Developing Measures of Reproductive Empowerment

A Qualitative Study in Zambia

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MEASURE Evaluation

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ABBREVIATIONS

CC	critical consciousness
CCU	covert contraceptive use
FGD	focus group discussion
RE	reproductive empowerment
SRH	sexual and reproductive health
USAID	United States Agency for International Development
ZDHS	Zambia Demographic and Health Survey

EXECUTIVE SUMMARY

Background

Women's empowerment has been a major focus of development work for decades. The lack of women's empowerment in social, political, and economic contexts is linked to poor health outcomes. However, the relationship between women's lack of empowerment and their sexual and reproductive health is unclear. Researchers have recently begun to look at reproduction as a distinct aspect of women's empowerment, known as reproductive empowerment (RE).

MEASURE Evaluation—funded by the United States Agency for International Development (USAID)—undertook research to develop measures of RE to improve evaluations of interventions aimed at increasing RE. Our research is part of a three-phased activity to conceptualize and develop better measurement tools to accurately assess RE. During the first phase of this project, together with the International Center for Research on Women (ICRW), we created a conceptual framework based on definitions of empowerment and the socioecological model (Sallis, Owen, & Fisher, 2015). Through this framework, we defined RE as the outcome of a transformative process of change whereby individuals expand their capacity to make informed decisions about their reproductive lives, amplify their ability to participate meaningfully in public and private discussions related to reproduction, and act on their preferences and choices to achieve desired reproductive outcomes, free of violence, retribution, or fear. We emphasize that RE is a dynamic process in which women and their partners have resources that impact their agency at three levels: (1) individually, (2) within their relationships and community (the immediate relational level), and (3) with the broader environment (distant relational level).

We also conducted a literature review to see how RE has been measured. From this, we extracted a series of validated scales used to measure aspects of RE. Most scales either measured empowerment in areas not directly related to reproduction or were based on formative research in Southeast Asia; all had limited applicability to sub-Saharan African settings.

To understand the relationship between empowerment and reproductive health outcomes better, our team identified the need for new measures of RE based on the realities of women in sub-Saharan Africa. As the first step, we conducted qualitative research with women and men in Zambia to explore RE.

Purpose

The goal of this phase of the study was to develop a set of contextually relevant indicators that measure key domains of RE among women in sub-Saharan Africa and that can be used within population-based or special surveys. Our specific objectives were to:

1) Explore and define agency and resources related to RE that are "contextually appropriate" to women in Zambia.[1]

[1] The working definition of "contextually appropriate" refers to expressing awareness and sensitivity that people share common characteristics such as language, traditions, attitudes, beliefs, and values that shape their lives. This understanding of cultural norms will help create measures that are relevant to women in Zambia, and perhaps in other parts of sub-Saharan Africa.

2) Explore the thematic intersections between RE and family planning use.

3) Formulate draft survey items for subscales, informed by formative research, that measure select domains of RE among women in Zambia.

Methods

The study team conducted a qualitative study in Zambia during October and November 2016. We held 14 focus group discussions (FGDs) in the urban Lusaka District and the rural Chipata District with women (n=10) and men (n=4) with a total of 109 respondents. Groups were stratified by age and parity. Focus group participants answered questions around reproductive decision making, spousal communication, sexual negotiation, gender roles, and access to health services and information.

Findings

Sexual and Reproductive Decision Making

Participants discussed how decisions about sex and reproduction are made. Most people agreed that husbands are generally the ones who make decisions about when and how many children a couple will have, and therefore whether to use family planning. Although it was agreed that husbands dominate these decisions, women and men both acknowledged and endorsed the idea that women can (and sometimes should) access contraception in secret if their husbands were against using contraception. Many male and female participants agreed that women should be the ones to make more of these decisions, as pregnancy and child-rearing responsibilities impact them more than men.

When it came to the ability to negotiate when to have sex, participants discussed substantial power imbalances within couples. Sex was discussed as a core component of marriage and a woman's duty. Refusing sex with one's husband was talked about as neglecting her marital responsibilities. Some female participants said that if a husband was understanding, the wife might be able to negotiate to have sex later. When asked about initiating sex, it was generally agreed that it was up to men to initiate sex with women, and a woman initiating might lead to loss of respect.

Levels of Agency and Resources

At the distant relational level (also referred to as the enabling environment), participants discussed how gender norms, culture, and religion were at the root of power imbalances between men and women. Participants emphasized rigid gender roles as the core reasons for why women do not have sole decision-making power about using contraceptives, or the power to initiate or refuse sex with their partner. When probed on where these roles came from, women repeatedly mentioned cultural traditions such as the marriage training women go through in which they are taught to be submissive and how to take care of their future husbands. Many women also pointed to religion as a major driver of upholding men's dominance.

Within the immediate relational level, male and female participants talked about the quality of relationships and communication between couples as being key to joint decision making around childbearing, contraception, and the ability to negotiate sex. It was generally agreed that partners in a

couple should be able to talk to each other about major life choices, and that their ability to have such conversations and negotiation is made possible when there is mutual trust and understanding.

Participants (both men and women) also acknowledged that conflicts within couples over decisions around childbearing and contraception are common. They said that family are key resources for couples seeking an agreeable solution. Women said they called on family members or other health resources within the community to help convince husbands about the benefits of child spacing, as some husbands might not listen to their wives' point of view.

At the individual level, participants explored issues of self-confidence, demographic characteristics, and critical consciousness as being vital to a woman's ability to exercise her agency. When asked what the differences were between women who went along with whatever their husbands said and those who could exert more reproductive control, many women talked about the importance of having more education and therefore self-confidence. When comparing the urban and rural FGDs, we found that women in rural areas discussed more rigid adherence to gender roles within marriage as a reason for lacking agency.

Recommendations and Next Steps

Our findings led us to develop a list of draft measures of RE. A panel of experts in women's empowerment and family planning will review these measures. After this validation process, we will conduct cognitive testing of the measures for face validity, with the goal of creating a standard set of indicators and implementation guidance that can be used to measure RE in sub-Saharan Africa.

BACKGROUND

Modern family planning is an essential healthcare service for promoting and ensuring reproductive health, yet at least 200 million women globally lack access to it (Singh, Darroch, Ashford, & Vlassoff, 2009). Family planning can reduce maternal mortality, by preventing unwanted pregnancies and unsafe abortions and by promoting healthy pregnancies. It enables couples to determine whether to have children, when to have them, and how many to have; such decisions are crucial to safe motherhood and healthy families. A range of factors influences whether individual women or couples can get and use the family planning services and products they need.

USAID supports Family Planning 2020's goal to expand access to voluntary family planning information, contraceptives, and services to 120 million more women and girls in the world's poorest countries by 2020.[2] In line with this goal, the USAID-funded MEASURE Evaluation undertook research to develop RE measures to improve evaluations of interventions that seek to increase RE as a way to increase contraceptive use.

[2] United States Agency for International Development. (2017). Family planning and reproductive health. (Website). Retrieved from https://www.usaid.gov/what-we-do/global-health/family-planning

INTRODUCTION

Many studies have demonstrated that power inequality within sexual relationships is linked to poor health outcomes, especially in sexual and reproductive health (SRH) for women worldwide (Amaro, 1995; Blanc, 2001; Gage & Hutchinson, 2006; Pettifor, Measham, Rees, & Padian, 2004). Over the past two decades, women's empowerment has become a focus for development efforts. In 2000, nearly 190 countries signed the eight Millennium Development Goals, which included a commitment to promoting gender equality and empowering women (Bernstein & Hansen, 2006). More recently, the Sustainable Development Goals have provided impetus for continued action to tackle inequalities and empower all women and girls (United Nations, 2015). Goal 5 of the sustainable development goals explicitly links gender equality to reproductive health by aiming to ensure universal access to sexual and reproductive health and reproductive rights. Along with the Rio+20 Summit and the London Family Planning Summit, these global commitments have presented transformational opportunities to support sexual and reproductive health and rights of women and girls through gender equality and empowerment (Bernstein & Hansen, 2006; Family Planning Foundation, 2017; UN, 2015).

As part of these efforts, the global health field has attempted to conceptualize and measure women's empowerment and to understand its dimensions, such as economic, political, and social empowerment (Malhotra, Schuler, & Boender, 2002). This has enhanced the understanding that empowerment within one dimension does not necessarily translate into empowerment into other dimensions or facets of women's lives (Gipson & Hindin, 2007; Malhotra, et al., 2002). For example, because a woman has decision-making power over household purchases does not mean she has the same power for making decisions on whether to use contraceptives.

Other studies have demonstrated that women's empowerment positively affects reproductive health outcomes, such as ideal family size preference (El-Zeini, 2008; Hindin, 2000; Hindin & Muntifering, 2011; McAllister, Gurven, Kaplan, & Stieglitz, 2012; Upadhyay & Karasek, 2012); birth intervals (Al Riyami & Afifi, 2003; Upadhyay & Hindin, 2005); ability to make fertility decisions (Gwako & Laban, 1997; Jin, 1995; Mason & Smith, 2000; Upadhyay, Gipson, et al., 2014); unintended pregnancies (Pallitto & O'Campo, 2005; Wiliams & Sobieszczyk, 2000); and abortion (Agrawal, 2012; Lee-Rife, 2010).

However, a recent systematic literature review of women's empowerment and fertility revealed that more than 20 of 60 studies resulted in significant inverse findings and/or nonsignificant associations (Upadhyay, Gipson, et al., 2014). This inconsistency suggests that the relationship between fertility and empowerment remains unclear across empowerment domains. Hence a focus on empowerment specifically as it is linked to family planning and other SRH outcomes may be useful. This domain of empowerment is referred to as reproductive empowerment.

Reproductive Empowerment Definition and Conceptual Framework

Women's empowerment has been defined as "the expansion in women's ability to make strategic choices in a context where this ability was previously denied to them" (Kabeer, 1999). Building on this definition, we define RE as:

> The transformative process of change whereby individuals expand their capacity to make informed decisions about their reproductive lives, amplify their ability to meaningfully participate in public and private discussions related to reproduction, and act on their preferences and choices to achieve desired reproductive outcomes, free of violence, retribution, or fear.

