

1. INTRODUCTION

1.1 BACKGROUND

Child bearing is one of the most important and fulfilling roles of a woman. However, for a physiological process, pregnancy is surprisingly hazardous. Unwanted, unplanned and poorly planned pregnancies can cause disability and death.^{16,48,59} According to estimates by the United Nations Population Fund (UNFPA), about 75 million of the 175 million pregnancies each year are unintended.⁵⁶

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year.^{16, 17, 24, 58, 59} Over 99 % of these deaths occur in developing countries such as Zambia.^{17, 24} For every woman or girl who dies as a result of pregnancy-related causes, between 20 and 30 more will develop short-and long-term disabilities such as obstetric fistulae, ruptured uterus or pelvic infection.²⁴ Most of these deaths and some disabilities can be prevented with cost-effective health care services such as antenatal care, emergency obstetric care, adequate post partum care and family planning services.

Family planning has become increasingly important on the agenda of developing countries, including Zambia. It is a key component of reproductive health and one of the effective interventions for the attainment of the high level of reproductive health. It plays a major role in the reduction of maternal and infant mortality. In Zambia, family planning activities were started as early as the 1960s. However, nationwide family

planning programmes only started in the early 1970s with the inception of the Planned Parenthood Association of Zambia (PPAZ) in 1972.^{31,33} Despite this, about 65.8% of eligible couples in Zambia are still unprotected against conception.¹² One of the reasons for the non-usage of family planning methods by married women is the perceived disapproval from husbands.^{4, 11, 58,59}

It has been recognized that men play important roles in decisions crucial to women's reproductive health, and that men's participation is a promising strategy for addressing some of the world's reproductive health problems. At the 1994 International Conference on Population and Development (ICPD) held in Cairo, representatives from 180 countries formally recognized the importance of men to women's reproductive health.^{3, 16, 55}

In 1975, a World Health Organization (WHO) expert committee defined five methods to evaluate the success of family planning programmes. One of them is the evaluation of knowledge, attitude, motivation and behaviour among people.⁴⁴ Men have often been neglected in both family planning programmes and in surveys used to design and evaluate such programmes. Since men are the dominant decision makers, it is prudent to discover the knowledge, attitude and contraceptive practices of men and improve their involvement in reproductive health needs of the families. Hence the decision to study the knowledge, attitude and practices of married men regarding the adoption of family planning methods.

1.2 STATEMENT OF THE PROBLEM

Family planning programmes have long been recognized for their importance in the health of women and children, and in reducing population growth rates. In Zambia, family planning activities were started as early as the 1960s, although nationwide family planning programmes only started in the 1970s.^{31,33} Unfortunately, contraceptive utilization rate is still very low. According to the findings of the 2001 – 2002 Zambia Demographic and Health Survey (ZDHS), 98% of married women in Zambia know at least one method of family planning. Despite this knowledge, the contraceptive usage rate is only 34.2% among married women. The unmet need for family planning among married women is 27.4%.¹² The available family planning methods are poorly used due to several factors that include poor knowledge of each method and the perceived disapproval from husbands.

Despite the recognition of the importance of family planning and identification of factors that influence utilization of family planning services, Zambia still exhibits high fertility rate and low contraceptive usage. Although the fertility levels have been declining over the past 20 years, they remain among the highest in sub-Saharan Africa. Zambia's total fertility rate is 5.6 children per woman.¹²

Zambia's maternal mortality ratio (MMR) continues to be at an unacceptably high level. It has been showing an upward trend, increasing from 200 in 1992 to 649 in 1996 and 729 deaths per 100,000 live births in 2001.¹² Most of these deaths could be prevented

with cost-effective health care services such as antenatal care, emergency obstetric care, adequate postpartum care and family planning services.

Lusaka district has a population of about 1,084,703 and about 215, 316 households.¹³ It is home to various ethnic and religious groups, and individuals of diverse socio-economic and education background. The district has a good number of health centres and non-governmental clinics offering family planning services. The family planning services are, therefore, relatively easily accessible. However, the family planning utilization rate for Lusaka district is only 47.1%, which is very low. At 27.1%, the unmet need for family planning in the district is high.¹²

Given the critical role that Zambian men play in family decisions, men's support and involvement are essential for family planning to become more widespread. If organized family planning programmes are to reach out to men, a better understanding of their reproductive intentions is essential. The intention of this study was to contribute towards that understanding.

1.3 LITERATURE REVIEW

1.3.1 Overview of Family Planning

The World Health Organization (WHO) defines family planning as the ability of individuals and couples to anticipate and attain their desired number of children, and the spacing and timing of their births. This is achieved through the use of contraceptive methods and the treatment of involuntary infertility.

There are various methods of contraception. The modern methods include the pill, male and female condoms, male and female sterilization (vasectomy and tubal ligation respectively), intra-uterine device (IUD), implants, injectables, spermicides (foaming tablets, jelly), diaphragms, and emergency contraceptives. The traditional methods include the lactational amenorrhoea method (LAM), periodic abstinence or rhythm method, and withdrawal method (coitus interruptus).

It has been shown that complications of pregnancy are more likely after a woman has had five children.^{1,51,53} Although Zambia's total fertility rate (TFR) has shown a down ward trend over the last twenty years, it remains one of the highest in sub-Saharan Africa. Zambia's TFR is currently 5.6 children per woman.¹²

The length of interval between births influences overall fertility levels, as well as the health status of the mother and child. It has been shown that children born too soon after

a previous birth are at an increased risk of low birth weight (LBW), infection and death.^{17,21,52} When women have the ability to space their births, they are better able to recover from nutritional depletion, blood loss and reproductive system damage. This enables them to have healthier children.

Research has confirmed the beneficial effects of family planning on maternal and child health. Women's use of safe and effective contraception helps reduce maternal mortality and morbidity by reducing the number of high-risk pregnancies and births, and helps lower child mortality by reducing the number of high-risk births.^{18,50}

1.3.2 Male Involvement

Men are frequently blamed for many of women's reproductive health problems. They are potential partners in and advocates for good reproductive health. However, family planning programmes in the past have focused on women instead of men. Some of the reasons for this scenario are that women bear the risks and burdens of pregnancy and childbearing, and that most modern contraceptives are for women.¹⁶ Other family planning programmes have avoided men because they assume that men are indifferent or even opposed to family planning.^{14,28,32,34,47}

Although women are using contraceptives, the methods that require male involvement (such as condoms, periodic abstinence, withdrawal and vasectomy) are less used.²³ Traditionally, wives in the African society consider their husbands as overall heads. The husband decides upon most things and his wife is expected to abide by his spoken

decisions or his perceived wishes. Different studies have revealed that involvement of husbands in family planning programmes would result in subsequent rise in the prevalence of contraceptive use. For example, in a study conducted in Addis Ababa, more than 500 married women who were not using any modern method agreed to home visits by a two-member family planning educational team. About half of the women received family planning counselling alone, while the education for others was given to both husband and wife. After one year, contraceptive use was nearly double among couples who received husband-wife counselling (33 percent), compared with use among couples in which women were counseled alone, without their husbands (17 percent).^{23,54}

Therefore, reproductive health programmes are now seeking better ways to understand men.

1.3.3 Knowledge about Family Planning

Acquiring knowledge about family planning is an important step towards gaining access to, and then using, a suitable method in a timely and effective manner. It has been shown that a large majority of men can identify at least one contraceptive method. In most African countries, men report higher levels of awareness of contraceptive methods than women do.^{19,25}

In two collaborative surveys which were conducted in Ndola in 1999, it was found that awareness of family planning was high among both men and women. About 90% of men and 94% of women reported that they had heard about family planning. Majority of men

(70%) understood family planning to mean spacing children, and 19% of them understood family planning as having the number of children that one can feed. During the same survey, it was noted that men saw nothing wrong in having many children, provided one could afford them.³⁷

1.3.4 Attitude Towards Family Planning

Attitudes toward family planning determine whether or not it is practiced. It has been estimated that about 100 million married women have unmet need for family planning worldwide.¹⁶ In a number of surveys, many married women with unmet need cite husbands' disapproval as the principal reason that they do not use contraception.^{9,56,57}

In a study conducted by Casterline and Sinding, husband's opposition was identified as a major reason for non-use of contraception.¹¹ Similar findings were noted by Worku and Fantahun. Other reasons mentioned in this study included inadequate knowledge and lack of couple communication.⁵⁹ In the 2001 – 2002 Zambia Demographic and Health Survey (ZDHS), it was found that about two thirds of married women believed their husbands approved of family planning, with 16% reporting that their husbands disapproved of family planning.¹²

Many surveys in Africa have revealed that men generally approve of family planning. However, men's approval rates are usually lower than women's.¹⁹ Research suggests that

in many regions, men view family planning favourably and can have a strong influence on the use of contraception.³⁶

The Ankole Fertility Survey, conducted in 1984 in South-Western Uganda, showed that men had a positive attitude towards family planning despite their extremely low level of contraceptive use.^{40,46} Similarly, Mwageni and colleagues observed that although low contraceptive prevalence was reportedly attributable to men's opposition to family planning, men expressed positive attitude towards fertility – regulating methods.³⁸ This observation was supported by studies conducted by Lawoyin and colleagues, and by Oyediran and colleagues respectively.^{30,43}

Despite the positive findings from recent studies, it is a woman's perception of her husband's attitude towards family planning that strongly influences whether she will use family planning methods. If a woman thinks that her husband approves of family planning, she is much more likely to use it.^{29,49}

Ideal family size is a good indicator of men's and women's attitude toward child bearing, even though actual reproductive behaviour may differ from stated desires. Studies have shown that African men generally desire larger families than do their wives.^{10, 47} This is because men think they gain socially and economically from a large number of children.¹⁰ According to a study in a remote community of South Ethiopia, female respondents reported that because of male dominance, women would be forced to bear a large number of children.²³

