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SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

A STUDY ON MALE INVOLVEMENT IN FAMILY PLANNING IN MPONGWE MISSION HOSPITAL CATCHMENT AREA

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BY

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
BBB	Basal body Temperature
CBOH	Central Board of Health
CBOs	Community Based Organizations
CHAZ	Churches Health Association of Zambia
COCs	Combined Oral Contraceptives
DMPA	Depot medroxyprogestrone acetate
FP	Family Planning
HIV	Human immune virus
IUDS	Intra-Uterine Devices
LAM	Lactation Amenorrhoea
MCH	Maternal Child Health
MMH	Mpongwe Mission Hospital
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NCDP	National Commission for Development Planning
NGO	Non Governmental Organization

SAP	Structured Adjustment Programme
SRH	Sexual Reproductive Health
TFR	Total Fertility rate
TFR	Total Fatality Rate
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey

DECLARATION

I, Ruth M. Kasoka, hereby declare that the work presented in this study for the Bachelor of Science in Nursing has not been presented either wholly or in part, for any other degree.

Signed.. Date 31/5/12 ....

Candidate

Approved:.. Date: 31/05/12 ....

Supervisor

STATEMENT

I, Ruth M. Kasoka hereby certify that this study is the result of my own labour and independent investigation. The sources, to which I am indebted, are clearly indicated throughout the text and in the references.

Sign.. Date:31/5/12..................................

Candidate

DEDICATION

To my husband for his love, encouragement, support and for taking care of our children.

To Wana, Chabota and Ozzy for their patience they had and being good boys while I was away from home.

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ABSTRACT

The purpose of the study was to determine knowledge, practice and attitude of male involvement in family planning in Mpongwe District. Literature from various scholars on knowledge, Practice and Attitude was reviewed on male involvement in family planning. A non interventional descriptive study design was used in order to identify and explore knowledge, practice and attitude towards contraceptive use by men. The sample consisted of 50 men who were selected using simple random sampling method. A pilot study was done at St Theresa Hospital and the actual study was done in the month of October and November 2011 at Mpongwe Mission Hospital and its catchment area. Data were collected using a semi structured interview schedule and analyzed using a data master sheet, frequency tables, pie charts and cross tabulation tables were used to determine the relationships between variables. The findings reviewed that half of the respondents 50% were within the age group 31 to 41 years, 72% resided in Mpongwe Hospital area and 94% were married. Most 38% of the respondent's religious denominations were Jehovah's Witness, 44% had attained primary level of education and 52% were in formal employment. Some 38% of the respondents had children in the range of 1-2 children, 92% had an age difference between their last two children of 1-3 years and 48% were Lamba by tribe. Majority 88% of the respondents defined family planning correctly, 84% of the respondents stated correctly what male involvement in family planning was and all the respondents had heard about permanent methods. 60% of the respondents were able to mention about 6-11 methods of contraceptives, 60% had never heard about Vasectomy and 74% did not know what vasectomy was. The findings revealed that 54% of the respondent's source of information on family planning was the health worker 66% were able to state the benefit of family planning correctly and 80% mentioned unwanted pregnancies as one of the disadvantages of not using contraceptives methods. Most 78% of the respondents had high knowledge levels on male involvement in family planning. All 100% the respondents stated that the nurse's attitude towards clients was positive, 94% stated that they would still go back for review at the same health facility, 80% said that couples should make decisions on family planning together and all 100%, the respondents had a positive attitude towards male involvement in family planning.

The study has shown that 90% of the respondents accessed family planning services from the Hospital, 50% lived less than 5km from the hospital, 66% used male contraceptives, 56% used male condoms and 64% did not advance any reason why they were using condoms as a method of contraceptive method. The majority of the respondent's partners were using family planning, 42% were using injectables and 66% were accessing family planning methods easily. Of those who were not accessing 66% did not give any reason of accessing the methods easily. All the respondents reported that they allowed their wives to use family planning methods and 58% reported that their partners approved use of male method of contraceptive. Some 21% of the respondents with high knowledge level were married. All the respondents with a positive attitude towards male contraceptives were aged between 31-41years, were married 100%, had attained primary level of education 100% and were in formal employment 100%. The respondents with satisfactory level of practice were aged between 31-41 years old, were married 100% had attained primary level of education and were in formal employment. The majority 89% of the married respondents who used male methods of family planning had attained secondary level of education and were businessmen .There is therefore a need to continue involving men in family planning by intensifying health education using various forms of communication media such as holding workshops, producing leaflets containing information on family planning and transmission of information using drama performances. When all these measures are used men will be knowledgeable and their support will be appreciated by women and the nation as a whole.

