternal health and access to reproductive health information from respondent. The first survey was carried out in 1992, and the latest in 2001. The findings of the latest survey have been in terms of exposure to family planning messages, radio, television and newspaper or magazines are potential media for disseminating family planning messages especially in urban areas. In Lusaka, 68 percent of women and 72 percent of males accessed family planning messages on radio. Meanwhile 25.8 percent females and 13.8 percent males accessed family planning messages from either health centres or neighbourhood health committees. The results further showed that in Lusaka at least 63. 1 percent of women and 73.1 percent of men know the source for VCT. The problem with this study is sometimes respondents tend to get tired or fatigue since the questionnaires are usually long hence respondents will be giving responses which may not be true, for the sake of finishing the interview (ZDHS,2001,p.16).

Access to health facilities and reproductive health information is a priority on the Zambia development agenda as it is highly related to residents' health. From the studies undertaken in selected developing countries, it was found that in these countries the extent of access of households to various amenities such as health facilities, good sanitation and reproductive health information is an important measure of the living conditions of the people. Across all communities in these countries, health issues are related to poverty and hunger, availability and effectiveness of health services as well as people's attitudes and practices in matters of personal or family care (CSO, 12012, p. 19).

The Central Board of Health (2009, p. 34) expressed the need to have health population because it contributes to the national development. It also stated that Government and Non Governmental Organizations are carrying information education and communications in communities. Information education and communication involves activities such as motivational talks on modern family planning methods, production of posters, pamphlets and T-Shirts and training peer educators. This is because it has been realized that the reproductive health problems in communities can be improved by providing reproductive health information to the women and men in communities

A research done by Civil Society for Poverty Reduction (CSRP) in 2008 on accessibility and dissemination of health information to residents of Linonenu and Sinungu compounds in Western Province of Zambia revealed that access and awareness of health services varied from site to site. The study used qualitative research techniques, which included semi-structured interviews of key informants and focus group discussion with members of the community in the research sites. The communities indicated that the presence of primary health care (PHC) units has improved the reproductive health situation. The communities confirmed that drugs are always available for common diseases. Their concerns particularly in Sinungu are the poor staffing levels at the primary health centres, where there is only a clinical officer and a classified

employee (CE). This compromises quality of health care provision. The people of Linonenu and Sinungu were aware of the services and their reproductive health situations improved due to information which they received (CSPR, 2004, p.25).

The Family Health International (2012, p.26) carried out a research on the programme called partner notification programme for sexually transmitted diseases patients at urban Heath Centres in Lusaka. One on one counselling session lasting 10-20 minutes was provided to patients at a Sexually Transmitted Diseases (STD) clinic. Female nurses talked with women patients and a male clinical officer talked to male patients. The counselling included reproductive health information on STDs, the need to complete treatment, not having sex during the treatment period and why they should inform their partners. The follow up study showed that those patients who received information from health workers got cured within a short period of time compared to the other group of patients who just received routine STD care. The patients who received reproductive health information from the clinic were cured within a short period because they utilized the information which they received.

Another study was conducted by Medical Association of Zambia in 1995 and 1996 in Lusaka's Chawama compound using focus group discussions. The study was aimed at assessing the provision of reproductive health information to residents. Almost all the groups viewed reproductive health problems as prevalent in the area. Access to reproductive health services was perceived to be problematic. A comparison between the male and the female groups showed that the women were more aware and concerned about provision of reproductive health information than men. Most men shunned accessing this information from public health centres due to negative attitudes of staff at these centres. The problems with focus group studies are the fact that group interviews have inherent limitations especially when dealing with highly sensitive issues such as those in reproductive health, which may be overlooked. Therefore, when using

focus group interviews as the sole method of data collection matters of validity, reliability and the quality of the data should be given utmost consideration.

Therefore it can be concluded that health problems, in particular reproductive health problems, can be solved by working at the community level and by building in community participation in the selection of the objectives. If health systems can work at the community level it can create opportunities for health empowerment. Reproductive health information can be accepted by individuals if the community can as well accept the information. This is because if the community does not approve of certain behaviours in line with good reproductive health even the individuals cannot use the information, which can be provided to them.

CHAPTER FIVE: FINDINGS AND DISCUSSION

5. Introduction

This chapter presents the analysis and the findings of the data that was collected through the quantitative and qualitative surveys. The chapter is divided in two parts: the first part deals with the findings of the quantitative study while the second part deals with the qualitative study. Bar, pie charts, pictures and cross tabulation have been used in the interpretation of data which attempts to meet the study objectives on the effectiveness of Mukonchi Rural Health Centre of Kapiri Mposhi District in providing reproductive health information to women of reproductive age.

5.1. Quantitative Survey

Quantitative experiments are useful for testing the results gained by a series of qualitative experiments, leading to a final answer and narrowing down of possible directions for follow up research to take.

5.1.1. Questionnaire Survey

This method was used because it involved personal contact with the respondents, chance was given to express views in their own words as they ticked or filled in the questionnaire. Open and closed ended questions were used in the questionnaire. The researcher had separate questions for both women and men but carrying similar questions.

5.1.1.1. Background information of the respondent

Two hundred (200) men and women of reproductive age were interviewed using a guided questionnaire. One Hundred (100) respondents were women while the other one hundred were men from Zambia Compound of Mukonchi in Kapiri district of Central Province.

Out of the total number of 200 questionnaires which were administered to women and men of Zambia Compound in Mukonchi it was observed that 27 questionnaires were incomplete therefore were considered invalid.

The valid number of questionnaires was 173 of which (78) 45.1 percent interviewed were male and (95) 54.9 percent were female. The high number of women interviewed points out that women are generally found at home more compared shunned away from the interview based on their analysis that the subject at hand dealt more with to their male counterparts, besides some men found at home who were in the process of being interviewed women issues.

The findings showed that 17.9 percent of the respondents were in the age group of 14 to 19 years old; 14.5 percent of the respondents were between 20 and 24 years old; 24.3 percent were between the ages 30 and 35 years; another 24.3 percent were in the ages 35 and above. 1.2 percent of the questionnaires were not collected.`

Interestingly, the largest groups in this study were the groups 25 to 29 years and 35 and above years which had 24.3 percent each, which shows these two groups were actively involved in reproductive health information.

In terms of the findings, 11.0 percent of the respondents did not attend any form of education; 41.6 percent of the respondents attained primary level, 38.7 percent of the respondents had attained secondary education and only 4.0 percent of respondents had attained college/ university. Meanwhile 4.6 percent of the respondents did not answer the questions correctly.

The research findings indicated that 22.0 were singles, interestingly the largest percentage of the respondents were married and amounted to 63.6 percent and the lowest number were those separated which amounted to 4 percent. 1.2 percent did not respond to the questions.

Table 1. Sex Distribution of respondents

Sex	**Frequency**	**Percent**
Male	78	45.1
Female	95	54.9
Total	173	100.0

Table 2. Age Distribution of respondents

Age at birthday	**Frequency**	**Percent**
14 – 19	31	17.9
20 – 24	25	14.5
25 – 29	31	17.9
30 – 35	42	24.3
35 years and above	42	24.3
Not reported	2	1.2
Total	173	100.0

Table 3. Sex Distribution of respondents

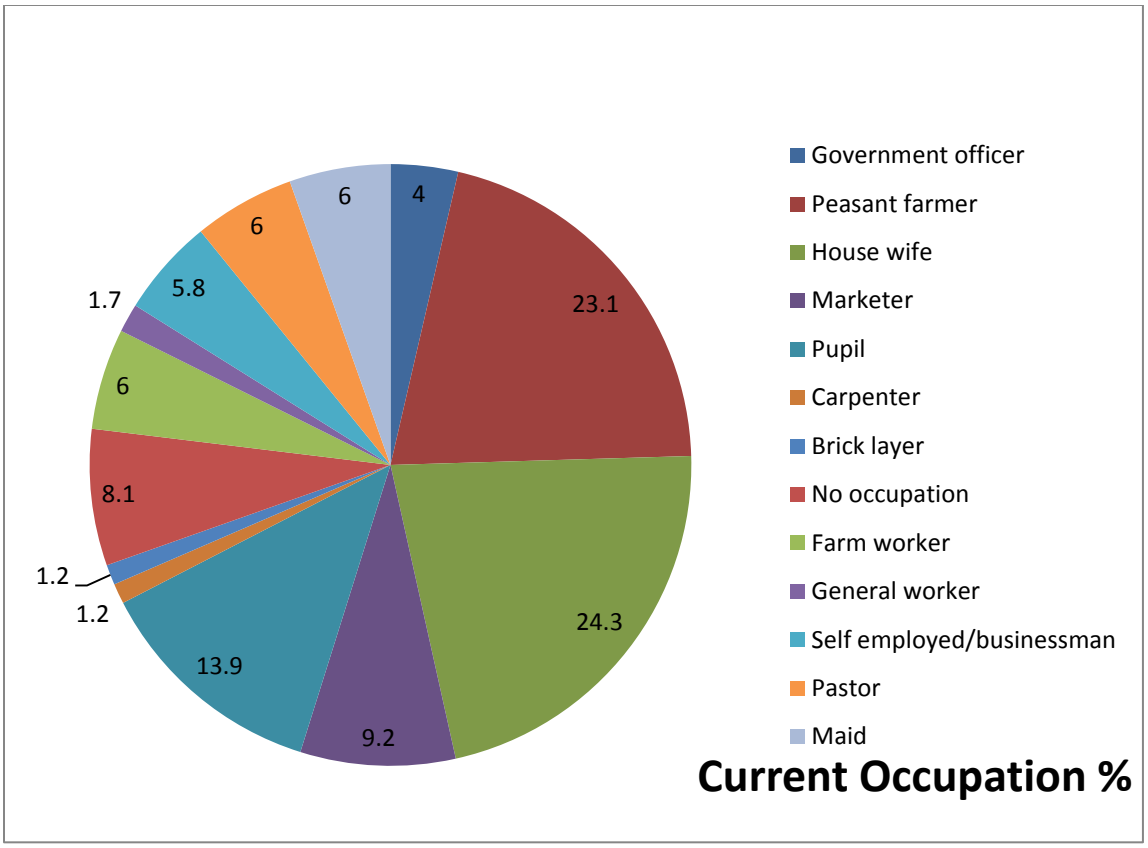
Education level attained	**Frequency**	**Percent**
None	19	11.0
Primary	72	41.6

Secondary	67	38.7
college/university	7	4.0
Sub total	165	95.4
Not reported	8	4.6
Total	173	100.0

5.1.1.1.2. Current Occupation

The research findings indicated that 4.0 percent of the respondents were Government officers, 23.1 percent were peasant farmers, majority of the respondents were house wives at 24.3 percent , 9.2 were marketers, 13.9 were pupils and lowest number of the respondents were carpenters and bricklayers at 1.2 percent each, 8.1 had no occupation, it further revealed that 6 percent of respondents were farm workers, pastors and Maids respectively, 1.7 were general workers meanwhile 5.8 were self employed/ businessmen, and the other 5.8 percent of the respondents did not answer the questionnaire.