1.3.5 Spousal Communication

Spousal communication can be a crucial step towards increasing men's participation in reproductive health. It enables husbands and wives to know each other's attitude towards family planning and contraceptive use. Research demonstrates that men and women who discuss family planning are more likely to use contraception, to use it effectively, and have fewer children.^{5,26,27,29,41} Qualitative data collected from married women and their husbands in Ndola, in 1997, revealed that women's covert use of contraceptives accounted for 6 to 20 per cent of all current contraceptive use. The multi-variate analysis indicated that difficult spousal communication about contraception was the strongest determinant of covert use.⁶

Review of some DHS studies has shown that in some societies where communication between partners about sexual matters is culturally unacceptable, the risk of unintended pregnancy is high.⁵⁵ In many African societies, few couples ever talk to each other about family planning. Several studies suggest that spousal communication about family planning usually begins only after the birth of one or two children.^{8,22}

Because women and their husbands often do not communicate about family planning, many wives think that their husbands oppose family planning when in fact the husbands approve.^{35,42,49} Some women decide to use contraception without telling their husbands. A small minority of women report doing so because they think their husbands would disapprove.⁵⁸ Literature provides evidence that women's adoption of family planning puts them at risk of adverse outcomes (e.g. partner violence) when their husbands are

opposed to contraception.⁴ Contraceptive discontinuation is also likely to be high for women who start using a method on assumption that their partner approves of use and later discovers he actually does not.¹⁵

1.3.6 Practice of Family Planning

Within marriage, in African cultures, men typically have more say than women in the decision to use contraceptives and in the number of children that the couple will have. In Ghana, for example, both DHS data and focus-group research reveal that the husband is usually the effective decision-maker about fertility. Furthermore, the husband's family planning attitudes and fertility goals are usually not influenced by their wives. When partners disagree on whether to use family planning methods, the man's preference usually dominates.⁵⁸

Recent empirical studies have revealed the processes through which spousal relations create barriers to using contraception. According to data from several settings, wives and husbands concur in their fertility preferences and in their views about contraception. However, husbands represent barriers to their wives' use of contraception in basically two ways. Firstly, wives frequently misperceive their husbands' attitudes. Secondly, while only a minority of husbands are strongly opposed to contraception than their wives, the husbands' view typically wins out in such instances.¹¹

Some studies have shown that while many men know about contraception and approve of it in general, not all who approve of contraception use it. On the other hand, a women's use of contraception is strongly influenced by her perception of her husband's attitude towards family planning. She is much more likely to use it if she thinks her husband approves of family planning.^{16,29,49}

2. STUDY QUESTIONS, OBJECTIVES AND JUSTIFICATION

2.1 STUDY QUESTIONS

There are a number of research questions regarding family planning. This study intended to answer some of these questions. These included:-

- (i) Do men in Lusaka district know about family planning?
- (ii) What is their attitude towards family planning?
- (iii) Do they practice family planning?
- (iv) What factors contribute towards their attitude and practice?

2.2 STUDY OBJECTIVES

2.2.1 General Objective

The general objective of the study was to assess the knowledge, attitude and practice regarding family planning among men in Lusaka district.

2.2.2 Specific Objectives

The specific objectives of the study were:-

- (i) To determine whether men in Lusaka district know about family planning.
- (ii) To establish whether men approve or disapprove of family planning.
- (iii) To find out whether men practice family planning.
- (iv) To determine the factors contributing towards their attitude and practice.
- (v) To compare in which ways and to what extent men's knowledge, attitude and practice differ from their wives'.
- (vi) To find out the implications of the research findings for future family planning programmes.

2.3 HYPOTHESES

The study hypothesized that:

- (i) The level of knowledge about family planning is low among men.
- (ii) Men have negative attitudes toward family planning.

2.4 JUSTIFICATION OF THE STUDY

A lot of reproductive health studies have been dominated by findings almost exclusively from women. Several surveys of men have been conducted in a number of countries (including Zambia) as part of the Demographic and Health Surveys, and Reproductive Health Surveys. However, there are still fewer surveys of men than those of women, and the information collected is inadequate.

A number of studies have been carried out in some of the African countries regarding the roles of men in family planning. However, very little data is available in the Zambian context. A study done in Ndola about eight years ago focused on men within the context of gender relations and the family. Much of the findings also reflected women's point of view. The study was conducted mainly in the rural set up, unlike Lusaka which is mainly urban.

This study intended to focus mainly on men and family planning in an urban set up. It combined both quantitative and qualitative data collection methods.

3. METHODOLOGY

3.1 STUDY DESIGN

The study was a cross-sectional, descriptive study conducted from 4th June to 27th July 2007 among married men residing in Lusaka district. It involved both quantitative and qualitative methods.

3.2 STUDY SETTING

The study was conducted in six residential areas of Lusaka district. These included low-density areas (Kabulonga and Munali), medium-density areas (Chilenje and Kabwata) and high-density areas (Chawama and Kanyama).

3.3 STUDY POPULATION SAMPLING

A multi stage sampling technique was applied to select the study population. A list of all residential areas in Lusaka district was made. In order to capture all levels of socio-economic status, these were grouped into three clusters based on population density (that is, high, medium and low density residential areas) as the area of residence generally correlates with socio-economic status. Two residential areas from each cluster were randomly selected by lottery. The number of households included in each residential area was determined in proportion with the total number of households found in each area as per 2000 Census of Population and Housing . A systematic random sampling method was

then employed to select the households. The first household was chosen randomly by spinning a pen and then every tenth household was selected in a clockwise direction.

Sample size

The sample size for the respondents to the questionnaire was 280 couples. Assuming the expected contraceptive usage rate in Lusaka district to be 47.1% as found in the 2001-2002 ZDHS, and taking 95% confidence level with a precision of 6%, the minimum sample size required was 266. (Details of calculation in Appendix 4.)

Inclusion Criteria

- i) Married men aged 20 years and above
- ii) Wives of eligible men, aged from 15 years to 49 years
- iii) First wife, in case of polygamous marriage
- iv) Couples married for at least 6 months.

Exclusion Criteria

- i) Unmarried men
- ii) Married men younger than 20 years old
- iii) Wives of eligible men aged less than 15 years and more than 49 years.
- iv) More than first order wives, in case of polygamous marriage
- v) Couples married for less than 6 months.

3.4 DATA COLLECTION AND ANALYSIS

A questionnaire involving both closed-and-open-ended questions was used to collect both quantitative and qualitative data. It was designed to capture socio-demographic variables such as age, religion, tribe, educational level, occupation and number of children. Additionally, questions on fertility preference, knowledge, attitude and practice of family planning were included.

After giving written or oral informed consent, men were interviewed by trained male interviewers, and their wives were interviewed by trained female interviewers. Both were interviewed separately and simultaneously.

The questionnaire was pre-tested in a residential area that was selected randomly from among those areas outside the study population. It involved 15 couples, the sample size having been determined arbitrarily. Modifications were made to the questionnaire according to the observations made from the pre-test.

After collection, data was entered on EPI-INFO and SPSS software for processing and analysis. Data analysis involved the use of proportions and chi-square tests.

3.5 ETHICAL CONSIDERATION

Before conducting the study, permission to carry it out was sought from the Research Ethics Committee of the University of Zambia. Informed consent was obtained from the participants before recruiting them into the study. Confidentiality was maintained, and their names and study numbers were unlinked.

4. RESEARCH FINDINGS

4.1 SOCIO-DEMOGRAPHIC PROFILE

A total of 560 respondents (280 men, and their wives) were interviewed using the structured questionnaire. The majority of the respondents (53.6%) resided in the high density areas of Lusaka district (Table 1). At the time of the study, about 34.6% of the couples had been married for 1 – 5 years, and 34.3% for 6 –10 years. The median duration of marriage was 7 years (range: 6 months to 30 years). One man (0.4%) reported having been married to two women, whilst three women (1.1%) reported being in polygamous marriages. Most couples reported having ever had a total of two children. The same number was the most reported as being alive at the time of the study. The median number of children ever had was 2 (range: 0 – 8 children) and that of those still alive was 2 (range: 0 – 7 children). About 8.9% of the couples were childless.

Men in this study were generally older than their wives. The median age of the men was 36 years (range: 20 – 61 years), whereas that of their wives was 30 years (range: 16 – 43 years). In the study areas, more than half of the respondent couples were non-pentecostal protestant Christians (Table 2). Most of the men were Bemba-speaking (28.1%) whereas most of the women were Nyanja-speaking (25.7%).

The educational level achieved by the respondents at the time of the study showed that about 89% of the males had attained at least secondary education, compared with 72% among the female partners. About 2.9% of the men and 3.6% of the women had not been

to school. About 68.2% of the male respondents reported being employed by either the government or non-governmental institutions. 22.1% of the men were self-employed. About 39.3% of the female respondents were full-time housewives. Only 48.6% (136) of the males disclosed their monthly income. About 48.5% (66) of these earned more than one million kwacha (K1,000,000.00) per month.

Table 1: Socio-demographic Profile of respondent couples (n=280)

Variable	Frequency	
	N	(%)*
<i>Residence</i>		
High-density	150	(53.6)
Medium-density	75	(26.8)
Low-density	55	(19.6)
<i>Duration of Marriage</i>		
< 1 year	20	(7.1)
1 – 5 years	97	(34.6)
6 – 10 years	96	(34.3)
> 10 years	67	(23.9)
<i>No. of Children ever had</i>		
None	21	(7.5)
1 – 3	195	(69.6)
4 – 6	56	(20.0)
7 – 10	8	(2.9)
<i>No. of Children alive</i>		
None	25	(8.9)
1 – 3	198	(70.7)
4 – 6	51	(18.2)
7 – 10	6	(2.1)

* Percentages may not add to 100% due to rounding off.

