EXPLORATION OF USEFULNESS OF FAMILY PLANNING METHODS UTILISED BY WOMEN IN KALULUSHI DISTRICT, ZAMBIA

By

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DECLARATION

I, **Mbashila Muzhinga**, do hereby declare that this dissertation is my own work and that all the sources that I have used or quoted have been acknowledged by means of complete references, and that it has never been previously submitted for a degree at the University of Zambia or any other University.

Signature: …… Dated: …….....

APPROVAL

This dissertation of **Mbashila Muzhinga** has been approved as partial fulfilment of the requirement for the award of Master of Science Degree in Counselling by the University of Zambia.

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DEDICATION

This work is dedicated to my darling loving wife Mumba Lapukeni and Children Kulung'a and Alemi, for the patience they showed me during the entire period of my studies. Your unwavering love, support and understanding is what gave me the impetus to go an extra mile seeing to it that this work was a success.

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ABSTRACT

Family planning has been found to be a very essential tool for sustainable global development. The medical benefits of family planning are immense and have been echoed by many authors. Nonetheless, little is known about the social benefits to women. The purpose of this study was to explore the usefulness of family planning to women in a social context in Kalulushi district. A qualitative enquiry using Case Study design was used. Data was collected from the District Nursing Officer, Providers, and Users of family planning services in three clinics of Kalulushi District. Semi-structured and Focus group interviews were used to collect data from 20 participants. Data was analysed through thematic content analysis.

The study revealed that "being in control of one's fertility" was the primary reason for utilizing family planning services by women. Pregnancy-related complications, a harsh economy and good health outcomes, are secondary factors. The methods of family planning commonly utilized by women in Kalulushi district include short-acting injection Depo-Provera, followed by the Pill. Male and female condoms, long-acting implants (Jadelle and Implanon) and the Intra-Uterine Contraceptive Device are not commonly utilized. Barriers to utilizing family planning methods include drug/commodity stock-outs, inadequate work spaces which compromise privacy, lack of skilled personnel to provide long-term methods, among others. The stock-out of family planning commodities affects users by limiting choice thereby forcing women to utilise the only available methods which in turn compromises quality. The Covid-19 pandemic has compounded the stock-out of family planning methods by hampering supply chain. In terms of usefulness, family planning promotes rights particularly, sexual and reproductive health rights of women; is vital for improving women and their household's health outcomes, and enables women who are the majority in the informal sector, to work and earn incomes that sustain their livelihoods, among others.

To ensure client satisfaction, it is therefore important that Kalulushi District Health Management should provide a wide range of family planning methods so that women have choice; staffs who provide family planning services should be trained in long-term family planning service provision; adequate family planning counselling should be integral part of service provision, and

last but not the least, providers of family planning should promote long-term family planning methods to counter erratic supply of short-term methods.

Key Words: Family planning, Usefulness, Social, Women, Kalulushi District, Zambia

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ACRONYMS AND ABBREVIATIONS

CEDAW	Convention on the Elimination of all forms of Discrimination
CPR	Contraceptive Prevalence Rate
CSO	Central Statistical Office
DISCOVER-Health	District Coverage of Health Services
DNO	District Nursing Officer
FP	Family Planning
HBM	Health Belief Model
ILO	International Labor Organization
IPPF	International Planned Parenthood Federation
JSI	John Snow Inc.
LARC	Long-Acting and Reversible Contraception
MCH	Mother and Child Health
MOH	Ministry of Health
MTCT	Mother to Child Transmission
ND	Not Dated
NGO	Non-Governmental Organization
PPAZ	Planned Parenthood Association of Zambia
SAFE	Supporting an AIDS Free Era
SDG	Sustainable Development Goals
UNDESA	United nations Department of Economic and Social Affairs
	Against Women
UNICEF	United Nations Children's Education Fund
UNFPA	United Nations Fund for Population Agency
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER ONE
INTRODUCTION

1.1 Overview

This chapter contains the background to the study, statement of the problem, purpose of the study, objectives and research question. Theoretical framework, significance of the study and operational definition of terms are all discussed in this chapter.

1.2. Background to the Study

Family planning is a decision by couples, together or individually, on the number of children that they would like to have in their lifetime, and the age interval between children, (Berhan, Garoma, Hurpa, and Wyllie, 2011). It is one of the leading strategies to improve family life and welfare, control unwanted population growth, and aid the development of any nation.

The history of family planning dates back to time immemorial. In Genesis 38:2-10 of the Bible, is a record of a man called Onan who did not want to bear children for his late brother through his widow Tamar by spilling semen on the ground each time he had sex with her, a thing which displeased God and therefore, he slew him. This is called “coitus interruptus” in modern day family planning. Other than this account, family planning is known to have been practiced in the early centuries through methods such as abstinence (avoiding sex around time of ovulation), use of herbs and amulets, (Planned Parenthood Federation of America, 2006 in Shah ND).

There are modern and traditional (natural) methods of family planning. Modern contraceptive methods are products or medical procedures that interfere with reproduction from acts of sexual intercourse. Traditional methods involve interference with reproduction from acts of sexual intercourse through use of non-medical products or procedures, (Hubacher and Trussel, 2015). The starting point of modern family planning dates back to 1916 when Sanger opened the first birth control clinic in 1916. India then formulated the first National Population Policy in 1952, and then the International Planned Parenthood Federation and Rockefeller’s Population Council were also established. Following this was seen significant transfers of financial and technical assistance from industrialised to developing countries in mid to late 1960s for population

programs, (Robinson and Ross 2007). This is the hallmark of modern family planning. There are many benefits of family planning. It is estimated that about 10 million adolescent girls (10 and 14 years) marry each year and begin bearing children. Childbirth by these young mothers or by older women above 35 years is associated with many health risks, (USAID, 2012). For example, adolescent girls are prone to trauma of the birth canal resulting in uncontrollable dripping of urine and faeces during child birth due to underdeveloped reproductive organs. Conversely, older women who have five or more children are 1.5 to 3 times more likely to die from complications of pregnancy and childbirth than women with three or less children, (USAID, 2012). Both these women can benefit from family planning and avoid these complications. Family planning also benefits people by affording them small families they can manage and thereby enabling them to engage in personal savings of surplus earnings. In turn, this results into them having healthier families and communities, (USAID, 2012). Further, family planning has been demonstrated to be an important contributor to national as well as global development. At national level, it ensures control of a country's population to a level that does not put strain on national natural resources, (USAID, 2012). In addition, family planning helps in the achievement of the global developments such as the 2030 Agenda for Sustainable Development, (SDG). SDG 3 target 3.7 specifically calls for ensuring universal access to sexual and reproductive healthcare services, including family planning. Since family planning has been shown to significantly reduce maternal mortality, its scale-up can enable achievement of SDGs related to health including those related to poverty, health, education and gender equality since they are interrelated. Furthermore, of the estimated 830 women who die every day from preventable causes related to pregnancy and childbirth, (over 300,000 per year) (UNICEF 2017, in United Nations, 2017), maternal mortality would drop by one-third if women had only the number of pregnancies they wanted, (USAID, 2012).

Despite the many medical benefits of family planning, few people use it nonetheless. In 2015, the global contraceptive prevalence was estimated at 758 million while the unmet need for family planning was estimated at 142 million among married or in-union women, majority of them in Africa, (United Nations, Department of Economic and Social Affairs, Population Division, 2015). Family planning prevalence refers to the proportion of women or whose sexual partner is currently using at least one method of family planning, regardless of the method, (United Nations

Department of Economic and Social Affairs Population Division, 2016). Unmet need for family planning means that although a couple wants to stop or delay childbearing, they are not using any contraception to prevent it, (USAID, 2012). Thus many African countries including Zambia have low contraceptive prevalence and consequent high unmet needs for family planning.

Zambia, a landlocked country in sub-Saharan African has a total surface area of 752,614 square kilometres. The country shares boundaries with Malawi, Mozambique, Zimbabwe, Botswana, Namibia, Angola, Democratic Republic of Congo and Tanzania. It lays between 8 and 18 south latitudes and longitudes 22 and 34 east. Administratively, the country is divided into 10 provinces namely; Central, Copper-belt, Eastern, Luapula, Lusaka, Muchinga, Northern, North Western, Southern and Western and further subdivided into 105 districts. Lusaka is the capital city of Zambia and seat of the government. In 2016, the population of Zambia was estimated at 16,405,229. Zambia's fertility rate of 6.2 births per woman is the highest in the world; associated with a growth rate of 2.8 percent, the population is projected to reach 30 million by 2030, (Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014).

The government of Zambia is grappling with many problems among them unemployment, increased disease burden, low literacy levels and others. In order to achieve meaningful development, government is alive to the fact that the population need to be kept under control so that it does not grow out un-proportionately. In addition, Zambia is party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa which guarantee the right of all women and couples to determine the number and spacing of children, and provide for the right to access information and education on family planning, (United Nations in Zambia, 2017). The government has made strides to domesticate this affirmation by formulating a family planning scale-up plan which was developed in 2012 to be implemented until 2020, including the National Health Strategic Plan 2017 - 2021, and the Reproductive Health Policy. Despite its importance, utilization of family planning methods appears to be low as evidenced from the low contraceptive prevalence (41 percent) and the high unmet need (27

percent) for family planning, (Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014).

In comparison with countries within the Eastern African region, Zambia's family planning utilization is relatively low (41 percent prevalence) while unmet need for family planning is high (27 percent) (Ministry of Health, 2013). This situation puts the country at risk of exponential population growth given the fertility rate. The government however is committed to keeping the population within manageable levels so that it does not fail to meet the needs of the population.

Kalulush District is on the Copper-belt province of Zambia. Health services including family planning are majorly provided by the government; the private sector (non-governmental organizations, mines, private clinics and pharmacies) also compliment service provision. This research will explore determinants of family planning methods by women of Kalulushi District on the Copper-belt province of Zambia. Questions such as motivators, barriers, and usefulness of family planning by women of Kalulushi District on the Copper-belt province of Zambia were considered.

1.3. Statement of the Problem

Zambia is party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa which guarantee the right of all women and couples to determine the number and spacing of children, and provide for the right to access information and education on family planning. Consequently, the government through Ministry of Health in 2012 formulated a plan to scale-up family planning services owing to the low contraceptive prevalence (41 percent) and a high unmet need for family planning (27 percent) to ensure the services reach many people by the year 2020. Zambia therefore seems to have clear vision and roadmap regarding family planning for its people. Although the medical benefits of family planning are well known, it is not clear the social benefits in terms of its usefulness to women in Zambia. Unless an investigation is done, the subject will remain an unexplained grey domain.

1.4. Purpose of the study

The purpose of this study was to explore the usefulness of family planning to women in Kalulushi district.

1.5. Specific Objectives

The study was guided by the following specific objectives:

i. Describe reasons why women seeking family planning services
ii. Describe the family planning methods available to women
iii. Explore the usefulness of family planning to women

1.6. Research Questions

The study was guided by the following research questions:

i. Why do women utilize family planning services?
ii. What family planning methods are available to women?
iii. How useful are family planning methods to women?

1.7. Theoretical Framework

In order to understand the usefulness of family planning by women of Kalulushi district, the Health Belief Model developed by Rosenstock, 1974 helped guide the study. According to Hall, 2012, the Health Belief Model is a social psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services. The model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action and self efficacy, explain engagement (or lack of it), in health-promoting behavior. Key variables of HBM are explained hereunder, (Hall, 2012).

Perceived susceptibility

Perceived susceptibility refers to subjective assessment of risk of developing a health problem, (Hall, 2012). The HBM predicts that individuals who perceive high susceptibility to a particular health problem will engage in behaviors to reduce risk whereas individuals with low perceived susceptibility are more likely to engage in unhealthy, or risky, behavior. In this study, the

researcher ascertained what women perceived as risks which prompted them to seek family planning services.

Perceived severity

This refers to the subjective assessment of the severity of a health problem or condition and its potential consequences, (Becker, 1974). It includes beliefs about the condition itself, if life-threatening or can cause pain or disability, including the broader impact of the condition on functioning in work and social roles. The HBM proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity), (Becker, 1974). In this study, the researcher explored the perceived serious problems of not using family planning services by women.

Perceived benefits

According to Polit and Beck, 2009, perceived benefits refer to an individual's assessment of the value of engaging in a health-promoting behavior to decrease risk of disease or condition. They state that individuals who believe that particular actions will reduce susceptibility to a health problem or decrease its seriousness are likely to engage in that behavior. In this study, we will assess whether or not women perceive any benefits in utilizing family planning services.

Perceived barriers

Refer to individual's assessment of obstacles to behavior change, (Polit and Beck, 2009). Despite perceiving certain health conditions as threatening and that particular actions can effectively reduce the threat, barriers may prevent people from engaging in health-promoting behavior. Perceived benefits must outweigh the barriers in order for behavior change to occur. Perceived barriers may include perceived inconvenience, expense; side effects of a medical procedure, among others. The researcher explored perceived barriers by women related to family planning utilization.

Modifying variables

Individual characteristics such as demographic (age, sex, race, ethnicity, and education); psychosocial (personality, social class, peer pressure); and structural variables (knowledge about

a given condition, prior contact with condition), can affect perceptions in terms of perceived seriousness, susceptibility, benefits, and barriers of health-related behaviors, (Polit and Beck, 2009). The HBM suggests that modifying these variables affect health-related behaviors indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers. In this study, the researcher explored how these variables influenced family planning service utilization by women.

Cues to action

Hall, 2012, defines a cue to action is a trigger necessary for prompting engagement in health-promoting behaviors and can be internal (pain and symptoms), or external (events, media, or a promotion by health care worker). In this study, the researcher ascertained cues which prompted women to seek family planning services.

Self-efficacy (Health motivation)

Motivation is the desire to comply with a treatment, (Polit and Beck, 2004). It also refers to an individual's perception of own competence to successfully perform and sustain a behavior. The HBM proposes that self-efficacy helps explain the motivation behind individuals' engagement in one-time health-related or long-time behavioural change activities, (Ibid). In this study, the researcher ascertained the motivation for women to seek one point or continuous family planning services

1.8. Significance of the Study

The Government of Zambia attaches great importance to family planning services knowing that family planning is essential to the development of any nation. It is no wonder that in 2012, a roadmap to scale up family planning services by 2020 was drawn. It is hoped that the contraception prevalence will be raised while the unmet need for family planning will be reduced. This study may help to answer questions such as motivators for family planning use by women, the methods available to them; the barriers they face as well highlight the usefulness of family planning to women. Findings of the research may therefore be essential for improving service provision and beneficial to women accessing these services. It is envisaged that findings of this study may be used by the health care workers involved in provision of family planning services

to provide quality services to the clients. It is also hoped that through findings of this study, local policies may be formulated to mentor nurses and midwives at service points to help scale-up family planning services in line with the 2020 roadmap or scale-up plan by the Ministry of Health.

1.9. Scope and Delimitation of the Study

The study was focused on exploring the usefulness of family planning methods by married or women in-union aged 15 to 49 years in Kalulushi district. The participants for this enquiry were purposively selected due to their experience as users of family planning services. Because of their disposition as direct beneficiaries of family planning services, they were the right group of people to provide rich and detailed information for this study. Providers of family planning services who are the nurses and midwives working in Maternal and Child Health (MCH) Units of various health facilities of Kalulushi District including the District Nursing Officer for Reproductive Health were also involved in the inquiry for their role in providing and implementing family planning services in the district.

1.10. Operational Definition of Terms

For the purpose of giving a contextual understanding of the meaning of terms to be used in this study, the researcher gave the operational definition of terms as follows:

Family planning

This was taken to mean the decision-making process by couples, together or individually, on the number of children that they would like to have in their lifetime, and the age interval between children, (Berhan, *et al*, 2011).

Family planning prevalence

This was taken to mean the proportion of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method being used, (United Nations Department of Economic and Social Affairs Population Division, 2016).

