A STUDY ON FACTORS CONTRIBUTING TO INADEQUATE MALE INVOLVEMENT IN FAMILY PLANNING IN SESHEKE DISTRICT

By

MIYOSA P. MAPANI
REGISTERED NURSE 1992, LUSAKA, ZAMBIA
REGISTERED MIDWIFE 1999, NDOLA, ZAMBIA

A RESEARCH STUDY SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE BACHELOR OF SCIENCE DEGREE IN NURSING TO THE UNIVERSITY OF ZAMBIA.
ACKNOWLEDGEMENT

My sincere gratitude goes to the following for the contribution and support offered during this research:

- The Ministry of Health for sponsorship.
- Mrs. C. Ngoma, my supervisor for her guidance.
- Dr. M. Maimbolwa for the knowledge she imparted in me in nursing research.
- My friend Ezia Malawo for allowing me to use her Internet services.
- Office of the District Commissioner, Seseke, for the permission to carry out the study.
TABLE OF CONTENT

- Acknowledgement
- Table of contents
- List of abbreviations
- List of tables
- List of figures
- Declaration
- Statement
- Dedication
- Abstract

PAGE

- ii
- iii
- vi
- vii
- viii
- ix
- x
- xi
- xii

CHAPTER ONE

1.0 Introduction
  1.1 Background information
  1.2 Statement of the problem
  1.3 Factors contributing/influencing the problem
  1.4 Diagram of problem analysis
  1.5 Justification
  1.6 Research objectives
    1.6.1 General Objective
    1.6.2 Specific Objectives
  1.7 Hypothesis
  1.8 Operational definition of terms
  1.9 Variables and cut-off points

CHAPTER TWO

2.0 Literature Review
  2.1 Introduction
  2.2 Global perspective
  2.3 Regional perspective
  2.4 National perspective
  2.5 Conclusion

  12
  12
  13
  15
  15
  16
CHAPTER THREE

3.0 Research methodology 17
   3.1 Research design 17
   3.2 Research setting 17
   3.3 Study population 18
   3.4 Sampling Method 18
   3.5 Sample size 18
   3.6 Data collection tool 18
   3.7 Data Collection Technique 19
      3.7.1 Validity 20
      3.7.2 Reliability 20
   3.8 Pilot study 21
   3.9 Ethical and cultural consideration 21

CHAPTER FOUR

4.0 Data analysis and presentation of findings 22
   4.1 Introduction 22
   4.2 Data analysis 22
   4.3 Presentation of findings 22

CHAPTER FIVE

5.0 Discussions of findings and implications to the health care system 38
   5.1 Introduction 38
   5.2 Characteristics of the sample 38
   5.3 Knowledge of family planning 39
   5.4 Utilization of family planning 40
   5.5 Attitude towards family planning services 41
   5.6 Implications to the health care system 42
   5.7 Conclusion 45
   5.8 Recommendations 46
   5.9 Limitations of the study 48
   5.10 Dissemination of findings 48
References 49

Appendices

Appendix 1: Questionnaire 52
Appendix 2: Gantt chart 58
Appendix 3: Work plan 59
Appendix 4: Budget 60
LIST OF ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome
ANC - Antenatal Clinic
CARE - Cooperation for American Relief Everywhere
CBoH - Central Board of Health
DHMT - District Health Management Team
DHS - Demographic Health Surveys
DIM - District Integrated Meeting
HIV - Human Immune Virus
FP - Family planning
ICPD - International Conference on Population Development
IEC - Information Education and Communication
JHPCS - John Hopkins Center for communication Programmes
MCH - Maternal and Child Health
MMD - Movement for Multiparty Democracy
MoH - Ministry of Health
NBC - Namibian Broadcasting Corporation
NHR - National Health Reforms
NGO's - Non-Governmental Organization
PHC - Primary Health Care
PPAZ - Planned Parenthood Association of Zambia
SDHMT - Seshenbe District Health Management Team
STIs - Sexually Transmitted Infections
ZDHS - Zambia Demographic and Health Survey
List of tables

Table 1: Variables and cut off points
Table 2: Respondents occupation
Table 3: Respondents definition of Family planning
Table 4: Respondents knowledge of family planning methods
Table 5: Respondents source of information
Table 6: Methods of family planning
Table 7: Place of family planning methods acquisition
Table 8: Invitation to Family Planning clinics
Table 9: Persons who invited respondents to family planning clinics
Table 10: Attendance of Family Planning clinics by respondents
Table 11: Respondents opinion on benefits of family planning
Table 12: Discussion on family planning
Table 13: family Planning Discussants with respondent
Table 14: Age in relation to marital status
Table 15: Level of education in relation to knowledge
Table 16: Marital status in relation to knowledge
Table 17: Knowledge in relation to utilization
Table 18: Respondents attitude in relation to utilization
Table 19: Respondents marital status in relation to utilization
Table 20: respondents education to utilization
Table 21: Respondents denomination in relation to attitude
Table 22: Marital status in relation to attitude
List of figures

Figure 1: Age distribution 23
Figure 2: Marital status 23
Figure 3: Education attainment 24
Figure 4: Denomination 25
Figure 5: Number of children 25
Figure 6: Known methods of Family Planning 26
Figure 7: Level of knowledge 27
Figure 8: Use of family planning methods 28
Figure 9: Reason for attending/not attending family planning clinic 30
Figure 10: Respondents concern of sex of family planning provider 31
DECLARATION

I, hereby declare that the work presented in this study for a Bachelor of Science degree in nursing has not been presented either wholly or in part, for any other degree and is not being currently submitted for any other degree.

SIGNED ____________________________  DATE ____________________________
CANDIDATE

APPROVED BY: ____________________________  DATE ____________________________
SUPERVISOR
STATEMENT

I hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and references.

SIGNED

DATE 5th April 2006.
DEDICATION

This study is dedicated to my entire family for the love and support they have never ceased to offer to me.
ABSTRACT

Family planning is a dual commitment but most often it has been seen wholly as a woman's responsibility, because after all she's the one who gets pregnant. Failure to target men in family programmes has weakened the impact of family planning interventions.

The main objective of the study was to establish factors that contribute to inadequate male involvement in family planning in Sesheke District, so that ultimately areas that need intervention are identified. Literature from various scholars globally, regionally and nationally was reviewed on male involvement in family planning.

A descriptive study design with both qualitative and quantitative dimensions was used. The study population was men aged between 15-49 years. A pilot study was done in Katima-mulilo (Zambia). The study was conducted in five residential areas in Sesheke District. A probability sampling method known as simple random sampling using the lottery technique was used to select the respondents. Data was collected using a structured interview schedule from 50 respondents, 10 from each residential area. Data was analyzed manually using a data master sheet and has been presented in form of frequency tables, pie charts, bar graphs and cross tabulations which were used to determine special relationships between variables.

Study findings revealed that 93% of the men knew at least one method of family planning and 64% of the respondents had high knowledge in matters relating to family planning. The study also revealed that marital status and educational attainment had an influence on knowledge of family planning. The major sources of information on family planning among the men were friends (92%), radio (74%) and television (50%).

The major recommendations in view of the results of the study are

➢ The Ministry of Health and other stakeholders such as schools, churches, Non-Governmental Organizations need to formulate deliberate programmes on family planning and sexuality in order to reach men.
➢ Sesheke District Health Management Team to embark on massive community sensitization programmes on male involvement in family planning.

➢ The health center should create community based clubs which will increase men’s accessibility to family planning services.
CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

Zambia is a landlocked country, covering an area of 752,612 square kilometers and consisting of about 2.5% of the area of Africa. It lies between 8 and 18 south latitude and between 20 and 35 east longitude. The country shares borders with the Democratic Republic of Congo and Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the south; Namibia in the southwest and Angola in the west. Administratively, the country is divided into nine (9) provinces and 72 Districts. There are 73 dialects spoken in the country.

It has a tropical climate and vegetation with three distinct seasons, the dry season from May to August, a hot dry season during the months of September to October and a warm wet season from November to April.

The population of Zambia is 10.3 million, with the growth rate of 2.9% per year. The fertility rate is 6.0 while life expectancy at birth is 37 years for both males and females (ZDHS, 2001-2002). Prior independence the population was sparsely distributed especially in the rural areas and had no adequate health facilities. Health care facilities were concentrated along the line of rail. This prompted the government to review its health care provision after independence.

In 1964, following independence, the Zambian government declared free health services for all and the main emphasis at that time was curative as opposed to preventive medicine. Within a few years, the country's population grew very fast and health care standards began to fall. This was due to the rural urban drift, which led to overcrowding in the cities with poor housing and sanitation. In Zambia, government provided most of the health care services.
In 1981, the Zambian government through the Ministry of Health adopted the Primary Health Care (PHC) concept with the vision of providing health to all by the year 2000. This concept emphasizes that the health services should be provided as close to the family as possible through community participation and at a cost that families and communities can afford. The emphasis was more on preventive rather than curative medicine. In 1991, when the Movement for Multiparty Democracy (MMD) came to power, the government introduced the concept of National Health Reforms (NHR) whose vision was to provide equitable access to high quality, cost effective interventions as close to the family as possible (CBoH, 1997).

Health reforms also stress the need for families and communities to be self-reliant and to participate in their own health and development. Reproductive health is one of the components of Primary Health Care. Reproductive health care is a state of complete physical, mental and social well-being and not merely the absence of disease or infinity in matters relating to the reproductive health system and its functions and processes.

