

**CONTRACEPTIVE USE AMONG YOUNG MEN (15-24)
YEARS AND THEIR SEXUAL PARTNERS IN ZAMBIA**

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55th International Course in Health Development/ Master of Science in Public Health
(ICHD/MPH)

KIT (ROYAL TROPICAL INSTITUTE)

Vrije Universiteit Amsterdam (VU)

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A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in Public Health

BY

**SILENGA EVA. M
ZAMBIA**

Declaration

I hereby declare that this Research Report is the original work of my hands and is not in any way a duplicate. Where other peoples work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis **CONTRACEPTIVE USE AMONG YOUNG MEN (15-24) YEARS AND THEIR SEXUAL PARTNERS IN ZAMBIA** is my own work

Signature:



55th Master of Science in Public Health/International Course in Health Development
(ICHD/MPH)

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Dedication

To God Almighty for the life, strength and making it possible for me to undertake this program. This report is dedicated to my mom **Chama C Mushintampanga(MHSRIP), mom and dad,** my husband, son, niece and sister **Bristone, Chimuka, Mazuba and Nchimunya** for understanding when I needed to be away in order to achieve this goal. Finally to family and friends for being there for me and for your wise counsel at the time I needed you most. I remain indebted to you all more than words can say. Mom you should have lived to see me attain this.

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Definition of terms

Acceptability: Peoples willingness to seek services. Acceptability is low when patients perceive services to be ineffective or social and cultural factors (such as age, language, sex religion) of provider discourage them from seeking services (Levesque, 2013)

Affordability: The measure o people’s ability to pay for the services without any financial hardships, this does not only include price of health services but indirect and opportunity costs (Levesque, 2013)

Contraceptive Use: The use of any method such as injection, pill, intrauterine device, male or female condom, sterilization, diaphragms, implants, lactation amenorrhea, withdrawal, rhythm and standard days method that is used to avoid pregnancy, limit or delay the number of children.(MOH,2013).

Contraceptive Prevalence Rate: This is the percentage of married women aged 15-49 years who are currently practicing or whose sexual partners are practicing any form of contraceptives regardless of method (MOH, 2013)

Family Planning: The ability of individuals and couples to anticipate and attain their desired number of children, spacing and timing of their births (MOH, 2013)

Young People: In this study are persons aged between 15 and 24 years (United Nations (UN), 2019).

Acronyms

CBD	:	Community Based Distributors
CPR	:	Contraceptive Prevalence Rate
CSO	:	Central Statistical Office
FP	:	Family Planning
GDP	:	Gross Domestic Product
HIV	:	Human Immune Virus
ICPD	:	International Conference on Population and Development
MMR	:	Maternal Mortality Ratio
MOH	:	Ministry of Health
MOF	:	Ministry of Finance
MNDP	:	Ministry of National Development Planning
NGO	:	Non-Governmental Organization
NSHP	:	National Strategic Health Plan
PPAZ	:	Planned Parenthood Association of Zambia
SRH	:	Sexual Reproductive Health
SRHR	:	Sexual Reproductive Health Rights
STI	:	Sexual Transmitted Infections
UNFPA	:	United Nations Population Fund
WHO	:	World Health Organization
ZDA	:	Zambia Development Agency
ZDHS	:	Zambia Demographic Health Survey

Abstract

Background: With a universal knowledge on at least one contraceptive methods among young men contraceptive prevalence rate is low. Nonuse has resulted in unintended pregnancies, unsafe abortions which have further resulted into high maternal mortality. Factors that have influenced low uptake has been found as lack of or inadequate contraceptive knowledge, poor aptitude, unclear policies, myths and misconceptions.

Objective: To explore factors influencing the utilization of Contraceptives among young men and their partners in order to inform policy makers on strengthening SRHR policies that involve young men and enhance family planning programs that increase demand and uptake for young men and their partners in Zambia.

Methods: A desk review was conducted using the adapted Andersons Behavioural model of 1995 health services which was used as a guide to analyse the influencing factors.

Results: Results reveal that young men and their sexual partners had positive attitudes towards contraceptive use and were highly knowledgeable with at least one or two contraceptive methods, despite low use. Those with a low level of education and income were less likely to use contraceptives than those with a higher level of education and income. Gender norms and socio-cultural beliefs were barriers found to utilisation.

Conclusions and Recommendations: There is need to increase focus on young men as they have a role to play as users and partners in contraceptive use, thus reducing unintended pregnancies, unsafe abortions and Maternal mortality. This can be achieved by reducing health system, community and individual barriers and increase awareness.

Key words: Family planning, Contraceptives, Young men, Male involvement, Zambia.

WORD COUNT: 12,232

Introduction

I am a Nurse Manager working at a Public Pediatric Clinic (0-14 years) which also offers reproductive health services to men, women, youths and adolescents with a catchment population of over 90,000. Initially, the clinic is meant to only provide pediatric services, as a team, I saw it fit to Family Planning(FP) services to parents who brought their children to the clinic and provide a holistic service. During our static and outreach activities, we had a positive response from the community. However, I faced a number of challenges unskilled staff to provide Long acting-reversible contraceptives (LARC) equipment, commodities, stock outs and shortage of staff. Among other challenges were inadequate space for privacy which made youths shun or have access to our services as they feared to be stigmatised when seen by their parents or friends. In order to overcome some of these challenges, I partnered with two local NGOs i.e. Planned Parenthood of Zambia (PPAZ) and Dreams initiative. PPAZ provided us with skilled staff and regular suppliers and we saw an increase in the number of women coming to access the services. Dreams initiative an international organization on the other hand focused specifically on empowering those aged 15-24 years with information and life skills. The Organization also recruited girls and boys who were interested in attending focus group discussions on FP, HIV and sexuality.

Being a Nurse Manager, I had the responsibility of analyzing and reporting quarterly and annual data. Without adequate knowledge on consequences of low contraceptive use and high fertility, it was difficult and challenging to design and develop new strategies and programs to improve service delivery. In addition, interpreting indicators was a challenge thereby having less supplies and commodities to cope with the demand. With support from DHMT and two other partners, we refurbished one of the rooms and created an adolescent youth friendly corner. We started providing the young people with information and contraceptives as they have the highest population and most affected, with high pregnancy rates and unsafe abortions which led to maternal mortality. Unfortunately, there was still low uptake of contraceptives especially among the young men, who preferred to be circumcised. This was my motivation to find out why there was low contraceptive use among young men and their sexual partners despite the interventions put in place.

Unintended pregnancies, unsafe abortions and high maternal mortality remains a public health challenge. According to Bearak (2018), approximately 210 million pregnancies occur worldwide annually of which 44% are unintended while 56% abort. Darroch (2017) adds that about 214 million women in Low Middle Income Countries have an unmet need of modern contraceptives.

Family planning is one of the most important health interventions of the 21st century (Bongaarts et al 2012). It enables women to plan their births and determine the number of children to have. Its use has far-reaching benefits for individuals, couples, households, communities, and society at large, including maternal and child health improvements, educational advances, reduction of poverty and empowerment of women. Yet despite these benefits and ongoing efforts to expand its access, contraceptive use is still low and unmet need for family planning is high in developing countries in which Zambia is part of. It is estimated that 225 million women in the developing world have unmet need for family planning i.e. they wish to avoid or delay pregnancy but are not using any contraceptive method. This exposes them to unintended pregnancies, maternal and childhood deaths, morbidity and unsafe abortions (Singh et al, 2013). It is estimated that eliminating unmet need for FP in developing countries could avert up to 30% of pregnancy related deaths (National Research Council, USA, Institute of Medicine, 2011).

Contraceptive use among young men and their sexual partners (aged 15–24), whether married or unmarried, is lower than among relatively older men and women. In Zambia, fertility rate has continued to decrease from 6.5 % (ZDHS, 1992) to 5.3% (ZDHS, 2014), and the preliminary findings of (ZDHS, 2018) indicate that fertility further decreased to 4.7%. This was as a result of commitment and interventions by Government through Ministry of Health to support family planning programs and reduce population growth. Despite having free family planning services and interventions in place, young men in Zambia still have challenges to access contraceptives at individual, community and at health service delivery level. Hence, overall contraceptive prevalence rate still remains low. This research therefore is aimed at exploring factors influencing the utilization of contraceptives among young men and their sexual partners between the age of 15-24years in Zambia.

CHAPTER ONE: BACKGROUND INFORMATION

1.1 Demography

Zambia is a landlocked country in sub-Saharan Africa, and shares its borders with eight other countries namely, the Democratic Republic of Congo, Tanzania, Malawi, Mozambique, Zimbabwe, Botswana, Namibia and Angola. The Central Statistical Office (2010), projected a population increase during the census year, with the higher population of people living in the rural (60.5%) than in the urban (39.5%). With an annual population growth rate of 2.8% between 2000 and 2010, the population had increased by more than three million (33.3%) with the majority being young people. The percentage of young people aged 15-24 years was 20% of the total population, while those below 15 years accounted for 45.4% from which we observe a young population structure (CSO, 2010). This youthful population structure meant a high population growth which had resulted from a high fertility rate since the majority were in the reproductive age. Despite a drop in the fertility rate over the years from 6.5% in 1992 to 5.3% in 2014 with current preliminary findings of 4.7% births in 2018 (ZDHS,2018), the rate has remained high. In addition, due to increase in annual growth rate of 3.3% as estimated by the United Nations (2019), population has been estimated to increase upto over three million in 2019. This poses a threat on the health system especially on the provision of health services for the young people coupled with shortage of staff and limited skills to serve this population.

FIGURE 1: Map of Zambia



Source: Mapsoftheworld.com

1.2 Economy

Zambia as Africa's second-largest copper producer achieved middle-income country status in 2011, after a decade (2004-2014) of impressive economic growth, averaging 7.4% per year. However, growth only benefitted a small segment of the urban population and had limited impact on poverty. Zambia ranks among the countries with highest level of inequality globally whereby 58% of Zambia's 17.2 million (Labour Force Survey, 2017) people earn less than the international poverty line of \$1.90 per day (compared to 41% across Sub-Saharan Africa), and three quarters of the poor live in rural areas.

Zambia's Human Development value in 2017 was 0.588. The figure put the country in the medium human development category, positioning it at 144 out of 189 countries and territories. Between 1990 and 2017, Zambia's HDI value increased from 0.401 to 0.588, representing a percentage increase of 46.7, with life expectancy at birth increased by 17.3 years, mean years of schooling increased by 2.3 years and expected years of schooling increased by 5.0 years. Zambia's GNI per capita increased by about 71.3 percent between 1990 and 2017 (UNDP, 2018).

Family planning and contraceptive programmes (FP/C) play a critical role in national and human development. They facilitate regulated population growth that results in social-economic benefits decreased poverty levels, enhanced education opportunities and reduced gender inequality (Denton, 2014). Furthermore, they provide an opportunity for improved maternal and child health, through prevention of sexually transmitted diseases (STIs), unwanted, early pregnancies, and unsafe abortions (Hubacher et al, 2008). Cates et al (2010) state that FP/C programmes are among the most cost-effective development investments because of their direct influence on improving lives through national security and enhanced financial resources for communities.

