TITLE : LOW UTILISATION OF FAMILY PLANNING SERVICES AMONG MEN IN ZAMBIA

BY

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STATEMENT

I hereby certify that this study is in all entirety, the fruit of my own independent and laborious investigations. The various sources to which I am indebted are gratefully acknowledged in the text and in the references.

SIGNED BY:.....
(Student)

DECLARATION

I hereby declare that the work presented in this study for the Master in Public Health has not been presented either wholly or in part for any other Master in Public Health Degree and is not being currently submitted for any other Degree.

SIGNED:..... DATE: 19/3/98
(Student)

SIGNED:..... DATE: 20/03/98
(Supervising Lecturer)

DEDICATION

This study is whole heartedly dedicated to Mr. C. Kapungwe, a dear brother and friend who gave me the encouragement needed and did not grow weary in praying for me; my parents and all my family members for their love and support; the mighty women and men of valour for their prayers and care.

"God did it all for me." PTL

APPROVAL

This dissertation of MISS IRENE MUONGA MUSHINGE is approved in partial fulfilment of the requirements for the award of the Degree in Master of Public Health by the University of Zambia.

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ABSTRACT

Family planning programs have long been recognized for their importance in improving the health of women and children and in reducing population growth rates. However, Zambia like many other African countries has lagged behind other world regions in the adoption and expansion of family planning. Given the critical role that African men play in family decisions, men`s support and involvement are essential for family planning to become more widespread(Roudi.F and Ashford. L, 1996).

This paper has identified factors contributing to low utilisation of family planning among men in Zambia. It discusses findings from male respondents, health workers and participants of the focus group discussion.

A total number of 181 men were interviewed on the Copperbelt Province of Zambia. Three Companies having a large men population, such as ZCCM, were conveniently selected for the study. The main market of Kitwe District was also used for the focus group discussion with 10 men.

To supplement the findings of the study, a second sample of 27 health workers, fully involved in family planning, was obtained from systematically selected health institutions within the same Province.

The overall total sample for the study was therefore 218. The study was conducted from December 1996 to February 1997, with the help of three male nurses in data collection. A self administered questionnaire for health workers and an interview schedule for the men were used as data collection tools.

Key findings include:-

* men`s knowledge about the available male family planning methods is reasonably high except for vasectomy.
* A gap however, does exist between Zambian men's knowledge of family planning and their practice.
* Men do not seem to accept comfortably the available male methods in terms of their effectiveness.
* Accessibility to the male methods is one of the factors contributing to low levels of use of family planning among men.
* *The family planning clinics are still female oriented with almost nothing in place to attract men. Generally family planning services are being offered through maternal and child health care providers, by passing men`s involvement.
* Men who use modern family planning methods rely to a greater extent on their wives and the methods. Condom use is high, possibly due to the AIDS epidemic, but vasectomy is almost non existent.

* There seems to be some communication between husband and wife, this may increase the utilisation rate of male family planning in future.

There is need for policy makers and programme planners to give increased attention to include men in counselling services, and Information Education and Communication (I.E.C.) programmes. Most men hold positions of leadership and influence from the family unit up to the national level.Their involvement in family planning therefore would not only ease the responsibility borne by women in terms of decision-making for family planning matters, but would also accelerate the understanding and practice of family planning in general.

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LIST OF ABBREVIATIONS

1.	UNFPA	-	United Nations Population Fund
2.	M.P.H.	-	Master in Public Health
3.	U.T.H.	-	University Teaching Hospital
4.	I.E.C.	-	Information, Education and Communication
5.	M.C.H.	-	Maternal Child Health
6.	S.T.D.	-	Sexual Transmitted Disease
7.	G.R.Z.	-	Government of the Republic of Zambia
8.	M.O.H.	-	Ministry of Health
9.	C.H.N.	-	Community Health Nurses
10.	F.P.	-	Family Planning
11.	AIDS	-	Acquired Immune Deficiency Syndrome
12.	P.P.A.Z.	-	Planned Parenthood Association of Zambia
13.	W.H.O.	-	World Health Organisation
14.	I.U.D.	-	Intra Uterine Device
15.	Z.C.C.M.	-	Zambia Consolidated Copper Mining
16.	F.G.D.	-	Focus Group Discussion

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

In 1984, the now Ministry of Planning and Development Co-operation of Zambia, was given a mandate by the Government to initiate a draft population policy which would aim at achieving a population growth rate consistent with the growth of the economy of the country.

This mandate came about as a result of the 1980 population and housing census report which revealed a rapid population growth rate and the implied adverse effect on development and individual welfare.

The Zambia National Population Policy was formally launched in 1989 with the ultimate objective to improve the standard of living and quality of life of all Zambians targeting at:

(a) reducing the rate of population growth from 3.7% per annum in 1989 to 3.4% per annum by the year 2000 and to 2.5% by the year 2015.

(b) reducing the infant mortality rate from 97 per 1000 live births to 65 per 1000 live births by the year 2000 and 50 by the year 2015.

(c) reducing the total fertility rate from 7.2 to 6 by the year 2000 and to 4 by the year 2015.

(d) to make family planning services available, accessible and affordable by at least 30% of all adults in need of such services by the year 2000 (Gaise et al, 1993).

In Zambia, from 1989 to date, family planning services are being provided as part of the Maternal and child health services(M.C.H.),in health centres and Hospital out-patient clinics. These services include: counselling and giving information on various methods of family planning for both Women and men, screening for other Health problems like sexually transmitted diseases (S.T.D.) and distributing the actual family planning items according to the client's choice. They are given free and on demand.

Until recently, however, the trend in the delivery of family planning services was directed toward women. Piotrow et al(1992) pointed out that until 1988 the family planning programme in Zimbabwe focused almost exclusively on women. They went on to say that little attention was given to the role of men in family planning and few promotional activities were specifically directed toward men. This female bias in family planning is quite evident in many African countries today, Zambia included.

Culturally, in Zambia, men are poweful decision makers in the family and community regarding family planning and other family related issues. Only the few educated women or those from top and middle social classes may have a say.

The country's population also continues to grow due to the increase in family sizes. This coupled with high inflation and poverty, creates a vicious cycle which can only be broken if both men and women were actively involved in family planning.

1.2 STATEMENT OF THE PROBLEM

Globally men have not shared equally with women the responsibility for fertility regulation (Ringheim. K. 1993). Being an essential health service benefiting the individual, family, community and the nation as a whole, family planning should be given the attention it deserves by both men and women.

Current studies concerning the knowledge, attitude and practices in family planning among men in Africa have shown a positive attitude towards Family Planning Services. Mbizvo M.T. and Adamchak D.J (1991), for example, demonstrated in their study that male knowledge of various family planning methods was high, as well as their approval of family planning.

Piotrow et al (1992) also stated that recent surveys have shown that male approval of family planning in Africa has increased, especially for spacing births, indicating the need to reach men with family planning information. Despite the above statements, however, there are very few Countries, where fertility regulation is shared equally by men and women.

In countries outside Asia, for instance, the prevalence of female sterilisation far exceeds that of male sterilisation, even though vasectomy is a significant factor in fertility control in South Korea and China (Mbizvo M.T. and Adamchak D.J., 1991).

A similar trend was observed among the majority of men surveyed by Ringhein. K.(1993). These men expressed the belief that men should assume or share the responsibility for birth control with their wives, but a far smaller proportion does so.

Other studies have shown that the prevalence rate of use of family planning services among men is still low. A study conducted by Mayondi P.(1991) in Zambia revealed that only 5 men had had a vasectomy in 1990 at the University Teaching Hospital (U.T.H.), the largest referal Hospital in the Country. The figure did not change in 1995 with only 5 cases of vasectomy reported for that year(U.T.H,1995).

One wonders therefore, why the prevalence rate should remain low when other studies have reported a high knowledge and positive attitude towards family planning in men?

The advantages of family planning can not be over emphasized, these include, reduction in the risks associated with fetal death, birth defects, infant mortality, maternal mortality and a more relaxed sexual relation between men and women when they are confident that intercourse will not lead to unwanted or ill-timed pregnancies (Ministry of Health, 1990).

For the above advantages to be appreciated, men have to be actively involved in family planning.

It is a well known fact that in many parts of Africa, men often make decisions about family planning and family size even when their wives desire no more children. Policy and programme efforts that exclude men lessen the likelihood that men will perceive the potential benefits of family planning for themselves or their families(Ringheim. K, 1993).

In view of the above discussion, the researcher proposes to identify the factors contributing to the low prevalence use of Family Planning Services by men in Zambia.

