

## **CHAPTER 1: INTRODUCTION**

### **1.0 Introduction**

This chapter presents the background of the problem, the statement of the problem, objectives of the study, its significance and the structure of the thesis. It also describes in brief the social and cultural background of involving men in family planning.

### **1.1 Background of the Problem**

Family planning in Zambia like the rest of the world cannot be viewed in isolation but in a broader picture of reproductive health and specifically in safe motherhood. This is because it affects safe motherhood in many ways. For example, family planning helps to save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies (UNFPA, 2004). According to Feuerstein (1993), safe motherhood entails creating the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does, ensuring that she receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, access to emergency obstetric care if she needs it and care after birth so that death or disability from complications of pregnancy and child birth are avoided.

In Zambia, maternal mortality rate is high at 591 Per 100,000 live births and infant mortality rate is estimated at 70 Per 1,000 live births (CSO et al., 2007). However the choice of whether to become pregnant or not and the effort of planning for a family cannot be achieved by women alone. There is need for men to get involved if good results are to be achieved since they are in most cases key decision makers in homes, societies and are perceived as custodians of cultural, traditional practices and values

(Odhiamba, 1997; Popoola, 1999). Because of this, many of the decisions concerning reproductive health intentions and family planning are made in the context of gender relations that affect the extent of use.

Traditionally, family planning programmes have viewed women as their primary clients because it is the women who become pregnant and most contraceptive methods are designed for women. In addition, reproductive health services are offered more conveniently as part of maternal and child health services. The 1994 International Conference on Population and Development (ICPD) reminded the world audience that good reproductive health is the right of all people, men and women alike and that together they share responsibility for reproductive matters. By emphasizing gender relations, the conference drew attention to the fact that if men are left out of the reproductive health equation, they are unlikely to be able to exercise responsible behaviour in the effort to achieving reproductive health rights (Green, 1995).

Reproductive health practitioners have also recognized that the failure to target men in programmes has weakened the impact of reproductive health programmes since men can significantly influence their partners' reproductive health decision-making and the use of health resources (Mbizvo & Bassett, 1996). Green (1995) asserts that, 'as interest in men's participation in family planning has grown, more attention is being given to learning how to reach them effectively so that family planning programmes become more inclusive.'

## **1.2 Statement of the Problem**

Family planning and involving men in family planning has been recognized as important the world over. Globally, men have not shared equally with women the responsibility for fertility regulation and planning for a family (Ringheim, 1993). In Zambia, the extent of men's participation in family planning is not documented. However, their participation is critical as they have strong influence on women's health, their access to care and access and usage of family planning services (Drennan, 1998). 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. Available data indicate that unsafe motherhood and infant mortality rates are still high in Zambia and there is need to reverse these trends in order to reach the Millennium Development Goals (MDG's) on reducing child mortality and improve maternal health by 2015 (USAID, 2004). In all these efforts men are critical as involving them in family planning would enable them understand pregnancy related and other risks that their partners' might be exposed to and how those risks may affect their partners' health.

## **1.3 OBJECTIVES**

### **1.3.1 General Objective**

The general objective of this study was to examine men's participation in family planning in the Chilanga Ward of Chilanga Constituency in Kafue District.

### **1.3.2 Specific objectives**

The specific objectives of the study were:

- (i) To find out the role that men play in family planning;

- (ii) To establish the patterns and extent of men's participation in family planning;
- (iii) To examine gender differences in attitudes towards family size and birth spacing;
- (iv) To examine the existing family planning systems and establish obstacles to men's participation in family planning; and
- (v) To identify problems faced by women when discussing family planning issues with their partners.

#### **1.4 Significance of the Study**

Since men have a stake in reproductive health through multiple roles as sexual partners, husbands and fathers, reproductive health programmes need to address their behaviour in these various roles. Involving men in family planning is important because culturally they already have an all encompassing involvement in decisions pertaining to family and society. It is therefore logical that they share the burdens of preventing health complications and deaths as a result of unwanted and poorly spaced pregnancies through active participation in family planning. It is in this regard that this study focused on men's participation in family planning in Chilanga. The study findings will facilitate strategic planning in mitigating the obstacles of men's participation in family planning while providing new insights into the problem of low male involvement in family planning.

#### **1.5 Conceptual and Operational Definitions**

- 1. Family planning** – means working out a plan by a couple on when and how many children to have and how to prevent unwanted pregnancies.

2. **Use of family planning** – the ability and practice of an individual man or woman to use family planning services and contraceptives.
3. **Interest in family planning** – for purposes of this study, it refers to the drive or motivation of men to use family planning services. In this study, it is determined by whether male respondents answer in the affirmative to questions as to whether they use or think they should use family planning as well as participate in family planning.
4. **Men’s participation** – refers to men’s active involvement in issues around them. In this study, men’s participation is measured on the basis of men’s acceptance and support of their partners’ use of family planning as well as responsibility of their sexual behaviour.
5. **Spouse/partner** – men or women who are either married, living together or who are sexually involved and have children together.
6. **Gender** – refers to the different roles that men and women play in society.
7. **Sex** – refers to biological and physical differences between men and women as they get classified as “male” and “female”.
8. **Attitude** – is a feeling or a way of thinking, for purposes of this study towards discussion and issues concerning family planning.
9. **Perception** – immediate or intuitive recognition or appreciation of something. In this study, perception is viewed in the area of recognizing and appreciating issues of family planning.

**10. Unmet need** – it refers to a situation where a couple does not want have another child or they would want to space the next birth but are not using a family planning method.

## **1.6 Structure of Thesis**

The focus of Chapter 1 is on the background of the problem, the statement, significance of the study as well as the objectives and structure of the thesis. Chapter 2 presents the introduction to the chapter and a review of the literature on studies conducted in family planning and men's participation in family planning. Chapter 3 explains in detail the methods used during data collection and how data were The chapter also explains ethical considerations of the study. In Chapter 4, the findings and discussion are presented. Among other issues, the chapter focuses on the socio-economic and demographic background of all the participants and discusses in detail men's attitudes towards family planning, the extent of their participation in family planning and obstacles to their participation. Finally, Chapter 5 presents the summary of the findings, the conclusion and recommendations on strategies that would encourage men's participation in family planning.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.0 Introduction**

This chapter reviews the literature related to family planning and men's participation in family planning across the world. The studies that have been reviewed in this chapter are relevant as they provide a premise to the understanding of men's participation in family planning.

### **2.1. Family Planning**

Family planning is often discussed in terms of its impact on women's physical health because it is one of the effective actions that support women's right to safe motherhood (Smyke, 1991). Different authors have used the term "family planning" synonymous with "birth control". However, family planning does not just involve contraception. The World Health Organization has defined family planning 'the decision on whether to have children or not, when to have children and how many children to have.' Family planning in this context therefore includes planning the births of children and spacing births by the use of contraceptives.

Studies conducted by the Women's Studies Project in some selected countries across the world concluded that family planning should be viewed in broader terms, as a 'long-term activity that affects the quality of women's psychological health, their domestic lives, their ability to participate in the work force, and their ability to join in community activities' (Barnett & Stein, 1998).

According to the Zambia National Population Policy (1989), the Zambian Government recognizes the need for family planning to reduce the annual population growth to 2.5%

and reduce infant mortality rate to 50 per 1000 live births by 2015 through the provision of family planning services at public health institutions. The Policy also aims at reducing total fertility to 4% by 2015 by making family planning services accessible and affordable to the adult population. The key findings of the 2007 Zambia Demographic and Health Survey has recorded that public health institutions provide contraceptives to 68% of current users while the private sector provides methods to 17% of users. These services are provided free of charge at public health and are part of maternal and child health services. However, the Survey has recorded that 27% of currently married women have an unmet need for family planning and the majority are in rural areas. The unmet need has largely contributed to the population growth over years. It is argued that with the current population growth rate, it is estimated that the population will increase to 21 million by 2025 (Borne et al., 1996). The increase in population is however not commensurate with the uplifting of the standards of living for the majority of the population.

### **2.1.1 Benefits of Family Planning**

The importance of family planning cannot be over emphasized. The United Nations Population Fund has recorded some of the health benefits of family planning which include reduction in the risks associated with fetal deaths, birth defects, infant mortality, maternal mortality and general improvement of the health of the mother and child. The other benefit is that of having more relaxed sexual relations between men and women when they are confident that intercourse will not lead to unwanted and ill-timed pregnancies (UNFPA, 2004). According to the United States Agency for International Development (USAID), family planning is important for the health of the children and

the mother, and for the economic situation of the family. The financial impact of having children includes the medical costs of a pregnancy and birth, and the subsequent cost for raising children. Because parents have a responsibility to provide food, clothing, shelter and education for their children, family planning has a significant and long-term impact on a family's financial situation.

#### **2.1.1.1 Family Planning and Maternal Mortality**

According to the 9<sup>th</sup> Edition of the International Classification of Diseases by World Health Organization quoted in Feuerstein (1993), maternal mortality is, 'the death of a woman while pregnant or within 42 days of termination pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.' Doyal (1995) contends that, 'the rate of maternal mortality shows a woman's risk in each pregnancy she encounters.'

Maternal mortality in many developing countries remains at distressingly high levels despite improvements in hospital obstetrics. The World Health Organization estimates that quarter a million maternal deaths occur each year, 99% of which are in developing countries. In Sub-saharan Africa maternal deaths are associated with infections, health service factors, reproductive health factors, socio-economic and cultural factors (Nsemukila, 1994; Shah et al., 1989). It is argued that one of the most important indicators in assessing a country's quality of health including safe motherhood is maternal mortality data. This provides revealing measure of the status of women, their access to health care and the ability of the health care system to respond to their needs.

WHO, (2000) also considers maternal mortality as an indicator of disparity and inequity between men and women, between communities and among countries.

There is a relationship between maternal mortality and contraceptive use. In a study in Bangladesh, maternal mortality ratio dropped by 22% over a period of 12 years because of the increase in contraceptive use (Berer, 2007). This was despite the fact that about 90% of births took place in homes and were assisted by unskilled birth attendants. The decline in maternal mortality rates was attributed to a decline in fertility and unplanned pregnancies. Thus, reducing the number of pregnancies through the use of contraceptives reduces the risks of maternal deaths thereby saving women's lives. Contraceptive use therefore gives women respite from unwanted and too closely spaced pregnancies.

In countries such as China, Cuba, Egypt, Jamaica, Malaysia, Sri Lanka, Thailand and Tunisia, significant declines in maternal mortality had occurred as more women gained access to family planning and skilled birth attendance with backup emergency obstetric care (UNFPA, 2004). According to the United Nations, voluntary family planning has been estimated to prevent a quarter of maternal deaths by helping women delay early pregnancy and childbirth, prevent closely spaced births and reduce the risk of HIV transmission' ([www.un.org/esa/socdev/unpfii/documents](http://www.un.org/esa/socdev/unpfii/documents)) .

According to the UNFPA (2009), family planning use influences the maternal mortality ratio only to the extent that it reduces the proportion of pregnancies to high-risk women. The maternal mortality rate can be substantially influenced by the prevalence of contraception, but it is primarily the reduction in the number of births that exerts the influence. In developing countries, modern obstetric care is often available only in a few

teaching hospitals but family planning programs are feasible even in remote areas. While implementing family planning programs is not easy, it is more feasible than the implementation of significant improvements in the quality and availability of obstetric care. The contribution of family planning to lower maternal mortality and morbidity should not therefore be underestimated.

### **2.1.1.2 Family Planning and Infant and Child Mortality**

Infant and child mortality have been defined as, ‘the probability of an infant dying before the 1<sup>st</sup> birthday and the probability of dying between the 1<sup>st</sup> and 5<sup>th</sup> birthday respectively (CSO et al., 2007). According to the UNFPA (2004), there is a relationship between maternal, infant and child mortality as maternal deaths have a significant impact on infant and child mortality. This is because the chance of survival of the baby becomes slim after the death of the mother. Accordingly to Smyke (1991), too closely spaced pregnancies among other factors such as nutrition and access to specialized health care facilities also have an effect on infant and child mortality. This entails that with the reduced number of pregnancies due to family planning, there will be reduced cases of infant and child deaths. In addition, mothers will be able to give extra care to the children, thus reducing the number of children dying between their 1<sup>st</sup> and 5<sup>th</sup> birthdays.