Unmet need for family planning

It means that although a couple wants to stop or delay childbearing, they are not using any method of family planning to prevent it, (USAID, 2012).

Usefulness

This was taken to mean the motivation that drives women to seek family planning services including the ultimate benefit derived from using or utilizing family planning.

Social

This was taken to mean relating to society, or its organization..

Summary

The study focused on exploring the usefulness of family planning to women in Kalulushi district in order to help understand how really useful the service is based on the local context. It should be noted that just as communities and regions are different, so do their perception, experiences and ultimately their worldview. This enquiry was therefore very important in understanding the usefulness of family planning to women within the Zambian.

CHAPTER TWO
REVIEW OF RELATED LITERATURE

2.1 Overview

Literature review is an organized written presentation of what has been published on a topic by scholars and presents a strong knowledge base for the conduct of the research (Burns and Grove, 2005). For this study, review of related literature begins by highlighting family planning programs as a whole from the global, regional and Zambian perspectives, then later focuses on the objectives; "Why women utilize family planning, Methods available to them, and the Usefulness of family planning methods to women."

2.2 Global Perspective of Family Planning

Family planning has been found to be a very essential tool for development globally and, not just development but sustainable global development. It is not surprising that among the goals set by the global community for sustainable development is Goal number 3.7 which states, **"**to ensure universal access to sexual and reproductive health care services, including family planning (FP) information and education, and the integration of reproductive health into national strategies and programmes by 2030." The World Health Organization (WHO) estimates that approximately 210 million pregnancies occur each year globally with over 135 million resulting live-born infants while the remaining 75 million end in stillbirth or abortion (spontaneous or induced) (WHO 2011). The WHO further indicates that about 80 million pregnancies are unintended and about 42 million of these pregnancies (or 1 in 5) end in induced abortions each year, 36 million of which take place in low and middle-income countries, (Obare et al, 2014). Twenty-two million of these abortions are considered unsafe or performed by untrained practitioners and provided in unhygienic settings (Ibid). Unsafe abortion accounts for 13% (47,000) of global maternal deaths while about 60 per cent of abortion-related deaths take place in Africa (Shah and Åhman 2008; United Nations 2010). This picture is very true across many countries in sub-Sahara that are resource constrained and where poverty is rife. Obare *et al* 2014 asserts this when they indicate that in Kenya for example, 35% of maternal deaths are attributable to unsafe abortion with absolute figures of well over 2,600 women dying annually from complications of unsafe abortion and over a third of the women admitted with abortion complications occur in the second trimester of pregnancy when risks of severe complications and mortality are substantially higher in the

country, (Obare *et al* 2014). This clearly indicates that many people are not utilising family planning services although reasons for not doing so could be varied and not similar for all regions.

Nonetheless, these staggering figures of maternal death arising from complications of unsafe abortion due unplanned pregnancies could be averted had the women used family planning services or contraception to prevent conception the first place. Mbitzyo *et al* 2019 emphasizes this point by indicating that meeting all contraceptive and maternal and newborn health care needs would result in substantial health and development gains, yielding dramatic reductions of 76% in unintended pregnancy, 74% in less-than-safe and unsafe abortions, 64% in maternal deaths, and 76% in newborn deaths. As indicated above, the gains from family planning and contraceptive use are immense and investments in family planning offer benefits beyond fertility, further downstream of the maternal and newborn care continuum.

In terms of contraception use or family planning utilization on a global scale, the picture is varied as can be seen from the variations in the indicators such as contraceptive prevalence, met and unmet need for family planning. For example, according to the United Nations Department of Economic and Social Affairs Population Division, the global family planning prevalence in 2015 was 758 million. The report also indicates that 64 percent of married or in-union women of reproductive age worldwide were using family planning. However, use was much lower in the least developed countries (40 percent), particularly in Africa (33 per cent). It was higher in Oceania (59 percent), and Northern America, (75 percent), (United Nations, Department of Economic and Social Affairs, 2015). Eastern Asia had the highest family planning users (82 percent) of all the world regions in 2015, due to a high level of contraceptive use in China (84 per cent). In Bangladesh, the Contraceptive Prevalence Rate (CPR) has increased tremendously by up to eightfold over the last four decades to 61.2%, in 2011. This translates to about 25 million of 41 million eligible couples in absolute figures, (Streamfield, 2015).

There are small regional contrasts in family planning utilization in Latin America and the Caribbean, although the level of contraceptive use was lower in the Caribbean (62 per cent) than it was in North, Central and South America (70, 71, and 75 percent respectively), (United

Nations, Department of Economic and Social Affairs, 2015). In Europe, family planning use was highest in Northern Europe (77 percent) and lowest in Southern Europe (65 percent). In Oceania, the level of contraception use in Australia and New Zealand was typical of levels in regions of Europe, whereas lower in Melanesia, Micronesia and Polynesia (39 percent), (United Nations, Department of Economic and Social Affairs, 2015). In terms of contraception prevalence by wealth index, high income countries are reported to have the highest (above 70 percent), commonly Europe, North, Central and South America. Regarding unmet need for family planning, atleast 1 in 10 married or an in-union woman globally has an unmet need for family planning (12 percent). The level is much higher in least developed countries (22 percent), with many in sub-Saharan Africa which is also the region presenting the highest unmet need for contraception (24 percent), double the world average in 2015. It is lowest in Eastern Asia, North and Western Europe and Northern America, (below 10 percent).

More recent studies on family planning use indicate a surge in the Contraceptive Prevalence Rate globally. According to the United Nations Department of Economic and Social Affairs, Population Division 2019, about 922 million women of reproductive age or their partners were using contraceptives or some sort of family planning method as of 2019, demonstrating an upward surge in the number of users from the 758 million reported in 2015. Among the 1.9 billion women of reproductive age (15-49 years) living in the world in 2019, 1.1 billion have a need for family planning, that is, they are either current users of contraceptives; 842 million use modern methods of contraception and 80 million use traditional methods or have an unmet need for family planning; 190 million women want to avoid pregnancy and do not use any contraceptive method. The proportion of women who had their need for family planning satisfied by modern methods (SDG indicator 3.7.1) was 76 per cent in 2019, (Ibid).

2.3. Regional Perspective of Family Planning

There is a wide variation in family planning utilization on the African continent. While some countries demonstrate high levels of family planning and contraception services, some countries show low levels of family planning utilization. This can be seen from the predictive indicators of contraceptive prevalence and met and unmet needs for family planning including growth rate of countries. These indicators occur in inverse terms meaning that the increase in one will

subsequently lead to a reduction in the other and the opposite is true. It is noteworthy to indicate here that contraceptive prevalence and the met need for family planning are synonymous concepts as both are a measure of adoption or non-adoption, use or non-use of family planning or contraception method. When the contraceptive prevalence and met need for family planning increases, the subsequent consequence is that the unmet need for family planning reduces and ultimately, the total fertility rate of a given geographical jurisdiction.

Case studies by the United States Agency for International Development Africa Bureau (USAID/Africa) show tremendous and steady increase in the use of family planning services and contraceptives by married women in three countries in eastern Africa countries namely Ethiopia, Rwanda and Malawi in the past two decades starting from 1992 to the year 2010. Although Rwanda a slight slump in the use of modern contraceptives or family planning services following the genocide of 1994, there has been steady rise in the use of these services following that event and the successes are still being recorded. The report also shows that the overall demand for family planning in all three countries has increased in recent years culminating in a steady decline in unmet need for family planning. In Ethiopia for instance, the unmet need for family planning (counting all methods) is 29 percent, 26 percent in Malawi, and 24 percent in Rwanda, (Ibid). According to the same report, these successes are attributable to many factors among them political commitment beyond the health sector, having notable champions and partner collaboration, community provision of services and scale-up vision, community engagements and establishment of effective strategies and systems.

Evidence suggests that some countries in Africa are still using traditional methods of family planning which often tend to be more unreliable due to the increased failure rate, as alternatives of modern contraceptive methods, (Saifuddin *et al* 2011). They note that the use of these traditional methods tends to be higher in settings where acceptance of family planning is low and use of family planning programs is weak. Although there is still use of these traditional methods, their use has declined substantially while the use of modern methods has increased. Marked increases in modern contraceptive use are observed in countries with the greatest increases in contraceptive rate which include Madagascar, Malawi, Namibia, Zambia, and Zimbabwe. Use of traditional methods in these countries has either remained stagnant or has decreased. On the other

hand, Ghana, Kenya, Tanzania, and Uganda shows increases in use of modern methods while maintaining use of traditional methods. In West African countries such as Benin, Burkina Faso, Cameroon, Senegal, and Togo, use of traditional method shows a decline while showing relatively modest gains in modern contraceptive method use, (Ibid). It is noteworthy to indicate here that Family planning programs that have been successful in Africa are those that have promoted birth spacing as opposed to birth limiting as seen in the Asian region which have emphasized permanent contraceptive methods, such as sterilization and abortion programs.
Saifuddin *et al* 2011 have suggested that successful family planning program strategies in Africa must promote methods that are temporary, can be used covertly by women, and do not have to be stored at home, (Ibid)

Overall, Africa generally demonstrates low family planning prevalence compared to other regions of the world although varying widely across countries within the region as has been indicated in the above passages. Some countries within Africa have contraceptive prevalence of up to 60 percent: they include the islands (Cape Verde, Mauritius Réunion); countries located in the north of the continent (Algeria, Egypt, Morocco and Tunisia); and countries in Southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland). Eastern Africa countries (Kenya, Malawi, Rwanda, Zambia and Zimbabwe) have contraceptive prevalence of 50 percent or more although Zambia has 41 percent prevalence. Those with prevalence less than 20 percent include Nigeria, (16 percent), Chad, Guinea, and South Sudan (less than 10 percent) and these are the countries which demonstrate some higher prevalence of traditional contraception method alongside modern method use in the African region. Perhaps this could explain why the unmet need for family planning is highest in Eastern, Middle, and Western African regions of above 20 percent, United Nations 2017), compared to other sub-regions of the African region because as Saiffuddin *et al* 2011 note, traditional methods of family planning or contraception are less effective compare to modern methods as can be seen from their failure rates,

2.4. Zambian Perspective of Family Planning

Family planning in Zambia was first introduced in 1972 by the Planned Parenthood Association of Zambia (PPAZ), whose primary objective was to motivate people to accept family planning and to procure contraceptives for the country, (Banda *et al*, 2004). A decade later in 1982, the

Family Planning program was integrated into MCH services the context of primary healthcare of the Ministry of Health (MOH). The government launched a population policy in 1989 which saw a full range of family planning services being made available throughout the country. Based on the Primary Health Care concept, the vision was to see the full range of family planning services accessible to all people of reproductive age as close to the family as possible. Over the past two decades, the government of Zambia has undertaken extensive health reforms which have transformed the way health care services are provided to the community for the better. Among these reform include the extension of health care services to the very base of the community through construction of Health Posts; increased human resources training and employment, for example, training Community Health Assistants and employing to work in these health posts at the community level delivering health services including family planning; decentralization of the commodity management unit of the Ministry of Health which is the Medical Stores Limited by creation of zonal hubs within certain big central district to curtail the delays in the supply chain of medical supplies including family planning, among many other reforms. The health policy reforms have demonstrated the government's commitment to improving the health of Zambians by increasing access to and acceptance of family planning information and services.

Furthermore, Zambia has made strides to try and domesticate CEDAW. For instance, owing to low contraceptive prevalence and high unmet need family planning, the government through Ministry of Health in 2012 formulated a plan to scale-up services and ensure that they trickle down to every part of the country. This plan has since seen programmatic and policy changes such as community provision of family planning service, among others.

In addition, family planning services are not only offered by the government structures; the private sector in the form of Pharmacies, Private Clinics and Hospitals, Non-Governmental Organizations (NGOs) such as Planned Parenthood Association of Zambia, USAID supported organizations like John Snow Inc, Equip, Jhpeigo and many others complement the efforts of the government of Zambia in the provision of quality family planning services. Family planning services in these facilities are provided by trained health providers who include Doctors, Clinical Officers, Midwives, Nurses, Community Health Assistants and Community Based Distributors depending on the level of the health care facility being considered.

Today, family planning is still a priority for the Government of Zambia as highlighted in the current Seventh National Development Plan, 2017-2021 (Ministry of National Development, 2017). It is also considered an essential component of the country's National Health Strategic Plan 2017 – 2021 (MoH, 2017). Government is committed to scaling up family planning services so as to enable access by many people. To demonstrate this commitment, government in 2013 formulated the Family Planning Scale-up Plan 2012 – 2020 and other policy documents such as the Reproductive Health Policy and the National Health Strategic Plan 2017 – 2021 which have since seen programmatic changes in family planning service delivery. For example, Community Based Distributors have been trained beyond only providing pills and distributing condoms for family planning. They can now administer injections for family planning as well. These efforts have not been without reward; for instance, family planning prevalence had increased from 41% to 45% and the unmet need for family planning had reduced from 27% to 21% in 2007 and 2013 respectively; it is also indicated that there is universal knowledge of family planning by almost all women in Zambia (Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014).

2.5. Why Women utilize Family Planning Methods

The motivation for women's utilization of family planning methods is often varied. From the many literatures reviewed the common denominator which serves as motivation for women or couples to consider utilizing family planning is the desire to limit or delay conception. This motivation emanates from different factors that vary region from region and from one individual to another, often with culture, socio-economy, religious as well as education factors playing major influences.

Mwanangombe *et al* 2020, in a study conducted in secondary schools in Chongwe District, Lusaka province of Zambia on contraceptive use among adolescent girls, indicated that the motivation for use of contraception by these adolescent school going girls was in order to delay conception until the time when they completed their studies and become ready to bear the responsibility of child bearing. The report indicated that contraception use among these girls was there often propagated by the need to avoid school disruption and avoidance of pregnancy. Based on this evidence, it can be deduced that this section of young people utilize family planning to

enable them complete their studies without disruption. It is established that at this stage, these young people do engage in sexual activities and can result in unplanned pregnancy if no preventive measures are used.

Fertility preference is another factor which motivates women to consider utilizing family planning. Prata *et al,* 2017 in their study dubbed "Partner Support for Family Planning and Modern Contraceptive Use in Luanda, Angola," asserted that indeed fertility preference was a motivating factor that caused some women to utilize family planning. When a couple will have attained their desired number of children (satisfied parity), they would consider engaging in an intervention that can enable them to limit any more number of children and often family planning method utilization is the one of the best alternative they have to help them. In another study by the same author, Prata, 2007 reiterates that family planning provides couples with tools to reach their desired family size; can significantly impact maternal and child mortality by decreasing fertility and optimizing child spacing; and by decreasing fertility, slow population growth.

Empirical evidence shows that waiting between births by 2-3 years has better health outcomes for both the mother and the children. According to Karra and Miller 2017, short birth intervals and high fertility are likely to contribute to poor child growth and development of the child with resultant stunting and malnutrition; the opposite is also true. The investigator states that interventions that aim to lower fertility and increase birth intervals, including family planning and reproductive health services that reinforce healthy timing and spacing of pregnancy therefore have the potential to substantially reduce the number of stunted and underweight children. In another study by Davanzo *et al,* 2004 dubbed Assessing the Impact of Birth Spacing on Child Health Trajectories, they indicate that inter-birth intervals less than 24 months in duration are associated with significantly higher risks of early neonatal mortality, and that inter-birth intervals of less than 36 months are associated with significantly higher risks of late neonatal mortality, post-neonatal mortality, and child mortality. Non-live births (abortion) and premature live births are among other neonatal associated risks. According to their report, effects on women with short inter-pregnancy interval of between 18 and 24 months significant higher risk of pre-eclampsia, high blood pressure, and premature rupture of membranes compared to those with an interval of 27-50 months. They further indicate that preceding inter-pregnancy of less than six months

duration is associated with an elevated risk of maternal mortality compared to intervals of 27-50 months. With the foregoing, women and couples who are enlightened on these associated risks decide to utilize family planning in order to help them have optimal spacing and therefore reduce the risks to both the mother and the baby.