It is hoped that the findings from this study will be useful to all the organisations engaged in family planning services, in formulating strategies that target both women and men infertility regulation.

1.3 LITERATURE REVIEW

A review of the literature has shown that there have been few research studies done to identify factors contributing to low utilisation of family planning service by male clients.

This made it almost impossible to find literature on the subject related to Zambia. However, there is some literature on studies done in other countries like Zimbabwe, Uganda, Kenya, India and other Western Countries.

In the literature reviewed, almost all authors appear to support an increased emphasis on male involvement as a step forward in implementing family planning services successfully.

Family Planning is important in improving the living standards and quality of life of every individual, family or community. It can be defined as a decision made by a couple or an individual on the number of children they want, how to space the children, when to start a family and when to stop (M.O.H. 1990).

The Zambian Government has recognised fully the need for Family Planning to reduce the population growth rate to 3.2 percent annually. At such a rate, the population of Zambia (current 9.8 million), is projected to approach 12 million by the year 2000 and 21 million by 2025 (Francine et al, 1996).

In an address to the Nation on World Population Day in 1995, President Chiluba noted that "Negative impact of past increases in size and growth rate of our population on the Government's ability to maintain, not to mention improve upon, the existing living standard and quality life of our people is self-evident." He further stated that," while the Government does acknowledge, and will continue to promote the fundamental right of every Zambian to decide freely and responsibly the number and spacing of children, [W] shall also encourage our people to consider the negative and other implications for our children and their mothers of very early child bearing, of too closely spaced births, and of having too many children."

For the purpose of an orderly presentation of literature review, the literature has been organised and is presented using the following categories:-

(a) Importance of male involvement in family planning.

(b) Factors affecting male utilisation of family planning services:

I. Health provider factors

ii. Health service factors

iii. Client factors

(c) Possible solutions.

A. IMPORTANCE OF MALE INVOLVEMENT IN FAMILY PLANNING

Male involvement in family planning will go a long way in achieving the targets of the National population policy as well as in the implementation of effective family planning services. Fayorsey (1989) has pointed out the importance of African men in making decisions about family size, in giving their wives permission to use contraceptives, in obtaining contraceptive supplies (especially condoms) and in initiating the use of traditional methods such as withdrawal and rhythm. He also argues that increasing male involvement in family planning will not detract from efforts to improve the status of women, because, in the long run, doing so may lead to enhanced communication within marriages and more equality in decision making for women.

The decision was made early in many developing countries to target women in the promotion of family planning, such as pragmatic emphasis on effective female methods and the cost effectiveness of targetting only one partner.

This decision failed to take into account that men frequently hold the contraceptive decision making power, even when their wives desire no more children. Policy and program efforts that exclude men lessen the likelihood that men will perceive the potential benefits of family planning (Ringheim, K. 1993).

A study on the men's role in family planning and the extent to which couples agree on fertility issues such as contraceptive use,revealed that men initiated most major fertility and reproductive decisions, including use of contraceptives. The results also indicated that the adoption as well as the successful use of contraceptive within marriages depend largely on the man's desire to stop child-bearing. The study concluded that men should be targetted by the Government family planning programme in order to increase contraceptive use (Khana j. et al, 1994).

Where men are not utilising the available family planning methods or being taught how to use the male dependant contraceptive methods to improve their effectiveness, for example the withdrawal method, periodic abstinence, it may result in them feeling that the responsibility of planning their families rests in their wives.

This may lead to women being blamed for unwanted pregnancies in the family or barreness because of their previous use of family planning methods. These misunderstandings can lead to marital break down (Mayondi.p,1990).

Although family planning professionals in Zambia recognise the need to involve men in decision making to a greater degree than has been done in the past, little is known about men's knowledge, attitudes and practices with regard to family planning (Francine et al,1996).However with the difficulties in supporting large families in a period of economic crisis, family planning specialists anticipate an increase in male support of contraceptive use (Chirambo. K, 1992).

B. FACTORS AFFECTING MALE UTILISATION OF FAMILY PLANNING SERVICES

Health Provider Factors

Studies have shown that limited knowledge of and skills in providing family planning services can have a negative effect on contraceptive prevalence (Francine et al, 1996).

The Ministry of Health also acknowledges that service providers are not qualified to counsel potential clients and that they rarely ask their clients what their family planning needs and concerns are (M.O.H. 1989).

A report of community health nurses (CHN) and family planning services for men (1990) revealed that among the two thirds of the nurses who worked with men in their reproductive years, only 17.8% delivered or administered family planning services to men despite having positive attitudes toward male family planning and their belief that family planning providers have a responsibility to provide services to men.

Increased educational preparation may improve CHN'S knowledge about men and family planning and enable them to feel professionally prepared to deliver and administer the services they feel are necessary for male as well as female clients (Swanson et al, 1990).

Health Care Service Factors

In many Countries, Zambia included, family planning clinics are seen as places for women and children to go, and men may find it difficult to enter them. A recent study found that Ugandan men were less embarrassed to obtain condoms from a Pharmacy than from a family planning clinic (Kirumira, 1991).

Family Planning clinics may have to adopt strategies to attract men, for example, by offering special hours, if male methods are to have fair exposure (Population Reports, 1986).

Clinics devoted exclusively to family planning services and home visits by single-purpose family planning workers can cause embarrassment. In such situations, family planning and contraceptive services integrated with other health services are preferable, since they preserve the "anonymity" of the client (W.H.O., 1992).

Integration of family planning services with other MCH activities, a stated objective of the Zambian Government, has not yet been achieved. This is primarily due to the relatively low prestige given to family planning issues among many Ministry of Health personnel (M.O.H, 1995).

On the other hand, numerous studies have shown that low prevalence of use of any method for men does not necessarily mean that men have unfavourable attitudes towards family planning, a number of factors may be responsible, for example, family planning centres are frequently staffed by women, who may be biased by training and tradition to focus on female methods (Posner and Mbodji, 1989).

Family Planning is concerned with the quality of life of the family group and thus contributes to economic and social development. It should not be pursued in isolation but should be combined with a number of other MCH measures whose objective is to improve the health of the family (W.H.O., 1990).

It is also assumed that condoms appear to be a popular male method partly due to the ease with which they can be obtained from barbers, chemists, supermarkets and family planning clinics and the fact that they provide some protection from Sexually Transmitted Diseases (STD'S) (Cowper and Young, 1989)

Client Factors Affecting utilisation of Family Planning Services.

Acceptance of Family Planning Services has been occuring at a very slow pace in Africa. It was generally believed that the African male, due to his conservatism, was an obstacle to the acceptance and use of contraception by, his female partner. Chipfakacha's study (1993), however, showed that the attitude of the African male towards contraception has changed drastically during the last thirty years, from ultra-conservatism during the 60s to very liberal in the 80s and 90s.

Mayondi's study (1990), has also shown that in Lusaka, Zambian men are willing to participate in planning their families and may only require motivation.

It is important therefore to conduct research on how to attract the attention of men who are not currently motivated to regulate fertility or who are content with leaving birth control up to their partners. (Posner and Mbodji, 1989).

Other client factors affecting low utilisation of family planning services result from religious, moral and social convictions of the couple and of the society in which they live (Kleinman, 1967).

Cowper and Young(1989) showed that it was difficult to convince some people that controlling family size is an advantage when they receive child allowances, housing improvements and the pleasure of having a large loving family in their old age.

There is also evidence that employment, educational attainment and other socio-economic characteristics greatly influence the ability of women to participate actively in decisions about child bearing.

However relations between men and women vary considerably from culture to culture, as does reproductive behaviour, and these issues must be explored with great attention in the social context. While focussing on factors that improve women's status is important, the role of men in fertility decisions can not be ignored (Khama et al, 1994).

Lack of knowledge about male methods of family planning may be another client factor. In Mayondi's study (1990), it was revealed that some men did not know of family planning methods for men, while others felt it was their wives' responsibility to attend family planning clinics.

C. POSSIBLE SOLUTIONS

In view of the importance of family planning, maximum efforts should be made to motivate couples towards the acceptance of various methods of family planning (Kleinman, 1967).

To improve family planning service provision, Siamwiza (1989) recommends the following steps: upgrading in-service programmes, enhancing service providers' counselling skills, developing and maintaining a health information system, using service monitoring tools and coordinating communication interventions.