Chart 1. Current occupation of Respondents



5.1.1.1.3. Religious Denomination

The research findings revealed that majority of the respondents were of Christian's religious denomination at 85. 5 percent, 5.8 percent were Muslim while the lowest number of the respondents at 2.9 percent was from the African tradition as shown on the table.

Table 4. Religious Denominations of respondents

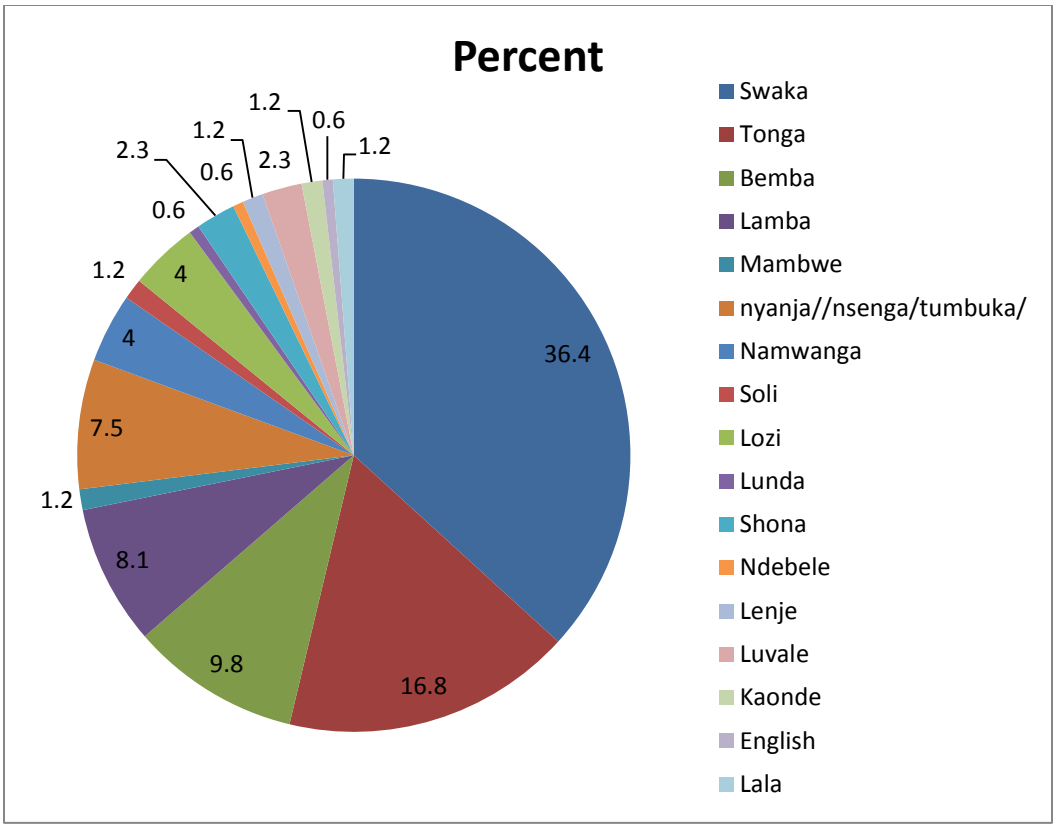
Religion	Frequency	Percent
Christian	148	85.5
Moslem	10	5.8

African tradition	5	2.9
Sub total	165	95.4
Religion	Frequency	Percent

5.1.1.1.4. Daily Language Used

The research findings revealed that 36.4 percent of the respondents used Swaka. This shows that majority of the respondents in this area are Swaka, 16.8 percent were Tonga, 9.8 percent used Bemba and only 1.2 percent used Mabwe, Luvale, Soli, Lenje and Kaonde. Those who were able to speak Nyanja, Nsenga and Tumbuka were at 7.5 percent, meanwhile 4 percent of the respondents were speaking Namwala and Lozi. Furthermore, 6 percent of the respondents were able to speak Lunda, English and Ndebele. Among other languages from the respondents were 2.3 percent Shona and Luvale, and 2 percent of the questionnaires were not collected as shown on the chart.

Chart 2. Language used by Respondents Daily



5.2. Knowledge, Attitude, Practices and Beliefs on Reproductive Health Information

It was important to investigate on the knowledge, attitude, practices and beliefs on reproductive health because a society with certain beliefs and attitudes towards an innovation can be a challenge in adopting.

In order to measure knowledge, attitude, practice and beliefs on reproductive health, the men were asked if they were ever responsible for a pregnancy. The table revealed that the majority 85.1 percent of the respondents agreed that they have been responsible while 12.6 percent had not been responsible for a pregnancy. 2.3 percent did not respond to the questions.

Table 5. Respondents' Responsibility for Pregnancy

Ever been responsible for a pregnancy	Frequency	Percent
Yes	148	85.1
No	22	12.6
Sub total	170	97.7
Not responded	4	2.3
Total	174	100.0

5.2.1. Awareness on Reproduction Health Information

The table shows that majority 79.9 percent of the respondents are aware of the reproductive health information provided by the clinic and 16.7 percent said that they did not know that Mukonchi clinic provided reproductive health information, 3.4 percent did not report on the findings.

Table 6. Respondent's Distribution of awareness of Reproductive Health Information

Aware of Reproductive Health	Frequency	Percent
Yes	139	79.9
No	29	16.7
Sub total	168	96.6
Not reported	6	3.4
Total	174	100.0

5.2.2. Reasons for not being aware of Reproductive Health Information

The question was asked as to why the respondents do not access information from the clinic. The majority about 69.0 percent did not respond to the question, 4.6 percent said that the distance was far away, 2.9 said the staff at the clinic were not friendly and 5.7 percent said information is

not helpful. 9.2 percent said that there is no confidentiality at the clinic that is why they do not go there and then 8.0 percent said that there was no need to visit the clinic.

Table 7. Reasons why Respondents weren't aware of Reproductive Health Information

Reasons for not accessing RHI	Frequency	Percent
it is far	8	4.6
staff not friendly	5	2.9
no confidentiality	16	9.2
information not helpful	11	5.7
no need to visit the clinic	14	8.0
Total	54	31.0
Not responded	120	69.0
Total	174	100

5.2.3. How Respondents leant about Reproductive Health Information at Mukonchi Clinic

The respondents were asked to state how they knew that Munkonchi Clinic provides reproductive health information. Table 8 shows that out of the total sample of respondents, 31 percent said that they came to know about it through friends. Then 1.7 percent of the respondents said they leant through publication of leaflets which the clinic gives to the people, 14.9 percent said that they knew through the drama group which was sensitizing in the community, 10.9 percent knew through the peer educators, 24.1 percent of the respondents revealed that they knew through the personnel at the Clinic. Meanwhile 5.2 percent said no one informed them. 6 percent knew through their spouses, another 6 percent knew through Care International. 10.9 percent respondents did not report.

Table 8. How Respondent's learnt about Reproductive Health Information

How did you know about reproductive health at the RHC	Frequency	Percent
through a friend	54	31.0
publication leaflets	3	1.7
Drama	26	14.9
peer educators	19	10.9
personnel at the clinic	42	24.1
No one	9	5.2
Spouse	1	6
Care International	1	6
Sub total	155	89.1
Not reported	19	10.9
Total	174	100.0

5.2.4. Number of Times Respondents have been Responsible for a Pregnancy

Table 9 shows that 16.1 percent of the respondents said that they have been responsible for a pregnancy once, 17.2 percent of respondents said that they have been responsible of the pregnancy twice. 27 percent of the respondents have been responsible for a pregnancy three time and 21.3 percent of the respondents said that they have been responsible for a pregnancy more than five times. 8.6 percent have never been responsible for a pregnancy, 6 percent of the respondents stated that they have been responsible for a pregnancy six times, 1.7 percent have been responsible for a pregnancy four times. 1.1 respondents stated that they have been responsible for a pregnancy for 5 times and 6.3 percent did not respond.

Table 9. Number of times Respondent's have been responsible for a pregnancy.

Number of times responsible for pregnancy	Frequency	Percent
Once	28	16.1
Twice	30	17.2
three times	47	27.0
more than five times	37	21.3
None	15	8.6
Six	1	.6
Four	3	1.7
Five	2	1.1
Sub total	163	93.7
Not reported	11	6.3
Total	174	100.0

5.2.5. Number of Children Respondents Plan to Have

The question was asked to the respondents as to what number of children they plan to have. The majority of the respondents 20.1 percent said for as many as God allows, 2.9 percent responded that one was enough looking at rural hardships. The findings show that 10.3 percent of the respondents stated that two or three children were enough, meanwhile 19.5 responded that more than five children was better, those who opted for 6 to eight and 10 children were at 1.7 percent respectively. Furthermore, 6 percent of the respondents said that nine children were okay in case of death. Those who were not yet decided on the number of children they planned to have were at 4 percent, 14.4 percent of the respondents said it better to have four children and 2.9 did not respond to the question.

Table 10. Number of children respondent's plan to have

Number of children plan to have	Frequency	Percent
as many as God can give	35	20.1
One	5	2.9
Two	18	10.3
more than five	34	19.5
Five	14	8.0
Six	3	1.7
Seven	3	1.7
Eight	3	1.7
Nine	1	.6
Ten	3	1.7
not yet decided	7	4.0
Three	18	10.3
Four	25	14.4
Sub total	169	97.1
Not reported	5	2.9
Total	174	100.0

5.2.6. Methods of Sexual Intercourse Used

The question was asked to the respondents as what method of sexual intercourse they used. The majority which were 40.2 used condoms, 23 percent used family planning, furthermore, 11.5 percent responded that they use natural methods, traditional methods were at 6.9 percent. 9.8 percent responded that they use injection. Those who had no sexual intercourse were at 2.9 percent, 5.7 percent of the respondents did not answer the question.

Table 11. Respondent's Method of Sexual Intercourse

Method of sexual intercourse	Frequency	Percent
Condom	70	40.2
family planning pills	40	23.0
natural method	20	11.5
traditional method	12	6.9
Injection	17	9.8
intercourse None	5	2.9
Sub total	164	94.3
Not reported	10	5.7
Total	174	100.0

5.2.7. Last Time Accessed Reproductive Health Exam from a Doctor or Medical Professional

The question was asked to the respondents as when was the last time received or accessed reproductive health information from the doctor or medical professional. The findings were that 10.3 percent said last week, the majority 33.9 percent said last month due to monthly checkups, furthermore those who responded that last year were 23.6, meanwhile 27.0 responded that they have never been. The findings also stated that 1.1 percent they accessed information more than a year ago. 4 percent did not respond to the question.

Table 12. Last time Respondent had a Reproductive Health Examination from Medical Personnel.