The aims of reproductive health care in Zambia are:

- Reduction of pregnancy related mortality and morbidity and reduction of newborn deaths and disabilities.
- Need for couples and individuals to have safe, effective and affordable methods of fertility regulation of their choice.
- Prevention and management of reproductive tract infections, including those that are sexually transmitted and targeting adolescents and involving men in service provision and receipt.

In addition, Zambia developed a National Reproductive Policy in 1997. The Reproductive Health Policy is seen as an umbrella policy which encompasses other policies such as the Family Planning Policy, the National Sexually Transmitted Infection/Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (STI/HIV/AIDS) policy and safe motherhood policy.
According to CBoH (1997) the impetus for a National Reproductive Health Policy was the 1994 International Conference on Population Development (ICDP) that was held in Cairo, Egypt and its programme of action, which Zambia signed.

In April 1997, Zambia participated in the regional conference on men's participation in reproductive health held in Zimbabwe. Zambia made the following pledges:

- To integrate men's participation into all reproductive health information programmes including all STI/HIV and family planning and information education and communication activities.
- To promote male participation in reproductive health through information education and communication activities.
- Increase male participation in family planning programmes (Better Together).

The Zambian government together with some international organizations and non-governmental organizations such as Planned Parenthood Association of Zambia (PPAZ) and John Hopkins center for communication programmes (JHPCS) family planning projects have been trying ways of involving men in reproductive health services particularly family planning. Men have been involved in condom distribution and have accessed vasectomy and condoms as family planning methods.

1.2 STATEMENT OF THE PROBLEM

Male involvement in family planning has become a major concern world over due to the increase in HIV/AIDS, millions of unintended pregnancies and raising maternal mortality rate (Salem 2004). For instance the risk of dying from pregnancy and childbirth complications in Zambia is high with the mortality rates at 729/200,000 live births (ZDHS, 2001-2002). It is most likely that if males were involved in reproductive care such as family planning, maternal deaths would have been reduced.
According to the Ministry of Health (2004), male participation in family planning is absolutely low as seen by the marginal increase in condom use from 3.5% in 1996 to 3.8% in the ZDHS 2001-2002 amongst married women aged between 15-49 years. Services for reproductive health counseling are very weak and male oriented services are particularly weak.

Male involvement in reproductive health is a promising strategy to addressing some of Zambia's pressing reproductive health problems with HIV now spreading faster among women than men. The AIDS pandemic has focused attention on the health consequences of men's behavior. The other reason is that millions of pregnancies are unintended and each year thousands of women die as a result of pregnancy related complications.

The traditional FP programmes are targeted to women. "If men are brought into a wide range of reproductive health services in such a way that they are supported as equal partners and responsible parents, as well as clients in their own right, better out comes are expected in reproductive health indicators such as contraception acceptance and continuation"(Pachuri 2001)

The advantages of involving men in reproductive health is that men are powerful decision makers within the couple, the home and community in many ways including the choice of family planning methods by their partners (Better together, 1996).

The majority of the clientele in the family planning clinics are women. One factor that is likely to contribute to the above scenario is the misconceptions and myths related to the use of family planning services. A study conducted in Columbia by Finger (1997) revealed that people believed that vasectomy affected a man's sexual performance.

Inadequate male involvement in family planning may contribute to the apathy on the part of women to utilize family planning services. It could also result in unwanted pregnancies, non-use of contraceptive methods, increased fertility rates and unsafe abortion (Green 2000).
This could be attributed to the fact that men are not participating in family planning and neither are they encouraging their wives, partners and girlfriends to participate in family planning (Salem, 2004)

In view of the above, the researcher decided to conduct a study on contributing factors to inadequate male involvement in family planning services.

1.3 FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING
There are several factors that may influence male involvement in family planning and these are as follows:

1.3.1 SERVICE-RELATED FACTORS

1.3.1.1 Inadequate Privacy
Health facilities have limited infrastructure and are therefore unable to keep separate rooms for services for men. This makes it difficult for men to utilize family planning services because they do not want to be seen by others when seeking a service.

1.3.1.2 Attitude of the Health Workers
The staff shortages leave health workers stressed and burnt out and therefore they do not find the time to educate or even invite men to family planning sessions.

1.3.1.3 Inadequate Information, Education and Communication
Health workers may not be aware of the importance of involving men in planning and have not seen the benefits of educating them on its benefits.

1.3.1.4 Staff Shortage
Low staffing levels in the health facilities may discourage men from utilizing services because clients take long to be attended to when they visit the health facilities.
1.3.1.5 Staff Training

Health workers without training in reproductive health may not be aware of the new developments in reproductive health and may not attend to male clients due to lack of knowledge.

1.3.1.6 Access to Reproductive Health Services

- Distance to the health facilities especially in rural areas can prevent men from using the services.
- Shortage of equipment and supplies at the health facilities.
- Clinic operating times may not be convenient for men.
- Waiting times due to staff shortage may limit access.

1.3.2 SOCIAL-CULTURAL FACTORS

1.3.2.1 Cultural Beliefs

Traditionally, family planning is perceived as a feminine role and so it’s seen as not being a masculine role. The other reason is that culturally large families are preferred as children enhance status of parents. Children are considered as social security for parents in old age.

1.3.2.2 Economic Factors

Men are breadwinners in most homes and are often away when clinics are in session. It is not easy for them to leave work to attend a family planning service. The men are off duty during weekends when services are not offered. Men without any source of livelihood are more likely to use family planning services than those who are well off.

1.3.2.3 Inadequate Knowledge

Men may not be aware that they can also access family planning services.

1.3.2.4 Age

Young men are more likely to utilize family planning services than older men.
1.3.2.5  **Level of Education**

Educated men are more likely to utilize family planning services than illiterate men.

1.3.2.6  **Marital Status**

Married men are more likely to use family planning than those who are not married.

1.3.2.7  **Level of Knowledge**

Men who know about the availability of family planning services and their benefits are likely to utilize the services.
1.4 DIAGRAM OF PROBLEM ANALYSIS

Figure 1:
SOCIO-CULTURAL FACTORS

- Level of knowledge
- Economic factors
- Cultural beliefs

- Age
- Marital status
- Level of education

FACTORS CONTRIBUTING TO INADEQUATE INVOLVEMENT OF MEN IN FAMILY PLANNING

SERVICE RELATED FACTORS

- Inadequate of privacy
- Staff attitudes
- Access to services
- Distance
- Shortage of supplies and equipment
- Waiting hours
- Staff shortages
- Staff training
- Inadequate IEC
1.5 JUSTIFICATION
The purpose of this study is to determine factors contributing to inadequate male involvement in family planning services. It is assumed that if males were involved in family planning and reproductive health they would protect their family and women from HIV/AIDS, unwanted pregnancies, unsafe abortions and complications of pregnancy and childbirth. This would drastically reduce unwanted pregnancies, complications of pregnancy and eventually maternal mortality rates. The study will serve as an indicator for evaluating family planning programmes in Seseke.

It is hoped that the results of this study will increase the involvement of men in family planning and this will improve the health of women and children. The results of this study will help policy makers, family planning managers, NGOs involved in reproductive health and reproductive healthcare providers in Seseke to improve service delivery to men and make family planning services more inclusive of men.

1.6 RESEARCH OBJECTIVES
1.6.1 General Objective
To establish factors, contributing to inadequate male involvement in family planning.

1.6.2 Specific Objectives
1. To assess men's knowledge on family planning.
2. To determine men's utilization of family planning.
3. To identify factors contributing to inadequate male involvement in family planning.
4. To identify areas for further research.
5. To make recommendations to relevant authorities.
1.7 HYPOTHESIS

1. There is no difference in male involvement in family planning between men who have high knowledge about family planning and those that have low knowledge about family planning.

2. There is a difference in male involvement in family planning between men who have high knowledge about family planning and those that have low knowledge about family planning.

1.8 OPERATIONAL DEFINITIONS

1.8.1 Attitude: The respondent's way of perceiving family planning.

1.8.2 Knowledge: Level of understanding or awareness of family planning.

1.8.3 Partner: A person of the opposite sex with whom one has sexual relationships.

1.8.4 Male involvement: Inviting men to participate in family planning.

1.8.5 Utilization: Ability of a man to take at least one method of family planning
### 1.9 VARIABLES AND CUT OFF POINTS

#### Table 1: Variables and Cut off Points

<table>
<thead>
<tr>
<th>Variables</th>
<th>Indicators</th>
<th>Cut off points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Independent</td>
<td>Good</td>
<td>Number of men participating in family planning</td>
</tr>
<tr>
<td>Male involvement in family</td>
<td>Fair</td>
<td>Above 80% participating</td>
</tr>
<tr>
<td>planning</td>
<td>Poor</td>
<td>50-70% participating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 -40% participating</td>
</tr>
<tr>
<td>2. Dependent Knowledge</td>
<td>High</td>
<td>7 - 9 points</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>3-6 points</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>0-3 points</td>
</tr>
<tr>
<td>Utilization</td>
<td>Good</td>
<td>Men utilizing family planning.</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>Men not utilizing family planning services.</td>
</tr>
<tr>
<td>Attitude</td>
<td>Positive</td>
<td>Men view family planning as having benefits.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>Men view family planning as having no benefits.</td>
</tr>
</tbody>
</table>
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in context or as the basis for an implementation project (Polit and Hungler, 1995).