CHAPTER 1

1:0 INTRODUCTIONS

This chapter provides information on the background information on the health care system, family planning methods available in Zambia and the statement of the problem.

1:1 BACKGROUND

Zambia is one of the developing countries in the sub-Saharan Africa. It covers the area of 752,614 square kilometres. The country lies between latitudes 8 and 18 degrees south of the equator and between longitudes 20 and 35 degrees east of the meridian line. Zambia has a tropical type of climate with three distinct seasons namely cool dry season, hot dry season and warm wet season. The northern parts of the country receive an average rainfall of 1400 mm while the drought prone southern parts receive about 600mm of rainfall per year. The country has a population of 12 million people (CSO, 2002).

Health Care Systems in Zambia

When Zambia got independence in 1964, it was supported by high earnings from copper exports. The country's population was around 4.3 million people with an annual growth rate of 3.2%. The Government by then was able to fulfill its obligation of providing social service to its citizens. Hospitals, health centres and health training institutions were constructed and the health care services were declared free (Center for Health and Gender Equity, 2000).

The rapid increase in population started in 1970s and this was a burden on the economy of the country. In the 1980s, the Zambian government started making adjustments aimed at correcting its economy. The Zambian government first introduced the Structure Adjustment Programme (SAP) which did not produce the desired results in boosting the economy. In 1984, the National Commission for Development Planning (NCDP) was given a mandate to initiate a draft population policy which would aim at achieving a population growth rate consistent with the growth rate of the economy (NCDP, 1989). The National Population Policy was in place in May 1989 and still the growth rate remained high with increase in maternal deaths and for this reason, Zambia launched safe motherhood in 1996 in view to reduce Maternal Mortality Rate (MMR).The national family planning program was put in place to reduce on the fertility rate and by 1994 there was a

rise in the usage of family planning methods in all the District of Zambia. Family planning allows women to space births, and longer birth intervals reduce maternal and infant mortality rates. Family planning and birth spacing also reduce unwanted pregnancy among HIV-positive women. According to the 2001-2002 Zambia Demographic and Health Survey Report (ZDHS), the Total Fertility Rate (TFR) is almost the same as from the 2000 Census of Population and Housing which stands at 6.0. The General Fertility Rate is 204 births per 1000.

In the 1990s, following the reintroduction of multiparty politics; Zambia had changes in health sector. Zambia, like many African countries in the developing world embarked on an ambitious plan aimed at resuscitating the health sector. In 1991, a vision was conceived and articulated ''providing Zambians with equity of access to quality, cost effective health care as close to the family as possible''. This vision gave birth to the National Health Reforms which were intended to transform the vision into reality. Cost sharing schemes were introduced in health institutions to assist in financing the health sector. More local and international partners came on board to supplement the government's efforts of providing health services (Zambia Integrated Health Project, 2004).

The health delivery system in Zambia operates under the principles of health reforms of leadership, accountability and partnership. Accountability focused on making health providers more answerable to clients while partnership entailed building relationships with users. It was also envisioned that partnership would be fostered with donor and external technical agencies, Non Governmental Organizations (NGOs), Community Based Organizations (CBOs) and Faith Based Organizations like Churches Health Association of Zambia (CHAZ). Decentralization of decision making power and resources was considered essential to the goal of partnership in Zambia (Simutowe et al, 2001). Over the past 30 years, there have been significant advances in the development of new contraceptive technologies, including transition from high-dose to low-dose combined oral contraceptives, and from inert to copper and levonorgestrel-releasing Intra-Uterine Devices (IUDs). In addition, combined hormonal, Injectable contraceptives and implants were introduced (WHO, 2005).