When it comes to choosing a specific method of family planning for use by women, many factors are seen to be responsible for motivating women to decide on the method, including a motivation factor such as, persuasion through such activities as information giving, media promotions of the family planning method, and attractive packaging of the method. This was reported by Qasim and Bashir 2013 in research titled, "Motivational Factor and Adoption of Family Planning Methods by Married Women," based on their study conducted in Gujarat, Pakistani.

2.6. Methods of Family Planning Available to Women

Modern contraceptive methods can be permanent, or reversible, (Cleland, *et al*, 2014). Permanent methods include surgical sterilization of both men and women; reversible methods on the other hand are divided into long-acting (Implants and IUCDs), and short-acting (pill, injectables, hormonal patches, barrier methods such as male and female condoms, sponges, diaphragms and spermicides, (Singh *et al*., 2009 in Cleland et al, 2014). It is noteworthy to indicate here that the methods of family planning that are commonly available and utilized in different regions and countries of the world vary markedly. Cleland *et al*, 2014 indicates that this variance is often as a result of past policy decisions to promote specific methods rather than cultural preferences or the user's personal preferences. In many countries, one or two methods account for the majority of use (Sullivan et al., 2006 in Cleland, *et al* 2014).

Globally, the most commonly used contraceptives are female sterilization, the pill and IUCDs (Sullivan et al., 2006). Female sterilization is more prevalent in Asian countries such as China (29%) and India (37%) and in Latin America (26%) than in sub-Saharan African countries (1.6%) (Sullivan, *et al.*, 2006; UNDESA, 2011). The highest use of the contraceptive pill is seen in Europe, the Americas and Oceania, and the IUCD has its highest prevalence in Asia. In 2019, 23.7 percent of the 219 million women who were using contraception relied on female sterilization; the male condom (189 million), Intra-uterine Contraceptive Device (159 million)

and the pill (151 million) family planning methods had more than 100 million users worldwide in 2019. Overall, 45.2 percent of contraceptive users relied on permanent or long-acting methods (female and male sterilization, IUCD, implant), 46.1 per cent on a short-acting method such as male condom, the pill, injectables and other modern methods and 8.7 per cent on traditional methods which include withdrawal, rhythm methods and other traditional methods. For example, in China, because of their one-child policy, sterilization had been used in a coercive way to limit the number of children and was even imposed on women with disabilities or people of low income and those from disadvantaged groupings, hence seemingly very common in that region of the world.

In regional terms, variations do exist with some regions preferring long-acting contraceptive methods to short-term methods. Black *et al* 2009, indicates that in Eastern and South-Eastern Asia, IUCD is the most common contraceptive method used (18.6 per cent of women rely on this method), followed closely by male condom (17.0 per cent). In Europe and Northern America, the pill and male condom are the most commonly used methods (17.8 and 14.6 per cent of women, respectively), while in Latin America and the Caribbean it is female sterilisation and the pill (16.0 and 14.9 per cent, respectively). In Oceania, the dominant method is the pill (16.9 per cent) and in Central and Southern Asia it is female sterilisation (21.8 per cent of women rely on this method). In Northern Africa and Western Asia, the two most common methods are the pill (10.5 per cent) and IUCD (9.5 per cent). Sub-Saharan Africa is the only region in which injectable contraceptives are the dominant method with a prevalence of 9.6 per cent among women of reproductive age, (Ibid).

In Zambia, injections are the most widely used modern methods of family planning (19 percent) followed by the pill (12 percent), implants (6 percent), and the male condom (4 percent), (Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014).

2.7. Usefulness of family planning

It is commonly said “when you empower a woman, you empower the whole nation.” We can never overstate the importance of family planning than it is already known. The benefits of

family planning are immense and they are not limited to the individual user but are beneficial to the family, community, the economy and the country as a whole. The World Health Organization reiterates that Family planning not only saves lives of women and children; it improves the quality of life for all. It has also been shown to be one of the best investments that can be made to help ensure the health and well-being of women, children, and communities, (WHO, 1995).

According to the WHO, the use of contraception by women reduces maternal mortality and improves women's health by preventing unwanted and high-risk pregnancies and reducing the need for unsafe abortions. Some contraceptives also improve women's health by reducing the likelihood of disease transmission and protecting against certain cancers and health problems, (Ibid). In addition, it has been shown that when used to space births at least two years apart, contraceptives can save children's lives. When births are spaced less than two years apart, particularly less than 18 months, infants are more likely to be premature and have a low birth weight, two factors that lead to increased mortality. This entails that family planning is useful in improving child health.

WHO 1995 states that there are family and community health benefits of using family planning. It is stated that "by providing a means for couples to have smaller healthier families, family planning helps reduce the economic and emotional burden of parenthood." Families with fewer and healthier children can devote more resources to providing their children with adequate food, clothing, housing, and educational opportunities, (Ibid).

Mutombo *et al*, 2014 in their study "Benefits of Family Planning: An assessment of Women's Knowledge in Rural Western Kenya" reiterates that the benefits of family planning transcends the individual and have far reaching positive consequences beyond the user and family. They indicate that some benefits are specific to the health of mothers and their children and include reduction in child and maternal mortality associated with unintended pregnancies and unsafe abortions, childbirth, and childhood illnesses respectively. Family planning also has been shown to enable birth spacing which ultimately reduces child mortality while enhancing the nutritional status of both mother and child. Others include socioeconomic benefits such as women being

able to advance their education and careers by delaying or limiting childbearing and this which in turn can bring better economic prospects to the household, (Ibid).

Furthermore, contraceptive use has also been shown to improve women's status and quality of life. It has been indicated that women with smaller healthier families are likely to have increased opportunities for participation in educational, economic, and social activities. In contrast, when girls leave school early for marriage and childbearing, it perpetuates the cycle of low status and high fertility including poverty.

Mamadou and colleagues 1999 in their study in Mali and Zimbabwe on "the Impact of Family Planning on the Lives of Women" indicated in their report that family planning was useful in many ways to the lives of women. In their report, family planning reduced fear of unplanned pregnancy and afforded women the freedom to enjoy sexual relationships more fully; relieved them from physical and financial stress of caring for a large family; it allowed them to pursue education and in turn gain a measure of economic security; it provided them a means to avoid a pregnancy that may be too early in life, too late, or too soon following a previous birth, among other benefits, (Ibid).

The International Planned Parenthood Federation (IPPF) 2015 indicates that family planning empowers women in the household as demonstrated by the strong correlations between increased use of family planning and women's growing decision-making power in the family. According to the IPPF, access to contraceptives increases women's ability to decide on the number and structure of family she wants to have without the undue influence of the man. Couples choose to have fewer children, daughters become as valued as sons, and parents begin to invest more in their daughters' education thereby empowering the female gender.

As a consequence of the parents investing more in a daughter's education, the bar for the girls' education is raised. As more families send their daughters to school, girls have better prospects for training and work throughout their lives. Over time, educated women are more likely to have educated children, particularly daughters. The IPPF suggests that meeting the family planning needs of women and couples today has an impact in the next generation. In many cases, girls are

forced to abandon their studies due to unplanned pregnancy, and in some countries, girls are immediately expelled if they are found to be pregnant, (IPPF 2015). Once a girl in school has access to information and voluntary family planning services, she will have the ability and in some cases the choice to stay in school and complete her studies without disruption.

In addition, family planning has been shown to increase women's participation in the economy and labour market. The IPPF 2015 indicates that Women who use contraceptives are more likely to be active in the workforce. This gives them more earning power and the ability to improve their own and their family's economic security. This is in part because family planning enables women to coordinate the timing of their children and size of their families with their need and desire to earn a wage. Ultimately, a woman who can plan her family is better able to plan her life.

The civil and human rights of girls and women can be promoted through family planning. More often than not, women suffer exclusion from participation in development and governance issues simply because the issues of childbirth puts them aside for substantial amounts of time planned or unplanned emanating from pregnancy. Through use of family planning, women and girls have control over these events and make sure that they remain relevant by not suffering exclusion at the hands of the opposite gender. Family planning therefore is a route to gender equality. Empowering women and girls through family planning services by ensuring their access to voluntary family planning is a crucial step towards more widespread gender equality in communities, societies and states. Gender inequality has many causes, but it is rooted in socio-cultural norms and myths about what is permissible behaviour for women and men, girls and boys, (IPPF, 2015).

Consequently family planning could contribute significantly to the empowerment of women, achieving universal education for all, achieving long-term environmental sustainability and generally contribute to attainment of many Sustainable Development Goals when both men and women have inclusive engagement in development agenda. The foregoing therefore underscores the importance of family planning when pursued for the common good of society.

2.8. Barriers to Family Planning Use

Family planning is not without challenges which are barriers to use by women and couples. Mamadou and colleagues 1999 indicated lack of acceptance by some religious faiths for use of family planning among their members, family planning being unacceptable norm in some communities and therefore women risked isolation, rejection and divorce in these instances. Some women had anxieties about physical side effects since some contraceptive methods have the ability to alter body; others were worried that these contraceptives may alter their ability to work, care for their families or go to school.

Other barriers to contraception include refusal by spouse and ultimate abandonment, structural barriers especially for the young girls who are not welcomed in health facilities often being rejected by elderly heath care workers who often take parental role than provider role and deny giving family planning services to the young girls and therefore end up missing on the opportunity to protect themselves from unwanted unplanned pregnancy. Spousal awareness of the wife's use of contraception has been shown to be a factor which can either work as a barrier or an enhancer to use of contraception by the woman. For example, in Kenya, discussion of family planning with spouse has been found to be critical in the use of contraception methods. A study conducted by Mutombo and colleagues entitled "benefits of family planning: An assessment of women's knowledge in rural Western Kenya, 2014" indicated that women who discussed with their spouses about, and had their partner's approval for family planning used modern contraception more readily than those who did not consult their spouses at all. This situation can lead to either discontinuation of the method use for fear of contention with the spouse or the woman risks several discontinuations of method along the line of care making the method ineffective. Similar studies in other sub-Saharan Africa countries are consistent with this finding. For example, a study conducted in urban Ndola district on the Copper-belt province of Zambia indicated that women with spousal approval of use of family planning used contraception more than those who did not have spousal approval at all, (Kurimoto, 2010). Spousal approval is therefore closely associated with contraceptive use and the opposite is true. In addition, some women and men opposed to the use of contraception were concerned that the availability of contraceptives could encourage negative sexual behaviors, such as early age of sexual initiation and adultery, (Ibid).

Intimate partner violence is another barrier to family planning use by women. Some women who in abusive relationships of varying nature are likely to shun use of contraception for fear of being physically of emotionally abused by the partner should he find out that she is using contraception. This sometimes emanates from the culture that tends to portray the woman as property owned by the man and she has no say over issues that concern her but simply to oblige to the demands of the man. This male domineering culture is very oppressive of the woman and makes her unable to negotiate on the size of the family she wants let alone negotiating for family planning method use, in turn, succumbing to the dictates of the man.

Other barriers identified include communities and societies where children are viewed as a symbol of wealth and status of the family contributes to the non-use or ineffective use of contraception. In this case especially in patriarchal traditions or societies, couples prefer having many children and often are opposed to using contraception as it is viewed as a deterrent to their goal of having many children which is wealth for them. Mamadou and colleagues 1999 in their study dubbed "Impact of Family Planning on Women's Lives: Findings from the Women's Studies Project in Mali and Zimbabwe" further indicated that the practice of polygamy practice, as seen from the Swazi people in Zimbabwe demonstrated women's social and economic status including their well-being were dependent on men. As a result, women were expected to have as many children as they could, especially sons, which would guarantee their stability in the man's life. In this case, being childless of having few children often carried stigma and because of this, contraception was not a probable option for many Swazi couples. In addition, having many children guaranteed security and social support for the elderly or senior parents since the Swazi government did not provide social support for their senior citizens. Therefore, having many children without regard to family planning use was a sure way of ensuring this was achieved. In addition, the high under-5 mortality rates in some poor communities serve as threats to couples who want to achieve a large family size (Gule, 1993; UN, 2010; United Nations Children's Fund [UNICEF], 2009 in Mamadou *et al*, 1999).

2.9 Summary

Family planning is very essential for the development of any nation. Family planning is not only beneficial to the individual user but the benefits transcends to the greater society as a whole. It

has also been indicated that family planning is not without challenges. Some of these challenges could be the barriers that hinder the utilization of family planning services and addressing them could otherwise improve the outlook. The literature reviewed has shown the extent of family planning around the globe, some of the challenges faced by women in utilizing the service as well as some benefits of family planning service.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Overview

This chapter focuses on research design, study setting, population, sample selection, data collection tools and analysis of data, validity and reliability of the tools for data collection, pilot study, ethical considerations, plans for data analysis, and plans for dissemination of the findings.

3.2. Research Design

Research design, also sometimes referred to as research methodology, is the blueprint or roadmap that guides a study, (Lapan *et al,* 2012). Thus research methodology and research design are sometimes used interchangeably (Ibid). In other words, research design is a guide chosen by the researcher to answer questions. An appropriate design enables the researcher to address critical issues to ensure that data produced are credible and interpretable within a chosen perspective. Common designs used in social science research that employ qualitative methods include case study, ethnography, among others.

This was a qualitative design and employed a Case Study approach. Lapan *et al,* 2012 explains that a Case study research is an investigative approach used to thoroughly describe complex phenomena, such as recent events, important issues, or programs, in ways to unearth new and deeper understanding of these phenomena. They state that specifically, this methodology focuses on the concept of case, the particular example or instance from a class or group of events, issues, or programs, and how people interact with components of this phenomenon.

3.3. Study Site

Study site is also referred to as research setting. Polit and Beck, 2008 describes a research setting as the physical location and conditions in which data collection takes place in a study. This study was conducted in Maternal and Child Health Units within clinics of Kalulushi district where family planning services are provided.

3.4. Study Population

Walter *et al.*, 2005 defines study population as the entire number of units under study. The study participants included married or in a union as well as unmarried women using family planning in Kalulushi district.

3.5. Study Sample

Neuman 2014 describes a sample as a small set of cases that a researcher selects from a large pool and generalizes it to the population. There are no rules for sample size determination in qualitative research except that it is usually determined based on informational needs. Hence, a guiding principle in sampling is saturation. Saturation is sampling to the point at which no new information is obtained and redundancy is achieved, (Neuman, 2014). Based on the foregoing, the size of the sample for this study was determined until saturation was reached. The number of participants included fifteen (15) users of family planning, for their experience using family planning methods. Four providers of family (Health Care Workers) also participated in the study and were recruited for their rich experience and knowledge in family planning service provision. In addition, the District Nursing Officer for Reproductive Health for Kalulushi also participated in the study owing to her role in managing family planning programs in the district level and family planning policy interpretation and implementation.

3.6. Sampling Technique

According to Burns and Grove 2009, sample selection is the process of selecting a group, event, behaviors or other elements that are representative of the population being studied. According to Cresswell 2009, the sampling technique often used for qualitative data collection or in qualitative research is purposeful sampling. In purposeful sampling, individuals are selected because they have experienced the central phenomenon and therefore can provide rich data pertaining to the phenomenon under study which is in contrast to quantitative researches which often involve random sampling so that each individual has an equal probability of being selected, and the sample can be generalized to the larger population. In this study, the sample was selected using purposeful sampling and involved women of reproductive age group 15-49 years who were current users of family planning. The Providers of family planning (Health care Workers)

including the Nursing Officer for Reproductive Health were also purposefully recruited in the study for their role in family planning provision and policy implementation respectively.