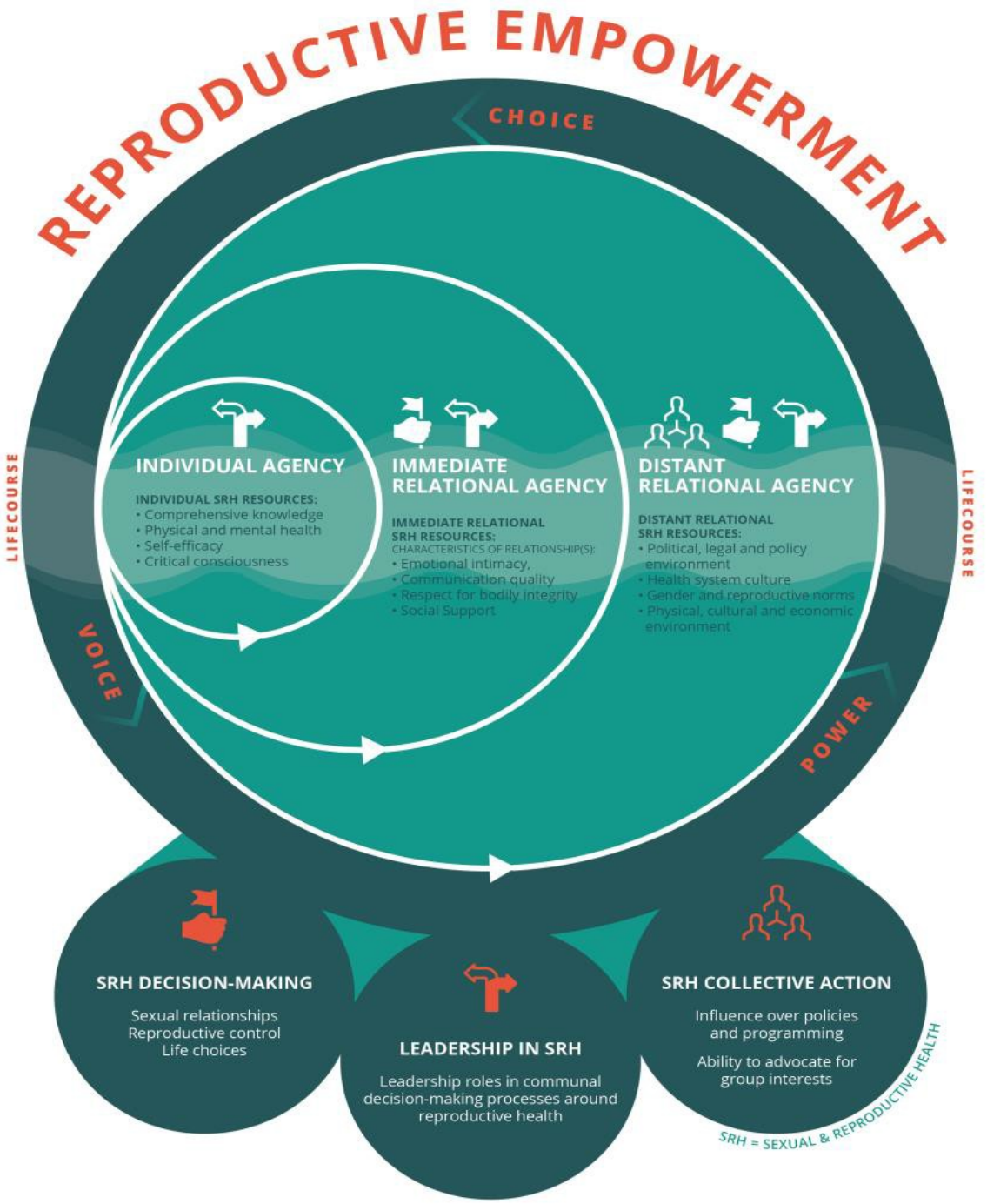
This definition has two features, process and agency, that are central to most definitions of women's empowerment. Our definition distinguishes RE from related concepts such as autonomy and broader discussions around "women's status." Both process and agency are key to understanding empowerment, but agency is widely regarded as the essence of empowerment itself (Malhotra, et al., 2002), acting as a key mediator between an individual's desire to bring about change and the achievement of this goal. As with empowerment, there is little consensus on the meaning of agency. Broadly this is conceptualized as the capacity for purposive action that draws on social and material resources at multiple levels to realize preferences and choices, enhance voice, and increase power and influence.

Expressions of Empowerment

Our conceptual framework (Figure 1) highlights three main expressions of empowerment in SRH: (1) decision making, (2) leadership, and (3) collective action. Decision making refers to the ability of an individual to influence and make decisions, and to be able to act upon them. This includes the capacity to exercise voice and power when influencing or making decisions, especially when it comes to reproductive control, life choices, and negotiating sexual relationships. Even though individuals may prefer to make choices jointly or alone, their autonomy in making the choice whether to include others in the decision-making process is critical to their empowerment; this highlights the role that power plays in shaping empowered decision making.

Simply participating in a decision-making process does not necessarily imply that this has been done in a meaningful way that reflects true empowerment. For example, individuals may have been included in communication about a decision, but have no real influence on the outcome. As with the concept of choice, attention should be paid to "first order" decisions that have direct and long-term implications for the life prospects of individuals and their overall empowerment. For this project, we are focusing on SRH decision making. SRH leadership and collective action will be explored later.

Figure 1. Conceptual framework of reproductive empowerment



Levels of Agency and Resources

One of the central concepts in our framework is understanding that, even though RE is fundamentally an individual concept, it is expressed through relationships at multiple levels that interact in various ways. The three levels are: individual, immediate relational, and distant relational. At each of these levels resources or domains are relevant in shaping the levels of agency.

- **Individual level**. In the context of this framework, "individual agency" refers primarily to the ability of individuals to conceptualize and define reproductive desires and goals, to develop plans for utilizing available resources in pursuit of these goals, and to confidently exercise voice to demand meaningful engagement in decision-making processes. At this level, the resources that are particularly relevant to RE are internal to the individuals. These resources include people's knowledge about sexual reproductive health and rights, their physical and mental health, and their self-efficacy with regard to their own SRH (such as self-confidence in themselves and their ability to negotiate and overall self-esteem), critical consciousness around gender inequality, and where and how to access health services.
- **Immediate relational level.** At this level, "agency" refers to people's ability to exercise choice and voice in their interactions with actors in their most immediate environment, primarily through the decision-making process around their sexual and reproductive health. Here we conceptualize the relevant resources as being the "character" of that specific relationship, particularly in terms of emotional intimacy, the power balance between the individual and the other actor(s), the level and type of couple communication (such as bargaining and negotiation), and the level of reproductive coercion (including physical or psychological threats or actions by one person to control his or her sexual partner's reproductive decisions).
- **Distant relational level.** "Agency" at this level is based primarily on people's ability to exert voice, choice, and power in their interactions with actors outside of the realm of immediate relationships. These actors may be at the community, regional, or national level, such as healthcare providers, religious and political leaders, institutions (such as the legal, political, and health systems themselves), and the international development community.

Because the conceptual framework is based on a socioecological model, the levels overlap and influence one another. For example, the culture of the health system is part of the larger enabling environment, but has a direct impact on a woman's self-efficacy to access family planning at the local clinic.

Measurement of Reproductive Empowerment

Literature Review

Lack of specific attention to RE and variation in the conceptualization of RE have resulted in inconsistent measures of RE in research on the determinants of reproductive behavior relating to empowerment. To assess the state of the field and what it means for future attempts to measure RE, we conducted a systematic literature review of studies seeking to measure RE and family planning and reproductive health outcomes. A search of key terms from three databases yielded the 406 full-text articles that we reviewed.

We abstracted data from 45 studies that either created and validated their own scale, used a previously validated measure, or employed a combination of the two. The studies represent diverse geographical areas in 23 countries,[3] reinforcing the broad interest in measuring and understanding RE for women/girls, men/boys, and couples in various cultural contexts. Half of the studies (n=23) were conducted in the United States or Canada, with the second greatest number of studies (n=9) conducted in

[3] Bolivia, Botswana, Brazil, Canada, Côte d'Ivoire, Ecuador, Ethiopia, Ghana, Kenya, India, Iran, Namibia, Nepal, Nigeria, Oman, Philippines, Portugal, Tanzania, Turkey, Uganda, USA, Vietnam, and Zambia

sub-Saharan Africa. Although RE was conceptualized and measured in various ways, certain subdomains of RE were measured more often than others such as decision making and levels of coercion and violence. Further, some of the studies used measures of women's empowerment more generally, such as decision making related to households, finances, and healthcare.

Gaps in Measurement of Reproductive Empowerment

Our review of the literature points to several gaps in measuring RE. First, we found nine studies using measures of RE in sub-Saharan Africa compared to 23 studies from North America. There was a strong focus on the individual level of resources and examining "self-efficacy to express, negotiate, and carry out one's sexual and reproductive desires and outcomes" in the North American studies. The sub-Saharan African studies focused more on "shared sexual and reproductive decision making" and "freedom from violence." It is unclear whether these differences may indicate a need to test these measures in different settings or if cross-cultural applicability is limited (ICRW & MEASURE Evaluation, 2016).

It is still unknown if the same domains of overall empowerment that were developed elsewhere are relevant in sub-Saharan Africa, where the gender environment is different from other regions of the world. For example, in South Asia, women's freedom of movement in public places is limited, whereas in sub-Saharan Africa it is much less restricted. Except for the WE-MEASR survey tool (CARE, 2014), our literature review found that very few studies conducted in sub-Saharan Africa included measures of mobility. Thus, the need remains for contextually relevant measures of RE for this part of the world.

RESEARCH GOALS

Building on the findings from our literature review, we undertook qualitative research to develop a set of contextually relevant indicators that measure key domains of RE among women in sub-Saharan Africa and that can be used within population-based or special surveys for evaluations. Our specific objectives were to:

(1) Define domains of RE and resources supporting RE that are "contextually-appropriate" to women in a sub-Saharan African country.[4]

(2) Explore the thematic intersections between RE and family planning use.

(3) Develop draft survey items to form subscales, informed by formative research, that measure select domains of RE among women in a sub-Saharan African country.

Country Setting

Data from the 2013–2014 Zambia Demographic and Health Survey (ZDHS) (Zambia Ministry of Health, 2015) reveal social and demographic characteristics, gender norms, and determinants of unmet need that underscore the need for improved reproductive health and family planning outcomes in Zambia. Educational attainment is low both for men and women in Zambia, with median years of schooling at 4.3 years for females and 5.1 years for males. There are also considerable differences in educational attainment between women in urban (8.2 years) and rural (5.5 years) areas. The median age at first marriage among women ages 25–49 is 18.4 years.

Several other factors describe the country's gender norms. More than 30 percent of women in Zambia agreed with wife beating for at least one of the specified reasons.[5] This measure was higher among women in rural areas (38%) than in urban areas (25%). Similarly, a third (35 percent) of currently married women who earn cash said that they themselves mainly decide how their earnings are used; one in two (49 percent) said that they make the decision jointly with their husband; and 16 percent said that their husband is mainly the one who makes the decision.