Other studies have also identified additional aspects that can be looked into to effectively implement family planning services, such as, the need for innovatory management, staff training in attitude, motivation and counselling skills, clinic hours of operation, educating clients on possible side effects and post-partum contraception, and male involvement in family practice (PPAZ, 1993).

In Zimbabwe (1987-1994), the national family planning council put on weekly radio and dramas to address men about family planning. They found that men often made decisions about family planning and family size and that men wanted more information about family planning (Population Reports, 1992).

To maximize and sustain the impact on health programs and strengthen gains in contraceptive use, Zambia will need to:

1. Increase and coordinate Information, Education and Communication (IEC) activities for family planning and health.
2. Emphasize institutional and human resource capacity building at both the National and local levels.
3. Involve men and young people, as well as women, in culturally appropriate ways (Francine et al, 1996).

The need for couples to communicate about family planning responsibilities can not be over emphasized. A number of studies conducted in various countries have indicated that husband - wife communication about family planning and their actual use of contraception are closely related (Francine et al, 1996).

In 1990 Chirwa et al, conducted 10 focus group discussions with men and women between the ages of 16 and 39 in Lusaka, Kabwe and Kasama. Results revealed that couples rarely discussed AIDS and Condom use.

It has also been observed that family planning discussion between spouses in Zambia is more common among more highly educated and urban couples(Francine et al, 1996). Such a trend should change to include couples at all levels and from the rural setting.

Finally, the current integrated maternal child health - *family planning services have to be re-evaluated to actively and effectively accommodate men (Were and Karanja, 1994).*

1.4 OPERATIONAL DEFINITIONS

1 Family planning (Fertility regulation or birth control): Decision made by a couple or an individual on the number of children they want, how to space them, when to start a family and when to stop.

2. Female sterilisation: Permanent method of family planning in females i.e. Tubal-ligation.

3. Male sterilisation: Permanent method of family planning in males: i.e. vasectomy

4. Contraceptive methods: Methods of family planning e.g. condom, oral contraceptives, intrauterine device.

5. Family planning providers/distributors: Health workers who deliver family planning services.

6. Natural Family Planning Methods - these are methods that require the couple to avoid sex during the period that the woman is fertile. They include, calendar - based methods, basal body temperature and symptothermal methods.

CHAPTER 2

OBJECTIVES AND HYPOTHESES

2.1 General Objective

To identify factors contributing to low utilization of *family planning services among men in Zambia.*

2.1.1 *Specific Objectives*

A) To determine whether low utilisation of family planning among men results from the following:

1. Knowledge about the available methods.

ii. Acceptability of the available methods.

i. Accessibility of the methods.

v. Preference of traditional methods as compared to modern methods.

v. Females as distributors of the methods.

) To determine whether or not the existing family planning clinics or centres have any special program/activities for men.

To identify problem areas for further research in order to have men actively involved in family planning.

To recommend measures to improve the utilisation of family planning services by men.

2.2 Hypotheses

2.2.1 Lack of information about male family planning methods is a major factor in men`s lack of use of them.

2.2.2 Men do not use family planning services because they feel it is their wives' responsibility.

CHAPTER 3

METHODOLOGY

3.1 Research Design

The purpose of the study was to identify the contributing factors to low utilisation of family planning services by male clients. A descriptive research design was used. This involved systematic collection and presentation of data in an effort to show the association between various independent variables and the dependent variable.

A descriptive study is one that is used to answer a question, satisfy curiosity, solve a problem or establish an association. It involves the systematic collection and presentation of data to give a clear picture of a particular phenomena (Treece and Treece, 1977).

The study was also qualitative, because it sought to identify and explore the factors contributing to low utilisation of family planning services by men. It was further concerned with finding out the perception and opinions of men and health workers about male involvement in family planning.

Variables

The dependent variable for the study was low utilisation of family planning services by men. Several independent variables were identified. (See annex 1).

Research Setting

The study was conducted on the copperbelt province of Zambia. Three (3) companies having a large number of men were included in the study,that is:-ZCCM-NCHANGA DIVISION,(Chingola District) SCAW and MONARCH (kitwe district).The market at the town centre of kitwe was used for the Focus Group Discussion. Kitwe Central Hospital (K.C.H.) and three Health Centres (Ndeke, Chimwemwe and City Square), within kitwe district, were selected to recruit health workers from. K.C.H. is one of the hospitals serving the largest population of patients/clients in kitwe.The 3 Health centres are involved in delivering M.C.H/F.P services.

Sample Selection and Approach

Study Population

The study population was men and health workers from the copperbelt province of Zambia.

The study units were :

(a) Men (18 years old and above)

(b) Health Workers (Men and Women) who are involved with Family Planning Services.

Sample Size

The overall total sample was 218 subjects, of these 181 were men from 3 companies, 10 men from main market (Chisokone) as participants of the FGD and 27 health workers from selected health institutions.

SAMPLE 1: Was arrived at by the following formular:-

LEVEL/GRADE	TOTAL NO. OF WORKERS	2% SAMPLE
1. Company - ZCCM		
a. Top management	4	1
b. Middle management	313	6
c. General Workers - Union Represented	7828	157
TOTAL	8145	164
2. Company - SCAW		2% sample
a. Top management	5	1
b. Middle management	276	5
c. General workers	369	7
TOTAL	650	13
3. Company - Monarch		2% sample
a. Top management	3	1
b. Middle managment	15	1
d. General workers	96	2
TOTAL	114	4

Inclusion Criteria

1. Care was taken to see that nobody was below 18 years of age.
2. Only those who opted to participate in the study were included.

Exclusion Criteria

1. Below 18 years old.
2. Temporary workers.
3. Those whose consent was not available.

Sampling Methods

The subjects were selected from each institution, using employees' lists from the Human Resources Departments. To ensure adequate representation, men were recruited from all levels of operations, that is ,top management, middle management and general workers. Randomisation could not be done because of different shifts of the employees and not all employees were available, according to the lists. Some had left employment, others were on leave and still others were retrenched. This meant picking the next person on the list. Often an appointment was fixed before hand for convenience purposes.

To obtain the sample of health workers, all health workers available at each selected health institution were included.

3.2 Data Collection Technique

A self administered questionnaire for health workers and an interview schedule for the men were used. Focus group discussion was also conducted at the main market in Kitwe District.

Data Collection

Data was collected during the months of December 1996 and January 1997. Permission was sought from the management of each institution that was sampled.

(i) Questionnaire

Self administered questionnaires were distributed to all the health workers and collected as soon as they were completed to avoid introduction of bias.

(ii) Interview with men

Interviews were conducted by trained male Research Assistants,taking approximately 10 minutes with each participant.

(iii) Focus Group Discussion

Focus group discussion involved 10 men, conveniently selected from one of the largest market in Kitwe City Centre. This market was chosen to ensure that men from a mixed social background are included. Recording during the discussion was done with the assistance of one male nurse from Kitwe Central Hospital.

3.3 Ethical Considerations

The study is quite sensitive and involved some ethical considerations. Clearance to undertake the study was obtained from the Research and Ethics Committee, of the University of Zambia, based at the School of Medicine.

Written Consents were also obtained from each participant after explaining to them fully the purpose of the study.

They were assured of confidentiality of the information they gave. The names were not recorded on these forms.

3.4 Pilot Study

The data collection tools were pre-tested during the month of November 1996, at the University Teaching Hospital (U.T.H). Thirty men were interviewed and 5 health workers given questionnaires to complete. Following the pilot study, changes were made as follows:

-Some questions were clarified and others dropped.

-Three new questions were added to the list and re-pretested.

-The sequence of some of the questions on family planning was re-arranged.

3.5 LIMITATIONS OF THE STUDY

(i) Data collection period had to be extended in that the research proposal was also subjected to the research and ethical committee of ZCCM before giving the researcher permission to go ahead with data collection.

(ii) Funds were not adequate and the researcher used some money from her meagre salary to complete her project.

(iii) Permission was not granted from one of the initially chosen companies, the researcher conveniently replaced it with another one, whose male population was much lower than the other two companies chosen.

CHAPTER 4

4.0 PRESENTATION AND ANALYSIS OF DATA.

Data analysis

The findings were presented in table form, figures, graphs, pie charts and as comments. It was found suitable to use tables and figures because they summarise results in a meaningful way enabling the reader to understand the authors` intentions in the study.

Findings of the male respondents were presented in section A, those for the health workers in section B and the last section C, contained results from the focus group discussion.

DATA PROCESSING AND ANALYSIS

Data collected from the questionnaires was entered into a spread sheet then analysed using EPI-INFO and a scientific calculator.Raw data was first checked for completeness and internal consistency then entered into EPI-INFO. Responses from open ended questions were recorded as comments.