Table 2: Comparative socio-demographic characteristics of respondents

Characteristic	Husbands (n=280)		Wives (n=280)	
	N	(%) *	N	(%) *
Age				
15 – 20 years	3	(1.1)	11	(3.9)
21 – 30 years	76	(27.1)	166	(59.3)
31 – 30 years	151	(53.9)	98	(35.0)
> 40 years	50	(17.9)	5	(1.8)
Religion				
Catholic	40	(14.3)	30	(10.7)
Pentecostal Protestant	67	(23.9)	82	(29.3)
Non-Pentecostal Protestant	141	(50.4)	147	(52.5)
Other	20	(7.1)	14	(5.0)
Unspecified	12	(4.3)	7	(2.5)
Tribe				
Nyanja	61	(21.8)	72	(25.7)
Bemba	77	(27.5)	60	(21.4)
Tonga	70	(25.0)	44	(15.7)
Lozi	37	(13.2)	31	(11.1)
Lunda/Luvale/Kaonde	24	(8.6)	55	(19.6)
Alien	5	(1.8)	7	(2.5)
Unspecified	6	(2.1)	11	(3.9)
Educational level				
None	8	(2.9)	10	(3.6)
Primary	22	(7.9)	68	(24.3)
Secondary	109	(38.9)	104	(37.1)
Tertiary	141	(50.4)	98	(35.0)
Occupation				
Management & Officer	86	(30.7)	56	(20.0)
Clerical Staff	67	(23.9)	32	(11.4)
Labourer	38	(13.6)	15	(5.4)
Self-employed	62	(22.1)	67	(23.9)
House wife	0	(0.0)	110	(39.3)
Unspecified	27	(9.6)	0	(0.0)

* Percentages may not add up to 100% due to rounding off.

4.2 KNOWLEDGE ABOUT FAMILY PLANNING

Family planning awareness was almost universal among both men and their wives. About 97.9% of men and 97.5% of women reported that they had heard about family planning (Table 3). The most commonly known methods were the pill, male condom and injectables among both men and women. However, more men than women knew about the male condom ($p < 0.001$), and more women than men knew about the injectables ($p = 0.007$). Tubal ligation and foaming tablets were the least known methods among the men. Among the women, tubal ligation and lactational amenorrhoea method were the least known methods. Generally, the modern methods were better known than the traditional ones. Among the traditional methods, periodic abstinence was the most commonly known method.

The main source of information on family planning was the health facility. Significantly more women (81.4%) heard about family planning from health facilities than did the men, (67.9%) ($p < 0.001$). More men than women heard about family planning from the electronic and print media ($p < 0.001$).

Table 3: Knowledge of Family Planning Methods

Method *	Men (n=280)		Women (n=280)	
	N	(%)	N	(%)
Any method	274	(97.9)	273	(97.5)
Pill	229	(81.8)	240	(85.7)
Injectables	151	(53.9)	181	(64.6)
Implant	79	(28.2)	70	(25.0)
Male condom	174	(62.1)	120	(42.9)
Female condom	37	(13.2)	30	(10.7)
Diaphragm	16	(5.7)	8	(2.9)
IUD ^a	47	(16.8)	70	(25.0)
Foaming tablets	15	(5.4)	12	(4.3)
Tubal ligation	8	(2.9)	2	(0.7)
Vasectomy	28	(10.0)	13	(4.6)
Periodic abstinence	66	(23.6)	35	(12.5)
LAM ^b	26	(9.3)	4	(1.4)
Withdrawal	44	(14.6)	32	(11.4)

*Methods are not mutually exclusive since an individual could have heard about more than one method of family planning.

a Intra-uterine device, b Lactational amenorrhoea method

About two fifth of both men and women understood family planning to mean limiting the family size, and 28.6% of men and 37.1% of women understood family planning as spacing children.

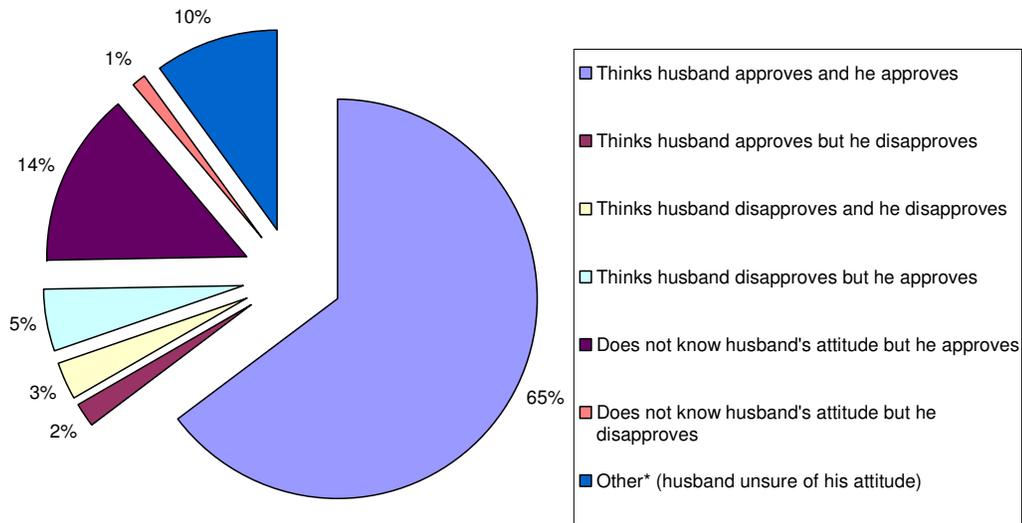
4.3 ATTITUDE TOWARDS FAMILY PLANNING

Couples were found to generally approve of family planning. About 82.4% of men and 83.4% of women reported that they approved of family planning. The main reason for approval was to avoid unnecessary pregnancies or children. Another reason was that family planning was good for the health of the mother and/or child.

Less than a quarter of the respondents disapproved of family planning. The major reason mentioned for disapproval was side-effects (31.6% among men and 91.7% among women). The side effects mentioned included causation of cancer and infertility, and the woman generally getting sick. Other reasons mentioned included religious beliefs.

Majority of the respondents thought that their spouses approved of family planning. About 82.1% of men thought that their wives approved of family planning and 70.7% of women thought that their husbands approved of family planning . However, more women than men thought their spouses disapproved of family planning ($p=0.009$). A proportion of women misperceived their husbands' attitude (see fig. 1)

Figure 1: Wives' perception of husbands' attitude towards family planning and husbands' actual attitude



4.4 REPRODUCTIVE INTENTIONS AND PREFERENCES

Amongst the male respondents, 13.9% (39) reported that their wives were pregnant at the time of the study. 14.3% (40) of the women reported that they were pregnant. About 3.2% of the men and 3.6% of the women were not sure about their pregnancy status. Significantly more men (84.6%) than women (60.0%) stated that the pregnancy was planned ($p= 0.015$).

About 51.3% of men among the pregnant couples said that they would like to have another child after the one they were expecting. . About 55.0% of their wives wanted another child. More women than men wanted another child, but there was no statistically significant difference among the couples ($p= 0.590$). Majority of the men (65%) reported

that they would like to wait for 1 – 3 years before having another child after the birth of the child they were expecting at the time of the study whilst majority of the women (45.5%) would like to wait for more than 3 years ($p=0.053$).

Unlike their pregnant counterparts, significantly fewer non-pregnant women (7.5%) than their husbands (50.2%) wanted some more children ($p<0.001$). More than 90% of the women were undecided regarding their desire for more children. At the time of the study, the majority of men (71.9%) among the non-pregnant couples wanted to wait for 1 – 3 years before having a child or another child . Proportionally more women than their husbands wanted to wait for less than 1 year and more than 3 years respectively. ($p>0.05$)

When asked about the number of children the respondents would like to have if they had a choice, more than two thirds of them stated that they would choose to have 3 – 5 children. The mean ideal family size was stated to be 3.9 children (range: 1-10children) by both men and women. The median was 3 children for the men and 4 children for the women. There was no significant difference between the men and their wives ($p=0.057$). About 66 per cent of the men thought that their wives wanted the same number of children as they did. However, more women (16.1%) than men (6.0%) thought that their spouses wanted more children ($p= 0.002$).

4.5 CONTRACEPTIVE USE

Majority of the couples had used contraceptives before, and were using contraceptives at the time of the study. However, the current usage rate was significantly lower than the past usage rate. About 87.2% of men and 88.2% of women reported ever using any method of family planning compared with 64.6% of men and 61.1% of women reporting current usage of family planning methods ($p < 0.001$). The pill, male condom, and injectables were the most commonly used methods among both men and women (figure 2). Men generally reported higher levels of contraceptive use than women. Although 3.4% of the men (8) reported the use of female sterilization (tubal ligation) before, none of their wives reported ever using that method. None of the respondent reported ever using vasectomy. The diaphragm, foaming tablets and tubal ligation were not being used by any of the respondents at the time of the study.