In Zambia, a number of family planning methods which are available in both the government and the private health sector include the hormonal methods, barrier methods, permanent and natural

methods (MOH, 2006). Below are the family planning methods available for use by clients in health institutions:

1. BARRIER METHODS

This method can be used by both male and female to prevent pregnancy. It acts by preventing the spermatozoa reaching the ovum hence no fertilization can occur. The barrier methods available in Zambia are male and female condoms, cervical cup and spermicides. The use of condoms is effective in preventing Sexually Transmitted Infections where condoms are used correct (MOH, 2006).

2. HORMONAL METHODS

Hormonal methods of contraception is effective when used correctly and these include Norplant, the Combined Oral Contraceptives (COCs), Progesterone Only Contraceptives is very effective in breast feeding mothers since it does not affect milk production, Emergency contraception, depot-medroxyprogestrone acetate (DMPA) and norethisterone enanthate . The Hormonal methods of family act by preventing ovulation from occurring hence no pregnancy occurs (MOH, 2006)

3. PERMANENT METHOD (TUBALIGATION IN FEMALE AND VASECTOMY IN MALES).

As with female sterilization, vasectomy requires appropriate counselling and informed consent. This method is irreversible (no return to fertility) hence the couple is made aware. The procedure involves minor surgery; it can be done under local or general surgery anaesthesia. In males a small cut is made in the scrotum and the vas deferens are cut and tied, this way no sperm can pass .This method is very effective as the failure rate is less than 0.5%.The method does not interfere with sexual intercourse but does not protect against sexually Transmitted illnesses. In females the fallopian tubes are cut or tied after a small incision is made on the abdomen (Zambia Family Planning Guidelines 2006).

4. NATURAL METHOD OF FAMILY PLANNING

The couple using this method have to be aware of fertility periods and this requires of them to periodic abstinence from vaginal intercourse. The couple has to be aware of Basal Body Temperature (BBT), the cervical secretions, calendar (Rhythm) these period suggests the time of ovulation when a woman can easily conceive. The method is cheap, effective, reversible and has

no physical side effects. However the methods require continued cooperation and commitment of the couple. Where the couple have difficulties in abstinence there is a high failure rate and a woman can fall pregnant. The other natural scientific method is Lactation Amenorrhoea Method (LAM). LAM utilizes the temporary infertility that occurs during breast feeding period when there is no ovulation. LAM is effective up to six months post partum and prevents pregnancy more than 98% (MOH, 2006).

The people of Mpongwe access their family planning services at the institution and Health centre in Mpongwe District. Mpongwe Mission Hospital provides different types of family planning methods to clients who come for this service. These methods include the barrier method, hormonal methods, permanent method (Tubaligation in female and vasectomy in males) and natural method of family planning where there is use of cycle beads.

According to Simutowe et al, (2001), nearly all health institutions in Northern Province are providing basic reproductive health service in which family planning is one of the services.

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partners and their peers to use Family Planning (Nkondwani, 1992).

1.2 STATEMENT OF THE PROBLEM

Lack of male involvement in family planning is a major problem in developing countries such as Zambia. This is because culturally, FP was regarded as a women's issue. This has resulted in adverse health effects on women because men are decision makers in homes. They make decisions regarding reproductive and family planning use. According to Ministry of Health (2004), male involvement in family planning is absolutely low as seen by marginal increase in condom use from 3.5% in 1996 to 3.8% in ZDHS in 2001-2002 amongst married women aged 15-49 years. This is because of weak tools used in reproductive health to orient men in family planning services. Furthermore, the usage of family planning methods among females is estimated at 46%. These figures are very low and indicate lack of male involvement in family planning.

The coverage of family planning among men users at Mpongwe Mission Hospital has been at 27% for condom use and males supporting their partners in permanent method of family planning. The institution has different types of family planning services which include condoms and vasectomy available for men. The institution also is running a programme for men being involved in Maternal Child Health activities in Maternal and Child Health Department (MCH department) and the program has been running for three years now. This programme encourages men to take part in these activities and escorting their wives to family planning clinics or getting refills for their wives. The low statistics on male involvement in family planning services at Mpongwe Mission Hospital need to be investigated to assess why men are not utilizing family planning services at Mpongwe Mission Hospital.