The purpose of literature review is to determine what is already known about the topic being studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. It also gives the researcher clues to the methodology and instruments that people used before and therefore provide information on what has been tried in regard to approaches and methods and what types of data collecting instruments exist and do not work. It also helps the researcher to refine certain parts of the study.

The literature reviewed is mainly on men’s use of family planning. The literature reviewed is presented and discussed from the works of various scholars from around the globe. The literature is arranged in three (3) parts, global perspective, regional perspective and national perspective respectively.

Men’s participation in family planning is a promising strategy for addressing some of the world’s most pressing reproductive health problems, with the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and sexually Transmitted Infections (STI’s) spreading fast throughout the world. The need for men to practice safer sex is becoming urgent. Above all, men need to use condoms correctly and consistently and limit the number of sexual partners if HIV/AIDS/STI spread is to be addressed (Drennan, 1998).
2.2. GLOBAL PERSPECTIVE

Surveys around the world are increasingly interviewing men and they are also reporting on their contraceptive use, reproductive preferences, attitudes towards family planning and sexual behaviors. This increase in the surveys reflects the widening recognition of men's importance in sexual and reproductive health. International conferences held in 1990s formally encouraged programmes to emphasize men's shared responsibility for women's reproductive health and to promote men's active commitment to responsible parenthood, sexual and reproductive health (Salem, 2004).

In 1994, the International Conference on Population Development (ICPD) set a new agenda when it talked about the importance of male responsibility and participation in reproductive health and family planning. This was further affirmed at the Beijing Conference, in 1995. The ICPD that was held in Cairo reminded the world that reproductive health was a right for both men and women and that together they share responsibility (Robey and Drennan, 1998).

Existing literature and perception in the international community on family planning and maternal health programmes attributes the major cause of failure of reproductive health programmes interventions throughout the world to lack of attention to the needs of men (Green, 2000) stated that services for men have been relatively few and far between as have efforts to include them in services for women.

In a report prepared by Drennan (1998), he notes that a growing number of reproductive health programmes and providers have seen that men deserve more attention for their own sake, for the sake of their families and their communities. In the new perspective men are seen as potential partners in reproductive health and advocates for good reproductive health, other than be by-standers, barriers or adversaries (Drennan, 1998).

According to Reproductive Health Outlook (http: www.rho.org/menurh-keyissues.htm) there has been a growing concern to involve men in family
planning as it has a positive impact on women’s and children’s health in a number of ways such as:

- Improving maternal and child health care.
- Preventing or reducing the spread of HIV/AIDS and sexually transmitted infections and improving contraceptive use.

Involving men in family planning is being advocated for, so as to tackle the spread of HIV/AIDS, prevent the millions of unintended pregnancies and prevent death of women resulting from complications of pregnancy and childbirth (Drennan, 1998).

In 1998, a conference of African countries that are French speaking was held and barriers to male participation in reproductive health and family planning were identified as being inadequate trained health providers, little reproductive health information and few services designed for men. Cultural and religious beliefs that are against reproductive health and lack of policies that address men’s reproductive health needs were also identified as reasons men do not participate in family planning.

Traditionally, reproductive and family planning programme have been viewed as exclusively feminine because, it is women who become pregnant, most contraceptive methods are designed for women, and reproductive health services can be offered conveniently as part of maternal and child health services (Robey and Drennan 1998).

Research done by Walston (2005) indicates that opposition to male involvement stems from males themselves. Men are reluctant to change their practices regarding reproductive health, have feelings of embarrassment and believe that reproductive health particularly child spacing should remain the concern of women.
In a study done by Suliman (2001) he found that men were concerned with the sex of the provider, but they did express support for their wives to practice family planning and promote their health.

2.3 REGIONAL PERSPECTIVE

In African societies, men play a key role in reproductive health, as individuals, as community leaders and as decision makers. However, most reproductive health care focuses on women. Reaching men is important to making family planning more widely used, ensuring safe motherhood and limiting the spread of HIV/AIDS (Robey and Drennan 1998).

In the research study findings presented at the French speaking countries in Ouagadougou it showed that it is important to target men as:

- Men are powerful decision makers and are used to making decisions about reproductive health without discussion with their wives.
- Men have little opportunities to be involved in family planning as participants or advocates.
- Most reproductive health services are oriented to women and children and are mainly offered in the maternal and children's health department where men cannot access them.

Robey and Drennan (1998) indicate that men are more likely to be involved in family planning than other reproductive health activities. According to recent Demographic Health Surveys (DHS) carried out in 15 countries men were more likely to know about family planning than women. In most countries surveyed the men who wanted more children was only slight higher than women who wanted another child.

2.4 NATIONAL PERSPECTIVE

According to 2001-2002 ZDHS data, contraceptive methods that require the participation of men during use – condoms, withdrawal and periodic abstinence – make up 38 percent of all contraceptives use among married women and 35 percent among all women.
The PPAZ has been the lead implementing organization in bringing family planning issues to the attention of men. It recently introduced a male clinic on Saturday at their Rachael Lumpa Clinic. The PPAZ also provides family planning services to companies.

In the ZDHS (2001-2002) survey it reported that two in three women reported having used male method of contraception at some time, 48 percent reported using a modern male method and 49 percent used a traditional male method. Of the two modern male methods, the condom is the more common method (48 percent) than male sterilization. As for the traditional method withdrawal (36 percent) is more common than natural family planning (28 percent).

Although family planning professionals in Zambia recognized the need to involve men in reproductive health infrastructure and services have remained exclusively for women in 1999, two (2) collaborative studies were done on the Copperbelt. It showed that men have been excluded from family planning programmes by the maternal and child health (MCH) focus (Muvandi, et al, 2000).

2.5 CONCLUSION

Literature that has so far been reviewed indicate that male involvement in family planning is the answer to pressing issues affecting women such as unintended pregnancies, complications of pregnancies and childbirth as well as reducing maternity mortality rates. Lack of information and cultural beliefs are among are among the reasons sited as being the reasons men are not involved in family planning.
CHAPTER THREE

3.0 RESEARCH METHODOLOGY
The study was aimed at describing the various factors contributing to inadequate male involvement in family planning.

3.1 RESEARCH DESIGN
Polit and Hungler, (1997) define a research design as the overall plan for addressing a research question, including specifications for enhancing the integrity of the study. It spells out in advance the strategies the investigator will adopt to develop information that is accurate and interpretable.

A descriptive study design with both qualitative and quantitative dimensions was used. A descriptive study involves the systematic collection of data to give a clear picture of a particular situation (Varkevisser, et al 1991). The study described the relationship between the various factors (independent variables) and male involvement in family planning (dependent variable). The investigator used a non-experimental study because no interventions or manipulations were done to the environment.

3.2 THE RESEARCH SETTING
The study was conducted in Sesheke District. The study was conducted in the communities of Sesheke District. Sesheke District is one of the seven districts of Western Province and is approximately 870 kilometers southwest of Lusaka, the capital city of Zambia. The District covers an area of 29,272 square kilometers with an estimated population of 87,598 square kilometers for the year 2005 (Sesheke, DHMT 2003).

The study was conducted in 5 residential areas of Sesheke District, which were conveniently chosen because they were within reach of the investigator. The residential areas chosen were Sabelo, Sesheke Secondary School Teacher's Compound, Kashongami, Nakatindia and Rentals compound.
These areas provide a cross section of men from different cultural, traditional and educational background.

3.3 STUDY POPULATION
A study population is the total group of individual people or things meeting the designated criteria of interest to the researcher (Dempsey and Dempsey, 2000). The study population was all men aged between 15 to 49 years.

3.4 SAMPLING METHOD
Sampling is a process of selecting a portion of the population to represent the entire population (Polit and Hungler, 1997). A probability sampling method called simple random sampling using the lottery technique was used to select the sample. This method allowed each element in the population an equal independent chance of being selected. The researcher placed papers with figures 1 to 5 in a container. Any man that picked a paper with figure five was eligible for the interview.

3.5 SAMPLE SIZE
A sample is a subset of a population selected to participate in a research study (Dempsey and Dempsey, 2000). The sample size comprised of 50 men aged between 15 and 49 years.

3.6 DATA COLLECTION TOOL
Data collection is gathering of information needed to address a research question (Polit and Hungler, 2001). An interview schedule was used to collect data from the respondents (Appendix 1 Page 52).

The interview schedule had both open ended and closed ended questions. The interview schedule was divided into 4 sections (A, B, C and D). Section A elicited demographic data, section B elicited information on family planning knowledge and Section C was on the utilization of family planning services while Section D elicited data about men's attitude on family planning.
The following are some of the advantages and disadvantages of an interview.

3.6.1 Advantages of Interviews

1. Data for each interview are usable.
2. Depth of the response can be assured, since the researcher can pursue any question of interest.
3. If the interviewee does not understand one of the questions during the interview he/she may request it to be repeated.
4. The interview procedure may serve time for the interviewee, because he/she does not have to go through the process of returning the instrument.

3.6.2 Disadvantages

1. The interviewee has little or no choice in the date or the place of the interview.
2. It may be difficult to make comparisons of one interviewer's data with another interviewer data unless a rigid procedure is followed at all times.
3. In a large research project there is need to hire interviewers and suitable persons may not be readily available.

3.7 DATA COLLECTION TECHNIQUE

Data was collected over a period of 15 days and a range of three to five interviews were done per day. After getting consent the investigator administered the Questionnaire. The researcher asked questions and followed the questions as listed in the interview schedule. The interviewer read out the questions to the respondents. The interviewer then entered the responses as given by the respondents. At the end of the interview the investigator went through the interview schedule to note for consistency in the answers given and for completeness of the interview schedule and then thanked the respondent for taking part in the study.
3.7.1 Validity

Validity is the degree to which an instrument measures what it is intended to measure (Polit and Hungler, 1997).

