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Understanding Couple Communication and Family Planning in Zambia: Formative Research Study Findings and Recommendations

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EXECUTIVE SUMMARY

This report summarizes the results of a formative research study on the role of couple communication in family planning within the context of child marriages in Zambia.¹ The study was designed to help inform service delivery and social and behavioral change communication interventions to improve couple communication and increase male support for voluntary family planning, with a focus on men who have married adolescent girls. Given the high prevalence of child marriage in Zambia and the lack of evidence regarding communication dynamics among couples in which women married before the age of 18, this study both fills a gap in the evidence base and helps to inform PSI's family planning programs in Zambia.

ICRW and SFH-Zambia conducted the study in two research sites in Central Province, Zambia—a region with one of the highest prevalence rates of child marriage in the country. A cross-sectional qualitative research design was employed to examine the ways in which couples communicate about fertility intentions and family planning use in unions where men have married adolescent girls. Data collection, carried out in December 2015, consisted of 48 in-depth interviews (IDIs) with both members of couples in which women married before the age of 18, and four focus group discussions (FGDs), two with young married women and two with men married to younger women.

The study focused on understanding communication dynamics and family planning within marital relationships shaped by early marriage. For most of the couples in the study, unintended pregnancies were the main cause of early marriage for both sexes. Intra-spousal communication on fertility desires and plans was found to be limited, as evidenced by discordant accounts from spouses on the desired number of children and child gender preferences, family planning use and timing and spacing of children. Women mostly deferred to their husbands' preferences on family planning and household decisions, and men were regarded as heads of households. Participants considered family planning to be a woman's responsibility; hence many husbands refrained from accompanying their wives to the clinic in fear of being seen as "weak." Family members' expectations and strict gender norms influenced couple communication and family planning decision-making dynamics.

The study concludes that adolescent girls exposed to early marriage may benefit from efforts to improve intra-spousal communication and partner support for family planning, especially in contexts where unequal gender norms limit girls' agency to negotiate their reproductive desires. Recommendations are provided to inform the design of gender-synchronized interventions aimed at improving couple communication and increasing male support for family planning in the context of child marriages.

¹ The study was led by the International Center for Research on Women (ICRW), in partnership with Population Services International (PSI) and its Zambian network member, the Society for Family Health (SFH-Zambia), under the auspices of the Support for International Family Planning and Health Organizations 2: Sustainable Networks (SIFPO 2) project, funded by the U.S. Agency for International Development's Office of Population and Reproductive Health. The SIFPO 2 project is designed to strengthen voluntary family planning programs and other health services worldwide, with a focus on strengthening private sector channels including social franchise networks. PSI's objectives under SIFPO 2 include strengthening youth-friendly and gender-sensitive family planning programs worldwide.

BACKGROUND

Despite decades of investments in reproductive health programs, unmet need for family planning continues to remain high in many regions of the world. This situation has led to heightened recognition of the need to understand the key barriers to and facilitators of successful adoption and use of voluntary family planning. The International Conference on Population and Development (1994) placed a clear emphasis on the need to view family planning decision-making within the context of a couple. Over the years, several studies have examined the role that partner communication plays in reproductive decision-making and family planning use. While some studies have characterized men's role as "absent or problematic,"² several studies indicate a positive association between partner communication and contraceptive use.³ Other studies, however, describe how partner communication is limited or nonexistent, often reflected in high rates of discordant reporting of family planning use by couples, or in findings that suggest that couples may not be using contraception because each falsely believes their spouse does not approve of its use.⁴ Little is known about how couple communication and family planning decision-making dynamics play out within the context of child marriages.⁵ This study was designed to shed light on these issues in Zambia and to design context-specific family planning interventions that take these dynamics into account.

The demographic profile of Zambia is similar to many sub-Saharan African countries in the Southern and Eastern regions. Zambia is among the countries with the highest prevalence rates of child marriage,⁶ and it has a high overall fertility rate of about six children per woman of childbearing age⁷. UNFPA reports that 42 percent of women aged 20 – 24 married before the age of 18,⁸ and according to the 2013-14 Demographic and Health Surveys, 61% of 25-49 year olds gave birth to at least one

² Greene ME, Biddlecom AE. Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles. *Popul Dev Rev.* 2000;26(1):81–115; Gipson JD, Hindin MJ. "Marriage Means Having Children and Forming Your Family, So What Is the Need of Discussion?" Communication and Negotiation of Childbearing Preferences among Bangladeshi Couples. *Cult Health Sex.* 2007;9(2):185–98.

³ Cox CM, Hindin MJ, Otupiri E, Larsen-Reindorf R. Understanding Couples' Relationship Quality and Contraceptive Use in Kumasi, Ghana. *Int Perspect Sex Reprod Health.* 2013 Dec;39(4):185–94; Irani L, Speizer IS, Fotso J-C. Relationship Characteristics and Contraceptive Use Among Couples in Urban Kenya. *Int Perspect Sex Reprod Health.* 2014;40(1):11–20; Dodoo FN-A. Marriage Type and Reproductive Decisions: A Comparative Study in Sub-Saharan Africa. *J Marriage Fam.* 1998;60(1):232–42; Becker S. Couples and Reproductive Health: A Review of Couple Studies. *Stud Fam Plann.* 1996;27(6):291–306; Link CF. Spousal Communication and Contraceptive Use in Rural Nepal: An Event History Analysis. *Stud Fam Plann.* 2011;42(2):83–92; Bawah AA. Spousal Communication and Family Planning Behavior in Navrongo: A Longitudinal Assessment. *Stud Fam Plann.* 2002;33(2):185–94; Feyisetan BJ. Spousal communication and contraceptive use among the Yoruba of Nigeria. *Popul Res Policy Rev.* 2000 Feb;19(1):29–45; Bankole A. Desired Fertility and Fertility Behaviour among the Yoruba of Nigeria: A Study of Couple Preferences and Subsequent Fertility. *Popul Stud.* 1995;49(2):317–28.