The Population Action publication for May, 2007 reports that infant mortality has declined in Egypt, Indonesia, Bangladesh, Nepal and the Philippines according to a State of the World Mothers’ report released by Save the Children. Much of this achievement can be attributed to access to family planning services which give women the ability to space their children at healthy intervals and plan the size of their families. The successes

of these 5 countries show how crucial financial and political commitments to family planning are to curbing child mortality, as well as meeting other development goals ([www.savethechildren.org](http://www.savethechildren.org)).

According to the publication, Egypt's remarkable 68% reduction in child deaths in the last 15 years puts the nation right on track to meet Millennium Development Goal 4 on reducing child mortality by two thirds by 2015. After hosting the International Conference on Population and Development in 1994, Egypt committed itself to investing in the health of mothers and children. The country aimed to reduce child mortality, reduce the fertility rate and to improve pregnancy outcomes. Through public health initiatives that provided healthcare for pregnant women and improved access to family planning education and services including contraceptives, the fertility rate has declined from 4.3 to 3.1 births per woman, contraceptive use has increased to nearly 60% and child mortality has declined significantly ([www.savethechildren.org](http://www.savethechildren.org)).

The United Nations (2004) reports that infants that are spaced more than 3 years apart are more than 3 times as likely to survive as infants than those born less than one and half years apart. Considering that each year 10 million children under 5 years die primarily from preventable causes, and in poor countries as well as an additional half a million mothers die in childbirth or pregnancy, it is clear that family planning must remain on top of any development agenda ([www.un.org/esa/socdev/unpfii/documents](http://www.un.org/esa/socdev/unpfii/documents)).

### **2.1.1.3 Family Planning and Women's Self Determination**

For most women, family planning experiences increase their self-esteem and autonomy. A study conducted in Bolivia found that modern contraceptive users had higher levels of

self-determination than non-users and were more satisfied with their sexual relationships (Barnett & Stein, 1998). With the use of family planning, women have power to make decisions that would make positive impacts in their lives thereby determining when and how many children to have.

The Women's Studies Project (1998) reviewed that women did not see family planning as an isolated event in their lives, but an on-going process that helped them achieve desired practical goals. Decisions to use family planning were connected to other individual and family needs. For example, study participants said that contraceptive use was not only a way to protect women's health from the stress of too many and too closely spaced pregnancies but also led to improvements in the economic status of individual families while women's contributions to household income afforded them more decision-making power (Barnett & Stein, 1998).

Family planning practice also allows women to obtain an education, participate in the work force or devote additional time to their husbands and children or a way to enhance the quality of the couple's sexual relationship by minimizing the fear of pregnancy.

#### **2.1.1.4 Family Planning and Family Economics**

Some studies conducted by the Women's Studies Project suggest that family planning use leads to improvements in couple relationships and stability at home. Across cultures, women and men surveyed in the studies identified smaller family size as one of the benefits of family planning as it led to increased family income.

Qualitative and quantitative data from different countries in the Women's Studies Project showed that both women and men generally believed that family planning was beneficial. For example, in a study conducted in Zimbabwe, women and men said that family planning was an important element of quality of life. a similar study conducted in Indonesia, couples stated that family planning offered them a means to achieve financial stability and harmony within the home (Barnett & Stein, 1998). Family planning is therefore a way that ensures that family size matches the family economic resources. In another study conducted in Uganda according to Popoola (1999), it was found that family planning legitimized preferences for smaller families and helped meet latent demand for fertility regulation in high fertility societies.

It is therefore logical to conclude that family planning is one of strategies that women have available to improve their lives both physically socially and the lives of their families. However, some studies on family planning have argued that contraceptive use does not lead to gender equity. In a study conducted in Zimbabwe, women were pleased that family planning allowed them to participate in the labour force but gender inequality in the labour market was still prominent (Barnett & Stein, 1998). Thus, family planning exists within the context of gender norms, family dynamics and economic realities that limit women's opportunities within and outside the home.

Despite the health and other benefits of family planning, there are many barriers to family planning service use in many developing countries according to the International Family Planning Perspective (IFPP) of June 2006. In a variety of countries and settings, demographic, socio-economic, cultural and health experiences are factors have been

shown to influence the use of family planning services. The socio-economic indicators include urban residence, household living conditions, household income, women's education and employment in skilled work outside the home and husbands' education and occupational status (Popoola (1999)). These have been shown to be strong predictors of a woman's likelihood to access family planning services.

In Zambia, efforts to improve reproductive health have been modest. At the present rates of progress, it would be impossible to meet the Millennium Development Goal's (MDG's) targets on reproductive health. Multifaceted e will need to be put in place to ensure improvement in overall reproductive health and effective family planning strategies form part of the solution for improvement.

Investing more in family planning and other reproductive health services is vital in mitigating the economic and environmental impact of po growth but family planning and reproductive health services are not uniformly available around the country and are not always well linked to HIV and AIDS interventions (USAID, 2004).

## **2.2 Involving Men in Family Planning**

According to Toure (1996), male involvement in family planning means more than increasing the number of men using condoms and having vasectomies. It includes the number of men who encourage and support their partners to use family planning. Male involvement therefore entails 'all activities aimed at men as a discreet group which the objective of increasing the acceptability and prevalence of family planning practice of either sex.'

During the past several years, especially since the 1994 International Conference on Population and Development (ICPD), there has been increased attention around the world on constructive male involvement in reproductive health (Kim & Kols, 2001). Until recently, data about men's family planning knowledge, attitudes, and practices were scarce. Most large-scale family planning surveys such as the Knowledge, Attitudes and Practice Surveys, the World Fertility Surveys, the Contraceptive Prevalence Surveys, and the first round of the Demographic and Health Surveys included only women and focused on determinants of their contraceptive use (Petro-Nustas, 1999). The lack of attention to men in surveys reflected their limited options for participating in contraceptive use (Ringheim, 1993).

Prior to the 1994 Conference however, studies on knowledge, attitude and practice of family planning conducted among men in Africa showed that there was a positive attitude by men towards family planning services (Mbizvo & Adamchak, 1991). This was demonstrated by their knowledge of various family planning methods which was reported as high and their approval of family planning. Despite these findings however, there are very few countries in Africa and the rest of the world where fertility regulation is shared almost equally by men and women (Ringheim, 1993).

Most men, like most women approve of family planning. The Ezeh analysis which offers an analysis of developing countries portrait of male participation in 15 African and Asian countries, it was found that 7 out of 15 countries surveyed, 90% of men approved of using contraceptives (<http://www.fhi.org>). In Ghana, for example, the percentage of men who approved of family planning rose from 77% in 1988 to 90% in 1993. In other countries

such as Malawi and Pakistan men were also more likely than women to approve of family planning. In the rest of the countries however, men were less likely than women to approve family planning. This fact in part may explain why men often are pictured as obstacles to contraceptive use. In nearly all countries surveyed according to the Family Health International, better-educated men expressed greater approval of family planning than men with less education (<http://www.fhi.org>).

The above findings correlate with other findings on men's participation in reproductive health which concluded that men who are educated are more likely to support their partners in contraceptive use, use contraception themselves and demonstrate greater responsibility for their children (Grady, 1996).

In a study in the United States of America on men's participation in family planning, 78% of men sampled said that contraception was a joint decision with their partners while 87% of men strongly agreed that men should have the same responsibility as women for the children they father (Grady, 1996).

Men's involvement in family planning therefore stresses the need for men to assume responsibility for the consequences of their sexual and reproductive behaviour such as caring for their off springs and using contraception to take the burden off their partners. Roughly one third of men surveyed in developing countries in 1989 stated that family planning should be a joint decision between partners, the rest were more likely to assign responsibility to the man rather than the woman (Green, 1995). Therefore, individual attitudes and behaviours among men vary, on balance however, the evidence suggests

that many more men would participate in family planning if they had more opportunity to do so.

It is argued that where family planning programmes have reached men, male attitudes have changed and contraceptive use has increased (Kim & Kols, 2001). However, reaching men with reproductive health care is more difficult than reaching women for whom maternal and child health services are designed (Green, 1995). Since many men are reluctant to seek reproductive health care, family planning programmes should explore other opportunities to reach out to them (Becker & Robinson, 1998).

Some writers have argued that while family planning programmes have been interested in involving men for many years, it is only recently that men's participation became the focus of substantial attention. It is asserted that, one important reason has been the rising global concern over the rapid spread of HIV (Danforth & Roberts, 1997). 'The prominence of HIV and AIDS has opened up the discussion of sexual behaviour and programmes to prevent HIV have focused on both men and women with nearly equal attention in contrast to family planning programmes which have focused mainly on women' (Green, 1997).

Since male behaviour is critical to preventing the transmission of HIV and AIDS and other Sexually Transmitted Infections (STI's), HIV and AIDS programmes encourage men to adopt positive behaviours such as consistent condom use and remaining faithful to one sexual partner. The use of condoms in Zambia and other African countries is the easiest way and direct approach to involve men in family planning and responsible behaviour. This is a good measure not only in the fight against HIV and STI's but also in

child spacing and avoidance of unintended pregnancies the lesser contraceptive options available for men. In Sub-Saharan Africa however, condom use is far below the level needed to alleviate serious threats to sexual and reproductive health according to the International Family Planning Perspective of 2004. In the current condom use is still low although it has risen from 3.8% in 2001-2002 to 4.7% in 2007 (CSO et al., 2007).

Men have a strong influence on women's health and their access to care (Drennan, 1998). Because of this, reproductive health programmes are increasingly trying to involve them. It is argued that 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, 1993). Programmes on male involvement should therefore promote shared responsibility for family planning as it is assumed that women are more likely to adopt and continue using a contraceptive method if they have their partner's active support (Tapsoba, 1993). Several studies have found that involving men in family planning and contraceptive counseling increases contraceptive adoption, client satisfaction, contraceptive use effectiveness, and contraceptive continuation (Fisek et al., 1978; Tapsoba, 1993; Terefe, 1993; Wang, 1998).

Despite the above, efforts to reach men with reproductive health messages must remain sensitive to the needs of women. Critics of men's involvement in reproductive health argue that involving men may limit women's control over reproductive health decisions and help perpetuate existing gender roles that place women in a subordinate position

(Berer, 1996; and Helzner, 1996). Male involvement programmes must therefore promote gender equality alongside other reproductive health messages.

The first step towards increasing men's participation in family planning is to understand their knowledge, attitudes and practices regarding a range of reproductive health issues. To effectively reach out to them, policy makers need to understand their views and needs and use the knowledge to design programmes that would emphasize their participation in family planning while drawing attention to the need to do more for women as well (Becker, 1996).

Therefore, increasing men's participation may help improve women's programmes because more men would understand and be likely to support better reproductive health care for women as well as for themselves (Kim & Kols, 2001). 'In order to make a sustained difference in the reproductive lives of both men and women, it is critical that men's involvement in reproductive health be seen as a framework that can be applied to all areas of reproductive health including safe motherhood, post-abortion care, cervical cancer prevention, adolescent health and gender-based violence' (Kim & Kols, 2001).

### **2.2.1 Gender Norms**

Oakley (1972) describes gender as, 'patterns of behaviour which are culturally specific and are attached to the sexes of being male or female.' These patterns of behaviour are learnt through the process of socialization. Socialization plays a vital role in influencing male and female behaviour as 'it prepares individuals for the roles they are to play in

society providing them with necessary repertoire of habits, beliefs and values, the appropriate patterns of emotional response and the modes of perception,' (Chinoy, 1961).

Blanc, (2001) observes that the implications of gender in family involves the distribution of power and the ability of one partner to act independently to dominate decision-making, to engage in behaviour against the other partner's wishes or control a partner's actions which include sexual relationship. Supported by traditional beliefs men have successfully managed to suppress women over centuries.

In Africa, a married woman is expected to prove her fertility before the thought of using any contraceptives. Use of modern contraceptives particularly among married women in Sub-Saharan Africa is very low (Berer, 2007). This is because cultural norms expect that married women are supposed to have children if they are to earn respect from society. Women's gender identities and social statuses are tied to motherhood and childlessness is highly stigmatized (Cooper, 2007; IPSRH, 2009). Because of this, currently married women may feel pressured to prove their fertility. In the context of Sub-Saharan Africa, it has also been argued that high fertility regimes have been sustained by cultural norms embodied in religious and lineage systems (Madhavan et al., 2003).