Validity was maintained by ensuring that all variables under study were covered in the interview schedule. Questions were clearly constructed to avoid ambiguity and were peer reviewed. The investigator translated the questionnaire in the locally spoken language, Lozi, so that the questions were well understood by the respondents who did not understand English. The interview schedule was tested in Katima-mulilo (Zambia) where the study did not take place. This was done in order to ensure that the instrument measured what is supposed to be measured. The supervising lecturer and other experts in the area under study checked the interview schedule.

3.7.2 Reliability

Reliability is the degree of consistency or dependability with which an instrument measures the attribute. It is designed to measure (Polit and Hungler, 1997). The instrument was able to bring out the accurate information whereby if the same instrument was used after some time, it should have the same responses. The same instrument was used to collect data from all the respondents and it elicited the same data. The pre-tested questions yielded similar findings when compared with the use in study.

3.8 PILOT STUDY

A pilot study is a small-scale version of the actual study conducted with the purpose of testing and potentially refining the research plan. Sometimes called an exploratory study (Dempsey and Dempsey, 2000).

A pilot study was done in Katima-Mulilo Township, which has similar characteristics as the actual population in which the study was conducted. The pilot study sample constituted 10% of the actual study sample. A sample of 5 men was randomly selected for the pilot study. The main reasons for conducting a pilot study were:
1. To detect any errors in the interview schedule for the main study
2. To assess the appropriateness and clarity of the questions.
3. To test the feasibility, validity and reliability of the questionnaire.

3.9 ETHICAL AND CULTURAL CONSIDERATIONS
The researcher obtained written permission to collect data for the pilot and actual study from the District Commissioner for Sesheke District. Verbal permission was sought from each and every respondent. No respondents were forced to take part in the study. The nature and purpose of the study were thoroughly explained to the respondents so that they could make informed decisions. The respondents were assured of anonymity and confidentiality. No names were used on the interview schedule except numbers.
CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 Introduction
The data collected and presented in this chapter were gathered from 50 respondents. Data were sorted out and tallied on the data master sheet.

4.2 Data analysis
Data analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using those data (Polit and Hungler, 1995). Data was collected from 50 respondents in the community. All questionnaires were checked for completeness and consistence in the responses. Data collected from the respondents were entered on a data master sheet. The data were sorted out, categorized and coded.

A coding book was developed this is essentially an outline that explains what each research question is and the values associated with each question and what numerical value are to represent each question (Bless and Kathuria, 1993).

Qualitative data were categorized before being entered on the data master sheet to avoid misplacement or loss of data. These were presented in form of cross tabulation, figures and were summarized using frequencies and percentages. These were done according to the sequence of the questionnaire. The table summarized the results to enable the readers to follow and understand the researchers' intention in the study.

4.3 Presentation of findings
In the tabulation of data descriptive statistics and percentages were used. Pie charts, graphs and tables were used to present data in a meaningful manner. This enables any reader to understand the intent in the study more easily.
### 4.4 Respondents perspective

**Figure 1: RESPONDENTS AGE DISTRIBUTION (n=50)**

Thirty-eight percent of the respondents were aged between 35-44 years, 36% were in the age group 15-24 years and 14% were aged 45-49 years while 25-44 year olds accounted for 12% of the respondents.

**Figure: 2 RESPONDENTS MARRITAL STATUS (n=50)**

Majority of the respondents (62%) were married men. 28% of the respondents were men who have never been married, 6% of the respondents were widowers and 4% were divorced men.
34% of the respondents' attained secondary education and 32% of the respondents have received tertiary education. 26% of the respondents have received primary education while 4% of the respondents had no education at all.

Table 2: RESPONDENTS OCCUPATION (n=50)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Formal</td>
<td>22</td>
<td>44%</td>
</tr>
<tr>
<td>Informal</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Forty-four percent of the men that were involved in the study were in formal employment, 36% were in informal employment while the remaining 22% were not employed.
Majority of the respondents (52%) belonged to the protestant churches, 36% were Catholics, and 8% were Jehovah's witnesses while the remaining 4% did not congregate at all.

Thirty-two percent of the respondents had 1-3 children, 24% had above seven children, 22% had no children and the remaining 22% were those with between 4 – 7 children.
Knowledge

Table 3: RESPONDENTS DEFINITION OF FAMILY PLANNING (n=50).

<table>
<thead>
<tr>
<th>Definition of family planning</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct definition</td>
<td>32</td>
<td>64%</td>
</tr>
<tr>
<td>Incorrect definition</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents (64%) defined family planning correctly while the remaining 36% defined it incorrectly.

Table 4: KNOWLEDGE OF FAMILY PLANNING (n=50)

<table>
<thead>
<tr>
<th>Knowledge of family planning methods</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49</td>
<td>98%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Ninety-eight percent of the respondents acknowledged knowing a method of family planning while only 2% did not know a method of family planning.

Figure 6: FAMILY PLANNING METHODS MENTIONED (n=49)

Forty-three percent of the respondents were able to mention 3 methods of family planning spontaneously, 36% could mention 2 methods of family planning, and 20% of the respondents could mention four methods of family planning.
Table 5: SOURCE OF INFORMATION (n=50)

<table>
<thead>
<tr>
<th>Source of information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Friends</td>
<td>46</td>
<td>92</td>
</tr>
<tr>
<td>Radio</td>
<td>37</td>
<td>74</td>
</tr>
<tr>
<td>Television</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Health worker</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>School</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

* Multiple answers

Ninety-two percent of the respondents got their information regarding types of family planning from their friends. Seventy-four percent got their information from radio and fifty percent from television.

Figure 7: LEVEL OF KNOWLEDGE (n=50)

Majority (60%) of the respondents had high knowledge in regards to family planning. 22% had low knowledge while 18% had average knowledge.
Utilization

Figure 8: USE OF FAMILY PLANNING (n=50)

Sixty-six of the respondents acknowledged using a family planning method while 34% said that they have never used a family planning method before.

Table 6. METHODS OF FAMILY PLANNING (n=33)

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>19</td>
<td>58</td>
</tr>
<tr>
<td>Injectables</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Condoms</td>
<td>28</td>
<td>85</td>
</tr>
<tr>
<td>Sterilization</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

* Multiple answers

Majority (85%) of the men said they had used the condom, 58% said they had used the pill and only 12% were using sterilization.
Table 7: PLACE OF FAMILY PLANNING ACQUISITION (n=33)

<table>
<thead>
<tr>
<th>Place of acquisition</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Health center</td>
<td>18</td>
<td>54</td>
</tr>
<tr>
<td>Drug store</td>
<td>28</td>
<td>85</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

* Multiple answers

Eighty-five percent of respondents that were users of family planning acquire their methods of family planning from drug stores. Fifty-four percent said they got their family planning supplies from health centers.

Attitude

Table 8: INVITATION TO FAMILY PLANNING CLINICS (n=50)

<table>
<thead>
<tr>
<th>Invitation to family planning clinic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>No</td>
<td>44</td>
<td>88%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents (88%) have never been invited to a family planning clinic, while 12% said that they had been invited to a family planning clinic.

Table 9: PERSONS WHO INVITED RESPONDENTS TO FAMILY PLANNING CLINIC. (n=6)

<table>
<thead>
<tr>
<th>Persons that invited respondent to family planning clinic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife and health worker</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Health worker</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100%</td>
</tr>
</tbody>
</table>

83% of those that were invited said they had been invited by health workers while 17% said that both wife and health worker had invited them.
Table 10: ATTENDANCE OF FAMILY PLANNING CLINIC BY INVITED RESPONDENTS (n=6)

<table>
<thead>
<tr>
<th>Attendance of clinic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>67%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sixty-seven percent of respondents who acknowledged being invited to a family planning clinic did not attend the clinic while the remaining 33% attended the clinic.

Figure 9: RESPONDENTS REASON FOR ATTENDING/ NOT ATTENDING THE CLINIC. (n=6)

Half (50%) of the respondents that were invited to attend the clinic said that they lacked time to attend the clinic. 33% said that they attend the clinic so that they could be counseled. 17% saw no need for attending the clinic.
Table 11: OPINION ON BENEFITS OF FAMILY PLANNING (n=50)

<table>
<thead>
<tr>
<th>Benefits of family planning</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42</td>
<td>84%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents (84%) said that family planning had benefits while 16% said that family planning had no benefits.

Table 10: RESPONDENTS CONCERN ON SEX OF FAMILY PLANNING PROVIDER (n=50)

Eighty-six percent of the respondents said that they did not mind the sex of their family planning provider and 14% of the respondents said they minded about the sex of their family planning provider.
Table 12: DISCUSSION ON FAMILY PLANNING

<table>
<thead>
<tr>
<th>Discusses family planning</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46</td>
<td>92%</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Ninety-two percent of the respondents acknowledged discussing family planning while 8% said that they had not discussed family planning.

Table 13: FAMILY PLANNING DISCUSANTS WITH RESPONDENTS (n=46)

<table>
<thead>
<tr>
<th>Discussants</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>25</td>
<td>54</td>
</tr>
<tr>
<td>Friends</td>
<td>45</td>
<td>98</td>
</tr>
<tr>
<td>Health worker</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

* Multiple answers

Ninety eight percent of the respondents said that they discussed family planning with their friends, 54% said that they discussed with their wives while 22% said they discussed with a health worker.