⁴ DeRose LF, Ezech AC. Men's Influence on the Onset and Progress of Fertility Decline in Ghana, 1988-98. *Popul Stud.* 2005;59(2):197–210; Tilahun T, Coene G, Temmerman M, Degomme O. Spousal discordance on fertility preference and its effect on contraceptive practice among married couples in Jimma zone, Ethiopia. *Reprod Health.* 2014;11:27.


⁵ Shattuck D, Kerner B, Gilles K, Hartmann M, Ng'ombe T, Guest G. Encouraging Contraceptive Uptake by Motivating Men to Communicate About Family Planning: The Malawi Male Motivator Project. *Am J Public Health.* 2011 Jun;101(6):1089–95; Mathur S, Greene ME, Malhotra A. Too Young to Wed: the Lives, Rights and Health of Young Married Girls [Internet]. ICRW; 2003. Available from: <https://www.icrw.org/files/publications/Too-Young-to-Wed-the-Lives-Rights-and-Health-of-Young-Married-Girls.pdf>

⁶ International Center for Research on Women. Child Marriage Facts and Figures. Retrieved: <http://www.icrw.org/child-marriage-facts-and-figures>

⁷ Population Reference Bureau. 2014. World Population Data Sheet. Retrieved: <http://www.prb.org/Publications/Datasheets/2014/2014-world-population-data-sheet/data-sheet.aspx>.

⁸ Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007.

Calverton, Maryland, USA: CSO and Macro International Inc. and <http://www.girlsnotbrides.org/reports-and-publications/unfpa-child-marriage-country-profile-zambia/>



child before the age of 20.⁹ Rates of modern contraceptive use overall, at 45% among married women of reproductive age, are higher than a number of sub-Saharan African countries, but lower than most Southern African countries. In the Central Province of Zambia, early marriage rates are slightly higher than the national average with the median age at first marriage for women who are 20-49 years-old being 18.4 years, compared to the overall national median of 18.7 years. Rates of contraceptive use are slightly lower than the national figures with 41.3% of currently married women of reproductive age (15-49) reporting current use of a modern contraception in the Central Province, compared with a national rate of 44.8%.¹⁰ Therefore, while there are slightly higher early marriage rates in the Central Province, there is slightly lower contraceptive use among this population and therefore likely higher levels of unmet need. Based on these factors, the Central Province was selected as the region of focus for the study.

The formative research sought to provide an understanding of the following themes within the context of child marriages in the Central Province of Zambia:

- The extent and character of couple communication on fertility intentions and family planning use;
- The frequency of couple communication concerning fertility and family planning;
- The role of power dynamics in communication on fertility intentions and contraceptive use, discordant reporting on fertility and family planning and women's agency in communicating reproductive desires/intentions;
- Barriers and facilitators to men's involvement in family planning;
- Whether and how other family members or beliefs about the community's expectations of couple communication or approval of fertility and contraceptive use influence fertility intentions and family planning for either/both members of the couple; and
- Women's and men's experiences and challenges with accessing family planning services and utilizing family planning methods.

⁹ Zambia Demographic and Health Survey 2014.

¹⁰ Zambia DHS, 2014 <http://dhsprogram.com/pubs/pdf/FR304/FR304.pdf>

METHODOLOGY

Design

The study employed a cross-sectional research design using qualitative research methods. Data were collected using in-depth interviews (IDIs) and focus group discussions (FGDs) in an urban and rural location within Central Province, Zambia.

Participants


Study participants were purposely selected and included married women aged 15-24 and married men aged 18-40. The inclusion criteria for research subjects varied slightly with the research method. For the IDIs, we focused on individual interviews with each member of a couple, specifically where the couple had been married or cohabiting for at least six months, and the couple began their marriage/cohabitation when the wife was under the age of 18. We also included couples with smaller (less than four years) and larger (five years and above) differences in age to explore the role of spousal age gap in gendered power dynamics. To ensure a rich conversation about family planning communication (or lack thereof), we only included couples who had at least one child together or those who were expecting their first child together. We excluded couples in polygamous unions because we anticipated their dynamics would be very different from monogamous couples.¹¹ FGDs were sex segregated; the men and women we included in the FGDs were not married to one another. To ensure homogenous groups for the FGDs, we restricted the age range (18-24 for women and 20-30 for men) and education levels and made certain that members of these groups resided in the same zone (urban versus rural). Finally, similar to the IDIs, to facilitate an easier flow of conversation regarding communication norms and negotiation of fertility decision-making and family planning use within couples and families, we only included participants who already had at least one child.

Study sites and sample recruitment

Given that contraceptive prevalence rates, accessibility and fertility intentions often all differ between urban and rural areas, we stratified our sample by urban and rural residence. We collected data in urban Kabwe, the capital of Central Province, and Ngawe district (rural Kabwe). In both sites we purposely selected communities with characteristics that reflected similar settings within the province. For instance, in Ngawe we selected a rural community with characteristics typical of rural communities in the province by excluding any community that had a large hospital, an unusually well financed reproductive health clinic, a secondary school or other amenities atypical of rural communities in this province of Zambia. Likewise, within urban Kabwe, we selected a characteristic community, one that is neither particularly poor nor well off, in which to work. Again, we made certain that access to reproductive health care in this community was not unusually high or low as compared to other communities within the city.