It is argued that women's experience with family planning is likely to be determined by society's expectations of their multiple roles as wives, mothers and members of their community. This is because individuals conform to society's expectation of acceptable norms (Parsons, 1956; Chinoy, 1961). Despite the importance of male participation in family planning, gender norms play a major role in determining their active participation and to what extent women can use contraceptives for fertility control (Madhavan et al.,

2003). To be effective therefore, reproductive health policies and programmes must take this into account. Since most women value motherhood as important and often the most important role in their lives according to Clausen (1968), family planning messages must acknowledge this by highlighting the benefits of child spacing for the health of the mother and her children.

In a study in Zimbabwe under the Women's Studies Project, even when husbands approved of family planning, it was felt that women needed to prove their fertility before using any contraceptives (Barnett & Stein, 1998). Men's participation in family planning therefore occurs in a "gendered" context in which societal and cultural beliefs and practices that define roles, opportunities and limitations for men and women play an important role (Moser, 1993). Thus, gender norms play an important role in determining if, how, and to what extent men and women can participate in reproductive health. In Africa, males are brought up to think that family planning or reproductive health matters are women's issues and for that reason, they may not be willing to actively participate. These norms are re-enforced by the society and families (Chinoy, 1961).

### **2.2.2 Gender Differences in Attitudes towards Family Planning and Family Size**

As noted from the reviewed literature in the discussions above, men and women's attitudes towards family planning are generally positive. This is because of the perceived health related and other benefits of practicing family planning. For example, in the studies by the Women's Studies Project, it was noted that both men and women viewed family planning as beneficial across cultures. In China and Zimbabwe for instance, both sexes said that family planning enhanced their ability to earn income and this was viewed

as beneficial to the family. It was also noted that smaller family sizes as a result of contraceptive use led to increased family income (Barnett & Stein, 1998).

In a study on men's attitudes in family planning in Jordan, it was found that most couples practised family planning for economic reasons as the primary reason for wanting to limit their family size (Petro-Nustas, 1999). In another study on gender differences in attitudes towards family size conducted on adolescents in India, it was noted that there were minimal variations between males and females as regards family size with males preferring smaller families compared to females (Stycos, 1999). According to the study, on overall, 90% of respondents preferred small families and a substantial number of them chose small family sizes for poor families as compared to rich families citing economic reasons. Popoola (1999) observes that the desire for large families is also associated with social and economic status within a society where the male takes the pride and the high levels of unpredictable child survival.

As noted above, gender attitudes towards family size and other reproductive preferences for both men and women are similar but with small variations in different communities. In the Ezeh analysis of men in 11 countries in Sub-Saharan Africa and Bangladesh, Egypt, Morocco and Pakistan on knowledge and attitudes, between a quarter and two thirds of men surveyed did not want any more children (<http://www.fhi.org>). In other studies in Brazil, men were more likely than women to say they did not want more children.

The Ezeh analysis further reviewed that the number of men wanted another child was only slightly higher than the number of women. In Kenya and Pakistan for instance, only a minority of men wanted to have another child while in Egypt and Bangladesh less than one third of men wanted another child (<http://www.fhi.org>). In West Africa however, men were substantially more likely than women to want children. In Niger for instance 93% of men wanted more children to 82% of women. In other studies in Nigeria which compared men's attitudes with regard to family size, men preferred small families than women and therefore were mostly interested in family planning (Green, 1997).

### **2.2.3 Gender Equity**

In the Women's Studies Project, it is illustrated that increased contraceptive prevalence does not automatically translate into gender or class equity (Barnett & Stein, 1998). Although women who use family planning may be empowered to control the timing and spacing of their pregnancies, however, they are not necessarily empowered in other spheres of their lives. 'They may use family planning but still suffer from domestic violence for instance, still bear the dual burden of housework and work outside the home, and still find themselves financially dependent on men' (Barnett & Stein, 1998).

In a study conducted in South Africa by the Planned Parenthood Association of South Africa (PPASA), Reproductive Health Research Unit and Health on men's knowledge, attitudes, and practices with respect to sexual and reproductive health indicate that working with men on issues of gender equity and violence are key to helping them become supportive partners in the quest to involve them in reproductive health

issues (Kim & Kols, 2001). Therefore, efforts to involve men in family planning should not ignore issues of gender equity.

As already alluded to, socio-cultural factors such as inequitable gender roles and women's position within the household have influenced of family planning services. It is asserted that increased gender equality is a pre-requisite for achieving improvements in reproductive health.

#### **2.2.4 Decision Making**

The Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) asserted that, 'improving the status of women enhances their decision making capacity at all levels in all spheres life, especially in the area of sexuality and reproduction,' (UNFPA, 2006). In a study in South Asia, it was concluded that women's involvement in decision making was an important aspect of their household position (Furuta & Salway, 2006).

In some studies on reproductive health, separate roles ascribed to women and men translate into different responsibilities for contraceptive decision-making. In a Zimbabwean study that examined social constructs of quality of life, men were willing to give women the lead in decisions about family size, since 'women are the pillars of the home and the ones ultimately responsible for family welfare,' (Mutambirwa et al., 1998). Although most Zimbabwean men believed that family planning should be a joint decision, others were not willing to share their control because it was believed that men had the final say in all decisions (Wekwete, 1998).

In the Women's Studies Project, Indonesian women sought their husbands' opinions on most decisions, including household finances and contraception. This is because the women often felt caught up between cultural expectations of wives' subordination to husbands (Barnett & Stein, 1998). In a similar study in Mali, even husbands who supported family planning in principle emphasized that men were the primary decision-makers in the home. Commenting on men's dominance, Thompson (1999) argued that among the social, economic and political factors which prevented women attaining good health and which undermines women's human rights were unequal power relationships between men and women. This limited women's decision-making ability and their freedom to access health care. The United Nations Population Fund reports that the level of unintended pregnancy is lowest in countries with greatest access to effective methods of contraception and where women play a major role in family decision making (UNFPA, 2004).

Decision making on reproductive health by a woman is determined mainly by cultural norms and religious orientation according to the conclusion in the study on Decision making and reproductive issues of expectant married mothers at Chainama Clinic in Lusaka by Mungaila (2007). In the same study, it was found that although socio-economic status of women influenced their role in a home, it was negligible when it came to major reproductive health decisions. This is because marriages in the African setting are largely influenced by cultural norms where men are considered as final decision makers in a home (Djamba, 1994). Since men are viewed as primary decision-makers, 'services that include counseling to promote gender balance in reproductive decisions

could improve couple communication and allow women greater household autonomy, (Kim, 2000).

### **2.2.5 Couple Communication**

One of the key recommendations of both the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women was that programs should encourage husbands and wives to share in responsibilities pertaining to fertility and reproductive health. ‘Strengthening communication between partners about reproductive health and involving men in health promotion can lead to better health for the entire family,’ (Drennan, 1998).

Reproductive health experts agree that the more husbands and wives discuss family planning, the higher the level of contraceptive use (Becker & Robinson, 1998). It is argued that discussions on family planning stimulate contraceptive use. It is also argued that the closeness of the husband-wife bond and the degree of communication between spouses is cited as one of the important dimensions of increased contraceptive use by couples (Furuta & Salway, 2006). Studies show that when husbands approve of family planning or when wives think that husbands support it, the wives are more likely to use contraception (Fisek et al., 1978).

## **CHAPTER 3: METHODOLOGY**

### **3.0 Introduction**

This chapter outlines the research methodology that was employed in this study. The chapter looks at the research design under which the type of research, the target population, and sampling design are discussed. The chapter further explains the research instruments that were used, research process, data analysis process, limitations of the study and ethical considerations.

### **3.1 Research Design**

Cooper and Schindler (2003) contend that, ‘research design is the plan and structure of investigation so conceived as to obtain answers to research questions.’ Coldwell and Herbst (2004) observe that a research design is ‘the strategy for the study and the plan by which the strategy is to be carried out.’ This study is a survey and makes use of both the quantitative and qualitative methods of data collection.

#### **3.1.1 Type of Research**

The study employed a descriptive survey approach. In the data collection, a questionnaire was used and focus group discussions were also conducted to obtain in-depth information on the research topic. A questionnaire which contained semi-structured questions was designed for both men and women respondents with some specific sections preserved for either sex. The questionnaire aimed at finding out the knowledge, attitude and practice of child spacing, family planning, contraceptive use and family size. The questionnaire was also used to find out the knowledge, attitude and practice of antenatal and postnatal care. The above methods were cost effective and time efficient for primary data collection.

### **3.1.2 Research Paradigm**

Academics distinguish two main types of research, namely; quantitative research and qualitative research. Quantitative research involves an objective way of studying things and is sometimes referred to “as positivist”, and is scientific in approach. On the other hand, a qualitative approach assumes that this is difficult and the research is subjective (White, 2002). This study employed both quantitative and qualitative methods. The quantitative method was chosen because it places a premium on objectivity and reliability of findings and encourages replication while the qualitative method was chosen to provide more insights on the study topic and the research findings are specific to the experiences of the respondents (Cooper and Schindler, 2003).

### **3.1.3 Target Population**

The study was conducted in Chilanga Ward, Chilanga Constituency which is under Kafue District. Chilanga is located 17 kilometres south of the city of Lusaka and has a total population of 56, 673 people. Chilanga Ward however, has a total population of 6,543 people (CSO, 2003). The main reason for selecting the study area was that the location represents a semi-rural set up of Kafue District. The area was also convenient for the researcher as transport was readily available to enable the researcher conduct the survey. The study location was classified into 4 different areas, that is, the Census Enumeration Areas comprising low density residential areas located around the business centre, townships located on the western side and small scale farming blocks located along the boundaries of Chilanga Ward.

### **3.1.4 The Sample**

According to Ghosh (2002), sampling is ‘the collection of information from a portion of the total population and on the basis of the information collected from the subset, to infer something about the whole target population.’ Zikmund (2003) outlines that the major ways of taking a sample may be grouped into probability and non-probability techniques.

The sampling frame used for the study was adopted from the Census of Population and Housing of the Republic of Zambia (CPH) conducted in 2000, provided by the Central Statistical Office. The frame consisted of 16,757 Standard Enumeration Areas (SEA) created for the Census of Population and Housing for 2000. A SEA is a convenient geographical area with an average size of 130 households or 600 people. A SEA contains information about its location, the type of residence, the number of households and the number of males and females in the population. Each SEA has a cartographical map, which delimits the boundaries and shows the main landmarks of the SEA.

In this study, simple random sampling was used and a sample of 200 was selected from the 4 SEA of Chilanga Ward. The sample comprised both men and women. The respondents’ ages ranged from 15-49 years for women representing sexually active and reproductive age groups and 15-60 years for males. There were 70 male and 80 female respondents who were administered with semi-structured closed and open ended questionnaires. A total of 50 men and women attended focus group discussions in groups of 5-8 people. A total of 7 focus group discussions were therefore conducted.

### **3.2. The Questionnaire**

According to Saunders et al. (2003), the choice of questionnaire is influenced by a variety of factors related to one's research question(s) and objectives such as, the characteristics of the respondents, importance of reaching a particular person as respondent, the importance of the respondent's answer being accurate, sample size, the type of questions asked to collect data and the number of questions one needs to ask to collect data.

In this study, when constructing the questionnaire, the researcher ensured that the demographic questions in the questionnaire were directed in order to indicate the sub-groups in the sample. The data was collected by self administered questionnaires and in this case, the test items were brief and clear in wording and the items were made to be as simple to understand as possible (Oakshott, 2001).

#### **3.2.1 The Questionnaire Items**

The questionnaire comprised 66 questions with 12 being socio-economic and demographic questions. These items were structured in way that they were easy to understand, answer and analyse.

#### **3.2.2 Administration of Questionnaires**

The researcher administered the questionnaire to the respondents by hand in order to ensure that the right respondents received them.

### **3.2.3 Focus Group Discussions**

A topic guide for focus group discussions was designed for both male and female participants. This was meant to guide the questions during the discussion (Morgan, 2007; Stewart & Shamadasani, 1990; Debus & Novelli, 1988). The discussions were tape recorded, transcribed and translated from Nyanja to English language. During the discussions, in-depth interviews were conducted to gain more knowledge on men's involvement and attitudes towards family planning as well as gender differences in attitudes towards family size. One of the female elders in the local church who was also one of the participants helped in organizing women who took part in the focus group discussions as well as the venue where the discussions were conducted.

The focus group discussions for men were organized by section Chairman of an informal grouping known as neighborhood watch in the respective areas. The discussions for female participants were conducted outside the church grounds while for males were conducted outside the yard of one of the male participants. The venues were in natural settings where participants were free to express themselves.