3.7. Data Collection Instruments

Data Collection Instruments, also referred to as Research instruments are tools that the researcher uses to collect data needed to address research questions (Polit and Beck, 2009). According to Hancock 2002, qualitative approaches to data collection usually involve direct interaction with individuals on a one on one basis or in a group setting. Hancock further asserts that qualitative research employs multiple forms of data gathering such as interviews, observations, and documents, rather than rely on a single data source. As such, data collection methods are time consuming and consequently data is collected from smaller numbers of people than would usually be the case in quantitative approaches. However, the benefits of using these approaches include richness of data and deeper insight into the phenomena under study, (Hancock, 2002). When interviews and focus group discussions among other tools for qualitative enquiry are used to generate data, the resultant is rich data that provides the investigator with deeper insights into the phenomenon, (Hancock *et al* 2007). Interviews can be structured, semi-structured or unstructured, (Ibid). Structured interviews involves the investigator asking each respondent the same questions in the same way and does not allow the interviewee freedom to give elaborate responses due to its restrictive questioning style. Semi-structured interviews involves use of open ended questions based on the topic areas the interviewer wants to cover and therefore provides opportunities for both interviewer and interviewee to discuss some topics in more detail. The interviewer can use cues or prompts to encourage the interviewee to consider the question further in cases of brief responses. Unstructured interviews have very little structure; further questioning depends on previous interviewee responses. Hancock et al 2007, further contend that qualitative interviews ought to be semi-structured or unstructured because if too structured, this may hinder the phenomena under investigation from being explored in details in terms of breadth or depth. Interviewees should feel as though they are participating in a conversation or discussion rather than in a formal question and answer situation.

Cohen et al 2000, describes a focus group as a contrived setting that brings together a specifically chosen sector of the population to discuss a particular given theme or topic, where the interaction with the group leads to data and outcomes. They reiterate that focus groups help in yielding insights that may not otherwise be available in a straightforward interview; they are economical on time, producing a large amount of data in a short period of time, but they tend to produce less data than interviews with the same number of individuals on a one-to-one basis. Focus group discussions might be useful for triangulating data that are obtained using the traditional forms of interviewing, questionnaire, observation and others. Disadvantages include some members of the group dominating the discussion while other members are overshadowed because they cannot express themselves freely in a group, (Cohen *et al,* 2000).

In this study, semi-structured interviews were employed to gather data from the respondents and were administered on a one on one basis. Furthermore, two focus groups each comprising five (5) people of carefully and purposefully selected participants from the population were engaged to discuss the research topic. This enabled triangulation of the data that were collected using interviews as well as served as adjunct to the same. Semi-structured interviews were also used to collect data from Providers of family planning as well as from the Nursing Officer for Reproductive Health.

3.7.1. Interview Guide for Users of Family Planning, Service Providers and Nursing Officer

Kasonde, 2018 defines an interview schedule as a list of questions or topics that need to be covered by the interview. Kasonde further explains that there are two type of interviews namely semi-structured and structured interview. Semi-structured interview instruments are used in social science research. The main advantage of semi-structured interviews is that they involve personal and direct contact between interviewers and interviewees, thereby enabling the researcher to get detailed understanding of the phenomenon under investigation. They are flexible because they contain both open and closed ended questions. In-depth information is gathered by open-ended questions. Disadvantages include that they can be time consuming due to the open ended questions, analysis of data may be problematic, and respondents may be reserved of the answers given in closed ended questions. A structured interview on the other hand has a rigorous set of questions which does not allow one to divert. It is rigid in that the researcher strictly follows what

has been laid down and in essence disadvantages the interview by limiting the responses since the participant or respondent is restricted to what is laid down in the schedule.

For this research, the researcher used semi-structured interviews to get the perceptions and experiences of the Users of family planning, the providers of family planning who are the Health Care Workers working in health facilities of the district where the study was conducted pertaining the usefulness of family planning to women. Interview schedule was also used to collect data from the Nursing Officer for Reproductive Health for Kalulushi District in order to better understand from policy point of view how family planning services were running in the district including developing insights into successes and challenges faced in implementing family planning services in the district including mitigation.

3.7.2. Focus Group Discussion Guide for Users of Family Planning

The researcher also employed focus group discussions to collect adjunct data from the users of family planning which also served as a means for triangulating the immense data that was obtained on the topic. Two (2) focus groups comprising 5 members each were convened from among the women users of family planning to discuss their experiences utilising family planning while the researcher acted as facilitator and the discussion was tape recorded with their consent, for ease of recall. The researcher also acted as a facilitator during the discussion.

3.8. Data Analysis

Neuman, 2014 describes data analysis as a systematic organization, integration, and examination of data, searching for patterns and relationships among the specific details. Neuman further explains that when analysing data, particular data are connected to concepts, generalizations are advanced while identifying broad trends or themes. Analysis therefore allows us to improve understanding, expand theory, and advance knowledge, (Neuman, 2014). Lacey and Luff, 2001 further indicate that there is no one right way to analyse qualitative data, instead, several approaches available. Nonetheless, much qualitative analysis falls under the general heading of ‘thematic content analysis’ (Lacey and Luff, 2001 p7). According to Lapan et al 2002, thematic content analysis is defined as a method of analysis for coding or scoring verbal materials to make inferences about characteristics and experiences of persons, social groups, or historical periods. It

requires the researcher to engage in an iterative process of critical thinking, questioning, and categorizing and primary analytic goal in thematic content analysis is to make inferences from verbal material, analyzed in the form of text in written transcripts. In the context of thematic content analysis, an inference is a conclusion that the researcher develops from systematic thinking and reasoning about the meaning of the narrative data that are the subject of analysis.

In this research, data collected was analysed through the process of thematic content analysis. First, the interview transcripts together with all the field notes were thoroughly read to help identify categories of data. The data collected then were categorised into major and minor themes depending on what was identified as major subjects being brought out as described by participants deciphering from the responses given in the interviews and focus group discussions. Following this, themes were then formed from the major categories and data from all the interview notes that are related to the themes were included in the appropriate themes. This process of content analysis involved continually revisiting the data and reviewing the categorisation of data until sure that the themes and categories used to summarise and describe the findings are a truthful and accurate reflection of the data.

3.9. Trustworthiness

Grove *et al* 2015, defines trustworthiness as a determination that a qualitative study is rigorous and of high quality and therefore can confidently be regarded as having no form of researcher or participant biases, (Grove *et al,* 2015). Trustworthiness is used in qualitative inquiry and is the equivalent of validity and reliability in quantitative inquiry, (Polit and Beck, 2010). Guba and Lincoln 1985 indicate that a qualitative research is trustworthy when it fulfils 4 criteria namely Credibility, Transferability, Dependability and Confirmability, (Polit and Beck, 2010). Dependability is documentation of steps taken and decisions made during analysis, (audit trail) and enables other researchers to follow through the process when they need to confirm conclusions of the researcher. Confirmability is the extent to which other researchers can review the audit trail and agree that the authors' conclusions are logical. Transferability refers to the extent to which qualitative findings can be transferred to (or have applicability in) other settings or groups, (Polit and Beck, 2010). Lapan *et al* 2012 further indicate that other tactics to improve the validity and trustworthiness of case study findings may include triangulation or the collection

of data using a variety of methods, (for example, interviewing, observing, and reviewing documents) and from multiple sources (for example, tutors, tutees, and administrators) and using a piloted and field-tested (or standardized) protocols for interviews and observations. Member checking (for example, reviewing draft findings by key informants to see if they affirm the validity of the report and recognize their contribution); and, if necessary, undertaking an external review and interpretation are also important measures to improve the validity and trustworthiness of case study findings.

In this inquiry, the investigator maintained an audit trial used when analyzing data, as well as provided sufficient descriptive data in the research report so that consumers can evaluate the applicability of the data to other contexts. Triangulation of data was also done through the use of different data gathering tools which included semi-structured interviews, focus discussions and observations as well as gathering the data from multiple sources who included women using family planning services, the Nursing Officer for Reproductive Health at the District Medical Office and the providers of family planning services in the study sites who were the nurses and midwives. In addition, the data gathering tools were standardized.

3.10. Dissemination of Findings

Findings of the study were disseminated through online publication; copies of the research report were made available to the University of Zambia libraries; the abstract was also sent to Kalulushi District Medical Office, and clinics from which the study was conducted.

3.11. Ethical and Cultural Considerations

This is concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants. To begin with, clearance was sought from the research the ethics committee of the University of Zambia before proceeding in the field to collect data. While in the field, written permission was sought from Kalulushi District Health Management in order to be allowed to conduct the study in their clinic settings; In addition, permission was sought from the In-Charges of the Health Centers in order to have access to the setting where participants were found. Furthermore, written consent was obtained from each participant following adequate explanation of the study including their right to withdraw from participating

at any time if they wish to. Participants were engaged in the study only when they expressly gave their consent and were not coerced in any way through inducements or threats. The participants have not been identified by name throughout the study. However, titles have been used in the case of managers at the District Medical Office who include the District Nursing Officer for Reproductive Health, the In-charges of Health facilities and the Nurses and Midwives who are the providers of Family Planning services to women in the study settings. All was done uphold rights of the research participants and ensure their privacy, anonymity and confidentiality.

3.12 Summary

In conclusion, this inquiry was a case study design within qualitative paradigm and was conducted in Kalulushi District of Zambia Participants included married, in-union and unmarried women purposively selected from among women attending family planning clinics at various Health Centers in Kalulushi District. Data were collected using semi-structured Interviews and Focus Group Discussions to facilitate for triangulation of the data collected. Data were analysed through thematic content analysis.

CHAPTER FOUR
PRESENTATION OF FINDINGS

4.1 Overview

In this chapter, the researcher presents the findings of the field work which was undertaken as per methodology described in the previous chapter. These results were obtained from data collected through detailed interviews and focus group discussions with the participants. The District Nursing Officer for Kalulushi was interviewed using a detailed Semi-structured interview together with the providers of family planning services while Focus Group Discussions and detailed Semi-structured interviews were used to collect data from users of family planning. The results are presented following the structure of the research questions of the study which were as follows:

1. Why do women seek family planning services?
2. What family planning methods are available to them?
3. How useful are family planning methods to women?

In order to demonstrate the owners of the voices quoted in this part of the research, the following table provides coded descriptions of the participants of the research.

Table 1: Coded description of research participants

Description of activity participated in	Serial number	Participant code
Detailed interviews with Users of family planning	1	D1
	2	D2
	3	D3
	4	D4
	5	D5
Detailed interviews with providers of family planning	1	P1
	2	P2
	3	P3
	4	P4
District Nursing Officer for Reproductive Health	1	DNO

Focus Group Discussion number one	1 2 3 4 5	F1 F2 F3 F4 F5
Focus Group Discussion number two	1 2 3 4 5	F6 F7 F8 F9 F10

Source: Research Field Work, 2020

4.2. Research Findings

This was a qualitative enquiry and employed a Case Study design. Of importance to note was the fact that both the interview guides and focus group discussion guides had similar questions which were tailored in line with the objectives of the research. Data was analyzed using thematic content analysis and involved identifying themes in relation to research objectives, as well as emerging themes from the views and experiences of the participants. Bracketting" or ''Epoche" was used as much as possible by taking the information as it came from the participants through verbatim reporting so as to give clear and precise descriptions of the responses from participants although in other cases, participant descriptions were paraphrased.

4.3. Demographics of Users of Family Planning

One of the things that the researcher determined to assess was the demographics of the users of family planning. It is essential to determine the demographics of people who are utilizing family planning because it can help with programming of family planning services and it also helps to understand the clientele of the service so that they can be reached with the right kind of information and ideal services.

The participants were of myriad demographics who were utilizing family planning methods in Kalulushi. The youngest among them was 18 years while the oldest was 40 years. Many of them

were in their mid twenties with a few in the early twenties and fewer in their late thirties. Regarding their religious faith, all the participants (users of family planning and the providers) were Christians and none faith. Among all the participants interviewed, there was none whose religious faith was a deterrent or hindrance to her using family planning. In fact, one woman said;

> "*It is sin before God for me to have many children whom I cannot mange to take care of, therefore it is my responsibility to ensure that I have only a sizable number of children whom I can manage to provide for and keep,"* (participant F1 details).

4.3.1. Sources of Information on Family Planning

All the participants indicated that they were informed about family planning during a visit to a health facility when they went seeking health services, many of them at Maternal and Child Health (MCH) department.

> *"I heard about family planning during Antenatal care and once I delivered my baby at the postnatal clinic at 6 weeks, the nurse talked to us about family planning and that is when I started using family planning,"* (said participant D2).

Health care workers also do provide information to clients on family planning at client visits, Provider P2 said:

> *"We reach out to our clients at various clinics in MCH such as Antenatal, Postnatal and under five with family planning messages. We talk to them about the benefits, methods available and the side effects, and provide those willing with the method of their choice."*

4.3.2. Partner Involvement in Family Planning

All the participants indicated that indeed partner involvement in family planning was essential and to a larger extent determined whether or not as a woman you would have successful use of family planning method or not. While they all agreed that that it was an important factor, not all of them had the support of their spouses but went ahead to utilize the service nonetheless. Out of the 5 detailed interviews, three had the support of their husbands while 2 said that their spouses did not know whether they were using family planning method or not. Participant D4 had this to say regarding partner involvement:

"My husband is Namwanga by tribe and they view children as wealth and was not supportive of me using family planning initially until our second child suffered malnutrition. He only became supportive after being talked to by the nurse at the clinic.

Participant D2 had this to say on the same:

"Partner involvement is very important because it is not only the woman who produces the children alone. In my case, my husband is very supportive of me using family planning; he reminds me when my appointment is due and even gives me K10 for transport to come and get an injection."

Although many users of family planning indicated that their spouses or partners were very supportive, a few said their men are not supportive at all of them using family planning. It is up to the woman to take it upon herself and try to prevent herself from getting pregnant and the man will not even know that she is using contraception. Participant F6 in a focus group discussion had this to say:

"Some men are very ill mannered, they don't care at all and they will make you bear many children for them until your beauty fades then they will dump you for a younger looking beautiful woman; woman is the key in family planning."

On the same point, another participant F10 had this to say:

"Some men are not supportive of their women utilizing family planning; therefore it is up to the woman to have a plan on how to control her fertility."

She went on to say a vernacular adage in Bemba as follows:

"Uwupanfiwe eulwa ne ciibi, namayo eupaapa abaana, kabili e-key" which means that it is an individual who is troubled who struggles to open the door; it is the woman who goes into labour and it is her who feels the pain, and therefore the woman has the key to conception."

4.4. Why do women utilize Family Planning services?

Research question one sought to explore the reasons why women utilized family planning services. The significance of the question lie in the fact that motivation for seeking family

planning services determines whether or not the service would be effective and the women would continue to use the service or they would discontinue to use it. Motivation is this case is the drive or impetus that makes women to leave their comfort zone at home and go all the way to the health facilities to seek family planning services. Detailed interviews were held with the Nursing Officer, providers of family planning services and users of family planning methods; focus group discussions were also held with the users of family planning method, all in order to help answer this question.

Figure 1: Why women utilize family planning methods

Source: Research Field Work, 2020

4.4.1. To Control one's Fertility

Almost all the users of family planning, providers of family planning services, including the Nursing Officer indicated that women utilize family planning services because they want to control their fertility. The DNO noted the following:

> *"You need to realise that family planning is a choice, and that people chose family planning for various reasons. Some would just want to limit themselves, others want to space or halt… family planning has been useful for families that have intended to halt procreation until they are ready."*

Participant in F2 from a focus group discussion at health facility K also reiterated how women can be in control of their fertility through utilization of family planning methods. She noted as follows:

> *"By using family planning, I have the key to decide the number and spacing of my children."*

Clearly from the statements echoed by the Nursing Officer and the users of family planning, it can be noted that with family planning, women are in enabled to be in control of their fertility and can decide to delay, limit and to space their children according to their desire.