Given the sensitivity of the study, ICRW and SFH-Zambia staff worked closely with community health outreach workers from the Ministry of Community Development and Maternal and Child Health

¹¹ The majority of Zambian women and men are in monogamous unions. Twelve percent of married women and 7 percent of married men are in polygynous unions. (DHS 2014)



(MCDMCH) who introduced us to the communities and guided data collectors to households where they were likely to find eligible participants. Households were selected based on the health workers' knowledge and familiarity with the communities in which they lived. First, the study team explained to the community health outreach workers about the study including characteristics of eligible participants. Then the health workers directed data collectors to households they believed, based on their familiarity with the community, had individuals who fit to participate in the study. Consequently, data collectors screened every potential participant to ensure that they qualified to participate in the study. Those that qualified were then provided with information about the study and if they agreed to participate they were asked to sign a consent form.

Data collection

Data collection was preceded by a week of training of research assistants and pilot testing of research instruments. A total of four data collectors (two men and two women) were trained on qualitative research methods and introduced to the SIFPO 2 project goals and study objectives as well as research tools, including interview guides, recruitment screeners and consent forms. Research tools were piloted for a day, and the necessary changes were made after a team debriefing. To minimize the risk of conflict within couples as a result of participation in the study, couples for IDIs were recruited and consented together, then interviewed concurrently. Husbands provided consent to their wives' participation in the study for women below the consenting age of 18. The wives then assented to participate in the study. No identifying information was collected from the study subjects. Codes were used to match couples data for analysis purposes (for instance, UrbanH1; UrbanW1 in reference to the first couple interviewed in the urban setting). Data collection in Ngawe began on Dec 7th and ended Dec 12th, followed by Urban Kabwe from Dec 13th – Dec 18th. In total, 48 IDIs (in-depth interviews with 24 couples) and 4 FGDs (2 with men and 2 with women) were completed. Half of the interviews were carried out in Urban Kabwe and the other half in Ngawe. All interviews were conducted in the local language spoken in that region, Bemba, and audio-recorded using digital recorders.

Research themes

The IDI guide was divided into three main sections. The first section had questions that sought to understand participant's childhood background, including their family structure and experiences as a child, their dreams and aspirations for the future as they grew up, experiences at school and education in general, as well as the process and circumstances under which they got married. The second section delved into marriage life and couple dynamics, including decision-making and couple communication on fertility intentions and family planning access and use. The final section sought to understand husbands' involvement, or lack thereof, in family planning. The focus groups discussed cultural norms around the issue of child marriage; decision-making within unions including husbands' verses wives' roles in determining the timing, spacing and number of children; and husbands' roles in family planning use and access.



Analysis

Under the supervision of a research associate at SFH-Zambia, research assistants who were fluent in both Bemba and English completed simultaneous transcription and translation into English of all audio records. Transcripts were then sent electronically to ICRW for analysis. An initial list of descriptive codes was developed based on research questions and field notes taken during team debriefings. These codes were then supplemented by more analytic codes following initial descriptive coding of a subset of interviews. Four research team members at ICRW conducted inter-coder agreement on 16% of the transcripts and resolved all coding discrepancies. Transcripts were then divided among the team for full coding. Inductive thematic method was used to code data with Nvivo 10 qualitative data analysis software. Resultant categories and emergent themes were then analyzed, discussed, and harmonized by the four research team members and shared with SFH-Zambia research team for validation. Study findings, presented below, were used to inform the recommendations included in the research report's conclusion.

FINDINGS

In total, 52 data collection events, 48 IDIs (in-depth interviews with 24 couples) and four FGDs (two with men and two with women) were completed. A combined total of 80 respondents participated in the study. Of these, 40 were men and 40 were women. Half of the interviews were carried out in Urban Kabwe and the other half in Ngawe. (See sample summary in Table 1).

Only two couples of the twenty-six that met the study criteria declined to participate in the study. Both couples were in urban Kabwe and had a known (by community) history of domestic violence.

Community health workers informed the research team that most likely the men in these two unions were afraid of being reported to the police if their wives opened up about the violence in the marriage. And the wives, even though over 18 years of age, deferred to their husbands' decision not to participate in the study.

Table 1: Sampling and Study Population by Research Method, Central Province, Zambia

Data Collection Method	Participant Type	Study Site	Total	Sub-Groups by Spousal Age Gap			Additional Characteristics, Categories not mutually exclusive*		
				<4	>4<7 years	>7 years	Age of wife < 18	Current FP users	Some 2ndary educ
In-depth Interviews	Young wives ages 15-24, married < age 18	Urban Kabwe	12	6	4	2	4	4	4
		(Bwacha) Rural Kabwe (Ngawe)	12	6	2	4	4	4	4
	Husbands of young wives ages 18-40	Urban Kabwe (Bwacha)	12	6	4	2			5
		Rural Kabwe (Ngawe)	12	6	2	4			5
Focus Group Discussions	6-8 Married women ages 18-24, married < age 18	Urban Kabwe (Bwacha)	1 FGD						
		Rural Kabwe (Ngawe)	1 FGD						
	6-8 Married men ages 20-30; married when wife was <18	Urban Kabwe (Bwacha)	1 FGD 1 FGD						
Total Study Participants		Urban Kabwe Rural Kabwe (Ngawe)	~40 ~40						
		Total	~80						

MAJOR THEMES

I. Poverty and Broken Dreams

Respondents from both urban and rural settings grew up in poverty-stricken families with little chance for economic opportunity. Many were orphaned at a young age and sent to live with members of their extended family. Some respondents were abandoned by one or both parents, though mostly by fathers who were polygamous or left the family to marry another woman. This displacement contributed greatly to a lack of money for school fees, and caused many men and women alike to drop out of school and marry at an early age.