### **3.3 Pilot Testing**

A pre-test was conducted to pilot the procedures involved and the questionnaire. This was meant to ascertain clarity of the questions. A total of 20 (10% of the sample size) 5 male and 5 female respondents were interviewed using the questionnaires while 10 attended focus group discussions in groups of 5. The pilot study was necessary in order to test the quality of the questionnaire and show whether there was need for refinement.

During the pilot, clear instructions were given to the respondents so that:

- (i) Responses could be given as openly as possible;
- (ii) Questions were encouraged where respondents were unclear; and
- (iii) Suggestions for improvement on questioning of the items were encouraged.

The pre-test fieldwork was conducted in the 4 areas of Chilanga Ward covering 10 households. Modifications to the questionnaire and focus group discussion guides were made based on lessons drawn from the exercise.

### **3.4 Data Gathering**

After the pilot study, questionnaires were ready for data collection as well as focus group discussions. Collection of data started in June, 2010 and lasted for 3 months.

### **3.5 Data Analysis**

Ghosh (2002) argues that, ‘the purpose of data analysis is to build up a sort of intellectual model where the relationships involved are carefully brought out so that some meaningful inferences can be drawn.’ After the collection of questionnaires, the data from respondents was collated and then recorded using numerical codes to categorize the given responses to each of the test items. As regards the demographic factors, the items were coded from 1 to 5. The researcher used the statistical package for social sciences (SPSS) version 12.0 for the purpose of getting descriptive statistical information which is presented in tables. For qualitative analysis, data from focus group discussions were transcribed and similar responses were clustered together to form themes.

## **3.6 Validity and Reliability**

### **3.6.1 Validity**

There are 3 forms that the study utilized. These were; content, criterion and concurrent Validity (Saunders et al., 2003). When conducting research according to Dantzker and Hunter (2000), a well constructed questionnaire eliminates the worries of validity (extent to which data collection method accurately measures what they were intended to measure) and reliability (degree to which data collection methods will yield consistent findings).

Under content validity, the literature review addressed the research questions and objectives of the study. The questionnaire items also their basis in it. The objectives formed sections of the literature review and the questionnaire. Criterion-related validity is the success of measures used for estimation (Cooper and Schindler, 2003).

### **3.6.2 Reliability**

Reliability has to do with the accuracy and precision of a measurement procedure while practicality is concerned with a wide range of factors of economy, convenience and interpretability. Reliability of a test instrument refers to consistency of the measurement of some phenomena (Saunders et al., 2003). A reliable instrument should produce stable responses at different times. There are 3 types of reliability and these are; alternative forms, test-retest and internal consistency. Since this study was using the questionnaire and focus group discussions, the test items did not have similar items to be tested for homogeneity, the test-retest 38 method was used. This type involves administering the same type of instrument to the same subjects at 2 different points in time. After this

process a correlation in the 2 sets of responses is checked (Saunders et al., 2003). It is essential that the time lapse between the measurements is reasonably sufficient so that respondents do not remember previous answers and repeat them (Cooper and Schindler, 2003). The respondents were advised the purpose of repeating the process. To ensure lesser deviation, the researcher administered the questionnaire after a week of administering the previous questionnaire. After re-administering the questionnaire twice on selected respondents, the researcher found that there were no deviations in the way questions were answered, showing reliability.

### **3.7 Limitations of the Study**

Although this study used both the qualitative and quantitative methods, it has a limitation in that the sample which was collected was specific to the geographical areas of Chilanga Ward. As such, the findings of the study cannot be generalized beyond the boundaries of the population sample unless on populations with similar socio-economic and demographic characteristics.

### **3.8 Ethical Issues**

Ethical consideration in the study is that the researcher obtained informed consent from the respondents. Personal details for respondents were also deliberately left out when designing the questionnaire and the focus group discussion guide in order to keep their confidentiality. In order to ensure that respondents felt comfortable when completing the questionnaire, a method of self administered questionnaires was used. This allowed for respondents to give their responses in the privacy of their homes without any

interference. The data obtained from the respondents were also kept but the general findings in the study were communicated to them.

## CHAPTER 4: FINDINGS AND DISCUSSION

### 4.0 Introduction

In this chapter analyses of data and discussion of findings from each instrument are carried out. The findings of the study are presented in form of figures, tables and comments.

### 4.1 Socio-Economic and Demographic Characteristics

It was necessary for the researcher to get insights about the respondents in terms of their age, level of education, income levels, number of children and other relevant variables.

All the respondents were drawn from Chilanga Ward in Chilanga Constituency in medium and low cost housing units. The respondents came from a diverse tribal and religious backgrounds with the majority being Christians 145 (96.3%) from different denominations, of that, the majority were Protestants. The respondents occupation also varied from formal employment 31 (20.6%), informal 56 (37.3%) and business 38 (25.3%). 25 (16.6%) constituted other occupations. Table 1 below shows number of respondents' religion by sex

**Table: 1 Number of respondents' religion by sex**

<b>Religion</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
Catholic	11	20	31	7.3	13.3	20.6
Protestant	19	38	57	12.6	25.3	37.9
Pentecostal	9	10	19	6	6.6	12.6
SDA	2	6	8	1.3	4	5.3

Christian other	19	2	21	12.6	1.3	13.9
Muslim	3	3	6	2	2	4
Buddhism	0	0	0	0	0	0
No religion	0	0	0	0	0	0
Other	3	0	3	2	0	2
<b>Total</b>	<b>66</b>	<b>79</b>	<b>145</b>	<b>43.8</b>	<b>52.5</b>	<b>96.3</b>

**Source: Field Data (2010)**

All the respondents were married with children and the number of years in marriage varied from one respondent to another. Most of the respondents 113 (75.3) had between 2-4 children. Respondents who had between 1-2 children indicated that they wanted to have more children within the next one and a half to two years. Concerning the total number of children desired, on average, the respondents reported that they wanted to have children between 3-5. The desire to have more male children was recorded o respondents who had female children while those who ha male children preferred a female child. The current number of children had a major influence in the practice of family planning by couples.

#### **4.1.1 Sex and Age**

Although the focus of the study was on men and their participation in family planning, the researcher saw it important to get information from both men and women. Most of the questionnaires were distributed to female respondents as they were readily available and willing to take part in the research. Table 2 below shows the number of respondents by sex and age.

**Table 2: Number of respondents by sex and age**

<b>Age Group</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
15-19	0	2	2	0	2.5	1.3
20-24	5	21	26	7.1	26.2	17.3
25-29	11	18	29	15.7	22.5	19.3
30-34	22	19	41	31.4	23.7	27.3
35-39	13	12	25	18.5	15	16.6
40-44	7	6	13	10	7.5	8.6
45-49	9	2	11	12.8	2.5	7.3
50 +	3	0	3	4.2	0	2
<b>Total</b>	<b>70</b>	<b>80</b>	<b>150</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Source: Field Data (2010)**

Table 2 illustrates the age groups of respondents in the study by sex. The majority of male 22 (31.4%) came from the age group 30-34 years while for female respondents came from the age group 20-24 years which is 21 (26.2%) from the total number of female respondents. Very few males 3 (4.2%) were aged 50 years and above. The study revealed that age had a major influence on the use and approval of family planning by both men and women. It also had a bearing on the extent of men's involvement in family planning.

#### **4.1.2 Level of Education**

The researcher considered level of education as an important variable in the study as it had an influence on the knowledge of family planning, practice and approval.

Education also determined participants' ability to influence decisions in the home. Table 3 below illustrates respondents' level of education.

**Table 3: Number of respondents by level of education**

<b>Level of Edu.</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
Junior Primary	0	0	0	0	0	0
Senior Primary	8	25	33	11.4	31.2	22
Junior Secondary	11	37	48	15.7	46.2	32
Senior Sec.	37	13	50	52.8	16.2	33.3
College	14	5	19	20	6.2	12.6
University	0	0	0	0	0	0
<b>Total</b>	<b>70</b>	<b>80</b>	<b>150</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Source: Field Data (2010)**

In table 3 above, the majority of male respondents 37 (52.8%) had obtained senior secondary education while for females, the majority 37 (46.2%) had obtained junior secondary education. The least educated males with senior primary education were 8 representing 11.4% of the total number of male respondents. For female respondents, 25 (31.2%) were the least educated with senior primary education. Only 5 (6.2%) of women had obtained college education as compared to 14 (20%) of male respondents.

### 4.1.3 Monthly Income

Monthly income is another variable that was seen as important by the researcher. This is because it had a major influence in decision making regarding family size. Table 4 shows the levels of monthly income for both male and female respondents.

**Table 4: Number of respondents by Monthly Income**

<b>Income Levels (K)</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
100,000-500,000	11	38	49	15.7	47.5	32.6
500,000-1,000,000	34	10	44	48.5	12.5	29.3
1,000,000-1, 500,000	17	8	25	24.2	10	16.6
1,500,000-2,000,000	8	2	10	11.4	2.5	6.6
2,000,000 +	0	0	0	0	0	0
No income	0	22	22	0	27.5	14.6
<b>Total</b>	<b>70</b>	<b>80</b>	<b>150</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Source: Field Data (2010)**

Table 4 illustrates income levels of respondents by sex. The majority of male 34 (48.5%) respondents earned between K500, 000 - K1, 000,000. While for female respondents, the majority 38 (47.5%) earned between K100, 000 - K500, 000 which was the least bracket for monthly income earnings in the study. Only 8 (11.4%) of males and 2 (2.5%) females earned between K1, 500,000 - K2, 000,000. A total of 22 (27.5%) female respondents had no sources of income and they indicated that they were house wives.

## **4.2 Objectives of the Study**

This study had five objectives as follows:

- (i) To find out the role that men play in family planning;
- (ii) To establish the patterns and extent of men's participation in family planning;
- (iii) To examine gender differences in attitudes towards family size and birth spacing;
- (iv) To examine the existing family planning systems and establish obstacles to men's participation in family planning; and
- (v) To identify problems faced by women when discussing family planning issues with their partners.

## **4.3 The Role that Men play in Family Planning**

This section explains the general roles that men play in family planning. These include their knowledge of family planning, approval of family planning and decision making on contraceptive use. Under this objective, a number of questions were asked, some of which were: what do you understand about family planning? Do you approve family planning and who decides on contraceptive use? Responses to the questions are presented in tables 5- 7 below:

Table 5 below shows distribution of male respondents' knowledge of family planning.

**Table 5: Male respondents' knowledge of family planning**

<b>Knowledge of family planning</b>	<b>Frequency</b>	<b>%</b>
Service offered to women to control number of children	31	44.2
Not having anymore children	2	2.8
Having children at the time convenient for the couple	36	51.4
Other	1	1.4
<b>Total</b>	<b>70</b>	<b>100</b>

**Source: Field Data (2010)**

Table 5 shows that the majority of men 36 (51.4%) indicated that family planning is having children at the time convenient for a couple while 31 (44.2%) said that it is a service offered to women to control the number of children.

During focus group discussions, a 29 year old man said that:

*'Family planning means going to the clinic to get advice and contraceptives. Only women are allowed to go there because they are the ones who get pregnant.'*

Another participant, 26 year old man added that:

*'Family planning means accessing contraceptives from the clinic. This is good for married women to control their fertility until the time they want to have children. Sometimes family planning is bad because even school going girls who are not even married can access contraceptives. This encourages promiscuous behaviour.'*

The above results show that men that took part in the study had a general understanding of family planning as they related it to contraceptive use, birth spacing and having children at the convenient time.

Table 6 below shows distribution of respondents' approval of family planning.

**Table 6: Distribution of respondents' approval of Family Planning**

<b>Approval of Family planning</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>
Approve	59	84.2	74	92.5
Do not approve	11	15.7	6	7.5
Total	70	100	80	100

**Source: Field Data (2010)**

On the issue of whether respondents approved family planning or not, table 6 above shows that 59 (84.2%) out of 70 male respondents indicated that they approved family planning while 11 (15.7%) did not. A total of 74 (92.5%) out of 80 women respondents said that their partners approved family planning while only 6 (7.5%) did not.

During focus group discussions, a 41 year old man said that:

*'Yes, I approve family planning but my wife is supposed to tell me when she goes for family planning because as her husband I have the right to know.'*

A 40 year old man added that:

*‘Of course I approve family planning as long as my wife openly tells me she is using family planning. Having children that are closely spaced is not good for a woman, so why should I not approve family planning?’*

Another 43 year old man said that:

*‘I personally do not approve family planning because of religious reasons. Why should a woman take medicine to control her fertility? I do not allow my wife to go to family planning clinics because she can control her fertility using natural means.’*

These results show that most men in Chilanga approved family planning because of the perceived benefits. Only a minority of men did not approve family planning citing religious reasons. However, those men supported natural methods of family planning as opposed to conventional methods. These findings therefore dispute the notion that men strongly oppose family planning.