Although contraceptive knowledge is almost universal in women (98.8%) and men (99.9%), only 45 percent of currently married women and 38 percent of sexually active unmarried women are using a modern method of family planning. Unmet need exceeds 20 percent and is greater among women in rural areas (24%) than in urban areas (17%).

[4] The working definition of "contextually-appropriate" refers to expressing awareness and sensitivity that people share common characteristics such as language, traditions, attitudes, beliefs, and values that shape their lives. This understanding of cultural norms will help create measures that are relevant to women in Zambia, and perhaps in other parts of sub-Saharan Africa.

[5] The questions in the ZDHS ask if a husband is justified in hitting or beating his wife if she (1) burns the food, (2) argues with him, (3) goes out without telling him, (4) neglects the children, or (5) refuses to have sex with him.

METHODS

Study Design

We used a qualitative design and collected data through focus group discussions (FGDs). We chose this approach to explore the social and gender norms and practices around SRH and decision making in Zambia.

Study Location and Population

The study included 84 women ages 15–49 who were sexually active, married, or cohabiting, and living in an urban setting in Lusaka District and a rural setting in Chipata. Twenty-five men ages 18–59 living in Chipata were also included.

Sample and Eligibility

We used a mix of purposive sampling strategies (namely snowball sampling and maximum variation sampling) to recruit FGD participants. We asked potential participants a series of questions to screen for eligibility and ensure demographic diversity (in age, marital status, and geographic location). For each FGD, participants were recruited and selected from the list of eligible women who (1) were living in the general vicinity of the focus-group locations; (2) were reachable by phone or in-person; and (3) expressed interest in participating.

Potential participants were identified through universities, markets, and other common meeting places. In both locations (Lusaka and Chipata), the local consultant/recruiter generated a list of potential participants and randomly selected them until recruitment quotas were met. A total of 14 FGDs were conducted: five in Lusaka with women and nine in Chipata (five with women and four with men) (Table 1). Male and female participants were stratified into groups based on age, place of residence (urban/rural), and whether they had children.

Table 1. Number and stratification of focus groups by location

	Chipata (Rural)		Lusaka (Urban)	
	Children	No Children	Children	No Children
Female Focus Groups				
15- to 17-year-old girls (married)	1	0	1	0
18- to 24-year-old women (single or married)	2	1	1	1
25- to 49-year-old women (single or married)	1	0	1	1
Male Focus Groups				
18- to 24-year-old men (single or married)	1	1	-	-
25- to 59-year-old men (single or married)	1	1	-	-

Data Collection

The FGDs were conducted October 22–November 30, 2016 in convenient central locations well-known to participants. The FGDs were led by an experienced moderator of the same gender as group

participants and conducted in a private space conducive to discussing sensitive topics. Each FGD was 60–90 minutes long. The FGD participants received 50 Kwachas (USD$5) for transportation expenses.

The moderators collected basic demographic information from each participant—age, education level, marital status, number of children, and previous contraceptive use during the past five years—and then asked for consent to audio-record the discussion.

The moderators used an FGD guide **(**Appendix A**)** to lead the group discussion. The guide covered dimensions of RE featured in the conceptual framework, such as couple communication, decision-making power or dominance, coercion, self-efficacy, and choice. These dimensions were explored using vignettes about a fictional character, "Amara," to discuss attitudes, norms, and beliefs about various family planning and reproductive health topics (such as contraception, unintended pregnancy, fertility preference, sexual activity, and gender-based violence), and different levels where gender-related power dynamics occur (such as with partners, households, service providers, and communities). The moderator presented the topics in situational vignettes to portray realistic scenarios about Amara and her husband, "Banda." Vignettes have been shown to be effective initiators of discussion of topics that may be perceived as personal or sensitive (Barter, 1999).

Data Processing, Coding, and Analysis

We ensured data quality and trustworthiness by adhering to rigorous standards for documentation, procedures, and auditability (Guba & Lincoln, 1994). First, audio-recordings from FGDs were transcribed and translated (as needed) into English by the study's local consultants; the UNC authors cross-checked the transcripts for accuracy. Any questions on the transcripts were sent back to the study consultants in Zambia for clarification. Transcripts from FGDs were updated with any revisions and then entered into Dedoose 7.5.9 software for qualitative analysis.

We read four transcripts and created summaries linked to FGD questions to identify preliminary emergent themes. Our team developed an initial codebook with predetermined codes based on the conceptual framework, levels of agency, and domains of interest (such as self-efficacy, decision making, partner communication, and negotiation skills). Using the initial codebook, we coded two transcripts to test the reliability of the coding scheme and identified additional themes and codes. The codebook was refined and one coder coded the remaining 12 transcripts (Appendix B). The revised codes were then applied to the previously coded transcripts through a second round of coding and consistency checks.

Initial analysis of the coded data consisted of pulling quotes by code, creating summaries, and exploring - subthemes. Further subanalyses were conducted to identify patterns by comparing responses between men and women, urban and rural women, and women who were in college and those who were not, and women in different age groups. Summaries of these results are presented below with illustrative quotes from FGD participants. Each quote is identified with the FGD it came from, using an identification code that reflects FGD number, location (Lusaka or Chipata), and whether it consisted of men or women. For example, FG01CF is the first FGD with females in Chipata. A table with the age, child-bearing status, and gender of the focus groups can be found in Appendix C.

Based on dominant themes reflected in the data, we selected several themes to highlight for developing potential measures such as SRH decision making, norms, relationship quality, partner communication, social and community support, and critical consciousness. Direct FGD comments were extracted for each theme, and possible statements and questions were created that could be used as measures. Finally, the list of scale items was then compiled, and similar items were combined and refined based on similar

constructs and wording. The scale items were then compared to similar validated measures then refined and updated with different wording as necessary.

Ethical Review

This study was approved by the Institutional Review Board at the University of North Carolina. It was also approved by ERES Converge, a private institutional review board in Zambia that is accredited by the Office for Protection of Human Research Participants in the United States.

FINDINGS

In this section, we first explore SRH decision making as it relates to reproductive control, sexual negotiation, and decisions about major life choices. These are the expressions of empowerment in our conceptual framework and the outcomes of interest in our analysis. We then discuss the resources at different levels that impact women's agency and empowerment.

Participant Characteristics

A total of 84 women and 25 men participated in the FGDs. The average age for female participants was 23 years (ranging from 16–46). Thirty-seven percent of female participants had attended or completed primary school; 31 percent had attended or completed some secondary school. More than one third (35%) of female participants were currently in school at the time of the FGDs. Nearly two-thirds (67%) had one or more children and the majority (63%) had used contraception in the past five years. Male participants' average age was 24 (ranging from 18–56) and the majority (60%) had only partial or no primary education. More than half of the men did not have any children and two-thirds (67%) had reported they or their partners had used contraception in the past five years. More details on participant demographics can be found in Appendix D.

Decision Making about Sexual and Reproductive Health

Participants were presented with the vignettes of Amara and her husband Banda, who had several young children. Amara was ready to stop having children or at least wait a few years for the birth of the next child, but her husband wanted more children. Male and female participants acknowledged that such conflicts over child spacing do occur between couples in Zambia. Among female participants the most common suggestion was that Amara should try to talk with her husband to convince him that they should stop or delay having children by using contraception. One woman said, "I think she should first talk to the husband before deciding to stop, because it involves the two" *(FG03LF)*. Most of the women in the FGDs, regardless of age or place of residence, mentioned or agreed that men are the ones who make the decision about family planning. Although women 25 years and older from Chipata agreed that men should make the final decision about family planning, they admitted that in real life, women are the ones who ultimately make that decision about using contraception.

Most female and male participants recognized that it might be difficult for Amara to convince her husband by herself and suggested that she seek support from friends, family, or healthcare workers to help persuade him. Many participants felt that Banda, Amara's husband, might resist the idea of using contraception because of lack of information. One man in Chipata explained, "In this case, the go-between [Nkhoswe] for both the husband and wife may also play a role in making such a decision. The wife must explain very well to such people; if anything, a good husband will understand" *(FG02CM)*.

The next most common suggestion from all female and a few male participants, was that Amara should decide on her own to access contraception secretly—a practice that was viewed as common when husbands didn't want wives to access contraception. Both women and men suggested that Amara should fabricate an excuse, such as having a sick child who needs medical care at the clinic, or needing to go to the market. As one participant explained, "If I were Amara, I would pretend that the child's body is warming up, so I need to take the baby to the clinic, yet my aim of going to the clinic is to go for contraception. Since he won't allow me, I create a small lie" (FG04CF). This theme is discussed in detail below.

A smaller group of participants felt that Amara should let her husband make the decision about having more children in order not to disrupt the power dynamic within the marriage. As one woman said, "If she still wants the marriage, she has to stay strong and continue having children" *(FG02CF).* Most female participants agreed that, in practice, husbands are the ones to make decisions about having children, and therefore, whether to access contraception, and that although women might not want to have more children, it was better to do that than to risk conflict in the marriage. Comments from female participants in Lusaka and Chipata illustrate how some women accepted that husbands are the ones who decide on family size.

> *The man is the one who decides how many children you should have as a couple, if you as the wife say "no" to his suggestion, then there will be problems so it's best that you do what he wants. When he is able to see that you have had enough children, he will say, "My wife, these children are enough. Let us stop."* (FG05LF)

> *Because he is the head of the house. Everything is under his control. Yes, the woman is the one who feels pain but after labor/giving birth, all the needs of that child fall on the man. Even for us to just eat at home, the man needs to provide.* (FG01CF)

In contrast to what participants indicated is the actual practice around childbearing decision making, when asked who *should* make decisions on the number of children, participants had much more mixed responses. Most women and some men said that because women have to carry the pregnancy, give birth, and take care of the children, they should be the ones making the decisions about using contraception and when and if to have children. These two FGD comments (the first from a woman, the second from a man) illustrate this idea:

> *Because she is the one who goes through all the pain of having that baby. She carries it in her womb for nine months…and that pain that the lady goes through! So, it is up to her to say, okay, this time I can and this time I can't.* (FG05CF)

> *The one to make the final decision is the wife, since she is the one who feel the pain.* (FG01CM)

Nearly half of men and approximately 15 percent of women indicated that men should be the final decision makers, because the man's role is to be the head of the family. When asked who should be the decision maker, one male participant said, "In my thinking, the one to make the final decision is the husband…. because all the powers lie in the husband" (FG03CM).