Table 14: SUGGESTIONS MADE BY MEN TO MAKE FAMILY PLANNING APPEALING TO MEN.

<table>
<thead>
<tr>
<th>Suggestions to make FP appealing to men</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate men on their role in FP</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Inform men that they can also attend FP clinics</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Extend clinic hours so that men can attend when free</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Nothing</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>

* Multiple answers

Thirty two percent of the respondents said to make family planning more appealing to men; health facilities should extend clinic hours to weekends when men are less busy.
Table 15: AGE IN RELATION TO MARITAL STATUS. (n=50)

<table>
<thead>
<tr>
<th>Age</th>
<th>Never married</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 24 years</td>
<td>14(100%)</td>
<td>14(13%)</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>25 – 34 years</td>
<td>0</td>
<td>5(16%)</td>
<td>1(50%)</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>35 – 44 years</td>
<td>0</td>
<td>16(52%)</td>
<td>0</td>
<td>3(100%)</td>
<td>19</td>
</tr>
<tr>
<td>45 – 49 years</td>
<td>0</td>
<td>6(19%)</td>
<td>1(50%)</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>14(100%)</td>
<td>31(100%)</td>
<td>2(100%)</td>
<td>3(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

All (100%) the respondents who were never married were in the age group 15 to 25 years. Majority (52%) of those that were married were in age group 35 to 44 years. Half of the divorced men were in 23 to 34 years age group while the other half were in the 44 to 49 years old age group.

Table 16: LEVEL OF EDUCATION IN RELATION TO KNOWLEDGE

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Level of knowledge</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>0</td>
<td>2(22%)</td>
<td>2(18%)</td>
<td>4</td>
</tr>
<tr>
<td>Primary</td>
<td></td>
<td>1(33%)</td>
<td>5(66%)</td>
<td>7(64%)</td>
<td>13</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td>13(43%)</td>
<td>2(22%)</td>
<td>2(18%)</td>
<td>17</td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
<td>16(52%)</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30(100%)</td>
<td>9(100%)</td>
<td>11(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

Majority (52%) of respondents with high knowledge in family planning have received tertiary education. 66% of respondents with average knowledge attained primary education. Majority (64%) of respondents with low knowledge have received primary education.
Table 17: MARITAL STATUS IN RELATION TO KNOWLEDGE

<table>
<thead>
<tr>
<th>Marital status</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>8(27%)</td>
<td>1(11%)</td>
<td>5(46%)</td>
<td>14</td>
</tr>
<tr>
<td>Married</td>
<td>19(63%)</td>
<td>8(89%)</td>
<td>4(36%)</td>
<td>31</td>
</tr>
<tr>
<td>Divorced</td>
<td>1(3%)</td>
<td>0(0%)</td>
<td>1(9%)</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>2(7%)</td>
<td>0(0%)</td>
<td>1(9%)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30(100%)</td>
<td>9(100%)</td>
<td>11(100%)</td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Eighty-nine percent of respondents with average knowledge in relation to family planning were married men. Sixty-three percent of respondents with high knowledge were married men, while 46% of men that had low knowledge were never married men.

Table 18: LEVEL OF KNOWLEDGE IN RELATION TO UTILISATION.

<table>
<thead>
<tr>
<th>Utilization</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24(80%)</td>
<td>6(67%)</td>
<td>3(27%)</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>6(20%)</td>
<td>3(33%)</td>
<td>8(73%)</td>
<td>17</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>30(100%)</td>
<td>9(100%)</td>
<td>11(100%)</td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Majority (84%) of men who had high knowledge used some form of family planning method. 67% of respondents with average knowledge used family planning. 73% of respondents with low knowledge were not using any family planning at all.
Table 19: UTILISATION OF FAMILY PLANNING IN RELATION TO ATTITUDE.

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Positive</th>
<th>Negative</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32(76%)</td>
<td>1(12%)</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>10(24%)</td>
<td>7(88%)</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>42(100%)</td>
<td>8(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

Majority (76%) of respondents with a positive attitude towards family planning acknowledged using some form of family planning while 88% of respondents with a negative attitude towards family planning have never used a method of family planning.

Table 20: RELATIONSHIP BETWEEN MARITAL STATUS AND UTILISATION

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Utilization</th>
<th>No</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>Yes</td>
<td>11(65%)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3(9%)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>Yes</td>
<td>25(76%)</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>6(35%)</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>Yes</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2(6%)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>Yes</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3(9%)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>33(100%)</td>
<td>17(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

Majority (76%) of respondents that were using some form of family planning were married men while 65% of the respondents that were not using any form of family planning were never married men.
Table 21: RELATIONSHIP BETWEEN EDUCATION ATTAINMENT AND UTILISATION OF FAMILY PLANNING.

<table>
<thead>
<tr>
<th>Utilization</th>
<th>None</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1(25%)</td>
<td>7(54%)</td>
<td>9(53%)</td>
<td>16(100%)</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>3(75%)</td>
<td>6(46%)</td>
<td>8(47%)</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4(100%)</td>
<td>13(100%)</td>
<td>17(100%)</td>
<td>16(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

All (100%) the respondents that attained tertiary education have used family planning before. 53% of respondents who attained secondary education acknowledged using a family planning method. 75% of respondents with no education said that they had never used a method of family planning.

Table 22: RELATIONSHIP BETWEEN DENOMINATION AND ATTITUDE TOWARDS FAMILY PLANNING.

<table>
<thead>
<tr>
<th>Attitude</th>
<th>None</th>
<th>Catholic</th>
<th>Protestant</th>
<th>Jehovah's witness</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>1(50%)</td>
<td>15(83%)</td>
<td>23(83%)</td>
<td>3(75%)</td>
<td>42</td>
</tr>
<tr>
<td>Negative</td>
<td>1(50%)</td>
<td>3(17%)</td>
<td>3(17%)</td>
<td>1(25%)</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2(100%)</td>
<td>18(100%)</td>
<td>26(100%)</td>
<td>4(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

Most (88%) of respondents that belonged to the protestant churches had a positive attitude towards family planning. 83% of the men that were catholic had a positive attitude towards family planning. 75% of respondents that were witnesses had a positive attitude towards family planning. Half of the respondents that do not congregate had a positive attitude towards family planning.
Table 23: RELATIONSHIP BETWEEN RESPONDENTS MARITAL STATUS AND ATTITUDE.

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Never married</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>11(78%)</td>
<td>26(84%)</td>
<td>2(100%)</td>
<td>3(100%)</td>
<td>42</td>
</tr>
<tr>
<td>Negative</td>
<td>3(22%)</td>
<td>5(16%)</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14(100%)</td>
<td>31(100%)</td>
<td>2(100%)</td>
<td>3(100%)</td>
<td>50</td>
</tr>
</tbody>
</table>

All (100%) respondents that were widowed and divorced had a positive attitude towards family planning. 84% of married men had a positive attitude towards family planning and 78% of never married men had a positive attitude towards family planning.
5.0 Chapter Five

5.1 Introduction

The findings of this study were based on an analysis of responses of respondents obtained from a sample of fifty men that live in the sub urban area of Sesheke District. The respondents were randomly chosen from five residential areas. The information obtained from the study provided the following highlights in relation to the study objectives.

5.2 Characteristics of the sample

The respondents' ages ranged from 15-49 years. Thirty eight percent of the respondents were aged between 35-44 years, followed by those that were in the 15-24 years age group (36%). Fourteen percent of the respondents were 44-49 years and 12% were aged between 25-34 years (Figure 1, Page 23). The marital status of the respondents was investigated, 62% of the respondents were married, 28% were never married, 6% were widowed and 4% were divorced (Figure 2, page 23). Marriage and cohabitation are generally considered to be primary indicators of exposure to the risk of pregnancy. It is commonly observed that people are in marriage between 30-40 years and this phase carries with it a lot of responsibility and decisions concerning family life. The results showed that 52% of respondents that were married were aged between 35-44 years, (Table 14, page 32) although in Zambia a union is not a prerequisite to bearing children. The findings revealed that 34% of respondents had attained secondary education, 32% had received tertiary education. Twenty six percent (26%) received primary education, while 4% had no education at all. (Figure 3, page 24)

Forty-two percent of respondents were in formal employment implying that they were professionals, 36% were in informal employment this implies that they were either business men involved in illicit beer brewing and sales or had seasonal jobs from the local investors (Table 2, page 24). Majority of the respondents (52%) belonged to the protestant churches followed by 36% that were Catholics. Eight percent (8%) of the respondents were Jehovah witness while 4% of the respondents did not congregate (Figure 4, page 25) the research also revealed that 32% had between 1-3 Children and 24% had above seven children. (Figure 5, page 25)
5.3 Knowledge of family planning

Having knowledge about fertility control is an important step toward gaining access to family planning facilities and using suitable family planning methods in a timely and effective manner. The findings of this study revealed that 64% of the respondents knew the meaning of family planning; where as 36% of the interviewed men did not define it correctly (Table 3, page 26). These findings are similar to Phiri (2002) who found that 80% of his respondents knew the meaning of family planning while the other 20% were not sure of what family planning was.