Table 7 below shows distribution of respondents’ decision making on contraceptive use.

**Table 7: Distribution of respondents’ decision making on contraceptive use**

<b>Contraceptive decision making</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>
Myself	6	8.6	66	82.5
My partner	61	87	0	0
Both of us	3	4.2	14	17.5
Total	70	100	80	100

**Source: Field Data (2010)**

On contraceptive use decision making, 66 (82.5%) of women out of 80 decided on the use of contraceptives including the methods to use. 61 (87%) of men out of 70 indicated that their partners made decisions on contraceptive use while 3 (4.2%) of men indicated that they made joint decisions. As regards women, 14 (17.5) said that they made joint decisions with their husbands. Even if decisions on contraceptive use were mostly made by women, women said that they consulted their husbands and they received support from them. The common methods that they said they were using at the time the research were the pill 34 (42.5%), injectables 26 (32.5%), natural family planning 10 (12.5%), withdrawal 4 (5%), implants 2 (2.5%) and others 4 (5%) and their partners knew about the family planning methods they were using. Male methods such as condom, male sterilization and withdrawal were among the least recorded.

During focus group discussions, one of the female respondents aged 35 years and mother of 3 children said that:

*'I decided to use contraceptives because my husband told me that I should not get pregnant soon as it is difficult to provide for the 3 children we already have. When our financial status improves then we can have the last child.'*

On the same topic, a 36 year old man said that:

*'I do not decide on the use of contraceptives, I leave it for my wife to decide because I am not the one who goes to the family planning clinic. My wife knows better about the options that are available for her to use and she has to decide to use them because it is expensive to have a lot of children.'*

The above findings clearly shows that even if men are decision makers in a home, decisions such as the use of family planning is present. This is because men do not generally know the methods of family planning and may not even be interested to know because they have been secluded by the available family planning services. Their concern is more on the number of children that they should have and also on their wives' use of contraceptives to space births.

#### **4.4 Patterns and Extent of Men's Participation in Family Planning**

This explains the patterns and extent of men's participation in family planning. Men's care and support during their partners' pregnancies and after delivery are discussed. Under this objective, a number of questions were asked, some of which were: What kind of support did you give to your partner during her pregnancy? After the birth of your child, what kind of care and support did you give your partner? Responses to these questions are presented in tables 8 and 9 below.

Table 8 below shows distribution of respondents care and support during wife's pregnancy.

**Table 8: Distribution of respondents' care and support during wife's pregnancy**

<b>Type of antenatal care and support</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Accompanied partner for antenatal checkups	0	0	0	0	0	0
Accompanied partner to health facility for delivery	42	28	47	31.3	89	59.3

Bought enough food	51	34	64	42.6	115	76.6
Helped with household chores	0	0	2	1.3	2	1.3
Provided transport and other logistics	44	29.3	48	32	92	61.3
Other	3	2	7	4.6	10	6.6

**Source: Field Data (2010)**

As regards care and support given to women during pregnancy, a total of 115 male and female respondents said that men bought enough food. This represents 76.6 % of the total number of respondents. Out of that total number, 51 (34%) were male while 64 (42.6%) were female. 92 (61.3%) reported that men provided transport and other logistics while 89 (59.3%) accompanied their partners to the health facility for delivery. Out of those numbers 44 (29.3%) were male while 48 (32%) were female and 42 (28%) male and 47 (31.3%) female respectively. Only 2 (1.3%) of women indicated that men helped with household chores while all respondents indicated that men did not accompany their partners for antenatal checkups. One of the major reasons given for not accompanying their partners for antenatal was that men saw antenatal as a woman’s responsibility and therefore it was embarrassing to accompany them.

During focus group discussions, a 47 year old man said that:

*‘I provided food so that my wife and baby could stay healthy. As a man, that’s my responsibility, I cannot accompany my wife for antenatal checkups, what would my friends and family think of me? If there is a problem after the visit to antenatal, I expect my wife to tell me.’*

Another man aged 45 years added that:

*‘I have never seen a man who accompanies his wife for antenatal here in Chilanga. When my wife was pregnant, I was summoned to the clinic so that I could be present when she was undergoing Voluntary Counselling and Testing. The health workers told me that other men were also summoned to give moral support to their wives on different days’.*

He continued: *‘As for household chores, it is not my responsibility, I am the man of the house, how can I do household chores? My wife and her family members helped with the chores.’*

Table 9 below shows distribution of respondents’ care and support after wife’s delivery.

**Table 9: Distribution of respondents’ care and support after wife’s delivery**

Type of postnatal care and support	Male	%	Female	%	Total	%
Accompanied partner for postnatal checkups	0	0	6	4	6	4
Provided transport and other logistics	61	40.6	76	50.6	137	91.2
Took the baby for immunization	0	0	0	0	0	0
Helped with household chores	0	0	2	1.3	2	1.3
Bathed the baby	0	0	0	0	0	0
Cooked for partner	0	0	2	1.3	2	1.3
Other	1	0.6	2	1.3	3	1.9

**Source: Field Data (2010)**

On postnatal care and support, table 9 above shows that the majority 137 (91.2%) reported that men provided transport and other logistics. Out of that number, 61 (40.6%) were male while 76 (50.6%) were female. The table also shows that 6 (4%) female respondents said that their husbands accompanied them for postnatal checkups. Only 2 (1.3%) helped with household chores and cooked for their partners. All respondents in the study said that men did not bath or take the baby for immunization.

During discussions, a 33 year old man said that:

*'After delivery of the baby, I took my wife to her relatives so that they could look after her. It is against our culture to allow a woman to cook or do household chores after she delivers. As a man, cooking and doing chores are not part of my duties as I provide necessities for my wife and family.'*

Another male participant aged 37 years added that:

*'What was important for me was when my wife gave birth and I brought her home with the baby. After that, her relatives took over and looked after her as you know that it is taboo for a man to take care of a woman after she delivers. Her sister bathed the baby, did household chores and also accompanied her for postnatal checkups.'*

#### **4.5 Gender differences in attitudes towards family size and birth spacing**

This objective examines gender differences in decision making on family size and spacing of births. Among the questions which were asked under this objective were: Who decides when to have children? Who makes the final decision on when to have children?

Who decides how many children to have and makes the final decision? Do you face any disagreements on the decisions made? How do you resolve the disagreements?

Table 10 below shows distribution of respondents on decision making on family size and birth spacing.

**Table 10: Decision making on family size and birth spacing**

<b>Decision-making</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Both</b>	<b>%</b>	<b>Total</b>	<b>%</b>
No. of children	107	71.3	27	18	16	10.6	150	100
Final decision	146	97.3	0	0	4	2.6	150	100
Birth spacing	6	4	93	62	51	34	150	100
Final decision	52	34.6	26	17.3	72	48	150	100

**Source: Field Data (2010)**

Table 10 above shows that most men 107 (71.3%) decided on the number of children to have as compared to women 27 (18%) and joint decision making 16 (10.6%). The table also shows that the majority of men made the final decision on the number of children that a couple should have. The majority of both respondents reported that when they faced disagreements on the decisions made, they either resolved them by having mutual discussions or receiving counseling from elders, friends or relatives.

Table 11 below shows distribution of respondents' preference of family size by sex.

**Table 11: Distribution of respondents' preference on family size by sex**

<b>No. of Children</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
0	0	0	0	0	0	0
1-2	7	33	40	4.6	22	26.6
2-4	61	28	89	40.6	18.6	59.2
4-6	2	13	15	1.3	8.6	9.9
6-8	0	6	6	0	4	4
8+	0	0	0	0	0	0
Total	70	80	150	46.5	53.2	100

**Source: Field Data (2010)**

On average, female respondents' family size preference ranged from 1-2 children within the age groups from 15-19 years to 20-24 years. In the age groups from 25-29 years to 35-39 years, respondents 28 (18.6%) on average preferred children between 2-4 while the older women preferred to have between 6-8 children respectively. This entails that as married women grew older, the preference on the number of children increased. This can be attributed to the fact that as women grow older, they become financially stable and capable to provide for the children. The other reason that older women would consider children as a source of security in old age. The table also reveals that the majority of men 61 (40.6%) preferred to have children between 2-4 while none of the men said that they preferred to have more than 6 children. Only 2 (1.3%) of men indicated that they preferred to have children between 4-6.

Table 12 below shows distribution of respondents' family size by sex.

**Table 12: Distribution of respondents' family size by sex**

<b>No. of Children</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Male%</b>	<b>Female %</b>	<b>Total %</b>
0	0	0	0	0	0	0
1-2	11	29	40	7.3	19.3	26.6
2-4	18	41	59	12	27.3	39.3
4-6	29	6	35	19.3	4	23.3
6-8	12	4	16	8	2.6	10.6
8+	0	0	0	0	0	0
Total	70	80	150	46.5	53.2	100

**Source: Field Data (2010)**

On whether the respondents wanted to have more children in the near future, the majority of the age groups from 40-44 years to 45-49 years expressed that they did not want to have any more children while the age groups from 15-19 years to 30-34 years reported that they wanted more children within the next one and half to two years.

As regards male respondents, family size ranged from 1-2 children within the age groups 20-24 years to 25-29 years which represents 11 (7.3%) from the total number of male respondents. The age groups from 30-34 years to 40-49 years reported as having 4-6 children from both their wives and girlfriends. This is represented by 29 (19.3%) from the total number of male respondents. However, most of the men in these age groups did not

want anymore children citing economic reasons. When asked the question on how many children they would have preferred to have, on average men preferred to have 3 children while women preferred an average of 4. This entails that women in this study preferred to have more children than men with a minimal variation. These findings correlate with a study conducted in India on adolescents' preference on family size where male adolescents preferred smaller family sizes than females (Stycos, 1999). However, almost all women were reported to have spaced their births either using the conventional family planning methods or traditional methods.

During discussions, a 39 year old man and father of 2 children said that:

*'I decide on the number of children to have because as a man I know how much I earn and how far I am able to provide for my family. My wife also knows this.'*

Another 52 year old man and father of 5 children said that:

*'I make decisions on the number of children to have but on two occasions my wife conceived without consulting me. Anyway, it happened and we cannot undo it and now I am happy to have 5 children although I would have preferred to have 3 children.'*

A 41 year old woman and mother of 4 children said that:

*'Although my husband made all decisions on family size, I once told him that I wanted to have 4 children but he did not like the idea. During certain times I used to stop using contraceptives so that I could conceive because I felt that children drew my husband and I together which created a strong bond between us.'*

#### **4.6 Existing family planning systems and obstacles to men' participation in family planning**

This discusses access of and information on family planning. This is essential in examining some of the structural obstacles to men's active participation in family planning. Some of the questions asked to male respondents to enable the researcher analyze data on this objective were: Where do you get on family planning? Where would you feel comfortable to receive information and male methods of family planning? Would you be willing to go with your partner to access information about family planning and who would you prefer to counsel you or distribute family planning methods to you? Table 13 below shows distribution of male respondents on access of information on family planning.

**Table 13: Distribution of male respondents on access of information on family planning**

<b>Access of information on family planning</b>	<b>Frequency</b>	<b>%</b>
Family planning clinic	0	0
Private pharmacy	0	0
workplace	0	0
friends	2	2.8
media	0	0
partner	13	18.5
other	3	4.2
No access to information	52	74.2
<b>Total</b>	<b>70</b>	<b>100%</b>

**Source: Field Data (2010)**

Table 13 above reveals that none of the men in the study was recorded as having accessed information on family planning from family planning clinics, private pharmacies, workplace and media. However, only 2 (2.8%) out of the 70 male respondents indicated that they accessed information from their friends, while 3 (4.2%) indicated that they got information from other sources such as male relatives, that is, uncles and cousins. A total of 13 (18.5%) men were recorded as accessing information from their partners while 52 (74.2%) said that they had no access to information on family planning. The findings therefore show that men have been left out on access to important information on family planning and other reproductive health matters. This is because there are no systems and structures in place where men can freely access the much needed information.