1.3 Education

The education system has a three tier education levels which include; Primary (7years), Secondary (5years) and Tertiary (1-7years depending on program). Important to note is that the sector provides free education at primary level and has in the past decade embarked on a number of initiatives to ensure universal access to education. Education is a fundamental and significant tool as it improves the lives of individuals, families, community and society as a whole. Further, the 7NDP (2017-2021) addresses issues of human development and their ability to be educated, be healthy so that the population can contribute to sustainable economic growth and reduce poverty in an effort to have a reasonable standard of living.

According to Census (2010), the national literacy level was 63.4%, while youth literacy was at 66% with males being at 69% and females 62%. The data clearly shows that males have a higher literacy rate than women. The disparities are due to inequalities in school attendance between males and females resulting in low literacy rate for women as compared to men. Social and economic development can be achieved when both men and women have equal participation in the development process. Nonetheless, policies on education have now focused on enrolling more females in order to have equal access to education. The education sector also introduced the re-admission policy aimed at helping girls who get pregnant go back to school after delivery.

1.4 Health System

Zambia has a well-developed private and public health care system which provides specialized medical services such as diagnostic, curative, etc. The private health sector in particular has earned the reputation as providers of good quality health care. Government has declared health care system as a priority sector (Zambia Development Agency, 2013).

Health systems in Zambia are classified into three major categories: First Level; comprising Health Posts, Rural Health Centres and District Hospitals, where primary health care and preventive health services are provided. Second Level; comprising the provincial and general hospitals, these provide the curative care; and Tertiary level; comprising Central hospitals and the National University Teaching Hospital providing specialized care (Zambia Development Agency, 2013).

According to MoH (2017), the total number of facilities are as follows; 34 second level hospitals, 99 first level hospitals, 1,839 health Centre's and 953 health posts. Despite having a good number of health facilities, not all Centre's provide family planning. This is due to a shortage of staff to meet the demands of people with unmet needs as in (table 2) below. Stock outs and shortage of family planning commodities are some of the challenges which disrupt service delivery.

Table 2: Number of staff posted per category in public sector by 2005 and September 2010, and the approved establishment for 2010.

	No. Of	No. of	Increase of	Estab. 2010	Gap to	Gap to
Health Staff	Staff 2005	Staff 2010	Staff		Estab.	Estab. (%)
Clinical Officer	1,161	1,535	374	4,000	2,465	62
Dentistry	56	257	201	633	376	59
Doctors	646	911	265	2,300	1,389	60
Nutrition	65	139	74	200	61	31
Laboratory Services	417	939	222	1,560	921	59
Pharmacy	108	371	263	347	- 24	- 7
Physiotherapy	86	239	153	300	61	20
Radiography	142	259	117	233	- 26	- 11
Midwives	2,273	2,671	398	5,600	2,929	52
Nurses	6,096	7,669	1,573	16,732	9,063	54
Environmental health	803	1,203	400	1,640	437	27
Other Health Worker	320	363	43	5,818	5,452	94
Total clinical staff	12,173	16,256	4,083	39,360	23,104	59
Administration	11,003	14,457	3,454	12,054	- 2,403	- 20
Overall total	23,176	30,713	7,537	51,414	20,701	40

Source: MOH. E-Healthy Strategy (2016)

However, according to the 2018 Annual Economic Review by the Ministry of Finance, the number of workers in the health sector increased to 56, 688 from 50,527 in 2017. A total of 6, 161 workers were recruited during the review period contributing to an improvement of the health workers per 1,000 population to 3.22 in 2018 from 2.97 in 2017. The ratio was above the WTO minimum threshold of 2.5 health workers per 1,000 population (MoF, 2018).

1.5 Health Financing

The country's budget is mainly financed by domestic taxes and the higher percentage is from donors. Funding allocated to family planning is low because the component is integrated into the maternal and child health budget. According to the 2019 Zambia National Budget Analysis, 9.3% of the country's' budget was allocated to health sector. This fell short of 15% requirement by the Abuja Declaration (UN, 2012). In addition, due to a drop in donor funding and reduction in the Gross Domestic Product at 2.8% (MOH, 2017), government has started working on interventions which could improve financing. Following the London summit of 2012, the Government of the Republic of Zambia has committed to doubling the national budget for FP commodities for a period of eight (8) years in order to enhance CDBs and conduct outreach activities with a view to attaining the 58% CPR by 2020 (FP 2020).

CHAPTER TWO: PROBLEM STATEMENT, OBJECTIVES, METHODOLOGY AND CONCEPTUAL FRAMEWORK

This chapter describes the Problem Statement of the study, Justification, General Objectives, Conceptual Framework and Factors that have been linked to the Conceptual Framework.

2.1 Problem Statement

There is a global consensus that contraceptive use is key in preventing unintended pregnancies and men have not equally shared the responsibility of family planning. However, there has been low use of contraceptive in Zambia especially among young people aged between 15-24 years. It must be noted, that young people in Zambia between the age of 15-24 account for 20.6% of the total 17.2 million people (CSO: Labour Force Survey, 2017).

According to ZDHS (2018), 61.7% of unmarried young men and women between the age 15-19 and 51.4% between the ages of 20-24, were not using any method of contraception. Additionally, only 2.3% and 1.6% of young people aged 15-19 and 20-24 respectively, used a condom during their first sexual encounter (ZDHS, 2018). This indicates the poor use of contraceptives by the youths despite being sexually active.

There is a strong commitment from MOH to ensure FP is accessible to all citizens(MOH,2010) On the other hand, consistent male condom use among young adults(15-24years)at high risk sex(having sex with non-marital, non-cohabiting partner) in the last 12 months is low at 45.1%(DHS, 2014). The consequences of low use of contraceptives by the youths include contraction of sexually transmitted infections (STIs) like HIV/AIDS, unwanted pregnancies and unsafe abortions leading to high maternal mortality and maternal deaths of which the majority are of the age group between 15-24 (Ministry of Health, 2011).

In order to increase uptake of contraceptives among young people, the Government of the Republic of Zambia collaborated with Abt Associates, Society for Family Health, Planned Parenthood Association of Zambia (PPAZ) and Center for Infectious Disease Research in Zambia (CIDRZ), Marie Stopes and Scaling up Family Planning (SUFPP) to provide the commodities and undertake awareness activities (MOH, 2018). Further, the Government was currently implementing the Reproductive Health Policy which is aimed at reducing barriers adversely impacting the delivery of sexual and reproductive health services for adolescents and young people and scale up access to family planning through a variety of contraceptive methods and services in the hardest places to reach (MOH, 2000).

Despite Governments effort to increase uptake of contraceptives among young people, the response and the use of these contraceptives has been low. In view of the forgoing, the task of this report therefore, is to unearth factors influencing the utilization of contraceptives

among young men and their sexual partners aged 15-24 years in Zambia. Sexual partners is not referred to as having sex with men (MSM) but with casual and regular female partners, who should equally take a shared responsibility in contraception use and reduce gender inequalities in power relations.

In 2015, the Ministry of Youth, Sport and Child Development revised the 2006 National Youth Policy to make it more responsive and address the needs of young people including the use of contraceptives. Lack of access to basic information and diversity of methods has led to gaps in service provision contributing to low contraception use among young men and their sexual partners.

The aim of this study therefore, is to understand factors causing the low uptake of contraceptives among young men in Zambia and how they can be involved in their sexual reproductive health rights and those of their sexual partners. The study will also provide information on knowledge gaps in family planning provision, find ways of transitioning the knowledge into practice. Recommendations will be made based on findings to policy makers and planners to make policies and design programs which are effective and will increase uptake.

2.2 General Objective

To explore factors influencing the utilization of Contraceptives among young men (aged 15-24) and their sexual partners in order to inform policy makers to strengthen SRHR policies that involve young men and enhance contraception services that increase demand and uptake for young men and their sexual partners in Zambia.

Specific Objectives

- i. To explore perspectives of contraceptive use among young men in Zambia;
- ii. To identify the demographic, socio-economic and cultural factors that influence contraception use among young men and their sexual partners in Zambia;
- iii. To explore health system factors that influence the use of contraceptives among young men in Zambia;
- iv. To analyse the best practices/effective interventions in improving contraceptive use among young men and their sexual partners in Zambia and other relevant contexts.
- v. To provide recommendations to inform policy makers to focus on priority areas of intervention to strengthen and improve SRHS for young men.

2.3 Methodology-Literature Review

The method for this study is based on a desk review. Literature from published peer reviewed journals and grey literature articles will be used to explore factors influencing contraceptive use among young men and their sexual partners in Zambia and across sub-Saharan Africa. Literature is obtained from databases such as Google scholar, PubMed, the VU University e-Library and will include materials written in English which is the official language of the author. Literature review includes various national policies, strategic plans and Zambia Demographic Health Survey. In addition, Reports and documents from websites of international organizations such as WHO, UNICEF, UNFPA, and Government institutions like the Central Statistical Office (CSO), MOH and MoF were considered. Articles published between 1999 and 2019 are used to provide a wider scope of literature. However, other strategic documents such as ICPD 1994, National Population policy 1994 and other important articles will be included to see changes and progress after the revision of the policies and 1994 ICPD conference. Snowballing was also used to search other works that have been cited in different articles on similar topics since literature specific to Zambia was limited. In this study contraceptive use by young men refers to use of condoms and other methods by their sexual partner. Relevant literature was selected using my inclusion criteria below.

KEY WORDS were combined to have a wider search of literature such as Family Planning, Contraception, Men/Women, Adolescents/Young people, and male involvement/engagement, Zambia/sub-Saharan Africa/ Low –Middle Income Countries (LMIC). Accessibility/Affordability/Acceptability, Attitudes AND/OR Perceptions Socio-economic OR Cultural factors.

Table 1: Search strategy

Objectives	Source	Key Words
To explore perspectives and experiences of contraceptive use among young men in Zambia	PubMed, Google Scholar Vu elibrary	Attitudes, Perceptions, health beliefs, knowledge on contraceptives, benefits and barriers, Perceptions
To identify the demographic, socio-economic and cultural factors that influence contraception use among young men and their sexual partners in Zambia.	PubMed, Google Scholar and Vu elibrary Guttmacher Institute	Contextual factors, socio-economic AND/OR cultural young people, Attitudes, Perceptions ,gender and culture, beliefs and norms
To explore health system factors that influence use of contraceptives among young men in Zambia	PubMed, Google Scholar Vu elibrary and Strategic plan MoH Policies	Contextual factors, Policies, Community and health systems, accessibility, acceptability, affordability
To analyze the best practices that have been effective on improving contraceptive and male involvement from other countries among young men, and their sexual partners in Zambia	PubMed, Google Scholar Vu elibrary, Strategic plans Policies and Reports	Male involvement, engagement, interventions, policy decisions and recommendations

Inclusion criteria

- i. Studies that were conducted in English;
- ii. Articles that used mixed methods, qualitative or quantitative as these gave objective and subjective findings which provided a wide understanding of the topic;
- iii. Studies conducted in Zambia and in the sub-Saharan Africa; and
- iv. Studies focusing on contraceptives and male involvement as this is the focus of the study.

Exclusion Criteria

- i. All studies not conducted in English; and
- ii. Studies conducted in developed countries.

