



C-Change Endline Report: FP/HIV Integration through SBCC in Zambia September 2011



TABLE OF CONTENTS

| | |
|--|----|
| EXECUTIVE SUMMARY..... | 6 |
| CHAPTER 1: INTRODUCTION..... | 10 |
| CHAPTER 2: THE RESEARCH STUDY..... | 16 |
| CHAPTER 3: DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF RESPONDENTS | 21 |
| CHAPTER 4: SEX AND CHILDBEARING | 27 |
| CHAPTER 5: FAMILY PLANNING – KNOWLEDGE AND USE | 40 |
| CHAPTER 6: SERVICE STATISTICS | 54 |
| CHAPTER 7: EXPOSURE TO INFORMATION ON FAMILY PLANNING AND HIV | 59 |
| CHAPTER 8: GENDER RELATIONS | 66 |
| CHAPTER 9: STUDY LIMITATIONS | 73 |
| CHAPTER 10: SUMMARY AND CONCLUSIONS | 74 |
| APPENDICES | 80 |

LIST OF TABLES AND FIGURES

| | |
|---|------------------------------|
| Table 3.0 Demographic characteristics of focus group participants..... | Error! Bookmark not defined. |
| Table 3.1: Percent distribution of respondents by background characteristics and HIV status..... | 23 |
| Figure 3.0: Percent distribution of baseline, midline, and endline female sample by age group | 24 |
| Figure 3.1: Percent distribution of baseline, midline and endline male sample by age group | 25 |
| Table 3.2: Frequency of exposure to TV and radio, by sex and HIV status..... | 26 |
| Table 4.0: Age at first sexual intercourse, by sex and HIV status..... | 28 |
| Table 4.1: Median age at first sexual intercourse in the baseline and endline samples, by sex and HIV status | 29 |
| Table 4.2: Percent distribution of respondent’s number of living children, by sex and HIV status | 31 |
| Figure 4.0: Percent distribution of number of living children, by sex and HIV status..... | 32 |
| Table 4.3: Percent distribution of women’s desire for last pregnancy, by number of living children and HIV status | 32 |
| Table 4.4: Percent distribution of women’s desire for a/another child | 34 |
| in the baseline and endline samples, by HIV status..... | 34 |
| Table 4.5: Percent distribution of women’s desire for a/another child, by number of living children | 35 |
| Table 4.6: Ideal number of children for a woman, by sex and HIV status | 36 |
| Table 4.7: Ideal number of children for a man, by sex and HIV status..... | 37 |
| Table 4.8: Perceptions of community’s ideal number of children in the baseline and endline surveys, by sex and HIV status of respondent | 38 |
| Table 5.0: Ever use of contraception in the baseline, midline and endline samples, by sex and HIV status..... | 41 |
| Table 5.1: Current use of any modern method of contraception in the baseline, midline and endline samples, by sex and HIV status | 41 |
| Table 5.2: Percent distribution of family planning method use, by sex and HIV status | 42 |
| Table 5.3: Source of family planning method in the baseline, midline (), and endline [] surveys, by sex and HIV status..... | 44 |
| Table 5.4: Contraceptive use decision maker, by sex and HIV status..... | 46 |
| Table 5.5: Female respondents’ reasons for non-use of family planning, by HIV status | 47 |

| | |
|---|-------------------------------------|
| Table 5.6: Intended method among female non-users who intend to use family planning, by HIV status..... | 49 |
| Table 5.7: Approval for family planning in the baseline, midline and endline samples, by sex and HIV status | 50 |
| Table 5.8: Spouse or partner approval for family planning in the baseline, midline and endline samples, by sex and HIV status | 50 |
| Table 5.9: Approval for young couples' family planning use in the baseline, midline and endline samples, by sex and HIV status | 51 |
| Table 5.10: Belief that a woman who uses family planning will be unfaithful to her husband, by sex and HIV status..... | 53 |
| Table 6.0: Family planning commodities distributed and number of clients served at Mwase RHC and Mankhaka Health Post, June 2009-April 2011 | 55 |
| Figure 6.0: Total family planning clients served from Mwase RHC and Mankhaka Health Post, June 2009-April 2011..... | 56 |
| Figure 6.1: Contraceptives distributed by CBDs, September 2009-April 2011..... | 57 |
| Figure 6.2: CYP, June 2009-April 2011 | 58 |
| Table 7.0: Percent distribution of respondents who heard a message on family planning through radio, TV, or drama in the previous 12 months, by sex and HIV status..... | 59 |
| Table 7.1: Percent distribution of respondents who heard a message on HIV through radio, TV or drama in the previous 12 months, by sex and HIV status..... | 60 |
| Table 7.3: Percent distribution of respondents who attended a meeting where family planning was discussed in the previous 12 months, by sex and HIV status..... | 62 |
| Table 7.4: Percent distribution of respondents who attended a meeting where HIV was discussed in the previous 12 months, by sex and HIV status | 63 |
| Table 7.5: Percent distribution of respondents who were visited by a community health worker to discuss family planning in the previous 12 months, by sex and HIV status | 64 |
| Table 7.6: Percent distribution of respondents who were visited by a community health worker to discuss HIV in the previous 12 months, by sex and HIV status..... | 64 |
| Table 7.7: Percent distribution of respondents who visited a health facility and were spoken to about family planning by health staff, by sex and HIV status..... | 65 |
| Table 8.0: Percent distribution of respondents who agreed with or were unsure about gender norm statements, by sex and HIV status..... | Error! Bookmark not defined. |
| Table 8.1: Percent of respondents who agreed with (or were unsure about) gender norm statements, by sex and HIV status | Error! Bookmark not defined. |
| Table 8.2: Percent distribution of respondents who agreed with (or were unsure about) gender norm statements, by sex and HIV status | Error! Bookmark not defined. |

ABBREVIATIONS

| | |
|-------|--|
| AED | Academy for Educational Development |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BCC | Behavior Change Communication |
| CARE | Cooperative for Assistance and Relief Everywhere |
| CBD | Community-Based Distributor/Distribution |
| CHW | Community Health Worker |
| CYP | Couple Years of Protection |
| FGD | Focus Group Discussion |
| FHI | Family Health International |
| FP | Family Planning |
| GEM | Gender-Equitable Men |
| HIV | Human Immunodeficiency Virus |
| ITAP | Integrated Tuberculosis and AIDS Program |
| IUD | Intra-uterine device |
| MCH | Maternal and Child Health |
| OCP | Oral Contraceptive Pill |
| PI | Principal Investigator |
| PLHIV | People Living With HIV/AIDS |
| PMTCT | Preventing Mother to Child Transmission |
| RA | Research Assistants |
| RHC | Rural Health Center |
| SAA | Social Action and Analysis |
| SFH | Society for Family Health |
| TB | Tuberculosis |
| VCT | Voluntary HIV Counseling and Testing |

EXECUTIVE SUMMARY

Between November 2009 and June 2011, the Academy for Educational Development (AED)¹ partnered with CARE Zambia through the Communication for Social Change (C-Change) initiative to implement a project designed to explore the effects of social and behavior change communication on family planning uptake. The project aimed to increase family planning utilization and as well as address the underlying social norms that influence uptake of family planning services. The project had a particular goal of exploring the effect of these interventions on uptake of family planning among HIV-positive individuals.

The project was implemented in the Mwase Zonal Rural Health Center (Mwase RHC) catchment area in Lundazi District, Eastern Province, Zambia. Study participants included HIV-positive and HIV-negative men and women of reproductive age (18-50). Survey participants were selected from a sampling frame built from the Mwase RHC ART and VCT registers.

The project included two complementary sets of interventions. In order to improve access to family planning at the Mwase RHC, the team established a family planning screening and referral system from the outpatient department and ARV clinics to the MCH department (where family planning services are provided.)

The team also implemented a series of social and behavior change (SBCC) communication strategies at the community level with the goal of increasing demand for and reduce barriers to the uptake of family planning.

The first phase of SBCC strategies included participatory dialogues facilitated by community-based workers, who were trained using the CARE *Social Analysis and Action* (SAA) methodology. Volunteers were selected from local village health committees. Using tools and approaches from SAA, these volunteers facilitated ongoing community dialogues about gender roles, sexuality, HIV, family planning and the social/cultural factors that influence the uptake of family planning. After dialogues had been implemented for a year, the team trained these facilitators to integrate a field-tested SBCC tool into community dialogues. This tool was designed to guide discussions of the benefits of birth spacing and provide accurate information about family planning, including addressing myths and misconceptions. SBCC facilitators were trained to conduct one-on-one meetings with interested FP clients. During this second phase, dialogues were also complemented by community theatre performances about topics related to FP.

Outcomes of interest included: acceptance of family planning, FP uptake, and changes in the underlying social norms² that influence FP behaviors. Outcomes were measured using a

¹This is to advise that as of July 1, 2011, the Academy for Educational Development, Inc. ("AED") has transferred substantially all of its assets to FHI Development 360 LLC ("FHI 360"). The transfer makes FHI 360 the legal successor-in-interest to AED's rights and obligations under existing contracts.

² C-Change/USAID define social and gender norms as "the social expectations about how men and women should behave due to the fact that they are men and women" (C-Change: "Gender Equality," <http://c-changeprogram.org/focus-areas/gender->

singletime series research design. SBCC interventions were introduced one at a time, with results measured after implementation of each intervention. At baseline, midline and endline, both qualitative interviews and community-based surveys were used to assess acceptability and use of family planning, as well as to measure change in individual behavior and attitudes and beliefs about sexuality, gender norms and family planning. Monthly Mwase RHC FP service data was used to examine changes in quantity of family planning methods distributed and couple years of protection (CYP).

This report summarizes findings from the final project evaluation, which was conducted in May and June of 2011. The evaluation was intended to determine the effectiveness of the social and behaviour change communication (SBCC) approaches in increasing FP uptake.

Methods

The endline evaluation included a survey of 196 respondents (102 males and 94 females) which was conducted by appropriately trained local interviewers. All interviews were administered in the local language, Chewa. Additional quantitative data on FP commodity distribution were abstracted from the Mwase RHC FP clinic and community based distribution records by the study M&E Officer. Qualitative information was obtained through eight focus group discussions (FGDs) conducted separately with men and women ages 18-29 and 30-49 in the project area. FGDs were conducted in Chewa by research assistants (RAs) trained in qualitative data collection techniques. All data collection tools and informed consent transcripts contained both English and Chewa text for quality assurance.

Data management and analysis

Survey data were entered into EPI-INFO database system, using screens with consistency and range checks, and cleaned. Data were analyzed using SPSS. Data analysis was focused on determining current levels of key indicators – social norm indicators, approval for FP, and knowledge and use of contraception – and associations between outcome indicators and participants' demographic characteristics, with particular attention to changes since the baseline study (accounting for inter-survey differences in the baseline and endline samples).

Mwase RHC monthly FP service statistics were entered into an EXCEL database, and the couple-years of protection (CYP) estimated using the USAID formula.

FGD transcripts were translated into English and transcribed verbatim. Transcripts were uploaded into NVIVO and coded for content analysis.

[equality](#)). For the purposes of this report, social norms are not limited to those related to gender, and may include other expectations around individuals' behaviors as related to marriage, fertility, etc., though within these norms there are often gender-specific behavioral expectations.

Key highlights of findings at endline

Fertility intention and ideal family size:

At endline, a smaller proportion of female respondents were unsure of their fertility desires than at baseline, and more reported wanting no more children. Respondents continued to report perceptions of community family size norms that were higher than their personal family size ideals, indicating that these community norms are a possible inhibitor to individuals limiting their family size and using family planning. Qualitative data indicated that women in particular are sensitive to perceptions of community pressures and expectations when it comes to child-bearing.

However, inter-survey analyses indicated that perceived norms of ideal family size have shifted downwards for both male and female respondents. For example, whereas 67.5 percent of baseline female respondents believed that the community's ideal family size included six or more children, this proportion had decreased to 47.7 percent of endline female sample. Among male respondents, the proportion decreased from 66.2 percent to 54.6 percent. Inter-survey differences were not significant for the male samples, but were for female respondents overall ($p=.017$) and HIV-negative female respondents ($p=.032$).

Knowledge and use of family planning

Over the life of the project, female use of modern methods of FP increased significantly. By the endline over half of women in the survey sample were using a modern family planning method. Increases in current use of family planning were slightly statistically significant for the female sample overall ($p=.063$) and the female HIV-negative sub-sample ($p=.099$). Condoms, injectables, and OCPs continue to be the dominant methods used by the population, while long-term and permanent methods were reported rarely, if at all.

At endline, women reported higher approval for FP use and greater knowledge of FP sources and methods than baseline female respondents. Among respondents who reported using contraceptives, the proportion of endline male sample getting contraceptives from Mwase RHC increased from baseline. More endline female sample reported getting contraceptives from a CHW than did baseline female respondents.

Approval for family planning:

Approval for family planning was high among all groups, and was not significantly different by HIV status. Inter-survey comparisons indicated that female approval for FP increased significantly over the course of the project, for female respondents overall ($p=.012$) and for HIV-positive female respondents ($p=.031$). Male approval for FP was fairly constant across the three surveys.

Larger proportions of women in the endline sample reported that their husband or partner approved of FP compared to baseline female respondents ($p=.012$); the significance of this increase held for HIV-positive female respondents ($p=.079$) as well as HIV-negative female respondents (.035).

Approval for use of family planning by recently married couples, however, remained very low. This finding complements qualitative data revealing the strength of fertility-related norms in the community. These include the beliefs that couples who do not want children are not normal, and that the primary purpose of marriage is to bear children. Young unmarried couples' use of FP also seems to be contentious in the community, with some participants associating unmarried girls' use of FP with promiscuity and/or prostitution. There are some cases in which unmarried youth's use of FP might be viewed as acceptable, such as the use of FP to avoid pregnancy and continue pursuing an education.

Despite strong community expectations that young couples have children early in marriage, the proportion of male respondents who believed that it was up to a couple to decide how long they should wait to have a child after marriage increased between the baseline and the endline (from 22.5 percent to 35.3 percent). The increase was particularly significant among HIV-positive respondents, among whom the proportion of respondents who indicated that newly married couples should be able to decide how long to delay childbearing doubled between the baseline and endline (from 24.2 percent to 50.0 percent). Changes were statistically significant for the male population overall ($p=.051$) as well as among HIV-positive male respondents (.010). Reconciling these various themes in the quantitative and qualitative data, it may be that while community members were aware of norms that expect couples to bear children (and to do so early on in their marriage in order to give the marriage meaning), there is a possibility that norms are shifting to allow some space for birth delay by young couples.

Higher proportions of both male and female endline respondents rejected the idea that a woman who uses FP will be unfaithful than did respondents in the baseline, possibly suggesting changes in the prevailing perception that contraceptives promote promiscuity.

Gender attitudes and norms:

Endline data from both surveys and focus groups suggest a shift in some attitudes and beliefs related to gender. Strongly held norms around shared decision-making in couples were confirmed through FGDs, where several FGDs of both men and women of different ages indicated that the decision to have a certain number of children was made jointly by the couple. Importantly, however, qualitative data—supported by survey data on gender relations—also suggested that men had final decision-making authority in the household, including issues of childbearing (Chapter 8). In addition, previously discussed data from qualitative exercises indicated that women were more sensitive to external pressures around fertility (see Chapter 4). In sum, though joint decision-making appears to be the primary practice according to survey data, qualitative data indicated that joint decision-making by a couple did not necessarily equate to egalitarian decision-making, and that outside actors may have a role as well. Survey data also indicate a persistently high acceptance of violence against women in the community.

Challenges facing family planning provision:

Limited and irregular contraceptive supplies presented challenges to clinic-based and community-based distribution of contraceptives. Long-term and permanent methods of FP (such as IUDs and sterilization) are not consistently available or easily accessible for the population.

CHAPTER 1: INTRODUCTION

Background

There is growing evidence of the critical importance of improving access to family planning (FP) among people living with and at risk for HIV/AIDS.

Healthy timing and spacing of births helps ensure the health and well-being of all women and infants, regardless of their HIV-status.³ For HIV-positive women who do not wish to become pregnant or have more children, access to family planning not only prevents unwanted pregnancies but can prevent maternal to child transmission of HIV. In Africa, it is estimated that 160,000 HIV-positive births could be averted each year if all women who wished to avoid pregnancy had access to contraceptive services.⁴

Several studies have found that there is a high, unmet need for sexual and reproductive health services, among people living with HIV, including family planning services.⁵ Despite the great need, family planning is often not integrated or very poorly linked to HIV services⁶ and there are few well-evaluated models for effectively providing SRH services to people at risk for and living with HIV.⁷

This action research project aimed to explore how SBCC interventions could help increase access to family planning services. Lessons emerging from both family planning and HIV programs, including FP/HIV integration programs- highlight some key considerations that informed the design of this program.

Limited availability and access to FP information and services at the community level and from health clinics can be significant barriers to family planning. Myths and misconceptions about family planning can also be important barriers to the uptake of services.

³ Kate J Kerber, Joseph E de Graft-Johnson, Zulfi qar A Bhutta, Pius Okong, Ann Starrs, Joy E Lawn. 2007. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. *Lancet*; 370: 1358–69

⁴ Reynolds HW, Janowitz B, Wilcher R and Cates W. Contraception to prevent HIV-positive births: current contribution and potential cost-savings in PEPFAR countries. *Sex Transmi Infections* 2008; 84 (Supple 1): ii: 49-53.

⁵ .Adair, T. Macro International (2007). *Desire for Children and Unmet Need for Contraception among HIV-Positive Women in Lesotho.*

⁶ Wilcher R and Cates W. (No date.) AIDStar. *Spotlight on prevention: The astonishing neglect of an HIV-prevention strategy: The value of integrating family planning and HIV services.*

⁷ Brickley, Deborah Bain , Almers, Lucy , Kennedy, Caitlin E. , Spaulding, Alicen B. , Mirjahangir, Joy Kennedy, Gail E. , Packel, Laura , Osborne, Kevin , Mbizvo, Michael and Collins, Lynn 2011 .*Sexual and reproductive health services for people living with HIV: a systematic review, AIDS Care*, 23: 3, 303 — 314

In one FP/HIV integration program in Uganda, clinic staff supported integrating FP into HIV/AIDS services when practical guidelines and training were put into place, but significant efforts were still needed to address community stigma and fears. Women living with HIV wanted options for preventing pregnancies when their partners refused to use condoms, but had common misconceptions and were fearful of side effects and discriminatory practices. This program also highlighted the importance of including nuanced and contextually-appropriate interventions aimed at factors that influence FP decision-making, and the need for FP communications programs that target HIV-positive men.⁸

At both the community and the clinic levels, access to services is often limited by stigma and discrimination against PLHIV in health care settings; many providers also have discriminating attitudes about the rights of people living with HIV/AIDS to manage their own fertility.⁹ Gender-related bias also limits the effectiveness of family planning services. FP services are often geared solely towards women, leaving men without an easily accessible option for accessing FP services and information.¹⁰

Social and cultural barriers also limit the acceptability and utilization of family planning. Gender norms may limit women's ability to make autonomous decisions about their fertility, including community norms about gender roles and inequitable power dynamics in couples.¹¹ Community norms around ideal family size may limit the ability of couples to delay and space births or limit the number of children they have. Taboos about premarital sex may limit the ability of young, unmarried men and women to access family planning. People living with HIV may not have disclosed their HIV status to their family and/or may want no more children but feel pressured to reproduce.

HIV and Family Planning in Eastern Province, Zambia and CARE's Response

Zambia has a high HIV prevalence rate at 14.3 percent nationally. In rural areas, prevalence is slightly lower, at 10.3 percent, which is the same estimated prevalence for Eastern Province. Prevalence rates are slightly higher for women than men; 16.1 percent of Zambian women are HIV-positive, compared to 12.3 percent of Zambian men. Unmet need for contraception is also relatively high in Zambia at 26.5 percent, with a similar rate (24.2 percent) for Eastern Province.¹²

CARE provides financial, logistical, and technical assistance to strengthen government health structures at provincial, district, and community levels to deliver effective and high-quality health services. This includes improved capacity for optimal communication and referrals from

⁸ ACQUIRE. 2007. Integrating Family Planning with Antiretroviral Therapy Services in Uganda.

⁹ Shalini Bharat, a Vaishali Sharma Mahendra. 2007. Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers. *Reproductive Health Matters*. 15(29 Supplement):1-3

¹⁰ Karin Ringheim and Charlotte Feldman-Jacobs 2009. Engaging Men for Gender Equality and Improved Reproductive Health. Population Reference Bureau.

¹¹ Gupta GR. 2000: *Gender, sexuality and HIV/AIDS: The what, the why and the how*. Plenary address at the XII International AIDS Conference, Durban, South Africa, 9-14 July

¹² Central Statistical Office (CSO), Ministry of Health (MoH), Tropical Diseases Research Center (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*.

community-level volunteers to the primary health system. CARE trains community auxiliary health workers and volunteers, including traditional birth attendants and local leaders, in HIV and TB prevention, care, and support. As a complement to strengthened health services, CARE works with different community groups and the general population to raise awareness of HIV and TB issues, as well as to promote health services.

Integrated Tuberculosis and AIDS Program (ITAP) in Lundazi

From 2005 to mid-2009, CARE implemented the PEPFAR-funded Integrated Tuberculosis and AIDS Program (ITAP) through the Centers for Disease Control (CDC) in the Eastern Province. ITAP's focus areas and objectives included:

- (1) Prevention of Mother-to-Child Transmission (PMTCT): Provide a minimum PMTCT package, or access to PMTCT services for 13,000 women in 30 health facilities in three remote rural districts of the Eastern Province, including Lundazi.
- (2) Counseling and Testing: Provide HIV counseling and testing for 15,000 prospective HIV/AIDS clients in 47 health centers in six districts of Eastern Province, including Lundazi.
- (3) Basic Health Care and Support and TB/HIV care: Facilitate access to improved TB and HIV services for 5,000 prospective TB and/or HIV/AIDS clients in 117 health centers in four districts of Eastern Province, including Lundazi.

In 2008, Communication for Change (C-Change) partners CARE and AED (now FHI 360) proposed to integrate FP into ITAP through behavior-change communication (BCC) activities. ITAP had already facilitated the formation of “buddy groups” in order to increase adherence to treatment regimens (ART and TB) and address issues of stigma and discrimination. These project activities provided a potential entry point for introducing a community communication strategy on family planning, and provided a unique opportunity to reach PLHIV and their partners with FP information.

In September 2010, ITAP entered a second phase of program implementation and scaled down to three districts so that it no longer operated in Lundazi. This development did not affect the SBCC activities, as the basic structures necessary to implement and evaluate their impact—the Mwase RHC clinic and the network of informal community groups and facilitators—remained in place, and CARE Zambia continued to provide support through its Lundazi office.

Overview of Mwase Rural Health Center (RHC) FP service

Mwase RHC provides a range of FP services, including counseling and distribution of methods. The clinic supplies contraceptives to community based distributors (CBDs). The CBDs are trained volunteers who provide FP counseling and methods to community members. They are authorized to provide only two methods of FP—condoms and oral contraceptives (OCs). CBDs can distribute both male and female condoms, but mostly distribute male condoms, as female condoms are stocked only intermittently at Mwase RHC; when they were available, stocks are limited and quickly depleted. The CBDs were trained to refer to Mwase RHC any clients they

encountered in the community who were interested in a method other than OCPs or condoms—such as injections.

Mwase RHC provides a limited number of contraceptives on a regular basis: contraceptive pills (three major types—Microlut, Microgyn, and Oralcon F), condoms (both male and female), injectables (mainly Depo Provera), and implants (Jadelle). For permanent methods (male and female sterilization), clients are referred to the Lundazi District Hospital, where skilled personnel are trained to provide these methods.

In July and August 2010, a national NGO, Society for Family Health (SFH), arranged for skilled personnel to perform IUD insertions for interested clients at the Mwase Lundazi RHC. At the time, Mwase RHC staff indicated that the SFH IUD camps would be regular. However, by the time of writing the initial draft of this report (June 2011) SFH had not returned to Mwase Lundazi. There are no other locally available options for IUD insertion. The head maternal and child health (MCH) nurse at Mwase RHC was trained to perform IUD insertions, though supplies were not available. In theory, the Mwase RHC staff should refer interested clients to the Lundazi District Hospital for IUD insertion, although available information indicates that this does not happen because IUD supplies are not available at Lundazi District Hospital either.

Study population and participant inclusion

The study population included HIV-positive and HIV-negative men and women of reproductive ages (18-50) in the Mwase Zonal Rural Health Center (RHC) catchment area. HIV-positive and HIV-negative survey participants were selected from a sampling frame built from the Mwase RHC ART and VCT registers respectively.

Key Components of the SBCC program

Two sets of SBCC interventions were implemented sequentially.

The first set of interventions focused on the establishment and ongoing strengthening of a FP referral system intended to integrate family planning services into the out-patient department (OPD), ART clinic, and laboratory services at Mwase Zonal Rural Health Centre (RHC). Through this intervention, Mwase RHC staff were trained to ask all clients about their interest in FP, and provide referrals to the FP section accordingly. All clients referred to FP services at Mwase RHC—whether from CBDs in the community or from other sections of the clinic—receive a referral slip. Clients were directed to present the referral slip to the nurse in charge of MCH at the clinic, who then counseled the patients in the various FP methods available to them. This referral system was originally planned for implementation in November 2009, concurrent with the initiation of SBCC activities (see below) but due to implementation challenges at the RHC, was not initiated until February 2010. This component was implemented through the end of the behavior change project in May 2011. High staff turnover at Mwase RHC posed challenges to effective and consistent implementation of the referral system, despite engagement with RHC management and re-orientation of RHC staff.

The second set of interventions included community-based, horizontal communications strategies.

First, a cadre of community-based facilitators was trained to facilitate participatory community dialogues about family planning, sexuality and gender. Training and tools for community facilitators was adapted from CARE's *Social Action and Analysis* (SAA) methodology, with a focus on key concepts around gender and sexuality as well as the use of participatory tools to initiate dialogue and reflection. These facilitated dialogues were used to identify and address barriers to the uptake of FP and utilization of FP services. SBCC facilitators were also trained to conduct one-on-one meetings with interested FP clients.

In November 2009, community health workers from 11 Neighborhood Health Committees (NHCs) received training on the use of SAA strategies to explore social norms around gender, FP and HIV, and to challenge barriers to contraceptive uptake through community dialogues.

SAA dialogues began in December 2009, but were not organized continuously throughout the project period. Due to a perceived lack of community support, SAA facilitators suspended dialogues in February 2010, then resumed them in March 2010 after follow-up training. While the program target was to conduct nine to 15 community dialogues per month, activity reports indicate that only 14 dialogues were conducted in the April-May 2010 period. Further, due to miscommunication among program staff, SAA activities were again suspended in June 2010 in preparation for the midline research study, and resumed in August 2010. In order to re-invigorate the community dialogue process, in September 2010, CARE Zambia recruited a dedicated officer to support SAA. This officer conducted refresher training for facilitators to strengthen SAA implementation and an additional six facilitators were recruited and trained, bringing the total number of facilitators to 22. As a result, 43 community dialogues were held between September 2010 and January 2011.

In January 2011, three additional facilitators were recruited and the group (of 25) was trained to deliver the next SBCC intervention, which consisted of a set of SBCC tools intended to guide community discussions about family planning. The tool ("A Family Planning Dialogue Guide for Community Facilitators") was adapted from a field-tested set of materials originally developed by C-Change project in the Democratic Republic of Congo (DRC). This tool consists of a set of picture codes with simple notes that assists facilitators to use the tools in community dialogues. The guide highlights the benefits of birth spacing using modern family planning methods, addresses common myths and misconceptions about family planning, and provides accurate information about a range of family planning methods, including long-acting contraceptive methods.

Through a consultative process involving CARE Zambia, AED (now FHI 360), and CARE USA, the tool was adapted for the Zambian context. The key messages were informed by findings from the baseline and midline assessments in Zambia, including commonly-held misconceptions and fears about family planning. A local artist was hired to adapt images for the local context. The

guide and picture codes were field-tested in three villages in the project catchment area; in each village the guide was tested with different categories of community members: females 18-29, males 30-50, and community leaders and the elderly. Participants were asked to provide feedback on the clarity, appropriateness, and relevance of the messages and picture codes. Once the guide and codes were finalized, hard copies of the guide and large prints of the picture codes were distributed to each BCC volunteer.

Community educational drama was also initiated in the second phase of the program. Community drama complemented the dialogues. Often, performances preceded community discussions that used the SBCC tool, and helped bring together groups for these discussions as well as to highlight “real-life” examples of issues that were then discussed in the dialogues.

A total of 144 SBCC dialogues using the SBCC tool were conducted from February 2011-May 2011. Six of these dialogues were conducted during PMTCT sessions, by a facilitator who was also a clinic health worker. A total of 34 community skits were conducted in March and April 2011.

Facilitators faced several challenges in implementing both the SAA and BCC dialogues. Though the dialogues were designed to target young couples and traditional or community leaders, facilitators often had difficulty recruiting young participants. Young married people—particularly women—were reticent to discuss sex and FP in the presence of in-laws or community elders. The situation was compounded when facilitators tried to conduct mixed-sex groups. To circumvent these issues, facilitators attempted to conduct several same dialogues segregated by age and sex, simultaneously in the same community. However, communities resisted this segregation and facilitators found it too logistically challenging to manage. Elderly community members were also often reluctant to participate in dialogues, due to the beliefs that FP was no longer relevant in their lives and that their generation was unfamiliar with such practices. Generally, women were more likely to participate in SAA and BCC dialogues than men.