Involving men and obtaining their support and commitment to family planning is of crucial importance in Zambia in order to reduce on the fertility rate. In many homes men make decisions therefore if involved and impacted with knowledge on family planning, the nation can have the levels of male involvement in family planning raised. It is for this reason that the researcher has decided to study on male involvement in family planning to understand why males are not utilizing the service.

1.3 FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING

There are several factors that may influence male involvement in family planning. These factors are categorized into socio- cultural and economic factors and service related factors.

1.3.1 SOCIO-CULTURAL FACTORS

1.3.1.1 Cultural beliefs

Cultural beliefs and values on family planning that men have may influence their involvement in family planning services. The individual's beliefs on family planning can be true or false. A belief that family planning is for women only can be misinterpreted to mean that men have nothing to do with family planning. Another belief held by men is that when a woman uses family planning she discharges a lot of water vaginally hence sex is not enjoyable. Most societies believe in having many children because this is regarded as a source of parental care/support when parents grow old

(Nkondwani, 1992). These beliefs can influence men's knowledge, attitude and practice on the choice of contraceptive method to use as a couple.

1.3.1.2 Religious beliefs

Male involvement in family planning may be hindered by religious factors in cases where some religion does not support the usage of family planning e.g. the Catholics do not believe in the use of family planning other than use of natural family planning. Believers and followers of this religion tend to adhere to norms and values of their church hence influencing the men's knowledge on the choice of family planning to use as a couple.

1.3.1.3 Educational level

Education has significant effects on the increased knowledge, changing attitudes and practices of family planning and reproductive decision-making on males (Adlakha, 2005). Therefore men with high levels of education will have increased knowledge in male contraceptives than those with low education.

1.3.1.4 Level of Knowledge on family planning

The level of knowledge on contraceptives may influence male's involvement in family planning. For instance men with high knowledge level on contraceptives are more likely to use contraceptives or encourage their wives to use family planning methods. Hence need to give the males accurate information on family planning.

1.3.2 SERVICE RELATED FACTORS

The Service related factors are those related to the health services provided, health policies in place for delivery of quality services, the infrastructure and health personnel who provide the service to the people. The Service factors are linked and influence the core problem and may directly or indirectly influence the problem. Service related factors include the following:-

1.3.2.1Availability of male contraceptives

Availability of male contraceptives is crucial to male involvement in family planning. Males need a range of family planning methods from which they can choose from. The type of contraception

must be available at all times. This can also minimize interruptions in the use of the selected method. When male's methods of family planning are not available at the health facilities males will not visit the facility again and may even discourage their wives and others from visiting the health facility.

1.3.2.2 Health providers' competences

Health professionals play an important role in giving information on different family planning methods available for men and also emphasize on men escorting their partners to the health facility for family planning. Health service provider's experience and their expertise are essential for dissemination of appropriate information on family planning (Adlakha, 2005). Men can learn and also teach other men about male involvement in the family planning. The training needs can cover skills and knowledge in counseling as well as demonstrating on the use of the contraception e.g. demonstration on condom use and male vasectomy. The males can also be counseled on the importance of escorting their wives to family planning clinic and encouraged to choose a method to use.

1.3.2.3 Attitude of health providers

The providers can influence the male's involvement in the family planning. When the health provider's attitude towards their work is bad the males may shun the service