2.4 Limitations of the Methodology

1. Study limited to literature review, collection of primary data was going to provide more in-depth information and experiences from participants;
2. Data in DHS main focus is on women, difficult to compare with men;
3. Many studies had a higher sample size of women as compared to men which may not be generally representative to the male population; and

2.5 Conceptual Framework

The study is guided by a conceptual framework adopted from the behavioural model of service utilisation by Anderson (1995). This model has been used and revised by many researchers starting in the 1960s. The researchers wanted to understand why people use health services and what influences them. Later, it was revised by Anderson and Newman which suggested that utilisation of health services can be influenced by various factors such as the environment, individual and societal factors. After thorough search and comparison of different models, this model has been selected as it seeks to associate how different factors influence each other in utilisation of family planning and will answer the overall objective of this study, which is to explore factors influencing the utilisation contraception among young men and their sexual partners aged 15-24 in Zambia. Using the Andersons (1995) model, a new adapted version was developed which applied the individual, societal and health systems levels to understand the linkages which show that young men can be influenced to utilise contraceptives when all three factors interplay and are well addressed.

Health System Factors

Structural Factors

This section will discuss structural factors such as policies and how they can facilitate or hinder contraceptive use. Health system structural related factors are important in the effective delivery and use of the health services.

Service Delivery Factors

Service factors such as acceptability, accommodation, distance and transport costs were not included in the original model but these have been adapted in this study. Other factors which facilitate service utilization at personal, family and community level include household income, education and employment level. These must exist and enable young men to access available facilities which are provided and this illustrates that when there is a missing link between the factors (for example low income or unemployment) demand for the service could be low or could result in non-use of the service. Since the concentration of this study is on young men, gender norms and equity will also be analyzed as these are the demand driving factors for service utilization. According to the theory of reasoned action, service utilization depends on the knowledge and information that an individual has acquired and this influences a health seeking behavior attitude.

Provider Related Factors

It is important to note that, the competence levels especially the beliefs and values that providers have towards the young population use of contraceptives, and the way the service is provided, contributes significantly to low or high utilization rates.

Individual Factors

In this model, characteristics such as demographics include; age, marital status, level of education, knowledge on contraception and religion have an influence on the use or non-use of contraception and will be used in this study. **Socio-economic factors** such as income or employment determines an individual's social status and how it affects health seeking behaviour. **Other social cultural issues** include; health and cultural beliefs, which includes attitudes, values, and norms play a great role in the way an individual perceives healthcare and the desire to access the service. The knowledge and attitude that one has about their health and that of others can greatly impact the decision and perception of healthcare services (Andersen, 1995).

Need Factors

Perceived needs, in this study are factors which suggests health issues or problems and will cause an individual to immediately use and seek health services. Need factors according to Behavioral Model (1995), focused on the attitudes, knowledge and values on various health

problems and services in relation to their perception of whether they require a health service or not. These can be perceived benefits and perceived barriers. The need to or not to seek care gives an understanding to health seeking behaviour which is beneficial to themselves or their partners in contraception use. Health behaviour are personal health practices such as contraception use, understanding their role in contraception use can directly influence utilization outcomes.

CONCEPTUAL FRAMEWORK

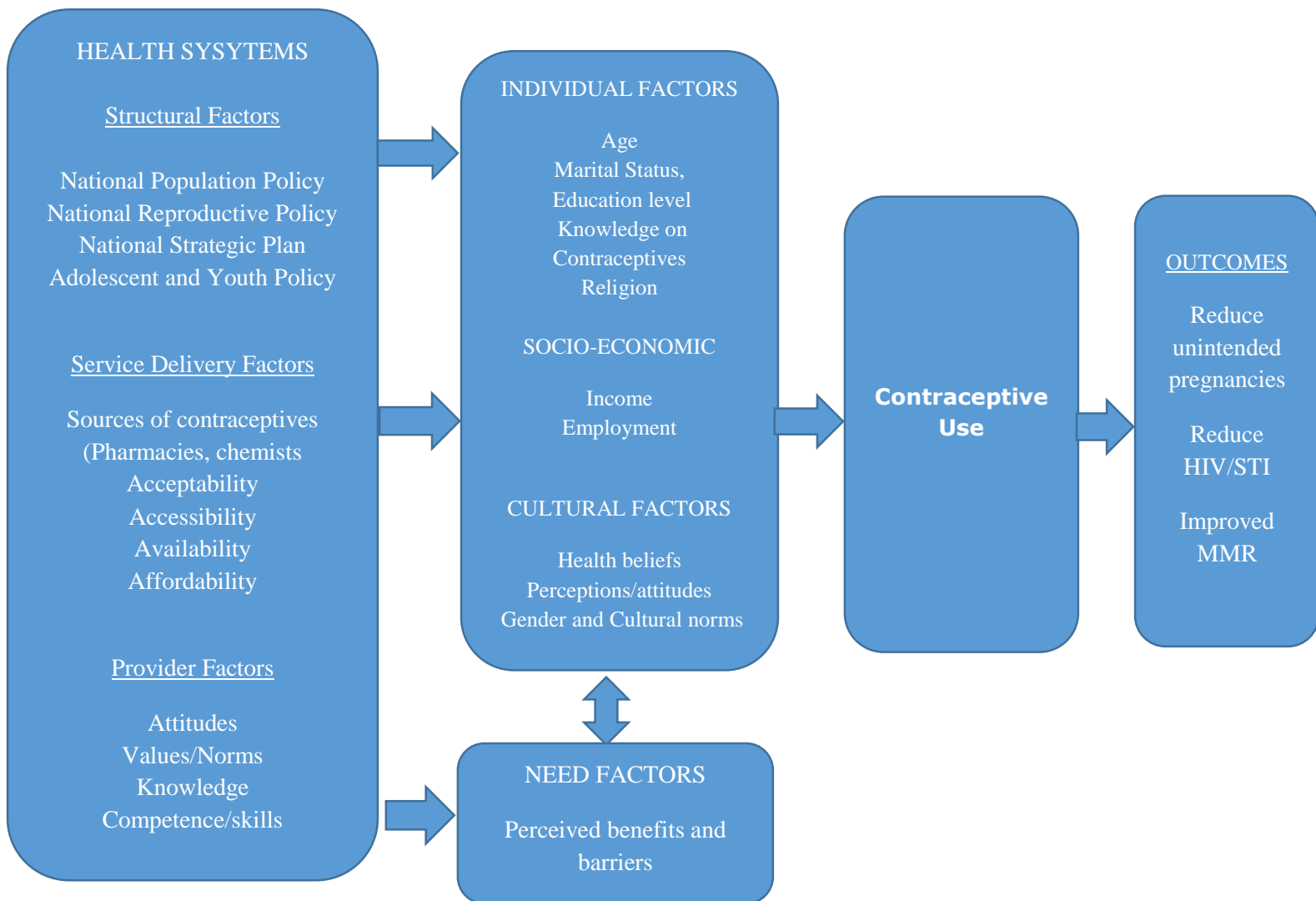


FIGURE 2: Adapted from the Anderson and Newman Framework (1995)

CHAPTER THREE: FINDINGS

3.1 Factors Influencing Contraception use

This chapter will explore and present findings of factors that influence contraception use among young men in Zambia. In this analysis, contraception is the use of a method for protection against a pregnancy. There are a variety of contraceptives available and, condoms (male and female) are listed among the modern contraceptives that are used today. Variables to help present the findings have been adapted from the Andersons model and illustrate how they influence each other at three different levels.

3.1.1 Health System Structural Factors

National Population Policy

The population and housing census of 1980 observed a rapid population growth which would have consequences on the country's economic growth and development. The immediate implications were that the structure of the population and growth rate may surpass socioeconomic development. The youthful population structure observed in the 1980s remains high in present day, due to a high population group which is still in the reproductive age aged 15-35 and another group below the age of 15 years. According to the Fourth National Development Plan (1993), revealed that the population growth will continue to rise and will have implications on resources and services such as education and health. Overall the NCDP did not focus on male interventions and involvement but was focused at reducing population growth for economic development (MOH, 2011). In May 1989, this policy was developed and adopted, which was later revised in 1996 and 2007 respectively. However, after two decades of implementing these interventions of scaling up family planning, reduce fertility rates and strengthening policies, findings show that the country did not achieve the 2015 goals.

National Reproductive Policy

Adolescent and young people's sexuality is becoming a concern in Zambia resulting in unintended pregnancies, unsafe abortions leading to MMR. Family planning is one of the priority in the reproductive health programs which has focused on improving maternal and child health (MOH, 2011). In response to expanding the burden of reproductive ill health, reproductive needs, maternal mortality and an increase of family planning demand, a Reproductive Policy was adopted in 2008. The focus of this policy was to address safe motherhood conditions in an effort to attain sustainable human development. In order to achieve this, the policy was revised in 2011, which aimed at providing of guidelines involved in the implementation of reproductive health programs.

Following this, activities and programs have been implemented across the country by government and NGOs to address sexual reproductive issues of young people specifically girls, without significant improvement/impact especially in reduction of unintended pregnancies, unsafe abortions and HIV/STIs. The International Conference on Population and Development of 1994, called for gender equality and strategies that support men to take responsibility of their sexual reproductive health. Since, the declaration, there has been an improvement and increase in awareness of their role in FP and improved support for their partners. (United Nations, 1994).

In response to young men's reproductive needs, the policy also focused on increasing accessible, available and affordable youth friendly health services to young men through male youth friendly corners. In addition, in the FP2020 scale up plan, one of the objectives includes; Adolescents and Youth "To more effectively target and serve adolescents and youth with quality accessible SRH information and services in and out of school (MOH, 2013). Findings reveal that despite these interventions, gaps in logistics management and funding still exist. Inadequate provision of SRH and contraceptives through the youth corners is still on a small scale as there is no clear guideline and political will on how to involve the young men and effectively address contraceptive use.

National Strategic Plan

In 2011, National Health Strategic Plan (NHSP) was revised and the new policy document 2017-2021 was developed. Provision of family planning has been a primary healthcare focus as outlined in the National health policy which aims, to ensure that quality services are cost effective, accessible and close to the family as possible(MOH,2017). Provision and coverage of family planning services has been implemented through activities such as, policy revision, community based distribution of contraceptives and adolescent youth friendly services (AYFS). AYFS however, are currently not being implemented in all health facilities across the country (MOH, 2017). This is due to inadequate space, unclear policies to the health providers on how to provide SRH especially contraceptives to young men and their partners. Our findings show that the plan has focused on reducing teenage and unintended pregnancies by increasing the CPR through adolescent youth friendly services which are not fully being implemented across the county. This reveals that there is a gap in responding to access, inequalities and the plan has made no specific reference to reproductive health of young men.

Adolescent and Youth Policy

The National Youth Policy of 2006 was revised in 2015(MoYS, 2015) with a focus on addressing the social determinants of health which affect youth health. Other concerns for revision was to have a policy which was more responsive to the needs of youth. While the adolescent strategic plan was also developed in 2011 to address health problems of this group. The adolescent and youth strategic documents were developed in an effort to deliver appropriate, comprehensive and accessible Adolescent Youth Friendly Services (MOH, 2011). In line with the overall objectives, the two policies have responded to calls of strengthening and supporting SRHR including promotion of comprehensive sexuality education. However, in school and out of school contraceptive use and pregnancy prevention is not emphasized in the Comprehensive Sexuality Education (CSE) framework. In addition, the National Youth Policy (2015) and the 7NDP (MNDP, 2017) aims to promote human development through life skills, improving knowledge, skills and developing a positive attitude. Following these initiatives the policy has not target young men specifically and there is lack of political commitment in provision of funding and human resources to effectively respond to young men's reproductive health.