Covert Use of Contraceptives

Covert contraceptive use (CCU) seemed acceptable to women in Chipata and Lusaka, with many acknowledging it as a common practice in their communities. Younger women (15–24), both in Lusaka and Chipata, were more approving of secret use of contraceptives than were older women (25 or older). Generally, participants suggested that Amara talk to her husband first, but if he insisted on wanting more children, she should get contraception and hide it from him. One man said, "In my opinion, the wife should tell her husband that she is sick; she wants to go to the hospital. Then she can use the opportunity to see the nurse and get the help she needs on contraception" (FG02CM).

Of the participants who said the husband decides about family size and contraception, many also mentioned that Amara *should* get contraception secretly if her husband did not approve of it. There were five instances in different focus groups where the female participants or someone close to them had

accessed family planning without the husband knowing. However, Amara getting family planning services in secret was not generally framed as a decision, unless the moderator probed. Rather, it was seen by the participants as her doing what was best for her and her family. The husband still made a "final decision" (or at least he thought so). These two female comments illustrate this idea:

> *A man can decide but it is up to the woman to accept or refuse that decision.* (FG04LF)

> *If the man says we are going to have children and I don't want to have children, I might agree just to keep the whole conversation quiet, so that we don't talk about it but in my head and in my heart, I know that I am going to do something about it. So, I am going to make sure I find ways of avoiding that situation so like she said, I would go to the hospital, get the treatment done even without him knowing so even if he said it, I am the one who makes the final decision at the end of the day.* (FG02LF)

Even though female participants often endorsed the idea of a woman using contraception without her husband's consent, they recognized the potential consequences if she was discovered. They said consequences could involve mistrust, infidelity, physical abuse, withdrawal of financial support, and divorce. A woman in Lusaka said that using contraceptives secretly can create mistrust:

> *I think that marriage would end, because firstly, she did it without his consent and then most men in Zambia, when you use contraceptives…. they will say you want to be bitching around like sleeping with other guys so that's the first thing that will come to his head. "Why does she want to use it? Does it mean she wants to sleep with other men so she doesn't get pregnant?" and stuff like that.* (FG03LF)

Sexual Negotiation

Female and male participants were also presented a scenario where Amara was tired and did not want to have sex with her husband in the evening. More than two-thirds (67%) of women said that Amara should not avoid sex at all, because it was her duty as a wife to have sex with her husband and being tired is not a valid reason to avoid sex. One female participant said, "She needs to sleep with him. Yes, she might be tired from doing other work, but when the owner wants sex—I say owner, because he is the owner of your body—you cannot start setting rules for him*"* (FG01LF).

A smaller group of women suggested that if Amara explained to her husband that she is too tired to have sex, he might empathize and agree to have sex later, as long as it was not a common occurrence. One woman explained, "If it is a one-off, she says, 'My husband, I am tired today.' He would understand if it was a one-off thing, since this woman has been giving him sex before this day" (FG04LF).

Female participants also talked about sex as a physical need, often comparing it to eating or sleeping. For a wife to deny sex to her husband just because she is tired was compared to withholding food and perceived as a sign that the wife does not take care of her husband. Denying sex was also considered a sign that a wife must be unfaithful to her husband: "Refusing to have sex means she has someone else who makes her happy sexually. Her husband doesn't, so she doesn't want her husband; she wants this outsider" (FG05CF).

Focus groups also discussed initiating sex. Participants, both male and female, widely agreed that men were the ones to initiate sex and women initiating sex was unacceptable. Men were thought to have stronger sexual feelings, and it was their job to initiate sex and arouse the woman. Further, both male and female participants emphasized that women are supposed to be submissive and are too shy to initiate sex. One man said, "I think women are shy to say that therefore, husbands should tell their wives to have sex with them" (FG04CM). One woman said, "Women [initiate sex] as well but most women are shy and

because of that, it is rare that a woman can tell a man that she wants to have sex. She will just be quiet about it and control herself. Men are the ones that fail to control themselves" (FG05LF).

Several of the female participants discussed the shifting power dynamics that take place when a couple goes from dating to marriage, although this was not a part of the initial focus-group questions. When dating, women discussed having more control and autonomy when it came to negotiating sex. However, once a couple marries, the social norms dictate the man's family pays a bride price and once he has "bought" the wife, he has authority over her. After the facilitator asked if women could refuse sex with boyfriends, several participants replied:

> P2: *Even I once said no because we are not married so I can say no when I want to.*
>
> P6: *No, it is not marriage and I have every right to say no.*
>
> P3: *You can say no because the two of you are not married so really, if you do not want, you do not want.* (FG03LF)

Levels of Agency and Resources

Distant Level

Social, Cultural, and Gender Norms

The study participants discussed various norms that influenced their actions and relationships. First, they mentioned the societal importance of marriage, which grants women status and respect. Not being married or being divorced were seen as lessening a woman's worth in society. When discussing women's ability to access family planning or refuse sex when they are tired, the main consequence women feared was the husband leaving to be with another woman, something which could lead to social ridicule. One woman explained, "[O]ur culture believes that marriage gives you respect. When you are married, you are respected in society…. [I]f her husband leaves it will mean she will be divorced. Maybe neighbors will start laughing at her, even the friends" (FG02LF).

Focus group participants identified gender norms and expectations as the root causes of power imbalance within couples. They emphasized rigid gender roles as the core reason for why women do not have sole decision-making power about using contraceptives, or the power to initiate or refuse sex with their partners. These roles are particularly strong for married women, as the division of roles for men and women are embedded within the marriage contract. Most female FGD participants emphasized that men are the head of the household who provide for the family and women are expected to be submissive and take care of the children.

When asked about the origin of rigid gender roles within marriage, participants mentioned religious beliefs. The church was one major driver of power imbalance, with many participants discussing how the Bible says a woman should be submissive to her husband. When asked why women are submissive to their husbands, one female participant replied, "Our tradition and even Christianity is telling us to do that, and it's a Christian country" (FG03LF). Another woman explained, "God created a man first before he created a woman so we can follow it from that biblical background" (FG05CF).

Traditional Zambian women are expected to undergo three months of instruction on how to be a "good" wife. Such instruction is considered a major driver in shaping the power dynamic within couples. One female FGD participant said:

> *[*W*]hen we are being taught is when it all starts (the marriage training). When the man is being told how to be in marriage, he is told, "You are the one who will be controlling the marriage and your home." When we the women go through the marriage teachings we are told, "Whatever your husband says or does, you must do as well. Follow what he says. A man is not to be questioned."* (FG02LF)

These teachings are reinforced when the man pays a bride price, giving him "ownership" over his wife. Some participants talked about withholding sex if the full bride price had not been paid, but once it was paid in full, she was obligated to have sex with him.

Health Systems, Culture, and Access to Information

When asked about access to family planning, female participants in Chipata and Lusaka agreed that women could easily access clinics and would be treated well by healthcare staff if they sought contraceptive services. The women were confident that they (or Amara) would be able to get all of the information they needed on various methods, and make an informed choice themselves about which methods to use. As one woman said, "Since you are there for contraception, the nurse will assist you with the type of contraceptive you have chosen to use. It could be pills or injections" (FG04CF).

When asked if women are treated differently if they visit the clinic with their husbands, they generally agreed that they would be treated the same regardless, although nurses may ask women arriving alone if they have discussed contraception with their husbands.

A few women discussed getting preferential treatment at the clinic if they came with their husbands. One woman explained "[If] there is a queue there and you are all women, you have to wait in the queue if you go there alone but if you go with your husband, you will be attended too quickly" (FG01LF).

When asked about the types and availability of SRH information, both male and female participants said they could get reliable information within their communities. Respondents indicated they heard many messages on the importance of healthy child-spacing, as well as the various methods of contraception that were available. In several FGDs, respondents clearly knew about the methods available, as they would make suggestions about which methods Amara should use. The primary source of information on contraception and family planning was healthcare workers (both clinic and community-based). Other sources of SRH information mentioned were types of media including radio and television.

Immediate Relational Level

Community Support and Influence

Male and female participants also discussed various community resources (such as neighborhood health committees, community health workers, and church counselors) that could help couples make decisions about child spacing and contraceptive use. Many women mentioned that husbands may need more information to be able to agree with these steps. Community health workers were seen as the best sources of information, because they are experts in communicating the benefits of contraception and they are readily available in the community. One woman suggested:

> *Maybe she could ask her husband to go with her to the clinic or she could invite the neighborhood [health committee] to come and talk to them both about contraception. Whichever route she takes, both the clinic staff and the neighborhood team would explain how the life of a child-bearing woman needs to be taken care of.* (FG02CF)

Social Support and Influence

When it came to negotiation and conflict resolution within marriage, male and female participants in Chipata and Lusaka consistently discussed bringing in family or friends as a first step to help the couple resolve their issues. The most commonly mentioned person was the *Nkhoswe*, an older male or female relative of the groom or bride, who acts as the liaison when negotiating the marriage and continues to act as a counselor throughout the life of the marriage. *Nkhoswes* are seen as vital resources for such negotiations. One man said, "Each and every marriage has the go between; I believe when [disagreements around family planning] arise the husband and wife must run to these people" (FG02CM).

A female participant in Lusaka echoed the importance of calling on knowledgeable relatives for support:

> *In cases where the man insists on not using contraception, the best thing to do is to tell those relatives of his who know about family planning and contraception so that they advise him to stop rapid production of children by allowing me to go to the clinic for contraception.* (FG04LF)

Both men and women suggested finding someone who the husbands respect and would listen to for advice. Some women also said they would try to find female friends who have supportive husbands who would share the benefits of family planning with their husbands. One woman reflected:

> *[W]hat I think is that maybe even as guys you know guys open up whenever they meet as friends and stuff or maybe even just meeting them away from home say at work, having someone over, talking to them, I think that is when men easily understand because maybe at home when they have their wives they don't want to be proven wrong. But at least where there are people giving each other views like maybe something like this (the way we are seated), they seat maybe during lunch break I feel men can be convinced.* (FG03LF)

Social support was also key when it came to resolving issues around a couple's sex life. Participants discussed that when there is marital discord, the couple needs to seek help from families or elders to resolve them. One woman explained: "I think looking at our Zambian culture, the best person she should go to is their marriage advisors or counselors from either family. Those are the people to talk to concerning this issue" (FG02LF).

Women were clear that because they generally lack power within their relationships and husbands are supposed to be the authority on family matters, it would be difficult for a wife to change her husband's mind alone. The ability to call on friends and family resources was key for a wife to negotiate sensitive matters with the husband. This was acknowledged in all groups, but it was emphasized most by younger women in rural areas.