4.1 SECTION A: DEMOGRAPHIC CHARACTERISTICS

All the respondents in this section were men since the research project focused on utilisation of family planning services by men. A total of 181 men were interviewed, out of these 178 completed the questionnaires, where as 3 did not and hence these questionnaires were thrown out.The average age of the 178 respondents was 36.70 years (SD=7.58, RANGE=20-53 years). Of these 172(96.6%) were married with one wife.

Only 1(0.6%) respondent had no education,where as the majority 121(67.9%) have grade 10 to 12 level of education. However very few 3(1.7%) respondents were from top management, as per sampling method, the majority 161(90.4%) were general workers.A majority of the respondents 92(51.7%) reside in medium density area followed by 66(37.1%) residing in high density area. The respondents came from a diverse tribal background with the majority 80(44.9%) being Bembas (one of the major tribes of Zambia).(Very few 29(16.3%) respondents fell on other types of religion such as Watchtowers, Muslims and Seventhday Adventists). The majority 93(52.2%) were Protestants.

(Table 1, page 36).

Most of the respondents 108(61.7%) have between 1-4 children,and the majority have all their children living. Majority 81(46.3%) had their youngest child aged over 2 years age. Regarding the ideal number of children,most of the respondents 137(77.8%) would prefer to have more than 4 children.Out of 178 respondents, 60(33.7%) would prefer to have an equal number of both girls and boys. There was no strong preference for males but overall a slight bias (table 2,page 37).

FAMILY PLANNING SERVICES

Over half of the respondents 93(52.2%) gave the correct definition of family planning,(i.e having children at the time convenient for the couple). Among the respondents 163(91.6%) who felt it was important to have male family planning, a majority 60(36.1%) felt the idea would encourage them to get actively involved in family planning.

Nearly half of the respondents 82(46.1%) felt it would be a good idea to have separate male family planning clinics. Among these, the majority 74(90.2%) said they would use them.

Out of 178 respondents, 105(59.3%) would prefer to receive male methods from the family planning clinics (figure 1, page 70).

MALE FAMILY PLANNING METHODS

While 101(56.7%) have used a male method of family planning before, only 76 (23.2%) are currently using a male method. Figure 2, page 70, shows the male family planning methods in current use.

Most of the respondents 67(37.7%) are depending on their wives using a contraceptive method, followed by 49(27.7%) who are using condoms and only 2(1.1%) have had a vasectomy.

Out of 156 respondents, 53(34.0%) knew about condoms as the only method of family planning and 15(9.6%) knew about other methods like withdrawal and periodic abstinence.

However, 88(56.4%) said they knew other methods which included, traditional medicines, injections and pills for men (figure 3, page 71). Men seem to be well informed about male family planning,90(51.1%) of them said their source of information about male family planning was the media followed by 60(34.1%) who got information from other sources like literature and traditional marriage counsellors. The lowest group 16(9.1%) had no information about male family planning (figure4, page 72).

SPOUSE INVOLVEMENT

Out of the 178 interviewed,150(84.7%) do discuss family planning issues with their wives. When respondents were asked whether they would be willing to go with their wives to the family planning clinic, 141(79.7%) said yes. Among the 36(20.3%) who said no, most of them 10(32.3%) argued that they had no time to do so, followed by 8(25.8%) who felt it was an embarrassing thing for them to do.

As to who, in their views, should take the responsibility of family planning, 156(87.6%) felt both the wife and husband were responsible and only a few 6(3.4%) said the wife only should take the responsibility (figure 5, page 73). The majority of the respondents 137(77.4%) felt both the male and female health workers should distribute male family planning methods (figure 6, page 73).

A lot of useful suggestions were made on ways of encouraging men to use family planning services in Zambia (figure 7, page 74).

FAMILY PLANNING USE

A total of 101 (56.7%) men had used male family planning methods before where as 76 (23.2%) had not. A comparison was made between those men who used a male method and those who did not, against some selected characteristics.

Men who have ever used a male family planning method were younger,had a lower mean marriage length and fewer number of living children than men who have not used a method. There was no difference regarding the number of dead children or the age of the last child. Neither was there any difference between Roman Catholics and non Roman Catholics in use despite the conventional Roman Catholic attitude to non-natural family planning. However,a higher percentage of men who have used a method before, have attained secondary school level of education compared to their counterparts and most of them were able to define family planning correctly. Over 75% of the respondents in both groups felt it was important to have male family planning, but almost half in each group would not like to have separate male family planning clinics. Most of the respondents who have used family planning before do discuss the subject with their wives and feel family planning is the responsibility of both husband and wife.

They would also be willing to go with their wives to the family planning clinic (table 3, pages 38-39). Further comparisons were made between men who have ever used a method and those who have not by selected individual characteristics:

(tables 4 to 10, pages 40-43).

Out of 92 (51.7%) men aged 32-43,agood number of them 62 (61.4%), have used male family planning methods before. More men 89 (88.1%) with a higher level of education (grade 8-12),have used a method before compared to those who have not. The same pattern was seen with the men who are currently using a male method.

Concerning the ideal number of children, nobody with lower educational level (grade 1-7), would like to have 3 children and below. More men 71 (70.3%) with fewer children (0-5), have used a method before compared with 30 (29.7%),having 6-14 number of children, and the same applies to those who are currently using a male family planning method.

The majority of the men 24 (49.0%) currently using a male method are protestants and very few 8 (16.3%), from other religions. The bembas 47 (53.4%), have used a male method more than the other tribes.

Regarding length of marriage,most of the men who have ever used a male method have stayed in marriage for 5 years and less.

KNOWLEDGE AND PRACTICE OF FAMILY PLANNING

A comparison was made between the men who knew about a male method and their practice, out of 122 men who knew about condoms as a male family planning method, only 21 use condoms, 22 men knew about withdrawal but only 4 use the method,6 knew about periodic abstinence but only 1 use the method, and only 3 knew about vasectomy with only 2 men who had a vasectomy.

4.2 SECTION B - HEALTH WORKERS

DEMOGRAPHIC CHARACTERISTICS

All the respondents 27(100%) were females, with 8(29.6%) falling within the age group of 40-44 years old, followed by 6(22.2%) aged 25-29 years.

All the respondents have had some form of education, with 23 (85.2%) having gone as far as grade 12. over half 14(51.9%) of the respondents working with family planning were general nurses, followed by 13(48.1%) midwives. The majority of the respondents 15(55.6%) were protestants and only 4(14.8%) from other religions like Watchtowers and Seventh day Adventists (Table 11, page 44).

FAMILY PLANNING SERVICES

Twenty six(96.3%) health workers gave the correct definition of family planning(i.e having children at the time convenient to the couple).

All the respondents felt it was important to have family planning services for men, although most of them 25(92.6%) said they did not have any family planning activities for men at their clinics, counselling sessions included.

Of the 27 health workers 19(70.4%) feel adequate to provide family planning services to men. Among those who did not feel adequate 8(29.6%), most of them 5(62.5%) said they lacked training in family planning.

Most of the health workers 15(55.6%) have been asking wives to attend family planning clinics with their husbands as a way of motivating men to use family planning services, but only 6(22.2%) ensure the availability of male methods(condoms) at their clinics(figure 8A, page 75).

MALE METHODS

Regarding the male family planning methods being supplied/discussed at family planning clinics, all the respondents (27) said they did supply condoms but only 1(3.7%) said she discussed withdrawal method with clients.

Regarding responsibility of family planning, majority 25 (92.6%) of the health workers felt that both the wife and husband should be responsible.

SUGGESTIONS

A number of suggestions were made by health workers on how to encourage men to use family planning services in Zambia. (figure 9, page 79).

SECTION A

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF MALE RESPONDENTS

AGE GROUP	FREQUENCY	PERCENT
20 -25	9	5.1
26 -31	34	19.1
32 -37	63	35.4
38 -43	33	18.5
44 -49	31	17.4
50 -55	8	4.5
TOTAL	178	100
MARITAL STATUS		
Single	3	1.7
Married	172	96.6
Divorced	2	1.1
Widowed	1	0.6
TOTAL	178	100
YEARS OF EDUCATION		
< grade 7	1	0.6
grade 7-9	9	5.1
grade 10-12	47	26.4
TOTAL	121	67.9
	178	100
OCCUPATION		
Top.magt	3	1.7
Middle magt.	14	7.9
Gen.workers	161	90.4
TOTAL	178	100
RESIDENCE		
High dens.	66	37.1
Medium dens.	92	51.7
Low dens.	20	11.1
TOTAL	178	100
RELIGION		
Protestants	93	52.2
Catholics	56	31.5
Others	29	16.3
TOTAL	178	100

TRIBE		
Bemba	80	44.9
Nyanja	32	18.0
Kaonde	19	7.9
Namwanga	14	10.7
Lamba	13	7.3
Others	20	11.2
TOTAL	178	100

TABLE 1 CONTINUED!