1.3.2.4 Distance to health centres

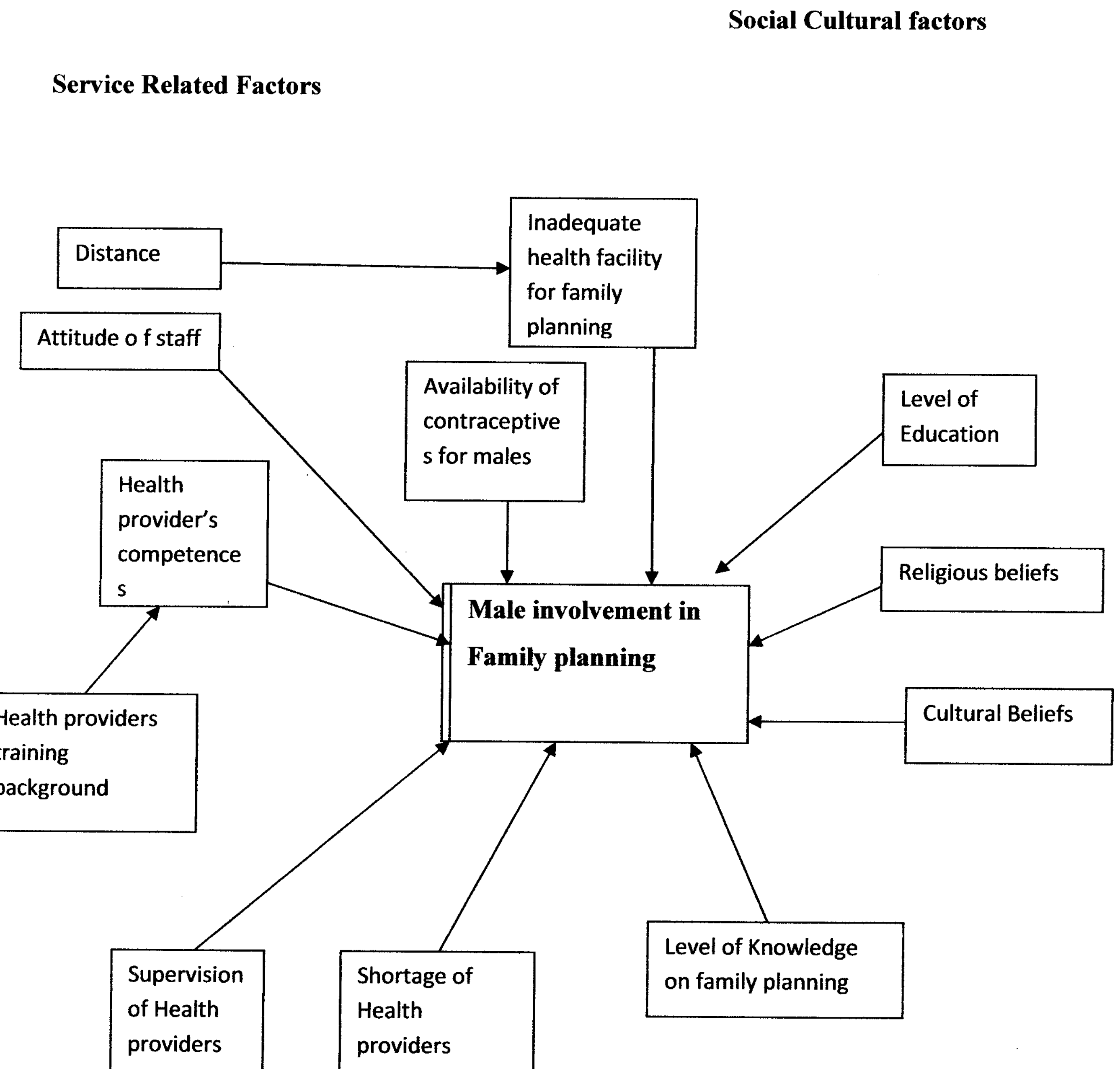
Distance to the health facility may be a barrier for men to access family planning services. This is because in rural areas health facilities are not within walking distance and this can discourage men from accessing family planning.

1.3.2.5 Inadequate health facilities for family planning

In Zambia, there are not many facilities offering family planning services and this may prevent men from getting involved in family planning. The Government policy of establishing health facilities every after 12 kilometers is still not reached hence many people do not have access to health services as close to the family as possible. People have to walk long distances to access health facilities.