When was the last time you received a reproductive health exam from doctor or Medical professional	Frequency	Percent
last week	18	10.3
last month	59	33.9
last year	41	23.6
None	47	27.0
More than a year ago	2	1.1
Sub total	167	96.0
Not reported	7	4.0
Total	174	100.0

5.2.8. Ways of Reproductive Health Information

In order to measure what is included on reproductive health, the respondents were asked to indicate what they felt reproductive health includes. Table 13 shows that 35.1 percent of the respondents felt that family planning is included in the reproductive health, 25.3 percent of the respondents said that HIV and AIDS are included in reproductive health, those who felt that malaria was included in reproductive health information were 6.9 percent, further more the findings showed that those who said mother health care and tuberculosis are included in reproductive health were 5.2 percent respectively.

Table 13. What is included in Reproductive Health Information according to Respondents

Included in reproductive health	Frequency	Percent
family planning	61	35.1
HIV/AIDS	44	25.3
Malaria	12	6.9
mother child health care	9	5.2
tuberculosis (TB)	9	5.2
sexually transmitted infection	12	6.9
maternal health care	10	5.7
Not reported	17	9.8
Total	174	100.0

5.2.9. Reasons for not being Aware of Reproductive Health Information

The question was asked to the respondents as to why are they were not aware of reproductive health information provision at Mukonchi Rural Health Centre. The findings were that 8.0 percent said they were not interested in reproductive health information,3.4 percent of the respondents have not been there to find out about reproductive health information. 4.0 percent of the respondents have not been informed by anyone that there is reproductive health information at Mukonchi, one percent of the findings shows that the respondents did not specify the reasons for not being aware of the information. Furthermore, the majority of the respondents at about 83 percents did not answer the question.

Table 14. Why Respondents were not aware of Provision of Reproductive Health Information

If not aware why?	Frequency	Percent
not interested in RH information	14	8.0
have not been there to find out	6	3.4
have not been informed	7	4.0
Others not specified	2	1
Not reported	145	83.3
Total		100

5.2.10. Other Sources of Information

The question was asked to the respondents if not the source of information what the source of information is. The findings were that 23.6 percent said that the media was their source of information. 31 percent of the respondents said it was through friends and relatives. 17.8 percent of the respondents said that through reading books. Further findings show that 1.7 percent was from the youth friendly corner. 4 percent of the respondents had nothing to say and 4.6 percent of the respondents said it was through drama or video. Further findings from the respondents revealed that 6 percent got the information from Non Governmental Organisations, DAPP, Church, and clinic talks and 1.1 percent of the findings of the respondents show that it was through their spouses. Unfortunately, 13.8 percent did not respond.

Table 15. Respondents other sources of Reproductive Health Information

If not the source what is the source of your information	Frequency	Percent
media and press	41	23.6
Friends and relatives	54	31.0
Books	31	17.8
youth friendly corner	3	1.7
None	7	4.0
Drama/Video	8	4.6
NGOs	1	.6
Spouse	2	1.1
DAPP	1	.6
Church	1	.6
Clinic talks	1	.6
Not reported	24	13.8
Total	174	100.0

5.3. Mode of Reproductive Health Provision

It is important to highlight respondents' mode of reproduction health provision to weighing the levels of information the clinic provides to the reproductive women and men.

5.3.1. Visitation to the Health Centre

67.2 percent of all those interviewed had visited Mukonchi Rural health centre while 60.5 percent had never been to the clinic to get information on reproductive health information. In addition the number of women going to the clinic for reproductive health is more than the men.

As it can be seen from the table 16, out of the 68.6 percent who said that they had been to the clinic for RHI, 40.8 percent were women and 27.8 percent were men.

Table 16. Respondents visits to the Clinic if ever

Ever visited the RHC for RHI		**Sex**		**Total**
		Male	**Female**	
Yes	Count	47	69	116
	% of Total	27.8%	40.8%	68.6%
No	Count	29	24	53
	% of Total	17.2%	14.2%	31.4%
	Count	76	93	169
	% of Total	45.0%	55.0%	100.0%

5.3.2. Distance to the Health Centre

In terms of distance covered by people to access the clinic for RHI, 76.4 percent reported that the distance was convenient and 18.4 percent said that it was inconvenient. See table below.

Table 17. Respondents distance to the Clinic

What do you think about the distance	**Frequency**	**Percent**
Convenient	133	76.4
Inconvenient	32	18.4
not reported	9	5.2
Total	174	100.0

5.3.3. Dissemination of Information Used by the Clinic

The ways that the clinic can use to disseminate information were reported to be clinic talks, peer education, pamphlets, leaflets, drama and video games. Clinic talks at 42 percent and peer educators at 20.1 percent were reported to be the main ways the clinic can disseminate information.

Table 18. Ways the Clinic disseminates Reproductive Health Information

Ways the clinic can disseminate RHI	Frequency	Percent
clinic talks	73	42.0
peer educators	35	20.1
pamphlets/leaflets	10	5.7
Drama	29	16.7
video games	7	4.0
Sub total	154	88.5
Not reported	20	11.5
Total	174	100.0

5.3.4. Effectiveness of the Clinic in providing Reproductive Health Information

When asked about ways of providing information used by the Rural Health Centre that were effective, 40.8 percent mentioned clinic talks, 23 percent peer educators, 20.1 percent drama and 5.7 percent pamphlets or leaflets.

Table 19. Effective methods of Reproductive Health Information Dissemination.

Ways of information provision used by the RHC that are effective	Frequency	Percent
clinic talks	71	40.8
peer educators	40	23.0
pamphlets/leaflets	10	5.7
Drama	35	20.1
Sub total	156	89.7
Not reported	18	10.3
Total	174	100.0

5.3.5. Types of Reproductive Health Information not provided by the Clinic

It was found out that the Rural Health Centre did not provide reproductive health information on sexually transmitted diseases, gender based violence, rape, abortion and maternal health care. Of all the respondents when asked about the type of reproductive health information not being provided at the health centre that should be provided but was not being provided, 40.2 mentioned rape and gender based violence, 25.3 percent abortion, 14.9 sexually transmitted infections and 6.9 percent maternal health care.

Table 20. Types of Information not being provided by the RHC that should be available.

Type of RHI not being provided at the RHC that should be available	Frequency	Percent
STIs/STDs	26	14.9
Rape/Gender based violence	70	40.2
Abortion	44	25.3
maternal health care	12	6.9
Not reported	22	12.6
Total	174	100.0

5.3.6. Respondents benefits on the use of Reproductive Health Information

Respondents also alluded to the fact that they have been helped through the use of reproductive health information in various ways such as enabling them to practice spacing of children, HIV and AIDS and STIs prevention, pregnancy care and child health matters. 30.5 percent said they had been helped on child spacing matters, 29.9 percent HIV and AIDs prevention, 11.5 percent concerning on how to look after children, 7.5 percent prevention against STIs and 6.9 said were helped while they were pregnant.

Table 21. Ways in which the RHC has helped Respondents on RHI

How have you been helped through the use of RHI	Frequency	Percent
for spacing up children	53	30.5
prevention against HIV/AIDS	52	29.9
prevention against STIs	13	7.5
helped while pregnant	12	6.9
helped on how to look after children	20	11.5
Not reported	24	13.8
Total	174	100.0

5.3.7. Respondents' Satisfaction of Reproductive Health Information

In terms of the level of satisfaction of reproductive health information, the people interviewed were generally satisfied with the information from the rural health centre despite some constraints and information gaps. Of all respondents interviewed, 39.7 described information provided as being very adequate, 38.5 adequate and only 12.5 percent said the information was not adequate.

Table 22. Level of Satisfaction of Respondents on RHI provided by the RHC

How would you describe RHI provided by Mukonchi RHC?	Frequency	Percent
very adequate	69	39.7
Adequate	67	38.5
not adequate	21	12.5
Sub total	157	90.2
Not reported	17	9.8
Total	174	100.0

5.3.8. Time Taken for Health Workers to Attend to the People at the Clinic

When asked how long it takes for health workers to attend to them, 44.3 reported that it takes very long, 26.4 percent quite long and 16.1 said it does not take long.

Table 23. Time taken by Health Workers to Attend to Respondents

How long does it take for Health workers to attend to you?	Frequency	Percent
very long	77	44.3
quite long	46	26.4
not long	28	16.1
Not reported	23	13.2
Total	174	100.0

5.3.9. Perception of Reproductive Health Information

In terms of perception of reproductive health information provided, respondents were happy and said that it was important information. 36.2 percent who said it was good information, 23.6 percent said that it was helpful and useful and 8 percent said information provided was encouraging. However, some of them said that reproductive health information was for women only and this opinion was from 1 percent of the male respondents.

Table 24. Perception of Reproductive Health Information

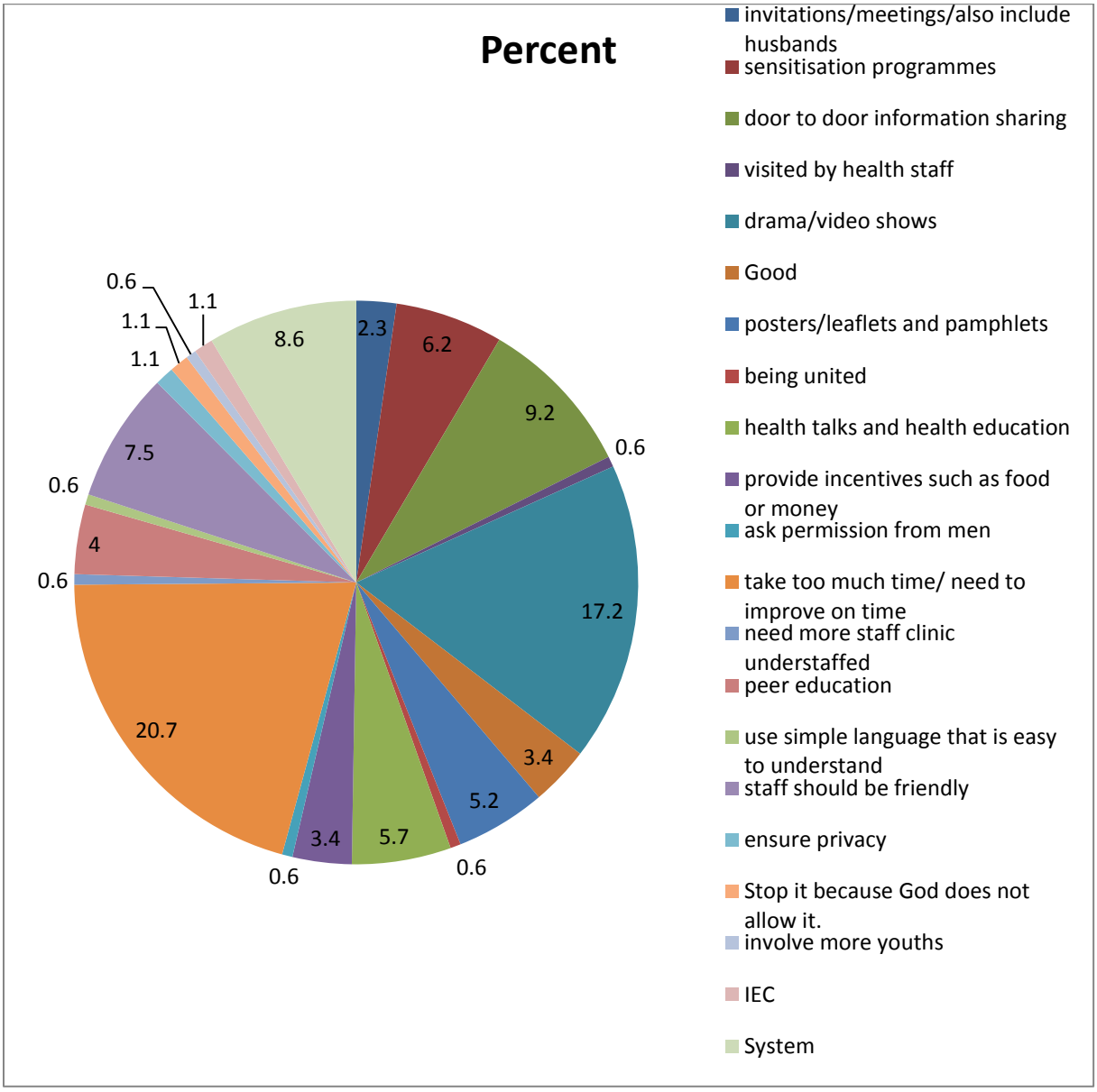
What do you know about RHI provided by the clinic	Frequency	Percent
Encouraging	14	8.0
not helpful	5	2.9
helpful/useful	41	23.6
very important	11	6.3
not good	1	6
quite good/good	63	36.2
very good	15	9.0
not important	2	1.1
program for women only	1	6

don’t know	2	7
it is a sin to talk about RHI/its a taboo	2	1.1
Nor reported	17	9.8
Total	174	100.0