During focus group discussions, a 36 year old male participant said that:

*'I have no access to information on family planning and there is no need for me to know anything about family planning because it is not me who should space the pregnancies but my wife so why should I know? If my wife knows the time it is enough. My concern is only to look for means to provide for her and the family and tell her that it is time to have another baby so that she can stop using family planning methods.'*

Another male participant aged 41 years said that:

*'We as men are not taught to behave like women. If I start going round looking for information on family planning, people will laugh at me, asking what is going on with me. That information should be given to women not men unless of course people come to my house and tell me about family planning. In any case, my wife tells me what she knows about family planning.'*

The above sentiments show hostility by men when it comes to information on family planning. Access to family planning information was seen as less of a concern for most men as they viewed family planning as women’s business due to traditional influences and lack of exposure to family planning information.

Muvundi et al. (2000) has also observed that men have inadequate information and knowledge about family planning since they are not directly involved during information sharing and dissemination. Adequate information concerning the importance of men involvement in family planning does not reach them because programmes continually exclude them. The neglect of men has been based on the belief that most men are not interested in family planning or strongly oppose it (UNFPA, 1995). It is also argued that family planning programmes have avoided serving men in the belief that many women need privacy and autonomy in reproductive health matters. However, where programmes have reached men, male attitudes have changed and contraceptive use has increased (Kim & Kols, 2001).

Table 14 below shows distribution of male respondents on preference on access of information and family planning methods.

**Table 14: Distribution of male respondents on preference on access of information and family planning methods**

<b>Preference on information and male family planning methods</b>	<b>Frequency</b>	<b>%</b>
Family planning clinic	6	8.5
Private pharmacy	13	18.5

workplace	27	38.5
friends	6	8.5
media	10	14.2
partner	5	7.1
other	3	4.2
<b>Total</b>	<b>70</b>	<b>100%</b>

**Source: Field Data (2010)**

Table 14 above reveals that the majority of men 27 (38.5%) preferred to access information and methods of family planning from their workplaces while 13 (18.5%) preferred private pharmacies. 10 (14.2%) said that they preferred the media. Only 6 (8.5%) preferred family planning clinics and friends respectively. 5 out of 70 respondents said that they preferred their partners while 3 (4.2) preferred other sources such as male relatives.

Most men did not prefer to get information from family planning clinics citing lack of services available for them. Most men also said that it was time wasting instead of being at work or doing business. Almost ¾ (71%) of the male respondents said that they did not want their partners to accompany them to receive information and access family planning methods because it would be embarrassing for them and because their friends would look down on them. About the same number of men said that they preferred to receive counsel and methods of family planning from both male and female family planning providers.

During focus group discussions, a 33 year old man said that:

*'I would prefer to get information on family planning from my work place. If field workers cannot come to my workplace then it is better to set up a tent like they do with Voluntary Counselling and Testing near my work area or anywhere where other men can easily reach it so that they can access the services. I can not depend on family planning clinics because I do not see men go there because there are no services available for them.'*

In agreeing with the previous speaker, a 31 year old man said that:

*'I prefer field workers that would come where men are gathered so that they can receive information and access family planning methods. It is time wasting to go to the clinic because of long queues waiting with women, unless a male clinic is opened.'*

Another man aged 36 years added that:

*'If the Government wanted us to access information and family planning methods then they would have introduced the services. You see, family planning is for women but it is better if men also know things that women know because time has changed, it is not like the olden days. Nowadays men want to know a lot of things.'*

In addition he said that:

*'If the family planning clinic summoned me from time to time to explain the changes that are happening to my wife whenever she is expecting the child it would help me to understand her and also know how to look after her until she delivers. I think family planning clinics for couples should be introduced, then I can access the services with my wife.'*

From the above, it is clear that family planning programs have made little effort to consider men's reproductive health needs or to reach out to them and as a result men have few or no contacts with the reproductive health care system (Green, 1990). It is argued that although men often have a dominant role in family decisions, they tend to be marginalized by family planning programs. Nevertheless, reaching men with reproductive health care is more difficult than reaching women for whom maternal and child care services were designed and which services have historically focused on serving women (Fisek et al., 1978). Men have fewer opportunities than women for receiving counseling in reproductive health matters from service providers and as a result few men are reached out.

#### **4.7 Problems faced by women when discussing family planning issues with their partners**

On the problems that women face in discussing family planning issues with their partners, a 24 year old woman said that:

*'My husband and I discussed family planning issues once when we just got married and we talked about how many children we should have. After that he tells me that I should be concerned with making sure that I do not get pregnant before the time we have planned or else we will have nothing to give to the children as he does not earn a lot of money.'*

Another woman aged 29 years added that:

*'My husband tells me to discuss such matters with my friends as other men do not discuss family planning with their wives.'*

She added that her husband says:

*'Whenever you go to the family planning clinic, you should inform me and also what you have been told after the visit including the method of family planning you have been given. As your husband I want to know what is going on but the rest of the information you can discuss with your friends.'*

Another 42 year old woman said that:

*'I do not discuss many issues with my husband including family planning. My husband is the type of man who likes to make major decisions on his own and only informs me what he has decided. We have on several occasions argued and our elders were called to counsel us but it did not help much as they sided with my husband. They told me that I should not waste my energy to complain that my husband makes decisions without consulting me because my duty is to look after the house and family.'*

Another 39 year old working woman said that:

*'My husband and I discuss all family issues including family planning. He appreciates my contributions during discussions and he respects me as much as I respect him.'*

When she was asked whose responsibility it was to provide for the family, the woman said that:

*'I am a working woman so I also contribute financially to the welfare of the family. My husband and I treat each other as partners although of course I respect him as the head of the house.'*

The above shows that men approve family planning even though they are not involved in family planning discussions to a larger extent. Discussions of family planning like other discussions in a home are influenced by the different traditional roles that men and women play. Most of the discussions are influenced by traditional values that have defined men's and women's roles which are distinctive and which roles do not overlap. This has continued to place women in subordinate positions when it comes to family planning discussions as the men make the final decisions in a home even when the decisions may disadvantage the women or may compromise their health. Some researches in family planning suggest that husband's support or disapproval impacts on the adoption or continued use of contraceptives by women (Tapsoba, 1995).

Although most wives during focus group discussions said that they discussed child spacing in their homes, they ended up with what their husbands wanted. According to the wives the fact that they were able to discuss child spacing and contraceptive use with their husbands was a milestone in terms of shared decision making on reproductive health issues. All wives perceived that their husbands' consent was to be sought even if they claimed that they made decisions on what kind of contraceptives to use. These findings correlate with surveys conducted in Nigeria and Zaire according to Djamba (1994). Djamba (1994) asserts that conjugal relationships are to a larger extent defined in cultural terms and that there is evidence that many African men and women believe that husbands are the primary decision makers regarding their marital sexual activity.

A majority of women during focus group discussions said that they discuss issues concerning the number of children with their husbands and that they tended to agree with

their husbands decisions citing finance as the determinant. When wives were asked about decisions on family size, they said that it was okay for their husbands to make final decisions as they provided for the family. This entails that being providers in a home gives men more decision making powers when it comes to decisions on reproductive health. However, women who had sources of income assumed some level of decision making when it came to family size and other reproductive health matters. This means that socio-economic status is a major contributor to women's decision making behaviour and open discussion regarding reproductive health matters.

#### **4.8 Conclusion**

Generally, the study has revealed that men are interested in family planning although they do not have access to the services. Men showed support of their partners' use of family planning methods. There were also a number of hindrances to male participation in family planning which are institutional, social and cultural. Institutional because there are no structures to support men's participation in family planning. Social and cultural factors include the fear of societal ridicule for male participation in family planning as well as hindrances to do with the different roles that society has ascribed to males and females. These have influence on male participation in family planning as males are expected to conform to behaviour that has culturally been ascribed to them.

Some reproductive health experts have argued that the messages of effective communication for reaching women can be applied to male audiences. However, both the form and content of that communication must be adapted to men's needs, concerns, and situation without compromising women's control over reproductive health decisions or

perpetuating existing unequal gender roles (Kim & Kols, 2001). ‘For the communication professionals who design male involvement campaigns, this means additional research on male audiences and on existing gender stereotypes to uncover effective messages and communication channels,’ (Kim & Kols, 2001). It is also argued that good counseling requires health care providers to respond to the individual needs and concerns of clients. Given gender differences in reproductive health needs and concerns, lifestyle and exposure, men presumably require different communication approaches than women.

Therefore, increasing men’s involvement in reproductive health care system without detracting from services for women requires that family planning institutions develop creative initiatives tailored to the unique circumstances of the individual community and culture (Kim & Kols, 2001). In Turkey for instance, some institutions tried to do this by making use of existing opportunities within the health care system to provide targeted information, counseling and services for men (Kim & Kols, 2001).

## **CHAPTER 5: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

### **5.0 Introduction**

This chapter outlines the summary of the findings in the study, the conclusions and recommendations.

### **5.1 The Role that Men play in Family Planning**

The findings in the study revealed that most men participate and are interested in family planning. The role that they play was seen from the support they gave to their partner's use of contraceptives. According to the study men have great influence on their partners' use of contraceptives as the majority 146 (97.3%) made final decisions on family size.

The study further revealed that most decisions on contraceptive use were made by women. This is represented by 66 (82.5%) of female respondents. However, even if decisions on contraceptive use were mostly made by them, women in the study said that they consulted their husbands and that they received support from them. Most women said that although their husbands supported the use of contraceptives as a way to space the children, most men were not ready to use any form of male contraceptives such as condoms. For that reason, male contraceptive methods were recorded as the least methods used by couples.

### **5.2 Patterns and Extent of Men's Participation in Family Planning**

As regards, the extent of men's participation in family planning, the study revealed that most men gave support to their partners during antenatal and postnatal. The majority of

men 137 (91.3%) provided support in terms of provision of necessities and other logistics during antenatal and postnatal according to responses from both male and female respondents. As regards contraceptive choice and decision making, the majority of men 61 (87.1%) were not involved.

Further findings revealed that few men 6 (4%) and 2 (1.3%) accompanied their wives for postnatal care and helped with household chores while 11 respondents indicated that men did not accompany their partners for antenatal checkups. The study also revealed that no man was recorded as having taken the baby for immunization.

### **5.3 Gender differences in attitudes towards family size and birth spacing**

According to the findings in the study, gender differences in attitudes towards family size and birth spacing revealed that the majority of men 107 (71.3%) dominated decisions concerning family size. The study also revealed that the majority of men 146 (97.3%) made the final decision on the number of children in a home. On the other hand, birth spacing and decisions on the types of contraceptives to use were preserved for women. Further findings indicate that women who had lower levels of education (senior primary) 25 (31.2%) and the lowest bracket of income (K100,000 – K500,000) 38 (47.5) or no sources of income 22 (27.5) were more likely to be submissive to their husbands thereby allowing them to make almost all the decisions pertaining to family size and contraceptive use. The study also revealed that men preferred smaller family sizes than women citing economic reasons.

#### **5.4 Existing family planning systems and obstacles to men's participation in family planning**

Although the above findings reveal that men generally participate in family planning, they expressed more desire to get information and methods of family planning from service providers. According to the findings, lack of adequate information on the available male methods and information on family planning, lack of structures to support their participation and cultural factors have all been identified as hindrances for male active participation in family planning.

#### **5.5 Problems faced by women when discussing family planning issues with their partners**

As regards problems that women face when discussing family planning issues with their partners, the study revealed that women who received some formal education and those who had sources of income were less likely to face problems in family planning discussions. On the other hand, women who were less educated and were housewives did not discuss family planning issues with their husbands.

Discussions of family planning issues like other discussions in a home were influenced by the different traditional roles that men and women play. Most of the discussions according to the study are influenced by traditional values that define men's and women's roles which are distinctive and of which roles do not overlap. This situation has continued to place women in subordinate positions when it comes to discussions of family planning and other reproductive health matters – the men make final decisions in a home even when the decisions may disadvantage the health of women. However, the

study noted that women who obtained formal education and went as far as senior secondary 13 (16.2) and tertiary 5 (6.2) education and those who had sources of income 58 (72.5) either from business or employment had some level of decision making powers than women with lower levels of education and those without income even if their partners influenced the use of contraceptives. However, the decision making powers they had were jointly owned with their partners.

In this regard, it can be concluded that men have greater reproductive health decision making powers than women in a home.

## **5.6 Conclusion**

Based on the study findings, it is concluded that factors such as lack of adequate information available for men to take active participation in family planning as well as lack of structures to support their involvement in family planning are the main reasons why men still lag behind in their involvement in family planning as compared to women. Although it can be noted from the findings that men support their partners' access to and use of contraceptives, they have overall decision making powers as they make final decisions regarding family size and birth spacing.