TABLE 2: PERCENT OF MALE RESPONDENTS BY SELECTED CHARACTERISTICS

MARRIAGE LENGTH	FREQUENCY	PERCENT
1 -5	47	26.9
6 -10	51	29.1
11 -15	31	17.7
16 -20	28	16.0
21 -25	12	6.9
26 -30	5	2.8
31 -35	1	0.6
TOTAL	175	100
LIVING CHILDREN		
nil	4	2.3
1 -4	108	61.7
5 -8	49	28.0
9 -12	13	7.4
13 -16	1	0.6
TOTAL	175	100
DEAD CHILDREN		
nil	124	70.9
1	36	20.6
2	13	7.4
3	2	1.1
TOTAL	175	100
AGE LAST CHILD		
0- 12 mths	65	37.1
12- 24 mths	29	16.6
24 and above	81	46.3
TOTAL	175	100
IDEAL NO. CHILD		
1	1	0.6
2	11	6.3
3	27	15.3
4 and above	137	77.8
TOTAL	176	100

PREFERRED CHILD SEX		
male	48	27.0
female	10	5.6
any	60	33.7
equal	60	33.7
TOTAL	178	100

N.B : The total number of respondents dropped to 175 on some of the responses here because out of 178 respindents, 3 were not married.

TABLE 2 CONTINUED

TABLE 3: SELECTED CHARACTERISTICS AND MEN WHO USED A METHOD COMPARED TO THOSE WHO DID NOT.

CHARACTISTICS	USED	DID NOT USE	X^2	P. VALUE
1. Mean age	35.62 SD = 6.84	38.12 SD = 8.29	3.42 Df (1)	0.06
2. Mean marriage length	-9.71 SD = 6.39	12.55 SD = 7.70	5.87 Df (1)	0.02
3. Mean No. living children	3.76 SD = 2.75	4.51 SD = 2.86	3.27 Df (1)	0.07
4. No dead children	71(70.3%) zero	53(71.6%) zero	0.01 Df (1)	0.92
5. Mean age last child	2.02 SD = 0.89	2.19 SD = 0.93	1.61 Df (1)	0.20
6. Total No. children preferred 4 and above	77(77.0%)	60(78.9%)	0.30 Df (1)	0.59
7. Religion Protestant Catholics	51(50.5%) 34(33.7%)	42(54.5%) 22(28.6%)	0.13 Df(1)	0.72
8. Ed. Level Primary (1-7) Secondary (8-12)	12(11.9%) 89(81.1%)	8(10.4%) 69(89.6%)	0.29 Df (1)	0.59
9. FP def. Correct def. (1)	58(57.4%)	35 (45.5%)	1.95 Df (1)	0.16
10. Male FP important? yes	92(91.1%)	71(92.2%)	0.08 Df (1)	0.78

11. Separate male FP clinics? yes no	46(46.5%) 53(53.5%)	34(44.2%) 43(55.8%)	0.09 Df (1)	0.76
12. If yes to No. 13 would they use them? yes	44(95.7%)	30(83.3%)	3.44 Df (1)	0.06
13. Willingness to go with wife for FP? yes	81(80.2%)	60(78.9%)	0.04 Df (1)	0.84
14. Responsibility of FP? husband and wife	93(92.1%)	63(81.8%)	4.25 Df (1)	0.39

TABLE 3 CONTINUED!

TABLE 4 : MEN WHO HAVE EVER USED A MALE METHOD AND THOSE WHO HAVE NOT BY EDUCATION.

EDUC. LEVEL	USED	DID NOT USE	TOTAL
Primary (1-7)	12 (11.9%)	8 (10.4%)	20 (11.2%0
Secondary (8-12)	89 (88.1%)	69 (89.6%)	158 (88.8%)
TOTAL	101 (56.7%)	77 (43.3%)	178 (100%)

X^2 = 0.10
P.VALUE = O.75
ODDS RATIO= 1.16
CONFIDENCE 95% LIMITS

TABLE 5 :MEN WHO ARE CURRENTLY USING A MALE METHOD BY EDUCATIONAL LEVEL.

EDUC. LEVEL	USING	NOT USING	TOTAL
Primary(1-7)	6 (14.6%)	14 (10.3%)	20 (11.3%)
Secondary (8-12)	35 (85.4%)	122 (89.7%)	157 (88.8%)
TOTAL	41 (23.3%)	136 (76.8%)	177 (100%)

X^2 = 0.59
P.VALUE = 0.44
ODDS RATIO= 1.49
95% CONFIDENCE LIMITS

TABLE 6 : MEN WHO HAVE EVER USED A MALE METHOD AND THOSE WHO HAVE NOT BY NUMBER OF LIVING CHILDREN.

NO. OF CHILDREN	USED	DID NOT USE	TOTAL
0 -5	71 (70.3%)	45 (60.8%)	116 (66.3%)
6 -14	30 (29.7%)	29 (39.2%)	59 (33.7%)
TOTAL	101 (57.7%)	74 (42.3%)	175 (100%)

X^2 =1.72
P.VALUE =0.18
ODDS RATIO =1.53
95% CONFIDENCE LIMITS

TABLE 7 : MEN WHO ARE CURRENTLY USING A MALE METHOD BY NUMBER OF LIVING CHILDREN.

NO. OF LIVING CHILDREN	USING	NOT USING	TOTAL
0 -5	25 (62.5%)	96 (71.1%)	121 (69.1%)
6 -14	15 (37.5%)	39 (28.9%)	54 (30.9%)
TOTAL	40 (22.9%)	135 (77.1%)	175 (100%)

X^2 =1.07
P. VALUE =0.30
ODDS RATIO =0.68
95% CONFIDENCE LIMITS

TABLE 8 :MEN WHO ARE CURRENTLY USING A MALE METHOD BY AGE OF THEIR LAST CHILD.

AGE-LAST CHILD	USING	NOT USING	TOTAL
0 -12 mths	14 (35.0%)	51 (37.8%)	65 (37.1%0
12 -24 mths	4 (10.05)	25 (18.5%)	29 (16.6%)
above 24 mths	22 (55.0%)	59 (43.7%)	81 (46.3%)
TOTAL	40 (22.9%0	135 (77.1%)	175 (100%)

X^2 =2.27
2 DEGREES OF FREEDOM
P. VALUE =0.32

TABLE 9 : MEN WHO HAVE EVER USED A MALE METHOD AND THOSE WHO HAVE NOT BY RELIGION.

RELIGION	USED	DID NOT USE	TOTAL
Protestant	34 (33.7%)	22 (28.6%)	56 (31.5%)
catholics	51 (50.5%)	42 (54.5%)	93 (52.2%)
other	16 (15.8%)	13 (16.9%)	29 (16.3%)
TOTAL	101 (56.7%)	77 (43.3%)	178 (100%)

X^2 =0.53
2 DEGREES OF FREEDOM
P VALUE =0.77

TABLE 10 : MEN WHO HAVE EVER USED A MALE METHOD AND THOSE WHO HAVE NOT BY TRIBE.

TRIBE	USED	DID NOT USE	TOTAL
Bemba	47 (53.4%)	33 (36.7%)	80 (44.9%)
Nyanja	20 (22.7%0	12 (13.3%)	32 (18.0%)
Other	21 (23.9%)	45 (50.0%)	66 (37.1%)
TOTAL	88 (49.4%)	90 (50.6%)	178 (100%)

X^2 =13.16
2 DEGREES OF FREEDOM
P.VALUE =0.00

SECTION B: HEALTH WORKERS

TABLE 11: DEMOGRAPHIC CHARACTERISTICS OF HEALTH WORKERS

CHARACTERISTIC	FREQUENCY	PERCENT
Age group		
20-25	1	3.7
25-29	6	22.2
30-34	4	14.9
35-39	5	18.5
40-44	8	29.6
45-49	3	11.1
total	27	100
Marital status		
Single	1	3.7
Married	21	77.8
Divorced	2	7.4
Widowed	3	11.1
Total	27	100
Ed. Level		
Grade 9	2	7.4
Grade10	2	7.4
Grade12	23	85.2
Total	27	100
Prof.Qualification		
Doctor	nil	nil
Midwife	13	48.1
General nurse	14	51.9
General worker	nil	nil
Total	27	100

Religion		
Protestant	15	55.86
Catholics	8	29.6
Other	4	14.8
Total	27	100

n=27

TABLE 11 CONTINUED!