"My experience in school was not an easy one; I would say it was a struggling journey. I have said so because as you know it's not easy for a child whose parents are divorced to get quality education. After my parents divorced, I used to stay with my mother and things were a bit fine, but unfortunately, my mother died and hardships now started because I now started moving from one relative's home to another and to some I was like a burden, especially to their children..." IDI Urban Husband12

"If my mother was still there I would have completed school; but after mum died I started struggling in the boarding school hence could not finish; instead I dropped out on the way. My uncle never used to send me money for the school fees and up keep; that is how I decided to leave and start my own life." IDI Rural Husband5

"I used to stay in Kafulamate at a farm right here in Kabwe. My father abandoned us and life was tough, and that is how I found myself in marriage without finishing school." IDI Urban Wife9

For women in particular, pregnancy and early marriage, both voluntary and forced, were also drivers of school dropout, though some men also reported dropping out of school to get married or because their girlfriends/wives were pregnant, and they could not afford both school and a child. A few women said they dropped out of school due to household chores, to care for sick or disabled family members or because the distance from their houses to school was too far to travel.

"I passed my grade seven exams, and it was only when I got pregnant that I stopped going to school; it wasn't a straight marriage it was just damage [damage is a term used when a man impregnates a woman before he is married to her]." IDI Urban Wife1

"I used to grow very well at my parents' house; they gave me full support; I started schooling in 1999; it was because of her pregnancy [referring to the wife] that I stopped going to school in grade 11 when she was put on antenatal leave; I stayed for one year, but I still went back to school, but she remained because she was with the child." IDI Urban Husband5

"That is how I stopped going to school because my mother is disabled and all my elder siblings

got married then the school was far from where I was staying, so I stopped school and did house chores because my mother is disabled such that she can't walk or carry anything." IDI Rural Wife10

Almost all respondents mentioned having dreams of staying in school and pursuing various career options. The most common career goals for women interviewed were teachers and nurses. Many men said they had wanted to become teachers as well. The second most popular career goal mentioned by men was to become a soldier. However, due to poverty, a lack of opportunity and family support and early pregnancy and marriage, none of the respondents had been able to achieve their career goals at the time of the interviews.

"What I was thinking of big time is that if I could finish school, I wanted to do the job that my father used to do, being a teacher because I use to admire a lot being a teacher." IDI Rural Husband9

"I really envy the nurses; I wanted to be a nurse." IDI Rural Wife6

II. Marriage Timing, Household Dynamics, and Decision-Making

For all respondents, marriage was deemed important and a way that men and women in the community earned respect, though marriage was particularly valued for women, who are often considered "promiscuous" until married.

"Marriage really matters because when you are single, everyone will be pointing a finger at you that you are having an affair with their husbands, but once you get married there will be no such accusations so marriage really matters. The other thing is that when you are alone you will be short of so many things but once you get married you gain some kind of respect." FGD Rural Women

Although some respondents (five of the 24 couples), both men and women, said that they fell in love and jointly decided to get married at an early age, about half of respondents (both men and women), reported that they got married because of an unintended pregnancy. Many of these couples were forced to marry, either by their families or strongly encouraged to do so by the church.

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"Like I briefly said in my introduction, I met her the time I was selling plastic backs in the streets in town. She was also selling same fruits in the streets and on a daily basis we could meet and chat. So we loved each other and ended up getting married." IDI Urban Husband11

“What is common here is when you are impregnated even when you don’t love each other they will force you to stay together.” FGD Urban Women

“The neighbor I used to play with, when she got pregnant she was taken to the man who was responsible for her pregnancy but the man didn’t love the girl so he used to tell his neighbors that he is not married and that they just forced him to be staying with her, the man run away and left the girl with child as we talk.” FGD Urban Women

“I can’t cheat you sir; me and my wife we started as a boy and girlfriend; I had two girlfriends by then; to my surprise I just met once with her and she became pregnant; I couldn’t believe it because the one I met with on several occasions was not pregnant at any time. I almost refused the pregnancy till I was told that ladies differ; others their uterus is so near such that they conceive very fast. That is how I accepted the pregnancy and we were helped to marry. In fact before I accepted the pregnancy I almost committed suicide. The church leadership encouraged me to take her.” IDI Urban Husband1

While some interviewed women reported that arranged marriages no longer exist, other female respondents (eight out of 24) disagreed, telling stories of their own forced marriages, some of which occurred seemingly covertly late at night. For most of these women, they had not met their husbands prior to their wedding day. For these arranged marriages, unintended pregnancy was not a factor.


“I use to live in Ngwerere and I did my school just there; my father lived in Chilonga and this other holiday he called me over to his place that’s how I came over and that was before I even started my menses. When time came for me to go back to school, my father refused—that he had found a man to marry me. I told him no, I am still very young; he still refused and said no just get married; that’s how I stopped school and got married.” IDI Rural Wife6

“When I dropped out of school, I came and stayed here with my mother and that’s how he made advances on me, and I refused the first time he attempted, after two months his parents came with nsalamu [initial portion of dowry payment]. I refused and said I am still young, my mother came in and said no, you will not complete your school, it is better you just get married before you just get pregnant, and that is how I just got married.” IDI Rural Wife5

It is important to note that arranged marriages were more prevalent in rural areas while unwanted pregnancies (as a driver of child marriage) were more prevalent in urban areas.