Contraception knowledge is universal in Zambia with 98% of men and women knowing at least one method of family planning (CBoH 2003). The findings of this study revealed that 98% of the respondents knew a method of family planning (Table 4, page 26). These findings agree with the findings of ZDHS 2001-2002, where it was found that 98% of the men knew at least one method of family planning. Oyediran et al, (2002) who did a study in Nigeria also found that family planning knowledge was high among men. In the same study about 90% of the respondents knew at least one method of family planning.

In this study men were asked to mention spontaneously any four methods of family planning they knew. This did not necessarily mean the respondent knew how to use the method, understood its effectiveness or side effects or approved of it. Forty two percent of respondents that knew a family planning method were able to mention 3 methods of family planning, 36% of the respondents could mention 2 methods and only 20% of the respondents managed to mention 4 methods of family planning spontaneously. (Figure 6, page 26). The most common methods of family planning that were mentioned were the condom, pill and injectable contraceptives in that order. This information is similar to the findings of ZDHS (2001-2002) were the commonly known method was the male condom. According to the findings of this study the level of knowledge the respondent had, had a bearing on the utilization of family planning. Majority of the respondents with high knowledge had used a method of family planning before. Seventy-three percent of respondents with low knowledge have never used any family planning method before (Table 18, page 34)

The main sources of information in this study were friends (92%), radio (74%) and television (52%) (Table 5, page 27) These finding are similar to the findings of Manda (1989), who observed that friends were a primary source of information.
among male users and nonusers of family planning. These findings were contrary to a study done in Turkey which showed that the main sources of information were television/Radio followed by friends and newspapers/magazines, (Mistik et al, 2003). These findings are also contrary to Phiri (2002) where none of his respondents had got their information from wives or girlfriends but this study revealed that 40% of the respondents got information from their spouses (Table 5, page 27).

This study further revealed that marital status has a bearing on contraception knowledge as 63% of married men had high knowledge while 46% of those that had low knowledge were never married men (Table 17, page 34). These findings are similar to those of the ZDHS (2001-2002), which showed that married men knew an average of 6.9 methods compared to their unmarried counterparts who knew an average of 2.8 methods.

The results also revealed that the respondents’ level of education had an influence on the level of knowledge. As might be expected men with more schooling are more likely to know more methods of family planning. Fifty-two percent of respondents that had high knowledge in family planning had attained tertiary education (Table 16, page 33). These findings are similar to the findings of Oyediran et al (2002) who found that age, education, place of residents, number of children and being counseled for family planning as being factors in determining contraception knowledge and utilization.

5.4 Utilization of family planning
All the respondents that acknowledge knowing a family planning method were asked if they had used a method of Family planning before. Sixty six percent of the respondents acknowledge using a family planning method while 34% said they have never used a family panning method before (Figure 8, page 28). The men were asked whether they had used a male method or female method of family planning with their partners. The men were asked if they had used the pill, Injectables, female or male condoms and/or Sterilization. The most common method of contraception used by the men were the male condoms (85%) followed by the pill which accounted for 58% of the used methods of contraception (Table 6 page 28). These findings are contrary to those of ZDHS (2001-2002) where only 47.7% of men were utilizing the
condom, although the findings are similar to Phiri (2002), who found that the most commonly used method of family planning among his respondents, were the condoms.

Utilization of family planning was found to be higher among married men (76%) and 65% of never married men were not using any family planning (Table 20, page 35). These findings are contrary to Sishekanu (1998), who found that marital status had no influence in the use of family planning. According to Salem (2004), unmarried men used more contraception than married men. Married men that used condoms did so most often with women who were not their spouses.

The findings in this study revealed that there is a relationship between educational attainment of a respondent and utilization of family planning. Utilization was high (100%) among men who had attained tertiary education (Table 21, page 36). These findings agree with Sishekanu (1998) who found that educational attainment and place of residence had an influence on the utilization of family planning by men.

The men that used family planning methods were further asked where they or their wives got their family planning methods and who their providers of family planning were. Thirty one percent of the respondents said they got their supplies from health centers (Table 7, page 29). This agrees with the findings in ZDHS (2001-2002), were pills and injections were collected from the public sector while condoms were mainly bought from shops.

5.5 Respondents Attitude towards family planning Services.

Men’s attitude towards family planning was also assessed. The men where asked if they had ever been invited to a family planning clinic by a wife friend or health worker, 88% of the respondents said they had never been invited to a family planning clinic and 12% of the respondents acknowledged being invited to a family planning clinic. (Table 8, page 29). These findings agree with Chella (1998) who found that 67% of the respondents that attended family planning were never invited to the family planning. The men that were invited to a family planning clinic were asked on who invited them to the clinic eighty three percent of the respondents said they were invited by a health worker and only 17% were invited by both the health
worker and wife. (Table 9, page 29) These findings agree with the findings in Chella (1998)'s study which revealed that 33% of the women did not want their husbands to participate in family planning. Men’s non-invitation and participation could be attributed to the findings of Syacumpi (2003), who found that Non Governmental Organizations (NGOs) that were dealing with community family planning programmes like the Co-operation for American Relief Everywhere (CARE) have shifted their focus to HIV/AIDS because there is greater funding.

The respondents that were invited to the family planning clinic were asked if they had attended the clinic, 33% of the respondents acknowledged attending the clinic. The remaining 67% said they did not attend the family planning clinics (Table 10, page 30). When asked why, those that did not attend cited lack of time as the reason for not going to the family planning clinic. (Figure 9, page 30) This agrees with Chella (1998)'s study were men wanted a situation that allowed them to attend family planning, especially over the weekends when they were off duty. Seventeen percent of the respondents who did not attend said they did not see any reason for them to go to the clinic. This can be attributed to their lack of knowledge that men can also attend family planning clinics, as knowledge is the power an individual has to participate in any activity. All the respondents that attended family planning sessions said they were happy and pleased with the information they obtained from the clinic. They said the nurse and medical officer were good with special emphasis on the teaching they got from the clinic.

Men’s attitude was also assessed through the benefits they saw in family planning. Majority (84%) of the respondents were positive about family planning, were as the remaining 16% were negative about the benefits of family planning (Table 11, page 31). Most of the respondents that were positive mentioned economic benefits as some of the benefits of family planning, some of the economic benefits mentioned were being able to afford to feed, cloth and educate the family members. Others mentioned health benefits such as allowing children to grow and giving room to women to recover following delivery. Targeting men as beneficiaries of reproductive care and as supportive partners could address a nation’s maternal and infant mortality rate (Walston, 2005). Among those that were negative about family planning some mentioned inability to prevent HIV/AIDS, infertility or growths in the
womb as negative benefits of family planning. Others said it is difficult to divorce a woman after she has been sterilized. These findings agree with the findings of a study done in Ghana by Adongo et al (1997), where many respondents believed that family planning could inflict infertility and even death to those that use it.

Men in this study were asked if they minded the sex of their family planning provider, 86% of the respondents said they did not mind. The remaining 14% said they minded, (Figure 10, page 31). The respondents were asked why, most of the respondents said people of the opposite gender should not see some body parts. These findings agree with Suliman (2001) who found that men were concerned with the sex of the Family planning provider.

The study reviewed that the men’s attitude was neither influenced by their denomination (table 22 page 36) or their marital status (table 23 page 37)

Many obstacles prevent men and women from talking about sexual and reproductive health issues, a complex web of social and cultural factors impede such discussions. In many societies, Zambia inclusive, sex is a taboo for men and women to discuss. Although discussion of family planning between husband and wife is not a precondition for adoption of contraception, its absence may be an obstacle to its use. Couples that discuss family planning are more likely to use contraception more effectively and to have fewer children than couples that do not discuss at all (Salem, 2004). In this study men were asked if they had discussed family planning with any one and how often they did the discussions. Majority of the respondents (92%) acknowledged discussing family planning, 8% said they had not discussed family planning at all (Table 12, page 32). These findings are similar to Chella (1998) were the majority (79%) of here respondents discussed family planning.

Inter spousal communication is an important intermediate step to eventual use and continuation of contraception. Lack of discussion may reflect hostility to the subject. To explore this, men in this study were asked who they discussed family planning with. Ninety eight percent of the respondents said they discussed family planning with friends and 54% discussed with their wives (Table 13, page 32). These findings are contrary to those of Chella (1998), where only forty two percent of respondents
that discussed family planning did so with friends, 35% discussed with their wives and friends.

All (100%) the respondents were asked if they had ever been chased from a family planning session, and if they where, the cadres of the person who had chased them. All the respondents denied being chased from the facility.

The men were asked to make suggestions on what they thought should be done to make family planning more appealing to men, 28% of the respondents said men need to be educated on the importance of their participation in family planning. Thirty percent of the respondents thought men needed information that they can also attend family planning clinics. Twenty four percent of the respondents said that clinic hours needed to be extended so that men could also attend when less busy and 16% felt that it was fine the way it is as long as women could attend. (Table 14 page 32.)

5.6 Implications to the Health Care System

The findings of this study revealed that 98% of the respondents knew a method of family planning and they could spontaneously mention at least one method of family planning. This implies that men have knowledge relating to matters concerning family planning methods. It therefore means that family planning Information Education and Communication (IEC) should be strengthened. It should not only focus on methods of family planning but must include the important roles men can play in family planning.

Majority of men relied on friends (92%) for family planning messages and information. Seventy four percent and fifty two percent relied on the radio and television respectively. The family planning programme managers need to double up their efforts in the provision of IEC; this can be through the use of peer educators. The media can also be used to disseminate family planning information and teachings. This is although difficult to do in Sesheke as there is currently no reception of the national broadcaster or local community radio station and the residents are mostly dependant on the Namibian broadcasting co-operation (NBC) for family planning messages. The District Health Management Team also needs to
buy Radio cassettes for the communities so that men can listen to the Sister Evelyne programmes.