Figure 2: Family planning methods ever used by respondent couples

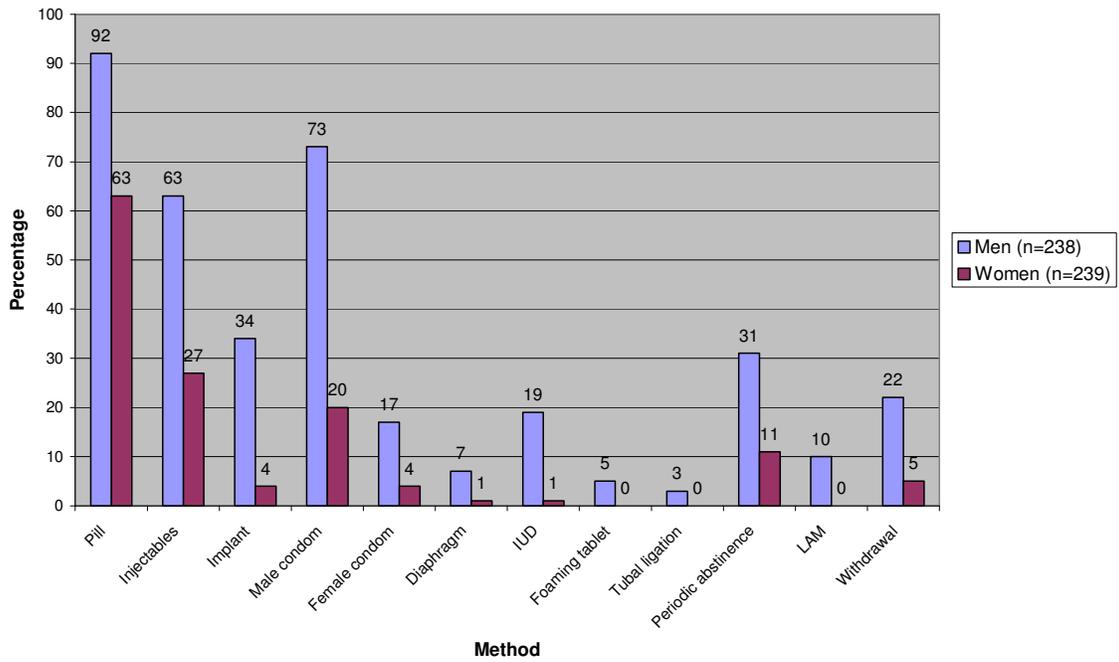
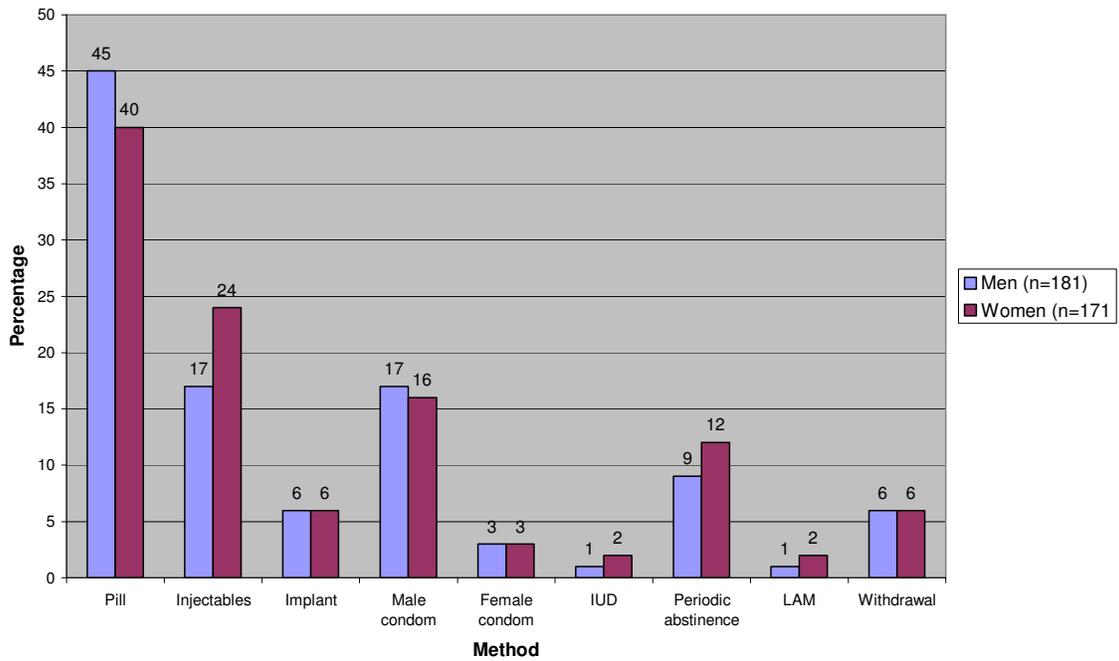


Figure 3: Family Planning methods currently used by married couples.



33.2% (93) of the men and 36.4% (102) of the women reported that they were not using any method of family planning at the time of the study. The main reasons for not using any family planning method were that the wife was pregnant, and that the couple wanted to have children at the time of the study (figures 4 and 5). 65.6% (61) of the men reported that they would use a method in future. 18.3% (17) of them reported that they would use any method, and the rest (16.1%) were undecided. Among the women who were not using any method at the time of the study, 74.5% (76) reported that they would use a method in future whilst 17.6% (18) reported that they would not do so. About 7.8% of the women were undecided regarding the future use of any family planning method.

Figure 4: Reasons for not currently using any family planning methods among men (n=93).

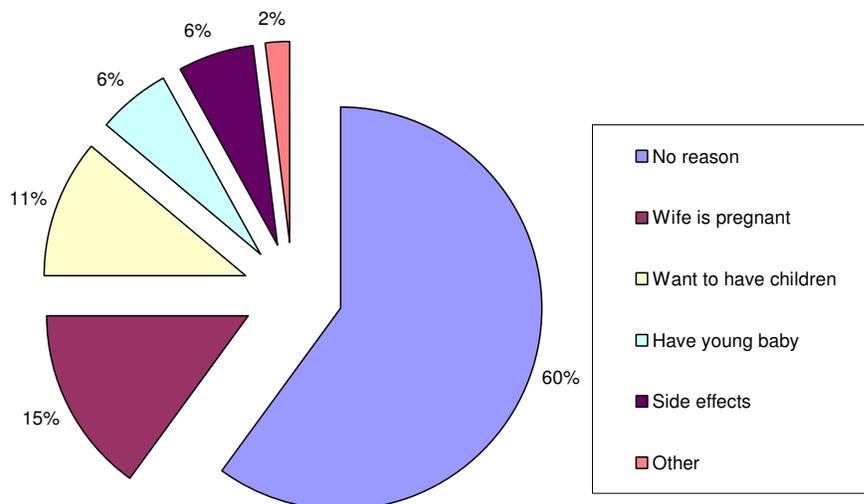
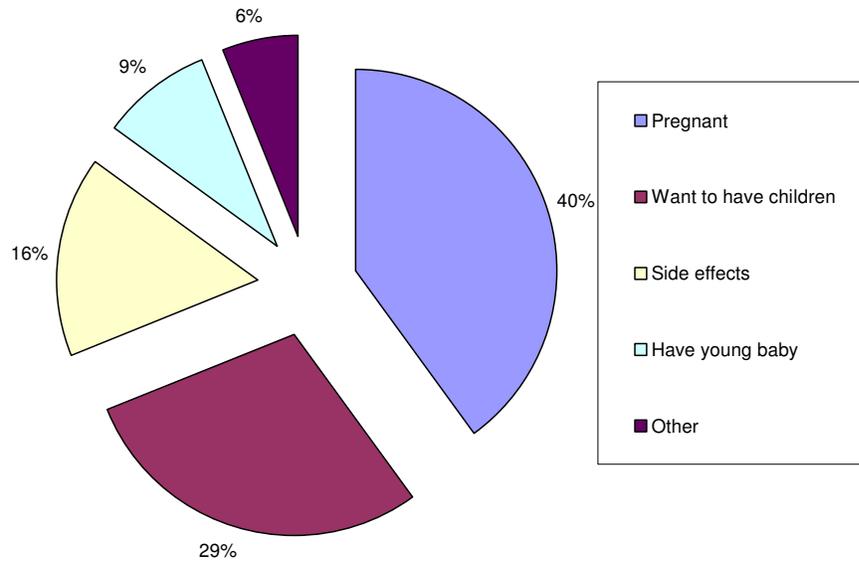
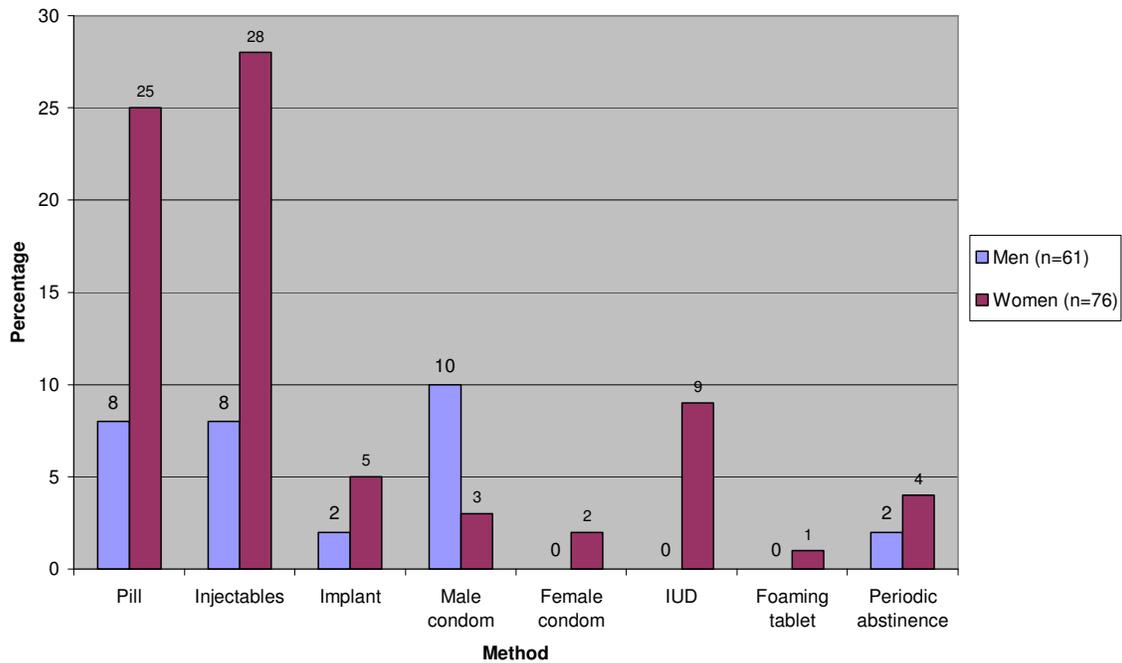


Figure 5: Reasons for not currently using any family planning methods among women (n=102)



Among the respondents who stated that they would use contraception in future, the most preferred method was the male condom among the men whilst the injectables were the most preferred method among the women. (Figure 6).