Despite the frequency of arranged and forced marriages among respondents, both husbands and wives said that they had good relationships with their spouses and, on the whole, with their in-laws. Disagreements between husbands and wives were centered on finances and husbands’ infidelity, alcohol use, staying out late, and relationship with his other children outside the marriage.

Most marital disputes were solved jointly within the couple though, in a few cases, couples engaged a third party such as a relative (mostly mother/sister-in-law or a grandmother), religious leaders or at



times marriage counselors played the mediating role between couples in a dispute and helped to resolve an impasse. Conflict with family members was most frequently mentioned between wives and their sisters-in-law, and between wives and their mothers-in-law, though to a lesser extent. Additionally, further probing on couples' conflict resolution revealed that family members had an indirect role in influencing household and family planning decision making, because they expressed certain gender role expectations. For instance, one husband pointed out that he would not consult with his wife on decisions because he feared that his family would question his authority in the household.

"The relationship between my wife and I is and has been very good, although once in a while as you know we are just human, one may wrong the other in words but still we still talk, ask for forgiveness and life continues." IDI Rural Husband7

"We [my wife and I] just relate well; we only differ when I want to support my child I had whilst at school with another lady; she doesn't want me to support my child." IDI Rural Husband2

"I approached one of his family members who was his aunt, she went and scolded the same woman he was having an affair with and that's how he stopped until today." IDI Rural Wife5

"My mother would wonder who is the head of my house... even my sister, everyone... if I ask her [referring to his wife] what we are supposed to be doing. IDI Rural Husband5


Husbands and their wives shared in decision-making about finances or purchases, and for the most part, either spouse could suggest what to purchase. However, conflict and mistrust on the use and appropriation of finances were evident in many couples. When couples disagreed on how to spend money, husbands made the final decision.

"What happens is that when I come up with a decision to buy something I tell my wife about it and then we put our heads together to see how best we can handle it, and also the same thing with her, when she wants to buy something she brings the idea to me. So that is how we handle it." IDI Rural Husband9

"Sometimes he gets paid without telling me and will only bring part of his salary and not the whole amount." FGD Urban Women

"A man is the one who is supposed to make all decisions in a home and so if we want to buy something in our house, I plan for it and see how we can buy it. All I need to tell her is that I am thinking of buying something, for instance, roofing sheets. Then we begin to keep some money aside." IDI Rural Husband10

"In the past she wanted us to buy the generator so that it can be used for watching television but I refused and suggested a battery and a solar; she didn't agree with me, so I just left for town and



bought the battery and solar; to my surprise she was very happy when she saw them.” IDI Rural Husband6

The man was the sole breadwinner in most households. In a few families both parties engaged in some form of economic activity and contributed to the household income, especially in urban areas. Women, for the most part, assumed the role of home keeper. Women were responsible for household chores, including child-rearing responsibilities, such as taking the child to the clinic when sick and making decisions around children’s schooling.

“The role that a husband plays in a home is that normally they look for money and just leave the money for relish [leafy greens]and wives normally we are in charge of the kitchen and the children, who need to go to school.” FGD Urban Women

“There are some [women] who do pieces of work here and there and others sell stuff like clothes or vegetables then you put the money together and make plans.” FGD Women Urban


Similar household dynamics and decision-making patterns were observed from couples with different age gaps.

III. Couples Communication on Fertility Intentions and Family Planning Use

A comparison between spousal responses on a series of questions related to fertility intentions, including the desired number of children and child gender preferences, family planning use and timing and spacing of children, indicates discordant accounts between husbands and wives for the majority of the couples. Contradictory responses suggest that intra-spousal communication around these issues was non-existent, infrequent or ineffective. With regard to family planning use, there was also evidence of false perceptions by one party that the other was against family planning use, when that was often not the case. While some women revealed that they lied to their husbands because they did not agree with the decisions imposed on them, to use or not to use a family planning method, others stated that they used a method covertly or discontinued a method without their husbands’ notice because they feared that husbands would not be supportive of their choices on the use of contraception. The table below exemplifies how one couple from Urban Kabwe provided differing responses to questions on fertility intentions and family planning use, an indication that their communication on these issues was limited. The disparities between the husband’s and wife’s responses were typical of many couples in the study, as demonstrated by Table 2, below.

Table 2: Spouses' Discordant Responses

Fertility Intention FP Use Question	IDI Urban Wife¹⁰ Response	IDI Urban Husband¹⁰ Response
How many children do you want?	"4"	"5"
How many children does your spouse want?	"2"	"5"
Do you have any preferences for the gender your children?	<i>"I want girls so they can care for me when I am sick"</i>	<i>"I want 3 girls and 2 boys"</i>
Does your spouse have any preferences for the gender your children?	<i>"He wants boys to keep his name alive"</i>	<i>"We both want mixed, boys and girls"</i>
Would be happy if they found out you're expecting another child now?	"No"	"No"
Would your spouse be happy if they found out you're expecting another child now?	"No"	"Yes"
Have you discussed FP use with your spouse?	<i>"At first I went for a 3 months injection and I did not tell him. I did not want him to refuse. But after we talked about it he now encourages me now to use family planning. He even told me to go and get the 5 years injection"</i>	<i>"...She (his wife) had gone on her own to get an injection without telling me because she thought we needed to take a birth break and she thought I would say no. This made me feel bad that she did this without telling me... but it was already done so I just said it was fine."</i>
Are you or your spouse currently using any form FP method?	<i>"Yes, I am using the 3 months injection... the 5 years one made me sick and made my periods long... the 3 months one is much better..."</i>	<i>"... the injection gave her complications, she was feeling weak and dizzy... now she is on a pill... we only have sex about 3 times a week so she doesn't get pregnant."</i>



The fear associated with the financial burden of an additional child or unintended pregnancy was among the main reasons respondents chose to use a family planning method. Most couples agreed to wait until they were better off financially before having another child. In addition, child/pregnancy spacing was noted as being an important reason for the uptake of family planning methods to ensure the health and wellbeing of children. However, when couples differed on preferred family size, the man's preferences prevailed because he was considered the head of the family and the sole breadwinner. Nonetheless, some women resorted to covert use of family planning as a way of asserting their own fertility preferences, though some noted that such secrets would mostly result in conflict or even end of a marriage if uncovered.