Relationship Quality and Partner Communication

Male and female participants felt that if there was mutual trust, transparency, empathy, or respect between partners, there was a higher chance of being able to have open and honest communication about sexual and reproductive issues. When focus groups were asked "What would happen if Amara was tired and didn't want to have sex with her husband," it was generally agreed that she should have sex anyway. However, some male and female participants discussed that a husband must be understanding in this situation and that if there was openness and trust between them, she would be able to communicate her needs more clearly to him. The following quote illustrates a common response from male and female participants, "It depends. If he saw how hard I worked during the day and he was understanding, I would ask him to forgive me and excuse me [from having sex] just for one night. I am sure he would understand and let me be" (FG01CF).

Similarly, female participants thought that if a husband was concerned with his wife's mental and physical health and the toll of having closely-spaced births and raising a lot of young children, he would be more likely to support using a family planning method. As one woman stated, "If the man loves his wife, he needs to agree to use contraception because having a child that often, destroys the life and health of a woman. If they talk about it thoroughly then the man will agree on his own and the woman will not force him" (FG01LF).

However, even when women felt that their partners were open to communicating about SRH issues, it was considered normal among both male and female participants to not bring up such topics. The ability to communicate with partners about major decisions (whether or not to have children) or relatively minor ones (whether or not to have sex tonight) was seen as fundamental to a woman being able to exercise her agency. Because men were predominantly viewed by women as the gatekeepers to accessing contraception, women talked about needing to openly discuss the issues with their partners to get what they want. When presented with the various scenarios (such as the desire to get family planning, negotiating when to have sex, or the husband physically abusing the wife over her secret contraceptive use), male and female participants generally suggested the need to have discussions and negotiate mutually agreeable solutions to the problems they faced. One woman explained:

> *The woman is the one who bears children and she seems to be burdened. She should tell her husband that, "Look how the children are many and young. They are on me all day. I can't even wash, bath, or take care of myself properly, because I am always busy with them. Please, I need to rest. What do you say?" Then he would agree.* (FG01CF)

A man in Chipata had a similar response to share:

> *If I was Amara I would sit my husband down mildly and talk to him about the benefits of contraception and how we can maintain a good child spacing between our children, as well as finding resources to care of our children.....And bearing in mind that pregnant women loses a lot of blood during child delivery, this means that when we force her, she might land into different problems which may include; death or even getting [pregnant] earlier than expected. If I was Amara, this is how I could convince my husband.* (FG04CM)

Female participants also felt that a lot of confusion and disagreements could be avoided by discussing the number of children the couple wanted before they got married. As a woman in said:

> *[B]efore getting into the marriage you are supposed to discuss how many children you should bear… you are supposed to come up with the final decision. "We are about to go into marriage, how many children are we supposed to have? And the spacing? the timing?" So that when you enter the marriage you know everything rather than being forced to do this, then again you start arguing over issues.* (FG03LF)

Individual Level

Demographic Factors

Although demographic factors were not specifically raised during the FGDs, many of the participants discussed how a woman's education specifically impacts her ability to set reproductive intentions and negotiate with her partner. Participants also talked about how lack of education and living in a rural area were factors in women not having autonomy. Having an education was perceived by participants as being more independent from men. One young woman in Lusaka who was not currently in school said, "If you have been to school and have some level of education, you know you can say "yes" to some things and

you can say "no" to other things. You are completely different from a person who hasn't been to school and constantly thinks she will get into trouble*"* (FG04LF).

There were some differences between rural and urban participants' views on women's agency. In rural Chipata, one woman explained how couple dynamics were different in rural locations:

> *If we bring it to how people away from the village setting live, if the woman is independent, she works, she will opt for divorce because she knows she can fend for herself but if the woman is a villager and completely depends on the man, whatever the man says will stand and so I think she will get pregnant.* (FG05CF)

Critical Consciousness

Female participants (especially those who were attending post-secondary education) had critical views of socially and culturally dictated norms around gender and reproduction; they had ideas of what needed to change to achieve greater gender equity. This theme was discussed a bit, though not extensively, in the male FGDs. Women discussed the need for greater bodily autonomy and women's rights to determine what she does with her body, despite cultural influences that did not support these rights. Many female participants were critical of men making the final decision about when and how many children to have. As one woman explained:

> *According to our [Zambian] tradition and culture, when a man speaks or makes a decision, you [women] are not supposed to answer back or refute it, if you do you will be considered disrespectful and so it is that tradition really that "kills" us in our homes and marriages. If we keep following what our grandparents used to do, we will be lost. There are some who follow that old generation and keep saying it is the man, the man, but we have seen women have changed. We need to speak out for ourselves, we should have that right and our opinions should be respected. According to culture, it is the man but according to me as of now, a woman.* (FG05LF)

Female FGD participants also said that if power dynamics were going to change within married couples, it would need to start from an early age. Participants from several FGDs explained how growing up in families where the fathers made all major decisions and sons received special treatment meant that boys and girls were being taught from a young age that women were inferior to men. One Lusaka woman said:

> *It just starts with traditions in Zambia. It doesn't empower women to be heard in homes and so if a man says no, whether you bring in a 4th or 3rd party, it'll be difficult to convince these men because that's how their parents have raised them; to be the heads of the house so that whatever they say goes. So, I think it would start with how parents are raising their sons and all that, how to treat their wives and all that. They have to learn that a home is built together with a woman but in this generation if a man says no it's no.* (FG03LF)

Indicators for Measurement of Reproductive Empowerment

Based on these commonly discussed themes of RE, we extracted FGD quotes by code, and created possible statements and questions that could be used as measures. Table 2 contains sample illustrative quotes and corresponding scale items. The long list of possible measures was then reduced based on the most commonly discussed themes including SRH decision making, norms, relationship quality, partner communication, social and community support, and critical consciousness. Some domains, such as SRH knowledge and quality of healthcare services, were discussed in focus groups but were not included in this step, as there are already validated indicators to measure those concepts. We chose to focus on domains closely linked to decision making for which there are not current robust measures.

Table 2. Reproductive empowerment domains, illustrative quotes, and corresponding scale items

Domain	Quote	Corresponding Scale Items
Decision making	"I think the final decision should be made by both. It is completely wrong if we say the husband should make the final decision."	Ideally, who has the most say about whether you use a method to prevent pregnancy?
Social norms	"We feel as though we will be looked down on if we make certain decisions like wanting to have sex."	Other people think I should be able to initiate sex with my partner.
Social support	"I would give my pills to the neighbor and go there every evening to take my pills."	I have friends or family who would help me access contraception without my partner knowing.
Partner communication	"While you are still [dating], there will be that talk and communication that, 'I want to have this number of children.' You will ask him and he will ask you and in the end, you agree on how many children you will have."	My partner and I have discussed how many children we want.
Critical consciousness	"[When dating] we both have same powers but then the bible says we should be submissive to our husbands so us being submissive starts right when we get married. When we get married, we do not continue to live in our parent's house, we go to him meaning he has got more power over us."	Our culture teaches married women to be submissive. Power dynamics between men and women change when they go from dating to married

We compared our reduced list of draft measures with existing validated measures identified in the literature review phase of this project (ICRW and MEASURE Evaluation, 2016). When appropriate we used or modified the existing measures to more accurately reflect the themes in our data; we reduced the measures so that SRH decision making and the selected resources had a subscale consisting of no more than 15 draft measures. (The draft measures will be further refined in the next phase of this study.)

Draft Measures of Reproductive Empowerment for Selected Domains

Because decision making is a standard measure for women's empowerment generally, we chose to make decision-making questions more specific to three decisions related to sex and reproduction: when to have children, using family planning, and initiating and negotiating sex. Many of our study participants felt husbands made the final decisions, but women wanted to have more say. In addition to measuring who has the most say over these items, we propose also asking women how they ideally would want the decisions to be made.

We recommend a full set of response options that reflect possible decision-making arrangements, and encourage exploration of what these mean in contextual settings. When it comes to empowerment, one cannot assume that sole decision making is preferable to joint decision making. Many women in the focus

groups wanted to make decisions jointly with their partners. This may depend on the woman's desire to share control, the structure of the household, and the power dimensions within the household. Not every decision we have chosen to ask about in the box below was discussed in the focus groups. We focused on questions about control over whom to marry, because that is a major decision in a woman's life and potentially indicative of the level of control she has in decision making (Table 3).

Table 3. Sexual and reproductive health decision making

The underlined bold [whether or not to use contraception] in this table can be replaced for other key SRH decisions, such as when to have sex, what method of contraception to use, when to have children, etc. (A full list of decisions that can be asked about is listed after the measures.)

Question	Response options
1. Who is involved in the decision about **[whether or not you use contraception]**?	☐ Myself alone ☐ Myself and my husband/partner ☐ My mother ☐ My father ☐ Father and mother together ☐ My husband/partner's parents ☐ My parents and my husband's parents together ☐ Another family member ☐ Other (specify): _____ ☐ Don't know ☐ *Refused to answer*
2. Which of the following best describes your role in the discussion about [**whether or not you use contraception]**?	☐ No role at all ☐ I was informed of decision, but not involved in making decision ☐ I was asked my opinion and gave it ☐ I gave my opinion, though was not asked for my thoughts ☐ I was involved in the decision but do not feel my opinion was valued ☐ We talked together and decided equally ☐ I made the final decision ☐ Other (specify): _____ ☐ Don't know ☐ *Refused to answer*
3. Who has the final say in **[whether or not you use contraception]**?	☐ Myself alone ☐ Myself and my husband/partner ☐ My mother ☐ My father ☐ Father and mother together ☐ My husband/partner's parents ☐ My parents and my husband's parents together ☐ Another family member ☐ Other (specify): _____ ☐ Don't know ☐ *Refused to answer*
4. If you disagreed with the decision about **whether or not you use contraception**, did you voice your opinion?	☐ No ☐ Yes ☐ *Refused to answer*

5. If your partner didn't want you to use contraception, but you wanted to use it, would you get it anyway?	☐ No ☐ Yes ☐ *Refused to answer*
6. If your partner didn't want you to use contraception, but you wanted to use it, could you get it anyway?	☐ No ☐ Yes ☐ *Refused to answer*
Response options for this question would be tailored based on the decision being discussed 7. When discussing **[whether or not you use contraception]**, I want to know about the influence you have in that discussion with your husband. Does he listen to your opinion and try to find the best solution for both of you, listen to your opinion but do what he wants, or not take your opinion into account?	☐ Listen to opinion and find best solution ☐ Listen but does what he wants ☐ Does not take my opinion into account ☐ We do not discuss whether to have children ☐ Other (specify): _____ ☐ *Refused to answer*

Study participants talked a great deal about social and gender norms and what was and was not permissible for women to do. In Tables 4–7 below, we adapted existing measures for social norms that look at what women do, what their peers do, and what women think they should do (Mackie, Moneti, Shakya, & Denny, 2015). Table 4 includes behavior, attitudes, and empirical and normative expectations on specific SRH topics.