1.4 Diagram of Problem Analysis

Fig 1: Factors influencing male involvement in family planning



1.5 THEORETICAL/CONCEPTUAL FRAMEWORK

DESCRIPTION OF PREDICTED RELATIONSHIP

CHANGE MODEL (STAGES OF CHANGE) – This model has a strong belief that behaviour change is a process and it's not only one time change. It was developed by Prachaska and Diclemente. The study was focused on people's ability to change and as individual's attempts to change behaviour, they move into five stages. These stages are pre-contemplation, contemplation, preparation, action and maintenance.

i) Pre-contemplation is the stage where an individual has no intention of taking action within six months. There is need to increase awareness about need to change. Health education is given and the importance of change of behaviour is emphasized.

ii) Contemplation is the stage where an individual intends to take action within six months but still not sure of what to do. The plan of action is drawn and communication is done on what to done. The individuals are involved in developing the plan of action.

iii) Preparation is the stage where an individual intends to take action within 30 days. There is need to assist an individual develop implementation plan according to set goals. The goals must be realistic and achievable.

iv) Action is the stage where an individual has changed behaviour within a period of six months. There is need to give a feedback by praising the person and give positive remarks on their changed behaviour. The individual can be used to educate others on behaviour change.

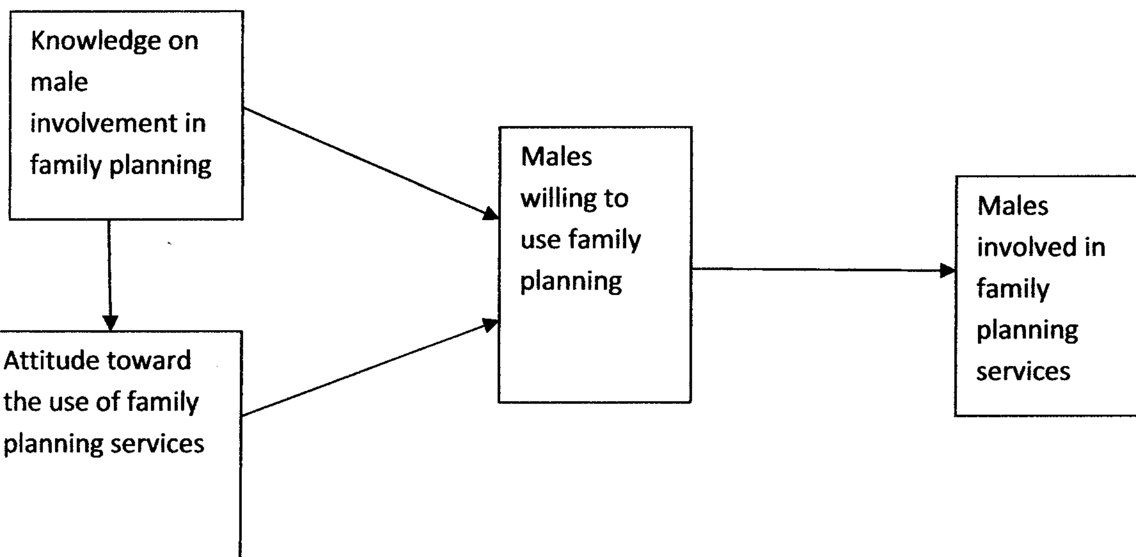
v) Maintenance is the stage where the new behaviour has been practiced for more than six months and at this stage an individual has completely changed. An individual is assisted with coping strategies with the new behaviour and avoiding situations which can make them go back to old behaviours.

According to the topic under study the variables identified are Knowledge, attitude, practice and acceptance. The variables relating them to the model can be described as follows:

In the Pre – contemplation stage, the men will lack knowledge about the importance of their involvement in family planning services therefore need for health professionals to increase on

the awareness of male involvement in family planning services. When the information is given to the men, they will contemplate on change of behaviour towards family planning services. Their attitude towards the service changes too. A plan will be drawn on how behaviour can be changed and at this stage of contemplation the men will be knowledgeable about family planning but will not be sure of what to do next. They will be motivated by involving them in making the plan. In the preparation stage, the men will intend to take action and change their behaviour towards their involvement in family planning services. An implementation plan will be made in line of achieving the stated goals. In the action stage the men practices their role of being involved in family planning services and this behaviour change is noticed for the period of six months. The males will be given a feedback on the changed behaviour and encouraged to disseminate the information on the importance of male involvement in family planning services. The behaviour change is then maintained by involving the men in various activities concerning family planning. They can be used as peer educators to attract more men to the health facility for family planning services and this can reduce on fertility rate hence the nation's economy can be boosted.