3.1.2 Health Service Related Factors

Sources of Contraception

Family planning services in Zambia are free in public institutions (health posts, clinics and hospitals). Currently 82% of women and men are using these facilities (ZDHS, 2014), of which 69% access the service from government clinics, 9% from hospitals while the remaining are

accessed through outreach programs (CBD, mobile services). In a study by Masiye et al (2010), the authors point out that the Private sector (pharmacies, clinics, hospitals, traditionalists) are playing their role by partnering with MOH and contribute positively in service provision accounting for 9% users, which come with cost barriers especially for those without an income. Cases of female sterilization and vasectomy are under-utilised as they are seen to be a method which is irreversible especially if a user is not yet a satisfied party. Among young men condoms are the mostly known and preferred method of use as it is readily available. Findings reveal that young men access their condoms, from traditional outlets as pharmacies, drug stores, private and public clinics, while non-traditional are groceries, kiosks and bars but due to the challenges in accessing contraceptives, they opt to seek services from friends and other social networks (ZDHS, 2014). Furthermore, in public clinics condoms are accessed from HIV/AIDS/STI counselling rooms or sometimes placed at the gate (in security guards office) (authors observation) as a way of promoting access and reduced waiting time. Although some methods are easily accessible over the counter they may have affordability issues. Ineffectiveness and discontinuation rates of contraceptives have been reported due to health concerns, misconceptions, side effects and lack of adequate information and knowledge of how to use (especially condoms), and benefits of use..

Acceptability

Methods to be used should be acceptable by individuals and partners as this may encourage support and reduce the number of discontinuation and dropout rates, therefore, quality service should be provided. Studies reveal that services must be accepted in the society both by the providers and users (Levesque 2013). It is important to consider a gender sensitive approach as it can increase uptake. Non male friendly services, incompetence and attitude are among the factors which can influence the use by young men. Beliefs and cultural practices have to be considered when introducing or implementing health programs (contraception) in various communities. This is because some services may not be acceptable in some cultures and therefore, be rejected. In addition, adequate information should be provided to avoid misconceptions.

Condom use by young men is acceptable and they are responsible for ensuring that they carry and use the condom, while a girl or woman who buys or request for condom is seen to be unfaithful or promiscuous. A study in Malawi reveal that young men sometimes may not use a condom for fear of seen to be weak or when a girl appears appealing to them (Dral, 2018). Contraception for adolescents and young unmarried youths has not been welcomed in most societies. For example, in Muslim dominated regions, this service has not been accepted due to religious beliefs (Buto, 2015), while in other societies contraception has been socially accepted as a good practice.

Accessibility

The introduction of community based distributors (CBDs) is a good initiative, CBDs work in the communities. Community based distributors work within the communities and provide information on contraceptives, make referrals from community to facilities, distribute oral contraceptives and condoms (MOH, 2017). This is a way of reducing the gap of missed opportunities despite only being restricted to oral contraceptives and condoms which comes with challenges of stock outs. In addition, due to stock outs (unavailability) of commodities young men may not be willing to access services because they already perceive that the service is of poor quality with limited methods.

More distributors should be engaged and be provided with bicycles or motorbikes so that they are able to reach the unreachable areas. Distance to the point of service is among the challenges young men face in rural areas. Contraceptives are easily accessible within in urban areas compared to rural areas. However, young people especially adolescents' still face challenges of access despite being free and readily available. (Chandra-Mouli, 2014; Kabagenyi, 2014).

Consistent with most studies Benofu (2010) concludes that long distance has an indirect or direct cost in accessing contraceptives which decreases the use and the community does not accept that young people can access contraceptives. Young men who had access challenges did not support their partners to cover transport costs to access contraceptives as it was an economic cost on their part, so they engage in unprotected sex. Consistent with other findings, Buto (2015) and Chandra-Mouli (2014) agree that young men both in rural and urban areas encounter access barriers due to the fact that family planning has been integrated in the maternal health department and this makes it difficult for them to access contraceptives services due to stigma, judgmental attitudes by providers and community.

Availability

Young men have perceived non availability, non-variety of male methods and stock outs as an influence on contraceptive use. Studies by Buto, (2015) and Silumbwe, (2018) conducted in Zambia have found similar factors which include limited method mix which does not meet their needs.

Further, non-availability of skilled staff to provide long acting methods for their partners reduce service utilisation. Ministry of health has also recognized the challenge of inadequate skills mix and uneven distribution of staff. This poses a challenge to effective utilisation of healthcare, family planning inclusive (MOH, 2017). Young men should be able to have the ability to reach a FP service when they have information on operating hours and physical access like transport. Findings by Schriver et al (2014), reveal that waiting time, operating hours, language and availability of equipment for long-acting reversible contraception (LARC) to provide service discourages young men to use family planning and may discourage their partners. Services can be available, however, young men and their partners should be able to easily access and engage in decision making of their health choices.

Affordability

Affordability implies that contraceptives should be affordable, but they have a direct (service fees) or indirect cost (transport, waiting time) on the user (Do and Kumrimoto, 2012). Contraceptives donated and purchased by MOH and partners, are subsidised as they have cost barriers on the end user. These costs can cause delay to start contraceptive use which affects utilisation levels. Contraceptives for the young men and their partners are free and readily available in public clinics. However, due to unavailability in some instances they may have to pay for them. From a personal observation, when contraceptives are out of stock, young men access contraceptives among their peers, since they may not afford to buy, especially among the unemployed(authors observation).

Studies show that in sub-Saharan Africa, most health facilities condoms are free and readily available because they are within the reach of the community but utilisation levels are low because the services are not affordable in terms of direct and indirect costs (Williamson et al, 2009). Consistent with these findings, Vouking (2014) and ZDHS (2014) found that there is

increased contraceptive use in a household with high income. This suggest that generally women and men who have a source of income are more likely to use contraceptives than the unemployed.

3.1.3 Provider Factors

Attitudes, Knowledge and Competence

Health seeking behaviour and response depends on the quality of service provided to the users. Quality of care depends on the clients' perspective which could be waiting time, available methods (Anderson, 2015) competence of providers and client centred approach. Low contraceptive use in different studies has been linked to poor service provision by unskilled staff (Dehlendorf et al, 2018) who do not provide full information on most of the contraceptives, and often health providers have poor attitudes especially among unmarried young men. However, in Zambia health providers have been trained on contraceptives and sexuality for adolescents and young people, but young people have limited access to care (Mmari, 2003). Young unmarried men are stigmatised as contraceptives is considered to be for married adults. (Simataa, 2017 and Babirye, 2018)

In Kenya, health providers had challenges providing contraceptives to adolescents (Warenuis, 2006). Similarly in the same study conducted in Zambia, the findings were consistent and it further revealed that providers had challenges giving contraceptives as norms and values of society does not allow sex or use before marriage. Furthermore, nurses and midwives were not accommodating and welcoming, instead they play a parental role in service delivery and evaluated young men's needs without engaging young men (Warenuis, 2006). He further adds that midwives had more information than nurses and were likely to provide contraceptives. A study conducted in Malawi (Michaels-Igbokwe et al, 2011) reported that young men were two times more likely to choose a clinic with a male friendly provider. Female midwives and nurses are readily available than male nurses, making it difficult to specifically allocate a male provider to male friendly corners throughout a work session. Kabagenyi (2014) also states that in Uganda, findings are similar in that, most programs were women oriented and the settings were for women and children. Providers' perspective was non provision of contraceptives to young unmarried men, it was morally unacceptable to provide contraceptives to young men (Warenuis, 2006; Nalwadda, 2011) this discouraged men to use the services. Findings show that young people are willing to use contraceptives and prevent pregnancies but they are not ready to seek services from providers who play a parental role and fear their judgmental attitude towards use, despite their status and age.

3.2 Individual Factors

Age

A survey in Zambia ZDHS (2014) revealed that contraception use is varied by age, and condom use is the lowest at 4%, pills 12% with injectables at 19% respectively. Nyarko (2015) and Simataa, (2017) have cited age to be one of the factors influencing contraceptive use and results show that older people aged 20-24 years are more likely to use contraception than younger people (15-19). Those in the age below 19 are less likely to use contraceptives especially condoms due to infrequent sex, lack of partner support among other factors. However, Nyarko (2015) argues that younger men had more knowledge and were more likely to use contraceptives due to more exposure to social media like Facebook than older men. In the same study a comparison between women and men show that young women had more

knowledge of contraceptives than the young men. However, a survey conducted by Blanc (2009) in 40 developing countries, argues that overall use of contraceptives was higher among unmarried adolescents than among the older youths. Due to physiological, emotional and mental changes young men and women would like to explore their bodies and sexuality, but due to challenges of access as a result of age compels them to engage in sexual activity without contraceptives. This was followed by high discontinuation use by adolescents due to *ineffective use and other reasons*.

Marital Status

Marital status can determine whether a man or woman can or cannot use any family planning method. Due to the patriarchy system in many societies, men often have the gender power to make decisions when their partner can or cannot use contraceptives. This makes it more difficult for women to also negotiate condom use. Therefore, unmarried women and men are more likely to use condoms than married counterparts, who prefer other methods. Young unmarried men can have sex before marriage, while girls cannot as it is associated with promiscuity (Pinchoff, 2017). However, findings from the Zambia Sexual Behaviour Survey (2010), found that adolescents and unmarried young adults were less likely to use contraceptives, particularly condoms because it was associated with promiscuity. In support of this, Benefo (2010) further reports that condom use is common among married partners or in relationships which later decrease with time. However, Chandra-Mouli et al (2014), in his studies carried out in seven countries in SSA, reports that there is higher demand for contraception among unmarried than among the married adolescents. Two other studies (Vouking, 2014; Apanga, 2015; Pinchoff, 2017) show that age and marital status influence each other and there is an association between the demographics and use or non-use. From our findings, marital status, gender relations has an influence on contraceptive use. This also confirms that socially constructed gender norms and power relations have an influence on decisions men make for contraceptive use for themselves and their partners.

Education

Review of the Comprehensive Sexuality Education (CSE) framework shows that the framework has no in-depth content on contraceptive use, SRH and gender (MOE, 2016). Provision of contraceptives is not allowed in school premises. According to UNESCO (2016) it is reported that CSE activities which focus on gender and equality can result in reduced STIs and a reduction in unintended pregnancies. Despite sexuality education being a controversial issue, evidence proves that good quality CSE has positive effects on sexual knowledge, attitudes and communication (Kirby, 2011; UNESCO, 2009). However, a study in Uganda, reveals that teachers have a challenge in delivering CSE messages due to cultural and religious norms (Vanwesenbeek et al.2015). Regarding education and contraceptive use findings from Okechi (2011), Nyarko (2015) and Irja (2007) found that those with a higher level of education were likely to use contraceptives than those with no education. Other studies find consistencies of contraceptive use similar to those of young men (Vouking, 2014, Ijadumola, 2010). Research shows that there is a high level of knowledge on contraceptives among men 15-24 years in Zambia and across the sub-Saharan Africa. However, this may not translate into increased contraception use. Consistent with these findings, in Kenya it was reported that men with higher education level had increased odds (OR=2.13) of contraceptive use compared with those with no education especially those living in rural areas (Kabagenyi et al., 2014 as cited by Simataa 2017). Another study conducted by Okechi (2011) in Kenya, reveals that men who are educated have the potential to influence and support their partners

to use contraceptives and similarly their sexual partners can negotiate safer sex. Our findings show that young men have inadequate knowledge to make decisions on sexuality and are not adequately equipped. Therefore, there is need to equip young men with life skills and attitudes through CSE and provide safe spaces, in order to prevent sexual violence which may lead to unintended pregnancies; coordinate with facilities to address access and SRH issues. Overall the level of education has an influence on contraception use.