Figure 6: Preferred future family planning methods among men (n=61) and women (n=76).



Most of the decisions on whether or not to use any family planning method were made by both husbands and their wives. For the unilateral decisions, most of them were made by the wives (p=0.009).

Almost two thirds of the respondents reported discussing family planning with their spouses on more than two occasions during the previous six months (Table 16).

Significantly more women than men reported never discussing family planning issues with their spouses in the preceding six months (p=0.008).

Table 4: Family planning discussion frequency among married couples, during previous six months

Discussion Frequency	Husbands (n=267)		Wives (n=267)	
	N	(%)*	N	(%)
Never	41	(15.4)	58	(21.7)
Once	30	(11.2)	37	(13.9)
Twice	24	(9.0)	8	(3.0)
More Often	172	(64.4)	164	(61.4)

4.6 FACTORS ASSOCIATED WITH MEN’S KNOWLEDGE, ATTITUDE AND PRACTICE REGARDING FAMILY PLANNING

The knowledge about family planning was almost universal, and no factor was found to be significantly associated with the knowledge. However, those who had attained at least secondary education tended to know more than two methods of family planning.

The attitude of men towards family planning was affected by the experience of a still birth, religious affiliation and tribe. The educational level attained and frequency of family planning discussion with spouse also affected the men’s attitude. Men who had experienced a still birth were more likely to disapprove of family planning than those who had never experience a still birth (Table17). Amongst the men who had experienced a still birth, 70.3% approved of family planning, and 22.2% disapproved whilst among those who had never experienced a still birth, the approval and disapproval rates were 83.7% and 5.3% respectively ($p= 0.005$).

Catholic men were more likely to approve of family planning than men of other religious affiliation. About 91.9% of catholic men approved of family planning whilst 70.1% of pentecostal protestants and 84.9% of non-pentecostal protestants approved of family planning ($p = 0.008$). It was also observed that men belonging to the north-western province tribes were more likely to have a positive attitude than those belonging to other tribes. About 91.7% of men belonging to the north-western tribes approved of family planning whilst 74.1% of the Nyanja-speaking men approved. ($p = 0.007$). However, the Nyanja-speaking were the least likely to disapprove of family planning (1.7%).

Men who had attained tertiary education and those who had not been to school reported the highest family planning approval rates (85.4% and 85.7% respectively). Those who had attained primary education reported the lowest approval rate (66.7%). About 28.6% of the men who had attained primary education and 6.6% of those who had attained tertiary education disapproved of family planning ($p = 0.002$). Men who discussed family planning with their wives on more than two occasions in the previous six months were more likely to approve of family planning ($p = 0.005$).

Table 5: Factors significantly associated with men’s attitude towards family planning

Factor	Attitude					
	Approve		Disapprove		Unsure	
	N	(%)*	N	(%)*	N	(%)*
<i>Had Still birth</i>						
Yes (n = 27)	19	(70.3)	6	(22.2)	2	(7.4)
No (n = 245)	205	(83.7)	13	(5.3)	27	(11.0)
<i>Religion</i>						
Catholic (n = 37)	34	(91.9)	0	(0.0)	3	(8.1)
Pentecostal Protestant (n = 67)	47	(70.1)	5	(7.5)	15	(22.4)
Non- Pentecostal Protestant (n= 139)	118	(84.9)	13	(9.4)	8	(5.8)
<i>Tribe</i>						
Nyanja (n = 58)	43	(74.1)	1	(1.7)	14	(24.1)
Bemba (n = 75)	63	(84.0)	6	(8.0)	6	(8.0)
Tonga (n = 70)	61	(87.1)	6	(8.6)	3	(4.3)
Lozi (n = 34)	29	(85.1)	4	(11.8)	1	(2.9)
Lunda/Luvale/Kaonde (n = 24)	22	(91.7)	1	(4.2)	1	(4.2)
<i>Education level</i>						
None (n = 7)	6	(85.7)	0	(0.0)	1	(14.3)
Primary (n = 21)	14	(66.7)	6	(28.6)	1	(4.8)
Secondary (n = 107)	87	(81.3)	4	(3.7)	16	(15.0)
Tertiary (n = 137)	117	(85.4)	9	(6.6)	11	(8.0)
<i>FP Discussion in previous 6 months</i>						
Never (n = 41)	25	(61.0)	5	(12.2)	11	(26.8)
Once (n = 30)	26	(86.7)	2	(6.7)	2	(6.7)
Twice (n = 23)	18	(78.3)	1	(4.3)	4	(17.4)
More often (n = 169)	148	(87.6)	9	(5.3)	12	(7.1)

*Percentage may not add up to 100% due to rounding off.

It was observed that that one’s residential area, number of children, religion, educational level, occupation, fertility preference and frequency of family planning discussion had an effect on the current contraceptive use. As table 18 shows, the contraceptive usage rate was highest among the men residing in the low-density residential areas and lowest among those residing in high-density areas ($p = 0.004$). About 73.8% of men who had

attained tertiary education reported current use of family planning methods whereas only 12.5% of those who had no formal education reported doing so ($p < 0.001$). The current usage rate was also highest among businessmen (77.4%) and managers or “office” workers (73.3%). The clerical staff and labourers reported usage rate of 55.2% and 50.0% respectively ($p = 0.004$).

Men who had had 1 – 3 children and those who had more than six children at the time of the study reported the highest rate of contraceptive usage whilst those who had no children reported the lowest rates ($p < 0.001$). Men whose fertility preference was 3 – 5 children reported higher contraceptive usage rate than those who wanted fewer than three and more than five children respectively ($p = 0.027$).

About 72.4% of men who had discussed family planning with their wives on at least two occasions in the previous six months were currently using family planning methods. Only about 46.7% of those who had discussed only once were currently using any method of family planning ($p=0.005$). Couples who had discussed family planning were four times more likely to use family planning methods than those who had not discussed. It was also observed that the pentecostal protestants reported higher contraceptive usage rate than other religious groupings ($p = 0.024$).

Table 6: Factors significantly associated with current family planning practice among men.

Variable	Current Contraceptive Use	
	N	(%)
<i>Residence</i>		
High-density (n = 150)	88	(58.7)
Medium-density (= 75)	47	(62.7)
Low-density (n = 55)	46	(83.6)
<i>Number of Children ever had</i>		
None (n = 21)	5	(23.8)
1 – 3 (n = 195)	136	(69.7)
4 – 6 (n =56)	36	(64.3)
7 – 10 (n =8)	4	(50.0)
<i>Number of live children</i>		
None (n = 25)	6	(24.0)
1 – 3 (n = 198)	138	(70.0)
4 – 6 (n = 51)	30	(58.8)
>6 (n = 6)	5	(83.3)
<i>Religion</i>		
Catholic (n = 40)	29	(72.5)
Pentecostal Protestant (n = 67)	50	(74.6)
Non-Pentecostal Protestant (n = 141)	89	(63.1)
<i>Education level</i>		
None (n = 8)	1	(12.5)
Primary (n = 22)	6	(27.3)
Secondary (n = 109)	70	(64.2)
Tertiary (n = 141)	104	(73.8)
<i>Fertility preference</i>		
1 – 2 children (n = 46)	26	(56.5)
3 – 5 children (n = 178)	126	(70.8)
> 5 children (n = 44)	23	(52.3)
<i>FP discussion frequency in 6 months</i>		
Never (n = 41)	23	(56.1)
Once (n= 30)	14	(46.7)
More than once (n = 196)	142	(72.4)

5. DISCUSSION

The main objective of this study was to assess the knowledge, attitude and practice regarding family planning among men in Lusaka district. The main findings are that the level of knowledge, the approval rate and usage rate of family planning among men in Lusaka district are higher than expected.

5.1 FAMILY PLANNING KNOWLEDGE

Findings from this study show that most men in Lusaka district know about family planning. About 97.9% of men know at least one method of family planning. This is slightly lower than the national level of 99.6 percent¹¹, but higher than the level of 90% reported in the Ndola study of 1999.³⁶ Although the men's family planning awareness is higher than that of their partners, there is no statistically significant difference. These findings are consistent with those from the most recent ZDHS.¹¹ However, findings from the Ndola study showed a significant difference between men's awareness (90%) and that of women (95%).³⁷

As might be expected, men with higher level of education are more likely to know of at least two methods of family planning. Men are more likely to have heard of a modern method than a traditional one. Contrary to findings from most surveys, the most commonly known method among married men in Lusaka district is the pill, followed by the male condom and injectables. Other studies reported the male condom as being the

most commonly known method.^{11,15} The most commonly known traditional method among Lusaka men is periodic abstinence, contrary to the national data which show withdrawal as the most commonly known traditional method. These findings are comparable with those among their wives, except that women are more likely to know about injectables than male condoms.