4.3 SECTION C FOCUS GROUP DISCUSSION

PROVINCE- COPPERBELT

TOWN -KITWE

SPECIFIC SITE- CHISOKONE MARKET

AGE GROUP- MEN AGED 18 AND ABOVE

LANGUAGE USED -BEMBA

DATE - 4/1/1997

NUMBER OF PARTICIPANTS -10 (CONVENIENTLY SELECTED)

TIME STARTED -10.15 HOURS

TIME ENDED - 11.30 HOURS

CHARACTERISTICS OF THE GROUP

EDUTIONAL BACKGOUND -FROM GRADE 7 TO GRADE 12

MARITAL STATUS - ALL MARRIED

RELIGIOUS BACKGROUND -MIXED

TRIBE -MIXED

OBJECTIVES OF THE FOCUS GROUP DISCUSSION

The objectives of the focus group discussion were:

-To obtain men`s views about the definition and advantages of family planning

-To obtain their views about family planning with emphasis on male family planning

-To identify sources of information about male family planning as known by participants

-To establish men`s acess to the available male family planning methods

-To identify reasons for low utilisation of family planning among men

-To obtain suggestions from men on how they can be actively involved in family planning

TOPICS DISCUSSED

TOPIC ONE

A: FAMILY PLANNING DEFINITION

Most of the participants defined family planning as a method of deciding to have 2 children or more. A few said it meant planning with the spouse how to space their children, and the rest said it was deciding the number of children to have, according to one`s income.

B: ADVANTAGES OF FAMILY PLANNING

Almost all the participants agreed to the following advantages of family planning:

-to bring up your children well

-to give time to the mother to recover fully from her previous pregnancy

-to educate and feed your children properly

In addition to these, one of the participants pointed out that family planning also improves sexual relationship between husband and wife.

TOPIC TWO

A:MEN`S VIEWS ABOUT FAMILY PLANNING

All the men agreed that it was a good thing for them so as not to have children any how. A few added that family planning helps to minimise complications of pregnancy in a woman. Two of them concluded by saying that the couple is helped to have a manageable family size and that vasectomy in particular would help to reduce the number of children a man produces outside marriage.

B:SOURCES OF MALE FAMILY PLANNING METHODS AS KNOWN BY PARTICIPANTS

Most of the participants knew about the M.C.H. clinics as sources of methods like condoms. Two of them knew of P.P.A.Z. as well.

C: SOURCES OF INFORMATION ABOUT MALE FAMILY PLANNING

Almost all the participants recalled having heard about condoms from the media and the press, a few said that they have also heard about condoms from their friends.

Regarding the 2 traditional methods (periodic abstinence and withdrawal), traditional marriage counsellors and friends are the main sources of information. Three of them who have heard about vasectomy, said they heard it from their friends. All the participants said that they have never heard of other traditional methods for men like beads or herbs except for those being used by their wives.

D: ACCESSIBILITY TO THE AVAILABLE MALE FAMILY PLANNING METHODS

All the participants agreed that condoms can be found and bought any where and that the other 2 methods (periodic abstinence and withdrawal), are free and only needs the decision and cooperation of the couple. The participants however said they did not have access to vasectomy method.

E: TYPE OF FAMILY PLANNING METHODS IN CURRENT USE

Two of the participants were not using any method due to old age, some were using condoms once in a while and the rest depend on their wives who use contraceptive oral pills.

TOPIC THREE

A: REASONS FOR LOW UTILISATION OF FAMILY PLANNING SERVICES AMONG MEN

The majority of the participants agreed on the following as reasons:

- men are not comfortable with family planning clinics because of too many females.
- men do not think that there are family planning services for them.
- condoms and other methods like withdrawal are not very effective.
- men do not have much knowledge about methods like vasectomy.

B: SUGGESTIONS TO ACTIVELY INVOLVE MEN IN FAMILY PLANNING

A number of suggestions were given by participants on how to encourage men use family planning services

(figure 9, page 79).

CHAPTER 5

5.0 DISCUSSION

Introduction

The study identified a number of factors contributing to low utilisation of family planning services among men in Zambia. This was a cross sectional study of men on the Copperbelt province of Zambia.

The information obtained include the demographic data, knowledge about family planning as regards to; definition, importance, methods, responsibility, counselling, motivation, services and training facilities.

Information was also obtained concerning ways in which men can be encouraged to utilise family planning services.

To supplement the information given by male respondents,the researcher also looked at the health workers` basic knowledge about family planning and their views regarding male involvement in family planning.

Due to the method used of selecting the first sample size,most of the respondents were general workers, a few from the middle management and only 3 from the top management. This however, portrays the existing picture in most companies,but may affect the generalisability of the findings.

It would have been more interesting to include non- working men as well as to compare urban and rural men, but time to do this was inadequate.

Originally the first sample size for men was supposed to be 252,but due to difficulties with one of the companies, the researcher ended up with 181 male respondents.Thus, a response rate of 72%. No problems were experienced with the health workers and participants for the focus group discussion. Twenty seven out of thirty questionnaires were returned, giving a response rate of 90% for the Health workers,and all 10 participants for the F.G.D. managed to attend.The response rate for the overall total sample therefore, was 87 percent.

Although the response rate was reasonably high,it was felt still that a larger sample size could have revealed some more information in the study.

DEMOGRAPHIC PROFILE OF MALE RESPONDENTS

It is important to know the demographic characteristics of the respondents as these may have a bearing on how they respond to family planning services. This also helps one to assess the representativeness of the sample.

Results in this study show that the majority of the respondents were young and therefore more likely to produce more children than they currently have. Out of the 181 male respondents, the marjority 106 (60%) fell in the range of 20- 37 years old.

Almost all the men were married and would therefore be in a position to give genuine and realistic responses related to family planning. This includes the 3 who were either widowed or divorced. The 3 single men genuinely failed to respond to some of the questions because they may have not experienced married life before.

The findings in this study have shown that 137 (77%) of the married respondents wanted to have more than to have more that 4 children and above. These belongs to monogamous marriages. However, other studies have shown that men in polygamous marriages generally tend to have a higher ideal and actual family size than monogamous men, and that one reason African men practice polygamy is to achieve their desire for more children (Roudi .F and Ashoford. L, 1996).

121(67.9%) of the respondents have attained secondary school education. This is helpful for understanding family planning policies and their implications.

Respondents were overwhelmingly christian with muslims and other religions making up a very small proportion of all the respondents.It is a popular belief that catholics in particular do not support other methods of family planning except for the natural family planning. The findings of this study however, have revealed that this trend may be changing since some of the men who are even using condoms as a male method currently are Catholics. This may indicate that despite their religious background men are beginning to appreciate the importance of family planning.

In this study it was also necessary to look at the influence that some of the demographic characteristics may have on male family planning. As mentioned earlier and seen in Table 1, page marjority of the respondents fell under younger age group (20 - 37 years). This finding indicate that the younger a man is, the more likely he is to use a male family planning method, and suggesting that, older men having reached their desired ideal number of children may not be as interested as the young men in family planning.

Most of the respondents are trying to space their children (majority -2 years interval), but their ideal number of children is still high.

This may mean that despite having a concern for their children,men have not clearly understood their implications during pregnancy and child birth.

Men still have a preference of a boy child to that of a girl, indicating that a couple with girls only, will go on producing with the hope of having a boy child. This may eventually result in this couple ending up with more children than they can adequately support.

Regarding number of dead children, the marjority 124 (70.9%) of the respondents had none, this is a good indication in that the more children die the more a couple strives to have more, and hence they will not practice family planning at all.

Education still remains a strong predictor of men`s attitude towards the practice of family planning. The findings in this study are in agreement with the study conducted in Ghana, which revealed that 61 percent of the husbands that have completed secondary school or higher, practice family planning compared to 35 percent of those husbands whose education did not go beyond primary school and only 10% of those with no education (Roudi.f and Ashford.l , 1996).