An important challenge for the project overall was the limited, inconsistent supply of FP methods at Mwase RHC and in the community. Though field reports suggested that the three interventions were successful in generating an increased demand for FP—specifically pills and condoms—the supply at Mwase RHC was often insufficient to meet this demand. Because CBDs were supplied by the clinic, shortages at the clinic also meant shortages in the community, so that facilitators who were successful in generating FP demand were often frustrated by an inability to supply potential new users with methods. These issues are discussed further in Chapter 6, and should be noted for contextualizing project data on FP uptake.

Other FP communication programs in project area

Activities similar to those conducted by the pilot intervention above were also carried out by other organizations in the community. Africare, for example, employed volunteers (many of

whom were the same individuals who worked for C-Change as facilitators) to conduct community-based meetings on safe motherhood. The national NGO SIDAS also used community meetings under its PMTCT programming in the project area, as did the national NGO Thandizani for its HIV/AIDS awareness programs.

Mwase RHC also occasionally conducts its own community-based outreach, and has in the past used community meetings to promote male involvement in PMTCT. Given the variety of community-based activities, it is not feasible to determine how much of the exposure to information on FP and HIV through meetings (as presented in Tables 7.3 and 7.4) could be attributed to the C-Change project.

In addition to conducting community-based meetings, CHWs such as government CBDs visit community members individually. BCC volunteers were also trained to conduct one-on-one consultations with community members on request, or in cases in which a couple disagreed on FP use. Volunteers did not record information on the number of such one-on-one visits, thus there is no data on the intensity of this component of the BCC strategy.

CHAPTER 2: THE RESEARCH STUDY

This C-Change project was designed as action research study undertaken by CARE and AED (now FHI 360). Approval to conduct the study was granted by ERES Converge in Zambia and the AED IRB committee in the USA. The main objective of the C-Change study was to determine the effects of community-informed and community-based communication strategies on FP uptake and the social norms that influence it, particularly among HIV-positive individuals.

For the purposes of this report, social norms are defined as the community's expectations about how men and women should behave. Many of the norms discussed here are gender-specific—that is, they describe the ways in which men and women are expected to behave because they are men or women.

The study used a single time-series research design, with interventions introduced one at a time over the duration of the project period (November 2009-May 2011). Service data were analyzed for each intervention period to determine any changes in contraceptive uptake (measured by the quantity of contraceptives distributed by type, and couple-years of protection, or CYP). In addition to the service records, information on FP use and gender social norms was obtained through baseline, midline and endline community-based surveys and focus group discussions (FGD). Data were collected using a standardized interviewer-administered pre-coded questionnaire and qualitative interview guides.

The survey population included HIV-positive and HIV-negative men and women of reproductive ages (18-50). The protocol outlined sample targets of 120 male and 120 female individuals at each survey round (baseline, midline, and endline). A household-based selection of respondents was found to be inadequate for this study for two reasons: First, because no blood

specimens were collected (no biomarkers), it would be infeasible to determine the HIV status of respondents. Secondly, even if blood specimens were collected, the household-based sample selection approach might not yield adequate numbers of either group to enable meaningful analysis of data. Consequently, the ART and VCT registers of the Mwase Zonal Rural Health Center (RHC) were used as the sampling frames for HIV-positive and HIV-negative participants, respectively. For the HIV-positive sub-sample, separate lists of male and female patients within the age range were generated from the ART register, followed by random selection of about 50 HIV-positive males and females each. For the HIV-negative sub-sample, separate lists of male and female clients aged 18-49 with non-reactive HIV test results were generated from the VCT register, followed by random selection of about 70 HIV-negative males and females for the baseline survey, and 50 each for the midline survey. For the baseline and midline surveys, sample selection followed the research protocol.

This report outlines results from the endline survey conducted in May 2011, 18 months after the beginning of program implementation. The primary objective of the endline survey was to document the effects of the C-Change project, particularly with respect to reaching the target population with interventions and promoting changes in FP uptake and norms around contraceptive use. Because of limited numbers of ART and VCT clients at the time of the endline survey, sample selection for the endline deviated slightly from the protocol, and is described in greater depth below.

Sampling

As with the baseline and midline surveys, potential survey participants for the endline survey were selected from Mwase RHC clinic records. For the HIV-positive sub-sample, thorough records of all patients currently undergoing HIV care and treatment (ART) yielded 53 female and 50 male HIV-positive clients who met the age and residence criteria for study inclusion. All of these potential participants were selected for the survey. The final sample of successfully completed interviews comprised 35 female and 32 male HIV-positive respondents out of the planned 50 female and 50 male HIV respondents respectively. The two primary reasons for not meeting the target were incorrect/unidentifiable names and addresses of potential respondents, as well as the fact that many potential respondents had moved to new residences outside of the Mwase Lundazi catchment area.

Although the study protocol outlined that HIV-negative participants should be drawn from VCT records for the two months preceding the survey (in order to limit the number of respondents who might have contracted the virus since they last tested negative for HIV), VCT records for the two months preceding the endline study did not yield sufficient numbers of potential participants. As a result, the sampling time frame was extended to include the six months preceding the survey. A review of these records yielded 82 female and 83 male HIV-negative clients who met the age and residence criteria. As with the HIV-positive sub-sample, no randomization was performed for sample selection, and the complete list of potential participants was selected for the survey. In view of the preference for most-recently tested individuals (to avoid cases of post-test infection), replacements for HIV-negative respondents

were purposively selected from the most recent month (April 2011) moving backwards. Ultimately, data from successfully completed interviews with 59 female and 70 male HIV-negative respondents were included in the endline sample.

Selected participants were assigned unique participant ID codes. To protect participants' HIV status, only the research management team (the PI, M&E Officer, and SAA Officer) knew the relationship between a participant's unique ID code and his/her status. Replacements were drawn initially from the original sample frames, but as replacement needs exceeded the number of individuals available in the original frame, additional names were added from those who registered between the time the initial sample selection was made and the time data collection took place (May 2011).

Interviewer training

13 potential research assistants (RAs) were identified, including three RAs who had participated in the baseline and midline surveys; one potential RA dropped out at the beginning of the training period, leaving 12 RA candidates. Per standard project practice, the nine new RAs completed Family Health International's (FHI) online research ethics training curriculum; the three returning RAs had already undergone the same training. All 12 candidates completed a four-day training conducted by the Technical Advisor from CARE USA and the M&E Officer and the SAA Officer from CARE Zambia, using training modules adapted by AED. The training content detailed the study background, objectives, design, survey data collection tools, data security and confidentiality, and informed consent procedures.

The training was divided into qualitative and quantitative sections, and involved extensive role play and practice by the 12 RA candidates, with in-depth discussion on issues such as the rights of potential participants and accurate translation. From the 12 trained RAs, four who demonstrated competence in qualitative data collection after successfully completing field tests of the FGD exercise —two male and two female— were assigned to FGD data collection. The remaining eight RAs demonstrated competence in quantitative data collection through successful completion of two pre-test surveys (one male and one female each) in a neighbouring community. These eight comprised the quantitative data collection team. After the field pre-test, the study team and trainees refined survey tools with special attention to translation accuracy and skip patterns.

All 12 participating trainees were deployed to the field; one among them served as a field supervisor to coordinate daily operations and assist the M&E Officer in checking data quality. The SAA Officer was responsible for coordinating FGDs and supervising transcription of FGD data. The Principal Investigator from AED/FHI 360 provided technical support during the data collection process, as well as data validation through random visits to interviewed participants.

Introduction of field team to the study site

Preliminary meetings were held with key community representatives (CHWs, community volunteers, and clinic staff) before the start of data collection. The meetings served to: 1) introduce the data collectors to the communities; 2) prevent misconceptions among participating communities about the intentions and outcomes of the research; and 3) secure accommodation for the RAs. In addition, starting in April 2011, the SAA Officer used BCC dialogues as a forum to inform communities about the upcoming research.

Data collection and constraints

Data collection was divided into two parts: quantitative, using a standardized survey questionnaire, and qualitative, using a FGD guide. Data were collected concurrently by two different data collection teams. Both data collection instruments contained questions in English, and translation of the same in Chewa, the predominant local language.

Quantitative: Survey data were collected over a 20-day period, beginning on May 2, 2011. For efficiency and ease of movement, potential respondent lists were grouped by neighbourhood health committee (NHC)—an administrative area comprising a cluster of villages. Movement strategies were collaboratively proposed by the RA supervisor, M&E Officer, and SAA facilitator. RAs were provided with bicycles and driven to central locations within the 12 NHCs to canvas the area. The team worked weekends as well as early mornings and evenings to guarantee inclusion of working respondents.

All interviews were conducted in Chewa, with the exception of a small number of cases in which respondents expressed greater familiarity with English and requested that the interview be administered in English.

The survey team faced a variety of challenges recruiting study participants. Data were collected during the harvest season. Though originally this was viewed as an ideal time to conduct interviews, as most individuals would be home to contribute to harvesting activities, RAs found that in fact many respondents used the end of the harvest season to travel to other towns, visit relatives, etc.

In addition, RAs reported frequently encountering drunk potential respondents who were judged incapable of providing a complete and accurate interview. Whenever possible, follow-up appointments were scheduled.

Due to a shortage of female interviewers, around one third of the total interviews with female respondents were conducted by male interviewers.

Finally, many respondents could not be located (VCT clients as compared to ART clients have no incentive to provide accurate addresses, so this could reflect efforts by VCT clients to maintain secrecy and avoid stigma), while some had died, moved, or were found to be under or over age. The result of this combination of challenges was that the original sample frame had to be supplemented and the ultimate sample size reduced.

Qualitative: Ten FGDs were conducted over 12 days (May 2, 2011 through May, 13, 2011) in four NHCs, selected on the basis of their proximity to the Mwase RHC and their size. To ensure a cross section of participants, two NHCs were selected because they were large and located close to the health center, while two were selected because they were further from the health center. The first two FGDs were treated as a pre-test of the qualitative guide and were not tape-recorded. Of the remaining eight FGDs, two each were conducted with men and women ages 18-29 and 30-49, respectively.

Participants for the FGDs were selected with the help of SAA and BCC volunteers. On the day before a FGD was scheduled to take place, a volunteer visited the community and met with the village headman to explain the research activity and identify potential participants. Facilitators identified potential participants based solely on meeting age criteria (either 18-29 or 30-49), and explained to those interested participants the basics of the study and the opportunity to participate in a discussion the following day.

On the day of the scheduled FGD the research team (two male RAs, two female RAs, and the SAA Officer) arrived in the village to further explain the study and screen interested participants. In addition to the previously mentioned age criteria, community members were identified as eligible to participate in the FGD only if they had not taken part in a CARE-sponsored community dialogue in the two weeks preceding the study. Efforts were also made to exclude members of the community who held positions of authority from the discussions, to prevent such power dynamics from determining the course of the discussions.

Once a group of eligible participants had been identified, the research team led potential participants through the informed consent process. In cases in which the research team found a group of interested participants already assembled, the informed-consent script was read to the whole group, questions were elicited, and consent forms were signed and consent was granted individually. In other cases, the informed-consent process was conducted on an individual basis.

Data management, entry and analysis

Quantitative: Data quality was checked on a daily basis, with the RA supervisor conducting initial reviews of all completed surveys. Secondary review was completed by either the M&E Officer or the Principal Investigator from AED. Reviewers checked for internal consistency and completeness. This process not only contributed to data quality assurance, but also contributed to overall RA competence by providing on site supervision and feedback. Whenever possible, missing data were collected by RAs using follow-up visits to respondents. Surveys that had passed the double review process were transferred to the Lundazi CARE office, where they were securely stored until data entry.

Survey data were entered into an EPI-INFO database, using screens with consistency and range checks, and cleaned. Data were analyzed using SPSS. Data analysis was focused on determining

current levels of key indicators—social norm indicators, approval for FP, and knowledge and use of contraception—and associations between outcome indicators and participants’ demographic characteristics, with particular attention to changes since the baseline study (accounting for inter-survey differences in the baseline and endline samples).

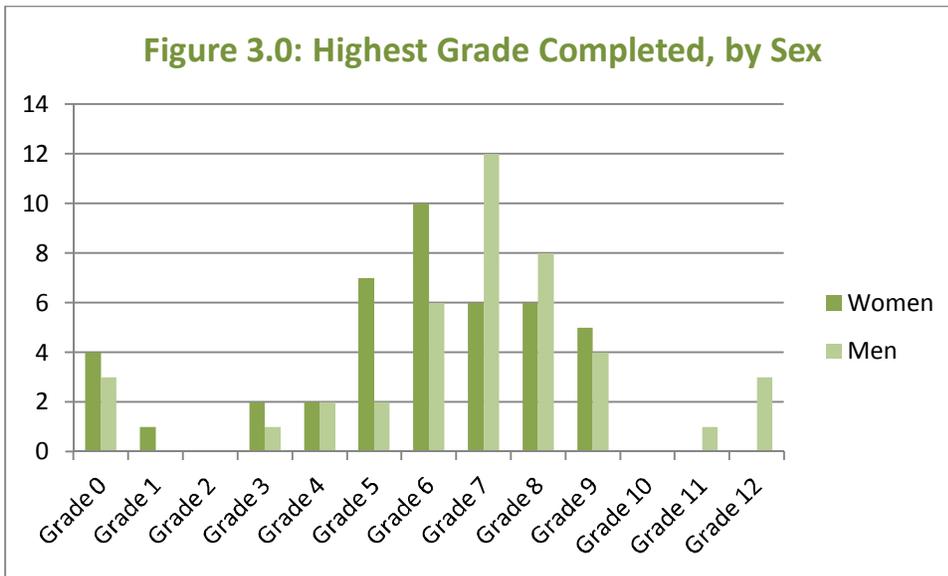
Mwase RHC monthly FP service statistics were entered into an EXCEL database, and the couple-years of protection (CYP) estimated using the USAID formula. The CYP is the estimated protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or distributed to clients during that period. The CYP is usually calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation took into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized. After conversion, CYPs for each method were summed to obtain a total CYP figure for that population.

Qualitative: Data from all ten FGDs were included in the analyses since review of the 2 test interviews indicated they contained substantially useful data. The 8 audio-taped were translated from Chewa (the local language in Lundazi district) into English by the facilitators as they were transcribed verbatim onto Microsoft Word documents. Complete field notes of the two non-audio-taped FGDs were similarly translated and transcribed into Microsoft Word. The co-Principal Investigator (co-PI), together with the SAA Officer who led the qualitative RAs, reviewed initial transcripts for content, interviewing, and transcription quality. Reviewed transcripts were shared with other study investigators, who also provided feedback to improve remaining discussions.

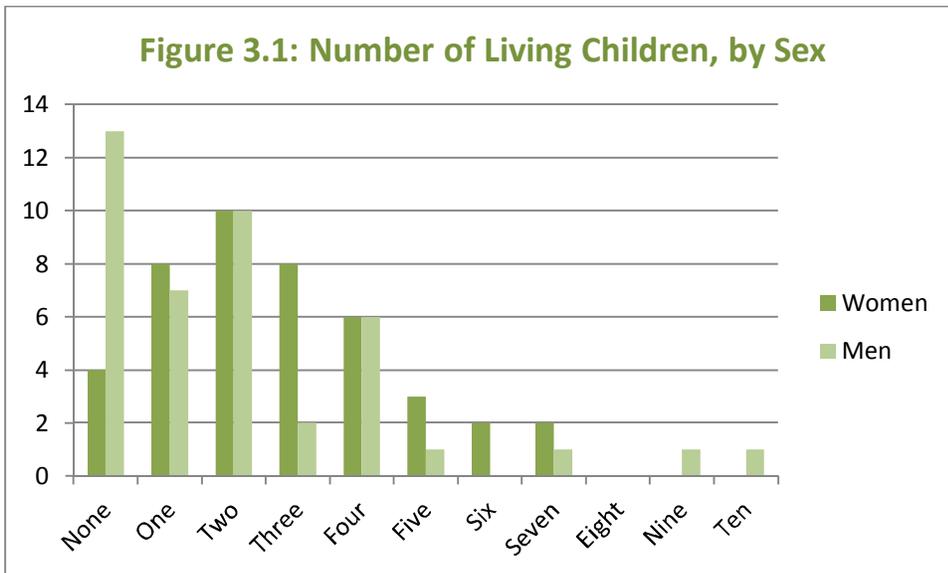
FGD transcripts were read by the co-PI after which a preliminary code book was developed by the co-PI in consultation with the SAA Officer. All ten FGD transcripts were uploaded into NVIVO for coding; the coding was subject to revision throughout the analysis process as themes emerged from the data. Data coding was performed by a CARE USA consultant in consultation with the SAA Officer; the two worked collaboratively to identify predominant themes and relationships as well as prepare display matrices for major themes.

CHAPTER 3: DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF RESPONDENTS

A total of 85 respondents participated in ten FGDs (43 women and 42 men). The median age among women was 28 and was 27 among men. Among women, 91 percent were married, while 74 percent of men were married. Median highest grade completed was six among women and seven among men.



Median number of living children among both men and women was two, and ranged from zero to ten among men and zero to seven among women.



A total of 196 respondents participated in the endline survey: 102 men and 94 women, representing 42 percent and 48 percent of the total sample, respectively. Among male respondents, 31.4 percent (n=32) were HIV-positive, while among female respondents 37.2 percent (n=35) were HIV-positive.

Table 3.0 below shows the age distribution of endline survey respondents by sex and HIV status. The median ages for the male (35.5) and female (34.3) samples are similar.

Within the endline male sample, age distribution differed by HIV status. The sub-sample of HIV-negative respondents was younger (55 percent were between the ages of 18 and 34) than the HIV-positive sub-sample, where 87.5 percent of respondents were between 35 and 50 years old. Age distribution differences between HIV -positive and HIV-negative male respondents were statistically significant ($p<.001$) when ages were grouped into three categories (18-24, 25-34, 35-50). There were no statistically significant differences by status for the endline female sample.

Table 3.0: Percent distribution of respondents by background characteristics and HIV status

| | Male | | | Female | | |
|-------------------------------------|-------------|-----------------------|------------------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Age of Respondents | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| 18-19 | 3.1 | 0.0 | 1.0 | 0.0 | 3.4 | 2.1 |
| 20-24 | 0.0 | 18.6 | 12.7 | 11.4 | 15.3 | 13.8 |
| 25-29 | 3.1 | 17.1 | 12.7 | 14.3 | 15.3 | 14.9 |
| 30-34 | 6.3 | 18.6 | 14.7 | 11.4 | 18.6 | 16.0 |
| 35-39 | 28.1 | 17.1 | 20.6 | 22.9 | 18.6 | 20.2 |
| 40-44 | 37.5 | 12.9 | 20.6 | 20.0 | 20.3 | 20.2 |
| 45-49/50 | 21.9 | 14.3 | 16.7 | 20.0 | 8.5 | 12.8 |
| Don't know | 0.0 | 1.4 | 1.0 | 0.0 | 0.0 | 0.0 |
| No response | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Median age | 39.8 | 33.6 (n=69) | 35.5 (n=101) | 35.6 | 33.5 | 34.3 |
| Ever attended school | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 96.9 | 90.0 | 92.2 | 97.1 | 93.2 | 94.7 |
| Highest level of education | N=31 | N=63 | N=94 | N=34 | N=55 | N=89 |
| Primary | 51.6 | 61.9 | 58.5 | 79.4 | 83.6 | 82.0 |
| Secondary and higher | 48.4 | 38.1 | 41.5 | 20.6 | 16.4 | 18.0 |
| Ever married | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 100.0 | 96.3 | 98.0 | 100.0 | 93.5 | 96.9 |
| Median age at first marriage | N=31 | N=65 | N=102 | N=32 | N=53 | N=85 |
| | 23.1 | 21.4 | 22.0 | 18.1 | 17.4 | 17.6 |

| Religion | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
|------------------|-------------|-------------|--------------|-------------|-------------|-------------|
| Catholic | 18.8 | 18.6 | 18.6 | 20.0 | 27.1 | 24.5 |
| Protestant | 71.9 | 72.9 | 72.5 | 71.4 | 64.4 | 67.0 |
| Muslim/other | 9.4 | 8.6 | 8.8 | 8.6 | 8.5 | 8.5 |
| Ethnicity | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| Chewa | 28.1 | 34.3 | 32.4 | 22.9 | 15.3 | 18.1 |
| Tumbuka | 53.1 | 55.7 | 54.9 | 71.4 | 69.5 | 70.2 |
| Ngoni | 15.6 | 8.6 | 10.8 | 5.7 | 5.1 | 5.3 |
| Other | 3.1 | 1.4 | 2.0 | 0.0 | 10.2 | 6.4 |

Comparisons between the baseline and endline samples showed no statistically significant differences in ages or age distributions. Figures 3.2 and 3.3 below summarize female and male age distributions across assessments.

Figure 3.2: Percent distribution of baseline, midline, and endline female sample by age group

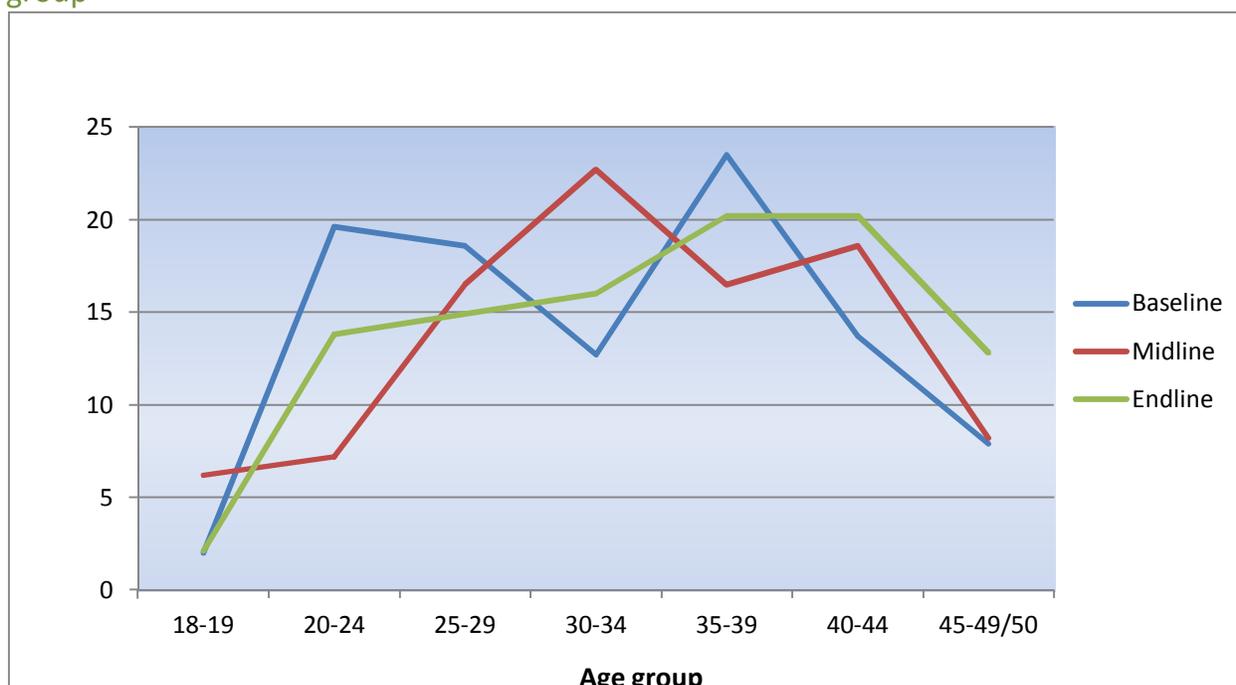
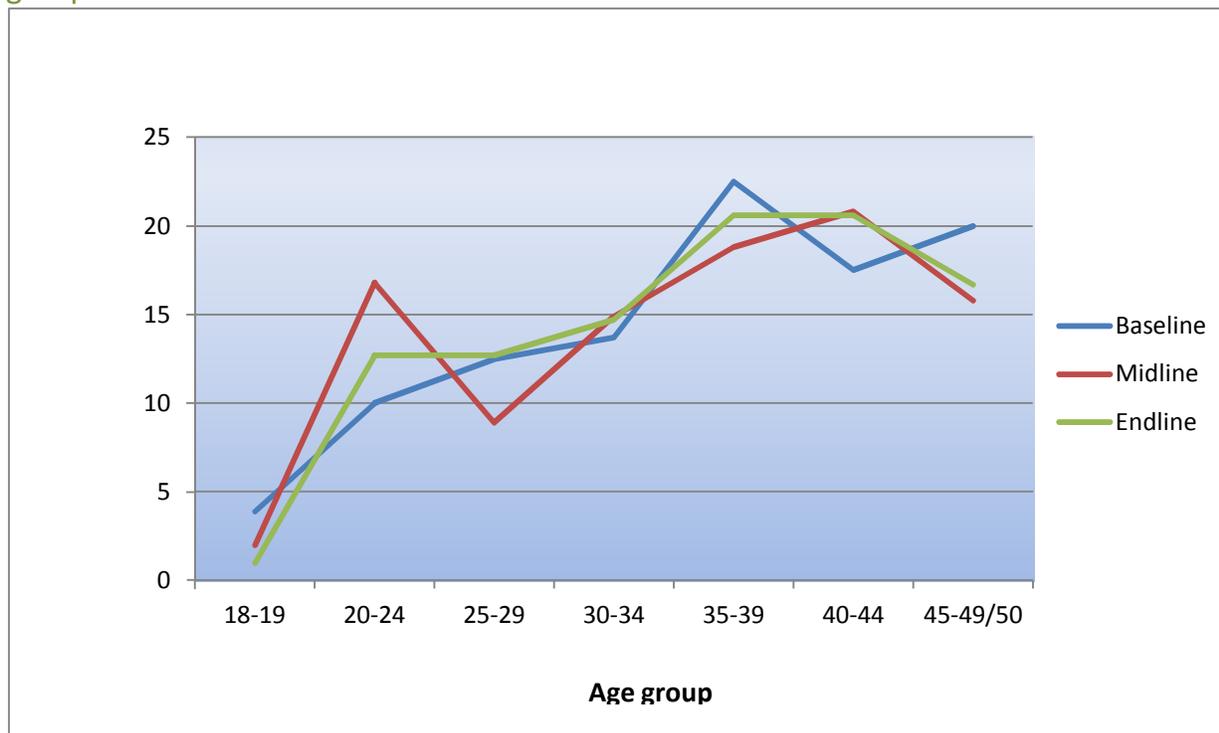


Figure 3.3: Percent distribution of baseline, midline and endline male sample by age group



Similar proportions of men (92.2 percent) and women (94.7 percent) in the endline survey sample reported having ever attended school. Among those who attended school, male respondents (41.5 percent) were more likely to have completed secondary school or higher than female respondents (18.0 percent). Within the male and female samples, educational attainment did not differ significantly by HIV status.

Inter-survey comparisons revealed that higher proportions of the endline female survey respondents (94.7 percent) had ever attended school, compared to the baseline female survey respondents (83.3 percent). This difference held for HIV-negative respondents when ever-attendance was analyzed by status: 93.2 percent of endline female HIV-negative respondents reported having ever attended school, compared to just 76 percent of baseline female HIV-negative respondents. Differences were statistically significant for the overall female sample ($p=.012$) and the HIV-negative female sub-sample ($p=.011$). These important differences between the baseline and endline samples should be considered when interpreting results comparing outcomes for women at baseline and endline, as education levels are known to be associated with FP uptake and may also influence other key variables such as knowledge about FP, attitudes toward gender norms, etc.

Overall, females in the endline survey reported earlier age at marriage compared to baseline female respondents. Mean age of marriage at endline was 17.6 years compared to 19.2 at

baseline ($p=.053$). This difference holds for HIV non-infected female respondents whose mean age of marriage was 17.4 at endline and 18.6 at baseline ($p=.066$).

The endline female sample also differed significantly from baseline female respondents by religion. While baseline female respondents identified as only Catholic or Protestant, a small proportion of endline female sample (8.5 percent) identified as Muslim or “other.” This difference was statistically significant ($p=.011$) and was also true for endline female HIV-positive respondents ($p=.099$) when analyzed by status.

Both endline male and female respondents reported higher levels of exposure to TV and radio than males and females in the baseline sample (Table 3.1.) —levels that were at times significantly higher when compared to baseline. For exposure to TV, statistically significant differences applied to female respondents overall ($p<.001$), HIV-positive female respondents ($p<.001$), and HIV-negative female respondents ($p=.004$), as well as male respondents overall ($p=.002$) and HIV-negative male respondents ($p=.004$).

Females in the endline sample also indicated higher exposure to radio than did baseline female respondents ($p=.001$); differences remained significant for female HIV-positive respondents ($p=.034$).

These increases may reflect greater availability of communication media over time in the population, or could indicate a slightly higher socioeconomic status of the endline sample. Irrespective of the source of the difference in exposure, exposure to media is often associated with greater levels of information and knowledge about family planning and exposure to different value systems, including attitudes and beliefs about gender. These differences in exposure to media must, therefore, also be considered when interpreting the baseline and endline results.