From the study findings, it can also be noted that more needs to be done in the areas of men's care and support of their partners during antenatal and postnatal periods as the provision of necessities alone is inadequate. Psychological and other forms of support are significant as they form part of the factors that can reduce deaths. The lack of support in these areas and in the shared responsibility of contraceptive use can be

attributed to the lack of knowledge on such issues, the lack of structures to support male and couple access to family planning services and the lack of publicity of men's role in reproductive health.

Support and use of family planning according to the findings are affected by a man's age, level of education, income, religion and the number of children. All these factors determine the extent of men's participation in family planning and are important factors to consider when developing strategies to address men's participation in family planning. Information on male preference to obtain family planning services at clinics and health centres and their preference to get those services from both male and female service providers is essential for developing strategies/programs that are specific to men to encourage their participation. Muvundi, et al. (2000) asserts that participation of men in reproductive health including family planning and safe motherhood aims at bringing men and women together as partners with equal responsibilities and equal access to information and health services. In this regard, men's participation and involvement is vital to achieve optimal women's health and reproductive health rights. Thompson (1999) and Feuerstein (1993) both argue that all women have the right to expect and receive sufficient care throughout pregnancy and child birth so as to avoid maternal deaths. Therefore, reproductive health and family planning should be a joint responsibility for both men and women.

## **5.7 Recommendations**

In view of the above findings, it is therefore recommended as follows:

- (i) Government through the Ministry of Health should formulate policies to scale up family planning services to include male and couple oriented services. In addition and with the help of stakeholders, develop programmes to sensitize men on the importance of their participation in family planning and other reproductive health matters;
- (ii) There is need for Government through the Ministry of Health which is a major stakeholder in issues of reproductive health including family planning to train family planning service providers on family planning services that focus on men. This training should be able to address specific needs of men from different backgrounds, education, age, income, number of children and other socio-economic and demographic characteristics. The training of staff in this regard will create confidence in the services and will encourage men to access the services;
- (iii) Men need more information on the available male oriented contraceptives so that they can share equal responsibility on fertility regulation and planning for a family. To achieve this, integrated family planning services should be introduced and special focus should be given to develop male oriented family planning services. This program will also provide various options for male oriented contraceptives for their acceptability. The male family planning services should also address other reproductive health issues such as STI's and HIV and AIDS. In addition, couple counseling should also form part of the family planning services package. This would encourage couples to communicate on various reproductive health issues that affect them and

henceforth break some of the traditional barriers that put women in subordinate positions in a home;

- (iv) There is need for program managers of family planning policy-makers to consider promoting family planning as a form of "health insurance" for both men and women because of the health benefits of family planning;
- (v) Programmes that encourage men to participate in family planning should be encouraged through the use of high profile men such as traditional leaders, politicians, opinion leaders, company executives and successful businessmen. These should be given special training and used for advocacy to encourage men's participation in family planning. These will also act as role models for men;
- (vi) More information needs to be disseminated on the roles that men should play in family planning and other reproductive health issues. In this regard, campaigns, and special programmes through the media, workplaces and clubs are essential to achieve this. This would also address the knowledge gap on the practice of family planning, contraceptive use and other issues relating to family planning;
- (vii) Antenatal and postnatal care programmes should be developed for men. This is essential as it would provide information such as adequate nutrition for the expectant mothers, symptoms of certain illnesses and how to look after their partners both physically and psychologically;
- (viii) There is need to intensify gender equality campaigns and interventions as gender inequality has continued to place women in subordinate positions

thereby restricting open discussion on reproductive health issues between sexes. In this regard, any interventions for male involvement in family planning should be made in the context of gender relations that exist; and

- (ix) There is need to sensitize women on the importance of family planning information with their partners to enable the couple develop norms of discussing family planning and other reproductive health matters. Couple communication has been viewed as one of the ways that encourage contraceptive use by couples. Communication and open discussion would therefore encourage men to get involved in family planning and would also help to overcome some of the cultural norms that have defined distinctive roles based on gender.

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## APPENDICES

### APPENDIX I: COMBINED QUESTIONNAIRE FOR MALE AND FEMALE RESPONDENTS



THE UNIVERSITY OF ZAMBIA  
DEPARTMENT OF GENDER STUDIES

MASTER OF ARTS IN GENDER STUDIES

#### PARTICIPANTS SEMI-STRUCTURED QUESTIONNAIRE

**Topic: Men's participation in family planning: A case study of Chilanga**

##### Introduction

Dear respondent,

My name is Christabel Phiri a postgraduate student at the University of Zambia conducting a research on the above topic. You have been randomly selected to take part in the study for being part of the residents of Chilanga. You are kindly requested to take part in this study by completing this questionnaire. Your participation is purely voluntary and you reserve the right to withdraw anytime without any explanation. Even when you agree you are free to refuse to answer any questions which you may not be comfortable with.

The purpose of the study is to examine the extent of men's involvement in family planning in Chilanga. The information obtained from you is confidential and will be used as such to the extent permitted by law. Although there are no benefits to you as an individual, you will have an opportunity to write about your experiences and offer valuable suggestions concerning men's involvement in family planning. As a participant in this research, you will not incur any material or financial costs and there are no risks attached for being a respondent. The findings of the research will be used to provide information to relevant stakeholders with the purpose of improving men's involvement in issues of family planning in the Chilanga community as well as at national level. If you need any clarification or help, please feel free to call my supervisor Dr. Kusanthan on Cell Number 0977 794730 or contact the Department of Gender Studies at the University of Zambia, Great East Road Campus on the following address:

School of Humanities and Social Sciences  
Department of Gender Studies  
P.O. Box 32379, LUSAKA

**INSTRUCTIONS**

- 1. Please answer all questions as accurately as possible
- 2. Tick the answer where appropriate

**SECTION A: SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS**

- 1.0 Location.....
- 2.0 Sex..... (1) Male (2) Female
- 3.0 Age..... (a) 15 – 19 years old [ ]  
(b) 20 -24 (c) 25 – 29 (d) 30 – 34 (e) 35 – 39 (f) 40 + years old
- 4.0 Marital Status..... (a) Married [ ]  
(b) Single (c) Divorced (d) Widowed (e) Separated  
(f) Other, specify.....
- 5.0 If the answer to question 4.0 is (a) above, for how long have you being married?  
Years: ..... Months: .....
- 6.0 Number of children.....  
Male children..... Female children.....
- 7.0 What total number of children would you like to have? .....  
Male children..... Female children.....
- 8.0 Level of education?  
(a) Junior primary (b) Senior primary (c) Junior dary (d) Senior secondary [ ]  
(e) College (f) University (g) Other, specify.....
- 9.0 Occupation..... (a) Peasant farmer [ ]  
(b) Formal employment (c) Informal employment (d) Business  
(e) Other, specify.....
- 10.0 Monthly income? (a) K100,000 – K500,000 [ ]  
(b) K500,000 – K1,000,000 (c) K1,000,000 – K1,500,000 (d) K1,500;000 – K2,000,000  
(e) K2, 000,000 and above (f) other specify.....
- 11.0 Tribe.....
- 12.0 Religion.....

**SECTION B: KNOWLEDGE/ATTITUDE & PRACTICE – CHILD SPACING AND FAMILY SIZE**

- 13.0 How many years are in between your first child and .....
- 14.0 Would you want to have any more children?

(a) Yes (b) No [ ]

15.0 How long would you like to wait from now before the birth of another child?

(a) 1 year (b) 1½ - 2years (c) 2 ½ - 3years (d) Above 3 years

(e) Other specify.....

16.0 Does your partner want the same number of children that you want or does he/she want more or fewer than you want?

(a) More than I want (b) Fewer than I want (c) We want same number of c (d) I

don't know (e) Other, specify.....

17.0 Who decides on the spacing in between your children? [ ]

(a) My wife (b) My husband (c) My girl friend (d) My boyfriend

(e) Myself (f) Both of us (g) Others, specify.....

18.0 Who makes the final decision on spacing of births?

(a) My wife (b) My husband (c) My girl friend (d) My boyfriend [ ]

(e) Myself (f) Both of us (d) Others, specify.....

19.0 Do you face any disagreements on the decision taken?

(a) Yes (b) No [ ]

20.0 How do you resolve the disagreements?

(a) By having mutual discussions [ ]

(b) By receiving counseling from elders, friends or relatives

(c) By ignoring the whole situation

(d) Other, specify.....

21.0 Who decides when to have children?

(a) My wife (b) My husband (c) My girl friend (d) My boyfriend

(e) Myself (f) Both of us (g) Others, specify..... [ ]

22.0 Who makes the final decision on when to have children?

(a) My wife (b) My husband (c) My girl friend (d) My boyfriend

(e) Myself (f) Both of us (g) Others, specify..... [ ]

23.0 Do you face any disagreements on the decision taken?

(a) Yes (b) No [ ]

24.0 How do you resolve the disagreements?

(a) By having mutual discussions (b) By receiving counseling from elders, friends or relatives

(c) By ignoring the whole situation [ ]

(d) Other, specify.....

25.0 Who decides how many children to have?  
 (a) My wife (b) My husband (c) My girl friend (d) My boyfriend  
 (e) Myself (f) Both of us (g) Others, specify..... [ ]

26.0 Who makes the final decision on how many children to have?  
 (a) My wife (b) My husband (c) My girl friend (d) My boyfriend  
 (e) Myself (f) Both of us (g) Others, specify..... [ ]

27.0 Do you face any disagreements on the decision taken?  
 (a) Yes (b) No [ ]

28.0 How do you resolve the disagreements?  
 (a) By having mutual discussions (b) By receiving counseling from elders, friends or relatives  
 (c) By ignoring the whole situation [ ]  
 (d) Other, specify.....

**SECTION C: KNOWLEDGE/ATTITUDE & PRACTICE – FAMILY PLANNING AND CONTRACEPTION**

29.0 What do you understand about family planning? [ ]  
 (a) A service offered to women to control the number of children [ ]  
 (b) Not having any more children (c) Having children at the time convenient for a couple  
 (d) Other, specify.....

30.0 Please tick the type(s) of family planning method that you know  
 (a) Pill (b) Injection (c) Emergency contraception (d) Male condom  
 (e) Female condom (f) Female sterilization (g) Male sterilization  
 (h) Diaphragm (i) Implants (j) Lactational Amenorrhoea (k) Withdrawal  
 (l) Rhythm/Natural family planning (m) Intra-Uterine Device (IUD) (n) Periodic abstinence (o) other, specify.....

31.0 Do you approve of family planning?  
 (a) Yes (b) No [ ]

32.0 Does your partner approve of family planning?  
 (a) Yes (b) No [ ]

33.0 Have you ever used anything or tried to use in anyway to delay or avoid getting pregnant/avoid getting your partner pregnant?  
 (a) Yes (b) No [ ]

34.0 Are you currently using any method of family planning?

- (a) Yes (b) No [ ]

35.0 If yes, to question 34.0 above, what methods of family planning are you currently using?

- (a) Pill (b) Injection (c) Emergency contraception (d) Male condom  
(e) Female condom (f) Female sterilization (g) Male sterilization  
(h) Diaphragm (i) Implants (j) Lactational Amenorrhoea (k) Withdrawal  
(l) Rhythm/Natural family planning (m) Intra-Uterine Device (IUD) (n) Periodic  
abstinence (o) Other, specify.....

36.0 Does your partner know about the family planning method you are using?

- (a) Yes (b) No [ ]

37.0 Who decides which method(s) to use?

- (a) My wife (b) My husband (c) My girl friend (d) My boyfriend  
(e) Myself (f) Both of us (g) Others, specify..... [ ]

38.0 Does your partner support/not support the type(s) of family planning methods that you use?

- (a) Support (b) Not support [ ]

39.0 If your answer in question 34.0 is (b), would you want to use a contraceptive method in future? (a) Yes (b) No [ ]

40.0 Have you ever discussed the practice of family planning with a health worker or health professional? (a) Yes (b) No [ ]

41.0 Have you ever received information on family planning with your partner at a health facility or anywhere else? (a) Yes (b) No [ ]

42.0 Have you ever discussed using family planning methods with your partner?

- (a) Yes (b) No [ ]

43.0 Do you face any problems when discussing family planning issues with your partner?

- (a) Yes (b) No [ ]

44.0 Who makes the final decisions on family planning issues in your home?

- (a) Husband/boyfriend (b) Wife/girlfriend (c) Both of us [ ]  
(d) Relatives (e) Other, specify.....