4.4.2. Health of the household members

Some women opt to use family planning methods because they believe it would enhance good health to the user. Commenting on this point, participant F4 in a focus group discussion had this to say:

> *"The more pregnancies you carry, the more your health deteriorates and you even age faster than your mates. You do not even have time to groom yourself to maintain your looks since most of your time you are preoccupied by caring for the children."*

The point advanced above was echoed by many users of family planning and looks like a very important reason for women that prompt them to consider utilizing family planning. Health of the woman is essential to the wellbeing of the entire household. The woman is often at the centre of childcare and home management in most cases and therefore if her health begins to fail her due to her conceiving multiple times without control, the entire household is disturbed including the children and the spouse themselves. The health benefits that occur as a result of the woman's choice of using family planning are immense and transcend beyond the individual user alone but flows to her entire household members particularly her children, dependants and the spouse or partner. Participant D5 from a detailed interview had commented as follows:

> *"The space between my first and second child was small, then I noticed that my older child's health was deteriorating due to malnutrition… then I started utilizing family planning and had good spacing of three years apart between births of my proceeding children and noted that their health was very much okay."*

On the same point, another participant D2 explained;

> *"Our health also improves as women when we utilize family planning because the stress of carrying pregnancies is minimized and only conceiving when we are ready, and waits to recuperate, only to conceive again when we would have rested enough."*

As presented above, many of the participants were of the view that the health of the mother and that of her children and the entire household members is a factor that causes women to consider utilizing family planning methods to control of their fertility, and decide on the number and space of procreation.

4.4.3. Prevention of pregnancy related complications and disease

One out of the five participants in one focus group discussion indicated that pregnancy poses many challenges to women in terms of complications and disease. She cited complications like raised blood pressure or hypertension during pregnancy, difficulty labour, and other complications which end up in the woman being operated upon theatre. She cited avoidance of these pregnancy related disease and complications as one of the reasons why women sought to utilize family planning methods. Participant F10 said:

> *"Nowadays, there are many diseases and complications resulting from pregnancy and child birth, therefore, to avoid them, it is better you use family planning so that you do not conceive in the first place."*

On a similar note, family planning provider D3 at health facility M noted the following:

> *"In my own opinion, most of the women who come to seek for family planning …while a few of them use family planning due to medical conditions."*

From both user and provider perspectives presented above, it can be noted that medical conditions and disease are other reasons why women utilize family planning methods. For some, it could be at the prescription of a Medical Officer for the reason that it may be risky to the woman's health and life for her to conceive and therefore recommend family planning to enable avoid getting pregnant. On the other hand, the users of family planning may have the fear themselves of conceiving due to fear of complications such as hypertension in pregnancy and

other conditions that occur in pregnancy and end up in operations as remediation. This therefore causes a woman to consider utilizing family planning method for that reason.

4.4.4. Economic reasons

A harsh economy appears to be another reason why women utilize family planning methods. This was echoed by both users of family planning and the providers of the methods. From both the detailed interviews and focus group discussions on this point, more than half of the participants interviewed said that the economy was harsh and was not sparing anyone; therefore it was necessary for individuals to limit the number of children to a number they can afford to take care of. According to them, the economy as now is very harsh and calls for individuals to be in control of their fertility, only considering conception when really ready and the economic conditions become much favourable.

> *"The economy is bad; family planning is therefore helping us to avert the shocks caused by the harsh economy,"* (commented participant F10).

Participant F9 also reiterated;

> *"The economy is so hard that it has become difficult to take care of one's family in terms of feeding, clothing, and even to have decent accommodation for your family and maintain the kind of lifestyle of your desire."*

Still another participant F3 commented:

> *"The economy is very harsh nowadays, even budgeting has become difficult due to the shocks being experienced in our economy and if you have too many children, it would even be more difficult to send them to school in order for them to have an education."*

It seems a harsh economy is a big factor that is causing women to consider family planning as highlighted above. This is because the bigger the family that one has, the bigger the household expenditure a family requires in order to make ends meet or satisfy household requirements. A bigger household dictates a bigger living space and therefore demands bigger spending on accommodation; a bigger family also demands a bigger expenditure on household essentials and impacts heavily on household income. And because the prices for goods and services are high at

the moment, many women are forced by the prevailing economic weather to consider using family planning to enable them be in control of their fertility and only conceive when really ready for the challenge. Some women indicated that through family planning, they are able to engage in economic ventures that supplement on household income. To amplify this point, participant F1 had this to say:

> *"Because I am using family planning, I have been able to determine when I to have children and their spacing; in turn, I have been able to attend to farm work which is a major source of my household's livelihood."*

Participant F6 noted:

> *I am a single mother of two children whose father does not support the children; I do a small business through selling Cabbages and Tomatoes at the market through which I am able to take care of my children. I have a boy friend…and have been able to avoid falling pregnant for him through utilization of family planning."*

To support what the participants above said, Provider P3 from health facility M explained the following:

> *"Many women are not just staying back at home these days. Some are engaging in economic ventures such as running businesses while others are going back to school in order for them to get jobs that will enable them become economically viable and be helpful to their families by supplementing on household income. Family planning is therefore helping them to achieve their ambitions in this regard."*

It can be noted from the above reports that many women are using family planning methods due to the harshness of the economy and others so that they can become economically viable or relevant and contribute to their household's income. In some cases, women are able to go back to school and pursue their academic ambitions without disruptions which may be posed by unintentional pregnancy thereby becoming relevant and dependable once they complete their studies. In some cases, the woman is the sole provider of the household or the breadwinner; family planning therefore enabling her to have control on the number of children that she can

have and afford to meet their needs as needed. Family planning in this case therefore has become a cushion or a safety net for their households against economic shocks and turmoil.

4.4.5. Prevention of Unintended Pregnancies

It was reported from the interviews with users of family planning and the providers and Nursing Officer that family planning afforded women with the choice or power to decide when they can conceive. This seems very important to the lives of women because having an unintended pregnancy could be one of the things that cause women to procure an abortion. To reiterate this point, provider P3 said the following:

> *"For the unmarried and the school-going, family planning is helping them prevent unwanted pregnancies, and also it is helping avoid abortions; because you know when they fall pregnant and they don't want that pregnancy, they tend to go for criminal abortions, so it's helping to prevent criminal abortion since they are not getting pregnant."*

4.5 Summary on why Women Utilize Family Planning

From the interaction and discussions with participants through detailed semi-structured interviews and focus group discussions, the main reason why women utilize family planning is so that they can be in control of their fertility for many reasons. The reasons advanced include but not limited to the following: good health of the household which includes that of the user herself and her children, avoidance of pregnancy related complications and disease, improved household economy and maintenance of one's beauty or image. The users of family planning are of varying demographics and differ in their education level; both married and the unmarried were found to be using family planning methods.

4.6. Family Planning Methods Available to Women

Research question two was aimed at exploring the methods of family planning available to women and to ascertain this, the researcher determined to assess how the users of family planning settled for the method of family planning which they are currently using amongst available options by identifying any influences from the healthcare workers, friends or significant others in their choice. Further, the researcher explored how the healthcare workers enabled the users of

family planning to choose the method of family planning that best suits their needs as necessary. The information was obtained from interviews to both the users themselves as well as the providers of family planning for triangulation and objectivity.

4.6.1. How Women choose their preferred Method of Family Planning

All the users of family planning reported that the healthcare workers played a big role in enabling them to choose the method of family planning which they were using. In many cases, the women do not have sufficient knowledge on the methods of family planning that are available as they present at the health facilities. Very often than not, the information they have on family planning is very scanty as they get it from their friends and relatives in the community who also in most cases do not know pertinent details other than just the name perhaps. When asked how they chose the method of family planning which they are currently using, this is what participant D2 had to say regarding her choice:

> *"The nurses explain to us the methods of family planning which are available, their benefits and side effects in detail, and then we make our own choice."*

In contrast to the above explanation given, Participant D5 had a different experience. She notes:

> *"Initially I was using Microgynon as my preferred method of family planning but the method started giving problem of prolonged menstrual bleeding. When I visited the hospital with this complaint, the Doctor told me to switch to another method, the Intra-Uterine Contraceptive Device or Loop… which worked better." And I have had it for almost 12 years now."*

The contrasting views demonstrate that is inconsistence in the way health care workers provide the methods of family planning. In as much as some providers educate their clients on the method before providing, some just dictate the method without enough explanation to the clients

For some users of family planning, there is not so much of a choice because of factors at play such as availability of commodities. Some users would begin to use a particular method of family planning simply because it is the only method available. On the point of ensuring choice of family planning methods by clients, provider P5 notes:

"Sometimes the methods of family planning run out of stock and then the clients end up switching to the only available alternatives. On our part as providers, we try by all means to make sure the methods are available by making orders to pharmacy and borrowing from nearby facilities but sometimes the problem is beyond or level."

When clients cannot have the family planning commodities they desire, this compromises quality. However, it should be noted that the health centres are not the creators of stock-out; challenges along the continuum of the supply chain are often the cause. The DNO had this say on the issue of choice of contraception by women:

"When you look at the issue of quality, I think you to look at where the services are being provided, do we have privacy in those rooms, do we have confidentiality being practiced, are patient's rights being observed… are patients able to choose the commodities or are they being coerced, you know that kind of story really, is the right kind of information being given so that someone chooses or the provider would just say today we only have Depoprovera, and everyone ends up receiving Depoprovera injection; if this is the situation, then it is not providing quality family planning services; you have got to have a choice to choose what you want, because if I don't have the options, then it is not quality services being provided; it is just forcing me, and I think we need to provide quality in the services that we are providing. And of course we need to ensure patient or customer satisfaction."

Based on the responses given by Users of family planning themselves, the Providers of care and the Nursing Officer, it can be noted that the users of family planning chose the methods of family planning that they used although their choice is sometimes affected by the limitation in availability of commodities. The providers of family planning do their part by giving appropriate family planning counselling and help clients to choose the methods which best suit their needs as needed. Needless to say, choice is choice when you have options or alternatives available.

4.6.2. Family Planning Methods available to Women

The researcher went a step further to explore the methods of family planning available to women in Kalulushi district. The information gathered from the users of family planning, their providers

of care including the District Nursing Officer helped the researcher to come up with the conclusions presented in this section.

Out of the fifteen participants users of family planning interviewed in detailed interviews and focus group discussions, thirteen were using Depo-Provera, a short term method that works for 3 months; 2 were using combined oral contraceptive pill and only 1 was on Intra-Uterine Contraceptive Device (IUCD). There was none utilizing implants Jadelle and Implanon, no one on Condoms and none wanted sterilization. Therefore, the most common method of family planning identified from the data collected was Depo-Provera injection. When asked about other family planning methods available at their respective health facilities, they indicated that there were other methods available. These include Noristerate injection which works for 2 months, the Minipill which is a daily dosage pill, Combined Oral Contraceptives (Microgynon, Zinia F and SafePlan), Implants (Jadelle and Implanon), the Intra-Uterine Contraceptive Device which works for 12 years, and male and female condoms. Male and female sterilization are not common methods of family planning in Kalulushi district based on the reports given by the participants of this enquiry. Although these methods are available, constant supply is never guaranteed as most of them run out of stock many times.

The provider perspective of method mix or availability is consistent with the user perspective of family planning method mix presented above as noted from the comment from provider P1 from health facility K below:

> *"We provide oral contraceptives that is the Mini pill and the Combined Oral Contraceptives, we do provide the injectable methods which are Noristerate, Depo-provera and the Depo sayana press; we also provide implants which include Jadelle and Implanon; we also provide Intra-Uterine Contraceptive Device (IUCD) although we have a challenge with the later because we lack instruments for IUCD insertion. We do not provide female or male sterilization and clients needing these services are referred to Kalulushi General Hospital.*

This was further reiterated by the District Nursing Officer who explained the following:

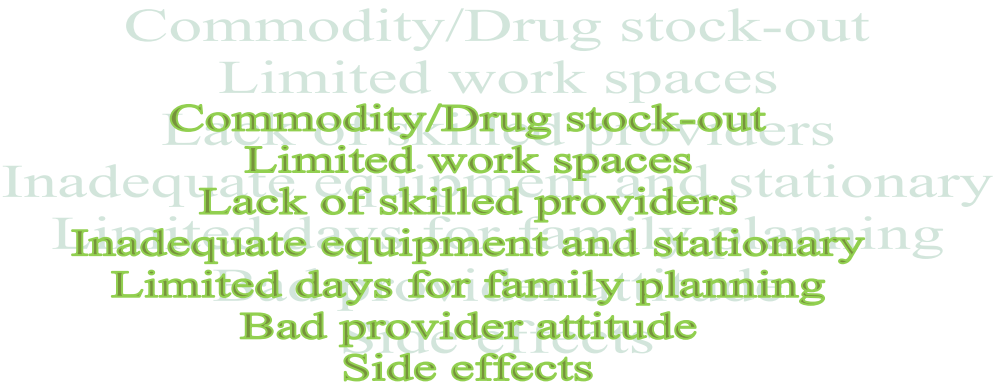
"In the 25 health facilities of our district,…, We have family planning services delivered in all of them and I think most of them have a wide range of commodities that are which include short-term as well as long-term methods. We are privileged to have partners who come to provide permanent methods periodically to clients needing them."

The data presented above indicates that most short-term and long-term family planning methods are available in Kalulushi district; however it is important to note that stock-outs are common for some methods especially the long term methods.

4.7 Challenges Women face in Utilizing Family Planning

Research question number three was aimed at exploring the usefulness of family planning methods to women in Kalulushi district. To ensure this question was answered in its entirety, the researcher had to identify the feelings of users of the family planning methods, the challenges they face in utilizing their preferred method of family planning and finally how useful the methods were to individual user.

Figure 2: Challenges faced by women in utilizing family planning methods



(Source: Research Field Work 2020)

The question on challenges unearthed many challenges which women in Kalulushi district face in utilizing family planning services. The commonest challenge highlighted in most of the interviews and discussions is stock-out of the commodity or drug. This fact was brought out not only by the users of family planning but also by the providers and the District Nursing Officer and this causes the family planning services not to be of quality since clients have disruptions and sometimes are left with no other choice than to switch to the only alternative which is available.

"Sometimes the method of family planning that you use is out of stock but the nurses always informs us about alternatives which you can use temporarily and revert back when your preferred method is available," (participant F10 explains).

The District Health Office was alive to the fact that some methods ran out of stock but however makes strides to ensure that atleast a method is available to women who need it:

"I think family planning commodities like any other commodity in the health care work have been affected by Covid-19 and so in terms of the supply chain, we are on the lower side in terms of commodities but we have not run out, we have been able to provide atleast a method to the people, be it a short-acting or long-acting at every point, but of course there is always room for improvement; in turn commodity supply affects clients choice," (remarked the DNO).

The District Nursing Officer especially recognises that Covid-19 has posed challenges in terms of supply chain of commodities for health services, and family planning has not been spared.

The other challenge that women face in utilizing family planning services is limited work spaces. Certain methods of family planning are too intimate and therefore require privacy. For example, the IUCD is inserted in the uterus through the vagina, therefore, to provide this method requires a secure room that is not crammed with many people. This is not only true for IUCD but even family planning counselling itself on a one on basis between client and provider requires privacy because there is a lot of other sensitive information that is shared between the provider and the client which should not be for the consumption of other clients. In addition, equipment required for the provision of IUCD is inadequate in many facilities and so hampers on service provision negatively.

"We have a challenge with providing IUCD due to inadequate space at our facility."(Provider P2 from facility K notes).

The District Nursing Officer noted the following on the issue of work spaces and equipment:

The other challenge we are facing in family planning service provision is that workplace spaces are not adequate. You find here is a one roomed facility and people have to have an IUCD inserted in the same space, hence privacy is compromised, (lamented DNO).

On the issue of equipment, she noted:

> *"As a district we have enjoyed a lot of partnerships with Non-Governmental Organizations, I think we are working with JSI DISCOVER-Health, JSI SAFE, we are working with PPAZ… and these partners have been helpful with equipments."*

The highlight in her statement above indicates the complementary role that partners of Ministry of Health play in supplementing in health services particularly family planning.