FAMILY PLANNING SERVICES

Most of the respondents know the definition of family planning and it`s importance,they also expressed their desire to get actively involved.These findings support other studies which have concluded that men do approve of family planning. Contrary to the health workers`views of having separate clinics for men, the majority of the male respondents would prefer combined clinics. This may as well mean that if the existing clinics are made conducive for male family planning, men would be willing to use them. According to the health workers interviwed,they do not have any family planning activities for men apart from supplying condoms.

MALE FAMILY PLANNING METHODS

The findings in this study have also shown that the overall knowledge of male family planning methods was quite high except for vasectomy. This high knowledge however has not translated into high use among Zambian men. The possible explanation to this knowledge -practice gap may be that men largely depend on their wives using a method, but they may also lack adequate information about other male methods, like vasectomy.

The findings have also revealed that the commonest male method known by men is the use of condoms.

One would certainly presume that this high knowledge about condoms is due to it being widely advertised as one way of preventing H.I.V and other S.T.D`s. The above findings have also supported the first hypothesis of lack of information about the available methods.

Further evidence of this assumption is seen from a few of the respondents who mentioned injections and pills as male methods. Being men from the urban area, they cited the media as their main source of information as well as literature. This finding however may be difficult to apply to men in rural areas where very few would have access to the media. On the other hand, this finding shows the positive impact that the media has on men regarding family planning methods, especially the use of condoms, with the emergence of the AIDS pandemic.

Although the health workers knew about other male methods like vasectomy, periodic abstinence and withdrawal, the only method being supplied to men at the clinics are condoms, adding to it`s popularity.

Male participants from the F.G.D, complained that the above mentioned male methods were not effective, where as vasectomy was misinterpreted as castration. This may explain partly why some men do not use the available methods, they have not accepted them fully.

The two traditional methods known by men were withdrawal and periodic abstinence. Of the two, periodic abstinence was commonly used while their wives had small babies.

Even though men were not asked how regularly they were using these methods, it is evident that they may be using these methods occasionally.

Contrary to the researcher`s assumption that men would prefer male distributors of the methods,men did not seem to agree with this assumption. Over half of them would prefer both males and females distributing the methods. This is an encouraging observation in that majority of the health workers in almost all the clinics are females and it may take a while to increase the number of male health workers.

SPOUSE INVOLVEMENT

On average men do discuss with their wives family planning issues, would be willing to accompany them to the family planning clinics and feel they are also responsible. This may imply that even though men do not fully use the services, they are in support of it, and while they appreciate their important role in most decisions pertaining to family life, they are realising the need to discuss as couples on the same issues.

The above findings refute the researcher`s second hypothesis which stated that men do not use family planning because they feel it is their wives` responsibility.

5.1 IMPLICATIONS OF THE STUDY

The findings from the study revealed that some men are utilising male family planning methods to some extent and that even through their user rate may not be as high as those for the females, men expressed their desire to get actively involved in family planning services.

Lack of information about the available male methods, existing female - oriented family planning clinics and limited male methods are some of the factors identified in the study as hinderances to full utilisation of family planning services.

Despite the men`s desire to use family planning services and their high knowledge about the male methods, men still have a high demand for more children and this does affect their practice to a certain degree.

Men still have a preference of boy children to girls despite some of their back ground characteristics like education, religion and tribe. Again this, may have an adverse effect on their family planning practice.

It has also been revealed by the study that men do discuss family planning issues with their wives. This is an encouraging observation, showing a shift in the men`s behaviour from that of conservatism to open dialogue with their spouses.

Studies have shown that communication between husbands and wives is one of the most important factors associated with family planning practice.

There is hope therefore that with this break through, men`s user rate of family planning will be increased.

Lack of programmes/activities for men in the family planning clinics would certainly discourage men from attending these clinics. Men would need clinics that are male friendly and attractive for them to get actively involved.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

Information on male needs and preferences is essential for developing programs relating to family planning. This paper has identified some of these needs and other factors that seem to have an influence on men`s practice of family planning. Generally people tend to think that men do not make efforts for family planning practice. The findings in this study however, have shown that men are actually using some male family planning methods, showing that they do have interest in family planning. It was necessary however to identify factors that may have on influence on their involvement in family planning. The study has shown that factors such as, age, tribe, and education may predict male family planning. These factors should be considered each time a family planning programme is being implemented for men. Despite the limited male family planning methods, men would use the available methods if they had adequate knowledge about the methods, accessibility to the methods and adequate motivation by the health workers.

Men once involved fully in family planning, would not just use the methods but would support their partners` decision to use the services. The support will affect the choice, adoption, contribution and correct use of female methods.

6.2 RECOMMENDATIONS

1. Service providers will require special training to successfully serve a male client and hence turn the focus on family planning from women to men.
2. Men still need more information on the available male family planning methods if they are to use them effectively. Motivational campaigns, I.E.C. activities, media and work place programmes can be used to increase men`s share in parental responsibility.
3. Men often cite lack of male contraceptive alternatives as the reason to avoid being involved in family planning. Vigorous attempts should be made to develop more acceptable male contraceptives.
4. The knowledge practice gap should be seriously addressed and means of closing the gap sought and implemented. Assessing local needs, would be one of the ways of going about this problem.

5. Appropriate service delivery strategies should be developed. Studies have shown that men do seem to value privacy, convenience, information, caring providers and attention to reproductive health needs beyond contraception. It may be advisable therefore to integrate male reproductive health care services, including family planning, impotence, S.T.D.`s a infertility and other conditions for male services.

6. Male - involvement initiatives should be reinforced by the media which appear to be the commonest source of information for the urban men.

7. Program managers, service providers, teachers and male opinion leaders need strong advocacy training to enable them to advocate for and propagate male family planning in their respective communities.

8. The present study should be considered a pilot study on which a bigger one should be based so that present findings could be more meaningful and significant.

ANNEX 1: REFERENCES

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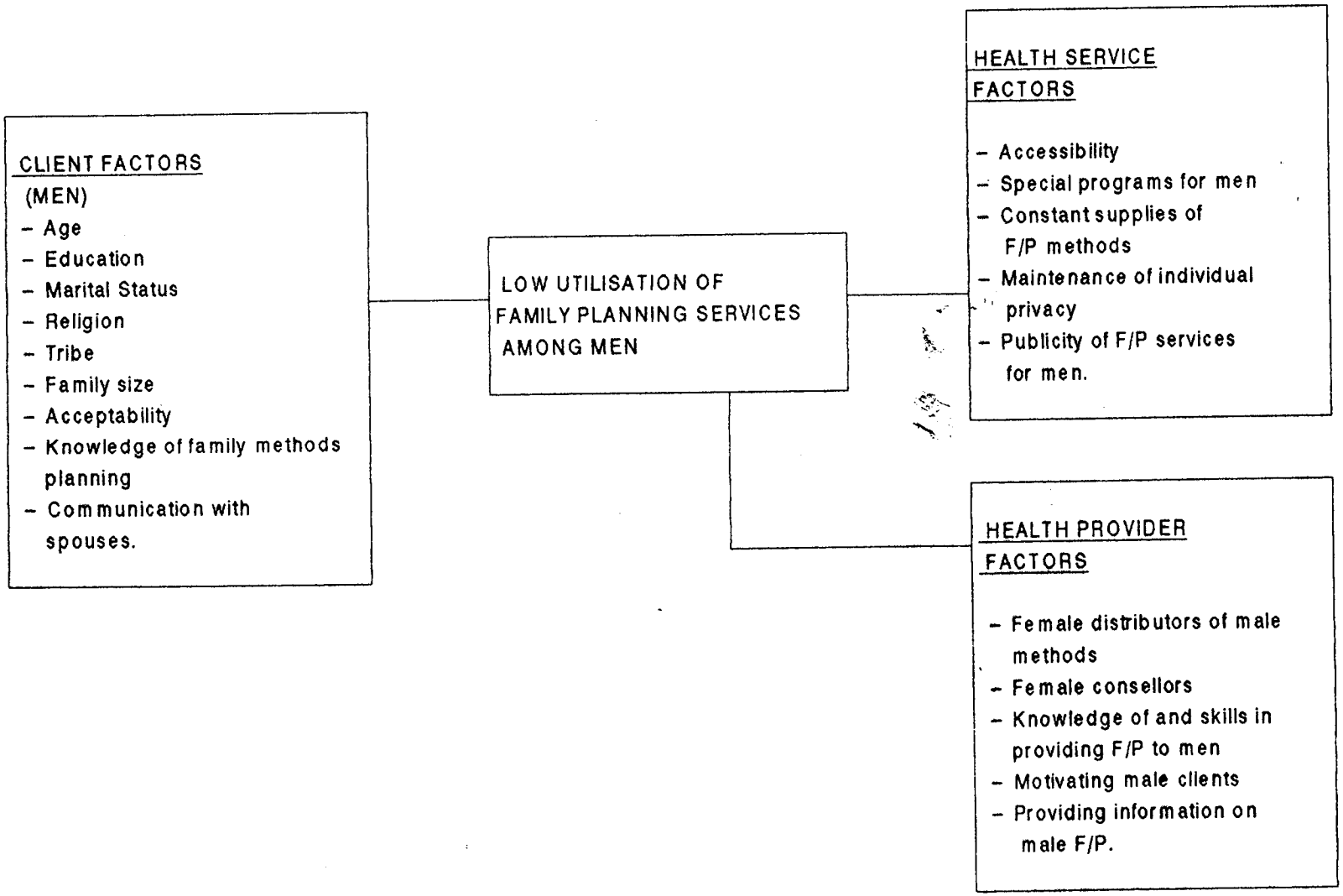
ANNEX: DEPENDENT VARIABLE AND INDEPENDENT VARIABLES



Annex : MATRIX OF THE 3 CLINICS INCLUDED IN THE STUDY BY SELECTED CHARACTERISTICS.