"... You can't have more children than your income. How can you feed them if you don't have enough income? Especially that here we are also sometimes pushed to marry by our parents of which at times we are not ready to do that because we have no stable source of income. We depend on fishing which is also seasonal, so as a man I would look at my potential to feed my family hence put my foot down as to how many children we are to have with my wife." FGD Rural Men

"That decision is made by the fathers because he is the head of the family hence responsible of providing; if my wife wants to stop conceiving we can even quarrel to an extent of ending the marriage." FGD Rural Men

"You discuss with your husband and if he is not interested, me as a woman am the one who understands what having many children is all about so I would know whether to have a child then or not, and if not I would be on a method privately and not tell my husband because I know I can't be having children anyhow." FGD Rural Women

"It is a good way of doing things because where you agree to have family planning there is more peace in the house; in fact family planning issues where the woman just does it on her own without the knowledge of the husband brings a lot of problems to some extent divorce can be a result; so a couple that makes decisions together on issues of family planning becomes stronger and healthier." FGD Rural Men

Still, many couples reported to have experienced an unintended pregnancy at some point, an indication of unmet family planning need. In general, unsupportive husbands, side effects, myths and misperceptions about family planning methods, inadequate knowledge and poor access to family planning were all described as the main factors that limited family planning use. Additionally, a woman's control of her fertility was influenced by her husband's preferences and family/community pressure to bear children.

"Yes, I was a bit worried because I know that family planning pills destroy the wombs of most women in that if they take them for a long time, it becomes very difficult for them to conceive.

There are also those five year injections¹² for family planning, I think those are not good too because after five years if a woman wants to have a baby they will have difficulties to conceive. But I still debate within myself about whether or not they really work.” IDI Rural Husband10

“There are some men who would consider that and say she will never conceive if she goes for family planning so what will become of me if I allow her now and she fails to give me children later. There are some that if you take contraceptives for a longer period you cannot conceive, in fact you become barren, again there are some that develop fibroids due to family planning” FGD Rural Women

“Other women are refusing the use of family planning because of cervical cancer that has come in today; others they are refusing to use a condom because of the lubricant on the condom; they say it gives cancer.” FGD Rural Men

“When I used to go to collect Safe Plan [oral contraceptives] at the clinic they may say, come on Monday, and when you go there you may find that there are a lot of people who have come for antenatal; they will tell you to come on Thursday and when you go on Thursday they may tell you to go back next week.” IDI Urban Wife7

IV. Male Involvement in Family Planning

While many respondents agreed that it is important for husbands to accompany their wives to the clinics to gain a better understanding of family planning methods, as well as to provide emotional support to their spouses, the sentiment that men who accompany their wives to family planning clinics are “weak” and controlled by their women was common among most men in the interviews.

[In response to the question of what people think of men who accompany their wives to the clinic] “The people will mock you saying it is because it is a new marriage; give them time and it will change; also that the man is under the woman’s government.” FGD Rural men

Conversely, some husbands felt that they were jointly responsible for family planning and expressed the importance of collective decision-making around contraceptive use. Some noted that men should also initiate discussions on family planning use and be supportive of their wives by accompanying them to the clinics so they could learn together and make the best family planning decision for their union. Others mentioned that they assumed responsibility for preventing unintended pregnancies by using male condoms. Lastly, several men expressed a need for family planning programs to educate and involve men in family planning, noting that such programs almost always focused on women.

“Husbands should also take a role of coming to the clinic to learn about family planning because I know my wife comes here to learn these things; so if both of us we can have knowledge about family planning we will encourage each other to use it. I must show interest for me to embrace it.

¹² A five-year injection FP method does not exist. Respondents used this term to describe an implant.

In fact when my wife gets information from me she will get more encouraged. In fact if the man is involved he can even be reminding the wife when to go and replace the expired method.” FGD Urban Men


“There is need to teach men as well on family planning; most of us here think that when a woman is using a family planning method then she is misbehaving so there is much need to teach people on this program to avoid the confusions happening.” FGD Rural men

“The way you have started teaching us, it will now be good because we shall also get involved; teaching only our wives is not a good idea... that’s why a lot of men have refused to follow them [FP programs] because they are coming through their wives.” FGD Rural Men

CONCLUSIONS: SUMMARY OF OVERALL FINDINGS

Study participants came mainly from poverty-stricken families and had unfulfilled childhood dreams about their future school achievements or careers. By far, unintended pregnancies were the leading cause of early marriage, for both sexes. Culturally, a man who “damaged” (impregnated) a woman was pressured by the community (mostly by the parents of the girl and religious leaders) to marry her. As such, unintended pregnancies led to most school dropout for both men and women, further continuing the cycle of poverty. Many respondents confessed that given a choice, they would not have gotten married when they did. However, some women were victims of arranged/forced marriages, and some others reported to have fallen in love and voluntarily married their suitors.