**FOR MALE RESPONDENTS ONLY**

45.0 Do you have access to information about family planning?

- (a) Yes (b) No [ ]

46.0 If yes to question 45.0 above, where do you get information on family planning?

- (a) Family planning clinic (b) Private pharmacy (c) Workplace (d) Friends

(e) Media (f) Wife/girlfriend (g) other specify.....

47.0 Where would you feel most comfortable to receive information and male methods of family planning? (a) Private pharmacy (b) Family planning clinic (c) Work place (d) Male club (e) Other, specify.....

48.0 (a) would you be willing to go with your wife/girlfriend to access information about family planning?

(a) Yes (b) No [ ]

48.0 (b) If the answer in question 44.0 (a) is (b), why not?

(a) It is embarrassing (b) it is against my culture (c) My friends may look less of me [ ] (d) Other, specify.....

49.0 Who would you prefer to counsel you or distribute male family planning methods to you?

(a) Females (b) Males (c) Both [ ]

50.0 Does your community support the idea of men's participation in family planning?

(a) Supports (b) Does not support I don't know [ ]

**SECTION D: KNOWLEDGE/ATTITUDE & PRACTICE OF ANTENATAL AND POSTNATAL CARE**

**FEMALE RESPONDENTS ONLY**

51.0 How many months pregnant were you when you first went for antenatal check up?

(a) 2 months (b) 3 months (c) 4 months (d) 5 months (e) Other, specify .....

52.0 Did you plan all your pregnancies?

(a) Yes (b) No [ ]

53.0 Were all your pregnancies wanted or they were unwanted?

(a) Wanted (b) Unwanted (c) Other, Specify.....

54.0 Did you experience any high risk pregnancies, as pregnancies that needed frequent medical attention?

(a) Yes (b) No [ ]

55.0 How often did you go for antenatal checkups?

(a) Weekly (b) fortnightly (c) monthly (d) once in 2 months (e) Other specify .....

56.0 What kind of support did you receive from your pa uring your pregnancy and delivery of the baby? Please tick

- (a) He accompanied me for antenatal checkups
- (b) He provided transport and other logistics
- (c) He bought enough food so that the baby and I remained healthy
- (d) He accompanied me to the clinic/hospital for delivery
- (e) Other, specify.....

57.0 What support did your partner provide after delivery of the baby? Please tick

- (a) He accompanied me for postnatal checkups
- (b) He provided port and other necessities
- (c) He took the baby for immunization
- (d) He helped with household chores
- (e) Other, specify .....

**MALE RESPONDENTS ONLY**

58.0 In your understanding, what is antenatal and postnatal care?

- (a) Services that are offered to women during pregnancy and after delivery [ ]
- (b) Services provided to all women whether pregnant or not
- (c) I don't know
- (d) Other, specify.....

59.0 Why do pregnant women go for antenatal checkups?

- (a) To find out if they and the baby are healthy
- (b) To find out if the baby is growing well
- (c) To get advice on what types of food to eat and how ok after themselves
- (d) To find out the sex of the baby
- (e) Other, specify.....

60.0 (a) When your partner was pregnant, did she go for any antenatal checkups?

- (a) Yes
- (b) No [ ]

60.0 (b) If the answer is (a) in question 60.0 (a) above, were you present during the checkups?

- (a) Yes
- (b) No [ ]

60.0 (c) If you were present/not present during the antenatal checkups, why? Why not? Please tick

- (a) I was busy
- (b) Antenatal is a woman's responsibility
- (c) It is embarrassing as other men do not accompany their partners
- (d) My partner and I share equal responsibility when it comes to pregnancy
- (e) Other, specify .....

61.0 At the time of delivery of your baby, did you make transport and other arrangements for your partner to enable her deliver at a health facility?

- (a) Yes
- (b) No [ ]

62.0 After the birth of your child, what kind of care did you give to your partner? Please tick

- (a) Cooked for her
- (b) Accompanied her for postnatal checkups
- (c) Bathed the baby
- (d) Took the baby for immunization
- (e) Other, specify.....

63.0 Why is it important for you as a man to get involved in antenatal and postnatal care for your partner? Please tick

- (a) It would ease her burden of pregnancy and effects of delivery [    ]
- (b) Pregnancy should be a shared responsibility between husband and wife [    ]
- (c) It would teach me to be a responsible father [    ]
- (d) Other, specify.....

**BOTH MALE AND FEMALE RESPONDENTS**

64.0 What in your view can be done to actively involve men in issues of family planning?

- (a) By raising awareness of the importance of their participation [    ]
- (b) By providing more male oriented family planning services [    ]
- (c) By encouraging couples to access family planning together [    ]
- (d) By providing user-friendly family planning services to men [    ]
- (e) Other, specify.....

65.0 Why should men actively participate in family planning?

- (a) Because they are key decision makers in a home [    ]
- (b) Because they are breadwinners and they command respect in a home and society [    ]
- (c) It would ease the burden of too closely spaced pregnancies for women [    ]
- (d) It would reduce on the number of women dying from pregnancy related causes [    ]
- (e) Other, specify.....

66.0 What suggestions do you have on men's participation in family planning?

.....  
 .....  
 .....

**- THE END -**

**THANK YOU FOR YOUR TIME AND HONEST CONTRIBUTIONS**

**APPENDIX II: FOCUS GROUP DISCUSSION GUIDE FOR FEMALE RESPONDENTS**

DATE:.....  
TIME:.....  
NUMBER OF PARTICIPANTS:.....  
CHARACTERISTICS OF PARTICIPANTS:.....  
.....

**Instructions to group facilitator**

1. Greet the participants
2. Introduce yourself and the note taker
3. Allow the participants to introduce themselves
4. Introduce the topic and the purpose of the study
5. Facilitate the discussion without taking part in it
6. Keep all information

This study is about men’s participation in family planning in Chilanga and in finding out the extent of their participation, a number of questions have been designed.

**1. Knowledge, Attitudes and Practice of Family Planning**

Currently, infant and maternal mortality rates are still high in Zambia estimated at 70 Per 1,000 live births and 591 Per 100,000 live births according to the Zambia Demographic and Health Survey of 2007. Research has shown that family is important in reducing infant mortality and preserving women’s lives through the proper spacing of births.

- (i) Have you ever heard of family planning? What have you heard about it?  
Probe: What types of family planning methods have you heard?

There are various ways through which a couple can delay or avoid pregnancy through the use of family planning methods.

- (ii) How do you and your partner space births?
- (iii) If you are not using any methods of family planning for child spacing, what are the main reasons why you are not using any?
- (iv) In your family, how do you discuss family planning issues?

## **2. Men's involvement in family planning**

It is common knowledge that men play an important role in issues of family life because of their roles as fathers and heads of households in a family.

- (i) In what areas is your partner generally involved in family planning?
- (ii) What are the general cultural practices relating to his involvement in family planning?
- (iii) What is your partner's attitude towards family planning and contraceptive use?
- (iv) How does your partner react when you tell him about your intentions to go to the family planning clinic or access family planning methods from the pharmacy?
- (v) How does your partner support you when it comes to issues of family planning?
- (vi) How do you normally resolve conflicts concerning family planning issues and the use of contraceptives?

## **3. Decision making on child spacing and family size**

Deciding on how many children to have, when to have them and how to space them is an important aspect in family planning.

- (i) What do you think about child spacing and family size?  
Probe: How do you discuss such matters with your partner?
- (ii) When do you have disagreements when deciding on child spacing and family size?  
Probe: How do you resolve the conflicts?

## **4. Male involvement in antenatal and postnatal care**

Antenatal and postnatal care are important to expectant mothers as they keep both the mothers and their unborn babies on check to ensure that they stay healthy and avoid pregnancy related complications.

- (i) What kind of care and support do you receive from your partner when you are expecting and after delivery?
- (ii) How do you think a male partner should be involved in antenatal and postnatal care?
- (iii) How does your partner get involved in antenatal and postnatal care?  
Probe: How would you like your partner to be involved in antenatal and postnatal care?
- (iv) What are the general cultural practices relating to pregnancy, giving birth and postnatal care?
- (v) What kind of abuse does your partner subject you to during pregnancy?

- (vi) How do you resolve conflicts relating to abuse and support from your partner during pregnancy and delivery?

#### **5. Obstacles to men's participation in family planning**

Looking at the answers you have given in the questions above, it is clear that men's participation in family planning cannot be equated to that of women. I would now like to discuss with you the obstacles you think men face in participating in family planning.

- (i) Why do men normally not involve themselves in family planning?

Probe: What are the hindrances to their involvement? Cultural related, institutional, social

- (ii) What are the cultural beliefs existing in the society would make us understand why men do not actively participate in family planning?

- (iii) In what areas of reproductive health matters do men generally participate in?

- (iv) How can we make men get more involved in family planning?

- (v) What do you generally feel are other issues concerning men's involvement in family planning that you would like to discuss with us?

Probe: Is there anything else you would like us to discuss?

- (vi) Are there any other general issues you would like to discuss concerning our topic?

**- THE END -**

**THANK YOU FOR YOUR TIME AND HONEST CONTRIBUTIONS**

**APPENDIX III: FOCUS GROUP DISCUSSION GUIDE FOR MALE RESPONDENTS**

DATE:.....  
TIME:.....  
NUMBER OF PARTICIPANTS:.....  
CHARACTERISTICS OF PARTICIPANTS:.....  
.....

**Instructions to group facilitator**

1. Greet the participants
2. Introduce yourself and the note taker
3. Allow the participants to introduce themselves
4. Introduce the topic and the purpose of the study
5. Facilitate the discussion without taking part in it
6. Keep all information

This study is about men’s participation in family planning in Chilanga and in finding out the extent of their participation, a number of questions have been designed.

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(i) Have you ever heard of family planning? What have you heard about it?

Probe: What types of family planning methods have you heard?

There are various ways through which a couple can delay or avoid pregnancy through the use of family planning methods.

(ii) How do you and your partner space births?

(iii) If you and your partner are not using any methods of family planning for child spacing, what are the main reasons why you are not using any?

(iv) In your family, how do you discuss family planning issues?

**2. Men’s involvement in family planning**

It is common knowledge that men play an important role in issues of family life because of their roles as fathers and heads of households in a family.

- (i) In what areas are you generally involved in family planning?
- (ii) What are the general cultural practices relating to your involvement in family planning?
- (iii) What are your thoughts regarding family planning and contraceptive use?
- (iv) How do you react when your partner tells you about her intentions to go to the family planning clinic or access family planning methods from the pharmacy?
- (v) How do you support your partner when it comes to issues of family planning?
- (vi) How do you normally resolve conflicts concerning family planning issues and the use of contraceptives?

### **3. Decision making on child spacing and family size**

Deciding on how many children to have, when to have them and how to space them is an important aspect in family planning.

- (i) What do you think about child spacing and family size?  
Probe: How do you discuss such matters with your partner?
- (ii) When do you have disagreements when deciding on child spacing and family size?  
Probe: How do you resolve the conflicts?

### **4. Male involvement in antenatal and postnatal care**

Antenatal and postnatal care are important to expectant mothers as they keep both the mothers and their unborn babies on check to ensure that they stay healthy and avoid pregnancy related complications.

- (i) What kind of care and support do you give to your partner when she is expecting and after delivery?
- (ii) How do you get involved in antenatal and postnatal care?  
Probe: How would your partner like you to be involved antenatal and postnatal care?
- (iii) What are the general cultural practices relating to pregnancy, giving birth and postnatal care when it comes to your involvement in such issues as a man?

### **5. Obstacles to men's participation in family planning**

Looking at the answers you have given in the questions above, it is clear that men's participation in family planning cannot be equated to of women. I would now like to discuss with you the obstacles you think men face in participating in family planning.

- (i) Why do men normally not involve themselves in family planning?  
Probe: What are the hindrances to their involvement? Cultural related, institutional, social

- (ii) What are the cultural beliefs existing in the society would make us understand why men do not actively participate in family planning?
- (iii) In what areas of reproductive health matters do men generally participate in?
- (iv) How can we make men get more involved in family planning?
- (v) What do you generally feel are other issues concerning men's involvement in family planning that you would like to discuss with us?  
Probe: Is there anything else you would like us to discuss?
- (vi) Are there any other general issues you would like to discuss concerning our topic?

**- THE END -**

**THANK YOU FOR YOUR TIME AND HONEST CONTRIBUTIONS**