Knowledge on Contraceptives

Knowledge as suggested by various studies has positively been associated to contraception use, but does not always translate into use. Theory of reasoned action assumes that humans make use of the information available to them to take action and rational decisions are made based on the knowledge they have (Albarracin et al. 2001). Evidence suggests that knowledge on contraceptives is universal between men (99%) and women (97%) (ZDHS, 2014) younger men have knowledge on at least one contraceptive method. While younger men had more knowledge about condoms and were more likely to use them as compared to women, as this was one of the two methods available to them. From other countries studies are consistent with the findings (Ijadunola et al, 2010; Cleland, 2011) which reveal that young men were aware of contraceptives with condoms being highest.

Despite having increased knowledge on methods of contraception through exposure to informal learning, media and other information sources, condom use among young men 15-24 years is low (45%). Many factors have been found to hinder men from utilising family planning services in SSA; social cultural, lack of knowledge on variety of methods, side effects and benefits of contraceptive use made young them disapprove the use by their partners (Kabagenyi, 2014. Kaida, 2005). On a positive note in the same study men were willing to acquire knowledge and learn about contraceptives especially if information came from the provider. In a qualitative study by Kabagenyi (2014) in Uganda, a key informant echoed this view on lack of knowledge;

“Men are not involved in family planning and promotion of contraceptive use because they do not know. It is common for women to be sensitized because they go for antenatal care, but the men do not go for antenatal care. There are only few who go there. At our village, there are no sensitisations targeting men. It is only a few women who educate their men, and they can’t explain to them very well”. Male FGD Participant, Mpigi

High knowledge levels shows that messages and information on contraceptives have been accepted and young men and women could decide a choice which suits them based on the acquired knowledge. It is also possible to assume that the disparity between high knowledge and use is as a result of ineffective use of method (Boussen, 2012) or had inadequate information about the method which resulted in non-use. Overall, this study finds that young men and women have limited comprehensive knowledge on contraceptives and does not translate into safer practices or use,

Religion

Religion is a significant part of the cultural system which has a major influence on contraceptive use in the communities especially among the unmarried. However, religions and practices of family planning and contraception are varied. Some have welcomed the programs while others have not accepted the policies which are available. In the recent past

girls have dropped out of school due to teenage and unintended pregnancies. The Churches Association of Zambia (CHAZ) engaged religious leaders in an effort to scale up family planning and disseminate information in the communities. Religious beliefs and teachings are believed to have an influence on family planning decisions, as the church is known to have a following of communities (Achana et al 2015). In Zambia, there is a proportion of the Apostolic sect (Religious group from Zimbabwe) commonly known as 'Mama Zezulu' who do not encourage family planning for women, often women secretly seek care when required.(Authors observation)

However, in regions where the majority are of the Christian protestant religion, contraceptive use is supported. However, in other studies conducted in Kenya and Zambia, Christian (protestants) are seen to be high users of contraceptives, while in other religions is considered a barrier to contraceptive use (Okech, 2011 and Mutombo, 2014). From our findings, religion has both a positive and negative influence on contraception use depending on the dominance of its religious beliefs and customs. It is also important to note that in Zambia, the majority of the population is Christian and contraception is morally accepted for the married while the unmarried and adolescents are encouraged to practice abstinence.

3.3 Socio - Economic Factors

Income/Employment

Currently, unemployment levels in Zambia are high especially among the young people and majority are living below the poverty line. It is important that the population is engaged in economic activities (LCMS, 2015) because this has a direct influence on health seeking behaviours and well-being. Secondary data from Zambia indicates that having a higher income had a positive association on contraceptive use for women(62%) as compared to those with no income (39%)(ZDHS,2014) Frequency of use increased as wealth increased or reduced with low wealth. Women who earned an own income have the ability to make decisions for their own health without waiting for approval from their partner (Do & Kurimoto, 2012). Presenting findings from a qualitative study in Kenya Butto (2015) reveals that men in the lower quintile who had a source of income through business or farming did not use contraceptives despite them being readily available. Income did not have any influence on their use maybe because they did not have any level of education and information on contraceptives. While those who had a formal job were highly involved in family planning. Consistent with these findings in Zambia, Pinchoff (2017), in his study found that those who did not use a male condom were the poor (54% in highest poverty wards; $p < 0.001$). This revealed that if income was lacking at household level, family planning declined and vice versa, Unemployment levels for young men is high this will translate in non-use of contraceptives, my study concludes, that economic status has an influence on contraceptive use. The 7NDP (2017-2021) addresses issues of human development and their ability to be educated, be healthy so that the population can contribute to sustainable economic growth and reduce poverty in an effort to have a reasonable standard of living.

3.4 Socio-Cultural Factors

Gender and Cultural Norms

Gender and cultural norms consider contraception use and sexuality for unmarried young men and their sexual partners as an immoral act, as F P and contraception is accepted only among the married. Findings reveal that young men have a positive attitude towards contraceptive

use and are willing to support their partners with available information (Pinchoff, 2017). Zambia is a patriarchal society and practicing a patrilineal system in which men are the decision makers. They control decisions of their partner's reproductive health and women can only use contraceptives after approval from them Okechi (2011). These gender norms and societal values have contributed to intimate partner violence, therefore to avoid conflict many women seek contraceptives secretly. Most cases, women have no right to discuss sexual matters or deny their partners sex with a condom, especially when they suspect an infection or infidelity. These unequal gender norms are persistent in Zambia and SSA, it is important to re-examine these power relations. Findings show that masculinity is a social construct (Okechi, 2011) and males are brought up to think that contraceptive use is a woman's business and may not use. Men use their masculinity and stereotypes to undermine women's ability to make informed decisions about contraception (UNFPA, 2014; Sonke, 2014; Starrs, 2018). In relation to gender and education, these two factors influence contraception use and it is important to note that as women's education increase, they are less likely to make their own decisions without consent from husband (ZDHS, 2014). In Kenya, 56% of women sought approval from their partner/Husband before using contraceptives, while 23% did not. This reveals that even when FP is seen as a woman's business, Gender and power relations has a great influence on contraceptive use and it is critical to consider gender sensitive approaches in programs an important aspect of male involvement.

Culturally, women are expected to be submissive and young men's sexual or desires are considered first before a woman's desire. They perceive that contraception use reduces sexual pleasure and may not use contraceptives (Withers, 2015). Young men have conformed to what societal norms expects of them, to be manly, strong and not weak. These roles determine if, how and to what extent they are will to use contraceptives and support their partners. Evidence reveal that FP interventions that have been targeted towards men have proved to work and increase use (Kim and Kols, 2001). Social cultural expectations is a barrier has a negative influence on young men's contraceptive use. To address this, community leaders should be involved in policy and programs design while using gender mainstreaming approaches.

Young Men's Health Beliefs/Perceptions and Attitudes

Due to Health Beliefs, Perceptions and Attitudes, women who have asked their sexual partners to use condoms have been regarded as promiscuous and have been at risk of gender based violence or intimate partner violence(GBV/IPV). Women and men across the region have varied beliefs, perceptions and attitudes towards contraceptives. For a long time now FP has been seen as a women's issue and men's role is to make decisions and provide money in the home. These masculinity norms negatively influence contraceptive use by men and have left the burden of using contraceptives to women. Misconceptions on side effects of contraceptive use is that they make you infertile and may develop health conditions like cancer, young men and their partners preferred using contraceptives after they had reproduced (Withers, 2015). It is interesting to note that young mens partners sometimes refuse using contraceptives even when they wanted to support them.

Studies in sub-Saharan Africa suggest that traditional beliefs and norms on contraceptive use was seen as a barrier in seeking contraceptives (Vouking, 2014 & Blanc, 2009). Furthermore, they add that some negative perceptions by men is that contraceptive use promoted promiscuity among women who used. In addition, men did not want to feel less manly or less powerful, they reveal that using condoms reduced sexual pleasure especially with a stable

partner, with time and building trust so they stop using condoms. Vasectomy was not accepted by men because it is a permanent method which made them infertile for the rest of their lives (Withers, 2015). On a positive note and from our findings from Nigeria suggest that, men were ready to take future contraceptive pills if available and support their partners if they had more information on contraceptives. (Ujuju et al, 2011). These results reveal that young men have general knowledge on contraceptives, however, beliefs, perceptions and masculinity had an effect on attitude towards FP which determined the utilization.

3.5 Need Factors

Perceived Benefits

Young men and their partners often feel the need to use contraceptives when they have been exposed to information on benefits of avoiding HIV/AIDS and unintended pregnancies (Buto, 2015; Onyango, 2010). This improves health seeking behaviour and may lead to positive attitudes towards contraceptive use. Responding to a health need, or ability to seek and engage in care depends on personal and social values which lead to positive or negative changes in attitude towards family planning. Anderson (1995) adds that benefits on fertility and limiting family size are likely to change men's attitudes towards contraception use when perceived benefits outweigh perceived disadvantages. These changes are likely to influence the use by themselves and support for their partners.

Perceived Barriers

Young men perceive many barriers which restrict them from seeking healthcare. According to the findings, perceived or actual barriers like cost, distance, poor attitude by staff, unavailability and limited methods have resulted in non-use (Silunbwe 2018; Onyango, 2010). Studies done by Shattuck (2011) and Dral (2018) emphasize the need to avail information on the benefits, side effects and solutions in order to make better choices and increase uptake of contraceptives among men. Evaluated need by the providers can lead to reduced contraception use as the decision to use contraceptive services is based on the provider's perceptions of their clients' characteristics and need.

On the other hand, contraceptive use is low due to the inadequate information that young men get from family, friends and their social connections which is most likely based on negative misconceptions and myths surrounding family planning (Butto, 2015) also perceptions of side effects, masculinity and gender relations.

CHAPTER FOUR: PROVEN STRATEGIES

Following interventions selected that have worked in other settings, some interventions were identified and could be applied to similar settings in LMIC. This section will discuss identified interventions and best practices from LMIC that had a common objective such as promoting contraception use, understanding gender norms and equality also encouraged partner support. While searching, literature interventions that were specific to young men were not found. To adopt and implement these best practices it will require a committed effort from government to increase funding and other resources if these interventions are to achieve similar results.