Only about one tenth of men are aware about vasectomy and LAM. However, findings from the focus-group discussion and in-depth interviews show that awareness of these two methods is non-existent. It is unusual that much more men than women are aware about tubal ligation. This could probably be due to the fact that men are more exposed to information sources than women.

The mass media are the key source of family planning information for men. Men are more exposed to mass media than are women probably because men generally have more free time, more education, and more disposable income than women. The mass media can, therefore, be used to expose men to messages that can influence their family planning knowledge, attitude and behaviour.

5.2 ATTITUDE TOWARDS FAMILY PLANNING

More than eighty percent of both married men and their wives in Lusaka district approve of family planning. Although several studies show that men's approval rate are usually lower than women's,^{15, 18} there is no significant difference in the approval rate between

men and their wives in Lusaka district. The percentage of married men who say that they approve of family planning is greater than the percentage of women who think that their husbands approve. Only about 9.4% of married women in Lusaka district think that their husbands disapprove of family planning, compared with the national rate of 16 percent.¹¹ About seven percent of Lusaka men actually disapprove of family planning. Their objection is generally because of worries about their wives' health and side effects of contraceptives. These are the same reasons cited by the women.

Even though findings from the couple interviews show that more than seventy percent of couple discuss family planning at least twice in six months, findings from the FGD with men show that communication between husbands and wives regarding family planning is almost non-existent. Because men and their wives often do not discuss family planning, many wives think that their husbands oppose family planning when in fact husbands approve. This misperception may be one reason for the wide spread belief that men oppose family planning. Such findings suggest that women's unmet need for family planning could be reduced by better communication between husbands and wives.

5.3 REPRODUCTIVE INTENTIONS

About 50.4% of married men in Lusaka district say that they want to have more children, whilst only 14.3% of the women want more children. However, amongst the pregnant couples, fewer men than women want to have more children. The desire for more children in Lusaka district is much less than the national levels of 67% and 60% for married men and women respectively.¹¹

Married men in Lusaka district are more likely to want to end child-bearing than their wives. About 36.4% of men say that they do not want any more children, compared with only 5% of women. (None of the non-pregnant women express the desire to end child bearing whilst 80.7% of all women are undecided.) This finding shows that more men and less women want no more children, compared with the national levels of 31% and 36% of married men and women who say that they want no more children respectively.¹¹

Lusaka men are more likely to want their next child soon, whereas women are more likely to want to wait for at least three years for their next child. This finding is similar to findings from earlier studies.¹¹ The mean ideal number of children for both men and their wives is 3.9. This level is lower than the national levels of 5.3 and 4.7 children for men and women respectively¹¹, and is consistent with the four children adopted as the ideal family size in the National Population Policy.³⁹

5.4 CONTRACEPTIVE USE

This study clearly shows that while almost all of the married men in Lusaka district have heard and approve of family planning, not all of them practice family planning. The contraceptive usage rate of 64.6% and 61.1% reported by the men and women, respectively, in this study are far much higher than the national prevalence rate of 34.2%.¹¹ The most commonly used modern methods are the pill, followed by injectables and male condoms. Periodic abstinence is the most commonly used traditional method. The findings regarding use of modern methods are consistent with those from previous

nationwide surveys. However, the most recent ZDHS found that, at 1.1%, periodic abstinence is the least practiced traditional method nation wide.¹¹

The use of methods which involve male co-operation (male condom, periodic abstinence and withdrawal) is generally low. None of the couple in this study have ever used vasectomy. However, the use of male condom is comparable to that of injectables. The use of traditional methods is probably greater than what the study suggests. Traditional methods may be used in combination with modern contraceptive methods. For example, male condoms may be used in conjunction with periodic abstinence, and couples who use the pill may practice withdrawal or abstinence if they forget to take the pill.

It might be expected that married men and women would report similar levels of contraceptive use, since couples use contraception together. However, men tend to report higher levels of contraceptive use than women do. This finding may suggest that some men use contraceptives in sexual relations outside marriage. The man may also be unaware that his partner has stopped using a method of family planning.

It might also be expected that if a couple has used a permanent method of family planning in the past, they would still be using the same method currently. However, findings from this study show that about three percent of men report having had used tubal ligation in the past, but none of them is currently using the method. About a third (i.e. 3 out of 8) of these men reported using natural methods whilst 2 men reported using the pill at the time of the study. This discrepancy could be because men tend to over-report contraceptive use, probably to avoid appearing too traditional or in order to be

perceived as good care takers. It is also possible that they could have re-married, and that they could have been referring to usage with different partners.

Education and socio-economic status have significant effect on men's general practice of family planning. Contraceptive usage rate is highest among men who have attained tertiary education, those who live in low-density residential areas, and among those with "white-collar" jobs. These findings are similar to those from earlier national wide surveys.¹¹ As may be expected, married men without any children are less likely to use contraceptives than men who have children.⁴⁵

Contrary to the general belief that catholics are anti-family planning, most of the catholic men in Lusaka district approve and practice family planning. More than ninety percent of catholic men approve of family planning, and at least two thirds of them use modern methods of family planning.

Men who discuss family planning with their partners are more likely to use contraception than those who do not discuss. Findings from this study show that couples who discuss FP are four times more likely to use a family planning method than those who do not discuss. These findings are similar to those from studies in other African countries,^{25,26,28} and they suggest that spousal discussion can be a crucial step towards increasing men's participation in family planning issues. Discussion enables husbands and wives to know each other's attitudes toward FP, and it can encourage shared decision making regarding contraceptive use.

According to the findings of this study, most of the decisions regarding the use of any family planning method are made by both husbands and wives. However, where decisions are made unilaterally, most of them are made by women, contrary to the general belief that most decisions are made by men.

5.5 STUDY LIMITATIONS

The study was conducted in only six residential areas of Lusaka district. Face-to-face interviews may not have elicited frank answers in some instances, thus introducing some information bias. The sample size was also small and the results may, therefore, not be generalized to the rest of the district or country.

6. CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

This study shows that married men in Lusaka district know about family planning. The most commonly known modern methods are the pill, male condom and injectables, whereas periodic abstinence is the most commonly known traditional method. Vasectomy and LAM awareness is almost non-existent. The radio and television are major sources of family planning information for men.

More than eighty percent of married men in Lusaka district approve of family planning whilst only seven percent of them disapprove. The main reason for disapproval is the fear of side effects of contraceptives. About one fifth of women either do not know or misperceive their husbands' attitudes towards family planning. This is because couples rarely discuss family planning issues.

Although almost all of the married men in Lusaka district know about and approve of family planning, not all of them practice it. However, the contraceptive usage rate is almost double the national rate. The most commonly used modern methods of contraception are the pill, injectables and male condom, whereas periodic abstinence is the most commonly used traditional method. The use of methods which involve male co-operation is generally low. Most of the decisions regarding contraceptive use are made jointly by husband and wives.

Men with more schooling and those of high socio-economic status are more likely to approve of family planning and practice contraception than those with less education and of low socio-economic status. Discussion of family planning with the spouse influences the attitude and practice regarding family planning. Men who discuss family planning with their partners are more likely to approve of family planning and use contraceptives than those who do not discuss.

The level of knowledge about family planning among married men in Lusaka is slightly higher than that of their wives, though not statistically significant. Although the men's family planning approval rate is high, it is lower than their wives'. However, men report higher rates of contraceptive use than their wives. Men's desire for more children is generally greater than that of their wives', but their ideal family size is the same.

Men are more interested in family planning than often assumed. However, they need more information about family planning.

6.2 RECOMMENDATIONS

1. Men should be provided with information and education about family planning in general, and various methods of contraception in particular.

When more men know the basic facts about and benefits of contraceptives, more will use them. Men need clear and factual information from reliable and trusted sources.

2. Men should be informed about the male methods of family planning, that is, the condom and vasectomy. Fears and misconceptions regarding these methods need to be dispelled.

3. Couples should be encouraged to discuss family planning as this can lead to increased contraceptive use.

4. Since men are likely to be exposed to radio, television and news papers, these media can be used in strategic ways to communicate with men regarding family planning issues.

5. Family planning information can also be taken to where men gather, such as work places, social clubs and sporting events.

REFERENCES

1. Bai J et al, Parity and Pregnancy Outcomes. *American Journal of Obstetrics and Gynecology*, 2002, **186**: 274 - 8
2. Bankole A and Singh S, Couples' Fertility and Contraceptive Decision-making in Developing Countries: Hearing the Man's Voice. *International Family Planning Perspectives*, 1998, **24**(1): 15-24
3. Basu AM, The International Conference on Population and Development, Cairo 1994. Is its Plan of Action Important, Desirable and Feasible? *Health Transition Review*, 1996, **6**(2): 225 - 229
4. Bawah AA et al, Women's Fears and Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana. *Studies in Family Planning*, 1999, **30**(1): 54 - 66
5. Becker S, Couples and Reproductive Health: A Review of Couple Studies. *Studies in Family Planning*, 1996, **27**(6): 291 - 306
6. Biddlecom AE and Fapohunda BM, Covert Contraceptive Use: Prevalence, Motivation and Consequences. *Studies in Family Planning*, 1998, **29**(4): 360 - 372

7. Biratu BT and Lindstrom DP, The Influence of Husbands' Approval on Women's Use of Prenatal Care: Results from Yirgalem and Jimma Towns, South West Ethiopia. *The Ethiopian Journal of Health Development*, 2006, **20**(2): 84 - 92
8. Blanc A et al, Negotiating Reproductive Outcomes in Uganda. Calverton, Maryland, Macro International, 1996
9. Bongaarts J and Bruce J, The Causes of Unmet Need for Contraception and the Social Content of Services. *New York, Population Council*, 1994
10. Caldwell JC and Caldwell P, Cultural Forces Tending to Sustain High Fertility. *Population Growth and Reproduction in Sub-Saharan Africa: Technical Analysis of Fertility and its Consequences*, 1990, **06**: 199 - 214
11. Casterline JB and Sinding SW, Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. *Policy Research Division Working Papers* 2000 (135)
12. Central Statistical Office (Zambia), Central Board of Health (Zambia) and ORC Marc 2003. *Zambia Demographic and Health Survey*, 2001 - 2002
13. Central Statistical Office (Zambia), *Summary Report:2000 Census of Population and Housing*, 2003.