Table 3.1: Frequency of exposure to TV and radio, by sex and HIV status

| | Male | | | Female | | |
|-----------------------|-------------|-------------|--------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Radio | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| Every day | 50.0 | 54.3 | 52.9 | 51.4 | 49.2 | 50.0 |
| At least once a week | 18.8 | 27.1 | 24.5 | 22.9 | 30.5 | 27.7 |
| Less than once a week | 9.4 | 12.9 | 11.8 | 11.4 | 1.7 | 5.3 |

| | | | | | | |
|-----------------------|-------------|-------------|--------------|-------------|-------------|-------------|
| Not at all | 21.9 | 5.7 | 10.8 | 14.3 | 18.6 | 17.0 |
| TV | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| Every day | 6.3 | 4.3 | 4.9 | 5.5 | 5.1 | 5.3 |
| At least once a week | 18.8 | 27.1 | 24.5 | 37.1 | 23.7 | 28.7 |
| Less than once a week | 12.5 | 24.3 | 20.6 | 20.0 | 16.9 | 18.1 |
| Not at all | 62.5 | 44.3 | 50.0 | 37.1 | 54.2 | 47.9 |

The distribution of other socio-demographic characteristics—marital status (measured as ever-married) and ethnicity—did not differ significantly by sex or HIV status in the endline sample and closely mirrored distributions from the baseline sample.

CHAPTER 4: SEX AND CHILDBEARING

This chapter presents data about the fertility-related behaviors of respondents as well as some of the underlying attitudes and perceptions that influence respondents' decisions related to sex and childbearing.

Data from inter-survey comparisons indicate several important changes among female respondents between project baseline and endline surveys. At endline, female respondents expressed lower future fertility desires than female respondents at baseline. Female respondents at endline also reported that they perceived community norms about family size to be lower than did female respondents at baseline. As noted above, when interpreting these results, it is important to note that some of these differences may be associated with the slightly higher educational status or the higher exposure to mass media among the endline female sample.

Age at first sexual experience

All respondents who reported having ever had sex (100 percent of male respondents and 98.9 percent of female respondents) were asked to state their age of sexual debut; their responses are summarized in Table 4.0. Overall, female respondents reported earlier age at debut as compared to male respondents, with 53.8 percent of female respondents having had sex before

the age of 17, compared to 42.2 percent of male respondents. HIV-positive female respondents reported a slightly later age of sexual debut than their HIV-negative counterparts.

Though early age at first sex is typically a risk factor for HIV infection, it is important to note that in Zambia the association is reversed. Data from the 2007 DHS show very clearly for women—and for men to some extent—that HIV prevalence tends to be higher among those whose first sex occurred in later age categories compared to earlier ones.¹³

Table 4.0: Age at first sexual intercourse, by sex and HIV status

| Age category | Male | | | Female | | |
|----------------------------------|------------------|------------------|----------------|------------------|------------------|---------------|
| | Positive N=32 | Negative N=70 | Total N=102 | Positive N=35 | Negative N=58 | Total N=93 |
| Below 15 | 15.6 | 10.0 | 11.8 | 8.6 | 17.2 | 14.0 |
| 15-17 | 25.0 | 32.9 | 30.4 | 37.1 | 41.4 | 39.8 |
| 18-19 | 28.1 | 17.1 | 20.6 | 37.1 | 17.2 | 24.7 |
| 20-24 | 6.3 | 21.4 | 16.7 | 5.7 | 10.3 | 8.6 |
| 25+ | 9.4 | 5.7 | 6.9 | 0.0 | 1.7 | 1.1 |
| Don't know | 15.6 | 12.9 | 13.7 | 11.4 | 12.1 | 11.8 |
| Median age at first sex | N=27 | N=61 | N=88 | N=31 | N=51 | N=82 |
| | 17.6 | 17.8 | 17.8 | 17.0 | 16.6 | 16.7 |
| First sex before marriage | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 56.3 | 57.1 | 56.9 | 25.7 | 23.7 | 24.5 |

¹³ For women, HIV prevalence was highest at 21.0 percent among those who had first had sex at age 20 or older, compared to 17.5 percent for under 16, 17.5 percent for 16-17, and 17.7 percent for 18-19. For men, prevalence was highest at 16.4 percent among those whose first sex fell between the ages of 18-19, compared to 12.8 percent for under 16, 12.9 percent for 16-17, and 13.9 percent for 20+. (Central Statistical Office (CSO), Ministry of Health (MoH), Tropical Diseases Research Center (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*).

When respondents' reported age at first sex was compared to their reported age at marriage, results show that more than twice as many male respondents as female respondents had pre-marital sex (56.9 percent compared to 24.5 percent). Engagement in sex before marriage did not differ significantly by HIV status.

The high prevalence of sex before marriage as documented in the quantitative data is of note, given the commonly expressed community belief that unmarried youth should not be having sex, and thus do not need information on sex or FP or access to FP services. Negative attitudes towards premarital sex were reported by community dialogue facilitators in the field and confirmed in focus group discussions.

Table 4.1: Median age at first sexual intercourse in the baseline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=23 | N=39 | N=62 | N=30 | N=32 | N=62 |
| | 18.1 | 17.9 | 18.0 | 17.5 | 18.3 | 17.9 |
| Endline | N=27 | N=61 | N=88 | N=31 | N=51 | N=82 |
| | 17.6 | 17.8 | 17.8 | 17.0 | 16.6 | 16.8 |

A dominant theme in FGD was the idea that family planning is only socially acceptable for married people. One young female participant pointed out a perceived contradiction between the term “family planning” and its practice by those who are not yet married: *“It is not allowed for a young unmarried woman to use family planning. Which family is she planning?”* (female, 18-29). The notion that FP is inappropriate for unmarried youth came up in almost all of the female FGD, including all three of the young (18-29) female groups, again indicating that this is a widely held community belief. Despite this, there were accounts that some young women did feel self-efficacious enough to discretely take some actions toward claiming their fertility rights and accessing family planning.

Qualitative data reveal the extent of negative community perceptions of the use of family planning by unmarried individuals, and the gender biases inherent within them. Focus group facilitators introduced the separate cases of a young unmarried man using FP and a young unmarried woman using FP. A common reaction was that it is unacceptable for young unmarried men or women to use FP (mentioned in 8 of 10 groups) and those doing so,

regardless of their sex, were considered to be prostitutes or promiscuous. Female groups reported greater negative perceptions of young unmarried women using family planning than their male counterparts.

However, all of the groups cited exceptions or reasons for which it might be considered acceptable for unmarried youth to use FP. Participants articulated different reasons for allowing these exceptions, which were related to gendered norms and expectations of women and men.

Some focus group participants indicated that it was acceptable for an unmarried girl student to use FP so that she can avoid pregnancy and continue her education. As one older male participant stated, *“The thing is, that girl is okay preventing pregnancy because she wants to further her education, and by so doing she will eventually come to help us in the community”* (male 30-49).

Similarly, focus group participants expressed that it might be acceptable or even desirable for unmarried men to use FP. Several participants expressed the belief that young men have strong sexual needs that must be met, and that they should protect themselves from HIV and/or problems that come with impregnating a woman they are not married to: *“He has made a decision to protect himself from diseases so that even if he runs around with a lot of women he will be safe”* (male 30-49). An older female participant explained, *“It is okay for a man to use family planning. In fact it is a good thing for him because men have high sexual feelings”* (female 30-49).

Sexual activity in the last 12 months

Men in the endline sample indicated higher levels of sexual activity than female respondents, with 91.2 percent of male and 79.6 percent of female respondents reporting that they had had sex in the last 12 months. HIV-positive male respondents reported significantly less sexual activity than their HIV-negative counterparts: 78.1 percent of HIV-positive male respondents had had sex in the previous 12 months compared to 97.1 percent of HIV-negative male respondents. This difference was statistically significant ($p=.004$). Fewer HIV-positive female respondents also reported sexual activity in the 12 months before the survey compared to their HIV-negative counterparts (74.3 percent compared to 82.8 percent), though the difference was not statistically significant. Although lower proportions of HIV-positive respondents overall reported having had sex in the year before the survey, sexual activity in the HIV-positive population is high, with approximately three-quarters of all HIV-positive respondents reporting sexual activity in the previous 12 months.

Number of living children

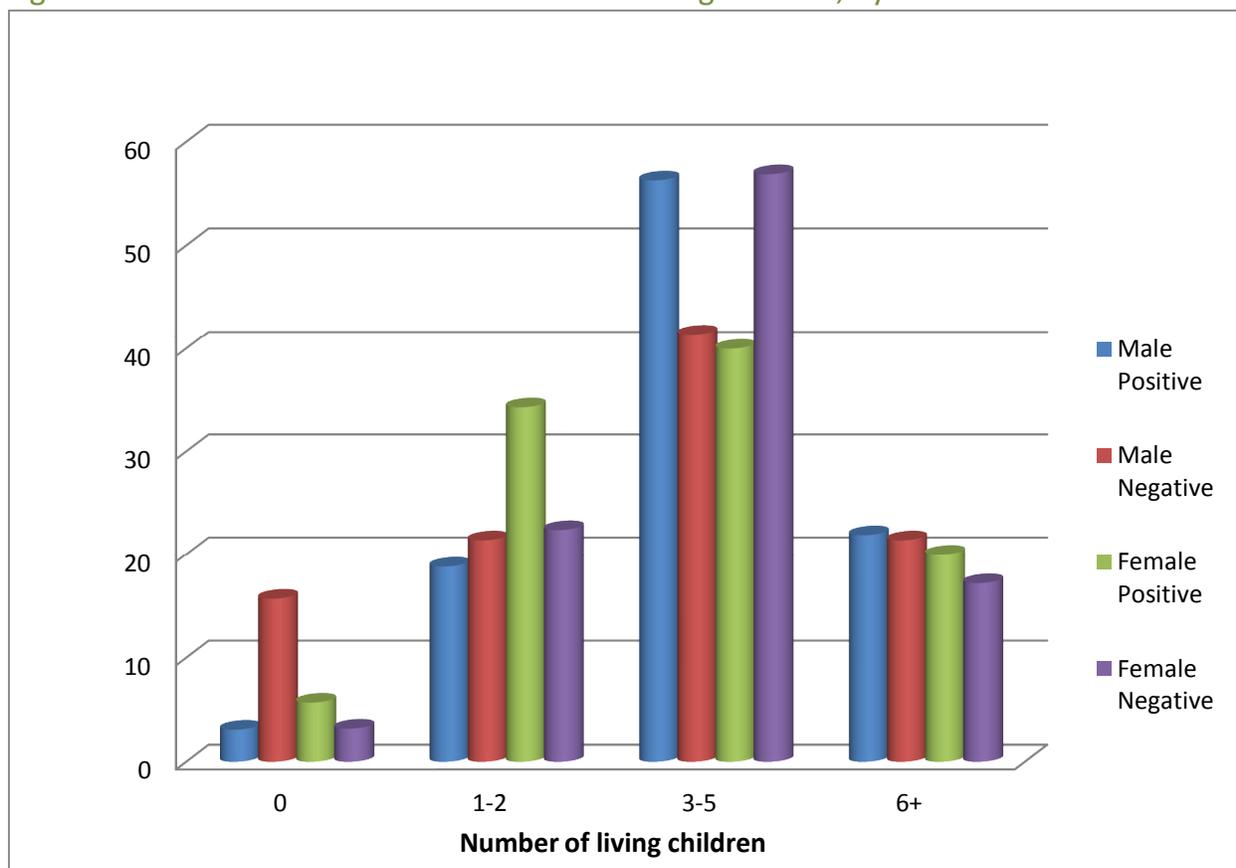
Table 4.2 shows the distribution of respondents by the number of living children. The greatest proportions of both male (46.1 percent) and female (50.5 percent) respondents reported having three to five children. Approximately one fifth of both male (21.6 percent) and female (18.3 percent) respondents had six or more children.

Table 4.2: Percent distribution of respondent's number of living children, by sex and HIV status

| | Male | | | Female | | |
|----------------------------------|-------------|-------------|--------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Number of living children | N=32 | N=70 | N=102 | N=35 | N=58 | N=93 |
| 0 | 3.1 | 15.7 | 11.8 | 5.7 | 3.4 | 4.3 |
| 1-2 | 18.8 | 21.4 | 20.6 | 34.3 | 22.4 | 26.9 |
| 3-5 | 56.3 | 41.4 | 46.1 | 40.0 | 56.9 | 50.5 |
| 6+ | 21.9 | 21.4 | 21.6 | 20.0 | 17.2 | 18.3 |

As Figure 4.0 illustrates, the distribution of number of living children among HIV-positive and HIV-negative respondents is overall similar. A greater proportion of HIV-negative female respondents compared to HIV-positive female respondents reported having three to five children (56.9 percent compared to 40.0 percent). Among endline male sample the converse was true, with more HIV-positive respondents indicating greater numbers of children than HIV-negative respondents (56.3 percent of HIV-positive males reported having three to five children compared to just 41.4 percent of HIV-negative males). Fitting this pattern, larger proportions of male HIV-negative respondents reported having zero children compared to their HIV-positive counterparts (15.7 percent compared to 3.1 percent).

Figure 4.0: Percent distribution of number of living children, by sex and HIV status



Desire for last pregnancy

Female survey respondents who were pregnant at the time of the survey or had at least one living child were asked to characterize their desire for their last pregnancy. Table 4.3 presents the distribution of women’s desire for their last pregnancy by number of living children as well as by HIV status. The majority of respondents overall and within the HIV-positive and HIV-negative sub-samples either did not want to be pregnant, wanted to wait, or had not thought about it—pointing to a clear unmet need for FP in the population.

Table 4.3: Percent distribution of women’s desire for last pregnancy, by number of living children and HIV status

| Desire for last pregnancy | 0-2 | 3-5 | 6+ |
|---------------------------|------|------|------|
| | N=29 | N=47 | N=17 |

| | | | |
|-----------------------------|------|------|------|
| Wanted to be pregnant | 58.6 | 42.6 | 23.5 |
| Wanted to wait | 6.9 | 25.5 | 17.6 |
| Did not want to be pregnant | 17.2 | 23.4 | 41.2 |
| Did not think about it | 17.2 | 8.5 | 17.6 |

Positive **Negative** **Total**
N=36 **N=57** **N=93**

| | | | |
|-----------------------------|------|------|------|
| Wanted to be pregnant | 39.7 | 47.4 | 44.4 |
| Wanted to wait | 29.4 | 12.3 | 18.9 |
| Did not want to be pregnant | 24.1 | 22.8 | 23.3 |
| Did not think about it | 6.7 | 17.5 | 13.3 |

When analyzed by the number of living children, only the majority of survey respondents with two children or less indicated that they had wanted to be pregnant at the time of their last pregnancy. The proportion decreases as the number of children increases. Correspondingly, the proportion of respondents who explicitly did not want to be pregnant increases with the number of living children.

Similar proportions of HIV-positive women and HIV-negative women indicated that they had wanted to be pregnant at the time of their last pregnancy. At the same time, a slightly higher proportion of HIV-positive women indicated that they had wanted to delay or avoid their last pregnancy as compared to their HIV-negative counterparts (53.5 percent of HIV-positive women compared to 35.1 percent of HIV-negative women). These two findings tend to underscore the global drive for integrated reproductive health programs and informed the pilot study in Lundazi.

Focus group discussions, however, indicate that there are mixed attitudes toward HIV-positive couples pursuing fertility. Participants in men’s and women’s groups of both ages articulated the belief that HIV-positive individuals should not have children, because they should avoid transmission and because of their higher likelihood of leaving behind orphaned children. On the other hand, some participants from focus groups with men expressed support for what they perceived as the natural fertility desires of HIV-positive couples: *“We will support them, why stop them?”* (male, 18-29).

Desire for children

As a measure of the potential demand for FP in the population, female survey respondents were asked about their desire to have another child, or to have a child if they had not yet had any. More than half of all respondents (55.9 percent) indicated that they wanted no more children; distributions were similar for HIV-positive and HIV-negative respondents.

Table 4.4: Percent distribution of women’s desire for a/another child in the baseline and endline samples, by HIV status

| | Female | | |
|---------------------|-------------|-------------|--------------|
| | Positive | Negative | Total |
| Baseline | N=52 | N=49 | N=101 |
| A/another child | 34.6 | 38.8 | 36.6 |
| No/no more children | 44.2 | 38.8 | 41.6 |
| Can’t get pregnant | 3.8 | 6.1 | 5.0 |
| Undecided | 17.3 | 16.4 | 16.8 |
| Endline | N=51 | N=46 | N=97 |
| A/another child | 40.0 | 34.5 | 36.6 |
| No/no more children | 54.3 | 56.9 | 55.9 |
| Can’t get pregnant | 5.7 | 1.7 | 3.2 |
| Undecided | 0.0 | 6.8 | 4.3 |

Inter-survey analysis revealed differences in fertility desires between the baseline and endline samples. Specifically, greater proportions of endline female respondents (regardless of status)

indicated a desire to have no children or no more children compared to baseline respondents. In addition, much lower proportions of endline respondents reported being undecided about their fertility desires. The difference between the baseline and endline responses in HIV-positive women who were undecided about whether they wanted more children was statistically significant ($p=.003$) but not in the HIV-negative group ($p=.201$).

Table 4.5: Percent distribution of women’s desire for a/another child, by number of living children

| Desire for last pregnancy | Number of living children | | | Mean |
|---------------------------|---------------------------|-------------|------------|------|
| | 0-2 N=29 | 3-5 N=47 | 6+ N=17 | |
| Have a/another child | 69.0 | 27.7 | 5.9 | 36.6 |
| No more | 20.7 | 63.8 | 94.1 | 55.9 |
| Can’t get pregnant | 6.9 | 2.1 | 0.0 | 3.2 |
| Undecided | 3.4 | 6.4 | 0.0 | 4.3 |

When fertility desire was analyzed by respondents’ number of living children, the majority of survey respondents who already had three to five children reported that they wanted no more children. This would suggest that women’s ideal number of children falls within this age range—a finding that is reinforced by later data confirming that most respondents (male and female) believe that the ideal number of children for women in the community is four to five children (Table 4.6).

Ideal number of children

Male and female respondents were asked to state the number of children they think a man or woman in their community should have (Tables 4.6 and 4.7). At endline, the greatest proportion of respondents (54.9 percent of men and 68.1 percent of women) stated that a woman should have four to five children. Male respondents overall did have a slightly higher ideal family size, however. Almost a third of men overall (30.4 percent) indicated that a man or woman should have six or more or more children.

Despite the fact that the majority of respondents indicated four to five as the ideal number of children, the most recent estimates show TFR for Eastern Province to be higher at 7.1.¹⁴ Though the C-Change study sample is not necessarily a representative sample of Eastern Province, if the TFR in Mwase Lundazi is similar to that of the region then there is a considerable discrepancy between real and ideal fertility. Many factors could contribute to this gap—including structural and social barriers to FP uptake. Among the possible social factors is the reality of men’s higher fertility desires (highlighted in the quantitative data above) combined with their dominant role in decision-making (evident in both quantitative and qualitative data; see Chapter 8). Other factors could include perceptions of high fertility norms in the community (Table 4.8), or limited accessibility and availability of FP for some groups in the population (Chapter 6).

Overall, HIV-positive men indicated lower family size ideals than HIV-negative men, with more than twice as many HIV-positive men responding that a woman should have zero to three children (21.9 percent compared to 10.0 percent). Slightly more than a third (34.4 percent) of HIV-negative men believed that a woman should have six or more children, whereas for HIV-positive men this proportion was much lower (21.9 percent).

Among female survey respondents, however, HIV-positive respondents overall endorsed larger ideal family sizes than HIV-negative respondents. More than twice as many HIV-positive than HIV-negative women expressed the belief that a woman should have six or more children (28.6 percent compared to 11.9 percent). HIV-positive men on the other hand were less likely to report an ideal family size of six or more children compared to their HIV-negative counterparts (21.9 percent versus 34.4 percent). Men were more likely to prefer six or more children for women as well as for men, though differences between male and female respondents were only marginally significant for ideal family size for women ($p=.06$).

Table 4.6: Ideal number of children for a woman, by sex and HIV status

| Ideal number of children | Male | | | Female | | |
|--------------------------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| 0-3 | 21.9 | 10.0 | 13.7 | 8.6 | 10.2 | 9.6 |
| 4-5 | 56.3 | 54.3 | 54.9 | 60.0 | 72.9 | 68.1 |
| 6+ | 21.9 | 34.4 | 30.4 | 28.6 | 11.9 | 18.1 |
| Don't know | 0.0 | 1.4 | 1.0 | 2.9 | 5.1 | 4.3 |

¹⁴ Central Statistical Office (CSO), Ministry of Health (MoH), Tropical Diseases Research Center (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*.

Table 4.7: Ideal number of children for a man, by sex and HIV status

| Ideal number of children | Male | | | Female | | |
|--------------------------|------------------|------------------|----------------|------------------|------------------|---------------|
| | Positive N=32 | Negative N=70 | Total N=102 | Positive N=35 | Negative N=59 | Total N=94 |
| 0-3 | 15.6 | 14.3 | 14.7 | 5.7 | 10.2 | 8.5 |
| 4-5 | 34.4 | 42.9 | 40.2 | 34.3 | 40.7 | 38.3 |
| 6+ | 46.9 | 41.4 | 43.1 | 54.3 | 40.7 | 45.7 |
| Don't know | 3.1 | 1.4 | 2.0 | 5.7 | 8.5 | 7.4 |

Both male and female survey respondents supported larger ideal family size for men, with the largest proportions of both samples indicating that a man should have six or more children. As with ideal family size for women, higher proportions of HIV-positive women than HIV-negative women responded that a man should have six or more children (54.3 percent compared to 40.7 percent). Differences were not statistically significant by status. Higher fertility expectations for men likely reflect local polygamous practices, which were frequently referenced in FGDs.

Perceptions of childbearing desires in the community

Survey respondents were also asked to state the number of boys and girls they thought that people in their community wanted to have—a reflection of community norms rather than personal values. The distributions of ideal number of sons and ideal number of daughters did not differ significantly by sex or by HIV status.

That male respondents perceived a slight sex preference for male children in the community was corroborated by qualitative data, as many participants in the focus groups expressed the community's preference for male children.

However, some focus group participants did mention a bias for female children. Among those male participants who did note a preference for female children, it was predominantly in reference to perceived financial benefits: the potential for receiving dowry when girl children were married, and the fact that girl children did not receive land so they did not burden families who have limited land to divide between male children.

Though the FGDs explored sex preference in depth, qualitative data indicate that sex preference does not appear to play a major role in couples' decisions about fertility and FP use

– both sexes were perceived desirable because of different gender roles. The role of sex preference in decision-making about family size was brought up only by a few men during FGD. Other factors—such as a couple’s ability to provide for their children, the issue of limited land size, and the direct and indirect effects of child mortality—featured more prominently and more consistently in participants’ explanations of the factors behind family size decision-making.

In the quantitative data, separate numbers for ideal numbers of daughters and sons were added to obtain the total number of children that respondents thought people in their community wanted to have. These totals were generated so that they might be compared to the ideal number of children respondents themselves thought that people should have (see Tables 4.6 and 4.7 in the previous section).

Table 4.8 shows that survey respondents—particularly female respondents—perceived high childbearing desire in the community. Whereas when asked about their own views, the greatest proportions of female respondents indicated that men or women should have 4-5 children (see Tables 4.6 and 4.7), the largest proportion of female respondents (44.3 percent) believed that people in their community wanted six or more children.

Inter-survey analyses indicated that perceived norms of ideal family size have shifted down for both male and female respondents. For example, whereas 67.5 percent of baseline female respondents believed that the community’s ideal family size was six or more children, this proportion had decreased to 47.7 percent of endline female sample. Among male respondents, the proportion decreased from 66.2 percent to 54.6 percent. Inter-survey differences were not significant for the male samples, but were for female respondents overall ($p=.017$) and HIV-negative female respondents ($p=.032$).

Perceptions of fertility desires and norms in the community may drive individuals’ childbearing choices. Perceptions of community preferences for family size did not differ from personal preference for family size for either men or women, at endline.

Table 4.8: Perceptions of community’s ideal number of children in the baseline and endline surveys, by sex and HIV status of respondent

| Number of children | Male | | | Female | | |
|--------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=30 | N=44 | N=74 | N=44 | N=39 | N=83 |
| 0-3 | 6.7 | 9.1 | 8.1 | 4.5 | 0.0 | 2.4 |
| 4-5 | 30.0 | 22.7 | 25.7 | 27.3 | 33.3 | 30.1 |

| | | | | | | |
|----------------|-------------|-------------|-------------|-------------|-------------|-------------|
| 6+ | 63.3 | 68.2 | 66.2 | 68.2 | 66.7 | 67.5 |
| Endline | N=31 | N=66 | N=97 | N=33 | N=55 | N=88 |
| 0-3 | 9.7 | 6.1 | 7.2 | 9.1 | 9.1 | 9.1 |
| 4-5 | 35.5 | 39.4 | 38.1 | 36.4 | 47.3 | 43.2 |
| 6+ | 54.8 | 54.5 | 54.6 | 54.5 | 43.6 | 47.7 |

Men's perceptions of community preferences did not differ significantly from baseline at endline; however, women's perceptions changed significantly ($p=.02$), with fewer suggesting community preferences for six or more, and more women suggesting community preferences for both the zero to three and the four to five categories.

Qualitative data suggested that women are explicitly conscious of the community's fertility desires and expectations. Two of the three young women's discussion groups noted that women, when deciding their own fertility and family-size desires, might "admire" and want to emulate others in the community with large families. Additionally, the concept of married couples choosing not to have children at all was virtually unheard of.

The issue of influence from a woman's parents-in-law in the context of a woman's fertility decision-making was raised, primarily by women's groups. Both older and younger women in FGD noted the strong influence that their husbands' parents can have, as well as the perceived consequences of not meeting the expectations of parents-in-law:

"The in-laws would not accept a woman who decided not to have any children because they take pride in having grandchildren so they would consider her to be useless. They can even chase her from their son's home and ask their son to marry someone else."
(female, 18-29)

The only female participant in FGD who asserted a woman's ability to resist pressure from parents-in-law justified hypothetical resistance on the basis of the couple's ability to provide for their family, a common theme in discussions about family size decision-making:

"Since they [parents-in-law] talk to us directly when they want a grandchild, we also tell them directly that the children we have are enough, and since we find it hard to provide basic needs for our small families, it would even be harder to provide for big families."
(female, 18-29)

In the FGD, only one male participant agreed- after prompting- with the suggestion that a man's parents could influence a couple's fertility decision-making. After much disagreement from the group he qualified his statement, specifying that parents might intervene in the case of a couple that has too many children that they could not take care of. This might suggest an opportunity to shift the perceived role of parents-in-law from promoting high fertility to promoting financially manageable family size.

While female participants discussed external influences on couples' decision-making, the idea that some couples could resist community pressure was raised primarily by men's groups. Only one young female participant asserted that women would be able to directly counter pressure from in-laws to have large number of children.

Throughout FGD, participants emphasized the importance of providing adequately for children. This might be a BCC message that could be tailored toward older generations: parents-in-law might be influenced to value having a few healthy, provided-for grandchildren, as opposed to larger numbers of grandchildren who might not be properly taken care of. Promoting these kinds of messages might harmonize fertility desires between young women and their parents-in-law, who seem to be an important source of decision-making influence in the eyes of young women.

CHAPTER 5: FAMILY PLANNING – KNOWLEDGE AND USE

A key objective of the SBCC interventions was to improve current use of FP as well as increase approval of FP among the study population, particularly HIV-positive participants. Results from the baseline, midline, and endline surveys revealed a number of key changes, particularly among female respondents. Endline female sample reported higher use of modern FP methods, higher approval for FP use, and greater knowledge of FP sources and methods than baseline female respondents. Higher proportions of both male and female endline respondents rejected the idea that a woman who uses FP will be unfaithful, possibly suggesting some progress against the prevailing perception that contraceptives promote promiscuity.

Among respondents who reported using contraceptives, the proportion of endline male sample getting contraceptives from Mwase RHC increased from baseline. More endline female sample reported getting contraceptives from a CHW than did baseline female respondents.

Ever use of contraception

Respondents who were currently married or had a sexual partner were asked whether they had ever used contraceptives (Table 5.0). Endline male sample overall indicated lower rates of ever-use than baseline male respondents ($p=.091$). By contrast, midline female respondents indicated higher rates of ever use than baseline female respondents, though differences were not significant.

Table 5.0: Ever use of contraception in the baseline, midline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|-----------------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=27 | N=44 | N=71 | N=41 | N=43 | N=84 |
| | 92.6 | 75.0 | 81.7 | 75.6 | 65.1 | 70.2 |
| Midline | N=43 | N=52 | N=95 | N=41 | N=38 | N=79 |
| | 88.4 | 57.7 | 71.6 | 85.4 | 73.7 | 79.7 |
| Endline | N=27 | N=67 | N=94 | N=26 | N=48 | N=74 |
| | 77.8 | 67.2 | 70.2 | 84.6 | 79.2 | 81.1 |

Current use of contraception

Survey respondents who had ever used contraception were asked about their current use. Table 5.1 illustrates significant increases in current use of contraceptives between baseline and endline among female respondents overall ($p=.063$) and female HIV-negative respondents ($p=.099$).

Apparent differences between female current use at baseline and female current use at endline may be a result of significant differences in the characteristics of the two populations. Overall, female endline respondents were more educated than female baseline respondents, and education levels are known to be associated with higher use of FP.

Additionally, female endline respondents indicated higher exposure to radio and TV. Because the interventions in the community were delivered through community activities as well as through media-based behaviour change communications, media exposure is the best available proxy for exposure to the project's interventions. However, media content aimed at promoting FP from other sources (e.g. government programs such as "Family Matters" and non-government programs) might also contribute to the observed increase in current use of FP.