Table 4. Sexual and reproductive health behavior, attitudes, and norms

(Response options, 5-point scale: "Strongly agree" to "Strongly disagree")
Individual behavior 1. I can go to the clinic whenever I want. 2. I can get contraception even if my partner didn't want me to. 3. I initiate sex whenever I want. 4. I can refuse sex if I don't want to have it. 5. I decide when to use family planning. 6. I decide whom to marry (date). **Personal attitude** 7. I think I should able to get contraception, even if my partner doesn't want me to. 8. I think I should be able to initiate sex whenever I want. 9. I think I should be able to refuse sex if I don't want to have it. 10. I think I should be able to decide when to use family planning. 11. I think I should be able to choose whom to marry (date). **Empirical expectations** *Instructions for respondent: For the following questions think of the women you are closest to who are about your same age. They could be friends or family members.* 12. Other women I know can decide when they want to use family planning. 13. Other women I know get contraception even when their partners don't want them to. 14. Other women I know can initiate sex with their partner. 15. Other women I know can refuse sex if they don't want to have it. 16. Other women I know decide whom to marry (date). **Normative expectations** *Instructions for respondent: For the following questions think of the people who greatly influence you in your life (such as your family, friends, neighbors, community members, and clergy).* 17. Other people think I should be able to decide when to use family planning. 18. Other people think I should be able to get contraception even when my partner doesn't want me to. 19. Other people think I should be able to initiate sex with my partner. 20. Other people think I should be able to refuse sex if I don't want to have it. 21. Other people think I should be able to decide whom to marry (date).

Participants consistently referenced the need for support from friends and family when it came to accessing contraception and resolving disagreements. For women especially, such support was viewed as one of the few ways women could exert influence over their partners. In Table 5, we list response options for getting support.

Table 5. Social support for sexual and reproductive health

(Response options, 5-point scale: "Strong agree" to "Strongly disagree")
1. I have friends or family who would help me access contraception without my partner knowing. 2. I have a friend or family member who could help me convince my partner to let me use contraception. 3. If my partner and I are having a disagreement within our marriage I have someone I can rely on to help me. 4. If my partner and I are having a major disagreement I have someone I can call on to help advocate for my perspective and resolve the issue 5. If my partner and I are having a disagreement within our marriage, there are resources in our community that could help us.

Mutual trust and mutual understanding also seem to influence women's agency. We chose to use several measures related to this that were used by Upadhyay, et al. in their Reproductive Autonomy Scale (Upadhyay, Dworkin, Weitz, & Foster, 2014). To measure relationship quality, we drew on the Emotional Intimacy Scale (Sinclair & Dowdy, 2005). Table 6 shows options for measuring partner communication.

Table 6. Partner communication

(Response options, 5-point scale: "Strong agree" to "Strongly disagree")
1. My partner and I have discussed using contraception. (response options "Yes" and No") 2. My partner and I have discussed how many children we want. 3. I am comfortable initiating conversations about contraception with my partner. 4. I don't have to have sex with my partner if I don't feel like it. 5. It is easier to get contraception in secret rather than try and discuss it with my partner.

Critical consciousness (CC) emerged as an important domain of RE in the focus groups. It wasn't as dominant as other themes we chose to highlight, but it is an area of great importance for measuring RE. Critical consciousness is broadly defined as "the capacity of oppressed or marginalized people to critically analyze their social and political conditions, endorsement of societal equality, and action to change perceived inequities" (Diemer, Rapa, Park, & Perry, 2014). We used the operational definition as: "Individuals able to observe and critique cultural and social norms around reproduction, conceptualize alternatives, and take action to change these norms."

We adapted a critical consciousness measurement scale (Diemer, et al., 2014) consisting of three subscales:

- Critical Reflection: Perceived inequality using a critical analysis of gendered constraints on opportunity
- Critical Reflection: Egalitarianism, namely the endorsement of groups being treated as equals
- Critical Action: Social or political participation in activities to change inequalities

These subscales were modified to include specific concepts that were discussed in the FGDs. Table 7 shows the adapted CC scale.

Table 7. Critical consciousness

Response options, 5-point scale: "Strong agree" to "Strongly disagree")
Critical Reflection. Perceived inequality: critical analysis of gendered constraints on opportunity
1. Our culture says men should have more control over when to have children than women. 2. Our culture says wives are their husband's property. 3. Our culture says women should get their husbands' consent if they want to use contraception. 4. Our culture teaches married women to be submissive. 5. Our culture teaches children to believe that boys are more important than girls.
Critical Reflection. Egalitarianism: endorsement of groups being treated as equals
6. Men and women should talk about using family planning. 7. Women should have the final say over getting contraception. 8. Men and women should decide together when to have children. 9. Men and women should decide together on how many children they should have. 10. Men and women should have the same educational opportunities. 11. Women should be taught to speak their minds. 12. Children should be taught that men and women are equal.
Critical Action. Sociopolitical participation in activities to change inequalities
In the past 12 months, have you:
13. Discussed the need for gender equality with friends or family? 14. Spoken to my family or friends about family planning? 15. Spoken to my family or friends about promoting women's rights?

DISCUSSION

Through this study we aimed to explore domains that may influence women's reproductive agency at the individual, immediate, and distant levels of the RE conceptual framework, and to develop measures grounded on this model. The direct quotes from women and men on their views about SRH and empowerment illustrate the validity and dependability of the study findings. The measures we have chosen to highlight do not encompass all aspects of RE; a range of factors interact to influence the level of agency women can have over their sexual and reproductive lives. However, many of these areas (such as relationship quality or access to quality healthcare services and SRH information) already have reliable and validated measures; hence we did not develop new measures for them. In this section, we discuss the findings from select domains of the conceptual framework that emerged from the FGDs.

Sexual and Reproductive Health Decision Making

Female and male participants explained that in many situations men are expected to be main decision makers, such as how many children to have and whether to use family planning methods or a method of choice. Participants in our study (similar to counterparts in other studies in sub-Saharan Africa) expressed perceptions that men are generally the decision makers because they are the breadwinners and traditional heads of the household (Bogale, Wondafrash, Tilahun, & Girma, 2011). Often participants attributed this expectation to patriarchal culture, which puts men in the domineering position and relegates women to subordinate status. However, there was not uniform agreement on this point, with some male and female participants saying that women have some control over making decisions.

Moreover, a woman simply participating in a decision-making process does not necessarily imply that this has been done in a meaningful way that reflects true empowerment. For example, a woman may have been included in communication about a decision, but have no real influence on the outcome. For these reasons, we focused on decision making about strategic life choices (whom to marry, whether to marry, whether to have children, how many children to have) that have direct and long-term implications for the life prospects of individuals and their overall RE.

The findings from this qualitative study have led us to reconsider how questions about decision making have been asked in prior health surveys such as the DHS. Participants in our FGDs discussed the decision-making process in less absolute terms than prior survey measures describe. Women in our study regarded husbands as the "final" decision maker but then found other ways to override his decision. This tells us we need to develop decision-making measures that consider other interpretations of the answers to questions about making "final" decisions. The lack of precision in wording of decision-making questions may help explain why previous work has found that women's empowerment measures that include decision-making items tend to have low reliability (Pulerwitz, Gortman, & DeJong, 2000; Bloom, Wypij, & Das Gupta, 2001). We agree with the recommendation from scholars about being cautious on determining whether joint or sole decision making on a given decision indicates empowerment, as this also depends on a women's situation and aspirations.

Covert Contraceptive Use

Our qualitative data support the findings from other studies showing that covert contraceptive use (CCU) is common among women in sub-Saharan Africa (Ajah, Dim, Ezegwui, Iyoke, & Ugwu, 2015; Baiden, Mensah, Akoto, Delvaux, & Appiah, 2016; Biddlecom & Fapohunda, 1998; Castle, Konate, Ulin, & Martin, 1999). One study found that CCU among women in Zambia accounts for 6 percent to 20 percent

of all current contraceptive use (Biddlecom, et al., 1998) and our research indicates it is still a fairly common practice.

In our study, we found that although participants agreed that men have the final say on using contraceptives and on the number of children to have, women in both Chipata and Lusaka said that women should and do use contraceptives in secret when their husbands do not approve of it. Several men in Chipata also recommended that women should use contraception discreetly if their husbands would not openly agree. Our study shows that men may have the final decision but women may take the final "action" to use contraceptives or not. Thus, many of our proposed measures ask about a woman's ability to get contraception herself, but do not phrase the questions in terms of decision making.

Covert contraceptive use has been linked to the degree to which women are able to exercise autonomy in their reproductive choices (Harrington, et al., 2016). On one hand, the need for CCU may indicate a woman's inability to freely exercise her reproductive rights. On the other hand, CCU may indicate that a woman is being resourceful and using her power to defy authority to meet her own reproductive needs. Initiating CCU is not an easy choice for women when they consider consequences such as marital mistrust and discord, partner violence, and divorce. Nevertheless, for many women, controlling when and if they have children is worth the risk.

Sexual Negotiation

Data from the ZDHS 2013 show that a large proportion of women in urban (79%) and rural (72%) areas can refuse sexual intercourse if they are tired or not in the mood. However, FGD participants agreed that control over sexual activity is difficult for married women, because they can neither initiate nor refuse sex with their husbands. Male and female FGD participants consistently referred to sex as central to marriage and one of a wife's core duties. Female participants perceived the act of refusing sex as being disrespectful to the husband and grounds for terminating the marriage. Although this was an area where married women didn't have much power, some FGD participants said that a woman should be able to communicate with her partner when she is too tired to have sex, so long as avoiding sex did not happen too often.

Social and Community Support and Influence

Throughout the FGDs, women and men talked about the influence and support of family and friends when negotiating important decisions such as using contraception. Women especially emphasized the need to call on family members *(Nkhoswe)* or friends to help influence their husbands. Because husbands are supposed to be dominant and make decisions, wives exerting their opinions and trying to convince them to alter a decision challenges the power dynamic. By calling on external resources to help persuade husbands, women are using their power, albeit indirectly.