5.3.10. Improvement on Service Delivery of Reproductive Health Information

On ways the Rural Health Centre can improve service delivery and areas of information provision, 20.7 percent said the staff at the clinic take too long and much of their time, 17.2 percent said the use of drama and video shows, 9.2 percent reported door to door information delivery, 7 percent said staff should be friendly, 6.2 percent said sensitisation programmes, 5.7 percent said health talks and education, 5.2 percent said posters, leaflets and pamphlets, 4 percent said peer education and 3.4 percent mentioned incentives in form of food and money. Some though very few talked about importance of privacy, permission from men, involvement of more youths and IEC.

Chart 3. Ways in which RHC can Improve RHI Information Delivery

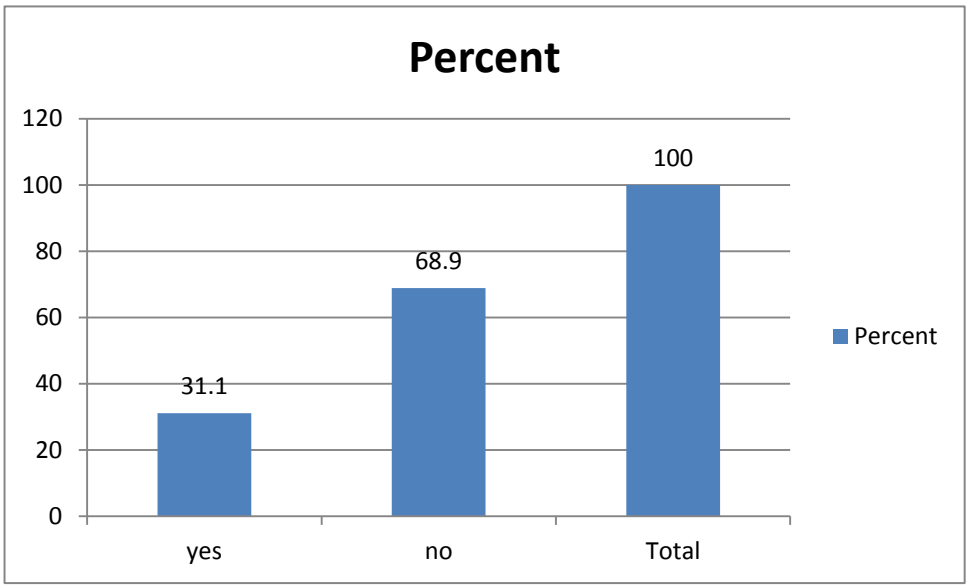


5.4. Male Involvement in Reproductive Health Information Services

Men can be involved in reproductive health activities and accessing information services by supporting women and as well as by being clients of the services. According to the study, most of the men do not escort their wives to RHC and they do not encourage each other to access services and information.

According to the study, it was found out that 68.9 males reported that they do not escort their wives to access RHI at the RHC while 31.1 said they did.

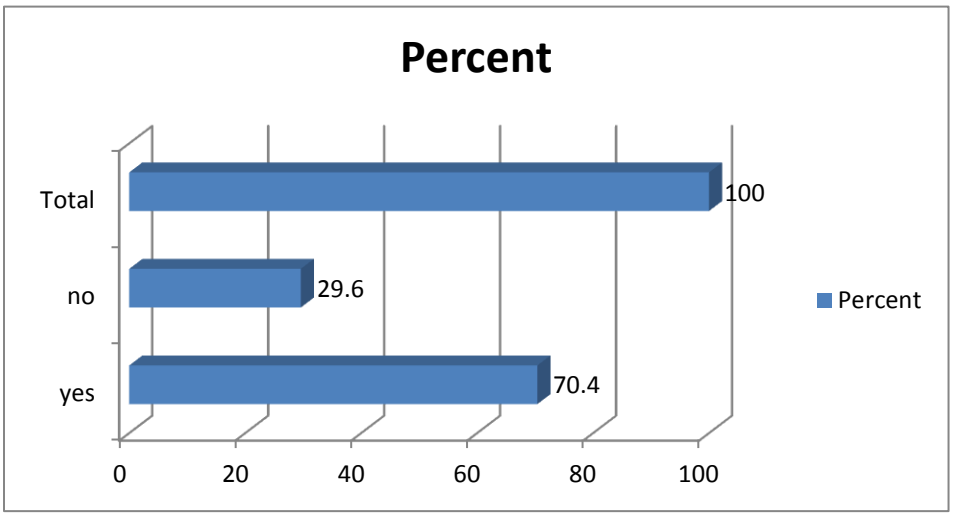
Graph 1.Respondents who escort their spouses/partners to access RHI at the RHC



5.4.1. Male Involvement in encouraging their spouses in attending Reproductive Health Information Services

70.4 percent males said they encourage their spouses or partners to attend RHI services at the RHC while 29.6 percent do not. This is Shown in graph 2

Graph 2. Male respondent's involvement in Reproductive Health Information.



In responding to the question on whether the staff at the RHC encourages their spouses or partners to attend RHI services, 75.3 percent of the men reported that they did while 24.7 said they did not.

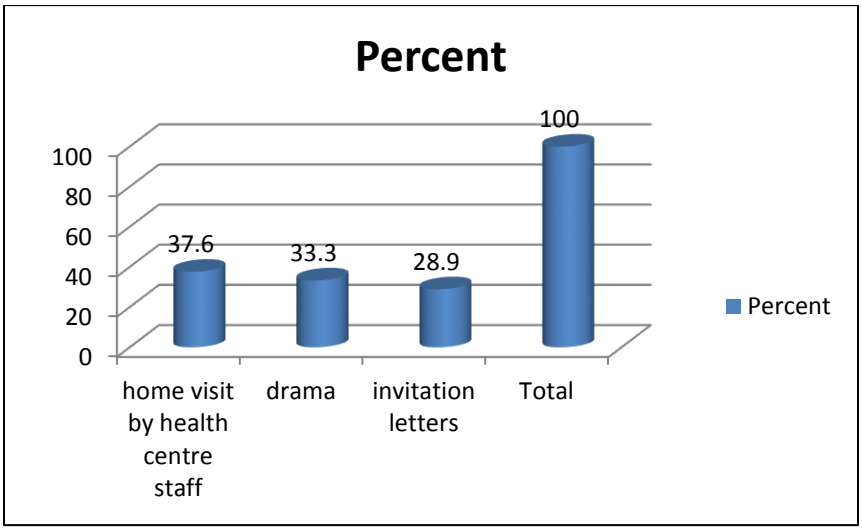
Table 25. Encouragement from Spouse on attending Reproductive Health Services

Do staff at the RHC encourage your spouse or partner to attend RHI information services	**Frequency**	**Percent**
Yes	55	75.3
No	18	24.7
Total	73	100.0

5.4.2. Ways in which RHC encourages Male involvement in RHI Services

Ways in which RHC can encourage male involvement in RHI services were mentioned to be through home visits by health centre staff, drama and invitations to attend meetings together with their spouses. In this regard, 37.6 percent mentioned home visits, 33.3 percent drama and 28.9 percent invitation letters.

Graph 3. Ways in which RHC can encourage male involvement in RHI services.



5.4.3. Attending Reproductive Health Information Mandatory for Couples

In terms of making attending RHI mandatory for couples, 23 percent of the males said they did agree while the majority 70 percent replied no.

Table 26. Male Responses on making RHI compulsory for spouses.

Do you think attending RHI services should be made mandatory for couples	Frequency	Percent
Yes	23	30.0
No	51	70.0
Total	74	100.0

5.6. Qualitative Survey

The tools which were used are focus group discussion, interviews and physical observation.

5.6.1. Focus Group Discussion

Under this survey, two Focus Group Discussions (FGDs) of reproductive women and men were organised. One FGD was held at Mukonchi Health clinic. The other FGD was held at Makafu primary school during an outreach educational health programme which covers 7 kilometres from Munkonchi clinic. In each FGD women and men from various villages ranged from Kapumba primary school, Makafu primary school. The researcher used existing schools to conduct the FGD because the nearest clinic was Mukonchi and Chibwe clinic.

The researcher was the principal facilitator of the Focus Group Discussions and spoke in her own dialect - Bemba. The clinic counsellors assisted in the language interpretation from English to the local dialect (Bemba) and vice versa.

Figure 4.One focus group discussion.

The following were the findings and analysis from the two FGD.

5.6.1.1. Definition of communication

The groups' defined communication as a process in which information travels from one person to another to understand a message and their being feedback from the receiver. It was also pointed out that messages received through the clinic complete communication. Some members pointed out that the use of clinic counsellors to communicate reproductive health information messages was very effective and provided interaction.

5.6.1.2. Communication methods used to disseminate reproductive information

The use of clinic counsellors and use of drama from youth groups stood out. When asked if they understood the reproductive health information provided by the clinic counsellors, they responded in the affirmative that they did because they had opportunities to ask questions and contribute; the sessions were usually very interactive. Asked whether the clinic was their source

of reproductive health information, they responded that Munkonchi clinic was usually their source of reproductive health information because most of the times when they visited the clinic they would be told to remain behind for lessons depending on the day. Usually the clinic have days to learn on HIV and AIDS, Family Planning, Child spacing and Malaria prevention in pregnant mothers and also on how to take care of themselves during pregnancy.