Marriage is highly valued within the respondents’ communities and seen as a way to earn respect, though particularly so for women who are often viewed as “promiscuous” (having premarital sex and/or sex with married men) if still unmarried into their late teens. Most respondents had a sense that they were “happily married,” though with more probing it became apparent that most couples experienced conflict and mistrust mainly as a result of husbands’ infidelity and alcohol use, and financial strain. Additionally, though a majority of couples stated that they resolved disputes independently, some confessed to having engaged a third party, mostly an in-law, a religious leader or a marriage counselor, at some point in their marriage to mediate or help break an impasse between them. Additionally, some decisions within a marriage were influenced by the gender roles and expectations held by other family members. Furthermore, the man was the sole breadwinner in most unions, a fact that placed him in a position of power with regard to decision-making on the family’s finances and other pivotal decisions, such as family size and family planning use and access. As such, women mostly deferred to their husbands’ preferences on family planning use, with the exception of a few who resorted to covert family planning use as a way of asserting their own fertility preferences. Nonetheless, discussions with couples revealed that sometimes a wife’s assumption that her husband would be opposed to her use of family planning was actually inaccurate. Intra-spousal communication on fertility desires and plans was nonexistent, limited or ineffective as evidenced by discordant accounts by spouses on the desired number of children and child gender preferences, family planning use and timing and spacing of children. It is, however, important to note



that conflicting accounts between spouses could also be explained by women's choice to use family planning covertly, which means that their husbands were ill-informed about their wives' fertility decisions, as well as inaccuracies inherent in self-reported data. Nonetheless, many couples strived to plan the timing and spacing of children, using different methods including condoms, a traditional method and at times another method (mostly pills or injectables) largely out of the fear associated with the financial burden of an additional child. Nonetheless, use of contraception was generally inconsistent and unintended pregnancies were still common in many unions. Reasons provided for not using family planning mainly centered on myths and misperceptions about family planning methods, as well as side effects.


While most respondents generally acknowledged the importance of male involvement in family planning, the idea of husbands accompanying their wives to the clinic was viewed as "unmanly" and "weak," especially among male respondents. Conversely, some husbands felt that they were jointly responsible for family planning and expressed the importance of a collective decision-making around contraceptive use. Several men, however, felt ill-informed about family planning methods in general and expressed a need for family planning programs to educate and involve men in family planning discussions, noting that such programs almost always focused on reaching women.

RECOMMENDATIONS: SPECIFIC STRATEGIES FOR CONSIDERATION

The study findings indicate that deeply embedded social norms related to gender roles lead to unmet need for family planning. This unmet need starts at a young age in Zambia, even before marriage, and in fact is itself a driver of early marriage. It is evident that adolescent girls exposed to early marriage would benefit from efforts to improve intra-spousal communication and partner support for family planning, especially in contexts where unequal gender norms limit girls' agency to negotiate their reproductive desires. At the same time, increased attention should also be paid to pregnancy prevention among unmarried adolescents, given that unintended pregnancies remain a major contributing factor to school dropout and ultimately early marriage, for both sexes.

The study findings support the need for programming geared toward increasing communications within couples and particularly to support male involvement in family planning and reproductive decision-making. Such programming should be designed strategically in ways that recognize and promote the importance of couple communications and of men's roles and influence decisions around family size and in the use of family planning to delay, space or end childbearing. The willingness by a fair number of men in our study to be involved in family planning and to share in the responsibility of planning their families is an indication that male involvement interventions have a potential for far-reaching advances in addressing the issue of unmet need in Zambia and perhaps within other resource-constrained settings.

The findings thus show that it is necessary to design multi-faceted interventions aimed at transforming the underlying gender norms that limit women's reproductive agency and that constrain constructive male engagement in family planning, starting at a young age. Since these restrictive



norms operate at various levels, interventions need to take a holistic approach to address unmet need for family planning across the life course by transforming gender and age-related norms at the individual, interpersonal, community and structural levels.

At the individual and interpersonal levels, it will be important to ensure that access to sexual and reproductive health information starts at an early age and takes into consideration the changing dynamics of interpersonal relationships across the life course, with a focus on communication and negotiation skills to support shared reproductive decision-making. At the community level, key influencers in the community must also be reached to help create an enabling, gender-equitable environment for couple communication and family planning. And finally, it is vital to ensure that the health system supports youth-friendly and gender-sensitive services. (See box for a summary of recommendations).

Strategies to Increase Access to Family Planning

Individual and interpersonal level


- Introduce body literacy and comprehensive sexual and reproductive health information to adolescents and young people, both in-school and through community-based groups.
- Reach couples and unmarried youth with information on partner communication skills, especially related to the negotiation of fertility intentions and family planning use.
- Reach couples and unmarried youth with information on healthy timing and spacing of pregnancies promoting shared reproductive decision-making.

Community level

- Reach key individuals/groups that influence social behavior in the community with messages and information geared towards changing norms, attitudes and ideas on the roles of men and women, e.g. male engagement and support for family planning.
- Train key influencers, such as community and religious leaders, including marriage counselors, on supportive family planning norms, methods and the importance of couple communication and shared decision-making.
- Support sensitization campaigns on equitable gender norms and family planning methods to counter myths and misperceptions.

Structural level

- Train family planning providers on counseling tailored for different kinds of couples and according to their life courses.
- Train health care providers on youth-friendly and gender-sensitive services that take couple dynamics into account and offer couple counseling.
- Provide vouchers to low-resource individual and couples to support access to family planning services
- Provide community-based distribution of family planning methods during times when men are home with their wives and include them in outreach services.