Lack of skilled personnel to provide family planning is another challenge faced in family planning program in Kalulushi district. All the providers interviewed indicated that their basic training as nurses and midwives alone was not enough for them to provide a full range of family planning services. Beside their basic nursing or midwifery training, they need apprenticeships, seminars, workshops, mentorships to enable them with skills and competences to provide family planning services. Four out of Five providers of family planning interviewed indicated that they were trained in Long Acting Reversible Contraception (LARC) provision although they still needed refresher courses. The other challenge presented was that the number of trained providers in LARC was small and this leaves a gap in service provision looking at the provider-client ratio:

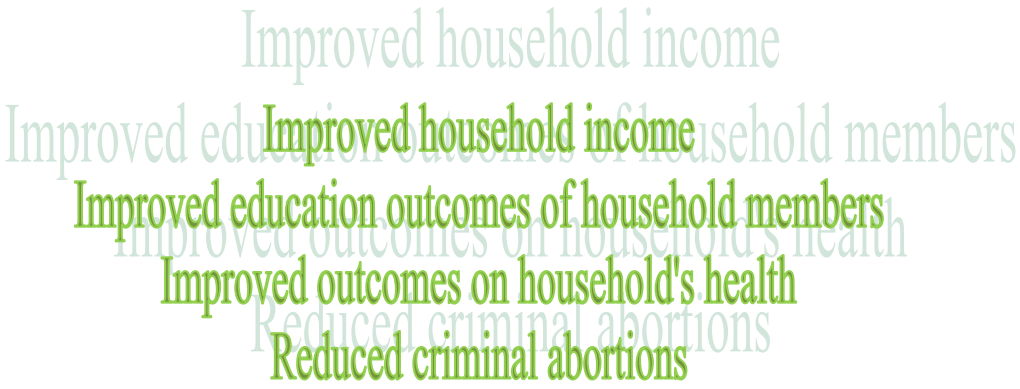
> *Staffing is another challenge in family planning. Because of the inadequate staffing in MCH departments, so we are not providing the required times for counselling. The family planning provided is often a hurried one and not adequate because there are a lot of other things that you need to do and you find that your family planning is not on the top of the agenda for a lot of people in MCH, they don't give the right information,…* (DNO complained).

The number of days on which family planning services were provided was yet another challenge. Some health centres do not operate on a supermarket basis; they had fixed days when they provide family planning services. Because of this, some clients got turned away when they come to seek family planning services on days that were not designated for that specific service.

4.8. Usefulness of Family Planning Methods

The researcher delved deep to explore the usefulness of family planning methods utilized by women in Kalulushi district. Users of family planning, providers of family planning as well as the District Nursing Officer for Reproductive Health were all interviewed for this variable and their responses reviewed, coded, categorised and reported as presented hereunder.

Figure 3: Usefulness of family planning methods



Source: Research Field Work, 2020

4.8.1. Improved outcomes of Household's Health

All the five participants in detailed interviews indicated that family planning methods were useful in improving health outcomes for household members. It was reported that the number of childhood malnutrition was curtailed through use of family planning. Because family planning has the ability to ensure that births are spaced well apart, this ensures that the woman has considerable time with her newborn and gives the child all the needed care until when the child is old enough when a new pregnancy or birth of another child does not pose a serious challenge to the development of the older child. Besides being useful for the good health of the children, it was also indicated that family planning is also useful for reducing pregnancy related complications and disease. In addition, family planning affords a woman the opportunity to recuperate by returning to near pre-pregnant state by averting pregnancy following a birth.

> *"Family planning is good for us women because it buys us the time for our bodies to return to normal before conceiving again,"* (noted participant F7).

The ill health of the mother impacts the entire household seeing that the woman in most cases is the primary care giver and manager of the home, therefore, if her health is not okay, this hampers negatively on the health of the entire household.

4.8.2. Improved Household Income

When the participants were asked to explain the usefulness of family planning, they explained concepts which could be classified under household economy as being benefits or usefulness of family planning to them. For example, through use of family planning, three of the five participants of detailed interviews indicated that family planning enabled them to have some savings because they were able to have only the number of children that they were able to take care of. An addition to the number of children is a cost to the household because it translated into subsequent increase in household spending or expenses on various services and goods consequently impacting on the household budget in terms of buying baby implements, food, accommodation, hospital bills and many other bills. Family planning enables women control their fertility which means that they have the power to decide when they can actually have their children, the spacing between the births. They equally have the power to control their expenditure or income at household level.

> *"Family planning has been very useful to me in many ways, for example, because I have been using family planning and we have been able to have only a small number of children that we wanted to have, this has enabled us to some savings which we have invested in a business*," (participant D5 shares her experience).

Providers of family planning also shared similar thoughts regarding how family planning is useful to women:

> *"Many women are not just sitting back at home nowadays and wait for their spouses to provide for their household needs. Some women are engaging in economically productive ventures that enable them to support their families such as work, running businesses and other activities. This can only be if the woman decides to use family planning in order for her to be in control of her fertility and limit the number of children to the number that she can manage without difficulty,"* (P3 indicated).

And the DNO shared:

> *"Family planning enables individuals to halt procreation until such a time when they are ready to do so."*

The readiness to procreate in this regard indicates that the individual is prepared in all aspects including financially, economically, emotionally and even physically. In terms of physical readiness, adolescent girls and young women whose body make-up is not mature yet for conception such as those around the teen years but are sexually active can and do use family planning methods to protect themselves from getting pregnant at that stage. Getting pregnant at a young age has many risks, therefore, many adolescent girls and young women whose physical stature is not ready for conception use family planning to delay procreation and save themselves from a lot of trouble including disruption in schooling.

4.8.3. Improved Education Outcomes

From the responses obtained from interviews and discussions with the users and providers of family planning, it was noted that family planning facilitated and improves educational outcomes for the user and her entire household. The benefit in terms of academic attainments did not only apply to the individual user but transcended to her entire household. For example, at the time when the woman is able to control her fertility using family planning, she is herself able to engage in academic activities and ensure that she completes her studies within the specified period of time without any disruptions which may be posed by pregnancy:

> *"I am pursuing a course in Clinical Medicine and I am using family planning so that I can complete my studies without any disruptions due to unintended pregnancy,"* (Participant D1 shared).

Providers of family planning shared the view highlighted above as participant P4 explained below:

> *"For the school going, family planning is useful because it prevents unwanted pregnancies and subsequently reduces on the number of criminal abortions."*

As indicated above, family planning is not only useful for preventing unwanted pregnancies; it is also useful in preventing induced or criminal abortions. Criminal abortions may result from attempts by people who are not ready to procreate at the time that they fall pregnant and they feel the best alternative is to get rid of the pregnancy.

Regarding the educational benefits of family planning to the household, participant F12 shared:

"I work as a hair dresser and through use of family planning, I am able to continue working without disruption of pregnancy and I can afford to send my children to school through the income I earn without much difficulty."

As can be noted from the above statement, the educational benefits of using family planning transcends beyond the individual user to her entire household.

4.9 Summary

Family planning is very useful to the users as well as their entire households. From the information presented above, it can be noted that the use of family planning by women has a ripple effect on many sectors of the society and economy. For example, through use of family planning methods, women are able to work and earn an income and save surplus which they are able to invest in businesses and to support their families. They are also able to take themselves and their children to school thereby improving their educational attainments or outcomes. In addition, improved health outcomes for the individual user and her family have been reported through avoidance of pregnancy related complications and disease; waiting for a considerable period of time before another conception which restores the health of the woman and improves her health prospects or outcomes whereas the health of her children who are well spaced is enhanced.

CHAPTER FIVE
DISCUSSION OF FINDINGS

5.1 Overview

In the previous chapter was the researcher's presentation of findings. In this chapter, the findings of the study have been discussed. The discussion was based on the findings presented in chapter four and discussed under themes derived from the study objectives. Additionally, the discussion was informed by the theoretical framework and other related literature in chapter two. The researcher made an effort to reflect, validate and broaden current knowledge in family planning in order to help the researcher interpret and outline what the findings meant to the study.

5.2. Why women Utilize Family Planning

Women are at the centre of the reproductive role. They carry the pregnancy, they labour and give birth, and they nurse the newborn and care and nurture the young until it is able to perform some functions of living independently. Generally, it appears the responsibility of care and nurture for the young rests almost entirely on the shoulders of women. Family planning is therefore seen to be more synonymous with the women because they are the ones who shoulder most of the reproductive responsibility as indicated above. It is no wonder why women seem to own family planning services to the extent that it is perceived as a woman's program and society perceives this to be so. This point has been advanced by Ashraf, Field and Lee (2012 who in their words posited that "fertility in Zambia is characterized by moral hazard due to the fact that family planning can only be perfectly observed by the woman." It is not surprising that even the Ministry of Health in Zambia has a dedicated unit in the name of "Mother and Child Health Unit" (MCH) which as the term suggests, is specifically dedicated to mothers and children alone excluding the man and it is in this unit where family planning services are mostly provided. Based on this observation, it is therefore essential that family planning services are availed to as many women as possible.

5.2.1. Control Fertility

The key finding from this research for the reason why women utilized family planning methods was that they want to be in control of their fertility. As rightly observed by Ashraf, and Lee (2012, women utilized family planning because they want to be in control of their fertility. This

has come about because society has along the ages viewed women to be at the centre stage of the reproductive role. Given the imbalance in decision making at household level in many traditional societies, which is also a common feature in sub-Sahara Africa, family planning could just be a way of empowering women with a voice so that they are can be in control of their own fertility and ultimately be enabled to control the affairs that concern them in the different spheres of society. From the findings of this research, control of fertility supersedes all other reasons for seeking and utilizing family planning services by women. In other words, it is the primary reason why women seek family planning services; all the others are secondary. This was echoed by many participants of this research who indicated that they wanted to be in control of when to have children and not be taken by surprise. It is a known fact that power dynamics between men and women in many communities differ but what is also true is the fact that many societies including Zambia, have a patriarchal skew or outlook when it comes to power which makes men to be more powerful in the homestead than women. The implication of this is that women very often than not take a subservient or subordinate role when it comes to power sharing at household level as well as at community level. In most cases, this has affected women in the negative sense by making them seem like "second class" members of society without an upper hand in matters of society. Family planning is therefore an alternative tool that women can use to ensure that they have a voice in society. Through it, they are able to determine when they can fall pregnant, how many children they can have and determine the spacing between the births. Family planning can be an opportunity to harness by women to change the longstanding status quo of women being viewed as subservient and subordinate to men because through it, women are able to control affairs that concern them, and in essence puts them in the position of power to control their economies, their health and that of their entire household members, their earning power; and eventually they can exert their influence and their voice to be heard in society.

5.3. Methods of Family Planning Available to Women

The key finding on the methods of family planning available to women in Kalulushi district is that the most common method is Depo-Provera, a short-term injection that works for a period of 3 months, followed by Combined Oral Contraceptive pill. The male and female condoms, implants Jadelle and Implanon, and IUCD are available sometimes but most women are not eager to utilize these methods. It was established that the availability of these long-term methods is

inconsistent and very much erratic. A woman who is therefore utilizing injection Depo-Provera was required to visit her health facility for an appointment with her provider of family planning every quarter, or four times in a year. These findings are consistent with those of Mwanangombe, Mundende, Muzata, Muleya, Kanyamuna and Simui (2020), who in their study of contraceptive use among adolescent school going girls indicated that the most common method utilized by that group is injection Depo-Provera. These results are also congruent with those reported by the United Nations in Zambia, 2017 who in their report dubbed "Status of Sexual and Reproductive Health and Rights in Zambia: Contraception and Family Planning, Preventing Unsafe Abortion and Accessing Post-abortion Care, and Maternal Health Care," indicated that the contraceptive method mix in Zambia is limited, especially in rural areas. They stated that the most commonly used contraceptives are injectables used by 19 percent of married women, followed by pills (12 percent). The use of long-acting and reversible contraceptives (LARCs), such as implants and intrauterine devices (IUCDs), is significantly low in Zambia, the report highlights. The implication of this is that it limits the ability of women to freely choose the type of contraceptives that meet their needs. Therefore, women are by default forced to utilize the only method which is available, not necessarily that they desire to utilise them.

In contrast, findings of this research disagrees with those of Black *et al* 2009 who indicated IUCD to be the most common contraception in Eastern and South-Eastern Asia, (at 18.6 per cent) followed closely by male condom (17.0 per cent). In Europe and Northern America, the pill and male condom are the most commonly used methods (17.8 and 14.6 per cent of women, respectively), while in Latin America and the Caribbean it is female sterilisation and the pill (16.0 and 14.9 per cent, respectively). In Northern Africa and Western Asia, the two most common methods are the pill (10.5 per cent) and IUCD (9.5 per cent). Nonetheless, the research findings agree with those of Black, *et al*, 2009 when they indicate that Sub-Saharan Africa is the only region where short-term injection contraceptives are the dominant method with a prevalence of 9.6 percent among women of reproductive age.

But what could be the reasons for the contrasting findings in the methods of family planning utilized by Asia, Europe, North and South America where they seem to be more inclined to use of long-term methods compared to the sub-Sahara Africa region which demonstrates use of short-

term family planning methods? It is not clear why there are strikingly contrasting regional findings in the use of family planning methods. This could be an avenue for further research to bring to light why there are these variations in contraception method preferences.

5.4. Challenges Women face in Utilization Family Planning

The challenges in family planning utilization by women are many and differ from one geographical location to the other. For example, in a study of contraceptive use among adolescent girls and young women in Chongwe district of Zambia by Mwanangombe *et al.* (2020), the common challenges faced by these users included side effects such as abnormal weight gain, blood clots, reduced libido and headaches as negative effects. Abdalla and Ahmmed 2017 in their study of barriers to family planning services in the white Nile of Sudan indicated that barriers that women faced in accessing family planning utilization included inadequate support for family planning services, followed by a refusal by husband; religious beliefs was another barrier reported that hindered family planning utilization in that region. Findings of this study however do not agree with findings of the above researches as being the common barriers to family planning use. Key findings demonstrate commodity stock-out as being the biggest challenge faced by women who utilize family planning in Kalulushi district. For the most part of this year, drug/commodity stock-out has been affected to a great extent by the Covid-19 pandemic which has basically disrupted all spheres of human endeavour. Health services have not been spared from the effects of this pandemic. The pandemic has seen transportation of goods and services disrupted and just the usual order of things turning in the reverse side. The big question that arises is how can health services such as family planning be adapted in order to cope with the effects of the pandemic seeing that the disease is very far from ending? Policy makers as well as providers of services need to look at ways of improving their services by ensuring that the effects of this pandemic are cushioned as much as possible and cause minimal shocks to the recipients of the service. One way could be beginning to look at promoting use of long-term methods of family planning to cut the frequent number of visitations that clients make to the health facilities to get their methods of family planning. If clients can be supplied with methods of family planning that last for a minimum of five years, it means one visit is all that is required for a client in the entire five year period all things being equal, serve only when she

experiences side effects. Now this could cut a lot trouble seen from the disruptions in family planning service provision caused by unforeseen eventualities such as the Covid-19 pandemic.

Other challenges include limited work spaces that hindered utilization of certain methods of family planning particularly the IUCD due to privacy concerns required for this method of family planning. Other barriers include lack of skilled providers to provide especially the long-term family planning method as these require further training beyond the basic nurse or midwifery training. It was found that personnel who were trained to provide Long Acting Reversible Contraception (LARC) were very few often causing clients to fail to access the long-term methods if available while the very few trained providers were often busy and overwhelmed with work as they provided other services also beside family planning. The other challenges are limited number of days on which family planning services are provided, lack of equipment and bad provider attitude to a less extent. Provision of family planning only on specific few days of the week is an impediment to utilization of family planning by many women. Most of the participants including the Nursing Officer indicated this as a cause for concern and suggested that family planning should be provided on all working days and not be limited to being provided in MCH alone but all other departments as well. The Integration of family planning into other departments would ensure that the service is availed to many women needing the service by maximising the scale on which the service is provided. Furthermore, a supermarket model for provision of family planning is more preferable as suggested by the Nursing Officer because it ensures easy access of service by clients while it also lessens on the congestion at service points posed by limiting the number of days upon which family planning service is provided.