Table 5.1: Current use of any modern method of contraception in the baseline, midline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|--|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |

| | | | | | | |
|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Baseline | N=27 | N=44 | N=71 | N=41 | N=43 | N=84 |
| | 63.0 | 45.5 | 52.1 | 43.9 | 41.9 | 42.9 |
| Midline | N=43 | N=52 | N=95 | N=41 | N=38 | N=79 |
| | 83.7 | 36.5 | 57.9 | 63.4 | 44.7 | 54.4 |
| Endline | N=27 | N=67 | N=94 | N=26 | N=48 | N=74 |
| | 70.4 | 34.3 | 44.7 | 57.7 | 52.1 | 54.1 |

In both the endline and baseline surveys, male HIV-positive men indicated more current contraceptive use than HIV-negative men. Differences in current use were significant among endline male sample by HIV status, with more than twice as many HIV-positive male respondents indicating current use compared to HIV-negative male respondents (70.4 percent compared to 34.3 percent), a difference that probably resulted from high condom use among HIV-positive male respondents (see Table 5.2). Differences were not significant by status for the endline female sample.

This finding may reflect the use of the male condom in this population, which could be selecting and using condoms for dual protection against unwanted pregnancy as well as prevention of HIV transmission among PLHIV. Male condoms are also very accessible: they are available at the Mwase RHC, the local health post, and in the community through community-based distribution. In FGDs, condoms were the most frequently mentioned method of family planning, and they were most commonly spoken about in the context of dual protection.

Behind condoms, injectables and oral contraceptive pills were the next most commonly reported methods in the survey population. They were also the most commonly mentioned methods in the FGDs beside condoms. The high prevalence of these methods is confirmed by service statistics from the Mwase RHC (see Table 6.0). For Oral Contraceptives (OCPs), high use is facilitated by the availability of the method at the clinic, the health post, and through community-based distribution.

Table 5.2: Percent distribution of family planning method use, by sex and HIV status (survey data)

| Male | | | Female | | |
|-----------------|-----------------|--------------|-----------------|-----------------|--------------|
| Positive | Negative | Total | Positive | Negative | Total |
| | | | | | |

| Family Planning Method | N=27 | N=67 | n=94 | N=26 | N=48 | N=74 |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Female sterilization | 0.0 | 0.0 | 0.0 | 0.0 | 4.2 | 2.7 |
| Male sterilization | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| IUD | 0.0 | 0.0 | 0.0 | 0.0 | 4.2 | 2.7 |
| Oral Pill | 3.7 | 13.4 | 10.6 | 15.4 | 20.8 | 18.9 |
| Injectables | 22.2 | 11.9 | 14.9 | 7.7 | 16.7 | 13.5 |
| Implant | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Male condom | 51.9 | 14.9 | 25.5 | 46.2 | 10.4 | 23.0 |
| Female condom | 0.0 | 1.5 | 1.1 | 0.0 | 0.0 | 0.0 |
| Traditional Methods | 0.0 | 1.5 | 1.1 | 0.0 | 0.0 | 0.0 |
| LAM | 0.0 | 1.5 | 1.1 | 0.0 | 0.0 | 0.0 |
| Rhythm | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Male and female sterilization procedures were not offered at Mwase RHC—the primary source of contraceptives for the sample — or at the local health post, which accounted for low reported use of these methods in the sample. IUDs were not consistently available at the clinic, although in July and August 2010, IUD insertion camps were held at Mwase RHC by a national NGO, Society for Family Health (SFH). Clients interested in sterilization or IUD insertion procedures were typically referred to the Lundazi District Hospital, though clinic staff reported that they rarely made referrals because they were aware that IUD materials were not actually available at the hospital.

Given that these long-term and permanent methods were not easily accessible for the study population, it is not surprising that they were not discussed in the FGDs. Only one female participant explained that she had undergone female sterilization as a result of complications during a delivery.

Though implants were available at Mwase RHC, their use was low (participants in surveys indicated no reported use of the method). There was no data to explain the unpopularity of implants in the population, though the sole mention of this method in the qualitative exercises might provide some hints.

| | | | | | | |
|-----------------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Government Health Center | 88.8 (77.8) [100.0] | 73.4 (89.5) [82.6] | 81.1 (81.8) [90.5] | 88.9 (76.0) [86.7] | 66.7 (82.4) [80.0] | 77.6 (78.6) [82.5] |
| Health post | 5.6 (13.9) [0.0] | 5.3 (10.5) [8.7] | 5.4 (12.7) [4.8] | 0.0 (20.0) [13.3] | 16.7 (11.8) [0.0] | 8.3 (16.7) [5.0] |
| Community health worker | 8.3 (8.3) [21.1] | 10.5 (10.5) [17.4] | 9.1 (9.1) [19.0] | 8.0 (8.0) [46.7] | 11.8 (11.8) [24.0] | 9.5 (9.5) [35.0] |
| Private hospital | 16.7 (0.0) [0.0] | 0.0 (0.0) [4.3] | 8.1 (0.0) [2.4] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] |
| Mission Hospital | 5.6 (0.0) [0.0] | 0.0 (0.0) [0.0] | 2.7 (0.0) [0.0] | 5.6 (0.0) [0.0] | 16.7 (0.0) [0.0] | 11.1 (0.0) [0.0] |
| Pharmacy | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] |
| Peer education or outreach worker | 11.1 (0.0) [0.0] | 0.0 (0.0) [0.0] | 5.4 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] | 0.0 (0.0) [0.0] |
| Shop | 0.0 (0.0) [5.3] | 5.3 (0.0) [4.3] | 2.7 (0.0) [4.8] | 5.6 (0.0) [13.3] | 5.6 (0.0) [0.0] | 5.6 (0.0) [5.0] |
| Friend / Relative | 5.6 (0.0) [0.0] | 15.8 (0.0) [8.7] | 10.8 (0.0) [4.8] | 5.6 (0.0) [0.0] | 5.6 (0.0) [0.0] | 5.6 (0.0) [0.0] |
| Other | 29.4 (2.8) [0.0] | 18.2 (0.0) [0.0] | 23.1 (1.8) [0.0] | 11.1 (0.0) [0.0] | 0.0 (0.0) [0.0] | 5.6 (0.0) [0.0] |

Among female respondents, reports of CHWs as a source for FP increased from the baseline. Increases were statistically significant for female respondents overall (p=.044) and marginally

significant for HIV-positive female respondents ($p=.101$). CHWs were also the second most commonly mentioned source of FP in the FGD.

Many community dialogue facilitators were also CBDs. It is possible that high participation in the SAA and BCC dialogues by female community members successfully generated demand for FP at the community level.

In general, female FGD participants expressed positive opinions about the quality of care from CHWs (male participants did not offer any opinions on CHW attitudes). Most female participants reported that CHWs were “understanding” and had community members’ “best interests” at heart; only one respondent noted that CHWs could be “rude” and “uncaring.”

Contraceptive use and decision-making

Survey respondents who reported current contraceptive use were asked to state who had made the decision to use that method. At endline, the majority of both male (62.2 percent) and female (56.4 percent) respondents indicated that they had made the decision jointly with their spouse or partner, though these proportions decreased from the midline. This decline cancelled out significant increases from the baseline to the midline so that comparisons between the baseline and endline showed no significant changes.

Strongly held norms around joint decision-making were confirmed through FGDs, where several FGDs of both men and women of different ages indicated that the decision to have a certain number of children was made by the couple. Importantly, however, qualitative data—supported by survey data on gender relations—also suggested that men had final decision-making authority, including issues of childbearing (Chapter 8). In addition, previously discussed data from qualitative exercises indicated that women were more sensitive to external pressures around fertility (see Chapter 4). In sum, though joint decision-making appears to be the primary practice according to survey data, qualitative data indicated that joint decision-making by a couple did not necessarily equate to egalitarian decision-making, and that outside actors may have a role as well.

Table 5.4: Contraceptive use decision maker, by sex and HIV status

| Decision maker | Male | | | Female | | |
|----------------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| | N=20 | N=25 | N=45 | N=15 | N=24 | N=39 |
| Respondent | 20.0 | 28.0 | 24.4 | 20.0 | 33.3 | 28.2 |
| Spouse or | 20.0 | 8.0 | 13.3 | 13.3 | 16.7 | 15.4 |

| partner | | | | | | |
|-----------------------------|------|------|------|------|------|------|
| Both respondent and partner | 60.0 | 64.0 | 62.2 | 66.7 | 50.0 | 56.4 |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Non-use of family planning

Female survey respondents who did not indicate current use of a FP method were asked to state their reasons for non-use. As in the baseline and midline samples, fertility-related reasons—including no sex or infrequent sex, menopause, hysterectomy, subfecundity/infecundity, breastfeeding, current pregnancy, or wanting more children—were the most frequently cited for non-use. Other commonly cited reasons included opposition to use from partners (11.8 percent) and fear of side effects (11.8 percent) comprised the other most frequently cited reasons, indicating the persistence of two major challenges to FP uptake in the population: myths around FP use, and resistance from males and other authoritative figures.

Fear of FP side effects was a common theme in the FGDs. Frequently mentioned side effects included barrenness, destruction to the uterus, growths in the uterus, cancer, deformed children, miscarriages, and prolonged periods. Participants typically mentioned these side effects with reference to family planning generally, though two participants (one female and one male, both from the younger age group) specifically mentioned perceived side effects associated with contraceptive use. Of note, all of the side effects that were specified described effects for women of the use of pills, suggesting that myths around FP methods do not have the same prohibitive effect on use of the male condom, the primary male method.

The distribution of reasons for non-use was significantly different for female respondents overall between baseline and endline ($p=.063$). A significant change was observed in the proportion of respondents who indicated lack of knowledge of a method or source of FP. In the endline, just 2.9 percent of respondents indicated this as their reason for non-use, compared to 16.7 percent of respondents in the baseline survey. As already discussed, the greater exposure to media that characterized the endline female sample might have contributed to this difference, though it might also indicate the success of some of the community-based interventions.

Table 5.5: Female respondents' reasons for non-use of family planning, by HIV status

| Reasons for non-use | HIV- Positive | HIV- Negative | Total |
|-----------------------------------|----------------------|----------------------|--------------|
| | N=11 | N=23 | N=34 |
| Marital | 0.0 | 0.0 | 0.0 |
| Fertility related | 45.5 | 60.9 | 55.9 |
| Opposition to use | | | |
| Opposition to use, respondent | 9.1 | 4.3 | 5.9 |
| Opposition to use, partner | 9.1 | 13.0 | 11.8 |
| Opposition to use, other | 0.0 | 0.0 | 0.0 |
| Lack of knowledge | 0.0 | 4.3 | 2.9 |
| Method related reasons | | | |
| Health concerns | 0.0 | 4.3 | 2.9 |
| Fear of side effects | 18.2 | 8.7 | 11.8 |
| Lack of access/too far | 0.0 | 0.0 | 0.0 |
| Costs too much | 0.0 | 0.0 | 0.0 |
| Inconvenient to use | 0.0 | 0.0 | 0.0 |
| Interferes with natural processes | 9.1 | 0.0 | 2.9 |
| Other | 9.1 | 4.3 | 5.9 |
| Don't know | 0.0 | 0.0 | 0.0 |

Intention to use family planning

Female respondents who did not report current use of FP were also asked to indicate their intention to use FP in the future. The majority (76.5 percent) of non-users reported the intention to use FP, a proportion quite similar to that from the baseline (79.2 percent). Intention to use did not differ significantly by HIV status.

Respondents who indicated intent to use were also asked to state which methods they planned to use. The majority of respondents (53.8 percent) reported intent to use injectables, possibly an indication of the increasing popularity of slightly longer-term methods (though the persistent unpopularity of implants would not be explained by this). The next most frequently cited methods were pills (19.2 percent) and male condoms (15.4 percent), possibly suggesting some degree of acceptability of these methods and their availability in the community relative to other family-planning methods.

Table 5.6: Intended method among female non-users who intend to use family planning, by HIV status

| Intended method | Positive N=8 | Negative N=18 | Total N=26 |
|------------------------|-------------------------|--------------------------|-----------------------|
| Female sterilization | 0.0 | 5.6 | 3.8 |
| Male sterilization | 0.0 | 0.0 | 0.0 |
| IUD | 0.0 | 5.6 | 3.8 |
| Pill | 25.0 | 16.7 | 19.2 |
| Injectables | 50.0 | 55.6 | 53.8 |
| Implants | 0.0 | 5.6 | 3.8 |
| Male condom | 25.0 | 11.1 | 15.4 |
| Female condom | 0.0 | 0.0 | 0.0 |
| LAM | 0.0 | 0.0 | 0.0 |
| Rhythm method | 0.0 | 0.0 | 0.0 |
| Other | 0.0 | 0.0 | 0.0 |
| Don't know | 0.0 | 0.0 | 0.0 |

Approval of family planning

Though the duration of the study was too short to achieve significant behaviour change in FP, the SBCC interventions might have had some effects on attitudes toward FP. Inter-survey

comparisons in fact indicated that female approval for FP increased significantly over the course of the project, for female respondents overall ($p=.012$) and for HIV-positive female respondents ($p=.031$). Male approval for FP was fairly constant across surveys. Approval was high among all groups, and was not significantly different by status.

Table 5.7: Approval for family planning in the baseline, midline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|----------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 87.9 | 89.4 | 88.8 | 76.9 | 84.0 | 80.4 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 76.6 | 88.9 | 83.2 | 96.1 | 95.7 | 95.9 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 81.3 | 85.7 | 84.3 | 94.3 | 91.5 | 92.6 |

Respondents who indicated having a spouse or partner were asked whether or not that spouse or partner approved of FP (Table 5.8). Larger proportions of endline female sample reported that their husband or partner approved of FP compared to baseline female respondents ($p=.012$); the significance of this increase held for HIV-positive female respondents ($p=.079$) as well as HIV-negative female respondents (.035).

Table 5.8: Spouse or partner approval for family planning in the baseline, midline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|----------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=49 | N=101 |
| | 90.9 | 91.5 | 91.3 | 73.1 | 61.2 | 67.3 |
| Midline | N=43 | N=52 | N=95 | N=41 | N=40 | N=81 |
| | 93.0 | 82.7 | 87.4 | 82.9 | 70.0 | 76.5 |

| Endline | N=28 | N=66 | N=94 | N=29 | N=51 | N=80 |
|---------|------|------|------|------|------|------|
| | 89.3 | 92.4 | 91.5 | 89.7 | 80.4 | 83.8 |

Respondents were also asked whether or not most of their friends in the community approved of couples using FP to delay or avoid pregnancy. Of note here, higher proportions of female respondents (87.2 percent) agreed that their friends would approve of FP compared to male respondents (66.7 percent).

Young couples and family planning

Male and female respondents were also asked whether or not they approved of a young recently married couple with no children using FP to avoid or delay pregnancy (Table 5.9). Although the midline survey captured significant increases in approval for young couples' use of FP, approval declined between the midline and endline such that there were no significant differences between baseline and endline responses. Approval for young couples' use of FP remained very low among male (15.7 percent) and female (20.2 percent) respondents.

Qualitative data confirmed the range of negative perceptions surrounding a young married couple's use of FP. A young couple's decision to not bear children was seen as so unnatural that most groups expressed the view that either the man must be impotent or that the woman must be infertile—that is, that the lack of child bearing reflected biological barriers rather than an explicit choice. All of the male groups and two of the female groups (one younger and one older) explained that cases in which a young unmarried woman did not want to have children would constitute grounds for divorce or polygamy. Only three groups (two female and one male) mentioned that if a man refused to bear children his wife could seek a divorce.

Table 5.9: Approval for young couples' family planning use in the baseline, midline and endline samples, by sex and HIV status

| | Male | | | Female | | |
|-----------------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 27.3 | 19.1 | 22.5 | 32.7 | 18.0 | 25.5 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 36.2 | 27.8 | 31.7 | 37.3 | 47.8 | 42.3 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |

| | | | | | |
|------|------|------|------|------|------|
| 25.0 | 11.4 | 15.7 | 14.3 | 23.7 | 20.2 |
|------|------|------|------|------|------|

Male respondents (from three groups) noted that if either a recently married man or woman refused to have children, it is likely that the community would intervene to try to identify and address the root of the problem. These kinds of social interventions speak to the strength of the social conviction that marriage is for procreation: “A home does not have real meaning if there are no children in it” (female, 18-29). This in fact was one of the most prevalent themes in all of the FGDs, and emerged in response to a number of different topics in the discussions.

A common sub-theme for why failure to have children may result in divorce and a woman being chased away was that it is specifically a woman’s duty in a marriage to produce children: “[A woman who does not want children] is not acceptable because the family and community expect you to have children. In fact, such a person will not be respected by the community because children bring respect to their parents” (male, 18-29). This sub-theme emerged in all of the male discussion groups, but in only one of the young women’s groups.

Quantitative data supported the findings from FGD that married couples face extremely high pressures to comply with childbearing expectations. The majority of both male (59.8 percent) and female (52.1 percent) respondents in the endline survey agreed with the statement that couples who do not want children are not normal. Strong pressures for couples to have children—and do so early on in the relationship—likely drive low birth delay and short birth spacing among young couples in the community.

Despite the strength of the quantitative and qualitative evidence indicating that young couples are expected to demonstrate their fertility early on, there was a suggestion in the quantitative data that norms might be changing to allow for some birth delay by young couples. The proportion of male respondents who believed that it was up to the couple to decide how long they should wait to have a child after marriage increased between the baseline and the endline (from 22.5 percent to 35.3 percent). The increase was particularly significant among HIV-positive respondents: the proportion of HIV-positive respondents who indicated that newly married couples should be able to decide how long to delay childbearing doubled between the baseline and endline (from 24.2 percent to 50.0 percent). Changes were statistically significant for the male population overall ($p=.051$) as well as HIV-positive male respondents (.010). Reconciling these various themes in the quantitative and qualitative data, it seemed that while community members were distinctly aware of norms that expect couples to bear children (and to do so early on in their marriage to give the marriage meaning), there is a possibility that norms are shifting to allow some space for birth delay by young couples.

Myths and perceptions about family planning

Willingness to use FP is in part shaped by perceptions of the effectiveness and side effects of different methods. Respondents were prompted about a series of myths about FP. The majority of male (68.6 percent) and female (68.1 percent) respondents either agreed with or

were unsure about the statement that an IUD can move inside of a woman’s body and hurt her. Misperceptions about this method may be linked to the fact that it is largely unavailable in the population (Chapter 6).

In further support of previously discussed data on the high acceptability and use of male condoms, belief that a condom could harm a man’s penis remained low among male (28.4 percent) and female (35.1 percent) respondents.

Looking at differences between surveys, significantly greater proportions of ednline female respondents disagreed with the statement that a man who has a vasectomy will become weak. The proportion of respondents who disagreed with this statement increased from 32.3 percent at baseline to 45.7 percent at endline (p=.056). Among HIV-positive female respondents, disagreement increased from 28.0 percent to 51.4 percent (p=.028). This might indicate an encouraging shift toward improved knowledge and attitudes around permanent FP methods, though it is of note that male sterilization did not come up in any FGD and female sterilization was only mentioned once in the context of an emergency procedure.

Table 5.10: Belief that a woman who uses family planning will be unfaithful to her husband, by sex and HIV status

| | Male | | | Female | | |
|-----------------|----------|----------|-------|----------|----------|-------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 36.4 | 31.9 | 33.8 | 23.1 | 32.0 | 27.5 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 27.7 | 27.8 | 31.7 | 37.3 | 47.8 | 42.3 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 9.4 | 25.7 | 20.6 | 11.4 | 16.9 | 14.9 |

A commonly expressed concern in FGD was that women who use FP are unfaithful or will become unfaithful. This belief was brought up in many focus groups. There was an indication that this idea was more commonly held by elders and by men in the community:

“Our elders in the village complain when we use family planning. They say we use family planning because we want to be prostitutes.”
(female, 30-49)

“Sometimes a woman will ask you... ‘I want to start using family planning.’ But we as men will say, ‘I don’t trust you. I suspect you are having extra marital affairs.’”
(male, 30-49)

Survey respondents were asked whether they agreed that a woman who uses family planning will be unfaithful (Table 5.10). Comparisons between the baseline and endline indicated that support for this belief has declined among both female and male respondents. Interpreting the quantitative data in light of the qualitative data suggested that while individuals were aware of and still sensitive to this norm (which persists especially among elder community members and men), norms might be shifting. Changes among survey respondents were significant for male respondents overall ($p=.05$) and HIV-positive male respondents ($p=.011$), as well as for female respondents overall ($p<.001$) and HIV-negative female respondents ($p<.001$).

CHAPTER 6: SERVICE STATISTICS

The primary objective of the FP/HIV Integration study was to promote behavior change towards FP through community-informed SBCC approaches. Though the duration of the study was relatively short (18 months) with the possibilities of large-scale and significant behaviour change somewhat constricted, data on FP uptake provide one means for measuring the extent to which the intervention was successful in changing behaviors. It is important to note that service statistics might underestimate actual demand for contraceptives since stock-outs were frequently reported. In this chapter, data are presented on the number of FP methods distributed, the number of people who received these methods, and the expected couple-years of protection (CYP) provided by FP commodities distributed at both the Mwase Lundazi RHC and by CBDs in the community. To permit an understanding of pre-project trends, data are presented beginning from June 2009; at the time of writing this report, the most recent data available were from April 2011. This chapter also attempts to contextualize the data by exploring the broader environment within which FP provision takes place in Mwase Lundazi.

Family planning methods provided

Mwase RHC provides a limited number of contraceptives on a regular basis: contraceptive pills (three major types— Microlut, Microgyn and Oralcon F), condoms (both male and female), injectables (mainly Depo Provera) and implants (Jadelle). Among these, all but implants were reported as highly used in the survey data and were consistently mentioned by FGD participants, though there were no data to indicate why implants were so infrequently used despite being available.

In July and August 2010, a national NGO—the Society for Family Health (SFH)—arranged for skilled personnel to perform IUD insertions for interested clients at the Mwase Lundazi RHC, as observed in Table 6.0. However, supplies were not available either at Mwase RHC or Lundazi District Hospital.

Service statistics

Data on the provision of FP were entered into a ledger by the MCH nurse. These data were collected bi-monthly by study staff through April 2011, and are presented below. Table 6.0 shows the number of commodities distributed and the number of clients who received them at the clinic between June 2009 and April 2011. The clinic did not record data on condom distribution. Also of note, a client who opted for the pill was provided three months' worth of cycles, which accounted for the discrepancies between the number of commodities distributed and the number of clients served with respect to OCPs.

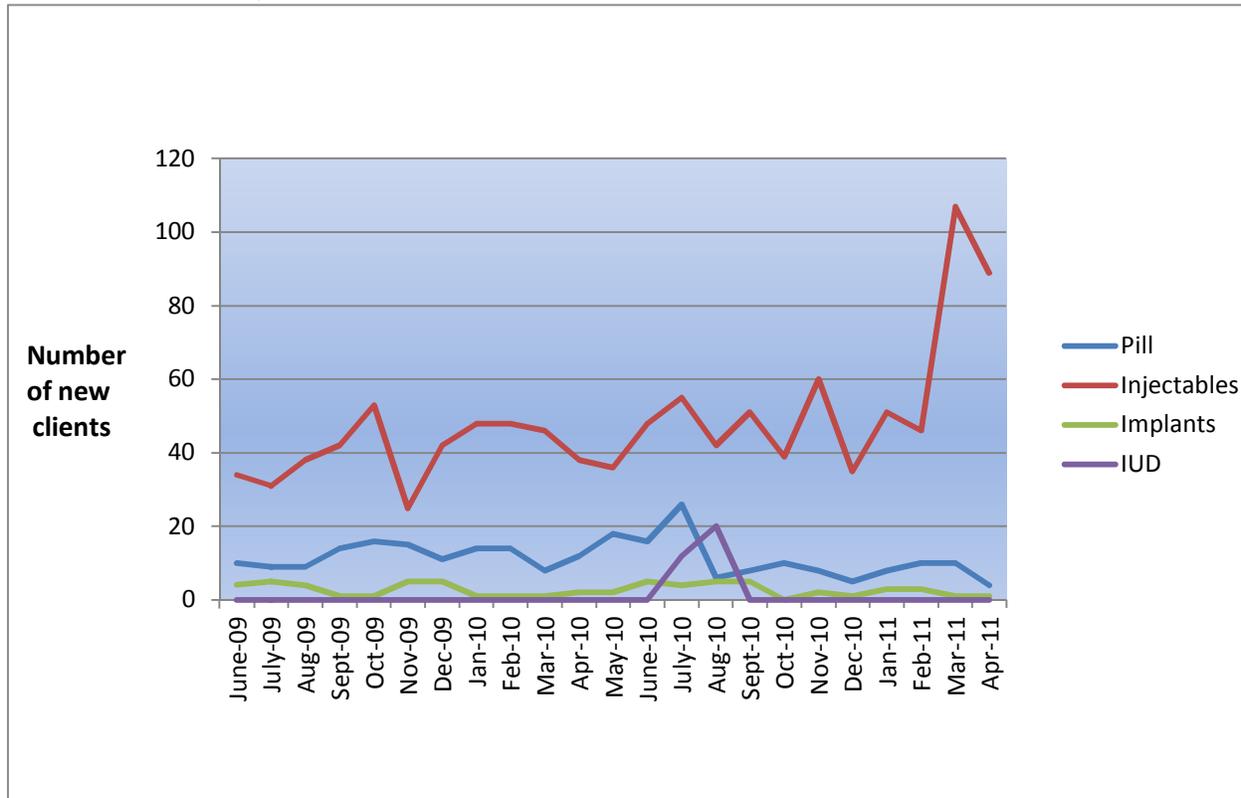
Table 6.0: Family planning commodities distributed and number of clients served at Mwase RHC and Mankhaka Health Post, June 2009-April 2011

| | Pill | | Injectables | | Implants | | IUD | |
|---------------|-------------------------|-------------------|-------------------------|-------------------|-------------------------|-------------------|-------------------------|-------------------|
| | Commodities Distributed | Number of clients |
| Jun 09 | 30 | 10 | 34 | 34 | 4 | 4 | 0 | 0 |
| Jul 09 | 27 | 9 | 31 | 31 | 5 | 5 | 0 | 0 |
| Aug 09 | 27 | 9 | 38 | 38 | 4 | 4 | 0 | 0 |
| Sep 09 | 42 | 14 | 42 | 42 | 1 | 1 | 0 | 0 |
| Oct 09 | 48 | 16 | 53 | 53 | 1 | 1 | 0 | 0 |
| Nov 09 | 45 | 15 | 25 | 25 | 5 | 5 | 0 | 0 |
| Dec 09 | 33 | 11 | 42 | 42 | 5 | 5 | 0 | 0 |
| Jan 10 | 42 | 14 | 48 | 48 | 1 | 1 | 0 | 0 |
| Feb 10 | 42 | 14 | 48 | 48 | 1 | 1 | 0 | 0 |
| Mar 10 | 24 | 8 | 46 | 46 | 1 | 1 | 0 | 0 |
| Apr 10 | 36 | 12 | 38 | 38 | 2 | 2 | 0 | 0 |
| May 10 | 54 | 18 | 36 | 36 | 2 | 2 | 0 | 0 |
| Jun 10 | 48 | 16 | 48 | 48 | 5 | 5 | 0 | 0 |
| Jul 10 | 78 | 26 | 55 | 55 | 4 | 4 | 12 | 12 |
| Aug 10 | 18 | 6 | 42 | 42 | 5 | 5 | 20 | 20 |
| Sep 10 | 24 | 8 | 51 | 51 | 5 | 5 | 0 | 0 |
| Oct 10 | 30 | 10 | 39 | 39 | 0 | 0 | 0 | 0 |
| Nov 10 | 24 | 8 | 60 | 60 | 2 | 2 | 0 | 0 |
| Dec 10 | 15 | 5 | 35 | 35 | 1 | 1 | 0 | 0 |
| Jan 11 | 24 | 8 | 51 | 51 | 3 | 3 | 0 | 0 |
| Feb 11 | 24 | 10 | 46 | 46 | 3 | 3 | 0 | 0 |
| Mar 11 | 30 | 10 | 107 | 107 | 1 | 1 | 0 | 0 |
| Apr 11 | 12 | 4 | 89 | 89 | 1 | 1 | 0 | 0 |

Source: Clinic records

There is a noticeable increase in number of injections provided toward the end of the data collection period, though clinic staff were not able to provide any particular reason for the spike.

Figure 6.0: Total family planning clients served from Mwase RHC and Mankhaka Health Post, June 2009-April 2011



Trends in family planning uptake from the community

Figure 6.1 shows the trends in the number of commodities distributed by CBDs from September 2009 to April 2011. There were three sharp drops in commodity distribution: January 2010, August 2010, and January 2011. The clinic staff attributed the sharp drops to reporting gaps rather than dramatic declines in distribution.

The number of male condoms distributed increased significantly from January 2010 to June 2010, possibly due to the SAA community dialogues which began shortly before that time period. Speculation about the causes of the distribution trends, however, must be tempered by the recognition of problems with inconsistent supply of contraceptive commodities and inconsistencies in record-keeping (discussed further below).

Low use of female condoms may be explained by the low level of stock at the clinic and the infrequency with which CBDs had access to the commodities, as explained above.