5.6.1.3. Effective communication tool used

From the two FGDs the researcher had, the use of Clinic Talks was indicated to be very effective because the women were participating in the discussions every time they visited the clinic which was usually done every week with different groups. When asked if lessons on reproductive health information taught at the clinic with the instructions from the clinic counsellors were effective to make them know what reproductive health information was, some respondents indicated it was fine because the clinic counsellors with the help of the nurses at the clinic would make follow ups through outreach education health programme visits in their specific areas and those who were HIV positive would be followed to see how they were taking their HIV therapy. They further suggested in the discussion that it would be better to make the programmes on video in which they could be watching already recorded programmes on their own without the clinic counsellors and share their views among themselves to enhance their understanding on reproductive health information.

5.6.1.4. On challenges on reproductive health information provided by the clinic

The common challenge that stood out in the two FGDs were that men were not willing to escort their wives to attend the sessions on reproductive health information such as on family planning, antenatal, and under five days. Furthermore, they stated that it was difficult to convince their spouses especially on issues of HIV and AIDS. Asked if the clinic makes an effort to encourage these men to attend to these reproductive health programmes especially participating in Family

Planning sessions, antenatal, under five and HIV and AIDS sessions, the participants agreed that the clinic makes an effort to make men understand that these programmes are for both men and women but the men themselves usually shun away from these programmes.

The participants further revealed that the clinic makes an effort by making sure that those men who attend the sessions are given free incentives such as T. Shirts, Mosquito nets and Condoms just to motivate them to these health programmes. During the Focus Group Discussions it was revealed that those in long distances, the clinic makes an effort to follow them in their near places such as Makafu, Kakwalesa, and Chibwe areas just to make the services effective but still men are not there most of the times.

Another challenge on effective communication is that most people in this area are illiterate hence convincing them on issues pertaining to family planning, abortions and HIV and AIDS is a problem. It was asked if they really understood the reason why they should continue using family planning, the respondents said that children are God given hence there was no need to block them using family planning pills or any other types. Furthermore some participants revealed that some type of family planning which were being offered were giving them problems such as over bleeding, and not doing their monthly periods for months. During the FGD it was observed that some respondents have myths towards family planning tablets such as making them develop mushrooms in their stomach which in the end develop into fibroids.

Those in distant places had no access to awareness information on reproductive information and practical lessons despite the clinic offering outreach health education programmes, which are only done once per month in each area on reproductive health information because some distances are far away, long stretch of the bush such that clinic officers face a challenge to meet their target. Besides Government does not provide transport but only 5 litres of fuel per trip of which some areas it is not enough.

5.6.1.5. Awareness of the existence of the reproductive health information at Mukonchi Clinic

When asked whether reproductive health information such as family planning, child care, sexual transmission diseases, abortions and HIV and AIDS they knew them very well and put it into practice, most women responded that it was suitable and beneficial in the sense that they were able to space their children through the use of family planning such as pills and injectable ones. Furthermore, it was revealed that women have become more knowledgeable on how to take care of their children in terms of diet. It was also revealed that it has made them understand issues of sexual transmissions diseases in case they got sick by getting the right medicine from the clinic than using the herbal ones from the bush. They also answered that the reproductive health information has helped them in issues pertaining to HIV and AIDS especially on discordant couples and how to follow the anti-retro viral drugs. It was further revealed that information on prevention of HIV of mother to child transmission was existing despite the mothers forgetting to take the drugs called Nevarapine (NVP) which depresses the virus during labour.

5.6.1.6. Challenge for not adopting the reproductive health information

The women were asked if there were any problems in accessing and adopting reproductive health information such family planning, maternal health care, STD, abortions, HIV and AIDS. All at once responded- pills!! They responded that It was a challenge for them to be swallowing family planning pills like safe plan, mycrogynon everyday as if they were on ARV's, others said injection type of family planning like Depo- Provera and Noristeratmake them miss their monthly periods for months hence it resulted in having a lot of body weights. Some women in the focus group discussion especially from Makafu primay school said that the distance which is 7 kilometres to the clinic was a challenge to be consisted in attending these meetings and become sustainable and adoptable. Findings from the FGD said it was also a challenge to convince their

husbands to be knowledgeable enough on issues of reproductive health information because their spouses treat reproductive health information as issues for women.

One woman gave her own case on how her husband was taking ARV's without her knowing for seven years until when she got pregnant and during antennal she was tested positive then the clinic officer told her that the husband was on ARV's for years and was not ready to bring you here. Another respondent testified on how her husband beats her up using the cane whenever she talks about Condoms and HIV and AIDS issues. Most women said that to them knowledge was there but their spouses are not there for them.

5.6.1.7. Suggestions to make reproductive health information provision effective

The women explained that they needed more outreach programmes from the clinic because distance was a hindrance to participate in reproduction health information, the clinic should make it compulsory for both men and women in attending to reproductive health information such as antenatal visits, family planning, HIV and AIDS sessions and under five visits these would help the men knowledgeable about reproductive health information. The clinic should also select among women and men some team leaders in sensitising the community on reproductive health information. The respondents also said that peer educators were needed in communities to enhance awareness of reproductive health information and effectiveness in the provision of reproduction health information.

5.6.1.8. Improvement of reproductive health Information

The respondents were asked what could be done to improve information flow on reproductive health information. They responded that they needed more than once a month programmes on reproductive health information, drama groups should be consistent and able to reach even in the outskirts of Munkonchi area. Also there was need for some organisations like Non Governmental Organisations such as DAPP and Society for Family Health to be based in Mukonchi not only in Kapiri District. They further stated that school girls should be actively involved in reproductive health information to reduce cases of abortions, STD's HIV and AIDS.

5.6.2. INDEPTH INTERVIEWS

Three indepth interviews were conducted; these included the Senior Clinical Officer in Charge, the Pastor from SDA Church, and The Mid Wife from family planning section and the ward counsellor from Zambian compound. All the three interviews centred on research objectives:

The findings from the three interviews were as follows:

5.6.2.1. Establishment of women's awareness of the existence of reproductive health information at Mukonchi Rural Health Centre

The findings from the Senior Clinical officer Mr Mwanza showed that information at Mukonchi clinic is there, they have health education programmes which they use to disseminate information on reproductive health to women of age. When asked the strategies used to disseminate the reproductive health information as the clinic, Mr. Mwanza said it was provided through health education programmes during women's visits to antennal and child care programmes. He said that it was done on weekly basis through clinic talks, the clinic also utilised days like national immunisation days to sensitise on reproductive health information,

5.6.2.1.2. To determine the knowledge, attitude, practices and beliefs in reproductive health information.

To determine the knowledge, attitude, practices and beliefs in reproductive health information, the researcher asked what role the clinic plays when the information given is perceived with mixed feelings, for example like the findings from the FGD were that family planning is an hindrance to God given children, also some women revealed that they do not want to use family planning because one can end up having abnormal growth such as mushrooms in the stomach due to family planning tablets.

The researcher went further to investigate why such myths were coming out on family planning. The answer was given by the midwife in family planning section, Mrs Mulenga, who had said that such issues are always there especially dealing with the rural community were majority have never been to school. However she further stated that to break this bridge the clinic uses traditional leaders such as ward councillors who sensitise to men and share the information to their spouses. She further stated that they also use the neighbourhood community leaders who sensitise information on reproduction health information. The other question was asked what role the clinic plays in making sure the information given is accepted and adopted by these women of age. The respondent said as a clinic, they rely so much on weekly health education programmes during antenatal, family planning, maternal care and HIV and AIDS counselling programmes. She further stated that they use drama sometimes to sensitise women on reproductive health information through youth drama groups.

5.6.2.1.3. Finding out how cooperative and encouraging the men (husbands are in assisting women to access reproductive health information

The Clinical Officer in Charge, Mr.Mwanza, said that they have been using traditional leaders and the neighbourhood community leaders to sensitise on reproductive health information. The researcher further asked if the clinic has managed to provide information to men, the response was yes, in the sense that the outcome from their wives was overwhelming hence it was proof enough to show that the men are aware of reproductive health information but little effort is needed to make the men physically show up to these reproductive health information. The researcher further asked why these men shun away from these meetings. The respondent said it was due to cultural barriers which say that women are the ones to attend to antenatal, HIV and AIDS, Maternal Health Care and Family planning programmes. The respondent further stated that it was making more efforts in making sure that traditional leaders such as the chiefs, ward counsellors, the community chairmen and neighbourhood community leaders are also involved fully to enhance more understanding to these men to participate in reproductive health information.

5.6.2.1.4. Interviews with the Seventh day Adventist (SDA) Pastor

The researcher carried an interview with the pastor from Munkonchi SDA Church to find out the knowledge, attitudes, practices and beliefs in reproductive health information. Furthermore, the researcher wanted to find out the awareness and adoption rate to the information given to these women of age and their spouses. The researcher also wanted to find out the criteria it uses in making sure that men also participate in reproductive health information and the mode of information provided to its members in the church if it was effective. The findings from interviews were gathered and were as follows:

Pastor Mweetwa from the SDA Church stated that information on reproductive health information was there at the church and the surrounding community. The researcher further

asked if the mode of information provided by the church was effective. The pastor stated that it was effective in the sense that the church divides church members in their categories for example members are divided in groups, the youths, couples and singles. The pastor emphasised that during these sessions information is given to them based on their groups. When couples are in these sessions, issues on family planning, maternal health and HIV/AIDS stood out strongly, meanwhile when talking with youths and singles issues on HIV/AIDS, Dangers on Abortions stood out usually. The respondent further said that youths are kept busy in reproductive health information activities such as giving them responsibilities to work with the neighbourhood community members in disseminating information on family planning, maternal health care, HIV/AIDS, STI's and abortions.

The researcher asked the question on how the adoption rate of the reproductive health information has been. The pastor said that it was good especially on the side of women and people living with HIV and AIDS. Some church members living with the HIV virus have come out in the open on their status and give testimonies on how reproductive health information had helped them to live happily. He further stated that couples also have adopted the family planning such that the numbers of children which they are having have reduced; also the space in between children is okay as compared to years back when reproductive information was not on board.

The researcher asked the Pastor what measures have been put in place in encouraging men accessing reproductive health information, in his answer he said men have been cooperative in responding to reproductive health information activities for example most men from the church are members of the neighbourhood community leaders, besides the outcome on the numbers of child spacing is the proof enough to show how cooperative and encouraging men have been in assisting their spouses, also issues of HIV and AIDS men have been in the lead to disseminate information for example on stigma, prevention mother to child transmission and STI's. Men have also been encouraged to accompany their wives during antennal though due to busy schedules sometimes it has looked like they are not cooperative.

5.6.3. PHYSICAL OBSERVATIONS

The researcher spent over two months in Mukonchi of Kapiri District while attached to the Mukonch Health Clinic and made several observations in relation to the subject under study. The observations made were as follows:

Figure 5. The researcher observing during under five visit.

5.6.3.1. Knowledge, attitudes, practices and beliefs in reproductive health information

It was observed that most reproductive women and men had little education levels or did not attend any form of education. Thus that the understanding of reproductive health information was a challenge. Then their main source of information was through clinic talks during weekly educational health programmes.