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Spousal approval and religion did not seem to be impediments to utilization of family planning in this study; in fact, many users of family planning indicated that they had support of their partners to utilize family planning services. Therefore the researcher asserts that there are regional variations when it comes to challenges faced by women in utilizing family planning services; an impediment in one region does not apply across all regions, therefore there is need to study the prevailing culture of a region if challenges in family planning utilization are to be identified and averted.

5.5. Usefulness of Family Planning Methods

Findings from this research highlight pertinent points that demonstrate the usefulness of family planning methods to women in Kalulushi district. The key findings on usefulness of family planning are indicated below:

5.5.1. Economic side of Family Planning

Findings of this research demonstrate that there is an economic side of family planning utilization by women. This was demonstrated entirely by almost all the participants of the study who indicated that family planning enabled them to work and earn an income to contribute to their household livelihoods. In Zambia for instance, and other developing countries, women contribute a great way to the economic viability of the country through small and medium scale businesses. Informal sector employment including small scale farming is largely dominated by women in Zambia and other underdeveloped countries in sub-Sahara Africa, including many other underdeveloped countries of the world. The researcher established that some women utilized family planning for economic reasons as family planning enabled them to have sufficient time to pursue economic ventures that can sustain their households and livelihoods. As highlighted in the Living Conditions Survey report by the International Labour Organization and Central Statistical Office, Zambia has more people employed in the informal sector (88.7 percent) while the remaining 21.3 percent is the proportion of those employed in the formal sector, of the total number of people in employment. The report further indicates that in terms of gender employed in the informal sector, there is a variation in informal sector employment between men and women with women demonstrating high levels of engagement (91 percent) than men (87 percent). Informal sector employment is varied but often covers a spectrum of work that includes self-employment, either in the agricultural sector or as street and market traders, seasonal employment such as on farms, daily wage earners, house aides, running a business, in the farming, fishing, or forestry industries, piece workers, and contributing family workers excluding those individuals looking for work, students, home makers, retired, or individuals who report being too old or too young to work, (ILO, 2019. Furthermore, some formal work places employ informal workers in janitorial or other roles. With informal sector largely comprising women, it is clear therefore that women shoulder most of the household shocks in terms of meeting the economic needs of households. Many of participants of this research indicated that family

planning enabled them to work and earn and therefore contribute to the economic wellbeing of their families. When these women cannot control their fertility and end up conceiving multiple times in uncontrolled manner, the implication of this is that this takes away their ability to work in these informal jobs and therefore cannot earn an income as they would normally do should they have conceived in a controlled way and consequently their ability to contribute to household income is dwindled. The researcher is of the view that investing in family planning has the capacity to improve the economic viability of many households since women form the largest proportion of workforce in Zambia which is found in the informal sector. The researcher asserts therefore that there is an economic side of family planning which is a very essential element of the Zambian economic outlook and it is just necessary that the government makes deliberate policies and innovations to make family planning services available to as many women as possible if Zambia is to see positive economic transformation. Family planning utilization by women means that the users are able to have sufficient time to be out there working and earning income for their households because they will spend less time nursing children which may be the case if they have no control of their fertility. Some of the solutions to our economic woes lie in lack of robust and meaningful investments in health services including family planning as evidenced from findings of this research.

5.5.2. Rights side of Family Planning

Women, just like men have rights including the right to sexual and reproductive health. Article 16 (1) [e] of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Article 1[b]) guarantee the right of all women and couples to determine the number and spacing of children and provide for the right to access information and education on family planning, (United Nations in Zambia, 2017). This is further reaffirmed in SDG number 3, target number 7 when it states, "by 2030, to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes," (United Nations Department for Economic and Social Affairs, 2019). Unfortunately in developing countries such as those in sub-Saharan Africa including Zambia, women do not seem to enjoy these rights; they are denied by default their privilege to full enjoyment of their right to sexual and reproductive

health. This can be evidenced from the way women are treated by being used just as merely tools or instruments for conceiving and their voice is not heard. Further, due to deep rooted cultural and societal norms, a woman is repressed by being taught to be obedient to the man or husband and always adopt a subservient role always in a homestead. Yet the law provides for the woman to be able to enjoy the full extent of her rights including those related to sexual and reproductive health, and be able to decide freely on the number of children she wants to have including the spacing thereof. The repression has resulted in many women conceiving disproportionately high numbers of children that even puts the women's lives at risk of complications related to child birth. Very often than not, the decision on the number of children and the spacing thereof is a prerogative of the men and men alone. Women are in a way just forced or coerced into submitting to the will and demands of the man when it comes to the issue of child bearing due to the patriarchal and oppressive nature of the African culture and tradition.

The key finding of this research as it relates to rights of women is that family planning enables the woman to be able to decide on the number and spacing of her children. Therefore, family planning uplifts the rights of women and girls. When individuals are able to put across what they want for themselves, this is a clear indication of the assertiveness and ability to decide what they want for themselves and claim their right. The fact that women are able to go to the health facilities on their own accord without coercion or duress and request family planning services is an indication of promotion and uplifting of their sexual and reproductive rights. It is therefore essential that governments should strive harder to ensure that a broad range of family planning services are made available to all women without discrimination on the basis of geographical location for all those who are within the reproductive age group. By attesting to the CEDAW, the government of Zambia has the obligation to all women of providing them comprehensive information on contraception and family planning and also to provide a broad range of contraceptive choices. At policy level, this is what the Nursing Officer for Reproductive Health reiterated regarding provision of family planning services in her district. She reiterated, "We are as a district working to ensure that every woman who visits a health facility atleast gets a method of family planning of their choice." Women should not be viewed simply as tools for conceiving or producing children. Rather, they should be regarded as partners even in the role of reproduction whereby their voice is heard in terms of concerning the number and spacing of the

children. They are the ones who carry pregnancies for the whole period of gestation, they are the ones who give birth, and they are the ones who carry out most of the care for the children until when the children are of a reasonable age when self care is inevitable. Family planning is just one way of ensuring that the sexual and reproductive health rights of girls and women are promoted or uplifted.

5.5.3. Improved Education Outcomes for Adolescent Girls

The other key finding of this research showed that family planning is useful in improving the educational outcomes of girls and women. Teenage and adolescent pregnancy is very high in Zambia. According to the 2013– 14 Zambia Demographic Health Survey, 28.5 percent of girls aged 15–19 have ever been pregnant or had a live birth, (Population Council, UNFPA, and Government of the Republic of Zambia. 2017). In the education sector, between 2007 and 2014, a total of 120,024 in-school girls became pregnant and dropped out. The majority of the girls, 103,621, were in primary school when they became pregnant as compared with 16,403 who were in secondary school, (Ibid). One provider of family planning from a health facility had this to say concerning family planning utilization by adolescent school going girls: "family planning utilization enables adolescent school going girls to complete their studies." Mwanangombe, *et al.* (2020), in their study on family planning use by school going adolescent girls reiterated this point in their report by indicating that it profoundly reduced the number of school girls dropping out of school and enabled them to complete their studies. Family planning can be a very important tool for ensuring that the adolescent school going girls and those that marry at a young age have an opportunity to go to school and complete their studies and become useful members of society.

5.5.4. Improved Health Outcomes

The issue of improvement in health outcomes as a result of use of family planning has been echoed by many other researchers including Cleland (2014) who indicated that family the health gains of using family planning often outweighs the risks of using these methods. The findings from this research are consistent with those advanced by Cleland (2014) cited above which highlighted reduction in maternal and child deaths, reduction of pregnancy related complications, improvement of child survival, and many others. When family planning was expeditiously utilised, many health benefits both from the user and trickling to her children and the entire

household members will be realised. By delaying or waiting for a considerable amount of time before conceiving another, the body of a woman is afforded ample time to recuperate or heal from the stress of the previous pregnancy, ensuring that she is healthy enough to carry proceeding pregnancies. It should be noted that carrying a baby in the womb for nine months is a stress to the woman and it has been shown to affect the health of the woman in many ways. In terms of how these good health outcomes translate and become usable to individuals and society at large, we could try to perceive family planning from the broader picture of Sustainable Development Goals (SDGs). Family planning use closely ties into SDGs number 4, 5, and 6 directly and indirectly. For example, SDG number 4 seeks to address and avert the many child deaths that occur globally. Family planning contributes to this important global goal by ensuring that there is enough spacing between the births of the children by allowing atleast spacing of between 2 and 3 years between the births which in turn evidence has shown to improve the survival rate of the children. This is echoed by Cates (2008) who indicated that many child deaths could be averted while maternal health outcomes can be improved through the use of family planning services.

Cates 2008 further indicates that family planning has been shown to be more effective in curtailing Mother to Child Transmission of HIV (MTCT) than even Anti-retroviral drugs as evidenced from a study done in Zambia. The implication of this is that the health outcomes of both the mother and that of the child is improved because too many births have the potential to reduce the immune system of a woman while too closely spaced births can cause childhood malnutrition as there is often disruption in the care of the newborn as the mother often struggles with divided care for her young children. This overwhelming evidence of improved health outcomes for households left the researcher to wonder why family planning services does not seem to be a robust area for investment by the Zambian government. The lack of investment in family planning can be evidenced form the what some of the participants of this study (users and providers) indicated when they said that sometimes the family planning commodities they wanted to use were not available at their various health facilities, especially the long term method Jadelle and Implanon and as a result they ended up choosing the only available method available which may not be suitable for their needs and eventually they may go off using the method and in turn end up getting pregnant. From this observation, there is serious need to relook into the possibility

of investing heavily in family planning programs if the country is to realise the many gains that family planning can offer in terms of health outcomes for members of community at large.

5.5.5. Beauty Side of Family Planning

It appears there is a beauty side to family planning method utilization. By beauty is meant the fact that some women begin utilizing family planning so that they avoid conceiving as much as possible, a factor that is known to alter the body of a woman in many ways. Women especially those in aesthetic business such as fashion and modelling have been known to avoid conceiving so that they can maintain their natural beauty. Findings from this research showed that some women used family planning method so that they could limit the number of births and in turn maintain their natural beauty. In turn, they believed that they would keep their partners glued to them if they maintain their natural beauty.

> *"Some men are not good' they make you bear many children for them and end up dumping you once you are faded for a beautiful looking younger woman"* (Lamented F3).

This clearly indicates how much women value their beauty to the extent they indulge in utilizing contraception to avoid falling pregnant many times which would lead them to losing their beauty.

5.6. How Women choose their Preferred Method of Family Planning

The choice of family planning method by the client is the process of how the client decides to use a particular method of family planning among other available options. Konje, Cornell, and Otolorin 1998 indicated that factors that influenced the choice of contraceptive methods included advice from friends and family members, intended duration of use and information from the media. They also indicated that ignorance, fear and unfounded cultural beliefs were factors responsible for the delay in seeking contraceptive advice. The mass media was an important source of information for most of the women. The findings of this research however do not agree with these findings regarding factors that influenced women's choice of family planning method.

There were two key findings from this research concerning reasons that made women choose the method of family planning they utilized. The first one is availability of the method. Like one client indicated, "you find that the method of family planning you want is not available so you get the only available option…" The most widely used method of family planning by women for

this study was injection Depo-Provera which is a short term method that works for 3 months and reasons that came out were that it was the most widely available method and was also tolerable by many in terms of side effects. This is in tandem with Mwanangombe *et al.* (2020), whose findings suggest that indeed injection Depo-Provera is the most widely available method of contraception to adolescent girls and young women. It appears that availability and non-availability of a family planning method greatly influenced the choice of family planning by women. This is because the woman would rather use atleast something than nothing at all in an attempt to control her fertility. At policy level, it is the desire of the government to provide a wide range of family planning methods to all women but there are challenges within the supply chain with some methods being in erratic supply whereby this time the method may be available and run out stock the next moment. Methods like the injection Depo-Provera and its other variant Sayana press were available most of the time which is why majority of the users opted to utilize the method. One of the challenges like for this year as highlighted by the Nursing Officer was that of the Covid-19 pandemic which has affected negatively the movement of commodities from one point to the other and supply chain as a whole. Family planning in this part of the world therefore cannot be said to be choice seeing that many people use the method they use because it is the most widely available. This is restriction in choice and therefore one cannot say there was choice for the woman;; the fact is it was the only option Available. The researcher is for the belief that should there be other methods of family planning readily available to clients, we would perhaps see a shift in the type of family planning methods being utilized by women.

The second key finding that influenced women's choice of family planning is family planning counselling. In as much as there were restrictions in the number of methods of family planning available to women, family planning counselling was said to influence the user's choice of family planning method also. Providers of family planning counselled the women on how each of the available method worked, the advantages and disadvantages of each of the methods available at every family planning session before clients would chose the method they preferred. The researcher is of the view therefore that family planning counselling is very essential in ensuring that clients make a better choice of the method of family planning that best suit their needs. Counselling dispels myths, misconceptions and misinformation and clears any doubts regarding a

method of family planning and just paves the way for a user to choose their preferred method of family planning.

5.7. Implication of the Theoretical Framework to the Study

This study has revealed that family planning is very useful to women and among its usefulness includes promotion or uplifting of women's rights particularly the sexual and reproductive health rights; it is useful for poverty alleviation through the improvement of household economies; it can be a powerful tool for addressing education inequities between male and female by overcoming the impediments that arise associated with the burden of conceiving and care of the young by women; family planning is also useful for improving the health outcomes of household members and communities at large. The Health Belief Model proposed by Rosenstock 1974 helps explain health-related behaviour such uptake of health services. The theory suggests that the factors such as perceived susceptibility (risk), perceived severity (potential consequences), perceived benefits (value derived from engaging in a behaviour), perceived barriers (obstacles, bottlenecks), and cues to action (stimulators or prompts).

In relation to the usefulness of family planning, perceived susceptibility include all factors that are seen as risks to a woman should she not control her fertility; they include pregnancy related complications, poor health outcomes for the woman and her entire household members, reduced education attainments, reduced household income, among others. Perceived benefits is the value that is derived from family planning utilization which include promotion and uplifting of human rights of the women particularly sexual and reproductive health rights, improved household income, and improved educational outcomes. Perceived barriers include all bottlenecks women face in family planning utilization which include stock-out of commodities, lack of skilled personnel to provide especially LARC methods of family planning, inadequate workspaces, limited days on which family planning is provided and bad provider attitudes. Finally, family planning counselling serves as a stimulator that prompts women to utilize family planning services (cue to action). With the above background therefore, the findings of this research are in tandem with the constructs of the Health Belief Model as proposed by Rosenstock (1974).

5.8 Summary

In this chapter, findings of the study have been discussed in detail. The discussion was based on the themes that emerged from the study findings. It was established that the primary reason why women utilize family planning methods was to enable them be in control of their fertility. Secondary reasons include economic shocks faced by individuals, the desire to improve one's educational outcomes, pregnancy related conditions and complications, and many others. The most common method of family planning available to women is injection Depo-Provera which is a short-term method of family planning that works for three months. Women prefer this method of family planning to other methods basically because of its availability most of the time and it is well tolerated in terms of side effects than other methods. Because it is the most widely available method, women make the choice to utilize Depo-Provera not because it is the best of all the methods of family planning there is.

The findings of this research indicate that women do not really have a choice because the range of methods is very limited. Women would therefore have atleast a method than not having any method at all. Therefore, the researcher is for the belief that provided there is a wide range of methods of family planning available all the time, the picture in terms of method choice by women may shift from the monopolized kind of picture to a more diverse range of method utilization. Challenges faced by women in utilizing family planning include commodity stock-out, inadequate work spaces, lack of skilled personnel to provide family planning methods, limited days on which family planning services are provided and bad attitude of the provider to a less extent.

CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

6.1 Overview

The researcher in this chapter presents the summary of the main findings of the research as answered by questions of the study. The researcher gives recommendations and suggestions for areas of further research. The essence of this enquiry was to explore the usefulness of family planning methods utilized by women of Kalulushi district, Zambia.

6.2. Conclusions

It was established from the findings of this research that the primary reason for utilizing family planning methods by women was so that they have control over their own fertility. Women want to be in control of their reproductive function so that pregnancy does not take them by surprise. Secondary reasons include economic shocks, pregnancy-related conditions and complications, desire to have better health outcomes for the user and her household, among other reasons. In terms of the methods available to women, the research established that Depo-Provera injection, a short-acting method of family planning was the most widely utilized method while the other methods which include the pill, condoms, Implants Jadelle and Implanon, and IUCD are available but not common.

The key finding why women preferred Depo-Provera injection to other methods was availability; it is the most widely available among all other methods in the various health facilities of Kalulushi district. As a result, women do not have a choice or many options to choose from and would rather use atleast a method of family planning than not to use any at all. The research also unearthed barriers in family planning utilization by women of Kalulushi district. They include commodity stock-out, lack of skilled personnel to provide especially the LARC, inadequate work spaces at service points, limited number of days on which family planning services are provided among others. The research further established that family planning is useful to women in Kalulushi district in many ways: on the economic side, family planning is useful as is enables women who are the majority in informal sector employment to work and earn an income to provide for their households. Family planning is also useful to women as it uplifts and promotes

their rights, particularly the sexual and reproductive health rights as required in target number 7 of the Sustainable Development Goal number 3. Family planning is also useful to women as it improves the educational outcomes of adolescent young women by facilitating their continuous stay in school and completion of their studies. Through family planning use by school going adolescent girls, unintended pregnancies and consequent school dropouts are prevented which in turn facilitates for the girl child to stay in school even when she is sexually active without falling pregnant and as a result, completing her schooling thereby contributing to SDG number 4 on education. Finally, the research established there was a beauty side to family planning. This entails that women who use family planning are able to groom themselves well and maintain their looks and enhance their beauty. This is important in the context of the woman in Kalulushi as it facilitates cementing of marital union with their spouses as marriage is a valuable institution for many women. Therefore, family planning fosters this marital cohesion and eventually family ties.

6.3. Recommendations

Based on the findings of this research, the following recommendations were made in order to ensure that family planning methods become useful to the in Kalulushi utilizing them:

1. The District Health Office in Kalulushi should consider providing a wide range of family planning methods so that women have choice from many options. The limitation in the methods of family planning currently forces women to utilize the only available methods. Women currently are utilizing the methods of family planning through what may be termed “coercion by default” and not by choice because there are no other reliable options to choose from.
2. The District Health Office in Kalulushi should consider equipping the staff in the health facilities where family planning services are provided with skills to provide quality family planning services. Basic nurse or midwifery training alone is not adequate to enable the graduates provide especially LARC methods of family planning. This can be done via mentorships, on-site trainings, workshops and seminars and technical support.
3. Health facilities that are providing family planning in Kalulushi district should consider providing family planning counselling which should be part and parcel of service provision. This will ensure that clients get correct information on the methods being

provided and ensure that they chose the method of family planning that best suits their needs.

4. Providers of family planning services should consider promoting long-term family planning method use by clients as this will curtail the disruptions in short-term family planning methods seen due unforeseen factors such as the Covid-19 pandemic. This will reduce the number of times a woman has to visit the health facility to access their family planning method. For example, if more women can be on long-term family planning method that works for a minimum of five years, it means that each woman will only need to visit once at time of accessing the method as well as at time of removal probably after the entire five year period is exhausted.
5. Since work spaces are a challenge at service points especially for provision of Long Acting and Reversible Contraception particularly the IUCD, the District Health Office should consider expanding the health facilities with limited work spaces. Where this is not possible, they should consider providing screens that can be used within the limited work spaces to demarcate the space and ensure there is privacy in the areas where family planning services are provided.

6.4. Suggestions for Further Research

The following are suggestions for further research:

1. The focus of this research was on exploring the usefulness of family planning methods to women in Kalulushi; it is being suggested that a study be conducted to evaluate male involvement in family planning services in Kalulushi District
2. A further study can be conducted to Assess the impact of Covid-19 on Family Planning Provision and Utilization by women in Kalulushi District

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APPENDIX I: INFORMATION SHEET

I am a final year student pursuing a Master of Science Degree in Counseling in the School of Education at the University of Zambia. As partial fulfillment of the Degree program, I am required to undertake research in any area of benefit to the provision of quality counseling services and to contribute to the body of knowledge. This study is aimed at exploring the usefulness of family planning methods utilized by women in Kalulushi District of Zambia. It is hoped that the results of this study will help prioritize the planning and formulation of effective Family Planning services to women in Kalulushi District as well as women in other regions of the country when the results of this research are replicated there.

You will notice that some questions will be of sensitive nature and may be uncomfortable to your sense of modesty. These questions are not in any way meant to ridicule you by associating you with the responses that you will provide, hence your name or initials will not appear on this questionnaire and all collected information will be kept confidential by locking the questionnaires in a lockable cabinet until the whole study is completed at which time they will be destroyed.

In addition, there are no risks involved or direct benefits to you as a result of participating in the enquiry as this is a purely academic study. If you have any questions and clarifications, please notify the researcher on cell 0965 605225 or use the address below of the Head, Department of Counseling, School of Education, University of Zambia or the Chairperson, Biomedical Research Ethics Committee using the addresses and contact phone numbers provided below.

Your support is highly appreciated.

Thank you.

Persons to contact

University of Zambia,
School of Education,
Department of Counselling,
P.O Box 50110,
Lusaka. Tel: 0211-256067
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Research Ethics Committee,
University of Zambia,
P.O Box 50110,
Lusaka. Tel: 0211-256067

APPENDIX II: INTERVIEW GUIDE FOR THE USERS OF FAMILY PLANNING

Welcome to this interview. My name is Mbashila Muzhinga. I am a student from the University of Zambia pursuing a Masters Degree programme in Counselling. I am conducting an enquiry to explore the usefulness of family planning utilized by women in Kalulushi District. The findings of this enquiry will be shared with the District Health Management which may in a way influence how family planning services may be improved for the benefit of the people of Kalulushi District.

You have been purposely selected for this interview because you are a user of family planning services at this clinic and being one, you have a better outlook and experience of how family planning services are provided and you are better placed to provide insight on how they can be improved. Your name will not be mentioned in this enquiry; instead, initials of your name will be used in order to ensure your privacy. The interview will take about 30 minutes; however, you are free to stop the interview at any point you like. Nevertheless, your participation is highly valued as it will help provide insight into the quality of family planning services provided to you and ensure improvements.

Demographic information

Respondent's initials:

Age on last birthday:

Marital status:

Education level:

Religious faith:

Research question 1: Why do women seek family planning services?

We begin our discussion by trying to understand reasons why women seek FP services.

1. How many children do you have, how many do you want to have, and how do you intend to achieve your reproductive goal?
2. How did you know about family planning services at this health facility?
3. People use FP for different reasons; some because of medical reasons, some because they want to complete school and others because of work and many others. Could you please explain the main reasons why you started using family planning services?
4. In what ways do you think partner involvement is important to consider when starting and using family planning? How has your partner supported you?

Research question 2: What family planning methods are available to women?

5. What method of FP are you using, how old were you at the time you started using FP and what were the reasons for your choice?
6. May you explain how you decided on the method of FP you are using (any influences from your partner, friends, health care worker, or options for your choice)?
7. In what ways do health care providers enable women's choice of contraception?
8. Explain the modern contraception methods available at this health facility

Research question 3: How is family planning useful to women?

9. How do you feel about the FP method that you are using? (the good, bad, the side effects)
10. Explain how you cope with side effects of this method of family planning (if any)?
11. In what ways has family planning been useful to you and your family?
12. What challenges have faced using your preferred method of family planning?
13. How do you cope with challenges you face in using your method of family planning?
14. What is your opinion of the family planning services provided at this health facility? (probe for how they like the services, the health workers attitudes, costs)
15. Do you have anything else you would like to share with me about modern family planning methods?

We have come to the end of our interview. Thank you very much for your time and responses. Like I indicated earlier, the responses you have given will not be used against you in any way and your name will not be used to ensure your privacy.

APPENDIX III: INTERVIEW GUIDE FOR FAMILY PLANNING SEVICE PROVIDERS

Welcome to this interview Date:

My name is Mbashila Muzhinga. I am a student from the University of Zambia pursuing a Masters Degree programme in Counselling. I am conducting an enquiry into the usefulness of family planning to women here in Kalulushi District. The findings of this enquiry will be shared with the District Health Management which may in a way influence how family planning services may be improved for the benefit of the people of Kalulushi District.

You have been purposely selected for this interview because you are a provider of family planning services at this clinic and being one, you have a better outlook on the use, quality and challenges of family planning services including ways of improving them. Your name will not be mentioned in this enquiry; instead, initials of your name will be used in order to ensure your privacy. The interview will take about 30 minutes; however, you are free to stop the interview at any point you like. Nevertheless, your participation is highly valued as it will help provide insight into the quality of family planning services provided to you and ensure improvements.

Demographic information

Respondent's initials:

Religious faith:

Profession:

Questions on motivation for women seeking FP service provision

1. What reasons do women give when they come seeking FP services from you?
2. Do you think there are skills/competences required for a provider to offer quality FP services to clients? What are they if any? Explain the competencies/skills you have in FP service provision

Questions on family planning methods available to women

3. What modern methods of family planning do you provide at this facility?
4. How do you ensure your clients chose family planning method that best suits their needs?
5. Briefly outline the steps you take when providing FP services to clients

Questions on barriers to family planning utilization

6. What challenges do you face FP services to your clients at this facility?
7. Explain how do you mitigate the challenges (if any) in order to improve service?
8. How do you help clients whose preference of FP method you cannot provide?

Questions on how useful is family planning to service providers

9. In what ways is family planning useful to your clients?
10. Do you have anything else you would like to share with me concerning the FP services you provide at this facility?

We have come to the end of our interview. Thank you very much for your time and responses. Like I indicated earlier, the purpose of this enquiry is to enable us have insight into family planning services in Kalulushi District and ensure improvements where possible. The responses you have given will not be used against you in any way and your name will not be used to ensure your privacy.

APPENDIX IV: FOCUS GROUP DISCUSSION GUIDE FOR USERS OF FAMILY PLANNING

WELCOME REMARKS

My name is Mbashila Muzhinga. I am a student from the University of Zambia pursuing a Masters Degree programme in Counselling. I am conducting an enquiry into usefulness of family planning methods utilized by women in Kalulushi District. The findings of this enquiry will be shared with the District Health Management which may in a way influence how family planning services may be improved for the benefit of the people of Kalulushi District.

You have been purposely selected for this discussion because being are users of family planning services at this clinic, you have a better outlook and experience of how family planning services are provided and you are better placed to provide insight on how they can be improved. The discussion will take about 45 minutes. Feel free to actively participate in the discussion.

TOPIC

Our topic is "Usefulness of Family Planning to Women in Kalulushi District."

GUIDELINES

- There are no right or wrong answers in this discussion, only differing points of view
- I am tape recording so that I do not forget the important points which will be discussed
- We are on a first name basis
- You do not need to agree with others, but must listen respectfully as others share their views
- I kindly ask that you turn off your phones or put them on vibration. If you cannot and if you must respond to a call please do so as quietly as possible and rejoin us as quickly as you can
- My role as moderator will be to guide the discussion

GUIDING QUESTIONS

1. We are going to begin our discussion by understanding family planning. What do you understand by family planning?
2. Let us now proceed to look at the motivation or reasons why women seek family planning services. What do you think motivates women to consider using family planning?
3. Let us discuss the types of family planning methods available at this health facility?
4. I want to get your views on how useful is family planning to women?
5. What challenges or barriers do you face utilizing family planning services at this facility?
6. Explain how your providers help avert the challenges you face in utilizing FP at this health facility?
7. How do you like the family planning service you receive from this health facility?
8. What would tell other women and couples out there about family planning?
9. Do you have anything else you would like to share with me about modern family planning methods?

SUMMARY

We have come to the end of our discussion on the "Usefulness of Family Planning to Women." We have discussed what family planning is, we have also discussed the motivation that drives women to use family planning, its usefulness to women, the challenges you face, how your family planning providers help avert your challenges and we have concluded by discussing how you like the family planning service that you receive from this health facility. Thank you very much for your time and active participation.

APPENDIX V: INTERVIEW GUIDE FOR NURSING OFFICER

Welcome to this interview

My name is Mbashila Muzhinga. I am a student from the University of Zambia pursuing a Masters Degree programme in Counselling. I am conducting an enquiry into the usefulness of family planning to women here in Kalulushi District. The findings of this enquiry will be shared with the District Health Management which may in a way influence how family planning services may be improved for the benefit of the people of Kalulushi District.

You have been purposely selected for this interview because you are the Nursing Officer for Reproductive Health who oversees family planning program in Kalulushi District. Your disposition as a Programs Officer makes you a valuable resource to help with this enquiry since family planning program falls under your office and your experience and expertise managing family planning at policy level will provide better insights into the utilization, quality and challenges of family planning services including ways of improving them. Your name will not be mentioned in this enquiry; your title or office you hold will be used instead in order to ensure your privacy. The interview will take about 30 minutes; however, you are free to stop the interview at any point you like. Nevertheless, your participation is highly valued as it will help provide insight into the quality of family planning services provided to you and ensure improvements.

Respondent's title:

1. What is your role in family planning program in the district?
2. In what ways is FP useful women in Kalulushi district?
3. What is your opinion on how family planning service is running in your district?
4. Explain the range of family planning services being provided in your district?
5. How do you ensure that that the clients in our health facilities in your district receive quality family planning services that ensures client satisfaction?
6. Comment on the human resource and family planning commodities available in the health centers in relation to service provision

7. Describe the challenges you face in ensuring quality family planning service is provided to clients in the district?
8. Explain how you manage some of the challenges you face in ensuring quality family planning services in the clinics of your district
9. Describe the role of partners in your district who are complementing government in family planning services?
10. Is there anything else you would to share with me concerning family planning in your district?

We have come to the end of our interview. Thank you very much for your time and responses. Like I indicated earlier, the purpose of this enquiry is to enable us have insight into family planning services in Kalulushi District and also for academic purposes. The responses you have given will not be used against you in any way and your name will not be used to ensure your privacy.

APPENDIX VI: GANTT CHART

Period → Activity ↓	Apr 2019 - Aug 2020	Sep 2020 Week 1 & 2	Sep 2020 Week 3 & 4	Oct 2020 Week 2 & 3	Nov 2020 Week 1, 2, 3, & 4	Dec 2020
Writing of Research proposal						
Submission of research proposal						
Data collection & analysis						
Writing research report						
Defense of thesis						
Submission of thesis						
Dissemination of findings						

APPENDIX VII: BUDGET

SN	ITEM	QTY	UNIT COST	TOTAL
1	A4 Bond Paper	04	50	200
2	Pen	20	1	20
3	Pencil	10	1	10
4	Folder	04	15	60
5	Eraser	03	2	10
6	Stapler	01	50	50
7	Staples	1 box	50	50
8	Perforator	01	50	50
9	Correction fluid	02	20	40
10	Flash disk	01	100	100
11	Printing services	-	-	1500
12	Binding of research proposal and report	4 copies	150	600
13	Transport cost		500	400
14	Printing and Binding Dissertation	4	250	1000
15	Contingency	10%		409
	TOTAL			K4,499

JUSTIFICATION OF THE BUDGET

The budget was not adequate hence the researcher excluded the use of research assistants for data collection. Due to the impact of Covi-19 pandemic, prices for goods and services were impacted negatively through upward adjustments and therefore spending the entire amount provided for in the budget.