Figure 6.1: Contraceptives distributed by CBDs, September 2009-April 2011

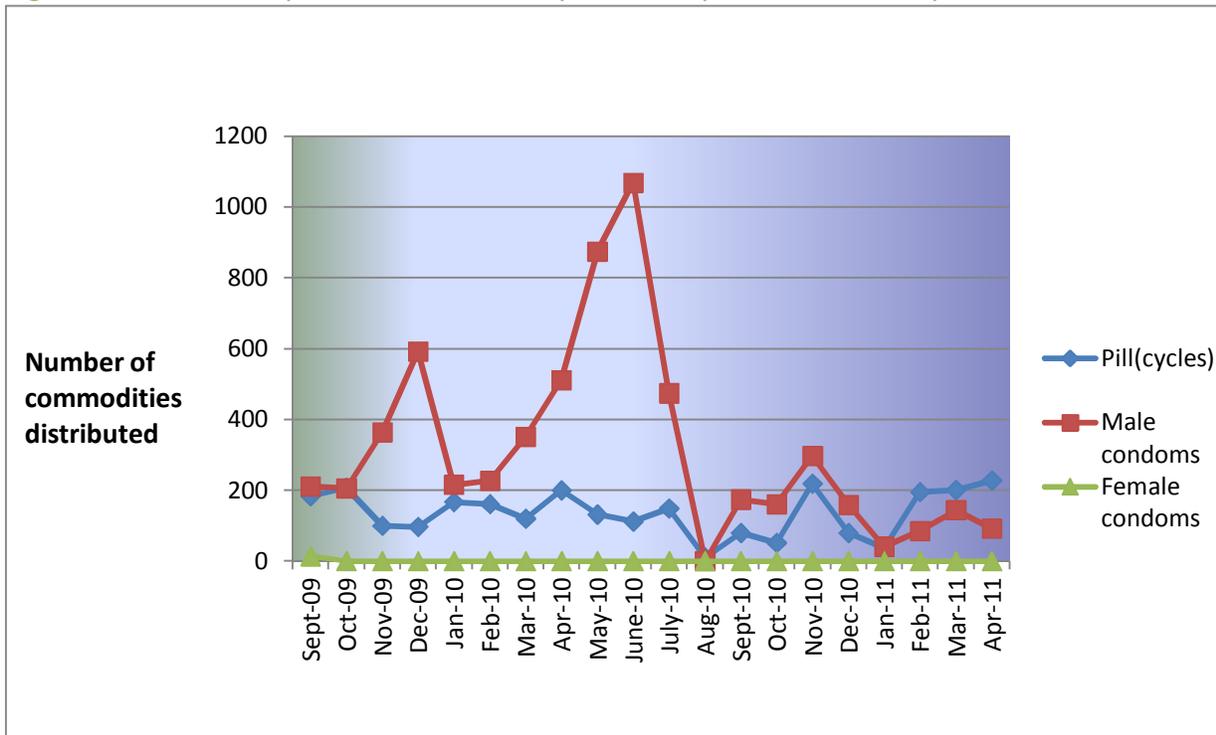


Figure 6.2: CYP, June 2009-April 2011

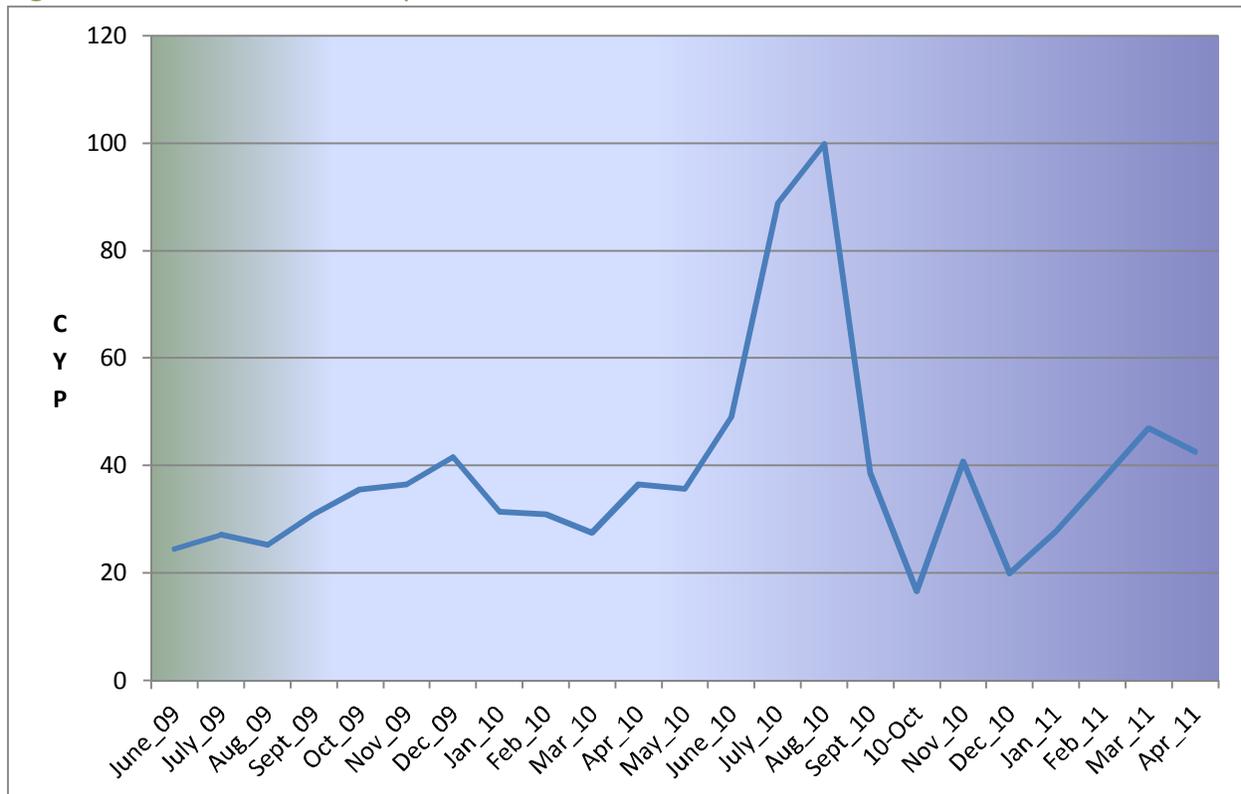


Figure 6.2 shows the CYP for the period June 2009 to April 2011. Data on community-based distribution of commodities were not available for the period June 2009 to September 2009, so the CYP for those months reflect only commodities distributed at the clinic.

Challenges facing family planning provision

Several challenges underlay the provision of FP services and commodities at the clinic and in the community during the reporting period. Foremost among these was the inadequate supply of contraceptives from CBDs compared to demand in the communities. Though in theory OCP clients should be provided with three months' worth of pill cycles at each visit, limited supplies led to many female clients receiving only one cycle at a time. Distance to the clinic and inconsistent supplies from CBDs were both frequently noted as barriers to FP access in qualitative exercises.

Another major challenge to effective provision of FP services was poor or lacking record keeping. Non-reporting and under-reporting by CBDs was another major challenge that affected not only data capture, but forecasting for the clinic, since commodity orders were based on past records of distributed products. Records showed that at least one CBD typically did not report distribution data, and many CBDs kept inaccurate or incomplete records.

In November 2010, the project took steps to address these monitoring and reporting issues by introducing a clearer and more comprehensive reporting form for CBDs. This form was developed in consultation with staff from the Mwase RHC as well as the District Health Office. CBDs were oriented on the new reporting form and on-site mentoring was undertaken to ensure accurate reporting. Efforts were also made to improve supply of contraceptives by engaging the clinic and improving record keeping.

CHAPTER 7: EXPOSURE TO INFORMATION ON FAMILY PLANNING AND HIV

Information and social norms— including those related to health and FP—may be influenced by exposure to mass media. In addition, knowledge and attitudes can be diffused through interpersonal interactions. The SAA and SBCC components of the action study sought to use more personal methods of communication—community-based theater, group dialogues, and one-on-one counselling—to challenge myths and negative perceptions about FP, as well as to promote positive norms related to gender and FP. This chapter looks at respondents’ exposure to information on FP and HIV through several pathways, including radio, TV, drama, and a range of interactions with health workers. Data indicated that over the course of the project female respondents benefitted from increased exposure to information from a number of sources: radio, TV or drama, community-based meetings, health worker visits, and counselling from health workers at the health facility. Male endline respondents, on the other hand, indicated only higher rates of attending meetings where FP was discussed.

Exposure to information through radio, TV or drama

Survey respondents were asked if they had heard any messages about FP or HIV through radio, TV, or drama. Almost twice as many female endline respondents (70.2 percent) indicated that they had heard a message about FP compared to baseline respondents (37.3 percent). Increased exposure proved to be significant for female respondents overall ($p < .001$), HIV-positive female respondents ($p = .009$), and HIV-negative female respondents ($p < .001$), though it should be noted here that endline female sample also indicated significantly higher rates of exposure to both TV (for females overall, HIV-positive females, and HIV-negative females) and radio (for females overall and for HIV-positive females) compared to baseline female respondents (Chapter 3).

Differences in exposure were not significant by HIV status for either male respondents or female respondents in the endline samples.

Table 7.0: Percent distribution of respondents who heard a message on family planning through radio, TV, or drama in the previous 12 months, by sex and HIV status

| Male | | | Female | | |
|----------|----------|-------|----------|----------|-------|
| Positive | Negative | Total | Positive | Negative | Total |
| | | | | | |

| | | | | | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|--------------|
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 54.5 | 74.5 | 66.3 | 36.5 | 38.0 | 37.3 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 72.3 | 63.0 | 67.3 | 60.8 | 52.2 | 56.7 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 65.6 | 68.1 | 67.3 | 65.7 | 72.9 | 70.2 |

As with exposure to FP messages, endline female sample reported much higher rates of exposure to messages about HIV through radio, TV, or drama compared to baseline female respondents. Again, these increases were significant for female respondents overall ($p < .001$), HIV-positive female respondents ($p = .040$), and HIV female negative respondents ($p = .001$). Distributions were similar by HIV status.

Table 7.1: Percent distribution of respondents who heard a message on HIV through radio, TV or drama in the previous 12 months, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|-------------|-------------|-------------|--------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 81.8 | 85.1 | 83.8 | 57.7 | 50.0 | 53.9 |
| Midline | N=44 | N=53 | N=97 | N=50 | N=45 | N=95 |
| | 90.9 | 79.2 | 84.5 | 80.0 | 64.4 | 72.6 |
| Endline | N=44 | N=53 | N=97 | N=50 | N=45 | N=95 |

| | | | | | |
|------|------|------|------|------|------|
| 87.5 | 92.9 | 91.2 | 80.0 | 81.4 | 80.9 |
|------|------|------|------|------|------|

The FP/HIV integration study employed community-based drama to disseminate messages as part of its overall BCC strategy. It did not, however, promote any messages through radio or TV. Because the data presented here derived from a survey question that did not differentiate between radio, TV, or drama, it was difficult to assess whether the increases could be attributed to the study interventions. Respondents who stated they had heard a message on FP or HIV were asked to identify the message heard and the medium through which they heard it. Among the 28 female respondents who heard a message on FP, only eight explicitly mentioned the source: four heard it on the radio, three through drama, and one through TV.

For HIV messages, 16 of 94 respondents who provided details on the message they had heard indicated the source through which they heard it: eight through drama, five through radio, and three through TV.

In the project area there were several other potential sources of information on FP or HIV that might have been captured by this survey question. For radio, the Mwase catchment area received transmission from both Radio Malawi (Malawi's government station) and Radio Chikaya (a community radio station based in Lundazi town). During the study, Radio Malawi regularly featured programming on FP and HIV; Radio Chikaya also addressed these subjects on occasion. On TV, respondents might have been exposed to national-level television programming that sometimes included information on FP or HIV/AIDS. Though there were no known projects conducting dramas in the community during the study, a local NGO, Thandizani, used community-based theatre until 2009 (prior to C-Change implementation) to raise awareness about HIV related issues.

Given the multiple modes of exposure to FP and HIV information it was challenging to assess whether the observed changes in the outcome variables such as current contraceptive use, approval for FP, or support for certain norms around FP and gender—could be attributed to the study interventions alone or to the other sources of FP promotion identified in the study area.

Exposure to family planning and HIV information at the community level

Another—and potentially more proximate—measure of study outputs captured interactions between individuals and community workers on issues of FP and HIV. SAA and BCC strategies relied heavily on group dialogues to foster discussion about FP and to disseminate messages on FP and HIV.

Survey data showed that the population overall had experienced greater exposure to reproductive health information through meetings over the course of the SBCC project. More than twice as many endline female sample as baseline female respondents reported having attended a meeting where FP was discussed in the 12 months prior to the survey (Table 7.3).

These increases were significant for female respondents overall ($p < .001$), HIV-positive female respondents ($p = .040$), and HIV-negative female respondents ($p < .001$).

Endline male respondents also reported attending significantly more meetings where FP was discussed than baseline male respondents. Differences were significant for male respondents overall ($p = .067$) and just short of significance at the 90 percent level for HIV-positive respondents ($p = .102$).

As campaigns that target HIV-positive individuals often deal with the subject of condom use and FP, it is unclear whether participants who attended a meeting where FP was discussed actually attended a meeting that focused on HIV issues. Among female respondents, attendance at dialogues was slightly higher for HIV-negative respondents (64.2 percent) than for HIV-positive respondents (57.7 percent). Among males, the converse was true, with a greater proportion of HIV-positive male respondents (65.6 percent) having attended a meeting where FP was discussed compared to HIV-negative respondents (50.0 percent). Differences by status were not significant for males or females.

Table 7.3: Percent distribution of respondents who attended a meeting where family planning was discussed in the previous 12 months, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|--------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 45.5 | 38.3 | 41.3 | 26.9 | 30.0 | 28.4 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 51.1 | 42.6 | 46.5 | 39.2 | 41.3 | 40.2 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 65.6 | 50.0 | 54.9 | 57.7 | 64.4 | 61.7 |

As with FP meetings, female endline respondents reported higher attendance at meetings where HIV was discussed, when compared to female baseline respondents (Table 7.4).

Increased attendance was significant for female respondents overall ($p < .001$), female HIV-positive respondents ($p = .019$) and female HIV-negative respondents ($p < .001$).

HIV-positive male and female respondents reported attending more meetings where HIV was discussed than HIV-negative respondents; this may be due to bias in self-reporting. Differences by status were significant for the male sample ($p = .005$).

Table 7.4: Percent distribution of respondents who attended a meeting where HIV was discussed in the previous 12 months, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|--------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 81.8 | 55.3 | 66.3 | 48.1 | 30.0 | 39.2 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 51.1 | 42.6 | 46.5 | 39.2 | 41.3 | 40.2 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 78.1 | 48.6 | 57.8 | 74.3 | 64.4 | 68.1 |

At baseline, midline and endline, survey respondents were asked if they had been visited by a health worker to discuss FP or HIV. The proportion of male respondents who reported to have been visited by a health worker to discuss FP remained fairly consistent across the surveys. However, more than three times as many endline female respondents reported having been visited by a health worker to discuss FP than did female respondents at baseline. These increases were significant for female respondents overall, including both HIV-positive female respondents, and HIV-negative female respondents ($p < .001$ for all). It is important to note that were it not for integration of FP and HIV services at the health center, reaching HIV-positive individuals for the survey might not have been possible.

Table 7.5: Percent distribution of respondents who were visited by a community health worker to discuss family planning in the previous 12 months, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|--------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 45.5 | 34.0 | 38.8 | 13.5 | 22.0 | 16.7 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |
| | 51.1 | 35.2 | 42.6 | 45.1 | 37.0 | 41.2 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 37.5 | 38.6 | 38.2 | 62.9 | 52.5 | 56.4 |

Among male respondents, reports of being visited by a health worker did not differ significantly at endline by HIV status. For female respondents, visits were higher (though not significantly so) among female HIV-positive respondents.

Table 7.6: Percent distribution of respondents who were visited by a community health worker to discuss HIV in the previous 12 months, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|--------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=33 | N=47 | N=80 | N=52 | N=50 | N=102 |
| | 51.5 | 36.2 | 42.5 | 42.3 | 20.0 | 31.4 |
| Midline | N=47 | N=54 | N=101 | N=51 | N=46 | N=97 |

| | | | | | | |
|----------------|-------------|-------------|--------------|-------------|-------------|-------------|
| | 55.3 | 33.3 | 43.6 | 49.0 | 23.9 | 37.1 |
| Endline | N=32 | N=70 | N=102 | N=35 | N=59 | N=94 |
| | 34.4 | 30.0 | 31.4 | 45.7 | 50.8 | 48.9 |

Respondents were also asked if they had been visited by a health worker to discuss HIV (Table 7.6). There was a slight decline between baseline and endline surveys in the percentage of male respondents who reported a visit by a health worker to discuss HIV, with the decline more noticeable (though not significant) among HIV-positive male respondents. A higher percentage of endline female sample, on the other hand, reported having been visited by a health worker to discuss HIV. Increases were significant for female respondents overall ($p=.014$) and for HIV-negative female respondents ($p<.001$).

Exposure to family planning and HIV information at the health facility

Interactions between respondents and health workers in a health facility provide another source of health information for the study population. Respondents who reported having visited a health facility in the 12 months prior to the endline survey were asked whether a staff-person there spoke to them about FP (Table 7.7). These data probably reflect the extent of implementation of the referral component.

Table 7.7: Percent distribution of respondents who visited a health facility and were spoken to about family planning by health staff, by sex and HIV status

| | Male | | | Female | | |
|-----------------|-------------|-------------|--------------|-------------|-------------|-------------|
| | Positive | Negative | Total | Positive | Negative | Total |
| Baseline | N=30 | N=43 | N=73 | N=50 | N=46 | N=96 |
| | 56.7 | 60.5 | 58.9 | 58.0 | 65.2 | 61.5 |
| Midline | N=43 | N=50 | N=93 | N=47 | N=40 | N=87 |
| | 62.8 | 48.0 | 54.8 | 63.8 | 67.5 | 65.5 |
| Endline | N=32 | N=70 | N=102 | N=34 | N=44 | N=97 |

| | | | | | |
|------|------|------|------|------|------|
| 62.5 | 68.6 | 66.7 | 76.5 | 77.2 | 76.9 |
|------|------|------|------|------|------|

Increases in exposure to FP at health facilities from the baseline to endline were only significant for female respondents ($p=.022$). Greater proportions of both HIV-positive and HIV-negative female respondents reported to have obtained information about FP during a health facility visit at the time of the endline survey as compared to the baseline survey, although increases were only significant for HIV-positive female respondents ($p=.064$).

CHAPTER 8: GENDER RELATIONS

In order to measure changes in gender attitudes and norms, the project team developed a scale including 25 items adapted from the Gender-Equitable Men (GEM) scale. The scale measured attitudes and beliefs related to gender roles and relations of FP and HIV—including beliefs about gender roles, sexuality, decision-making power and communication within couples.

This adaptation of the GEM included four domains: domestic chores and daily life (10 items), sexual relationships (8 items), reproductive health and disease prevention (7 items), and violence (3 items). Changes in men’s and women’s responses were compared between baseline and endline; analysis was repeated in the HIV-positive subsample. Significance tests were done using the [Freeman-Halton](#) extension of the Fisher exact probability test for a two-rows by three-columns contingency table, analyzing changes across the possible answers of “Agree”, “Unsure”, and “Disagree”.

Domestic chores and daily life

In the domain of domestic chores and daily life, men responded with the “more equitable” response significantly more often at endline than at baseline on several items. Among the HIV-positive subsample, change was significant for only one item; and significant for two items among all male respondents. Women also responded with the “more equitable” response more often on three items at endline; these changes, however, were significant only among all women and not among the HIV-positive subsample. At endline, men were more likely to support the idea that men and women should share household chores.

Table 8.1: Percent of male respondents who affirmed the “equitable” response to GEM Domestic Chores and Daily Life items, by HIV status at baseline and endline

| Domestic chores and daily life | Men | |
|--------------------------------|------|-------|
| | HIV+ | Total |
| | | |

| | Baseline | Endline | | Baseline | Endline | |
|---|-------------|-------------|----------|-------------|--------------|----------|
| <i>A man should have the final word about decisions in his home</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 15% | 13% | n/s | 23% | 16% | n/s |
| <i>My partner has more say than I do about important decisions that affect us</i> | N=33 | N=28 | | N=80 | N=95 | |
| Disagree | 61% | 54% | n/s | 61% | 59% | n/s |
| <i>Changing diapers. Giving the kids a bath, and feeding the kids are the mother's responsibilities</i> | N=33 | N=32 | + | N=80 | N=102 | |
| Disagree | 21% | 47% | p=.038 | 26% | 30% | n/s |
| <i>A woman should obey her husband in all things</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 39% | 45% | n/s | 35% | 37% | n/s |
| <i>Men and women should share household chores</i> | N=33 | N=32 | | N=80 | N=102 | + |
| Agree | 70% | 81% | n/s | 71% | 86% | p=.016 |
| <i>My partner dictates who I spend time with</i> | N=33 | N=28 | | N=80 | N=95 | + |
| Disagree | 67% | 79% | n/s | 69% | 85% | p=.014 |
| <i>When my partner and I disagree, they get their way most of the time</i> | N=33 | N=27 | | N=80 | N=94 | |
| Disagree | 61% | 63% | n/s | 66% | 57% | n/s |

Table 8.2: Percent of female respondents who affirmed the “equitable” response to GEM Domestic Chores and Daily Life items, by HIV status at baseline and endline

| Domestic chores and daily life | Women | | | | | |
|---|-------------|-------------|-----|--------------|-------------|----------|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>A man should have the final word about decisions in his home</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 27% | 9% | n/s | 24% | 19% | n/s |
| <i>My partner has more say than I do about important decisions that affect us</i> | N=52 | N=29 | | N=102 | N=81 | + |
| Disagree | 23% | 28% | n/s | 21% | 22% | p=.011 |
| <i>Changing diapers. Giving the kids a bath, and feeding the kids are the mother's responsibilities</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 13% | 6% | n/s | 9% | 4% | n/s |
| <i>A woman should obey her husband in all things</i> | N=52 | N=35 | | N=102 | N=94 | + |
| Disagree | 21% | 29% | n/s | 16% | 34% | p=.005 |
| <i>Men and women should share household chores</i> | N=52 | N=35 | | N=102 | N=94 | + |
| Agree | 81% | 80% | n/s | 79% | 79% | p=.019* |
| <i>My partner dictates who I spend time with</i> | N=52 | N=29 | | N=102 | N=79 | |

| | | | | | | |
|--|-------------|-------------|-----|--------------|-------------|-----|
| Disagree | 60% | 48% | n/s | 55% | 49% | n/s |
| <i>When my partner and I disagree, they get their way most of the time</i> | N=52 | N=29 | | N=102 | N=79 | |
| Disagree | 40% | 34% | n/s | 36% | 41% | n/s |

*Although the percentage of women giving the “more equitable” response did not change, the percentage who shifted from giving the “less equitable” response decreased and the percentage who were unsure increased.

Sexual relationships

At endline, men responded with the “more equitable” response significantly more often on two items relating to sexual relationships, as did women. Both men and women at endline were more likely to disagree with the statement that “men need other women even if things are fine with their wives”; this change was not significant in the HIV-positive subsample of men, but was in a consistent direction.

At endline, fewer HIV-positive men agreed with the statement “women should not initiate sex” than at baseline. Significantly more women at endline disagreed with the statement that “men are always ready to have sex” (but this difference was not significant among the HIV-positive subsample).

Focus group participants expressed the belief that men have greater sexual needs than women. Some participants associated this perceived greater need with extramarital sex or polygamy. For example, one participant said, “Sometimes when a woman wants to delay a pregnancy...the man may decide to marry another wife because men are always ready to have sex” (female, 18-29).

Table 8.3: Percent of male respondents who affirmed the “equitable” response to GEM Sexual Relationships items, by HIV status at baseline and endline

| Sexual relationships | Men | | | | | |
|--|-------------|-------------|-----|-------------|--------------|----------|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>Men are always ready to have sex</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 42.4% | 53.1% | n/s | 40.0% | 35.3% | n/s |
| <i>Men need sex more than women do</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 36.4% | 34.4% | n/s | 33.8% | 22.5% | n/s |
| <i>You don't talk about sex, you just do it</i> | N=33 | N=32 | | N=80 | N=100 | |
| Disagree | 69.7% | 78.1% | n/s | 76.3% | 76.0% | n/s |
| <i>A man needs other women even if things are fine with his wife</i> | N=33 | N=32 | | N=80 | N=102 | + |
| Disagree | 48.5% | 65.6% | n/s | 50.0% | 69.6% | p=.001 |

| | | | | | | |
|---|-------------|-------------|----------|-------------|--------------|-----|
| <i>I am more committed to this relationship than my partner</i> | N=33 | N=27 | | N=80 | N=94 | |
| Disagree | 36.4% | 33.3% | n/s | 38.8% | 33.0% | n/s |
| <i>A man should know what his partner likes during sex</i> | N=33 | N=32 | | N=80 | N=102 | |
| Agree | 93.9% | 90.6% | n/s | 93.7% | 95.1% | n/s |
| <i>A woman should be able to talk openly about sex with her husband</i> | N=33 | N=32 | | N=80 | N=102 | |
| Agree | 100.0% | 96.9% | n/s | 95.0% | 97.1% | n/s |
| <i>A woman should not initiate sex</i> | N=33 | N=32 | + | N=80 | N=101 | |
| Disagree | 45.5% | 68.8% | p=.03 | 56.3% | 56.4% | n/s |

Table 8.4: Percent of female respondents who affirmed the “equitable” response to GEM Sexual Relationships items, by HIV status, at baseline and endline

| Sexual relationships | Women | | | | | |
|---|-------------|-------------|----------|--------------|-------------|----------|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>Men are always ready to have sex</i> | N=52 | N=35 | | N=102 | N=94 | + |
| Disagree | 11.5% | 11.4% | n/s | 7.8% | 18.1% | p=.038 |
| <i>Men need sex more than women do</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 7.7% | 5.7% | n/s | 7.8% | 6.4% | n/s |
| <i>You don't talk about sex, you just do it</i> | N=52 | N=35 | | N=102 | N=93 | |
| Disagree | 63.5% | 60.0% | n/s | 56.9% | 61.3% | n/s |
| <i>A man needs other women even if things are fine with his wife</i> | N=52 | N=35 | + | N=102 | N=94 | + |
| Disagree | 40.4% | 77.1% | p<.001 | 40.2% | 59.6% | p=.02 |
| <i>I am more committed to this relationship than my partner</i> | N=52 | N=29 | | N=102 | N=79 | |
| Disagree | 26.9% | 48.3% | n/s | 34.3% | 34.2% | n/s |
| <i>A man should know what his partner likes during sex</i> | N=52 | N=35 | | N=102 | N=94 | |
| Agree | 94.2% | 91.4% | n/s | 95.1% | 93.6% | n/s |
| <i>A woman should be able to talk openly about sex with her husband</i> | N=52 | N=35 | | N=102 | N=94 | |
| Agree | 96.2% | 88.6% | n/s | 89.2% | 86.2% | n/s |
| <i>A woman should not initiate sex</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 48.1% | 51.4% | n/s | 43.1% | 51.1% | n/s |

Reproductive health and disease prevention

At endline, men and women were significantly more likely to say they feel comfortable discussing HIV with their partners; however, this change was not significant among HIV-positive sub-samples for either men or women. Men were also more likely to report feeling comfortable discussing family planning with their partners.

At endline, women were significantly less likely to disagree with the statement that “it is a woman’s responsibility to avoid getting pregnant”. This finding raises a question about the validity of this item for women; it is possible that exposure to family planning information would increase a woman’s sense of personal responsibility for avoiding pregnancy rather than decrease it.

Male authority in the realm of fertility-related decision-making was a strong theme in women’s FGDs. All five female FGD groups discussed a man’s dominant role in a couple’s decision-making around family size and FP uptake. Participants in two of the young women’s groups noted specifically that women had no power in decision-making, as men always had the final word. Older female respondents confirmed that men had the power to make the ultimate decision. By contrast, only one group of older men explicitly commented on the inequalities in decision-making: “*The decision maker is the man...because every judgment should be passed by a man. When you discuss things the man still has the privilege to judge in the family.*” (male, 30-49).