Men and women recognized that accessing accurate information was an important step in the decision-making process around family planning. They discussed accessing formal resources in the community such as healthcare workers or peer educators. Many social behavior-change communication programs measure access to information and knowledge, but our data indicate it may also be important to look at how and if couples are able to access resources within their communities when making reproductive decisions.

Most standard measures currently look primarily at individual attitude and behavior questions without looking at a woman's perceptions of the attitudes and behaviors of her partner, family, and community (Heckert & Fabic, 2013). Because many countries in Africa tend to value social inclusion and community over the individual (Heckert, et al., 2013), it is important to look at the social context in which reproductive health decisions and negotiation happen. To fill this gap, CARE has developed *WE-MEASR: A Tool to Measure Women's Empowerment in Sexual, Reproductive, and Maternal Health Programs* (CARE, 2014), which includes several subscales to measure social capital. However, these measures ask about community support in times of crisis, but do not measure the role of social support when it comes to reproductive decision making and negotiation.

Partner Communication

Our study, similar to previous studies in Africa (Bawah, 2002; Feyisetan, 2000; Paek, Lee, Salmon, & Witte, 2008), found female and male participants agreed that couples' partner communications and relationship quality were important elements in their sexual and reproductive decision-making process. However, similar to other studies in Africa (Blanc, 2001), our study suggests that women who hide their practice of contraception from their husbands do so because they find the subject of contraceptive use difficult to bring up. If women perceived that their partners would not be open to communicating about contraceptive use and other SRH issues, it was considered normative among both male and female participants to not bring up the conversations. In some cases, however, participants who disagreed with CCU suggested that a wife should have an open conversation with her husband to convince him.

Critical Consciousness

The relationship between critical consciousness (CC) and empowerment literature indicates a strong theoretical link. Critical consciousness involves dialogue that goes beyond a simple discussion of personal opinions. It involves questioning the source, purpose, and potential uses of information and choosing between alternative theories based on evidence (Campbell & MacPhail, 2002; Diemer, et al., 2014). Our FGD questions were not designed to directly ask about CC. However, it was evident from some of the FGD comments that women were applying critical-thinking skills to reflect, dialogue, and find solutions to gender inequalities. One woman said:

> *I have a suggestion. This generation that we are in is growing up with the rules of the past generation; that the man cannot bathe a child, a woman needs to do this and that but we are going to build the next generation so we should. We should make changes. It is up to us to make sure the next generation is how we want it to be. To change the things we now see as unfair. (FG05CF).*

Despite scholars' focus on CC in new theoretical frameworks and the linkages of CC to empowerment at the individual, intermediate, and distant levels, the literature remains limited on which measures of CC capture the link with sexual and reproductive health outcomes (Campbell & MacPhail, 2002).

Limitations

The findings from this study have some limitations:

- Because of ethical considerations, our findings do not include the perspective of unmarried young girls (age 15–17) who may be sexually active but are trying to avoid pregnancy. Therefore, further exploration may be needed when developing RE measures for this group.

- Four of the FGDs included women who were currently in post-secondary education. These groups may have included an over representation of women with university-level education.
- Data collection covered only two regions in Zambia; therefore, the views reflected in the data may not apply to other regions of the country, such as the Copperbelt Province where there is a high prevalence of early child marriage and polygamy (Zambia Ministry of Health, 2015).
- Men in urban Lusaka were not interviewed thus we could not compare that demographic with men in rural Chipata to see if they have different views.
- Some participants may have provided socially desirable answers, as they did not want to criticize their own practice or that of their friends. The moderators tried to offset this bias by reassuring the participants that confidentiality would be maintained and that their participation in this study would not affect access to any health or social services.

Recommendations and Next Steps

The findings from this study led to the development of a list of draft measures of RE that are focused on SRH decision making, partner communication, social norms, social support, and critical consciousness. These draft measures require a thorough validation process starting with a content review by experts in the field of gender, global reproductive health, empowerment, and measurement. The content reviewers' comments indicate a need for cognitive testing of the face validity of the measures in another sub-Saharan country to explore whether the domains of RE that were common in Zambia are applicable in another context. The cognitive interview process will help narrow the list of the standard measures of RE. These measures should be made available to researchers and program evaluators to use as part of standard surveys or evaluations to better understand RE and its relationship to health outcomes among women in sub-Saharan Africa.

In addition to the measures, our findings illustrate some important themes that could have implications for family planning and RE programs. Specific implications for family planning programs are in Table 8.

Table 8. Family planning program implications

1. Use communication programs that foster spousal interaction to facilitate satisfaction of both partners' unmet need. The relevance of spousal discussions of family planning issues is reinforced by our FGD findings. Where men and women experience substantial unmet need and discrepancies occur between spouses' levels of unmet need, husband-wife communication may lead to significant increases in contraceptive use.
2. Provide both couples and unmarried youth with information on healthy timing and spacing of pregnancies (HTSP), promoting shared reproductive decision making. Couples and unmarried youth would benefit from information on partner communication skill, especially related to decision making and negotiation of fertility intentions and family planning use throughout the life course, which, in turn, may help decrease covert contraceptive use.
3. Encourage male involvement (as clients, partners, and agents of change) in family planning clinics. Engaging men at an early age can have long-term benefits. Men can participate in family planning clinics not only to accompany their sexual partners, but also as active clients of family planning services and advocates for their partners. While encouraging gender-accommodating interventions, we must caution programmers to ensure that these interventions do not lead to negative unintended consequences, such as allowing married women who bring their partners to a family planning visit to be seen automatically before unmarried women or before other married women who are not with their husbands. This may be perceived as unfair treatment of unmarried women.
4. Enlist formal community institutions as well as traditional social support structures to challenge gendered power dynamics. Neighborhood health committees and other community-based entities not only need to inform people about contraceptive choices and the importance of child-spacing but also to be influential advocates when it comes to challenging gendered power dynamics and encouraging partner communication.
5. Emphasize the role played by *Nkhoswes* (go-betweens) in supporting couples. *Nkhoswes* are highly respected and listened to by married couples; however, they are not specifically included in family planning programs, because generally they are elders of couples and likely fall outside the reproductive age group. Programs can benefit from the role of the *Nkhoswes* to communicate the importance of couple communication and shared decision making prior to marriage and reinforce the importance of both during marriage.
6. Pilot programs could emphasize positive partner communication and family planning in the training process. This is also an opportunity to engage *Nkhoswes* in providing information geared toward changing norms, attitudes, and ideas about the roles of men and women (e.g., male engagement and support for family planning).
7. Train family planning providers on counseling and services tailored for clients according to their life courses. For example, a client who recently got married and wants to delay having children for a few years has different family planning needs than a client who has reached her total desired number of children. At a minimum, family planning providers can counsel on appropriate contraception for clients who want to (1) delay the start of childbearing; (2) control the interval between successive births; or (3) stop childbearing altogether. Consider providing youth-friendly and gender-sensitive services that take couple dynamics into account.

CONCLUSION

This qualitative study provides insight into other dimensions of RE, such as levels of resources and agency, expressions of empowerment, and what that process manifests among the sample of men and women in our focus groups. Our findings show that a range of factors (such as gender and cultural norms, social and community support, couple communication, and an individual's critical consciousness) plays an important role in whether a woman has reproductive agency.

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APPENDIX A. FOCUS GROUP GUIDE SAMPLE

Reproductive Empowerment FGD Guide

Women ages 25-49

Introductions

Welcome. Thank you for being here. My name is _____ and I work with _____. As we explained during the informed consent process, we are trying to understand the women's attitudes, perceptions, and experiences when trying to make various types of decisions. We are especially interested in women's choices and decision-making around things like the number of children to have and avoiding pregnancy. The information you provide will be used to eventually improve health programs for women. We will not use your names or otherwise identify you personally in the analysis and reporting of the results of our discussion today.

Ground Rules

We encourage everyone to participate, knowing there are no right or wrong answers. Speak up if you agree or disagree with someone, as we want to understand everyone's experiences and opinions. We will record this discussion to help us capture everything we need for the analysis and summary, but we will not identify you personally. Does everyone agree to record this discussion? This discussion will probably take about an hour. Do you have any questions before we get started?

Icebreaker: If you could visit any place in Zambia, or in the world, where would you go and why?

FOCUS GROUP QUESTIONS

INTRO: In our discussion today, I'd like you to think about relationships that other women your age have with their husbands and boyfriends; their family members; health service providers, and other people in their community.

I. Communication with spouse about contraceptive use

First, I'd like to get your opinions about this fictional story: Amara is 30 years old from [**say the name city of FGD]**. She and her husband of 10 years have 4 children together. The eldest is 9 years old and the youngest is 2 months. She does not want any more children, but she thinks her husband wants more. She has learned from one of her sisters that the town clinic offers different types of contraception. She wants to find out more information from the clinic, but it is only open on Wednesdays and Fridays, both days that her husband stays home. What do you think about these issues and problems that Amara is facing? (Domains: communication; decision-making; autonomy. Levels: individual; relational)

Probes

1.1 What can Amara do to convince her husband to not have any more children? How probable is it that Amara and her husband can come to an agreement about whether or not to have more children, and whether or not to use contraception? What might that agreement look like?

1.2 What choices are available to Amara so that she does not have to have more children? Is she able to act on these choices? If so, how? If not, why not?

1.3 Are there other people in the family or community that would be part of helping to make that decision? What would they say or do? Who would make the final decision about whether or not to have more children? Who would make the final decision about whether or not to use contraception?

1.4 In your opinion, who should make the final decision about whether or not to have more children? Whether or not to use contraception? Is this usually how it happens? If not, why not?

1. 5 What do you think might happen if Amara and her husband do not come to an agreement, and Amara decides to use contraception without her husband knowing? *If they say she wouldn't use contraception* --- are there any women who would go ahead and use contraception in this situation? How do you think they are different from Amara? *If they say she would just use it* --- are there women who would not use it, how are they different from Amara (probe: open communication, shared decision making, works and contributes to family incomes, greater education, etc.).

II. **Sexual negotiating**

Now I'd like to talk about another issue Amara faces from time to time. Amara works many hours every day farming and selling things in the market. When she is not busy with these things, she also tailors clothing for people in her area. Between this work and cooking meals and taking care of the children, Amara is usually very tired at night. Frequently when they go to bed her husband wants to have sex but she is so tired that she would rather not. What is likely to happen at these times? Think of how women you know in your community. How would they handle this situation? (Domains: communication; relationship control/sexual power dynamics. Level: individual; relational)

Probes

2.1 Would Amara have sex with her husband, or refuse to have sex?

2.2. If Amara did not want to have sex, how would she tell her husband that? If she refused to have sex with him, what would happen?