Case Study: Engaging Men in Pakistan: The FALAH Strategy

The project was implemented between 2008 and 2012 shows evidence that men can be included in FP using feasible and effective strategies to improve FP attitudes and behaviours in Pakistan and other countries (FALAH, 2012). FALAH, recorded a decrease in fertility (0.5children) and improvements in FP behaviour. The project reached more than 9 million married men and women in 20 districts with birth spacing messages. To achieve this the project designed a communication, advocacy and mobilisation strategy with messages on birth spacing, with five communication interventions with specific messages that addressed contraceptive choices, where to find services, side effects and impact of birth spacing. According to an evaluation the project created demand by increasing access in both public and private institutions through community mobilization, capacity building (skills development) improving supply chain and increasing social marketing activities(Sather,2015).

Results reveal that the project reached over nine (9) million married men and women with family planning messages. CPR increased by 8% from 29.6%(baseline) - 37.9%(endline) from 2008 - 2012.While, unmet need dropped from 14.25 to 10.8% with a total demand for FP increasing from 64% to 71%(FALAH,2012;Sather,2015).

Despite Pakistan practicing patriarchy system; men as decision makers, results from the intervention reveal that men are ready to change attitudes and participate in contraceptive use and support their wives if they are supported, empowered with skills and give them information required.

Project on Male Motivators in Malawi.

Male motivator were selected based on not having ever used contraceptives or their partner, findings from this intervention reveal male involvement and increased contraceptive uptake in Malawi (Hardee, 2017). The male motivators or peer educators were provided with information on family planning, where to find services and condom use. With these skills they shared the information with other men, promoted condom use and encouraged communication among partners. They were also motivators for women, provided contraceptives and made referrals for men in some cases. The intervention was not only focused on increasing contraceptive use but they also addressed use of male methods and promoted gender equality in contraceptive decision making. The male motivator project showed an increase in contraceptive use with 78% in the intervention group and 59% in the control group. Out of the men in the intervention group who reported FP uptake 56% reported using condoms, while in the control 63% (Hartmann et al. 2012; Shattuck, 2011). The impact of the project increased use among men and participation in family planning and increased partner support.

In summary, the project engaged married men to address gender norms, encouraged partner support and promote contraceptive use which resulted in increased use. In the male motivator project there was over a 50% rise in men reporting use. Similarly, interventions that are feasible and appropriate for young men could be applied.

Male Motivational Campaign in Guinea

A male motivational campaign which was aimed at changing attitudes and perceptions on gender, masculinity and FP was conducted in Guinea. It also aimed to increase contraceptive

prevalence through behavior change communication. Religious leaders (98) and (1045) men and women in reproductive age were selected in the intervention. The religious leaders and the men were targeted as they had a negative influence on contraception based on their religious beliefs. Communication strategies and trainings were conducted where leaders and other men shared information on FP. An influential gate keeper was also engaged to promote the campaign using different media such as posters, television and radio programs to promote FP and communication.

Findings reveal that there was increase knowledge on FP methods, which reduced perceptions of side effects, FP among the religious leaders themselves from 77% - 99%(Blake & Babalola,2002). The leaders also supported FP, communication between partners increased as well as attitude change toward family size. However, misconception on vasectomy was low as it was against their religion. While FP use increased slightly from 95 - 11 %(Blake & Babalola, 2002). Overall, the campaign recorded positive attitudes towards contraception and dispel gender myths, while communication messages should continue to address negative attitudes.

CHAPTER FIVE: DISCUSSION

This chapter will discuss the findings that have been drawn and established from other studies in Zambia and across the region on the factors that influence contraceptive use among young men and their sexual partners. This is based on our conceptual framework (FIG.2), the findings highlight health systems which include structural, service related and provider factors were found to affect contraception use.

Young men's Perspectives on Contraceptive use

Young men(adolescents) aged 15-19 years were less likely to use contraceptives than those aged 20-24 years this is because those aged between 15-19years had challenges of access, poor attitudes from providers and society. This can also be attributed to the fact that those below age 19years are most likely in the school going age and unlikely to be married. Even though the mean age for having sexual intercourse is 18 years, those using contraceptives are likely to be exposed to more information on sexuality and contraception in their social networks. Which means their demographic characteristics has a negative influence on accessing and using contraceptive. This is influenced by the beliefs and religious customs that sexuality and contraceptive use is for married people. However, findings from other studies conducted in sub-Sahara Africa reveal that younger men (15-19) years were higher users of contraceptives than those aged 20-14years. This could be that they are exposed to information and have access to services. The desire to experiment what they have learnt in school, due to peer pressure and physiological and mental changes taking place in their bodies influence contraceptive use. To address this it requires a multi sectoral approach from MOH, MOE, parents and civic leaders to play roles of gate keepers and discuss sexuality with the young men without fear; empowering them with knowledge targeting issues of physiological and mental changes and consequences (HIV/AIDS, unintended pregnancies and unsafe abortions) which comes with these changes if not managed or controlled. Health providers to have more information on guidelines addressing eligibility of contraceptive use.

Married and unmarried sexually active men were more likely to use contraceptives than married women because they (men) know the consequences of impregnating someone outside marriage, which comes with stigma and condemnation from society. While the

unmarried were likely not ready for marriage and child maintenance responsibilities. This shows that age, marital status and parity influences are used in both groups.

Evidence suggests that young men are aware of contraceptive methods, but have limited comprehensive knowledge and inadequate skills to make important decisions concerning their reproductive health. Despite, high knowledge levels discontinuations have been found to be due to inadequate information on how to correctly use the contraceptives. This can be seen from a high number of unintended pregnancies and unsafe abortions recorded. Despite the level of knowledge young men's perception on contraceptive use has been influenced by gender and cultural norms. Young men have been influenced to be the decision makers and may have sex with many women and is regarded as normal as they are exploring their manhood. While for a girl having with many men is not accepted and may be associated with being a prostitute. This illustration reveals that information on gender equality and masculinity is lacking as this may result in GBV/IPV. It is important that young men, their partners and civic leaders can be brought together and share information on gender and cultural issues, these information sharing sessions could also address issues of myths and misconceptions.

Further, it reveals that young men who had some formal education were more likely to use contraceptives than the uneducated men. Despite, having a CSE framework in schools, it is not comprehensive as it does not address issues of sexuality and contraceptives in depth for better decision making. Knowledge on contraceptive is found to be higher in men, this is because condoms is the common method used among men. They also understand the benefits that are associated with contraceptive use. The disparity between high knowledge and low utilisation could be related to inadequate CSE, which could be as a result of influence from misconception, misinformation and cultural beliefs on which further affects their ability to make decisions that safe guard their reproductive health. Teachers have a positive impact on the information that they pass on to their pupils or students it is perceived to be gospel truth. For example, pupils may dispute or argue with something you point out to them by emphasising that "teacher said". Interventions to address these is enhancing CSE framework by adding relevant content and empower teachers with skills that can improve young men's attitudes towards sexuality and gender equality. Furthermore, reduce school based home and facility barriers (different messages on contraceptives) but rather promote a linkage between these sectors that promote information sharing and increased awareness

Socio-Economic/Cultural Factors

Young men with a low economic status want to use contraceptives with adequate information and with no financial barriers. Findings show that young men with financial access had the ability to seek care despite the distance compared to those with less financial resources (e.g transport cost). This implies that those with an income could have some level of education as there is a linkage between education and income. Despite unemployment rates being high, young men who work or have some source of income are likely to use contraceptives than those not working and with no income. Residence, was not identified as a variable in this study. However, findings show that contraceptive use is higher among those in urban than rural areas as a result of distance, cost barriers to access contraceptives or unavailable stocks predisposing them to unintended pregnancies and unsafe abortions. The analysis is that if inequalities in service provision are not reduced between rural and urban or poor and rich CPR levels will continue to be low. In addition, poverty is associated with a non-health seeking behaviour. It is important that young men's social economic status is improved by

empowering them with life skills for example, bricklaying or carpentry that can earn them a living and be able to support their partners to access and information on contraceptives thus improving CPR and a reduction in pregnancies and unsafe abortions.

Young men's Gender Perspective

Partner decisions, gender and societal norms have been found to contribute to the use and non-use of contraceptive, as men have a masculinity influence over women. Masculinity influences young men to have a negative attitude and poor health seeking behaviour towards contraceptive use. This is because, they perceive it to be a woman's responsibility rather than a shared responsibility. In proving their masculinity, young men disapprove contraceptive use to satisfy their own sexual desires. Therefore, women perceive this as barriers to contraceptive use. Contraceptive negotiation was seen to be influenced by gender roles and marital status thereby putting women at risk of intimate partner violence and gender based violence.

Power relations influence decision making concerning the use of contraceptives. As such, men often feel they are the decision makers, this social construct is a barrier to women's access and use. Therefore, may undermine her ability to negotiate contraceptive use. Young men and women who have some level of knowledge can positively influence each other's decision to utilisation as they may be aware of benefits, side effects and alternate methods to use. Similarly, other studies suggest that not only men's disapproval influence use, but their partners' disapproval can lead to non-use. There is need to address these gender norms as the power relations can be attributed to why FP programs have not achieved their goals. More information sharing on the side effects, benefits of contraceptives and gender equality messages to be emphasized. Communication between partners can increase usage and couples are able to support each other and opt out for other methods when they experience side effects or health concerns.

Young men reported that cultural and religious beliefs has a negative influence on their utilisation. Long term methods like vasectomy have not been accepted by men and in most societies and women do not support it. Men perceive vasectomy to reduce their masculinity as it makes them infertile. This is due to fear of potency effects, reduced sex drive, inadequate information on benefits regarding vasectomy. Findings suggests mixed messages from providers, traditions and experiences of young men leads to misinformation on benefits and method choices which affects utilisation. This may require consolidation of these teachings in different languages and increase awareness through IEC materials in order to dispel myths, misconceptions on side effects and disseminate a common message. It is important to consider that some not all cultures and societal norms will accept contraceptive use by young men. Therefore, embracing these cultural norms and involving the community in decisions that affect young men can change their perspectives on contraception and support their sexual partners. Evidence has revealed and been argued that interventions and programs that have effectively reached men, have changed their attitudes towards use with an increase in contraceptive use observed.

Inter linkages across different factors were found in this study and how they influence each other, such as gender norms can be influenced by health beliefs and religious factors. Furthermore, age and marital status intersect and are further influenced by power relations (masculinity) of the young men. Health systems and cultural influence and contradict each other surrounding myths and misconceptions, side effects and benefits. These two factors

focus more on women as responsible for family planning, which discourages young men to use contraceptives.

Service Provision

Despite challenges of access to quality contraceptive services and acceptability, young men are eager to seek information and use contraceptives in environments that are friendly and non-judgemental. Unavailability of male providers may still be a challenge as there are more female nurses than males. As it may be a benefit to use male providers who are not readily available, what is needed is build capacity and a change of attitude by the providers towards contraception provision. Young men expressed a negative attitude from the providers, non-engagement attitude and inadequate information provided to them which could be as a result of non-comprehensive training on family planning. Regardless of the training health workers get in pre-service and in house trainings, cultural norms and personal values influence the way the service is provided. In a similar way empowering providers with knowledge and skills by engaging professional bodies so that they uphold professional vales before self-values as they provide services. Midwives are more equipped with issues of contraceptives and young men as they are taught in pre-service, while nurses learn on the job; there is need to enhance continuous professional development therefore, bridging the knowledge gap of between the cadres as this could compromise quality and dissemination of different messages which could impact utilization.