5.6.3.2. Knowledge

It was observed that the reproductive women of age had knowledge on reproductive health information and they knew that it is a good practice because it gives them good spacing on

children when it comes to family planning. On issues of HIV and AIDS it was observed that they knew it very well. But in terms of abortions, the knowledge was scanty as the clinic paid more attention to other issues other than abortions. When it came to issues of maternal health the women were knowledgeable enough along side with issues of STI's.

5.6.3.3. Attitudes, practices and beliefs in reproductive health information

The study revealed that the attitude, practices and beliefs of reproductive women of age towards the reproductive health information played a big role. For instance to accept change and stop an inappropriate thinking on certain myths about reproductive health information was proving to be difficult. Despite having the knowledge on reproductive health information they have doubts on the actual implementation of the information. For instance, even though they feel like taking family planning, yet they also think that it is an hindrance of God given children. This tore them apart. It was further revealed that for these women, family planning is taken because they feel there is no any alternative to family spacing. When it comes to beliefs on family planning it was revealed that when family planning is taken for a long, it can make them grow mushrooms in the stomach.

It was further revealed that attitudes towards HIV and AIDS were not taken serious as compared to family planning. This is due to the fact that most women are in polygamous marriages were one man may have as many as three or five women. The researcher had taken time to find out on how they felt living with more than one wife. Most of the women talked to were okay with the situation. It was observed by the researcher that HIV and AIDS was not much of an issue as compared to issues of family planning, maternal health care, and antenatal.

The researcher observed that men were not cooperative when it came to accompanying their spouses to the health centre to access reproductive health information. It was observed that men had a bad attitude towards involvement on reproductive health information such that they felt that reproductive information was meant for women. It was further revealed that men were not in a position do their HIV checkups as compared to women.

The researcher took time to listen to the headman from Zambian Compound Mr. Bweupe and observed his comments. The headman stated that it was a duty of a woman to go to the clinic and access reproductive health information because men are busy to look for food. Asked on issues of abortions, he answered that if a girl child aborts she was usually taken care of by their mothers hence you find that when a girl child aborts at home it was very hard for a man to know about issues of abortions. It was further observed that information on issues of HIV and AIDS are well known but they were not knowledgeable enough on disconduct couples where a man is sick while the wife was not or the vice versa.

The findings shows that females were more committed in accessing reproductive information compared to men. This is because men feel shy to attend to reproductive health information with women.

Figure 6. Showing Men's involvement in reproductive health information.

5.6.3.4.Sustainability and effectiveness of reproductive information

As regards to the sustainability and effectiveness of reproductive health information provided by the clinic, it was observed that the information was not sustainable because men are not involved much For this reproductive health information to be a success, men need to be there since it affects them too.

CHAPTER SIX: DISCUSSION OF THE RESULTS

6. Introduction

This chapter gives a discussion of the results of the study that are presented in chapter five. The main objective of the research as indicated earlier was on the effectiveness of Mukonchi clinic in providing reproductive health information to women of age: A case study of Zambian Coumpond of Mukonchi in Kapiri Mposhi District.

6.1. Communication health and health promotion

Communication Health means communication aimed at influencing the knowledge, attitudes, and beliefs of target audiences in favour of health behaviour choice (Rancer and Womack, 1997,p. 22).

Health Promotion is a general term which covers all health issues and includes all methods including improvement in services, promotion of healthy public policy and education/communication components of health promotion. The other term that is used for health education has been the term ‘information, education and communication’ usually abbreviated as IEC- and another term communication support (www.jhonhubley.co.uk-accessed on 12/10/2012).

Health Education messages are developed based on knowledge, attitude and practices (KAP). Messages will need to be tailored for cultural acceptability, literacy levels, and available infrastructure and for their specific target audience (Kailyaperul et al., 2003, p. 14).

The system of providing reproductive health information to women of age was important. But since their educational levels were low, involving team leaders among themselves was better. Horizontal transfer of knowledge among themselves carried more weight than the top-down from

the clinic training officers. The benefits of seeing what their fellow counterparts are doing would enhance motivation in them especially the men.

The World Health Organization (2000, p. 16) stated that information and education provide the informed base for making choices. It further stated that information and education are necessary and core components of health promotion, which aims at increasing knowledge and disseminating information related to health. Health information and education should include the public's perceptions and experiences of health and how it might be sought; knowledge from social science and epidemiology on the patterns of health, disease and factors affecting them. It also expressed that health information systems should collect and disseminate the information in the right channel to meet the needs of the community they are serving.

It is important to note that the findings on the mode of provision of reproductive health information to women of age were not unique much because most reproductive women were at the same level in terms of education despite the differences in ages hence, their understanding of reproductive health information was almost at the same level. During the research it was observed that the adoption process was happening at different levels. Some people within the group are early adopters, others are in the middle meanwhile others are late adopters (Rodgers, 2008, p. 23).

It is, therefore, worthy noting that the results obtained in the qualitative study were not different from those gathered from quantitative study, though those from qualitative method were articulate and more profound.

From the findings it has been discovered that majority of the respondents who access reproductive health information from the clinic are in the age range of 25-35 years. This means that most of the women in Mukonchi who access information are youths. According to the Family Health International (2005, p.17) it emphasized that woman in their early stages of their reproductive health need reproductive health information so that they are knowledgeable about

their way of living. Now from the findings it has been observed that teenagers do not access reproductive health information from the clinic as much as those in the 20s.

From the findings on the provision of reproductive health information, a great deal of work needs to bed one clinic in establishing women's awareness of the existence of reproductive health information for the process to be sustained. There were a lot of factors that limited the effectiveness of providing reproductive health information to women and men of age. These included the low level of education which impacted negatively because understanding was slow, grassroots were not handled properly to enhance information flow in the communities. The opinion leaders like the chiefs were not so much involved to enhance the adoption on reproductive health information to women and their spouses (Rodgers, 2008, p. 115).

6.1. Organisational communication

This is communication within an organization or between organizations. Effective communication in the workplace is essential to the delivery of successful organisational strategy and change, employee commitment, and ultimately competitive advantage (McQuail, 1994, p. 23).

Mukonchi clinic as a government institution has communication structures existing within and outside the institution. Communication at the clinic starts from the messages coming from the Provincial Coordinators' Office which is in Kapiri District to Mukonch clinic, then to the clinic specialists in various departments, to health educators and to the people who come to visit the clinic. Going by the results of the study, the most effective way of disseminating information on reproductive health is to disseminate information to the reproductive women and men through its officers during weekly education programmes such as antenatal, child care and family planning meetings.

It was also found that the clinic has a well organised structure for providing information to the women of age able to meet some of their intended goals. However the clinic as an organisation

lacked practical tools, techniques and model to penetrate to the most vulnerable audience in the community. The researcher observed that it lacked the effort to convince the opinion leaders in the community such as the traditional chiefs, ward counsellors, community chairmen, Church leaders and community health members. The clinic has concentrated so much on the women who were attending to the weekly health education programmes hence it was difficult for the community to enhance the adoption of the reproductive health information which the clinic was providing.

Taking an example from the theory of Diffusion of an Innovation, Rogers (2003.p 172) described the innovation-decision process as "an information seeking and information processing activity, where an individual is motivated to reduce uncertainty about advantages and disadvantages of an innovation". For Rodgers the innovation-decision process involves five steps. Knowledge, Persuasion, Decision, Implementation and Confirmation

According to Rogers, (2003, p.172) , revealing the findings, the researcher found that the clinic was able to provide the knowledge on reproductive health information. However the women were still in a dilemma on how it would work. For instance on family planning, most of the respondents were saying the children are God given.

Going by the persuasion stage of Rodgers, it occurs that when an individual has a negative or positive attitude towards the innovation, the formation of a favourable or unfavourable attitude toward an innovation does not always lead directly or indirectly to an adoption or rejection (Rodgers,2003, p. 176).

During the findings, it was observed that despite the women attending to the weekly health education programmes provided by the clinic, the issue of weekly programmes stood out as mandatory to them, in the sense that these programmes were done whenever they would go to attend to the weekly health programmes. Therefore, there was no persuasion but respondents felt like it was law to be in these meetings. Furthermore, it appears like women were having a

negative attitude towards an innovation .For example it was revealed that family planning would lead to having growing mushrooms in their wombs.

It was further revealed that despite the overwhelming response on the attendance of reproductive health information on these weekly meetings, it was found out that these women as they go for their medical routine checks ups, they are caught up in a web to be tested for HIV and AIDS especially for those who were pregnant which was sounding mandatory to these women of age. Hence, in the process when they go back to their communities to share with their spouses it becomes a problem. The findings show that this situation results in some women ending up delivering in their homes. To this effect, the adoption of innovation in reproductive health information becomes a challenge.

At Implementation Stage, this is where an innovation is put in to practice. However, an innovation brings in the newness in which some degree of uncertainty is involved in diffusion; thus, the implementer may need technical assistance from change agents and others to reduce the degree of uncertainty about the consequences (Imail, 2006, p. 17). Looking at the findings, it was found out that the change agents like the chiefs, community chairman, ward counsellors, church leaders and influential members in the community were not used much. Hence, it contributed so much in the slow adoption process of reproductive health information. The adoption process would have been improved if community leaders and change agents would have been used especially to convince men.

At Confirmation Stage as process of innovation – This is a situation whereby an innovation decision already has been made, but at the confirmation stage the individual looks for support for his or her decision. This decision can be reversed if the individual is exposed to conflicting messages about the innovation (Roders, 2003, p189). However, the individual tends to stay away from these messages and seeks supportive messages that confirm his or her decision; thus attitudes become more crucial at the confirmation stage depending on the support for adoption of the innovation and the attitude of the individual (Ismail 1997, p. 17).

For adoptable innovations to take place in communities, it's necessary to consider the five stages mentioned already and relate them to issues of modern communication that can easily be embraced by affected communities. In this case the provision of reproductive health information has to be accepted, it has to stand to their advantage compared to the methods they have used before, also the clinic has to look at their existing values and past experiences.

The findings show that despite the clinic providing reproductive health information, it did not look at the compatibility of methods used in transferring reproductive information, in this case family planning, maternal health care, STI's, HIV and AIDS. Through observation, the researcher had noticed that during these methods used in transferring information to women of age such as health educations programmes, it was revealed that when looking at family planning, HIV and AIDS, the respondents would be in one shed regardless of age. As a matter of fact, Mukonchi is a rural area where one would find a girl as young as 14 years have 2 to 3 children, meanwhile in the same shed one would find woman as old as 47 years having 8 to 13 children. Looking at this situation one would find that elder mothers would feel un comfortable to share the same meetings with the little ones.

Looking at the findings on the efficiency of the clinic in the provision of reproductive health information to women of age, it plays an important role in disseminating information to women of age in that it has to start by identifying the members of the social group like the staff from the clinic, the neighbourhood health committee, the church leaders like the SDA which works with the clinic on reproductive health information, the chairpersons in the surrounding communities and counsellors. These members in the social system have great influence in making reproductive health information a reality in communities. However, the clinic lacked that ingredient.