Table 8.5: Percent of male respondents who affirmed the “equitable” response to GEM Reproductive Health and Disease Prevention items, by HIV status, at baseline and endline

| Reproductive Health and Disease Prevention | Men | | | | | |
|---|-------------|-------------|-----|-------------|--------------|----------|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>It is a woman’s responsibility to avoid getting pregnant</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 42.4% | 43.8% | n/s | 42.5% | 40.2% | n/s |
| <i>A couple should decide together if they want to have children</i> | N=33 | N=32 | | N=80 | N=102 | |
| Agree | 100.0% | 96.9% | n/s | 97.5% | 98.0% | n/s |
| <i>A woman can suggest using condoms just like a man can</i> | N=33 | N=32 | | N=80 | N=102 | |
| Agree | 90.9% | 93.8% | n/s | 87.5% | 81.4% | n/s |
| <i>A man and woman should decide together what type of contraceptive to use</i> | N=33 | N=32 | | N=80 | N=102 | |
| Agree | 97.0% | 87.5% | n/s | 93.8% | 96.1% | n/s |
| <i>A real man produces a male child</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 45.5% | 65.6% | n/s | 53.8% | 53.9% | n/s |
| <i>I feel comfortable discussing FP with my partner</i> | N=33 | N=28 | | N=80 | N=95 | + |

| | | | | | | |
|--|-------------|-------------|-----|-------------|-------------|----------|
| Agree | 87.9% | 96.4% | n/s | 91.3% | 96.8% | p=.050 |
| <i>I feel comfortable discussing HIV with my partner</i> | N=33 | N=28 | | N=80 | N=95 | + |
| Agree | 93.9% | 100.0% | n/s | 95.0% | 97.9% | p=.021 |

Table 8.6: Percent of female respondents who affirmed the “equitable” response to GEM Reproductive Health and Disease Prevention items, by HIV status, at baseline and endline

| Reproductive Health and Disease Prevention | Women | | | | | |
|---|-------------|-------------|-----|--------------|-------------|----------|
| | HIV+ | | n/s | Total | | |
| | Baseline | Endline | | | Baseline | Endline |
| <i>It is a woman’s responsibility to avoid getting pregnant</i> | N=52 | N=35 | | N=102 | N=94 | - |
| Disagree | 19.2% | 8.6% | n/s | 22.5% | 7.4% | p=.004 |
| <i>A couple should decide together if they want to have children</i> | N=52 | N=35 | | N=102 | N=94 | |
| Agree | 96.2% | 100.0% | n/s | 91.2% | 96.8% | n/s |
| <i>A woman can suggest using condoms just like a man can</i> | N=52 | N=35 | | N=102 | N=94 | |
| Agree | 88.5% | 82.9% | n/s | 81.4% | 76.6% | n/s |
| <i>A man and woman should decide together what type of contraceptive to use</i> | N=52 | N=35 | | N=102 | N=94 | |
| Agree | 94.2% | 94.3% | n/s | 93.1% | 96.8% | n/s |
| <i>A real man produces a male child</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 48.1% | 57.1% | n/s | 41.2% | 52.1% | n/s |
| <i>I feel comfortable discussing FP with my partner</i> | N=52 | N=28 | | N=102 | N=79 | |
| Agree | 84.6% | 92.9% | n/s | 85.3% | 88.6% | n/s |
| <i>I feel comfortable discussing HIV with my partner</i> | N=52 | N=29 | | N=102 | N=79 | + |
| Agree | 94.2% | 89.7% | n/s | 85.3% | 92.4% | p=.029 |

Violence

Men were more likely at endline to endorse the view that women should tolerate violence than they were at baseline, as well as the idea that a man can hit his wife if she is unfaithful. Both findings were significant only in the total population but not in the HIV-positive subsamples.

Women also endorsed this view; the change was significant in the HIV-positive subsample, and consistent but nonsignificant in the overall population.

Table 8.7: Percent of male respondents who affirmed the “equitable” response to GEM Violence items, by HIV status, at baseline and endline

| Violence | Men | | | | | |
|---|-------------|-------------|-----|-------------|--------------|--------|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>A woman should tolerate violence to keep the family together</i> | N=33 | N=32 | | N=80 | N=102 | - |
| Disagree | 30.3% | 9.4% | n/s | 23.8% | 10.8% | p=.002 |
| <i>A man can hit his wife if she will not have sex with him</i> | N=33 | N=32 | | N=80 | N=102 | |
| Disagree | 60.6% | 68.8% | n/s | 65.0% | 60.8% | n/s |
| <i>A man can hit/beat his wife if she is unfaithful</i> | N=33 | N=32 | | N=80 | N=102 | - |
| Disagree | 30.3% | 21.9% | n/s | 37.5% | 16.7% | p=.001 |

Table 8.8: Percent of female respondents who affirmed the “equitable” response to GEM Violence items, by HIV status, at baseline and endline

| Violence | Women | | | | | |
|---|-------------|-------------|--------|--------------|-------------|-----|
| | HIV+ | | | Total | | |
| | Baseline | Endline | | Baseline | Endline | |
| <i>A woman should tolerate violence to keep the family together</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 19.2% | 8.6% | n/s | 14.7% | 6.4% | n/s |
| <i>A man can hit his wife if she will not have sex with him</i> | N=52 | N=35 | | N=102 | N=94 | |
| Disagree | 32.7% | 42.9% | n/s | 29.4% | 33.0% | n/s |
| <i>A man can hit/beat his wife if she is unfaithful</i> | N=52 | N=35 | - | N=102 | N=94 | |
| Disagree | 21.2% | 2.9% | p=.011 | 13.7% | 8.5% | n/s |

Discussion of findings

More gender-equitable changes were observed among both men and women in the domains of domestic life, sexual relationships, and reproductive health. Changes in attitudes and beliefs about gender roles and norms in these domains might reflect the effects of the SBCC interventions, which were designed to initiate and sustain reflection and dialogue about gender norms and how they affect health and well-being.

The fact that both men and women endorsed less gender-equitable views at endline than at baseline in the domain of violence is of note.

Due to the important differences between the baseline and endline samples, it is difficult to assess the extent to which these changes can be attributed to the interventions.

CHAPTER 9: STUDY LIMITATIONS

Despite promising findings, there are several key limitations that should be considered when evaluating the findings from this study.

First, addressing the complex social and cultural beliefs and practices that influence family planning practices (such as gender norms) may not be feasible in the short time-frame for the project.

Secondly, several implementation challenges impacted the continuity and intensity of key program activities. The family planning referral system within the Mwase health center – planned for initiation in November 2009 was not initiated until February 2010. Through the end of the project, high staff turnover at the center prevented effective and consistent implementation of referrals.

Throughout the project, there was inadequate supply of contraceptives due to shortages and stockouts at the clinic. The inadequate supply of commodities limited our ability to effectively measure the effects of our interventions through the amount of commodities distributed. The single time series research design adopted for this study relied heavily on a constant and adequate supply of commodities to enable us measure project effects through the amount of commodities distributed. Inconsistent supply affected availability of contraceptives both at the clinic and through community-based distributors. Supply for family planning commodities was consistently outstripped by demand from the communities. For example, although OCP clients should be provided with three months' worth of pill cycles at each visit, limited supplies meant that many female clients were only able to receive one cycle at a time.

In focus groups, both distance to the clinic and inconsistent supplies from CBDs were both frequently noted as barriers to FP access in qualitative exercises.

Family planning clinics often had poor record keeping practices, or did not collect records on family planning at all, making it difficult to assess changes in the uptake of family planning services- a key outcome for the study. Non-reporting and under-reporting of family planning service provision by CBDs was another major challenge that affected not only data capture, but impacted commodities forecasting at clinics and contributed to stock-outs (since commodity orders are based on past records of distributed products.) Records show that in a given month at least one CBD typically did not report distribution data, and many CBDs kept inaccurate or incomplete records.

In sum, although the SBCC activities may have generated increased demand for FP methods, several factors related to the supply of contraceptives made it difficult for the study to demonstrate highly significant increases in family planning use. Limited availability of FP methods at Mwase RHC was one challenge, with long-term and permanent methods (like IUDs and sterilization) largely unavailable to the population. Low supplies of male condoms and OCPs were reported by both clinic staff and CBDs. CBDs in particular noted the frequency with which their supplies of contraceptives did not meet the demand in the community. Finally, data on CYP and service statistics must be interpreted cautiously due to data quality issues.

The social and behavior change strategies (SBCC) were suspended or slowed down at several points in the project. While the program target was to conduct nine to 15 community dialogues per month, activity reports indicated that only 14 dialogues were conducted in the April-May 2010 period. Further, due to miscommunication, SAA activities were again suspended in June 2010 in preparation for the midline research study, and resumed in August 2010.

In September 2010, CARE Zambia employed additional staff and conducted refresher training for facilitators to strengthen implementation of SBCC activities, including an SBCC coordinator and additional six facilitators. The project regained momentum, with 43 community dialogues conducted between September 2010 and January 2011.

A key component of the SBCC strategy—the community family planning discussion guide—was introduced very late in the project (February 2011), allowing for only four months of use before the project endline in June 2011. Thus, it is very difficult to assess the “value added” of this SBCC tool.

CHAPTER 10: SUMMARY AND CONCLUSIONS

This endline report presents data collected on attitudes and behaviors related to sex, gender relations, and FP for a sample of the population in Mwase Lundazi, Eastern Province, Zambia in May 2011. Data were obtained from a survey of 196 HIV-positive and HIV-negative individuals and ten FGDs conducted with men and women of different ages in the study population. Key outcomes of interest included family planning uptake, approval for FP, and attitudes related to a series of norms describing gender relations.

Many of the findings presented in this report were analyzed for statistically significant changes from the baseline survey conducted in 2009. However, there are some differences in the characteristics of the baseline and endline survey samples. The endline female sample was characterized by higher rates of school attendance and earlier age at marriage compared to the baseline female sample. Both male and female respondents in the endline survey reported higher rates of exposure to TV compared to baseline respondents. Female endline respondents also reported higher rates of exposure to radio.

Educational background and exposure to mass media may both be associated with the outcomes of interest, as well as other measures presented in this report. As such, the differences in the characteristics of the two samples must be noted when interpreting apparent differences in reported outcomes between baseline and endline surveys.

Important changes in key outcome variables—such as increased current use of FP, increased approval for FP use, and improved attitudes related to a few gender norms—occurred primarily among female respondents. When significance was analyzed by HIV status, most changes were significant only for the female HIV-negative sub-sample.

Analysis of program reach variables also indicated greater effects of interventions among female respondents compared to male respondents. This finding might be related to greater attendance by females at SAA and BCC dialogues (as reported by a program officer); this might also be driven by common health worker biases that tend to result in targeting women instead of men with FP services, though there are no data to back up this hypothesis.

Observed increases in use of family planning among female respondents were typically significant for both sub-samples, although HIV-positive female respondents did exclusively report two key improvements that were not observed among HIV-negative female respondents: increased access to contraceptives from CHWs and increased interaction with clinic workers on the subject of FP. Together, these might suggest the success of efforts to improve the provision of FP services to HIV-positive individuals at the clinic and community levels.

Male respondents did report increases in two important variables related to program implementation: increased attendance at meetings where FP was discussed and increased access to contraceptives from Mwase RHC. For meeting attendance, the increase was significant for the male sample overall as well as for HIV-positive male respondents.

Fertility desire and intention

In both the baseline and the endline samples, a comparable proportion of female survey respondents indicated that they had not wanted to be pregnant or had wanted to delay pregnancy, compared to those who had wanted to be pregnant (in reference to their most recent pregnancy.) Distributions were similar by HIV status. This finding indicates a gap between fertility desire and practice for a large proportion of women.

There was an indication that, at baseline, women had a clearer idea about the number of children they want and when to have them. When asked about their desire to have another child, smaller proportions of endline female sample indicated being unsure about their fertility intentions, when compared to baseline respondents. In addition, at each level of the number of surviving children, larger proportions of endline female respondents compared to baseline respondents reported wanting no more children. Inter-survey differences were statistically significant for the female sample overall as well as for HIV-positive female respondents, possibly signalling the success of efforts to target HIV-positive women with FP messages.

The majority of male and female respondents stated that a woman in the community should have four to five children. Reported ideal family size for a man was slightly higher, with almost equal proportions of respondents saying a man should have either four to five children or six or more children.

When asked what they perceived to be the community's ideal family size, the modal size was 6 or more children among endline female. Though what people perceived to be the ideal family size in the community remained high, there appeared to be some decline between the baseline and endline surveys among female respondents overall and HIV-negative female respondents specifically.

These perceptions of high childbearing norms might help explain some of the apparent contradiction between low fertility desire and high actual fertility. Qualitative data on a number of sub-themes converge to suggest that women were more susceptible than men in the community to the perception of external pressure and community norms with respect to child-bearing.

Contraceptive uptake

Over half of endline female respondents reported using a modern method of FP at the time of the survey—an increase from the baseline that was statistically significant for all females and for HIV-negative female respondents (though the proportion of current users remained higher among HIV-positive female respondents than among HIV-negative female respondents).

Just under half of male respondents reported current use, with no significant changes from the baseline. Twice as many HIV-positive male respondents indicated current use compared to HIV-negative male respondents in the endline sample; the distribution did not differ significantly by HIV status in the endline female sample.

Male condoms continue to be the most commonly reported method of FP in the sample population, followed by injectables and OCPs. Use of long-term and permanent methods (like IUD and sterilization) remained low.

Data from FGDs revealed that myths around FP and fear of side effects persisted, and might contribute to low uptake. Approximately one in ten female non-users from the endline survey reported fear of side effects as their reason for not using FP. The proportion of female respondents who reported lack of knowledge of an FP method or source declined between the baseline and endline surveys, perhaps indicating the success of SBCC efforts to connect community members to FP services in their community. Changes were not significant when analyzed by HIV status.

Approval for FP

Approval for FP use generally remained high among all respondent groups, and increased significantly among female respondents overall and HIV-negative female respondents. By

contrast, approval for FP use by a newly married couple remained very low among both female and male respondents.

Despite low approval for the use of family planning by newly married couples, it is important to note that the proportion of male respondents who supported a couple deciding when to have children increased between the baseline and the endline (from 22.5 percent to 35.3 percent). The increase was particularly significant among HIV-positive respondents: the proportion of HIV-positive respondents who indicated that newly married couples should be able to decide how long to delay childbearing doubled between the baseline and endline (from 24.2 percent to 50.0 percent). Changes were statistically significant for the male population overall ($p=.051$) as well as HIV-positive male respondents (.010). Reconciling these various themes in the quantitative and qualitative data, it seemed that while community members were distinctly aware of norms that expect couples to bear children (and to do so early on in their marriage to give the marriage meaning), there is a possibility that norms are shifting to allow some space for birth delay by young couples.

Data from FGDs revealed the pervasiveness of the belief that the primary purpose of marriage is to produce children. Furthermore, there was evidence that this pressure dissuaded young couples from delaying birth and using FP. Male and female participants noted that refusal to produce children in a marriage—particularly for women, but also for men—could result in shame, divorce, and interference from other members of the family.

Though attitudes around unmarried couples' use of FP were not directly elicited in the survey, qualitative data show that strong norms in the community discouraged young people's use of FP. This is despite the fact that the study population was characterized by high rates of pre-marital sex: data suggested that more than half of married male respondents and a quarter of married female respondents had had sex before marriage.

In the study area, women's (married or unmarried) use of FP was often viewed in the community as being associated with promiscuity or prostitution. By contrast, young men's use of FP was sometimes viewed as a means of self-protection. FGD participants also indicated that there could be situations in which a young girl's use of FP would be more acceptable, for instance, to prevent pregnancy in order to enable her complete her education.

With respect to perceptions of and approval for FP use, the proportion of both male and female respondents who believed that a woman who uses FP will be unfaithful declined over the course of the study. Changes were significant for male respondents overall and HIV-positive male respondents; among females, changes were significant for the overall sample and the HIV-negative female sub-sample.

Program reach and barriers to FP provision

A number of items measured in the survey instrument captured data that could reflect the effects of SBCC implementation.

The study survey asked respondents whether they had heard a message on either FP or HIV through the radio, TV, or drama. Higher percentages of endline female respondents reported to have heard messages on both FP and HIV. Increases were statistically significant for HIV-positive and HIV-negative female respondents, as well as for the female sample overall. While the BCC strategy did employ community-based theater, the data did not permit investigation of whether these reported messages came from the study interventions or other sources.

The SBCC strategies included community meetings to conduct dialogues on FP- and HIV-related issues. Other programs in the area also used community meetings to disseminate messages on a range of issues, including PMTCT, safe motherhood, FP, and HIV. Consequently, it became difficult to adequately determine the effects of the study interventions.

Compared to baseline respondents, higher proportions of both male and female endline respondents reported to have attended a meeting where FP was discussed. More endline female sample also attended meetings where HIV was discussed. The increases in meeting attendance for both FP and HIV were significant for HIV-positive respondents, HIV-negative respondents, and the sample overall. The increase in male attendance at meetings where FP was discussed was significant for all males but not for sub-groups of males.

SBCC facilitators were also trained to conduct one-on-one meetings with interested FP clients. Almost three times as many endline female respondents as baseline female respondents reported to have been visited by a health worker to discuss FP; increases were significant for the female sample overall and for HIV-positive as well as HIV-negative sub-samples. Significantly higher proportions also said they had been visited by a health worker to discuss HIV, though increases were only significant for HIV-negative respondents and the sample overall.

The study also showed some improvements in community-based outreach efforts. The proportion of endline female respondents who received contraceptives from a CHW increased significantly from baseline. At the same time, there was also a significant increase in the proportion of female respondents who had been to a health clinic in the previous 12 months and had been spoken to about FP by a health worker. Increases for both variables were significant for female respondents overall as well as HIV-positive female respondents, possibly capturing the successful implementation of the SBCC interventions at the clinic as well as community level.

Among males who reported using a contraceptive method at the time of the survey, the percentage who obtained contraceptives from the government health center (Mwase RHC) increased significantly between the baseline and the endline for the overall sample (though increases were not significant by HIV status).

Gender relations

Survey respondents were asked to indicate the extent to which they agreed with a series of 25 statements describing gender relations.

There was some indication in the qualitative and survey data that joint decision-making did not necessarily signal gender equality in decision-making. The majority of male and female respondents agreed that a man should have final say about decisions in his home. The majority of respondents also believed that *“a woman should obey her husband in all things”* (though the proportions who disagreed with this statement increased significantly among female respondents and female HIV-negative respondents). Discussions around decision-making in the FGDs confirmed that men typically held final decision-making authority in the community and within relationships.

However, high proportions of respondents expressed the belief that a man and a woman should decide together what type of contraceptive to use. The majority of baseline and endline respondents who were using a modern method of FP at the time of the surveys reported that they and their partners had jointly made the decision to use that particular method.

Respondents almost universally endorsed the idea that a man and woman should decide together whether or not they want to have children. In fact, the proportion of female respondents who agreed with this statement increased significantly over the course of the study; the increase among female HIV-negative respondents was just short of significance.

Qualitative data suggest that couples’ autonomous decision-making might not extend past the widespread value placed on fertility in marriage. The FGDs revealed a strong belief in the community that the primary purpose of marriage was childbearing. In addition, the majority of survey respondents agreed that a couple that does not want children was not “normal,” further signaling strong norms around child-bearing that translated to pressure for young couples.

Survey responses indicated a general acceptance of violence against women in relationships. The majority of male and endline female sample agreed that a man can hit or beat his wife if she is unfaithful. In fact, the proportion of male respondents overall and male HIV-negative respondents who agreed with this statement increased over the study period. The majority of female respondents also agreed that a man can hit or beat his wife if she refuses to have sex with him, indicating the extent to which women themselves have come to accept violence against women. Unexpectedly, the proportion of male and female respondents who believed that a woman should tolerate violence to keep the family together increased significantly from the baseline, and constituted a high majority of respondents.

Finally, both quantitative and qualitative data reveal that men were perceived as having high sexual needs. In FGDs, this perception was often cited as an explanation for seemingly silent acceptance of common local practices such as extramarital affairs among men, and young unmarried men’s use of FP.

APPENDICES

ZAMBIA FP/HIV SURVEY FOR USE WITH FEMALE RESPONDENTS

SECTION 0: IDENTIFICATION PARTICULARS

| | | | | |
|-----------------------------|-----------------|------------------|------|---------|
| 001 QUEST. ID No. | _ _ _ _ _ _ _ _ | 002 VILLAGE_____ | CODE | _ _ _ _ |
| 008 LOCATION (U = 1; R = 2) | _ _2_ | | | |

Introduction: ðMy name isí I work for CARE Zambia, which is doing research work to help understand barriers to the use of modern methods of contraception in Zambia. We’re interviewing people here [name of village] to find out about the use and non-use of family planning methods as well as the factors that promote or hinder the use of these methods. Have you been interviewed in the past few weeks [or other appropriate time period] for this study? **IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.** Tell them you cannot interview them a second time, thank them, and end the interview. If they have not been interviewed before, continue:

Dzina Langa Ndine _____, ndi gwira nchito ku CARE – Zambia, bungwe limene lifuna kudziwa zobvuta kuti tigwiritse nchito njira zasopano zacilezi mu dziko la Zambia. Tilufunsa anthu pano _____ (dzina la mudzi) kuti tidziwe kugwiritsa kapena kusagwiritsa nchito njira cilezi ndiponso zobvuta zake. Kodi munafunsidwapo ca sopanopa pa kafuku-fuku? Ngati woyankha abvomera, osafunsanso. Lekezani mafunso anu powaonga ndi kuwauza kuti simungawafunsenso kaciwiri. Ngati sanafunsiwepo kale, pitilizani.

Confidentiality and consent: ðI’m going to ask you some very personal questions. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about 60 minutes to ask the questions.

Zacinsisi: “Ndizakufunsani mafunso apadera wokhuza inu. Mayankho anu azakhala acinsnci. Dzina lanu silizalembedwa pa pepala ili, musayankhe funso limene simufuna kuyankha ndiponso nthawi iliyonse mungathese kufunsidwa uku. Koma mayankho anu onse azatithandiza ife kudziwa zimene anthu amaganiza, amalankhula ndiponso zimene acita mumakambidwe ena ace. Tizathokoza kwambiri pakutithandiza kuyankha mafunso yakafuku-fuku. Kafuku-fuku uyu azatenga ola limodzi (60mins) , kufunsa mafunso.

[Interviewer asks if the respondent has any questions and provides the necessary clarification before proceeding with the informed consent].

Would you be willing to participate?
Kodi mudzipeleka kutengako mbali?

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Interviewer visit

| | Visit 1 | Visit 2 | Visit 3 |
|-------------|---------|---------|---------|
| Date | | | |
| Interviewer | | | |
| Result | | | |

Result codes: Completed 1; Partially Completed 2; Refused 3; Other 4.

009 INTERVIEWER: Code [__|__] Name _____

010 DATE OF INTERVIEW: __\ __\ 2011

011 CHECKED BY SUPERVISOR: Signature _____ CODE [__|__] Date _____

012 SIGNATURE AND CODE OF SAPC: _____ CODE [__|__]
 Date _____

ZAMBIA FP/HIV SURVEY

Section 1: Background characteristics

| | Questions and filters | Coding categories | Skip to |
|------|---|--|------------------|
| Q100 | Time Interview started Time interview ended | [__ __:__ __] AM/PM [__ __:__ __] AM/PM | |
| Q101 | How old were you at your last birthday? <i>Munali ndi zaka zingati zakubadwa chaka chatha?</i> | AGE IN COMPLETED YEARS [__ __] DONOT KNOW 88 NO RESPONSE 99 | |
| Q102 | Have you ever attended school? <i>Kodi munapitako kusukulu?</i> | YES 1 NO 2 NO RESPONSE 99 | → Q105 |
| Q103 | What is the highest level of school you attended: primary, secondary or higher? | PRIMARY 1 SECONDARY 2 HIGHER 3 | → |

| | | | |
|------|---|---|-------------|
| | <p><i>Mudafika Geredi bwanji Pulaimale, Sekondale kapena Univesite?</i></p> <p style="text-align: center;">CIRCLE ONE</p> | | Q105 |
| Q104 | <p>What is the highest grade you completed at that level?</p> <p><i>Mudafika Geredi bwanji lothera?</i></p> | GRADE [][] | |
| Q105 | <p>How long have you lived here in (NAME OF COMMUNITY/ TOWN NEIGHBORHOOD/ VILLAGE)?</p> <p><i>Mwakhala zaka zingati muno (MMUDZI /BOMA)?</i></p> | <p>NUMBER OF YEARS [][] RECORD 00 IF LESS THAN 1 YEAR</p> <p>DONØT KNOW 88 NO RESPONSE 99</p> | |
| Q106 | <p>Do you listen to the radio almost every day, at least once a week, less than once a week or not at all</p> <p><i>Kodi mumanvetsela ku wailesi; tsiku lililonse, kamodzi mu sabata, kosapitirira kamodzi pa sabata kapena kusamvererako konse.?</i></p> | <p>ALMOST EVERY DAY 1 AT LEAST ONCE A WEEK 2 LESS THAN ONCE A WEEK 3 NOT AT ALL 4</p> | |
| Q107 | <p>Do you watch the television almost every day, at least once a week, less than once a week or not at all</p> <p><i>Kodi m'maona wailesi yakanema; tsiku lililonse, kamodzi mu sabata, kosapitirira kamodzi pa sabata kapena kusamvererako konse.?</i></p> | <p>ALMOST EVERY DAY 1 AT LEAST ONCE A WEEK 2 LESS THAN ONCE A WEEK 3 NOT AT ALL 4</p> | |
| Q108 | <p>What is your religion?</p> <p><i>Mupemphera kuti?</i></p> <p style="text-align: center;">CIRCLE ONE.</p> | <p>CATHOLIC 1 PROTESTANT 2 MUSLIM 3</p> <p>OTHER [SPECIFY] í í í í í í í í í 4</p> | |
| Q109 | <p>Which tribe do you belong to?</p> <p><i>Ndinu atundu bwanji?</i></p> | | |

Section 2: Marriage

| No. | Questions and filters | Coding categories | Skip to |
|-----------|---|---|--|
| Q201 | Have you <i>ever</i> been married? <i>Munakhalapo m'banja?</i> | YES 1 NO 2 NO RESPONSE 3 | →Q20 3b →Q20 3b |
| Q202 | How old were you when you first married? <i>Munali ndi zaka zingati zobadwa polowa m'banja?</i> | Age in years [__ __] DONØT KNOW 88 NO RESPONSE 99 | |
| Q203 a | Are you í í (Probe) <i>Kodi muli</i> | currently married, living with spouse 1 living with other sexual partner 2 not living with spouse or any other sexual partner 3 Separated 4 Divorced 5 Widow 6 | →Q20 4 →Q20 4 } →Q30 2 |
| Q203 b | Are you í í <i>Kodi muli</i> | living with sexual partner 1 not living with sexual partner 2 NO RESPONSE 3 | →Q30 2 } →Q30 1 →Q30 1 |
| Q204 | Does your spouse/partner have other wives/other partners? <i>Kodi amuna anu ali ndi akazi ena?</i> | YES 1 NO 2 DONØT KNOW 8 NO RESPONSE 9 | } →Q30 2 →Q30 2 →Q30 2 →Q30 2 |

Section 3: Sexual and childbearing experience

Now I am going to ask you some personal questions about sex. Please answer the questions honestly.