2.3 What if she decided to just have sex, why might she have done that? Are there some women who usually just give in? How might they be different from women who usually or sometimes refuse sex when they are just too tired?

2.4. What about if Amara was not tired, but she just didn't want to have sex because she did not feel like it. How might that situation look different from if she did not want to have sex because she was tired?

2.5 If it was frequently the case that Amara did not want to have sex when her husband did, is there anything she could do about this?

III. Obtaining contraception against husband's will

Now I'd like to talk about another scenario. Amara decided to go to the clinic and get contraception, even though her husband does not agree. Her husband finds out somehow. He is angry that Amara got contraception without his approval and beats her. This is not the first time he has beat her. What do you think about this? (Domains: self-efficacy; autonomy; relationship control; coercion. Levels: individual; relational; enabling environment)

Probes

3.1 Who do you think is wrong in this situation – Amara or her husband or both of them? Is one more wrong that the other?
3.2 What else could Amara have done, rather than going to the clinic secretly? What else could Amara's husband have done, rather than beating her? How many people do you think do this differently (not as Amara and her husband did)? Other than doing things differently, what makes them different from Amara and her husband?
3.3 Is there anyone who could help Amara? Is there anyone who should help Amara? [If they don't offer any of these response, ask] Anyone in Amara's family? Her friends? Religious leaders? In a nearby health clinic? How can they help her?
3.4 Is there anyone who could help Amara's husband? Is there anyone who should help Amara's husband? Family? Friends? Religious leaders? Health service providers? How can they help him? Are there people who don't have this kind of help? Why not, what makes them different?

IV. Family planning by couple

Say Amara and her husband live in this community. They have decided they do not want any more children and they want to use contraception to avoid pregnancy. Amara goes to the local health clinic – the same one you and your friends might use - to find out more information about contraception. She meets with a nurse there to talk about family planning. What do you think would be Amara's experience during this visit? (Domains: decision-making power; autonomy. Levels: individual; enabling environment)

Probes

4.1 What kind of family planning services does this clinic offer? What types of contraception does the nurse suggest? (If not mentioned, would the nurse mention tubal ligation or vasectomy?)
4.2 How does the nurse interact with Amara? How much time would the nurse spend with her? What type of information would the nurse give Amara about contraception and family planning? Would Amara get enough information from the nurse so she would feel that she could make a decision about family planning herself? If not, what other type(s) information might help Amara make a decision about family planning?
4.3 How would the nurse treat Amara? Would the nurse treat Amara differently if Amara came alone compared to if Amara came with her husband? How? Or if Amara had fewer children?
4.4 If at the end of her visit Amara received birth control pills, is it likely because Amara herself chose to use pills, or because the nurse decided that pills were the best of form of contraception? Or, would it be a joint decision?

V. Availability and quality of family planning services

Now I'd like to learn more about what you hear about family planning in your town/community, but outside of the clinic setting. Now, tell me about the information and messages you hear in your town/community?

Probes
5.1 Where do you get most of your information about family planning and contraceptives? From family? Friends? Television ads? Billboards? Radio? Internet?
5.2 What types of messages and information do you get from these various people and places?
5.3 Do these messages make sense to you? Is there any information you hear that you find confusing? Any information you get that leave you with more questions?
5.4 Do you hear conflicting information and messages about family planning and contraceptives? From where do you hear these conflicting information, and what are they?
Is this information and these messages helpful for you in your own life? How? Are they helpful for you in making decisions, or learning new things you did not know before?

We've come to the end of my questions. Do any of you have anything more you'd like to discuss?

Closing

Thank you very much for your time and sharing your knowledge and opinions. The information you have provided will help people throughout Zambia and other countries to improve family planning programs. As a reminder, we will not share the discussion recordings with anyone outside the study team and you will not be identified in any results we share with others. We appreciate your participating in the discussion today.

APPENDIX B. CODEBOOK FOR FOCUS GROUPS

Code	Definition	Example
Parent code: Individual resources		
SRH knowledge/ education	Demonstrating knowledge of sexual and reproductive health issues including the biology of reproduction, fertility awareness, body literacy, methods of contraception as a personal resource.	
Health	Includes both physical and mental health, good or bad, that may facilitate or inhibit a woman's reproductive empowerment.	
Education	Any mention of a woman's education level impacting how she negotiates sexual and reproductive conversations.	
SRH self-efficacy	Belief that you have the ability to succeed at a given task related to SRH, including negotiating sex or contraceptive use.	
Self-esteem/self-confidence	Perceptions of worth and abilities	
Critical consciousness	Individuals able to observe and critique cultural and social norms around reproduction and conceptualize alternatives to these (1)	
Interpersonal power	The capacity or ability to direct or influence one's intimate partner.	
• Negotiation skills - contraception	Direct approaches used by the woman with husband to come to a mutually agreeable solution for child spacing and use of contraception. A woman calling on family/friends to assist in discussions with her husband, but not when he calls on others to persuade her.	
• Negotiation skills – sex	Direct approaches used by women to settle differences in determining when to have sex. A woman calling on family or friends to assist in discussions with her husband, but not when he calls on people to persuade her.	
Secrecy/discretion	Women hiding the truth or not being completely honest or open with partner about contraception or sex. Including making up reasons to go to the clinic, using friends to help hide contraception from partner, faking sickness to avoid sex.	
Decisional balance	The *process* of weighing the pros and cons of a given situation related to a woman's own sexual and reproductive health including sex or contraception.	
Sexuality	The way a person goes about expressing or experiencing himself or herself as a sexual being. Includes mentions of sex for pleasure, the need for sex not for procreation, feeling sexy desirable.	
Recognition of rights	Explicit mentioning of her own rights as a woman, perception of rights that belong to her, choice about her body.	
Parent code: Immediate Relational resources (relationship characteristics)		
Emotional intimacy with spouse/partner	Characteristics of the relationship including perception of closeness to another that involves mutual transparency, trust, understanding, and	

	respect, which allows sharing of personal feelings accompanied by expectations of understanding, affirmation, and demonstrations of caring.[6]
SRH Communication	Positive or negative conversation between intimate partners about sexual and reproductive health issues.
Bodily integrity	Value, respect, and protection of another person's physical body, including mentions of gender-based violence.
Gender-based violence	Various kinds of violence against women/girls.
Social support and influence	Role of social influencers such close friends or family, *Nkhoswe*, where they assist in facilitating negotiations, sensitizing partners, counseling the couple, or getting access to care.
Community institutional suppor	Community-based institutions such as Neighborhood Health Committees, Police, church, clinics, peer educators, etc. that couples can call on for support or help in discussions
Parent code: Distant relational	
Health system culture	Explanations of what happens at clinics, interactions with healthcare personnel including perceptions of quality
Gender norms	Rules of what men and women should do and how they should act, including roles within marriage, sex, reproduction.
Responsibility for children	Who takes care of the children and why
Social/cultural (non-gender) Norms	Rules of behavior that are considered acceptable within a given society, influenced by culture, tradition, etc.
Access to information and services	Availability of and access to products, services, information of SRH
Parent code: Decision making	
Reasons for refusing sex	Any responses such as (but not limited to) Had a baby, period, sickness, STDs, cheating, child sickness, husband or wife tired, including explanations for answers.
SRH decision making	The ability of the individual to meaningfully engage in the process through decisions about reproductive health are made within a given relationship[1] Including doing what they want without support from partners.
Deciding to have sex	Descriptions of who and when sex is initiated
Final decision: contraception and childbearing	Who makes the final decision as to whether (or not) a woman uses contraception.
Consequences: Refusing sex	Effects experienced by a woman because of refusing to have sex with her partner
Consequences: Contraception	Effects experienced by a woman as a result of using birth control without permission from her partner.

[6] Adapted from Sinclair, V.G. & Dowdy, S.W. (2005). Development and validation of the Emotional Intimacy Scale. *Journal of Nursing Measurement*, 13(3):193–206.

APPENDIX C. FOCUS GROUP CHARACTERISTICS

FGD ID	Location	Children	Age group	Gender	Currently in school
FG01CF	Chipata	Yes	25-49	Female	No
FG02CF	Chipata	Yes	18-24	Female	No
FG03CF	Chipata	Yes	15-17	Female	No
FG04CF	Chipata	Yes	18-24	Female	No
FG05CF	Chipata	No	18-24	Female	Yes
FG01CM	Chipata	No	18-24	Male	No
FG02CM	Chipata	Yes	25-59	Male	No
FG03CM	Chipata	Yes	18-24	Male	No
FG04CM	Chipata	No	25-59	Male	No
FG01LF	Lusaka	Yes	25-49	Female	No
FG02LF	Lusaka	No	18-24	Female	Yes
FG03LF	Lusaka	Yes	18-24	Female	Yes
FG04LF	Lusaka	Yes	15-17	Female	No
FG05LF	Lusaka	No	25-49	Female	Yes

APPENDIX D. FOCUS GROUP PARTICIPANT DEMOGRAPHICS, BY GENDER

	Women		Men		Total	
	n	(%)	n	(%)	n	(%)
Total participants	84	(77)	25	(23)	109	
Median age (min, max)	23 (16-46)		24 (18-56)		23 (16,56)	
Location						
Chipata	37	(44)	25	(100)	62	(57)
Lusaka	47	(56)			47	(43)
Level of education						
None	0	(0)	2	(8)	2	(2)
Partial primary	26	(31)	13	(52)	39	(36)
Completed primary	5	(6)	0	(0)	5	(5)
Partial secondary	21	(25)	9	(36)	30	(28)
Completed secondary	5	(6)	0	(0)	5	(5)
Partial post-secondary	27	(32)	0	(0)	27	(25)
NA	0	(0)	1	(4)	1	(1)
Currently in school						
Yes	29	(35)	1	(4)	30	(28)
No	55	(65)	24	(96)	79	(72)
Relationship status						
Married/steady partner	81	(96)	16	(64)	97	(89)
Dating/no steady partner	3	(4)	8	(32)	11	(10)
NA	0	(0)	1	(4)	1	(1)
Number of children						
0	28	(33)	14	(56)	42	(39)
1	30	(36)	4	(16)		(0)
2	10	(12)	1	(4)	11	(10)
3	7	(8)	0	(0)	7	(6)
4	3	(4)	2	(8)		(0)
5 or more	6	(7)	3	(12)	9	(8)
NA	0	(0)	1	(4)	1	(1)
Are you currently pregnant? *						
Yes	7	(8)			7	(6)
No	77	(92)			77	(71)

Used birth control in the past 5 years						
Yes	53	(63)	17	(68)	70	(64)
No	31	(37)	8	(32)	39	(36)
*** Women only**						

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