6.2. Communication for development

Communication for development implies the use of a communication process, techniques and strategies in promoting development ideas to raise peoples' awareness of their own and situation and the options they have at their disposal for activities involving change, as well as helping to resolve social conflicts and working together to reach a consensus (IIboudo, 2002, p. 17).

The aim of communication for development is to facilitate mutual understanding and consensus for action among stakeholders during every step of the process to ensure success and sustainability of the development effort. It seeks to integrate people's culture, attitudes, knowledge, practices, perceptions, needs and problems in the implementation of projects and programmes to guarantee that they are effective and relevant (Mefalopulos and Moetsabi 1999, p. 55).

In this study, communication for development was taken to mean the use of effectiveness on the mode of provision and approaches to enhance reproductive health information. Reproductive women of age need information at every level of the process – to increase access, awareness and understand the reproductive health methods. From the research findings there was a strong indication that communication on awareness, accessibility, efficiency, and methods used when providing reproductive health information among reproductive women of age was well received but it seemed to come only from the clinic through weekly health educational programmes and not much communication exchange among reproductive women or men and outside the society. If interactive communication channels such as community radio station which can be done in local language, more sensitisation on reproductive information to traditional leaders, more efforts in involving men in reproductive health information are encouraged the problem of low effectiveness in adoption reproductive health information can be addressed.

Looking at the multistep flow theory it provides the reality of how lives of the members of the social system are affected. The people in positions of authority at the health centre, members of

the neighbourhood health committee, church elders, chairpersons and counsellors will act as opinion leaders in relaying information to the community. It is evident that these have great influence over the members of the community and play a critical role in determining the flow of events in communities. The organizational structure depicts well this trend when information move from the clinic staff to the neighbourhood health committee and community leaders and finally to the grassroots (Katz and Lazarsfeld 1955 p.84 and Lowery and Defleur 1995 p.39).

6.5. Development

Development in this report understood as improvement in human life conditions at individual and social levels, and it is achieved through desirable but influential changes or adjustments in the environment (Kasoma, 1994, p. 34). Development can only be seen among reproductive women of age and their spouses when their standard of life improves by having health babies, through accessing reproductive health information like Child Care, HIV and AID, STI's and family planning be able to have a health population. This health population will be able to develop and have sustainable development. Development also entails alleviation of illiteracy levels by overcoming the low educational levels and becoming partners in the entire decision making process – overcoming barriers of effective communication challenges in reproductive health information. Therefore, influential persons and organisation have an important role to play in influencing change and creating a platform of exchange of ideas. Access to reproductive health information would contribute greatly to development of women of age and their spouses. Effective provision of reproductive health information would be able to make them knowledgeable enough as to be able to expose them to the much needed information.

The research also revealed that reproductive health information has helped some of the respondents in preventing themselves against HIV/AIDS and sexually transmitted infection, while some have been helped in spacing up children and others said that reproductive health information had helped them when they were pregnant.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

The study was on the effectiveness of Mukonchi Rural Health centre of Kapiri Mposhi District in providing reproductive health information to women of Zambian compound.

All respondents in qualitative and quantitative survey were asked the level of awareness and the existence of reproductive health information, finding out the mode of information provided by the clinic, women access to reproductive health information from the health centre and challenges encountered during the process of accessing the information and suggestions to overcome the challenges to improve the adoption rate among women and men.

The report established that Mukonch Health Centre District uses educational health programmes for awareness and sensitization on reproductive health information.

This study aimed at the effectiveness of Mukonchi clinic in providing reproductive health information to women of Zambian compound in Mukonchi of Kapiri District. It has been discovered that Mukonchi clinic was not adequate in terms providing reproductive health information to the women of Zambian compound. The findings show that the adoption process is where the problem had been observed. This is evident from the findings of this research, which shows that a lot of females attend to the weekly meetings provided by the clinic but they do not really know exactly how to go about with the reproductive health information. This means that they are not well informed by the information system which is supposed to provide information to them. The research has further shown that Mukonchi health clinic is not adequate in terms of information provision and this is evident by the findings that more than half of the population source their information on reproductive health not from the clinic but from friends and relatives as well as the media. The reason why most people access information through their relatives and friends is because most of the people in the community have low levels of education hence they feel uncomfortable to go to the clinic.

This study has also revealed that the most prominent method of providing reproductive health information to the people of Zambian compound is through weekly health educational talks. Even though the well known method of information provision is clinic talks, the most effective method is the peer education method. The reason why peer education is considered to be most effective is because it even encompasses those that do not go to the clinic to receive reproductive health information.

From this research it has been discovered that most of the women in Zambian compound have a positive attitude towards reproductive health information. Yet even though their attitude is positive, they felt that the information provided by the clinic is not adequate due to the fact that women still have some fears in the use of family planning and ARV therapies. This research also found that the health workers at the clinic take long to attend to the clients. So this could be one of the reasons why some of the people in Zambian compound do not go to access information from the clinic.

In this broad research it has been found that Mukonchi clinic not adequate in providing reproductive health information due to the fact that the adoption rate was a challenge. Also according to the findings it is revealed that the information provided by Mukonchi clinic is not adequate. Therefore the people in the community are facing reproductive health problems stated in the statement of the problem because the information system responsible for doing its work is not effective.

7.2. Recommendations

Based on the results of the study and discussions the following recommendations have been made to assist Mukonchi Health Clinic in providing reproductive health information to women of age and their spouses of Mukonch in Kapiri District and beyond. These following recommendations are made in order to make Mukonchi clinic become effective in disseminating reproductive health information to the women, and men of Zambian Compound and the surround areas.

- To extend the provision of reproductive health information to males so that they can be at par with females when making reproductive health decisions.
- The clinic should make sure that opinion leaders such as the chiefs, ward counsellors, community chairmen, the churches and the neighbourhood health committees are fully involved to enhance the adoption rate especially men who seem to shun away from reproductive health information meetings.
- The management at Mukonchi clinic should encourage its health workers to be more approachable so that a lot of women and their spouses can be going to the clinic to access reproductive health information.
- The presenters of health talks should reduce on the time of the presentations as a lot of women and their spouses do not go to listen to these talks because of the long presentations. It will be of help if the clinic involves team leaders from the communities themselves hence, make the teaching effective and interesting because the women would be listening from their fellow counterparts.
- To increase the number of peer educators so that they can reach out to every corner of the community and educate the members on reproductive health information.
- The management should improve the health services at the clinic so that the people can be attracted to access reproductive health information from the clinic.

- The information provision in the community by peer educators should be done on a regular basis so that the people can learn a lot from the peer educators.
- The Government of Zambia should employ more health workers at Mukonchi clinic so that the provision of information can be effective by alternating the health workers.
- The peer educators who go round in the area should be working together with the drama groups in the community so that they can enhance education and entertainment.
- To engage the opinions leaders so as they are able to convince the people they live with that reproductive health information was of good use.
- To find simpler ways of teaching because most people have low levels of education.
- The Government should also get involved in developing roads which are impassable to make it easier for the clinic staff to reach far flung areas and disseminate this reproductive health information.
- The Government should get involved to find a lasting solution in reaching out to far away areas by building more clinics

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http://www.unm.edu/~devalenz/handouts/defcomm.html

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http://www.wisegeek.com/what-is-family-planning.htm

http://www.unfpa.org/public/cache/bypass/parliamentarians/pid/3615?newsLId=6929

APPENDICES

Appendix 1: Questionnaire for women

INDIVIDUAL QUESTIONNAIRE

RESEARCH TOPIC:

To access the effectiveness of Mukonchi Rural Health Centre of Kapiri Mposhi District in providing reproductive health information to Women of Age in Mukonchi Rural area of Central Province. A case study of Zambian Compound.

Dear Respondent,

I am Susan Musonda, a student at the University of Zambia. You have been randomly selected to help with information on assessing the effectiveness of Mukonchi Rural Health Centre on disseminating reproductive information to Women of Age in Mukonchi Rural area. This information is required as part of an academic research exercise and will by no means be used against you. Information provided will be kept confidential. Your cooperation will be highly appreciated.

INSTRUCTIONS

Please read all questions carefully and provide answers accordingly, indicate your answer by ticking [✓], in the box provided. In case an explanation is needed, please use the provided space for short and clear answers.

Please read all questions carefully and provide answers accordingly.

Tick in the box all the answers that apply to you.

Ask women age range 14-49 years

SECTION A: BACKGROUND INFORMATION

NO	Questions and filters	Coding Category	Official use
Q01	How old were you at your last birthday?	(1) 14-19 years [ ] (2) 20-24 years [ ] (3)25-29 years [ ] (4) 30-35 years [ ] (5) 35 years and above [ ]	[ ]
Q02	Education level attained.	(1) None [ ] (2) Primary [ ] (3) Secondary [ ] (4) College/University [ ]	[ ]

Q03	What is your marital status?	(1) Single [ ] (2) Married [ ] (3) Divorced [ ] (4) Separated [ ] (5) Widowed [ ]	[ ]
Q4	What is your current occupation?	(1) Government officer [ ] (2)Peasant farmer [ ] (3)House wife [ ] (4)Marketeer [ ] (5)Other specify ……	
Q5	What is your religion?	(1) Christian [ ] (2)Moslem [ ] (3) African Tradition [ ] (4)Other Specify……	
Q6	What language do you use in your daily life?	(1) Bemba [ ] (2) Tonga [ ] (3) Nswaka [ ] (4) lamba [ ] (5) Other Specify……	

SECTION B: KNOWLEDGE, ATTITUDE, PRACTICES AND BELIEFS ON REPRODUCTIVE HEALTH INFORMATION

Q07	Have you ever been pregnant?	(1)Yes (2)No	
Q08	How many times have you been pregnant?	(1) once [ ] (2)twice [ ] (3)three times [ ] (4)more than five times [ ]	
Q9	How many children do you have?	(1)one [ ] (2)two [ ] (3)three [ ] (4)four [ ]	

		(5) Other Specify……..	
Q10	How many children do you plan to have?	(1)As many as God can give me [ ] (2)one [ ] (3)two [ ] (4)more than five [ ] (5) other specify……	
Q11	The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy and/or sexually transmitted infections?	(1)condom [ ] (2)family planning pills [ ] (3)Natural method [ ] (4)Traditional method (5) Others specify……	
Q12	When was the last time you received a reproductive health exam from a doctor or medical professional?	(1)last week (2)last month (3)last year (4)None (5) Others specify…….	