Tsopano ndizakufunsani mafunso pa zokhala malo amodzi. Conde muyankhe moona.

| No. | Questions and filters | Coding categories | Skip to |
|------|---|--|--------------------------|
| Q301 | <p>[ASK ONLY THOSE WHO HAVE NEVER BEEN MARRIED <u>NOR</u> ARE LIVING WITH A SEXUAL PARTNER]</p> <p>Have you ever had sexual intercourse?</p> <p><i>Kodi munakhalapo malo amozi ndi mwamuna?</i></p> | <p>YES 1 NO 2 NO RESPONSE 99</p> | <p>→Q31 1</p> |
| Q302 | <p>[ASK ONLY EVER MARRIED WOMEN <u>OR</u> WOMEN LIVING WITH A SEXUAL PARTNER]</p> <p>At what age did you first have sexual intercourse?</p> <p><i>Munali ndizaka zingati pamene munakhala ndi mwamuna malo amodzi koyamba?</i></p> | <p>AGE IN YEARS [_ _] DONØT KNOW 88 NO RESPONSE 99</p> | |

| | | | |
|------|---|---|-----------------------------|
| Q303 | <p>How much older or younger was the person with whom you had your first sexual experience? <i>Anali ndi zaka zochepekera zingati kapena zochulukapo motani pa msinkhu wanu pamene munakhala malo amodzi?</i></p> <p style="text-align: right;">READ OUT ANSWERS:</p> | <p>MORE THAN 10 YRS OLDER 1 5-10 YRS OLDER 2 LESS THAN 5 YRS OLDER 3 LESS THAN 5 YEARS YOUNGER 4 5 YEARS OR MORE YOUNGER 5 DONØT KNOW 88 NO RESPONSE 99</p> | |
| Q304 | <p>Have you had sexual intercourse in the last 12 months (i.e. since ___ May 2010)? <i>Munakhalapo malo amodzi ndi mwamuna m'miyenzi khumi ndi ziwiri yathayi (kucokera __May 2010)?</i></p> | <p>YES 1 NO 2 NO RESPONSE 99</p> | |
| Q305 | <p>How many children have you ever given birth to who are currently alive? <i>Mwabeleka ana angati amene ali moyo?</i></p> | <p>NUMBER OF CHILDREN [][] (Record 00 if the respondent has no children) NO RESPONSE 99</p> | <p>00→Q307 00→Q307</p> |
| Q306 | <p>Of the children alive: <i>Mwa ana alimoyo</i></p> <p>How many are boys? <i>Ndi angati amuna?</i></p> <p>How many are girls? <i>Ndi angati akazi?</i></p> | <p>NUMBER OF BOYS [][] NUMBER OF GIRLS [][]</p> | |
| Q307 | <p>Are you currently pregnant? <i>Lelo lino, kodi muli ndi pakati?</i></p> <p>IF NO in both Q305 and Q307, skip to Q309</p> | <p>YES 1 NO 2 NO RESPONSE 99</p> | |
| Q308 | <p>When you were pregnant with your last baby (or current baby if pregnant) did you want to become pregnant then, did you want to wait until later, did you not want to be pregnant at all, or did you not think about it? <i>Pamene munali ndi pakati pamwana wakupera, kodi munafuna kukhala ndi</i></p> | <p>WANTED TO BE PREGNANT 1 WANTED TO WAIT 2 DID NOT WANT TO BE PREGNANT 3 DID NOT THINK OF IT 4</p> | |

| | | | |
|------|--|---|-------|
| | <i>pakati nthawi imeneyo, munafuna kudikhila, simunali kufuna kukhala ndi pakati kapena simunaganizire zimenezi?</i> | | |
| Q309 | <p><u>IF NOT PREGNANT, ASK:</u> Would you like to have (a/another) child or would you prefer not to have any more children?</p> <p><i>Kodi mufuna kukhala ndi mwana ,kapena mwana wina ?Kapena simufuna kukhala ndiana ena ?</i></p> <p><u>IF PREGNANT, ASK:</u> After the child you are carrying now, would you like to have another child or would you prefer not to have any more children?</p> <p><i>Mtabeleka mwanayo, mungafune kukhala ndi mwana wina kapena iyai ?</i></p> | <p>HAVE (A/ANOTHER) CHILD 1 NO MORE/NONE 2 CANØT GET PREGNANT 3 UNDECIDED/DK AND PREGNANT 4 UNDECIDED/DK AND NOT PREGNANT OR UNSURE 5</p> | →Q311 |
| Q310 | <p><u>IF NOT PREGNANT, ASK:</u> How long would you like to wait from now before the birth of (a/another) child?</p> <p><i>Mungayembekeze mwakanthawi bwanji kuchokera lero kuti mukakhale ndi mwana kapena wina</i></p> <p><u>IF PREGNANT, ASK:</u> After the birth of the child you are expecting now, how long would you like to wait before the birth of (a/another) child?</p> <p><i>Mukabereka mwanayo munganiza mungakhale nthawi ya itali bwanji kuti mukhale ndi mwana wina?</i></p> | <p>MONTHS _ _ YEARS _ _ SOON/NOW 993 CANØT GET PREGNANT 994 DONØT KNOW 88</p> | |
| Q311 | <p>How many children do you think a woman in your community should have?</p> <p><i>Kwanu kuno, munganiza m'kazi</i></p> | <p>NUMBER OF CHILDREN _ _ DK 88</p> <p>NUMBER OF SONS _ _ </p> | |

| | | | |
|------|---|--|--|
| | <p><i>angakhale ndi ana angati?</i></p> <p>How many sons? <i>Amuna angati?</i></p> <p>How many daughters? <i>Akazi angati?</i></p> | <p style="text-align: right;">DK 88</p> <p>NUMBER OF DAUGHTERS _ _ DK 88</p> | |
| Q312 | <p>How many children do you think a man in your community should have? <i>Kwanu kuno, muganiza mwamuna angakhale ndi ana angati?</i></p> <p>How many sons? <i>Amuna angati?</i></p> <p>How many daughters? <i>Akazi angati?</i></p> | <p>NUMBER OF CHILDREN _ _ DK 88</p> <p>NUMBER OF SONS _ _ DK 88</p> <p>NUMBER OF DAUGHTERS _ _ DK 88</p> | |

Section 4a: Contraception

| No. | Questions and Filters | Coding categories | Skip to |
|------|--|---|-------------------------|
| Q401 | <p>IS RESPONDENT CURRENTLY MARRIED OR HAVING A SEXUAL PARTNER?</p> <p>CHECK ANSWERS TO Q201 AND Q203A</p> | <p>YES 1</p> <p>NO 2</p> | →Q412 |
| Q402 | <p>Have you or your sexual partner <i>ever</i> used anything or tried in any way to delay or avoid being pregnant?</p> <p><i>Kodi inu kapena amuna anu, munayesako kugwiritsa nchito kapena njira ina iliyonse kuletsa kukhala ndi pakati?</i></p> | <p>YES 1</p> <p>NO 2</p> <p>DONØT KNOW 88</p> <p>NO RESPONSE 9</p> | →Q409 |
| Q403 | <p>What have you used or done</p> <p><i>Munagwiritsa nchito njira yotani ?</i></p> | <p>ABSTAINED FROM SEX USED FP METHOD 1</p> <p>OTHER _____ 2</p> <p>(SPECIFY) 3</p> | →Q405 →Q405 →Q405 |
| Q404 | <p>What family planning method(s) have you or your partner ever used? (STATE ALL THAT APPLY)</p> | <p>FEMALE 01</p> <p>STERILIZATION 02</p> <p>MALE STERILIZATION 03</p> <p>IUD 04</p> | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------------|--|--|-------|---|---|-----------------------|--|--|---------------------|---|---|--------------------|---|---|-------------|---|---|------------------|---|---|--------|---|---|-------|--|--|------------------------|--|--|--|---|---|---------|---|---|-----------------|---|---|-------------------------|---|---|----------|--|--|--|
| | <i>Ndi njira za chilezi zotani z imene munagwiritsapo nchito? (chulani zonse)</i> | PILL 05 INJECTABLES 06 IMPLANTS 07 MALE CONDOM 08 FEMALE CONDOM 09 LACT AMEN. METHOD 10 RYTHM METHOD OTHER_____ 11 (SPECIFY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q405 | Are you or your sexual partner <u>currently</u> using anything or trying in any way to delay or avoid being pregnant? <i>Kodi inu kapena amuna anu mumagwiritsa nchito chilezi ?</i> | YES 1 NO 2 | →Q409 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q406 | What family planning method are you or your partner currently using? <i>Ndi njira yotani yachilezi imene mugwiritsa nchito lero?</i> (STATE ALL THAT APPLY) | FEMALE STERILIZATION 01 MALE STERILIZATION 02 IUD 03 PILL 04 INJECTABLES 05 IMPLANTS 06 MALE CONDOM 07 FEMALE CONDOM 08 LACT AMEN. METHOD 09 RYTHM METHOD 10 OTHER_____ 11 (SPECIFY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q407 | Where did you or your partner obtain the method(s) you are currently using? <i>Kodi njira izi munazitenga kuti ?</i> PROBE AND RECORD ALL ANSWERS Any others? <i>Pali zina?</i> | <table border="0"> <tr> <td></td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td colspan="3" style="text-align: center;">Public Sector:</td> </tr> <tr> <td>GOVERNMENT HOSPITAL</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>GOVT HEALTH CENTER</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>HEALTH POST</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>COMMUNITY HEALTH</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>WORKER</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>OTHER</td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;">Private Sector:</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PRIVATE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>HOSPITAL/DOCTOR</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>MISSION HOSPITAL/CLINIC</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PHARMACY</td> <td></td> <td></td> </tr> </table> | | Y | N | Public Sector: | | | GOVERNMENT HOSPITAL | 1 | 2 | GOVT HEALTH CENTER | 1 | 2 | HEALTH POST | 1 | 2 | COMMUNITY HEALTH | 1 | 2 | WORKER | 1 | 2 | OTHER | | | Private Sector: | | | | 1 | 2 | PRIVATE | 1 | 2 | HOSPITAL/DOCTOR | 1 | 2 | MISSION HOSPITAL/CLINIC | 1 | 2 | PHARMACY | | | |
| | Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Public Sector: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GOVERNMENT HOSPITAL | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GOVT HEALTH CENTER | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEALTH POST | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COMMUNITY HEALTH | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WORKER | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Private Sector: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PRIVATE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HOSPITAL/DOCTOR | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MISSION HOSPITAL/CLINIC | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PHARMACY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | |
|--|--|-------------------|-----|
| | | OTHER PRIVATE | |
| | | Other: | 1 2 |
| | | | 1 2 |
| | | COM HEALTH WORKER | |
| | | PEER EDUCATOR OR | 1 2 |
| | | OUTREACH WORKER | 1 2 |
| | | SHOP | 1 2 |
| | | FRIEND/RELATIVE | 1 2 |
| | | OTHER _____ | |
| | | NO RESPONSE | |

| | | | |
|------|---|--|---|
| Q408 | <p>Who made the decision to use the method you are currently using?</p> <p><i>Kodi ndani ana panga fundo yogwilitsa njira zimene mugwiritsa nchito lero</i></p> | <p>ME (SELF) 1 SPOUSE/PARTNER 2 BOTH SELF AND PARTNER 3 OTHER (SPECIFY) 4 _____</p> | <p>→Q412 →Q412 →Q412 →Q412</p> |
| Q409 | <p>What is the main reason you have never used or are not using a method of contraception to delay or avoid pregnancy?</p> <p><i>Cifukwa ninji simunagwiritsepo nchito kapena si mugwiritsa nchito njira zachilezi kupewa kapena kucedwetsa kukhala ndi pakati?</i></p> | <p><u>MARITAL REASON:</u> 10</p> <p>NOT MARRIED 11</p> <p><u>FERTILITY RELATED REASONS:</u></p> <p>NOT HAVING SEX 21 NOT HAVING SEX 22 INFREQUENT SEX 23 MENOPAUSAL/HYSTERECTOMY 24 SUBFECUND/INFECUND 25 POSTPARTUM BREASTFEEDING 26 PREGNANT 27 WANTS MORE CHILDREN 30</p> <p><u>OPPOSITION TO USE:</u></p> <p>RESPONDENT OPPOSED 31 HUSBAND OPPOSED 32 OTHERS OPPOSED 33 RELIGIOUS PROHIBITION 34</p> <p><u>LACK OF KNOWLEDGE:</u></p> <p>KNOWS NO METHOD 40 KNOWS NO SOURCE 41</p> <p><u>METHOD RELATED REASONS:</u></p> <p>HEALTH CONCERNS 42 FEAR OF SIDE EFFECTS 50 LACK OF ACCESS/TOO FAR 51 COST TOO MUCH 52 INCONVENIENT TO USE 53 INTERFERES WITH BODY'S NATURAL PROCESSES 54</p> | |

| | | | |
|------|---|---|-------|
| | | OTHER (SPECIFY) DONOT KNOW | |
| Q410 | Are you or your partner planning to use a family planning method in the future? <i>Musogolomu, kodi inu kapena amuna anu, muganiza zogwiritsa nchito njira yachilezi ?</i> | YES 1 NO 2 | →Q412 |
| Q411 | Which method will you use <i>Muzagwilitsa njira yotani ?</i> | FEMALE STERILIZATION 01 MALE STERILIZATION 02 IUD 03 PILL 04 INJECTABLES 05 IMPLANTS 06 MALE CONDOM 07 FEMALE CONDOM 08 LACT AMEN. METHOD 09 RYTHM METHOD 10 OTHER (Specify) 11 | |

Section 4b: Beliefs about Family Planning Methods

| No. | Questions and filters | Coding categories | Skip to |
|------|--|-----------------------------------|---------|
| | <p>Now I would like to read to you some statements about family planning methods. For each statement I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree)</p> <p><i>Tsopano ndizawerenga njira zachilezi .Pafunso iliyonse muzatha kunena mayankho awa ;(1=sidibvomekeza, 2=ndikaika, 3=ndibvomekeza)</i></p> <p>INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION</p> | | |
| Q412 | Women who take the oral pill will get fat <i>Akazi amène akumwa mapilisi yachilezi azanenepa.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q413 | Men who have a vasectomy (sterilization) will become weak <i>Amuna amène agwiritsa nchito njira yachilezi sazakhala ndi mphamvu</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q414 | An IUD can move inside a woman and hurt her <i>Katsulo ka IUD kakalowa mkati mwaukazi kangampweteke</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q415 | Condoms can do harm to a man's penis | DISAGREE 1 | |

| | | | |
|--|---|---|--|
| | <i>Mphila ya kondomu yingapweteke umuna wamwamuna.</i> | UNSURE 2 AGREE 3 | |
| <p>Now I would like to read to you some statements about what you may think about those who use family planning methods. For each statement I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree)</p> <p><i>Tsopano ndizawerenga kwa inu mfuno zokambidwa zimene muganiza pa iwo amène agwiritsa nchito njira yacilezi. Pa cokambidwa ciriconse, ndifuna mudiuze kapena (1= mukana naco, 2= kapena simudziwa bwino, 3= mwabvomekezana naco).</i></p> <p>INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION</p> | | | |
| Q416 | In general, I approve of couples using family planning to avoid or delay a pregnancy <i>Ndibvomekeza kuti am'mabanja afunika kusewenzetsa chilezi kuti apewe kapena asakhale ndipakati</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q417 | I think that most of my friends in this community would approve of couples using family planning to avoid or delay a pregnancy <i>Ndiganiza kuti ambiri mwa anzanga mu dela muno azavomekeza kuti mabanja aja wogwiritsa njira yachilezi kupewa pakati kapena kuchebwa kukhala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q418 | I think that my spouse would approve of couples using family planning to avoid or delay a pregnancy <i>Ndiganiza kuti amuna anga angabvomekeze mabanja aja wogwilitsa nchito njira ya chilezi kupewa pakati kapena kuchebwa kukhala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q419 | I approve of a young recently married couple with no children using family planning to avoid or delay a pregnancy <i>Ndibvomekeza kuti achichepele wolowa m'banja lasopano angagwiritse nchito njira poyopsya kutenga pakati kapena kuchebwa kukhala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q420 | A woman who uses contraception will be | DISAGREE 1 | |

| | | | |
|--|---|--------------------------------------|--|
| | unfaithful to her husband <i>Mkazi omwe atsewenzetsa njira yachilezi amakhala wosakhulupirika m'mbanja</i> | UNSURE 2 AGREE 3 | |
| Q421 | A man who lets his wife to use contraception will lose control of her <i>Mwamuna obvomeleza mkazi wake kusewenzetsa njira yachilezi sazamkwanitsa mkazi wake kusogolela.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q422 | A couple who does not want children are not normal <i>Anthu amabanja amene safunakukhaka ndi ana, Sali bwino mumaganizo awo.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Now I would like to ask you some questions about your community <i>Tsopano ndizafusa mafunso pa zakuno kudela kwanu.</i> | | | |
| Q423 | How many sons do you think people in this community want to have? <i>Muganiza kuti anthu kuno kudela amafuna kukhala ndi ana angati?</i> | NUMBER OF SONS __ __ DK 98 | |
| Q424 | How many daughters do you think people in this community want to have? <i>Ndi angati ana achikazi muganiza anthu kuno afuna kukhala nawo?</i> | NO OF DAUGHTERS __ __ DK 98 | |
| Q425 | What do you think is the ideal age at marriage for women in this community? <i>Muganiza Akazi ayenera kukhala ndi zaka zingati zobadwa kuti alowe m'banja kuno kwanu?</i> | IDEAL AGE AT MAR __ __ DK 98 | |
| Q426 | What do you think is the ideal age at marriage for men in this community? <i>Muganiza Amuna ayenera kukhala ndi zaka zingati zobadwa kuti akwatile wamkazi?</i> | IDEAL AGE AT MAR __ __ DK 98 | |

| | | | |
|------|---|--|--|
| Q427 | <p>After a couple gets married, how long should it be before they have their first child? Within one year, more than one year or is it up to the couple to decide?</p> <p><i>Atalowa m'banja, ayenera kukhala nthawi yaitali bwanji asanakhale</i></p> <p><i>Ndi manna woyamba (Caka Cimodzi, Kupitirirapo chaka, kapena chirri Kwa Iwo kusankha)</i></p> | <p>WITHIN ONE YEAR 1</p> <p>MORE THAN ONE YEAR 2</p> <p>UP TO THE COUPLE 3</p> | |
|------|---|--|--|

Section 5: Exposure to Information on FP and HIV

| No. | Questions and filters | Coding categories | Skip to |
|------|---|---|------------------------|
| Q501 | <p>Have you heard any message or seen any program about family planning on the radio, TV, print materials or through/drama within the last 12 months (i.e. since __May 2010)?</p> <p><i>Munambvako uthenga uliwonse pawailesi kapena kuwona pakanema, komanso kupyolera msewero, zipikicha pankhani za chilezi pamiyezi khumi ndiziwiri (12) kuchokera mchaka ca __May 2010</i></p> | <p>YES 1 NO 2 NO RESPONSE 3</p> | <p>→Q503 →Q503</p> |
| Q502 | <p>Which ones have you heard or seen?</p> <p><i>Munamvapo kapena kuona ziti?</i></p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | |
| Q503 | <p>Have you heard any message or seen any program about HIV on the radio, TV, print materials or through/drama within the last 12 months (i.e. since __May 2010)?</p> <p><i>Munambvako uthenga uliwonse pawailesi kapena kuwona pakanema ,komanso kupyolera msewero, zipikicha pankhani kalombo ka edzi pamiyezi khumi ndiziwiri(12) kuchokera mchaka ca __May 2010</i></p> | <p>YES 1 NO 2 NO RESPONSE 3</p> | <p>→Q505 →Q505</p> |
| Q504 | <p>Which ones have you heard or seen?</p> <p><i>Munamvapo kapena kuona ziti?</i></p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | |
| Q505 | <p>Have you attended any meetings (formal or informal) where family planning issues were discussed within the last 12 months (i.e. since __May 2010)?</p> <p><i>Kodi munapitako kumsonkhano kumene amakambilana pa zachilezi pa myezi khumi ndi ziwiri yapitayi (Kucokera __May 2010)?</i></p> | <p>YES 1 NO 2 NO RESPONSE 3</p> | <p>→Q506 →Q506</p> |

| | | | |
|------|--|--|---------------------------|
| | <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati?</i></p> | NUMBER OF TIMES __ __ | |
| Q506 | <p>Have you attended any meetings (formal or informal) where HIV related issues were discussed within the last 12 months (i.e. since __May 2010)?</p> <p><i>Kodi munapitako kumusonkhano kumene amakambilana za Edzi mu myezi khumi ndi iwiri yapitayi (Kucokera __May 2010)?</i></p> <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati?</i></p> | <p>YES 1</p> <p>NO 2</p> <p>NO RESPONSE 3</p> <p>NUMBER OF TIMES __ __ </p> | <p>→Q507</p> <p>→Q507</p> |

| | | | |
|-------------|---|--|------------------------|
| <p>Q507</p> | <p>Have you been visited by a CHW or any other health facility staff to discuss FP with you within the last 12 months (i.e. since ___May 2010)?</p> <p><i>Kodi anakuyendelaniko anthu woyanganila zaumoyo ku midzi mu miyezi khumi ndi iwiri yapitai (Kucokera ___May 2010)?</i></p> <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati?</i></p> | <p>YES 1 NO 2 NO RESPONSE 3</p> <p>NUMBER OF TIMES __ __ </p> | <p>→Q508 →Q508</p> |
| <p>Q508</p> | <p>Have you been visited by a CHW or any other health facility staff to discuss HIV issues with you within the last 12 months (i.e. since ___May 2010)?</p> <p><i>Kodi anakuyendelaniko anthu woyanganila zaumoyo ku midzi komanso azaumoyo pa zakukambilana za Edzi mu miyezi khumi ndi iwiri yapitai (Kucokera ___May 2010)?</i></p> <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati?</i></p> | <p>YES 1 NO 2 NO RESPONSE 3</p> <p>NUMBER OF TIMES __ __ </p> | <p>→Q509 →Q509</p> |
| <p>Q509</p> | <p>Have you visited a health facility for care for yourself (or your children) within the last 12 months (i.e. since ___May 2010)?</p> <p><i>Kodi munapitako kuchipala (kapena ana anu) kukapeza thandizo mu myezi khumi ndi iwiri yapitai (Kucokera ___May 2010)?</i></p> | <p>YES 1 NO 2</p> | <p>→Q512</p> |
| <p>Q510</p> | <p>Did any staff member at the health facility speak to you about family planning?</p> <p><i>Kodi azaumoyo analankhuzana namwe pa zachilezi?</i></p> | <p>YES 1 NO 2</p> | |
| <p>Q511</p> | <p>Did any staff member at the health facility speak to you about HIV?</p> <p><i>Mwina wa zaumoyo analankhuzana namwe</i></p> | <p>YES 1 NO 2</p> | |

| | | | |
|------|---|--|---------|
| | <i>pa za Edzi?</i> | | |
| Q512 | Have you ever been tested for HIV? (I will not ask you for your status.) <i>Kodi munapimitsapo magazi anu pazaka doyo ka edzi?</i> | YES 1 NO 2 NO RESPONSE 99 | } → 601 |
| Q513 | How long ago were you tested last? <i>Papita nthawi yotani kucokera pamene munapimitsira kothera?</i> | 12 MONTHS OR MORE AGO 1 6-11 MONTHS AGO 2 3-5 MONTHS AGO 3 LESS THAN 3 MONTHS AGO 4 NO RESPONSE 99 | |
| Q514 | Did you know the result of the last test? <i>kodi mukumbukila zotuluka zake pomwe munapimitsa kothera ?</i> | YES 1 NO 2 NO RESPONSE 99 | |

Section 6: Gender Relations

| No. | Questions and filters | Coding categories | Skip to |
|------|--|-----------------------------------|---------|
| | <p>Now I would like to read to you some statements and for each one I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree)</p> <p><i>Tsopano nizawerenga zokambidwa ndipo mudiuze mwina muvomekezana nazo, mukana nazo kapena Simuziziwa bwino. (1=sidibvomekeza, 2=ndikaika, 3=ndibvomekeza)</i></p> <p>INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION</p> | | |
| Q601 | It is a woman's responsibility to avoid getting pregnant <i>Ndi nchito yamukazi kuzicingiriza ku khala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q602 | A man should have the final word about decisions in his home <i>Fundo yosirizira iyenera kucokera kumwamuna.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q603 | Men are always ready to have sex <i>Nthawi ili yonse, mwamuna ndiwokonzeka ku khala malo amozi ndi mkazi .</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q604 | A woman should tolerate violence to keep the family | DISAGREE 1 | |

| | | | |
|------|---|---|--|
| | together <i>Kuti banja ikhalepo, mkazi ayenera kupirira, dzowawa.</i> | UNSURE 2 AGREE 3 | |
| Q605 | My partner has more say than I do about important decisions that affect us <i>Mwamuna wanga amapanga fundo zo khwima kupambana ine</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q606 | Men need sex more than women do <i>Amuna amafuna kukhala malo amozi kwambiri kupambana akazi.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q607 | You don't talk about sex, you just do it <i>Sitimakambilana zakukhala malo amodzi, timangokumana cabe</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q608 | A man needs other women even if things are fine with his wife <i>Mwamuna afunika akazi ena ngakhale kuti zonse zinthu ziri bwino ndi mkazi wace.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q609 | A man can hit/beat his wife if she will not have sex with him <i>Mwamuna angapande mkazi wace ngati akana kukhala malo amozi naye</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q610 | A man can hit/beat his wife if she is unfaithful <i>Mwamuna angapande m'kazi wake ngati akhala osakhulupirika.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q611 | A couple should decide together if they want to have children <i>Am'banja agwirizana ngati afuna kukhala ndi ana.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q612 | I am more committed to this relationship than my partner <i>Ine ndine nicita zambiri m'banja mwathu kupambana mwamuna wanga.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |

| | | | |
|------|---|--|-------------------|
| Q613 | Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibilities <i>Zotangata mwana ndi nchito ya mukazi.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q614 | A woman can suggest using condoms just like a man can <i>Wa m'kazi naye angathe kuganiza zogwiritsa nchito kondomu monga mwamuna.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q615 | A man should know what his partner likes during sex <i>Mwamuna ayenera kudziwa zimene mkazi wace akonda akakhala malo amodzi</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q616 | A woman should obey her husband in all things <i>Nthawi zonse, m'kazi ayenera kulondola zonse zimene mwamunawake afuna.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q617 | A man and a woman should decide together what type of contraceptive to use <i>Mwamuna ndi Mkazi ayenera kugwirizana pamodzi nfuno ya mtundu wa mankhwala a cilezi.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q618 | A real man produces a male child <i>Mwamuna weni-weni amabala mwana mwamuna.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q619 | Men and women should share household chores <i>Mwamuna ndi Mkazi azigwira pamodzi nchito za panyumba.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q620 | A woman should be able to talk openly about sex with her husband <i>M'kazi azikhala omasuka kukamba za zo kumana ndi mwamuna wake.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q621 | A woman should not initiate sex <i>M'kazi samafunika kuyambitsa zokhala malo amodzi.</i> | DISAGREE UNSURE AGREE | 1 2 3 |
| Q622 | My partner dictates who I spend time with <i>Mwamuna wanga amandiuza munthu oceza naye.</i> | DISAGREE UNSURE AGREE NO RESPONSE | 1 2 3 99 |
| Q623 | When my partner and I disagree, my partner get their way | DISAGREE | 1 |

| | | | |
|------|---|--|--|
| | <p>most of the time</p> <p><i>Mwanmuna wanga / chisumbalii changa tikayambana zotuluka zake zimakomela iye nthawi zambiri</i></p> | <p>UNSURE 2</p> <p>AGREE 3</p> <p>NO RESPONSE 99</p> | |
| Q624 | <p>I feel comfortable discussing family planning with my partner</p> <p><i>Palibe bvuto paku kambilana za cilezi ndi mwamuna wanga.</i></p> | <p>DISAGREE 1</p> <p>UNSURE 2</p> <p>AGREE 3</p> <p>NO RESPONSE 99</p> | |
| Q625 | <p>I feel comfortable discussing HIV with my partner</p> <p><i>Palibe bvuto kukambirana za Edzi ndi mwamuna wanga.</i></p> | <p>DISAGREE 1</p> <p>UNSURE 2</p> <p>AGREE 3</p> <p>NO RESPONSE 99</p> | |

THANK RESPONDENT FOR THEIR TIME AND INFORMATION

CHECK YOUR FORM FOR COMPLETENESS AND ACCURACY

**ZAMBIA FP/HIV SURVEY
FOR USE WITH MALE RESPONDENTS**

SECTION 0: IDENTIFICATION PARTICULARS

| | | | |
|--|--------------------------|------|-----|
| 001 QUEST. ID No. _ _ _ _ _ | 002 VILLAGE _____ | CODE | _ _ |
| 008 LOCATION (U = 1; R = 2) | _2_ | | |

Introduction: òMy name isí I work for CARE Zambia, which is doing research work to help understand barriers to the use of modern methods of contraception in Zambia. We’re interviewing people here [name of village] to find out about the use and non-use of family planning methods as well as the factors that promote or hinder the use of these methods. Have you been interviewed in the past few weeks [or other appropriate time period] for this study? **IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.** Tell them you cannot interview them a second time, thank them, and end the interview. If they have not been interviewed before, continue:

Dzina Langa Ndine _____, ndi gwira nchito ku CARE – Zambia, bungwe limene lifuna kudziwa zobvuta kuti tigwiritse nchito njira zasopano zacilezi mu dziko la Zambia. Tilufunsa anthu pano _____ (dzina la mudzi) kuti tidziwe kugwiritsa kapena kusagwiritsa nchito njira cilezi ndiponso zobvuta zake. Kodi munafunsidwapo ca sopanopa pa kafuku-fuku? Ngati woyankha abvomera, osafunsanso. Lekezani mafunso anu powaonga ndi kuwauza kuti simungawafunsenso kaciwiri. Ngati sanafunsiwepo kale, pitilizani.

Confidentiality and consent: òI’m going to ask you some very personal questions. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about 60 minutes to ask the questions.

Zacinsisi: “Nizamfunyani mafunso apadera wokhuza inu. Mayankho anu azakhala acinsi. Dzina lanu silizalembedwa pa pepala ili, osayankha funso limene simufuna kuyankha ndiponso nthawi iliyonse mungathese kufunsidwa uku. Koma mayankho anu onse azatithandiza ife kudziwa zimene anthu aganiza, alankhula ndiponso zimene acita mumakambidwe ena ace. Tizathokoza kwambiri pakutithandiza kuyankha mafunso yakafuku-fuku. Kafuku-fuku uyu azatenga ola limodzi (60mins), kufunsa mafunso.

[Interviewer asks if the respondent has any questions and provides the necessary clarification before proceeding with the informed consent].

Would you be willing to participate? ò
Kodi mudzipoleka kutengako mbali?

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Interviewer visit

| | Visit 1 | Visit 2 | Visit 3 |
|-------------|---------|---------|---------|
| Date | | | |
| Interviewer | | | |
| Result | | | |

Result codes: Completed 1; Partially Completed 2; Refused 3; Other 4.

009 INTERVIEWER: Code [___|___] Name _____

010 DATE OF INTERVIEW: ___\ ___\ 2011

011 CHECKED BY SUPERVISOR: Signature _____ CODE [___|___] Date _____

012 SIGNATURE AND CODE OF SAPC: _____ CODE [___|___]
Date _____

ZAMBIA FP/HIV SURVEY

Section 1: Background characteristics

| N | Questions and filters | Coding categories | Skip to |
|------|---|--|------------------|
| Q100 | Time Interview started Time interview ended | [__ __:__ __] AM/PM [__ __:__ __] AM/PM | |
| Q101 | How old were you at your last birthday? <i>Munali ndi zaka zingati zobadwa mchaka chata?</i> | AGE IN COMPLETED YEARS [__ __] DONOT KNOW 88 NO RESPONSE 99 | |
| Q102 | Have you ever attended school? <i>Kodi munapitako kusukulu?</i> | YES 1 NO 2 NO RESPONSE 99 | → Q105 |
| Q103 | What is the highest level of school you attended: primary, secondary or higher? <i>Mudafika Geredi bwanji Pulaimale, Sekondale kapena Univesite?</i> | PRIMARY 1 SECONDARY 2 HIGHER 3 | → Q105 |

| | | | |
|------|---|--|--|
| | CIRCLE ONE | | |
| Q104 | What is the highest grade you completed at that level? <i>Mudafika Geredi bwanji lothera?</i> | GRADE [][] | |
| Q105 | How long have you lived here in (NAME OF COMMUNITY/ TOWN NEIGHBORHOOD/ VILLAGE)? <i>Mwakhala zaka zingati muno (MMUDZI /BOMA)?</i> | NUMBER OF YEARS [][] RECORD 00 IF LESS THAN 1 YEAR DONOT KNOW 88 NO RESPONSE 99 | |
| Q106 | Do you listen to the radio almost every day, at least once a week, less than once a week or not at all <i>Kodi mumamvera ku wailesi; tsiku lililonse, kamodzi mu sabata, kosapitirira kamodzi pa sabata kapena kusamvererako konse.?</i> | ALMOST EVERY DAY 1 AT LEAST ONCE A WEEK 2 LESS THAN ONCE A WEEK 3 NOT AT ALL 4 | |
| Q107 | Do you watch the television almost every day, at least once a week, less than once a week or not at all <i>Kodi m' maona wailesi yakanema; tsiku lililonse, kamodzi mu sabata, kosapitirira kamodzi pa sabata kapena kusamvererako konse.?</i> | ALMOST EVERY DAY 1 AT LEAST ONCE A WEEK 2 LESS THAN ONCE A WEEK 3 NOT AT ALL 4 | |
| Q108 | What is your religion? <i>Mupemphera kuti?</i> CIRCLE ONE. | CATHOLIC 1 PROTESTANT 2 MUSLIM 3 OTHER [SPECIFY] í í í í í í í í í 4 | |
| Q109 | Which tribe do you belong to? <i>Ndinu atundu bwanji?</i> | | |

Section 2: Marriage

| No. | Questions and filters | Coding categories | Skip to |
|------|------------------------------------|-------------------|---------|
| Q201 | Have you <i>ever</i> been married? | YES 1 NO 2 | →Q203b |

| | | | |
|--------|--|---|-----------------------------------|
| | <i>Kodi munalowapo mbanja?</i> | NO RESPONSE 3 | →Q203b |
| Q202 | How old were you when you first married? <i>Munali ndi zaka zingati zobadwa polowa m'banja?</i> | Age in years [__ __] DONØT KNOW 88 NO RESPONSE 99 | |
| Q203 a | Are you í í (Probe) <i>Kodi muli</i> | currently married, living with spouse 1 living with other sexual partner 2 not living with spouse or any other sexual partner 3 Separated 4 Divorced 5 Widow 6 | →Q204 →Q204 } →Q302 |
| Q203 b | Are you í í <i>Kodi muli</i> | living with sexual partner 1 not living with sexual partner 2 NO RESPONSE 3 | →Q302 →Q301 →Q301 |
| Q204 | Does your spouse/partner have other partners? <i>Kodi akazi anu ali ndiamuna ena?</i> | NUMBER OF PARTNERS [__ __] DK 88 NO RESPONSE 99 | →Q302 →Q302 →Q302 |

Section 3: Sexual and childbearing experience

Now I am going to ask you some personal questions about sex. Please answer the questions honestly.