The finding further revealed that 66% of the respondents were using a family planning method. Fifty six percent of the respondents were using condoms and most (56%) of the respondents that were using family planning methods got them from drug stores. It is therefore important for family planning managers to ensure that they train people selling family planning methods so that they can educate men as they provide them with family planning services. The family planning programme managers should also conduct regular inspections to ensure that the drug stores are storing the methods correctly and are not selling expired methods to the men.

The study revealed that 46% of respondents with low knowledge in family planning never married men. They also constituted a large percentage (65%) of respondents who were not using family planning. All the never married men were aged between 15-24 years. Men are more likely to participate responsibly in family planning if they begin to do so at an early age, even before they get married. To help prepare boys and young men to become responsible sexual partners and spouses, programs can offer relevant information about sexuality and reproductive health, including the risks of sexually transmitted diseases and how to avoid them.

The study revealed that 92% of the respondents were never invited to a family planning session; nevertheless, none has ever been chased from a family planning clinic. This means are not being invited by family planning service providers to attend the clinics. Health facilities need to relay messages to men that can encourage them to attend family planning clinics.

5.7 Conclusion

This study was aimed at assessing the male involvement in family planning in Sesheke district. The study indicated that 92% of the men were knowledgeable in matters relating to family planning. Sixty four percent of the men knew the meaning of family planning whereas 36% were unable to define it correctly. Most of the respondents (92%) knew at least one method of family planning regardless of their educational attainment, marital status, occupation and denomination affiliation.
The knowledge of the respondents was influenced by their educational attainment, 52% of the respondents with high knowledge in family planning had attained tertiary education.

Marital status of the respondents had a bearing on the utilization of family planning 76% of the respondent using family planning in this study were married men. Eighty-eight of respondents said that they had never been invited to a family planning clinic. Of the six that were invited half (50%) said they did not attend because they had not found the time to go to the clinic.

When asked about family planning discussions 92% of the respondents said they had had discussions pertaining to family planning. Forty-two percent of the respondents said they discussed with their friends only, thirty-five percent discussed with both friends and wives.

The men were also asked to give their opinion on what they thought should be done to make family planning more appealing to men, twenty-eight percent (28%) of the men cited that men needed an education on the importance of their participation in family planning, thirty percent of the respondents said they needed information that they can also participate in family planning. In view of this we failed to reject the null hypothesis and rejected the alternative hypothesis.

5.8 Recommendations

Several options are available to men motivated in family planning. Men may become service providers, village health volunteers, peer educators, community based distributors and consumers of family planning. Men may also accompany their wives and partners to family planning clinics. The following are recommendations to the Ministry of Health (MoH) and Sesheke District Health Management Team (SDHMT) to improve male motivation and involvement in family planning.

5.8.1 Recommendations to Ministry of Health (MoH).

5.8.1.1. The Ministry of Health in conjunction with Ministry of Education should integrate family planning in junior secondary education so that men can understand their role in family planning at an early age.
5.8.1.2. The Ministry of Health should set up 'Male only' clinics if they have to encourage men to participate in family planning

5.8.1.3. Ministry of Health should put a deliberate policy to take family planning in the workplace so that men can easily access family planning during the week.

5.8.2. Recommendations to Sesheke District Health Management Team

5.8.2.1. Sesheke District Health Management Team (SDHMT) should train peer educators, male community based distributors and male family planning service providers so that they can reach men in their communities as well as the workplace.

5.8.2.2. The Sesheke District health Management Team should provide training to male service to family planning service providers so that they are enlightened on the importance of involving men in matters relating to family planning.

5.8.3. Recommendations to Health centers and family planning providers.

5.8.3.1. The health center staff should intensify the I.E.C on male involvement in family planning, as men are currently not accessing family planning. This was revealed by means of opinion on what must be done to make family planning more appealing to men.

5.8.3.2. The Health center staff should create community-based clubs, which will increase men's accessibility to family planning services as at the moment none exist.

5.8.3.3. The health center staff should ensure that they continuously supervise the youth friendly corners to monitor its activities. They can also plan to give talks at the schools in their catchments areas on family planning and sexuality.

5.9 Limitations of the study

5.9.1. Funding.
The study was poorly funded making it difficult and expensive to have the study done. Poor funding restricted the areas were the research could be done. The
research was only done within the walking distance of the investigator; this meant the sub-urban areas of Sesheke District were people have access to radio television and newspapers.

5.9.2. Sample.

5.9.2.1. There was a degree of biasness in the sample selection in that the sample chosen for the study came from the sub urban areas of Sesheke district implying that the sample is not representative of the Sesheke community.

5.9.2.2. The sample size was limited to fifty respondents due to inadequate funding making it difficult to generalize the findings.

5.9.3. Literature

Most studies in Zambia were done in the late 1990’s following the International Conference on Population Development (ICDP) in Cairo, very few studies have been done since then making it hard to measure the trends over time.

5.10 Dissemination of findings

Following data analysis the researcher wrote a report. The purpose of the research report was to communicate the findings to the public. A copy will be given to the Post Basic Nursing Department, University of Zambia, Ministry of Health/Central Board of Health and Sesheke District Health Office. The researcher will take advantage of District Integrated Meeting (DIM), which takes place in the last week of April to disseminate the findings of the research findings. The researcher will also use the District Health Management Meetings, which are held every month to ensure that the three zones in the district benefit from the discovered information.
REFERENCES


4. CBoH (2003): Reproductive health News Volume 1 CBoH.


16. Pachuri S (2001) Male involvement in reproductive health care, South and east Asia, population council, new Delhi


21. Reproductive Health outlook


29. Walston, N. (2005): Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia, Policy Project. USAID.

30. Zambia Demographic and Health Survey (2001-2002), CSO, Lusaka
APPENDIX 1

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

INTERVIEW SCHEDULE

TOPIC: MALE INVOLVEMENT IN FAMILY PLANNING

Village/Compound: ________________________________

Date of Interview: ______________________________

Time Interview Started: _________________________

Time Interview Ended: __________________________

Duration of Interview: __________________________

INSTRUCTIONS

1. Introduce yourself to the interviewee.

2. Explain the purpose of the interview.

3. Get verbal consent from the interviewee.

4. Assure the interviewee of confidentiality and anonymity.

5. Do not write the name of the respondent on the schedule to ensure anonymity.
SECTION A: DEMOGRAPHIC DATA

1. How old were you on your last birthday?
   1. 15 – 24 years
   2. 25 – 34 years
   3. 35 – 44 years
   4. 45 – 49 years

2. What is your marital status?
   1. Never married
   2. Married
   3. Divorced
   4. Widowed
   5. Separated

3. What is your highest level of education?
   1. None
   2. Primary
   3. Secondary
   4. Tertiary
   5. Other (specify) ________________

4. What is your occupation?
   1. None
   2. Formal
   3. Informal
   4. Other (specify) ________________

5. What is your religious denomination?
   1. None
   2. Catholic
   3. Protestant
   4. Jehovah’s Witness
   5. Other (specify) ________________
6. How many children do you have?
   1. None
   2. 1 - 3
   3. 4 - 7
   4. Above 7

SECTION B: KNOWLEDGE
7. What is family planning?
   1. Child spacing
   2. Number of children per household
   3. Not producing children
   4. Other (specify) __________________________

8. Do you know any methods of family planning?
   1. Yes
   2. No

9. If yes, mention 4 methods of family planning________________________
   __________________________

10. Where did you learn about the family planning methods
    You have mentioned in 9?
    1. Wife
    2. Radio
    3. Television
    4. Health Worker
    5. School
    6. Friends

SECTION C: USE OF FAMILY PLANNING
11. Have you ever used a method of family planning?
    1. Yes
    2. No
12. Which method would you prefer to use?
   a) Pill
   b) Injectables
   c) Condoms
   d) Sterilization
   e) Other (specify)

13. Where do you obtain the family planning services?
   1. Hospital
   2. Health Center
   3. Drug store
   4. Other (specify)

14. Who provides you with family planning services?
   1. Community Based Distributor
   2. Health worker
   3. Salesman
   4. Friends
   5. Other (specify)

SECTION D: ATTITUDES

15. Have you ever been invited to a family planning clinic/service?
   1. Yes
   2. No

16. If yes, who invited you to the service?
   1. Wife
   2. Health worker
   3. Friend
   4. Other (specify)

17. Did you attend the facility/service?
   1. Yes
   2. No
18. Give reasons for your answer in question 17.

________________________________________

19. If yes to question 17, what do you think of the family Planning service?
   1. Good
   2. Bad
   3. Other (specify)


________________________________________

21. In your own opinion, does family planning have any benefits?
   (a) Yes
   (b) No


________________________________________

23. Do you mind the sex of your family planning provider?
   1. Yes
   2. No

24. If yes, give reasons for your answer in Question 23.

________________________________________

25. Have you ever discussed family planning?
   1. Yes
   2. No
26. If yes to question 25, who did you discuss with?
   3. Wife
   4. Friends
   5. Health care provider