The national policy in Zambia, is to provide all sexually active men and women with contraceptives (WHO, 1995) in reality adolescents and young men have limited access to contraceptives (Mmari, 2003). However, policies and guidelines are not clear which makes it difficult for providers to effectively provide contraceptives to young men. Improving service delivery will need to review and amend policies that focus on young men and address issues of financing, supply management and human resources, as this can reduce barriers and scale up access. Guidelines to be clear for providers to effectively use so that they offer the services with confidence and without fear of providing service. Furthermore, strengthen linkages between community and health system. For example, referrals from community to clinics. From a policy and health provider perspective, there is a slow and health systems failure to respond to the needs of the young men and their sexual partners.

Family planning is integrated in the maternal and child health units which makes it difficult for young men to access contraceptives. Accessibility does not mean affordability or acceptability. These factors are difference and can influence each other and use or non-use of contraceptives

It is important to engage leadership which supports and recognise the need for equity of service and reduce inequality gaps in service provision. It is important to start strengthening and refocusing male oriented reproductive issues and how to feasibly integrate them into health polices and other sectors like education. This will give clear guidelines of operation and partner with other institutions with a similar objective. This will enhance Private Public Partnerships and coordination and increase contraceptive use.

Proven Interventions

Evidence from these approaches revealed that the projects had a positive impact on both men and women and overall contraceptive uptake increased for women whose partners participated in any intervention. Gender norms, masculinity and equality can be addressed

using these strategies and adopt activities which are feasible and sustainable. It is evident that men can change attitudes when interventions are targeted at them thus supporting their partners; to improve male uptake and participation there is need to increase financing, engage the young men as they have a key role to play in reproductive health and gender equality. Despite positive results achieved, it is difficult to determine if young men will practice what has been learnt as some changes may not be acceptable. Therefore, continuing promoting key FP messages and using gender transformative approaches that promote equality between partners and support communication thus rolling them out to other settings in order to increase coverage. In spite of interventions focusing on married men, these interventions can also be applied to young men.

Strengths and Weaknesses of Study

In this study articles and reports various data sources were used. However, I would like to acknowledge that there was a limited number of data specific to study area as most data on contraceptive use has been focused on women and leaving out special reference to young men, making it very challenging to find rich data. As described in limitations of method, primary data collection was not done to get real diverse experiences and perspectives to understand factors affecting use. In spite of limited data on young men contraception, this thesis can be applied to similar settings.

The Andersons behavioral model has been used in this study and was useful in analyzing factors that influence use, and the variables are comparable to other settings. Need factors may require more research to understand the impact of perceived and evaluated needs on contraceptive use.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The findings of the study as policies, accessibility, availability and provider attitudes affects contraception use for young men. Health systems face challenges of inequalities in service delivery, inadequate resources and non-implementation of gender sensitive approaches due to unclear policies which have been seen as barriers to access and discourage young men to utilise FP services. Engaging men as partners, in the health system and increasing access and availability of mixed method will increase uptake. Improving contraception use among young men will require reducing health system barriers which will increase access especially in underserved areas.

Individual and sociocultural factors such as age, knowledge, low income and educational levels had an influence on use. Furthermore, cultural beliefs, gender (masculinity), myths and misconceptions also had an influence on young men's contraceptive use. Family planning programs have focused primarily on women as it is seen as a woman's business. There is need to increase focus on young men as they have a role to play as partners in FP. It is shown that knowledge on contraceptives, not been translated into use. More information and empowering young men with knowledge and skills to make decisions improves and restores their sexual and reproductive health and that of their partners.

Effective interventions on male involvement have shown to increase contraceptive use between men and women across the sub-Saharan region over the years. To achieve FP results

one or two feasible interventions could be adopted and understand lessons learnt. That is to involve men in FP as users and partners and understand their reproductive needs.

6.2 Recommendations

Policy Level

Ministry of Health should develop policies that are responsive and inclusive of young men's contraception needs, to scale up male family planning services. This can be achieved by engaging civic leaders and representatives for young men in the consultative process to revise and strengthen SRH policies which address access and provision of SRH services and age of accessing contraceptives.

Ministry of health should develop capacity building and information communication and education (IEC) materials for health providers and engage young men and civic leaders, as gate keepers to disseminate and enhance messages on importance of male participation and shared responsibility through sensitisations, campaigns and media.

MOH and MOE to strengthen partnerships, train and build capacity in nurses and teachers on issues of reproductive health with a focus on young men. Engage professional regulatory bodies in the training so that professionalism and ethics can be addressed in an effort to create confidence and motivate nurse and teachers as they deliver these messages to the young men.

MOH to adopt best practices from Pakistan, Malawi and Senegal in young male focused sensitisation and awareness activities that can improve uptake by young men and their partners that are feasible to out settings

Strengthen partnership between MOH and MOE, revise the CSE framework to include comprehensive issues of sexuality and contraception. Design and develop a referral system between schools and health facilities which will improve access. Promote Public Private Partnerships (PPPs) and strengthen multi-sectoral coordination for effective response.

Social/community level

Civic leaders to play the role of male contraceptive ambassadors, so that they can address issues of misconceptions and improve communication strategies that promote the use of contraceptives.

Civic leaders to encourage young men to play key active roles in the promotion of contraception use, thus promoting ownerships of contraceptive programs and processes. Thus dispel myths and perceptions that FP is a woman's business by promoting social networks through information sharing. Promote gender equality and overcome socially constructed gender roles on family planning and contraception.

Civil Society

Civil society organisations to conduct sensitisations and work with traditional leaders, religious men and men as household heads and play key roles to address social norms and gender equality, should also focus on engaging young men as agents of change thus promoting a shared responsibility approach, communication and partner support, leading to access information and utilisation of SRH issues.

Civil society to engage with young men and women to create social networks and strengthen existing ones that will be used to promote information sharing, dispel myths and misconceptions about contraceptives; this platform can also be used to create awareness on dangers of GBV/IPV and promote safe sex practices between partners.

References

Albarracin, D, Johnson BT, Fishbern M & Muellerleile PA 2001, 'Theories of Reasoned Action and planned Behaviour as models of Condom use: A meta-analysis'. *Psychological Bulletin* Vol.127:1; 142-161

Andersen, RM 1995, 'Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?' *Journal of Health and Social Behavior*. 36:1-10.

Babirye, S, Akulume, M, Kisakye, AN & Kiwanuka SN 2018, 'Clients and Providers' Perceptions on the Quality and Provision of Contraceptive Services to Youths at Community Level in Rural Uganda: A Qualitative Study'. *International Journal of Reprod Fertil SEX Health*. Vol 5(2):118-125.

Bongaarts, J, Cleland, J, Townsend, JW, Bertrand, JT, Gupta, MD 2012, 'Family planning programs for the 21st century'. New York: Population Council.

Benefo, D, 2010, 'Determinants of condom use in Zambia: A multi-level analysis'. *Studies in Family Planning*. 4: 19-30.

Berendes, S, Heywood, P, Oliver, S & Garner P 2001, 'Quality of Private and Public Ambulatory Healthcare in Low and Middle Income Countries: Systematic Review of Comparative Studies' *PLoS Medicine*.

Bearak, J, Popinchalk, A, Alema, A & Sedgh, G, 2018, 'Global, regional and sub-regional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model'. *Lancet* 6:e380-89.

Blake, M & Babalola, S, 2002, 'Impact of a Male Motivational Campaign on Family Planning ideation and practice in Guinea'. Baltimore: Johns Hopkins University Bloomberg School of Public Health. Field Report No.13.

Blanc A, Tsui, A, Croft, T & Trevitt JZ, 2009, 'Patterns and Trends in adolescent's contraceptive use and discontinuation in developing countries and comparison with adult women'. *International Perspectives on Sexual and Reproductive Health*, 35(2):63-71

Buto, D, & Mburu, S 2015, 'Factors Associated with male involvement in family planning in West Pokot County, Kenya'. *Universal Journal of Public Health* 3(4):160-168
<http://www.hrpub.org>.

Cates, W 2010, 'Family planning: the essential link to achieving all eight millennium development goals'. *Contraception*.81 (6):460-1.

Central Statistical Office, (CSO) 2010, 'Census of Population and Housing'. Central Statistical Office, Lusaka, Zambia.

Central Statistical Office 2015, 'Living Conditions Monitoring Survey Report'. Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International 2014, 'Zambia Demographic and Health Survey 2013-14'. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF International

CSO, 2010, 'Zambia Sexual Behaviour Survey'. Central Statistical Office, Lusaka, Zambia.

Chandra-Mouli, V, McCarraher, DR, Phillips, JS, Williamson, NE & Hainsworth, G 2014, 'Contraception for adolescents in low and middle income countries: needs, barriers and access'. *Reproductive Health* 11:1 <http://www.reproductive-health-journal.com/content/11/1/1>

Cleland, JG, Ndugwa, RP & Zulu EM 2011, 'Family planning in sub-Saharan Africa: progress or stagnation?'. *Bull World Health Organ*; 89(2):137-43.

Darroch, JE, Sully, E & Biddlecom, A 2017, 'Adding it up: investing in contraception and maternal and newborn health'. Guttmacher Institute, NY. New York.

Dehlendorf, C, Levy, K, Ruskin, R & Steinauer, J 2010, 'Health care providers' Knowledge about contraceptive evidence: a barrier to quality family planning care?' *Contraception* 81:292-298

Do, M & Kurimoto, N 2012, 'Women's empowerment and choice of contraceptives method in selected African countries'. *International Perspectives on sexual and Reproductive Health*, vol.38 (10).

Denton, EH 2014, 'Benefits of family planning'. *Global Population Reproductive Health*. 199:199-219.

Dral, AA, Tolani, M, Smet, E & Luijn, AV 2018, 'Factors influencing male involvement in family planning in Ntchisi District, Malawi-A Qualitative Study'. *African Journal of Reproductive Health*; 22(4).

Family Advancement for life and health (FALAH) 2012, End of Project Report. Islamabad: Population Council.

Hardee, K, Galis-Croce, M & Gay, J 2017, 'Are men well served by Family Planning programs?' *Reprod Health* 14:14.

Hubacher, D, Mavranouzouli, I & McGinn, E 2008, 'Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it. *Contraception*'. 78(1):73-8.

Ijadunola, MY, Abiona, TC, Ijadunola, KT, Afolabi, OT, Esimai, OA & OlaOlorun, FM, 2010, 'Male involvement in family planning decision making in Iie-Ife, Osun State, Nigeria'. *Afr J Reprod Health*. 14:43-50

Jones, D, Chitalu, N, Ndubani, P, Mumbi, M, Weiss, S & Villar-Loubet O et al 2009, 'Sexual risk reduction among Zambian couples'. *Sahara Journal* 6:69-75.

Kabagenyi, A, Jennings, L, Reid, A, Nalwada, G, Ntozi, J & Atuyambe, L 2014, 'Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda'. *Reprod Health*. 11:21.

Kaida, A, Kipp, W, Hessel, P & Konde-Lule, J 2005, 'Male participation in family planning: results from a qualitative study in Mpigi District, Uganda'. *J Biosocial Sci*, 37:269–286.

Kim, YM & Kols 2001, *Programming for Male Involvement in Reproductive Health*. Report of the meeting of WHO Regional Advisors in Reproductive Health. WHO.