Tsopano ndizakufunsani mafunso pa zokhala malo amodzi. Conde muyankhe moona.

| No. | Questions and filters | Coding categories | Skip to |
|------|--|---------------------------------|---------|
| Q301 | [ASK ONLY MEN WHO HAVE NEVER BEEN MARRIED <u>NOR</u> ARE LIVING WITH SEXUAL PARTNER) Have you ever had sexual intercourse? | YES 1 NO 2 NO RESPONSE 99 | →Q307 |

| | | | |
|------|---|---|-----------------------------|
| | <i>Kodi munakhalapo malo amozi ndi wam'kazi?</i> | | |
| Q302 | <p>[ASK ONLY– EVER MARRIED MEN <u>OR</u> MEN LIVING WITH A SEXUAL PARTNER]</p> <p>At what age did you first have sexual intercourse?</p> <p><i>Munali ndizaka zingati pamene munakhalapo malo amozi ndi m'kazi ?</i></p> | <p>AGE IN YEARS [__ __] DONØT KNOW 88 NO RESPONSE 99</p> | |
| Q303 | <p>How much older or younger was the person with whom you had your first sexual experience?</p> <p><i>Kodi anali ndi zaka zingati zochulukilapo kapena zochepekelapo pamene munakhalanaye malo amozi koyamba?</i></p> <p>READ OUT ANSWERS:</p> | <p>MORE THAN 10 YRS OLDER 1 5-10 YRS OLDER 2 LESS THAN 5 YRS OLDER 3 LESS THAN 5 YEARS YOUNGER 4 5 YEARS OR MORE YOUNGER 5 DONØT KNOW 88 NO RESPONSE 99</p> | |
| Q304 | <p>Have you had sexual intercourse in the last 12 months (i.e. since ___ May 2010)?</p> <p><i>Munakhalapo malo amozi ndi mkazi miyezi khumi ndi ziwiri yathayi (kucokera ___ May mchaka ca 2010)?</i></p> | <p>YES 1 NO 2 NO RESPONSE 99</p> | |
| Q305 | <p>How many children do you have (from your wife/wives/partners) that are currently alive?</p> <p><i>Muli ndi ana angati amene alimoyo kwa akazi anu?</i></p> | <p>NUMBER OF CHILDREN [__ __] (Record 00 if the respondent has no children) NO RESPONSE 99</p> | <p>00→Q307 00→Q307</p> |
| Q306 | <p>Of the children alive: <i>Mwa ana anu alimoyo,</i></p> <p>How many are boys? <i>Ndi angati amuna</i></p> <p>How many are girls <i>Ndi angati akazi?</i></p> | <p>NUMBER OF BOYS [__ __] NUMBER OF GIRLS [__ __]</p> | |

| | | | |
|-------------|---|---|--|
| <p>Q307</p> | <p>How many children do you think a woman in your community should have? <i>Kuno kwanu, munganiza wamkazi angakhale ndi ana angati?</i></p> <p>How many sons? <i>Amuna angati?</i></p> <p>How many daughters? <i>Akazi angati?</i></p> | <p>NUMBER OF CHILDREN _ _ DK 88</p> <p>NUMBER OF SONS _ _ DK 88</p> <p>NUMBER OF DAUGHTERS _ _ DK 88</p> | |
| <p>Q308</p> | <p>How many children do you think a man in your community should have? <i>kuno kwanu, munganiza wam'muna angakhale ndi ana angati?</i></p> <p>How many sons? <i>Amuna angati</i></p> <p>How many daughters? <i>Akazi angati?</i></p> | <p>NUMBER OF CHILDREN _ _ DK 88</p> <p>NUMBER OF SONS _ _ DK 88</p> <p>NUMBER OF DAUGHTERS _ _ DK 88</p> | |

Section 4a: Contraception

| No. | Questions and Filters | Coding categories | Skip to |
|------|---|---|----------------------------------|
| Q401 | <p>IS RESPONDENT CURRENTLY MARRIED OR HAVING A SEXUAL PARTNER?</p> <p>CHECK ANSWERS TO Q201 AND Q203A</p> | <p>YES 1 NO 2</p> | →Q409 |
| Q402 | <p>Have you or your partner <i>ever</i> used anything or tried in any way to delay or avoid being pregnant?</p> <p><i>Kodi inu kapena akazi anu, munayesako kugwiritsa njira ina iliyonse kuletsa kukhala ndi pakati?</i></p> | <p>YES 1 NO 2 DONØT KNOW 88 NO RESPONSE 99</p> | <p>→Q409 →Q409 →Q409</p> |
| Q403 | <p>What have you used or done</p> <p><i>Munagwiritsa njira yanji?</i></p> | <p>ABSTAINED FROM SEX 1 USED FP METHOD 2 OTHER_____ 3 (SPECIFY)</p> | <p>→Q405 →Q405</p> |
| Q404 | <p>What family planning method(s) have you or your partner ever used? (STATE ALL THAT APPLY)</p> <p><i>Kodi m'banja mwanu, munagwiritsa njira yachilezi yotani kuti musabereke mwapafupi-pafupi?</i></p> | <p>FEMALE STERILIZATION 01 MALE STERILIZATION 02 IUD 03 PILL 04 INJECTABLES 05 IMPLANTS 06 MALE CONDOM 07 FEMALE CONDOM 08 LACT AMEN. METHOD 09 RYTHM METHOD 10 OTHER_____ 11 (SPECIFY)</p> | |
| Q405 | <p>Are you or your partner <u>currently</u> using anything or trying in any way to delay or avoid being pregnant?</p> <p><i>Kodi m'banja mwanu lero, mugwiritsa nchito njira ili</i></p> | <p>YES 1 NO 2</p> | →Q409 |

| | | | |
|------|--|---|--|
| | <i>yonse kuti mucedwetse kapena kuleka kukhala ndi pakati?</i> | | |
| Q406 | <p>What family planning method are you or your partner currently using?</p> <p><i>Ndi njira zotani zachilezi zimene mugwiritsa nchito lero?</i></p> <p>(STATE ALL THAT APPLY)</p> | <p>FEMALE 01</p> <p>STERILIZATION 02</p> <p>MALE STERILIZATION 03</p> <p>IUD 04</p> <p>PILL 05</p> <p>INJECTABLES 06</p> <p>IMPLANTS 07</p> <p>MALE CONDOM 08</p> <p>FEMALE CONDOM 09</p> <p>LACT AMEN. METHOD 10</p> <p>RYTHM METHOD 11</p> <p>OTHER _____ (SPECIFY)</p> | |

| | | | |
|-------------|--|---|--|
| <p>Q407</p> | <p>Where did you or your partner obtain the method(s) you are currently using?</p> <p><i>Kodi njirazi, munazitenga kuti?</i></p> <p>PROBE AND RECORD ALL ANSWERS</p> <p>Any others? <i>Pali zina?</i></p> | <p>Public Sector: Y N</p> <p>GOVERNMENT HOSPITAL 1 2</p> <p>GOVT HEALTH CENTER 1 2</p> <p>HEALTH POST 1 2</p> <p>COMMUNITY HEALTH WORKER 1 2</p> <p>OTHER Y N</p> <p>Private Sector:</p> <p>PRIVATE 1 2</p> <p>HOSPITAL/DOCTOR 1 2</p> <p>MISSION HOSPITAL/CLINIC 2 2</p> <p>PHARMACY</p> <p>OTHER PRIVATE Y N</p> <p>Other: 1 2</p> <p>1 2</p> <p>COM HEALTH WORKER</p> <p>PEER EDUCATOR OR</p> <p>OUTREACH WORKER 2 2</p> <p>SHOP 2 2</p> <p>FRIEND/RELATIVE</p> <p>OTHER_____ 1 2</p> <p>NO RESPONSE</p> | |
| <p>Q408</p> | <p>Who made the decision to use the method you are currently using?</p> <p><i>Kodi ndi ndani anapanga fundo yogwiritsa njira yachilezi imene mugwiritsa nchito lero?</i></p> | <p>ME (SELF) 1</p> <p>SPOUSE/PARTNER 2</p> <p>BOTH SELF AND PARTNER 3</p> <p>OTHER_____ 4</p> | |

Section 4b: Beliefs about Family Planning Methods

| No. | Questions and filters | Coding categories | Skip to |
|-----|---|-------------------|---------|
| | <p>Now I would like to read to you some statements about family planning methods. For each statement I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree)</p> <p><i>Tsopano, ndiza kuwengerani fundo pankhani zachilezi. Mufundozi, munene kapena mubvomekezanazo, mukanan nazo mwina simudziwa bwino. (1=sidibvomekeza, 2=ndikaika, 3=ndibvomekeza)</i></p> | | |

| INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION | | |
|--|---|-----------------------------------|
| Q409 | Women who take the oral pill will get fat <i>Akazi amene amamwa ma pilisi achilezi, azanenepa.</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| Q410 | Men who have a vasectomy (male sterilization) will become weak <i>Amuna amène agwiritsa nchito njira yachilezi sazakhala ndi mphamvu</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| Q411 | An IUD (coil, copper T) can move inside a woman and hurt her <i>IUD ingalowe mkati mwaukazi ndi kumupweteka.</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| Q412 | Condoms can do harm to a man's penis <i>Mphira yakondomu ingapweteke umuna.</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| <p>Now I would like to read you some statements about what you may think about those who use family planning methods. For each statement I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree)</p> <p><i>Tsopano ndizakuwerengerani fundo zimene mu ganiza pa iwo amene agwiritsa nchito njira yacilezi. Pa cokambidwa ciriconse ndifuna mundiuze ngati mubvomekedzana naco, kukanana naco, kapena simudziwa bwino. (1=sidibvomekeza, 2=ndikaika, 3=ndibvomekeza)</i></p> <p>INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION</p> | | |
| Q413 | In general, I approve of couples using family planning to avoid or delay a pregnancy <i>Muzonse, ndibvomekeza am'banja kugwiritsa nchito njira zacilezi kapena kucedwetsa kukhala ndi pakati?</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| Q414 | I think that most of my friends in this community would approve of couples using family planning to avoid or delay a pregnancy <i>Ndiganiza kuti anzanga ambiri kuno kwathu, angabvomereze a m'banja kugwiritsa nchito njira zoletsa kapena kucedwetsa kukhala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 |
| Q415 | I think that my spouse would approve of couples using family planning to avoid or | DISAGREE 1 UNSURE 2 |

| | | | |
|---|--|--|--|
| | <p>delay a pregnancy</p> <p><i>Ndiganiza kuti m'kazi wanga angabvomekeze kugwiritsa nchito njira zoletsa kapena kucedwetsa kukhala ndi pakati.</i></p> | <p>AGREE 3 NO RESPONSE 99</p> | |
| Q416 | <p>I approve of a young recently married couple with no children using family planning to avoid or delay a pregnancy</p> <p><i>Ndibvomekeza kuti anthu amene angolowa m'banja kapena opanda ana akhoza, kugwiritsa nchito njira zoletsa kapena kuchedwetsa kukhala ndi pakati.</i></p> | <p>DISAGREE 1 UNSURE 2 AGREE 3</p> | |
| Q417 | <p>A woman who uses contraception will be unfaithful to her husband</p> <p><i>Mzimai amene agwiritsa nchito njira zachilezi azakhala wosakhulupirika.</i></p> | <p>DISAGREE 1 UNSURE 2 AGREE 3</p> | |
| Q418 | <p>A man who lets his wife to use contraception will lose control of her</p> <p><i>Mwamuna obvomeleza mkazi wace kugwiritsa nchito chilezi, azakhala wopanda ulamuliro pamkaziyo.</i></p> | <p>DISAGREE 1 UNSURE 2 AGREE 3</p> | |
| Q419 | <p>A couple who does not want children are not normal</p> <p><i>Anthu a m'banja amene safuna ana, Sali bwino mumaganizo awo.</i></p> | <p>DISAGREE 1 UNSURE 2 AGREE 3</p> | |
| <p>Now I would like to ask you some questions about your community <i>Tsopano ndizakufunsankoni mafunso pa zakuno kwanu.</i></p> | | | |
| Q420 | <p>How many sons do you think people in this community want to have?</p> <p><i>Kuno kwanu, muganiza anthu amafuna kukhala ndi ana amuna angati?</i></p> | <p>NUMBER OF SONS __ __ DK 88</p> | |
| Q421 | <p>How many daughters do you think people in this community want to have?</p> <p><i>Kuno kwanu, muganiza anthu amafuna kukhala ndi ana akazi angati?</i></p> | <p>NO OF DAUGHTERS __ __ DK 88</p> | |
| Q422 | <p>What do you think is the ideal age at marriage for women in this community?</p> | <p>IDEAL AGE AT MAR __ __ DK 88</p> | |

| | | | |
|------|--|---|--|
| | <i>Muganiza akazi ayenera kukhala ndi zaka zingatizobadwa kuti alowe m'banja kuno kwano?</i> | | |
| Q423 | What do you think is the ideal age at marriage for men in this community? <i>Muganiza Amuna ayenera kukhala ndi zaka zingatizobadwa kuti alowe m'banja?</i> | IDEAL AGE AT MAR __ __ DK 88 | |
| Q424 | After a couple gets married, how long should it be before they have their first child? Within one year, more than one year or is it up to the couple to decide? <i>Atalowa m'banja, anthu ayenera kukhala nthawi yaitali bwanji asanakhale ndi mwana woyamba? Caka Cimodzi, Kupitirirapo, kapena ciri kwa iwo kusankha?</i> | WITHIN ONE YEAR 1 MORE THAN ONE YEAR 2 UP TO THE COUPLE 3 | |

Section 5: Exposure to Information on FP and HIV

| No. | Questions and filters | Coding categories | Skip to |
|------|--|---|----------------|
| Q501 | Have you heard any message or seen any program about family planning on the radio, TV, print materials or through/drama within the last 12 months (i.e. since __May 2010)? <i>Munambvako uthenga uliwonse pawailesi kapena kuwona pakanema, komanso kupyolera msewero, zipikicha pankhani yachilezi pamiyezi khumi ndiziwiri(12) kuchokera mchaka ca __May 2010</i> | YES 1 NO 2 NO RESPONSE 3 | →Q503 →Q503 |
| Q502 | Which ones have you heard or seen? <i>Munamvapo kapena kuona ziti?</i> | _____ _____ _____ _____ _____ | |
| Q503 | Have you heard any message or seen any program about HIV on the radio, TV, print material or through/drama within the last 12 months (i.e. since __May 2010)? | YES 1 NO 2 NO RESPONSE 3 | →Q505 →Q505 |

| | | | |
|------|---|--|----------------|
| | <i>Munamvako uthenga uliwonse pawaillesi kapena kuwona pakanema, komanso kupyolera masewelo, zipikicha pankhani yakadoyo ka edzi pamiyezi khumi ndiziwiri(12) kuchokera mchaka ca _May 2010</i> | | |
| Q504 | Which ones have you heard or seen? <i>Munamvapo kapena kuona ziti?</i> | _____ _____ _____ _____ | |
| Q505 | Have you attended any meetings (formal or informal) where family planning issues were discussed within the last 12 months (i.e. since May 2010)? <i>Kodi munapitako kumsonkhano kumene amakambilana pa zachilezi pa myezi khumi ndi ziwiri yapitayi (Kucokera __May 2010)?</i> IF YES: How many times? Probe <i>Ngati mubvomekeza ndikangati?</i> | YES 1 NO 2 NO RESPONSE 3 NUMBER OF TIMES __ __ | →Q506 →Q506 |
| Q506 | Have you attended any meetings (formal or informal) where HIV related issues were discussed within the last 12 months (i.e. since __May 2010_)? <i>Kodi munapitako kumusonkhano kumene amakambilana za Edzi mu myezi khumi ndi iwiri yapitayi (Kucokera __May 2010)?</i> IF YES: How many times? Probe <i>Ngati mubvomekeza ndikangati?</i> | YES 1 NO 2 NO RESPONSE 3 NUMBER OF TIMES __ __ | →Q507 →Q507 |
| Q507 | Have you been visited by a CHW or any other health facility staff to discuss FP with you within the last 12 months (i.e. since | YES 1 NO 2 NO RESPONSE 3 | →Q508 →Q508 |

| | | | |
|------|--|--|---------------------------|
| | <p>_May 2010)?</p> <p><i>Kodi anakuyendelaniko anthu woyanganila zaumoyo ku midzi mu miyezi khumi ndi iwiri yapitai (Kucokera __May 2010)?</i></p> <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati?</i></p> | NUMBER OF TIMES __ __ | |
| Q508 | <p>Have you been visited by a CHW or any other health facility staff to discuss HIV issues with you within the last 12 months (i.e. since __May 2010)?</p> <p><i>Kodi anakuyendelaniko anthu woyanganila zaumoyo ku midzi komanso azaumoyo pa zakukambilana za Edzi mu miyezi khumi ndi iwiri yapitai (Kucokera __May 2010)?</i></p> <p>IF YES:</p> <p>How many times? Probe <i>Ngati mubvomekeza ndikangati</i></p> | <p>YES 1</p> <p>NO 2</p> <p>NO RESPONSE 3</p> <p>NUMBER OF TIMES __ __ </p> | <p>→Q509</p> <p>→Q509</p> |
| Q509 | <p>Have you visited a health facility for care for yourself (or your children) within the last 12 months (i.e. since May 2010_)?</p> <p><i>Kodi munapitako kuchipatala (kapena ana anu) kukapeza thandizo mu myezi khumi ndi iwiri yapitai (Kucokera __May 2010)?</i></p> | <p>YES 1</p> <p>NO 2</p> | →Q512 |
| Q510 | <p>Did any staff member at the health facility speak to you about family planning?</p> <p><i>Mwina wa zaumoyo analankhuzana namwe pa zachilezi?</i></p> | <p>YES 1</p> <p>NO 2</p> | |
| Q511 | <p>Did any staff member at the health facility speak to you about HIV?</p> <p><i>Mwina wa zaumoyo analankhuzana namwe pa za Edzi?</i></p> | <p>YES 1</p> <p>NO 2</p> | |

| | | | |
|------|---|--|----------------|
| Q512 | Have you ever been tested for HIV? (I will not ask you for your status). <i>Kodi munapimitsapo magazi anu pazaka doyo ka edzi?</i> | YES 1 NO 2 NO RESPONSE 99 | →Q601 →Q601 |
| Q513 | How long ago were you tested last? <i>Papita nthawi yotani kucokera pamene munapimitsira kothera?</i> | 12 MONTHS OR MORE AGO 1 6-11 MONTHS AGO 2 3-5 MONTHS AGO 3 LESS THAN 3 MONTHS AGO 4 NO RESPONSE 99 | |
| Q514 | Did you know the result of the last test? <i>kodi mukumbukila zotuluka zake pomwe munapimitsa kothera ?</i> | YES 1 NO 2 | |

Section 6: Gender Relations

| No. | Questions and filters | Coding categories | Skip to |
|------|--|-----------------------------------|---------|
| | Now I would like to read to you some statements and for each one I would like you to tell me whether you agree, disagree or unsure (1 = disagree, 2 = unsure, 3 = agree) <i>Tsopano nizawerenga zokambidwa ndipo mudiuze mwina muvomekezana nazo, mukana nazo kapena Simuziziwa bwino. (1=sidibvomekeza, 2=ndikaika, 3=ndibvomekeza)</i> INTERVIEWER: CIRCLE A CODE FOR EACH QUESTION | | |
| Q601 | It is a woman's responsibility to avoid getting pregnant <i>Ndi nchito yamukazi kuzicingiriza ku khala ndi pakati.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q602 | A man should have the final word about decisions in his home <i>Fundo yosirizira iyenera kucokera kumwamuna.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q603 | Men are always ready to have sex. <i>Nthawi ili yonse, mwamuna ndiwokonzeka ku khala malo amozi ndi mkazi .</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q604 | A woman should tolerate violence to keep the family together <i>Kuti banja ikhalepo, mkazi ayenera kupirira, dzowawa.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |

| | | | |
|------|--|---|--|
| Q605 | My partner has more say than I do about important decisions that affect us <i>Mukazi wanga amapanga fundo zo khwima kupambana ine</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q606 | Men need sex more than women do <i>Amuna amafuna kukhala malo amozi kwambiri kupambana akazi.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q607 | You don't talk about sex, you just do it <i>Sitikambilana zo khala malo amozi, timangokumana cabe.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q608 | A man needs other women even if things are fine with his wife <i>Mwamuna afunika akazi ena ngakhale kuti zonse zinthu ziri bwino ndi mkazi wace wakunyumba.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q609 | A man can hit/beat his wife if she will not have sex with him <i>Mwamuna angapande mkazi wace ngati akana kukhala malo amozi naye</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q610 | A man can hit/beat his wife if she is unfaithful <i>Mwamuna angapande m'kazi wake ngati akhala osakhulupirika.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q611 | A couple should decide together if they want to have children <i>Am'banja agwirizana ngati afuna kukhala ndi ana.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q612 | I am more committed to this relationship than my partner <i>Ine ndine nicita zambiri m'banja mwathu kupambana m'kazi wanga.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q613 | Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibilities <i>Zotangata mwana ndi nchito ya mukazi.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q614 | A woman can suggest using condoms just like a man can <i>Wa m'kazi naye angathe kuganiza zogwiritsa nchito kondomu monga mwamuna.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q615 | A man should know what his partner likes during sex | DISAGREE 1 UNSURE 2 | |

| | | | |
|------|---|--|--|
| | <i>Mwamuna ayenera kudziwa zimene mkazi wache akonda akakhala malo amodzi.</i> | AGREE 3 | |
| Q616 | A woman should obey her husband in all things <i>Nthawi zonse, mkazi ayenera kulondola zonse zimene mwamuna wache afuna</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q617 | A man and a woman should decide together what type of contraceptive to use <i>Mwamuna ndi M'kazi ayenera kugwirizana pamodzi pa nfuno ya mtundu wa cilezi.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q618 | A real man produces a male child <i>Mwamuna weni-weni amabala mwana mwamuna.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q619 | Men and women should share household chores <i>Mwamuna ndi Akazi azigwira pamodzi nchito za panyumba.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q620 | A woman should be able to talk openly about sex with her husband <i>M'kazi azikhala omasuka kukamba za zo kumana ndi mwamuna wake.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q621 | A woman should not initiate sex <i>M'kazi safunika kuyambisa zokhala malo amodzi payekha.</i> | DISAGREE 1 UNSURE 2 AGREE 3 | |
| Q622 | My partner dictates who I spend time with <i>M'kazi wanga amandilamulira munthu ocheza naye.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q623 | When my partner and I disagree, my partner gets their way most of the time <i>M'kazi wanga / chisumbalii changa tikayambana zotuluka zake zimakomela iye nthawi zambiri.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q624 | I feel comfortable discussing family planning with my partner <i>Palibe bvuto paku kambilana za cilezi ndi m'kazi wanga.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |
| Q625 | I feel comfortable discussing HIV with my partner <i>Palibe bvuto kukambirana za Edzi ndi m'kazi wanga.</i> | DISAGREE 1 UNSURE 2 AGREE 3 NO RESPONSE 99 | |

THANK RESPONDENT FOR THEIR TIME AND INFORMATION
CHECK YOUR FORM FOR COMPLETENESS AND ACCURACY

Tool #2: Focus Group Discussion Guide

Social Influences on Family Planning

I would like to thank you all for coming to this meeting. My name is _____ and I am conducting these discussion groups as part of a research project on the ways in which men and women in this community decide on their family size. We are conducting this research to identify your views about the various ways men and women can decide on how many children they have. I would like to say that there are no right or wrong answers in our discussion; we will simply be discussing your views, opinions and experiences on a range of topics, so please feel comfortable to say what you honestly feel. During the discussion _____ will be taking notes and reminding me if I forget to ask something. Please do not be concerned about this, our discussion will remain completely confidential and will ONLY be used for this research project. Because we don't want to miss anything it is important that only one person talks at a time. Remember we want to hear as many different points of view as possible, so feel free to share your own opinions even if they seem to disagree with those of everyone else. We would like you all to have the chance to express your opinions, so please let everyone have their say. If at any time during the discussion you feel uncomfortable you are free to leave. You are also free to not answer any questions you feel uncomfortable about. Are there any questions before we start?

MODERATOR: *Allow time for questions, and address them as appropriate before continuing.*

Let us begin! ..

1. As an introduction perhaps each of you could tell me how many children you have, and how many boys and girls? Thank you for sharing that information. You can see from the discussion that people have different counts of children. Now thinking about this difference in numbers of children, can you tell us why people in this community decide to have certain **numbers** of children?
 - What are some of the reasons people in this community decide to have a certain **number of** boys/ girls?
 - Which is most important for families in this community to have ó boys or girls? Why?
 - Who or what influences the decision for families to have a given **number of** children?
 - What quantity is most important for families in this community to have ó many or less children? Why?
 - Are the spouses involved in these decisions? How?

2. Let us now think about the ways in which people decide to have children. I want you to think back to when you or someone you know had their last child, and any thoughts about that child or the pregnancy. Please do not mention names:
 - Would you say spouses in this community discuss whether to have a child?
 - What are the main issues people are likely to discuss?
 - Who would normally make the final decision? Why?

3. Let us think back to when you or someone you know were deciding to have their last child. Please do not mention names. Would you say anyone else influences decisions to have children in this community?
 - Would you say spouses consider what other people in the family might think? How?
 - Would you say spouses consider what their friends might think? Do people discuss with their friends?
 - Would you say spouses consider what other people in the community might think?
4. I would now like us to think about the community in which you live a little more. What do you think people in your community think about using contraceptive methods to avoid pregnancy?
 - Are there people in the community who are supportive?
 - Are these people different than other people in the community who may not be supportive? How?
5. Now let us think about the ways that HIV has affected your community. Can you think of any ways that HIV might influence family planning decisions?
 - How does HIV affect contraceptive use (for example, type of method)
 - Does HIV affect the number of children a couple can have? How?
 - Does HIV affect a preference for boys or girls? How?
6. I want to think more about how people in your community view having children. First of all, let us think about a situation in which we have a young unmarried girl who wants to use a method of contraception. How would people in your community feel about this?
 - How would this young woman be viewed/treated?
 - Would she be able to get family planning services here?
 - Should this young woman feel ashamed or embarrassed? Why or why not?
 - What if it were a young man? Would the situation be different? How?
7. Again thinking about how your community feels ó what do you think your community would think about a woman who decided not to have any children?
 - Would the woman be accepted by the rest of the community?
 - Should the woman feel embarrassed or ashamed? Why or why not?
 - What if a man decided not to have children? Would the situation be different?
8. Coming back to the topic of HIV, what would your community think about an HIV-positive couple who wanted to have children?
 - How would they be viewed/treated by the community?
 - Would they be able to receive services to prevent transmission to the child?
 - Should the couple feel embarrassed or ashamed? Why or why not?
 - If the couple did not have HIV, would the situation be different? How?
9. Staying on the topic of the community, do you ever hear people in your community discuss family planning issues?
 - Who discusses these issues and what do they discuss?
 - Where did you hear these discussions?

- Do influential people in this community ever discuss these issues? What do they discuss/say?

10. Finally I would like us to think about the different places/facilities in or near this community from which an individual can access family planning services. What kind of places/facilities are there? How many are there?

- Do you feel these are good places/facilities to obtain FP services?

- What do you like or dislike about these places/facilities?

- What are ways in which FP services can be improved in these places/facilities?

That brings us to the end of this discussion. I would like to thank you all for your participation; ask, Does any of you have questions for us?ø