One cannot understate the importance of providing age-appropriate, school-based (and out-of-school) fertility awareness and comprehensive sexuality education from an early age, linked with referrals to adolescent-friendly services and community sensitization about the importance of adolescents having access to such information and services so as to avoid early pregnancy and child marriage. This is especially so in the light of the recent [Lancet Commission](#) report (May 2016), which synthesizes the latest evidence and shows that school-based comprehensive sexuality education and adolescent-friendly services are both effective and cost-effective interventions.¹³

The authors recommend partnering with youth and community leaders to consider an intervention that builds upon existing entry points for education about body literacy, fertility, and family planning. For example, FHI 360's youth-focused UJANA project¹⁴ in Tanzania leveraged traditional initiation ceremonies for young girls to sensitize them and the community about HIV. Implemented through a local nongovernmental organization, Partnership for Youth Development (PAYODE), 21 initiators (called *manyakanga*) were trained on HIV prevention and supported to integrate HIV prevention education with the initiation teachings and ceremonies. A similar approach could be adapted and applied in Zambia to leverage local traditions (e.g., pre-marital counseling by traditional leaders) to educate young men and women on sexual and reproductive health as well as family planning. At the community level, past projects provide models that could be adapted in Zambia to create a social environment that enables young married couples to achieve their fertility desires. For example, the Institute for Reproductive Health (IRH) Tékponon Jikuagou project in Benin fostered reflective dialogue, catalyzed discussion about social norms related to family planning, and diffused information through formal and informal social groups, influential opinion leaders, and well-connected individuals.¹⁵


At the service provision level, the Zambian Ministry of Health's decision in January 2016 to authorize the nationwide scale-up of community-based distribution of injectables, among other voluntary contraceptive methods, presents a key opportunity to extend the reach of youth-friendly health services in Zambia. Integrating community health workers into the health system is one of several proven "high-impact practices in family planning" (HIPs) identified by a technical advisory group of international experts.¹⁶ In other parts of the country, SFH has begun to train and support community-based distributors from the public sector to add injectables to the range of methods they offer in rural and hard-to-reach communities. In Central Province, efforts should be made to ensure that community-based distribution of contraception is gender-sensitive and youth-friendly.

¹³ "Our Future: A Lancet Commission on Adolescent Health and Wellbeing," accessed June 20, 2016, <http://www.thelancet.com/commissions/adolescent-health-and-wellbeing>.

¹⁴ "Leveraging Tradition to Teach Girls About HIV," *Half the World*, August 31, 2011, <https://iywg.wordpress.com/2011/08/31/leveraging-tradition-to-teach-girls-about-hiv/>.

¹⁵ "Tékponon Jikuagou," *Institute for Reproductive Health*, accessed June 20, 2016, http://irh.org/projects/tekponon_jikuagou/.

¹⁶ "Community Health Workers: Bringing Family Planning Services to Where People Live and Work | Family Planning High Impact Practices," accessed June 20, 2016, <https://www.fphighimpactpractices.org/resources/community-health-workers-bringing-family-planning-services-where-people-live-and-work>.



Ensuring that existing contraceptive services are “friendly” to adolescents and youth enhances the impact of HIPs and commonly includes:

- Training and supporting providers to offer nonjudgmental services to adolescents,
- Enforcing confidentiality and ensuring audio and visual privacy,
- Offering a wide range of contraceptive methods,
- Providing free or subsidized services.¹⁷

The findings of this study suggest that it is particularly important for community-based distributors to be trained to provide private and confidential couples counseling on family planning, since gender norms in the community strongly discouraged men from going to clinics with their partners. Community-based distributors could also make referrals for other methods, and follow up with couples to respond to questions, assist with the management of side effects, and support voluntary continuation of use.

Given the high demand among men and women in the study for birth spacing, efforts could also be increased to reach postpartum women with voluntary family planning services. Antenatal care providers should be trained to offer youth-friendly counseling on postpartum family planning, giving pregnant women the opportunity to discuss postpartum contraceptive options with male partners and other family members before the delivery. This approach aligns well with the desire of many young women and men in the study to share decision-making about contraception with their partner and other family members. Postpartum family planning counseling during antenatal care was critical to SFH’s previous success supporting the Zambian MoH to provide more than 5,000 voluntary postpartum IUDs in the context of informed choice between 2009 and 2014.¹⁸

With these recommendations and practical examples taken into account, multi-level family planning interventions in Zambia will help create an enabling environment for girls, women, boys and men to recognize and realize their fertility desires. Especially in a context where early marriage greatly shapes couple dynamics and limits partner communication, family planning interventions need to be gender-synchronized, intentionally aiming to transform unequal gender norms among both male and female community members. Because unintended pregnancy is a key driver of early marriage in Zambia, gender-synchronized interventions that reach unmarried youth, including comprehensive sexuality education and youth-friendly services, have the potential to reduce child marriage, better meet the sexual and reproductive health needs of young people and catalyze broader change so that voluntary family planning becomes a shared responsibility for the women and men of Zambia.

¹⁷ “Adolescent-Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements into Existing Contraceptive Services | Family Planning High Impact Practices,” accessed June 20, 2016, https://www.fphighimpactpractices.org/sites/fphips/files/hip_afcs_brief.pdf

¹⁸ “Enabling the Healthy Spacing and Limiting of Pregnancies: Programmatic Approaches to Expand Postpartum IUD Access,” Population Services International, 2015, access June 20, 2016, http://www.psi.org/wp-content/uploads/2015/02/PPIUD_English-Web-a.pdf