Kirby, D 2011, 'Sex Education; Access and Impact on Sexual Behaviour of Young people'. New York: United Nations

Levesque, J, Harris, MF & Russell, G 2013, 'Patient-centered access to health care: Conceptualising access at the interface of health systems and populations'. *International Journal for equity in health*. 12:18

Mapsoftheworld.com

Masiye, F & Kaonga, O 2016, 'Determinants of Healthcare Utilisation and Out of pocket Payments in the Context of free public primary healthcare in Zambia'. *Int Journal Health Policy Manag* 5(12):693-703.

Michaels-Igbokwe, C, Terris-Prestholt, F, Lagarde, M, Chipeta, M, Cairns, EJ & Anglewicz P. (2015). 'Young people's preferences for family planning service providers in Rural Malawi: A discrete choice experiment'. *PLoS ONE*, 10, e0143287

Ministry of General Education 2016, 'Education Statistical Bulletin'. MoGE. Lusaka, Zambia

Ministry of Health 2010, 'National Health Strategic Plan (2011-2016)'. MOH. Lusaka, Zambia

Ministry of Health 2011, 'Adolescent Health Strategic Plan'. MOH. Lusaka, Zambia

Ministry of Health 2013, 'Family Planning Services': Integrated family planning scale up plan 2013-2020. Lusaka, Zambia.

Ministry of Health 2017, 'National Health Strategic Plan (2017-2021)'. MOH. Lusaka, Zambia.

Ministry of Health 2016, 'E-Health Strategy' MOH. Lusaka, Zambia.

Ministry of National Development Planning 2017, 'Seventh National Development Plan'. MNDP, Lusaka, Zambia.

Ministry of Youth and Sport 2015, 'National Youth Policy'. MOYS. Lusaka, Zambia.

Mmari, KN & Magnani, RJ 2003, 'Does making clinic based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia'. *Journal of Adolescent Health* 33:259-70.

Mutombo, N, Bakibinga, P 2014, 'The effect of joint contraceptive decisions on the use of Injectables, Long-Acting and Permanent Methods (ILAPMs) among married female (15–49) contraceptive users in Zambia': a cross-sectional study. *Reprod Health*. Vol 11:51.

Nalwadda, G, Mirembe, F, Tumwesigye, NM, Byaumugisha, J & Fanelid, E 2011, 'Constraints and prospects for contraceptive service provision to young people in Uganda; Providers' perspectives'. *BMC Health Services Research*: 11:220.

National Research Council, Institute of Medicine 2011, 'The science of adolescent risk-taking: workshop report'. Washington: National Academies Press; p. 6–33.

- Nyarko, HS 2015, 'Prevalence and correlates of contraceptives use among female adolescents in Ghana'. *BMC women's health* 15:60
- Okech, TC, Wawire, NW, Mburu, TK., (2011). 'Contraceptive Use among women of Reproductive Age in Kenya's city slums'. *International Journal of Business AND Social Science* Vol 2(1). Dissertation
- Onyango, MA, Owoko, S & Oguttu, M 2010, 'Factors that influence male involvement in sexual and reproductive health in western Kenya': A qualitative study. 14:32-42
- Pinchoff, J, Boyer, CB, Mutombo, N, Chowdhuri, RN & Ngo, T 2017, 'Why don't urban youth in Zambia use condoms? The influence of gender and marriage on non-use of male condoms among young adults' .*PLoS ONE* 12(3). <https://doi.org/10.1371/journal.pone.0172062>
- Sather, Z 2015, 'Male Involvement in family planning in Pakistan'. Population Council. Pakistan.
- Schriver, B, Meagley, K, Norris, S, Geary, R & Stein, AD 2014, 'Young people's perceptions of youth oriented health services in urban Soweto, South Africa: A qualitative investigation'. *BMC Health Services Research*, 14, 625. <http://www.biomedcentral.com/content/pdf/>
- Shattuck, D, Kerner, B, Gilles, K, Hartmann, M, Ng'ombe, T & Guest, G 2011, 'Encouraging contraceptive uptake by motivating men to communicate about family planning: the Malawi Male Motivator project'. *American Journal of Public Health*. 101(6):1089-95.
- Silumbwe, A, Nkole, T, Munakampe, MN, Milford, C, Cordero, JP, Kriel, Y, Zulu, JM & Steyn PS 2018, 'Community and health systems barriers and enablers to family planning and contraceptive services provision and use in Kabwe District, Zambia'. *BMC Health Serv Res*. 18:390.
- Simataa, M 2017, 'Factors associated with contraceptive use among youths aged 15-24 years in Zambia. UNZA, Lusaka, Zambia'. Dissertation
- Singh, S, Darroch, JE, Vlassoff, M & Nadeau, J 2013, 'Adding it up: the benefits of investing in sexual and reproductive health care'. New York: Alan Guttmacher Institute.
- Sonke Gender Justice Network, Policy Report 2014, 'Engaging men in HIV and GBV prevention, SRHR promotion, and parenting and LGBTI rights. Cape Town, South Africa'. The Lancet Commissions. Policy Report.
- Starrs, AM, Ezeh, AC, Barker, G, Basu, A, Bertrand, JT, Blum, R, Coll-Seck, AM, Grover, A, Laski, L, et al 2018, 'Accelerate progress-sexual and reproductive health and rights for all': Guttmacher-Lancet Commission. 391:2642-92. www.thelancet.com
- Tuloro, T, Deressa, W, Ali, A & Gail, DG 2009, 'The role of men in contraceptive use and fertility preference in Hosanna Town, southern Ethiopia'. *Ethiop J Health Dev*. 20(3):1-8.
- Ujuju, C, Anyanti, J, Adebayo, SB, Muhammad, F, Oluigbo, O & Gofwan, A 2011, 'Religion, culture and male involvement in the use of the Standard Days Method: evidence from Enugu and Katsina states of Nigeria'. *In Nurs Rev*, 58(40):484-90.

United Nations 1994, 'International conference on population and development. Programme of action'. United Nations, Dept for Economic and Social Information and Policy Analysis, New York (1995).

UNESCO 2009, 'International Technical Guidance on Sexuality Education: An evidence-informed Approach for schools, Teachers and Health Educators'. Paris; UNESCO with UNAIDS, UNFPA, UNICEF and WHO.

UNESCO 2015, 'Emerging Evidence, Lessons & practice in Comprehensive Sexuality Education. Paris, France.

UNFPA 2016, 'Zambia's Young People and the Road to 2030'. Population Council, Lusaka.

<https://zambia.unfpa.org/en/news/zambia>

USAID 2012, 'Delivering Sexual AND reproductive health services to young people: key lessons from Marie Stopes International programs'. Marie Stopes International. London

Vanwesenbeeck, I, Weseneng, J, De Boer, T, Reinders J & Zorge, R 2015, 'Lessons learned from a decade implementing Comprehensive Sexuality Education in resource poor settings: The World Starts with Me, Sex Education.

<http://dx.doi.org/10.1080/14681811.2015.1111203>

Vouking, MZ, Evina, CD, Tanenfok, CN 2014, 'Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests'. The Pan African Medical Journal, 19:349

Warenuis, UL, Faxelid, AE, Chishimba, NP, Musandu, OJ, Ong'any, AA & Nissen, ME 2006, 'Nurse-midwives' Attitudes towards Adolescent Sexual and reproductive Health in Kenya and Zambia. Reproductive Health Matters. An international journal on sexual and reproductive health rights. <https://doi.org/10.1016/S0968-8080>

Williamson, LM, Parkis, A, Wight, D, Petticrew, M & Hart JG 2009, 'Limits to modern contraceptive use among young women in developing countries; A Systematic Review of qualitative research. Reproductive Health 6:3.

Withers, M, Dworkin, SR, Onono, M, Oyier, B, Cohen, CR, Bukusi, EA & Newmann SR 2015, 'Mens Perspectives on their role in Family Planning in Nyanza Province, Kenya.

World Health Organisation 1995, 'An assessment of the need for contraceptive introduction in Zambia'. Geneva. WHO

World Health Organization 2011, 'Preventing Early Pregnancy: What the Evidence Says'. 2011.

Zambia Development Agency 2013, 'Investors Road Map'. Lusaka, Zambia

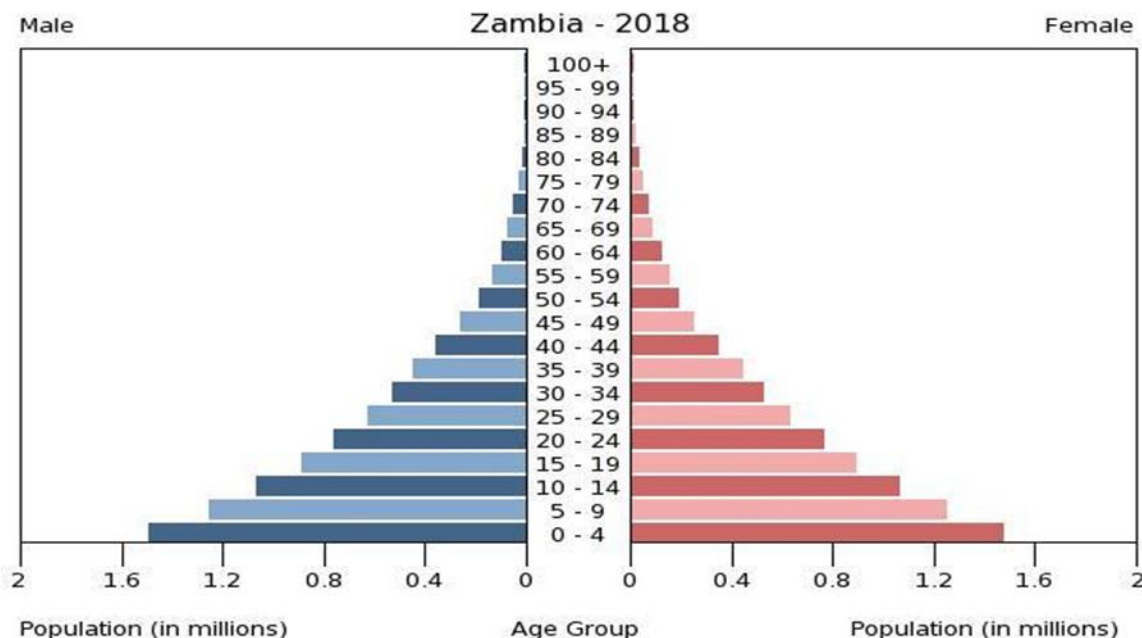
Zambia Population 2019, 'World Population Prospects-United Nations population estimates and projections'.

ANNEXES:

Annex 1: Structures, roles and responsibilities in Zambia’s decentralised health system

Level	Unit of structure	Roles/Responsibilities
Central level	Ministry of Health (HQ)	Policy and Regulation
Provincial level	Provincial Health Office	Administrative decentralization link between the central and district level
District level (hospital level)	District Health Management Teams	Technical support to the provision of services Support to hospital management
Health Centre level (community level)	Health Centre Committees	Community Participation to the management of health Centre’s
	Neighborhood Health Committees (NHCs)	Community participation in Health

Annex 2: Zambia 2010: Population, AGE and Sex Structure



Annex 3: Anderson and Newman Framework