Q13	Which of the following do you think are included in Reproductive Health? **(Multiple response)**	(1) Family planning (2) HIV/AIDS (3) Malaria (4) Mother Child Health Care (5) Tuberculosis (TB) (6) Sexually Transmitted Infection (7) Maternal health care	[ ] [ ] [ ] [ ] [ ] [ ] [ ]
Q14	Are you aware that Mukonchi Rural Health Centre provides Reproductive Health information?	(1) YES [ ] (2) NO [ ] if yes skip Q15	[ ]
Q15	Why are you not aware of the Reproductive Health information provision at Mukonchi Rural Health Centre ?	(1) Not interested in the RH information [ ] (2) You have not been there to find out [ ] (3) You Have not been informed [ ] (4) Other Specify.....	[ ]
Q16	How did you know that Mukonchi Rural Health Centre provide Reproductive Health information?	(1) Through a Friend [ ] (2) Publication leaflets [ ] (3) Drama [ ] (4) Peer Educators [ ]	[ ]

		(5) Personnel at the clinic [ ] (6) Other (Specify).....	
Q17	Do you access Reproductive Health ?	(1) YES [ ] (2) NO [ ] **(if NO, go to Q19)**	[ ]
Q18	How often do you access the Reproductive Health information?	(1) once week [ ] (2) once in month [ ] (3) once in 3 months [ ] (4) once in a year [ ]	[ ]
Q19	If you do not access Reproductive Health Information from Mukonchi Rural Health Centre, what are the reasons?	(1) It is far [ ] (2) Staff is not friendly [ ] (3) No Confidentiality [ ] (4) information not helpful [ ] (5) Have no need to visit the clinic [ ]	[ ] [ ] [ ] [ ] [ ]
Q20	If not the source of information then what is your source of Reproductive Health Information?	(1) Media and Press [ ] (2) Friends and Relative [ ] (3) Books and [ ] (4) Any other specify.....	[ ]

SECTION C: MODE OF REPRODUCTIVE HEALTH INFORMATION PROVISION

Q21	In your last visit, how long did it take you to reach the health centre?	(1) Less than 30 minutes (2) 30-60minutes (3) 60-90 minutes (4) 120 minutes	[ ] [ ] [ ] [ ]
Q22	What do you think about the distance?	(1) Convenient (2) Inconvenient	
Q23	In what ways does Mukonchi Rural Health Centre disseminate Reproductive Health information? **(Multiple response)**	(1) Clinic Talks [ ] (2) Peer Educators [ ] (3) Pamphlets/leaflets [ ] (4) Drama (5) Video shows [ ]	
Q24	Which of the following ways of information provision used by Mukonchi Rural Health		

	Centre are effective?	(1) Clinic Talks [ ] (2) Peer Educators [ ] (3) Pamphlets/leaflets [ ] (4) Drama [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Q25	What types of Reproductive Health Information do you think is not being provided by and yet Mukonchi Rural Health Centre should be providing? **(Multiple response)**	(1) STIs/STDs [ ] (2) Rape/Gender Based Violence [ ] (3) Abortion [ ] (4) Maternal health care [ ]	[ ] [ ] [ ] [ ]
Q26	How have you been helped through the use of reproductive health information?	(1) For spacing up children [ ] (2) Prevention against HIV/AIDS [ ] (3) Prevention against STIs [ ] (4) Helped you while pregnant [ ] (5) Helped you to look after your children [ ]	[ ] [ ] [ ] [ ] [ ]
Q27	How would you describe the Reproductive Health Information provided by Mukonchi Rural Health Centre?	(1) Very adequate [ ] (2) adequate [ ] (3) Not adequate [ ]	[ ]

Q28	How long does it take for the health worker to attend to you?	(1) very long [ ] (2 Quiet long [ ] (3) Not long [ ]	[ ]
Q29	What do you think about Reproductive Health information provided by Mukonchi Rural Health Centre?	....	[ ]
Q30	Suggest ways in which Mukonchi Rural Health Centre can be improved in terms of information provision	.....	[ ]

Appendix 2: Questionnaire for men

INSTRUCTIONS

Please read all questions carefully and provide answers accordingly.

Tick in the box all the answers that apply to you.

Ask Men age range 14-49 years

SECTION A: BACKGROUND INFORMATION

NO	Questions and filters	Coding Category	Official use
Q01	How old were you at your last birthday?	(1) 14-19 years [ ] (2) 20-24 years [ ] (3)25-29 years [ ] (4) 30-35 years [ ] (5) 35 years and above [ ]	[ ]
Q02	Education level attained.	(1) None [ ] (2) Primary [ ] (3) Secondary [ ] (4) College/University [ ]	[ ]

Q03	What is your marital status?	(1) Single [ ] (2) Married [ ] (3) Divorced [ ] (4) Separated [ ] (5) Widowed [ ]	[ ]
Q4	What is your current occupation?	(1) Government officer [ ] (2)Peasant farmer [ ] (3)House wife [ ] (4)Marketer [ ] (5)Other specify ……	
Q5	What is your religion?	(1) Christian [ ] (2)Moslem [ ] (3) African Tradition [ ] (4)Other Specify……	
Q6	What language do you use in your daily life?	(1) Bemba [ ] (2) Tonga [ ] (3) Nswaka [ ] (4) lamba [ ] (5) Other Specify……	

SECTION B: KNOWLEDGE, ATTITUDE, PRACTICES AND BELIEFS ON REPRODUCTIVE HEALTH INFORMATION

Q07	Have you ever been responsible for a pregnancy?	(1)Yes (2)No	
Q08	How many times have you been responsible for a pregnancy?	(1) once [ ] (2)twice [ ] (3)three times [ ] (4)more than five times [ ]	
Q9	How many children do you have?	(1)one [ ] (2)two [ ] (3)three [ ] (4)four [ ] (5) Other Specify……..	
Q10	How many children do you plan to have?	(1)As many as God can give me [ ] (2)one [ ] (3)two [ ]	

		(4)more than five [ ] (5) other specify……	
Q11	The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy and/or sexually transmitted infections?	(1)condom [ ] (2)family planning pills [ ] (3)Natural method [ ] (4)Traditional method (5) Others specify……	
Q12	When was the last time you received a reproductive health exam from a doctor or medical professional?	(1)last week (2)last month (3)last year (4)None (5) Others specify…….	
Q13	Which of the following do you think are included in Reproductive Health? **(Multiple response)**	(1) Family planning (2) HIV/AIDS (3) Malaria (4) Mother Child Health Care (5) Tuberculosis (TB) (6) Sexually Transmitted Infection	[ ] [ ] [ ] [ ] [ ] [ ]

		(7) Maternal health care	[ ]
Q14	Are you aware that Mukonchi Rural Health Centre provides Reproductive Health information?	(1) YES [ ] (2) NO [ ] if yes skip Q15	[ ]
Q15	Why are you not aware of the Reproductive Health information provision at Mukonchi Rural Health Centre ?	(1) Not interested in the RH information [ ] (2) You have not been there to find out [ ] (3) You Have not been informed [ ] (4) Other Specify.....	[ ]
Q16	How did you know that Mukonchi Rural Health Centre provide Reproductive Health information?	(1) Through a Friend [ ] (2) Publication leaflets [ ] (3) Drama [ ] (4) Peer Educators [ ] (5) Personnel at the clinic [ ] (6) Other (Specify).....	[ ]
Q17	Do you access Reproductive Health Information from Mukonchi Rural Health	(1) YES [ ] (3) NO [ ] **(if NO, go to Q19)**	[ ]

	Centre?		
Q18	How often do you access the Reproductive Health information?	(1) once week [ ] (2) once in month [ ] (3) once in 3 months [ ] (4) once in a year [ ]	[ ]
Q19	If you do not access Reproductive Health Information from Mukonchi Rural Health Centre, what are the reasons?	(1) It is far [ ] (2) Staff is not friendly [ ] (3) No Confidentiality [ ] (4) information not helpful [ ] (5) Have no need to visit the clinic [ ]	[ ] [ ] [ ] [ ] [ ]
Q20	If not the source of information then what is your source of Reproductive Health Information?	(1) Media and Press [ ] (2) Friends and Relative [ ] (3) Books and [ ] (4) Any other specify.....	[ ]

SECTION C: MODE OF REPRODUCTIVE HEALTH INFORMATION PROVISION

Q21	Have you ever visited Mukonchi Health Centre for reproductive health information services	(1) Yes (2) No	[ ] [ ]

			[
Q22	What do you think about the distance?	(1) Convenient (2) Inconvenient	
Q23	In what ways does Mukonchi Rural Health Centre disseminate Reproductive Health information? **(Multiple response)**	(1) Clinic Talks [ ] (2) Peer Educators [ ] (3) Pamphlets/leaflets [ ] (4) Drama (5) Video shows [ ]	
Q24	Which of the following ways of information provision used by Mukonchi Rural HealthCentre are effective?	(1) Clinic Talks [ ] (2) Peer Educators [ ] (3) Pamphlets/leaflets [ ] (4) Drama [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Q25	What types of Reproductive Health		

	Information do you think is not being provided by and yet Mukonchi Rural Health Centre should be providing? **(Multiple response)**	(1) STIs/STDs [ ] (2) Rape/Gender Based Violence [ ] (3) Abortion [ ] (4) Maternal health care [ ]	[ ] [ ] [ ] [ ]
Q26	How have you been helped through the use of reproductive health information?	(1) For spacing up children [ ] (2) Prevention against HIV/AIDS [ ] (3) Prevention against STIs [ ] (4) Helped you while pregnant [ ] (5) Helped you to look after your children [ ]	[ ] [ ] [ ] [ ] [ ]
Q27	How would you describe the Reproductive Health Information provided by Mukonchi Rural Health Centre?	(1) Very adequate [ ] (2) adequate [ ] (3) Not adequate [ ]	[ ]
Q28	How long does it take for the health worker to attend to you?	(1) very long [ ] (2 Quiet long [ ] (3) Not long [ ]	[ ]
Q29	What do you think about Reproductive Health information provided by Mukonchi Rural Health Centre?	....	[ ]

Q30	Suggest ways in which Mukonchi Rural Health Centre can be improved in terms of information provision	.....	[ ]

SECTION D: MALE INVOLVEMENT IN SUPPORTING REPRODUCTIVE HEALTH INFORMATION SERVICES FOR WOMEN

Q31	Do you escort your wife/partner to access reproductive health information services at Mukonchi Rural Health Centre?	(1) Yes (2) No	**[ ]** **[ ]**
Q32	Do you encourage your wife/partner to attend reproductive health information services at Mukonchi Rural Health Centre?	(1) Yes (2) No	**[ ]**
Q33	Does the staff at Mukonchi Rural Health Centre encourage your wife/partner to invite you to attend reproductive health information services?	(1) Yes (2) No	**[ ]**
Q34	Suggest ways in which Mukonchi Rural Health Centre staff can encourage male involvement in the reproductive health information services	**(**1) Home visit by health centre staff (2) Drama (3)Invitation letters (4) Other	**[ ]**
Q35	Do you think attending reproductive health information services should be made	(1) Yes	**[ ]**

	mandatory for couples?	(2) No	

Appendices 3

IN-DEPTH INTERVIEW QUESTION GUIDE

1) How is the women's awareness of the existence of reproductive health information at Mukonchi Rural Health Centre?

2) Outline the communication strategies used in to impart information to women of age and their spouses?

3) How effective is the communication system?

4) Any problems with the way the information is communicated?

5) Why the low adoption process among women and men especially men yet the innovation has potential of increasing the adoption rate?

6) What is people's perception on the reproductive health information provided by the clinic

7) Which communication methods seem influential?

8) Sustainability of the reproductive health information?