CLINIC	SPECIAL FP ACTIVITIES FOR MEN	MALE FP METHODS IN SUPPLY	MOTIVATING MEN TO USE FP	NUMBER OF RESPONSES
Chimwemwe	nil	condoms	- H\E in working places -use of mass media -wives to attend FP clinics with husbands	8
Ndeke	-counsel services	condoms	-H\e in working places -wives to attend FP clinics with husbands	9
City square	nil	condoms	-wives to attend FP clinics with husbands -use of posters -H\E in working places -use of mass media	10

ANNEX - 7: STRUCTURED INTERVIEW SCHEDULE FOR MEN

INTRODUCTIONS:

1. Introduce yourself to the respondent and explain the purpose of the interview.

2. Encourage the respondent to feel free during the discussion.

Serial Number_____Today's date{INTDATE}_____/_____/_____

BACKGROUND INFORMATION:

1. Age {AGE}_____years Date of birth{DOB}____/_____/____

2. Marital Status{MARITAL}

   1 = Married, 2 = Single, 3 = Divorced, 4 = Widowed

   5 = Separated, 6 = Other

3. If you answer to question 2 is married, for how have you been married?_____ years{MARRIED}

4. How many wives do you have?{WIVES}

   1 = one, 2 = two, 3 = three, 4 = other

5. Number of children{CHILDN}_____

6. What total number of children would you like to have{NO.CHILDN}_____

   1 = one, 2 = two, 3 = three, 4 = other

7. Occupation{OCCUP}_____

8. Residential Address{RESIDE}_____

9. Religion{RELIG}

   1 = Protestant, 2 = Catholic, 3 = Other:_____

10. Eductional Level in years{EDLEVEL}_____

11. Ethnic Group{TRIBE}_____

INFORMATION ABOUT FAMILY PLANNING

(Circle the number corresponding to your response where appropriate)

12. What is your definition of Family Planning?{FAPLAN}

1 = having children at the time convenient for the couple

2 = not having any more children

3 = a service offered to the women to control the number of children

13. It is important to have male Family Planning services available to you?{EPSAVA}

1 = Yes, 2 = No

14. If you answer to question 11 if yes, why?{WHYFPS}

1 = Family Planning is not just for women

2 = it will help us know the Family Planning methods available for men

3 = it will encourage us to get actively involved in Family Planning

4 = other_____

_____

15. Do you have Family Planning Services at your Company?{COMP.FP}

1 = Yes, 2 = No

16. If Yes to question 12, are you utilising the services?{USE}

1 = Yes, 2 = No

17. Do you think there should be separate Male Family Planning clinics?{MALEFP}

    1 = Yes, 2 = No

18. If yes to question 17, would you use them?{FPUSE}

    1 = Yes, 2 = No

19. Have you ever used only male Family Planning method?{USEDFP}

    1 = Yes, 2 = No

20. What Family Planning method are you currently using?{FPMUSE}

    0 = none, 1 = withdraw, 2 = periodic abstinence,
    3 = condoms, 4 =vasectomy, 5 =other_____

21. Mention all the male methods of Family Planning that you know about{METHOD}

    _____

    _____

    _____

22. Are you comfortable with the current male methods of Family Planning?{FPMETH}

    1 = Yes, 2 = No

23. From whon did you obtain your information about male Family Planning methods?{INFOFPM}

    1 = Family Planning clinic, 2 = wife, 3 = male friend

    4 = girl friend, 5 = no information

24. Have you ever discussed using a Family Planning method with your wife/girl friend?{FPDISC}

    1 = Yes, 2 = No

25. Would you be willing to go with your wife/girl friend to the Family Planning clinic?{GOFPC}

    1 = Yes, 2 = No

26. If No to question 16, why not?{FPCNO}

    1 = it is embarrasing, 2 = it is for women, 3 no time,

    4 = other:_____

27. Where would you feel most comfortable to receive male Family Planning Methods from?{FPMFROM}

    1 = Family Planning clinic, 2 = Private Pharmacy,

    3 = working place, 4 = other:_____

28. Who do you think should take the responsibility of Family Planning?{FPRESP}

    1 = wife, 2 = husband, 3 = wife and husband

29. Who would you prefer to distribute male Family Planning methods to you?{DISTRIB}

    1 = females, 2 = males, 3 = both

30. What suggestions would you like to make to encourage men utilize Family Planning services in Zambia?

    _____

    _____

    _____

ANNEX 8: QUESTIONNAIRE FOR HEALTH WORKERS

INSTRUCTIONS:

1. Do not write your name on the questionnaire
2. Please answer all questions as accurately as possible
3. Place a tick____ in the space provided, where appropriate.

Serial Number_____Today's date{Intdate}_____/_____/_____

BACKGROUND INFORMATION:

1. Sex{SEX} _____1=M, 2=F Date of birth{DOB}:___/___/___
2. Age{AGE}_____years
3. Marital Status{MARITAL} 1 = married, 2 = single

   3 = divorced, 4 = widowed, 5 = separated, 6 = other:_____
4. Educational Level{EDLEVEL} _____
5. Professional qualifications{PROQUAL}_____

   1 = Doctor, 2 = Midwife, 3 = General worker, 4 = other:_____
6. Religion{RELIG}

   1 = Protestant, 2 = Catholic, 3 = Other:_____

INFORMATION ABOUT FAMILY PLANNING:

(Circle the number corresponding to your response)

7. What is your definition of Family Planning?{FAPLAN}

   1 = having children at the time convenient for the couple

   2 = not having any more children

   3 = A service offered to women to control the number of children

8. Is it important to have Family Planning services available to men?{FPSAVA}

   1 = Yes

   2 = No

9. What Family Planning methods are your currently supplying to men?{FPMSUPP}

   YES = 1 NO = 2

   1 = withdrawal{Withdraw}

   2 = condoms{condoms}

   3 = vasectomy{vasect}

   4 = abstinence{abstine}

   5 = Other{other FP}

10. Who do you think should take the responsibility of Family Planning in a home?{FPRESP}

    1 = wife, 2 = husband, 3 = wife and husband, 4 = other____

11. How often, in a month do you counsel men on Family Planning services?{COUNCEL}

1 = none, 2 = once, 3 = twice, 4 = thrice, 5 = other:_____

12. Do you have any special Family Planning activities for men at your institution?{FPACTIV}

13. How do you motivate men to utilize Family Planning services?{FPMOTIV}

YES = 1 NO = 2

1 = giving Family Planning education in their working places{FPGIVE)

2 = asking their wives to come with them to the Family Planning clinics{FPCLINIC}

3 = ensuring availability of male methods of Family Planning {FPMALE}

4 = providing privacy for each couple{PRIVACY}

5 = use of male motivation materials like posters {MALE MOTI}

6 = use of mass media{MEDIA}

14. Do you feel adequate to provide Family Planning services to men?{KPROVIDE}

1 = Yes

2 = No

15. If No to question 16, why not?{PROVNO}

YES = 1 NO = 2

1 = not trained in Family Planning{Training}

2 = it is against my culture{culture}

3 = it is not practised at our Institution {NOT PRACT}

4 = no methods for men{METHOD}

5 = men are not seen at Family Planning clinics{NOT SEEN}

16. What suggestions would you like to make to encourage men utilize Family Planning services in Zambia?

_____

_____

_____