14. Danforth N, Let's Not Forget About Men. *Choices: The Human Development Magazine*, 1999, p 33 - 34
15. De Rose LF et al, Does Discussion of Family Planning Improve Knowledge of Partner's Attitudes Towards Contraceptives? *International Family Planning Perspectives*, 2004, **30**(2): 87 - 93
16. Drennan M, Reproductive Health: New Perspective on Men's Participation. *Population Reports*, 1998, Series J, Number 46.
17. Drife J and Magowan B, Contraception and Sterilization. *Clinical Obstetrics and Gyneacology*, 2004; 151 – 163.
18. Drife J and Magowan B, Women's Health in the 21st Century. *Clinical Obstetrics and Gyneacology*, 2004; 3 - 8
19. Ezeh AC et al, Men's Fertility, Contraceptive Use, and Reproductive Preferences. Calverton, Maryland, Marco International, 1996
20. Family Care International. *Safe Motherhood in Zambia: A Situation Analysis*, 1994.

21. Fathalla MF, Family Planning. In: Lawson JB, Harrison KA and Bergstrom S, *Maternity Care in Developing Countries*, 2003; 369 - 380
22. Fort A, Investigating the Social Context of Fertility and Family Planning: A Qualitative Study in Peru. *International Family Planning Perspective*, 1989, **15**(3): 88 - 95
23. Gebrekidan M, The Role of Men in Fertility and Family Planning Programs in Tigray Region, *Ethiopian Journal of Health and Development*, 2002, **16**(3): 247 - 255
24. Hill K, AbouZahr C, and Wardlaw T, Estimates of Maternal Mortality for 1995. *Bulletin of the World Health Organization*, 2001, **79**(3): 182 - 193
25. Hulton L and Falkingham J, Male Contraceptive Knowledge and Practice: What Do We Know? *Reproductive Health Matters*, 1996, (7): 90 - 100
26. Johns Hopkins Population Communication Services. Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects, 1986 – 1996. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, 1997.
27. Jolly KG, Impact of Inter-spouse Communication on Family Planning Adoption. *Journal of Family Welfare*, 1976, **23**(1): 38 - 44

28. Khorram S and Wells E, Involving Men in Reproductive Health. *Outlook*, 1997, **14** (3): 1- 8
29. Lasee A and Becker S, Husband-wife Communication About Family Planning and Contraceptive Use in Kenya. *International Family Planning Perspective*, 1997, **23**(1): 15 - 20
30. Lawoyin TO et al, Family Planning in Rural Nigeria: A Study Among Men. *African Journal of Medicine and Medical Sciences*, 2002, **31**(2): 159 - 162
31. Mac'wangi M, Some Aspects of Family Planning Development in Zambia: 1972 – 1982, 1983.
32. Mason KO and Taj AM, Differences Between Women's and Men's Reproductive Goals in Developing Countries. *Population and Development Review*, 1987, **13**(4): 611 - 633
33. Mbewe RK, An Evaluation of Norplant at the University Teaching Hospital, 1998.
34. Mbizvo MT and Basset MT, Reproductive Health and AIDS Prevention in sub-Saharan Africa: The Case for Increased Male Participation. *Health Policy and Planning*, 1996, **11**(1): 84 – 92.

35. Mc Ginn T et al, Male Knowledge, Use and Attitude Regarding Family Planning in Burkina Faso. *International Family Planning Perspectives*, 1989, **15**(3): 84 - 88
36. Men and Reproductive Health: Key Issues, *Reproductive Health Outlook*, 2001
37. Muvandi I, Dover P and Ilinigumugabo A, Heads, Tails or Equality: Men, Women and Reproductive Health in Zambia, 2000
38. Mwageni EA et al, Attitudes of Men Towards Family Planning in Mbeya Region, Tanzania: A Rural –urban Comparison of Qualitative Data. *Journal of Biosocial Science*, 1998, **30**(3): 381 – 392.
39. National Commission for Development Planning (NCDP) [Zambia], 1989. *Zambia's National Population Policy*. Lusaka, Zambia: National Commission for Development Planning
40. Ntozi JPM, The Role of Men in Determining Fertility Among the Banyankore of South-western Uganda. Kisubi, Uganda: Marianum Press, 1993.
41. Odimegwu OC, Family Planning Attitudes and Use in Nigeria: A factor Analysis. *International Family Planning Perspectives*, 1999, **25**(2): 86 – 91.

42. Oni GA and McCarthy J, Family Planning Knowledge, Attitudes and Practices of Male in Ilorin, Nigeria. *International Family Planning Perspectives*, 1991, **17**(2): 50 – 54.
43. Oyediran KA et al, Factors Affecting Ever-married Men’s Contraceptive Knowledge and Use in Nigeria. *Journal of Biosocial Science*, 2002, **34**(4): 497 – 510.
44. Reddy RS et al, Rapid Appraisal of Knowledge, Attitude and Practices Related to Family Planning Methods Among Men within 5 Years of Married Life. *Indian Journal of Preventive and Social Medicine*, 2003, **34**(2): 63 - 67
45. Robey B and Drennan M, Male Participation in Reproductive Health. *Net work*, 1998, **18**(3): 11 - 15
46. Roudi F and Ashford L, Men and Family Planning in Africa. *Population Reference Bureau*, New York : UN, 1996.
47. Salemu R, Men’s Surveys: New Findings. *Population Reports*, 2004, Series M, Number 18
48. Salter C et al, Care for Post-abortion Complications: Saving Women’s Lives. *Population Reports*, 1997, Series L, Number 10.

49. Salway S, How Attitudes Towards Family Planning and Discussion Between Wives and Husbands Affect Contraceptive Use in Ghana. *International Family Planning Perspectives*, 1994, **20**(2): 44 – 47.
50. Seltzer JR, The Origins and Evolution of Family Planning Programs in Developing Countries, 2002.
51. Shamshad Begum, Age and Parity Related Problems Affecting Outcome of Labor in Grand Multiparas. *Pakistan Journal of Medical Research*, 2003, **42**(4): 179 - 84
52. Sherpa H and Rai D, Safe Motherhood: It is a Family Responsibility. *Report on National Safe Motherhood Awareness Campaign*. Kathmandu, Nepal, Centre for Development and Population Activities, 1997.
53. Simonsen Ellis et al, Effects of Grand Multiparity on Intrapartum and Newborn Complications in Young Women. *Obstetrics and Gynecology*. 2005, **106**(3): 454 - 60
54. Terefe A, Larson CP. Modern Contraception Use in Ethiopia: Does Involving Husbands Make a Difference? *American Journal of Public Health* 1993, **83**(11): 1567-71.

55. United Nations (UN). *Programme of Action of the International Conference on Population and Development (Cairo)*. New York, UN, 1995.
56. United Nations Population Fund (UNFPA), *The State of the World Population 1997: The Right to Choose. Reproductive Rights and Reproductive Health*. New York, UNFPA, 1997
57. Westoff CF and Bankole A, The Time Dynamics of Unmet Need: An Example from Morocco. *International Family Planning Perspectives*, 1998, **24**(1):12-14
58. Who Makes Reproductive Decisions? *Population Reports*, 2001, Series M, Number 12.
59. Worku S and Fantahun M, Unintended Pregnancy and Induced Abortion in a Town with Accessible Family Planning Services: The Case of Harar in Eastern Ethiopia. *The Ethiopian Journal of Health Development*, 2006, **20**(2):79-83.

Appendix 1

Information Sheet

Men's knowledge and attitude towards family planning in Lusaka District

Good morning/ afternoon/ evening. Our names are _____

We are collecting data for a study being conducted by Dr Isaiah Hansingo. He is a postgraduate student in the Department of Obstetrics and Gynaecology. He is conducting a study on "Men's Knowledge and Attitude Towards Family Planning in Lusaka District". The aim of this study is to explore the men's knowledge and attitude towards family planning, and to what extent they differ from their wives.

A questionnaire has been designed which you and your spouse will be required to complete. Besides answering a few questions, no other procedures or tests will be carried out on you. However, some questions asked may be sensitive, but you have the right to refuse to answer them.

Your participation in this study is voluntary. Your consent to participate will not result in violation of your rights. You have the right to refuse to participate in this study.

There is no direct benefit to you if you choose to participate in this study. However, the information collected from this study may help policy- makers to come up with appropriate family planning programs. This will in turn reduce the number of unintended pregnancies and pregnancy- related deaths.

All information collected will be confidential and will not be released without your permission, or used for other purposes. If you wish, the findings of this study may be communicated to you.

In case of any further questions or clarifications, please contact Dr Isaiah Hansingo, Department of Obstetrics and Gynaecology, University Teaching Hospital, Private Bag RW 1X, Lusaka. Cell: 0955 817861; e-mail: ihansingo@yahoo.com

OR The Secretariat, The University of Zambia Research Ethics Committee, Ridgeway Campus, P.O. Box 50110, Lusaka; Tel: 260-1-256067, Fax: 260-1-250753; e-mail: unzarec@zamtel.zm.