27. How often have you discussed the family planning?
   6. Always
   7. Sometimes
   8. Rarely

28. Have you ever been denied access to family planning?
   a. Yes
   b. No

29. If Yes to question 30, who denied you the access?
   1. Nurse
   2. Clinical Officer
   3. Doctor
   4. Maid

30. What were the reasons for sending you away?

31. In your own opinion what things should be done to make Family-planning more appealing to men?

THANK YOU FOR ANSWERING THE QUESTIONS
# APPENDIX 2: GANTT CHART

<table>
<thead>
<tr>
<th>TASK PERFORMED</th>
<th>RESPONSIBLE PERSON</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize research proposal</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permission to conduct study</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printing of questionnaire</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of draft report</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of research report</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissemination of results</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 3: WORK PLAN

<table>
<thead>
<tr>
<th>TASK TO BE PERFORMED</th>
<th>DATE</th>
<th>PERSONNEL</th>
<th>PERSONS/DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature review</td>
<td>Continuous</td>
<td>Researcher and research assistant</td>
<td></td>
</tr>
<tr>
<td>2. Finalizing research proposal</td>
<td>9&lt;sup&gt;th&lt;/sup&gt; May to 22&lt;sup&gt;nd&lt;/sup&gt; August, 2005</td>
<td>102 x 2 days</td>
<td></td>
</tr>
<tr>
<td>3. Data collection tool</td>
<td>23&lt;sup&gt;rd&lt;/sup&gt; and 24&lt;sup&gt;th&lt;/sup&gt; August, 2005</td>
<td>Researcher and researcher supervisor</td>
<td></td>
</tr>
<tr>
<td>4. Clearance from national ethics committee and funding authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Data collection Pilot study</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; August, 2005</td>
<td>Researcher</td>
<td>1 day</td>
</tr>
<tr>
<td>6. Data analysis pilot</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; August, 2005</td>
<td>Researcher</td>
<td>1 day</td>
</tr>
<tr>
<td>Amendment tool</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; August to 1&lt;sup&gt;st&lt;/sup&gt; Sept, 2005</td>
<td>Researcher</td>
<td>2 days</td>
</tr>
<tr>
<td>7. Data collection Actual study</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; to 16&lt;sup&gt;th&lt;/sup&gt; Sept, 2005</td>
<td>Researcher</td>
<td>14 days</td>
</tr>
<tr>
<td>8. Data analysis</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; to 10&lt;sup&gt;th&lt;/sup&gt; October, 2005</td>
<td>Researcher and research assistant</td>
<td>23 x 2 days</td>
</tr>
<tr>
<td>9. Report writing</td>
<td>11&lt;sup&gt;th&lt;/sup&gt; October to 10&lt;sup&gt;th&lt;/sup&gt; Dec, 2005</td>
<td>Researcher and research assistant</td>
<td>60 days x 2</td>
</tr>
<tr>
<td>10. Draft report</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; December to 16&lt;sup&gt;th&lt;/sup&gt; January, 2006</td>
<td>Researcher and research supervisor</td>
<td>35 days x 2</td>
</tr>
<tr>
<td>11. Finalize of report</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; January to 20&lt;sup&gt;th&lt;/sup&gt; February, 2006</td>
<td>Researcher and research supervisor</td>
<td>35 days x 2</td>
</tr>
<tr>
<td>12. Monitoring and evaluation</td>
<td>Continuous</td>
<td>Researcher and research supervisor</td>
<td>-</td>
</tr>
</tbody>
</table>
## APPENDIX 4: STUDY BUDGET

<table>
<thead>
<tr>
<th>ITEM</th>
<th>UNIT COST IN KWACHA</th>
<th>QUANTITY</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Lunch allowance</td>
<td>50,000</td>
<td>5 days</td>
<td>250,000</td>
</tr>
<tr>
<td>(b) Transport to study area (Nakatindi Compound)</td>
<td>5,000</td>
<td>4 trips</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>270,000</strong></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stationery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Bond paper for typing</td>
<td>25,000</td>
<td>4 reams</td>
<td>100,000</td>
</tr>
<tr>
<td>(b) Notebook</td>
<td>5,000</td>
<td>1</td>
<td>5,000</td>
</tr>
<tr>
<td>(c) Pens</td>
<td>700</td>
<td>5</td>
<td>3,500</td>
</tr>
<tr>
<td>(d) Pencils</td>
<td>500</td>
<td>4</td>
<td>2,000</td>
</tr>
<tr>
<td>(e) Sharpener</td>
<td>4,000</td>
<td>1</td>
<td>4,000</td>
</tr>
<tr>
<td>(f) Eraser</td>
<td>4,000</td>
<td>1</td>
<td>4,000</td>
</tr>
<tr>
<td>(g) Markers</td>
<td>3,000</td>
<td>3</td>
<td>9,000</td>
</tr>
<tr>
<td>(h) Diskettes</td>
<td>4,000</td>
<td>4</td>
<td>16,000</td>
</tr>
<tr>
<td>(i) Correction fluid</td>
<td>8,000</td>
<td>1</td>
<td>8,000</td>
</tr>
<tr>
<td>(j) Flip charts</td>
<td>40,000</td>
<td>2</td>
<td>80,000</td>
</tr>
<tr>
<td>(k) Staples</td>
<td>5,000</td>
<td>1</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>236,500</strong></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typing services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Typing of questionnaire</td>
<td>2,000</td>
<td>7 pages</td>
<td>14,000</td>
</tr>
<tr>
<td>(b) Photocopying of questionnaire</td>
<td>200</td>
<td>7 pages x 60 copies</td>
<td>84,000</td>
</tr>
<tr>
<td>(c) Typing of research proposal</td>
<td>2,000</td>
<td>40 pages</td>
<td>80,000</td>
</tr>
<tr>
<td>(d) Typing of research proposal</td>
<td>2,000</td>
<td>90 pages</td>
<td>180,000</td>
</tr>
<tr>
<td>(e) Photocopying of research report</td>
<td>200</td>
<td>90 x 4</td>
<td>72,000</td>
</tr>
<tr>
<td>(f) Binding research report</td>
<td>20,000</td>
<td>4 copies</td>
<td>80,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>510,000</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>1,016,000</strong></td>
</tr>
<tr>
<td>Contingency Fund 10%</td>
<td></td>
<td></td>
<td><strong>101,600</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>1,117,600</strong></td>
</tr>
</tbody>
</table>
BUDGET JUSTIFICATION

Stationery
The 4 reams of paper were used for the printing and photocopying of the research proposal, questionnaires, draft report and the four (4) final research reports.

The diskettes were used for storage of data. The pens and pencils were for writing while the correction fluid and eraser were used for correcting any mistakes. The spirals and transparencies were for binding the research proposals. The flip chart was used for drawing up the data master sheets as well as dissemination of information.

Secretarial Services
Typing and printing of the questionnaire costed K2, 000 per page. Binding of each research report costs K20, 000 a copy and 4 copies are required at the end of the project.

Field Travel Expenses
Lunch allowance was paid to the investigator while she collects data. 10% of the total budget was for the unseen circumstances and for possible inflation.
The University of Zambia  
School of Medicine  
Department of Post Basic Nursing  
P. O. Box 50110  
LUSAKA

3rd August 2005

The District Commissioner  
Sesheke District

UFS: The Head  
Department of Post Basic Nursing  
Lusaka

Dear Sir,

Re: RESEARCH STUDY REQUEST

I am a fourth year (4th) student in the Department of Post Basic Nursing, School of Medicine at the University of Zambia, pursuing a Bachelor of Science Degree.

As partial fulfillment for my degree programme, I am required to carry out a research study. My topic of study is "A Study on Factors Contributing to Inadequate Male Involvement in Family Planning in Sesheke District."

I intend to collect data from randomly selected samples of residents in Sabelo, Sesheke Secondary School Compounds, Nakatindi Kashongami and Rentals Compounds.

I also intend to carry out a pilot study in Katima-Mulilo (Zambia). The purpose of this study is to kindly ask for permission to enable me carry out the study in the mentioned residential areas.

Thanking you in anticipation.

Yours faithfully,

Miyoba P. Mapani
8th August, 2005

Our Ref: DC/SESH/9/7/2

Miyoba P. Mapani  
University of Zambia  
School of Medicine  
P.O. Box 50110  
LUSAKA.

RE: RESEARCH STUDY REQUEST TO COLLECT DATA

I refer to your letter dated 10th August, 2005 in which you were requesting for permission to carry out a Research Study for the award of a Bachelor of Science Degree in Nursing.

I am authorising you to go ahead with your research work so long you restrict yourself to the purpose of your request.

Fabian Musialela  
DISTRICT COMMISSIONER
THE UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
DEPARTMENT OF POST BASIC NURSING

Telephone: 252453  
Telegrams: UNZA. LUSAKA  
UNZALUZA 44370  
Fax: +260-1-250753  
P.O. Box 50110  
Lusaka

10th August 2005

The District Commissioner  
Sesheke DHO  
Box 29  
SESHEKE

UFS: The Head of Department  
Post Basic Nursing  
Box 50110  
Lusaka.

Dear Madam,

RE: RESEARCH STUDY REQUEST TO COLLECT DATA

I am a 4th year student pursuing a BSc degree in Nursing at the University of Zambia, School of Medicine. As part of the fulfillment of a Degree Programme.

I am required to carry out a research Study for the award of Bachelor of Science Degree in Nursing. My Topic of study is "Factors contributing to inadequate male involvement in Family Planning."

I am hereby requesting for permission to collect data from Community Member of Sesheke from 29th August to 9th September, 2005.

Thanking you in advance.

Yours faithfully,

Miyoba P. Mapani  
4th year student

*Property of UNZA Library

3 3729 00482 1067