Appendix 2

Consent

Men's knowledge and attitude towards family planning in Lusaka District

I have understood the information that has been given to me, and my questions have been answered to my satisfaction. I do agree to participate in this study.

_____ Name of Participant	_____ Signature/ Thumb Print	_____ Date
_____ Name of Witness (If thumb print used)	_____ Signature	_____ Date
_____ Name of Interviewer	_____ Signature	_____ Date

Appendix 3A

Men's questionnaire

Men's knowledge and attitude towards family planning in Lusaka District

Residential area _____ Study number _____

A. Demographics

1. How old are you? _____ years
2. In what month and year were you born? _____
3. Are you married? (i) Yes
(ii) No
4. How many wives do you have? _____
5. For how long have you been married? _____
6. How many children have you ever had? _____
7. How many of these are: (i) Males? _____
(ii) Females? _____
8. How many of your children are alive? _____
9. Has your wife ever had: (a) Miscarriages? (i) Yes
(ii) No
(b) Stillbirths? (i) Yes
(ii) No
If yes, how many: (a) Miscarriages? _____
(b) Stillbirths? _____
10. What is your religion? (i) Christianity
(ii) Islam
(iii) Other (Specify) _____
If Christianity, what is your Church denomination? _____
11. What is your tribe/ethnicity? _____
12. What is the highest level of education that you have attained?
(i) None
(ii) Primary
(iii) Secondary
(iv) Tertiary
13. What is your occupation? _____
14. What is your estimated monthly income? _____

B. Fertility preferences

1. Is your wife pregnant now? (i) Yes
(ii) No
(iii) Not sure

If not pregnant or not sure, please go to question 4.

2. Was the pregnancy planned? (i) Yes
(ii) No
If no, did you want to wait until later or did you not want any (more) children at all? (i) Wait until later
(ii) Not at all
3. After the child you are expecting now, would you like to have another child? (i) Yes
(ii) No
(iii) Undecided
If yes, how long would you like to wait before having another child?
(i) _____ Months
(ii) _____ Years
(iii) Undecided

Please go to question 5.

4. Would you like to have a/another child? (i) Yes
(ii) No
(iii) Undecided
If yes, how long would you like to wait from now before you have a/another child? (i) _____ Months
(ii) _____ Year
(iii) Undecided
5. If you could choose exactly the number of children to have in your whole life, how many would that be? _____
6. Do you think your wife wants the same number of children that you want, or does she want more or fewer than you want? (i) Same
(ii) More
(iii) Fewer
(iv) Don't know

C. Family planning knowledge

1. Have you ever heard about family planning? (i) Yes
(ii) No
If yes, how did you hear about it? (i) Health personnel
(ii) Radio
(iii) Television
(iv) Newspaper/magazine
(v) Friends
(vi) Relatives
(vii) Other (Specify) _____

2. What do you understand by “family planning”? _____

3. What method(s) of family planning do you know? _____

4. Have you ever heard of any of the following methods of family planning?
(i) Pill
(ii) Injectables
(iii) Implants
(iv) Male condom
(v) Female condoms
(vi) Diaphragm
(vii) Intra-uterine contraceptive device/Loop
(viii) Foam tablets/jelly
(ix) Tubal ligation
(x) Vasectomy
(xi) Rhythm/ natural family planning method
(xii) Lactational amenorrhoea method
(xiii) Withdrawal method

D. Attitude

1. Do you approve or disapprove of couples using any method to avoid pregnancy? (i) Approve
(ii) Disapprove
(iii) Unsure

If unsure, please go to question 3.

2. What is the reason to your approval/ disapproval? _____

3. Do you think your wife approves or disapproves of couples using any method to avoid pregnancy? (i) Approves
(ii) Disapproves
(iii) Don't know

E. Practice

1. Have you ever used anything or done anything to delay or avoid pregnancy? (i) Yes
(ii) No
If yes, what have you used or done? _____

Please go to question 2

- If no, why haven't you done anything to avoid or delay pregnancy? _____

Please, go to question 3.

2. Are you currently doing something or using any method to delay or avoid pregnancy? (i) Yes
(ii) No
If yes, what method(s) are you using? _____

Please, go to question 4.

If no, why aren't you currently doing anything or using any method to delay or avoid pregnancy? _____

3. Do you think you will use any method to delay or avoid pregnancy at any time in future? (i) Yes
(ii) No
(iii) Undecided
If yes, which method would you prefer to use? _____

If no, what is/are the main reason(s)? _____

4. Whose decision was it for your usage or non-usage of any method to delay or avoid pregnancy? (i) Husband
(ii) Wife
(iii) Joint
5. How often have you talked to your wife about family planning in the last six months? (i) Never
(ii) Once
(iii) Twice
(iv) More often

Thank you for your participation

Appendix 3B

Women's questionnaire

Men's knowledge and attitude towards family planning in Lusaka District

Residential area _____ Study number _____

A. Demographics

1. How old are you? _____ years
2. In what month and year were you born? _____
3. Are you married? (i) Yes
(ii) No
4. How many wives does your husband have? _____
If more than one, what order are you? (i) First
(ii) Second
(iii) Beyond second
5. For how long have you been married? _____
6. How many children have you ever had? _____
7. How many of these are: (i) Males? _____
(ii) Females? _____
8. How many of your children are alive? _____
9. Have you ever had: (a) Miscarriages? (i) Yes
(ii) No
(b) Stillbirths? (i) Yes
(ii) No
If yes, how many: (a) Miscarriages? _____
(b) Stillbirths? _____
10. What is your religion? (i) Christianity
(ii) Islam
(iii) Other (Specify) _____
If Christianity, what is your Church denomination? _____

11. What is your tribe/ethnicity? _____
12. What is the highest level of education that you have attained?
(i) None
(ii) Primary
(iii) Secondary
(iv) Tertiary
13. What is your occupation? _____
14. What is your estimated monthly income? _____

B. Fertility preferences

1. Are you pregnant now? (i) Yes
(ii) No
(iii) Not sure

If not pregnant or not sure, please go to question 4.

2. Was the pregnancy planned? (i) Yes
(ii) No
If no, did you want to wait until later or did you not want any (more) children at all? (i) Wait until later
(ii) Not at all
3. After the child you are expecting now, would you like to have another child? (i) Yes
(ii) No
(iii) Undecided
If yes, how long would you like to wait before having another child?
(i) _____ Months
(ii) _____ Years
(iii) Undecided

Please go to question 5.

4. Would you like to have a/another child? (i) Yes
(ii) No
(iii) Undecided
If yes, how long would you like to wait from now before you have a/another child? (i) _____ Months
(ii) _____ Year
(iii) Undecided
5. If you could choose exactly the number of children to have in your whole life, how many would that be? _____
6. Do you think your husband wants the same number of children that you want, or does he want more or fewer than you want? (i) Same
(ii) More
(iii) Fewer
(iv) Don't know

C. Family planning knowledge

1. Have you ever heard about family planning? (i) Yes
(ii) No
If yes, how did you hear about it? (i) Health personnel
(ii) Radio
(iii) Television
(iv) Newspaper/magazine
(v) Friends
(vi) Relatives
(vii) Other (Specify) _____

2. What do you understand by “family planning”? _____

3. What method(s) of family planning do you know? _____

4. Have you ever heard of any of the following methods of family planning?
(i) Pill
(ii) Injectables
(iii) Implants
(iv) Male condom
(v) Female condoms
(vi) Diaphragm
(vii) Intra-uterine contraceptive device/Loop
(viii) Foam tablets/jelly
(ix) Tubal ligation
(x) Vasectomy
(xi) Rhythm/ natural family planning method
(xii) Lactational amenorrhoea method
(xiii) Withdrawal method

D. Attitude

1. Do you approve or disapprove of couples using any method to avoid pregnancy? (i) Approve
(ii) Disapprove
(iii) Unsure

If unsure, please go to question 3.

2. What is the reason to your approval/ disapproval? _____

3. Do you think your husband approves or disapproves of couples using any method to avoid pregnancy? (i) Approves
(ii) Disapproves
(iii) Don't know

E. Practice

1. Have you ever used anything or done anything to delay or avoid pregnancy? (i) Yes
(ii) No
If yes, what have you used or done? _____

Please go to question 2

If no, why haven't you done anything to avoid or delay pregnancy? _____

Please, go to question 3.

2. Are you currently doing something or using any method to delay or avoid pregnancy? (i) Yes
(ii) No
If yes, what method(s) are you using? _____

Please, go to question 4.

If no, why aren't you currently doing anything or using any method to delay or avoid pregnancy? _____

3. Do you think you will use any method to delay or avoid pregnancy at any time in future? (i) Yes
(ii) No
(iii) Undecided
If yes, which method would you prefer to use? _____

If no, what is/are the main reason(s)? _____

4. Whose decision was it for your usage or non-usage of any method to delay or avoid pregnancy? (i) Husband
(ii) Wife
(iii) Joint
5. How often have you talked to your husband about family planning in the last six months? (i) Never
(ii) Once
(iii) Twice
(iv) More often

Thank you for your participation

Appendix 4

Sample size calculation

Formula used: $n = Z^2 p(100-p) \div d^2$

where n= sample size

Z= Z statistic for a level of confidence

p= expected prevalence, and

d= precision

For the confidence level of 95%, the Z value is 1.96.

Therefore, taking expected prevalence as 47.1% at 95% confidence level with a precision of 6%,

$$\begin{aligned}n &= 1.96^2 \times 47.1 \times (100 - 47.1) \div 6^2 \\ &= 3.8416 \times 47.1 \times 52.9 \div 36 \\ &= \mathbf{265.88}\end{aligned}$$