Figure 2: DIAGRAM OF CONCEPTUAL FRAMEWORK



1.6 JUSTIFICATION OF THE PROBLEM

Family planning is an essential tool in the control of raised fertility rate in Zambia. In order to achieve this, both females and males have to be involved in family planning. Male involvement is

important because men are the decision makers in homes i.e. they decide on how many children they wish to have.

Male involvement can give morale to the women as their partners will be able to escort them to family planning clinics or the males choosing condoms or vasectomy as a family planning method. However not many males are involved in family planning because family planning is regarded as a women's issue. It is hoped that the findings of this study will be used by policy makers to plan strategies that will encourage male involvement in family planning. The findings will also be used by family planning managers and service providers to improve men's knowledge and attitudes towards family planning so that they become involved in family planning. This study will provide baseline data on male involvement in family planning as no study has been conducted on this topic in Mpongwe district.The study will also provide guidance for future studies to be conducted in Mpongwe District and other parts of the country in the area of male involvement in family planning services.

1.7 RESEARCH OBJECTIVES

1.7.1 General Objective

The main objective of this research is to:

Determine the knowledge, Practice and attitude of males towards male involvement in family planning in Mpongwe District and to make recommendations on the findings.

1.7.2 Specific Objectives

1. To determine knowledge levels on family planning among males accessing health services in Maternal Child Health (MCH) department at Mpongwe Mission Hospital.

2. To determine Practices of males towards family planning.

3. To establish the attitudes of males towards their involvement in family planning.

4. To make suggestions on how family planning services can be improved among men in Mpongwe District.

1.8 HYPOTHESES

1. Religious beliefs influence the males' knowledge and attitude on their involvement in family planning services.

2. The education level influences male's knowledge on family planning.

3. Lack of sensitization on the importance of male involvement in family planning by health workers has made the males to shun the service.

1.9 Conceptual Definition of Terms

A Concept is a term that abstractly describes and names an object, a phenomenon, or an idea, thus providing it with a separate identity or meaning. (Burns and Grove, 2004). The following are the conceptual definitions from the Model used (Change Model).

1) **Pre-contemplation** is the stage where an individual has no intention of taking action within six months. There is need to increase awareness about need to change. Health education is given and the importance of change of behaviour is emphasized.

2) **Contemplation** is the stage where an individual intends to take action within six months but still not sure of what to do. The plan of action is drawn and communication is done on what to do. The individuals are involved in developing the plan of action.

3) **Preparation** is the stage where an individual intends to take action within 30 days. There is need to assist an individual develop implementation plan according to set goals. The goals must be realistic and achievable.

4) **Action** is the stage where an individual has changed behaviour within a period of six months. There is need to give a feedback by praising the person and give positive remarks on their changed behaviour. The individual can be used to educate others on behaviour change.

5) **Maintenance** is the stage where the new behaviour has been practiced for more than six months and at this stage an individual has completely changed. An individual is assisted with coping strategies with the new behaviour and avoiding situations which can make them go back to old behaviours.

6) **Male involvement in family planning** - is enabling men to have access to family planning services.

1.9.1 VARIABLES AND CUT-OFF POINTS

Dependent variable – This is a response, behavior, or outcome that is predicted and measured in research; changes in the dependent variable are presumed to be caused by independent variable (Burns and Grove, 2004). In this study the dependent variables is Male involvement

Independent variables – The treatment, intervention, or experimental activity that is manipulated or varied by the researcher to create an effect on the dependent variable (Burns and Grove, 2004). In this study the independent variables are:

- Knowledge
- Attitude
- Practice
- Acceptance

Table 1 shows research variables

VARIABLE	INDICATOR	MARKS OR POINTS	QUESTION NUMBER
1.Knowledge	High knowledge level	A score of 18- 24 on knowledge questions on family planning indicates high knowledge.	1O - 19
	Moderate knowledge level	A score of 9-17 on knowledge questions on family planning indicates Moderate knowledge.	
	Low knowledge level	A score below 0-8 on knowledge questions on family planning indicates Low knowledge.	
3.Practice	Satisfactory	A score of 5-9 indicates use of family planning	23 - 32
	Unsatisfaction	A score of 0-4 indicates non use of F.P	
4.Acceptance	Acceptance	A score of 4-5 indicates acceptance of F.P	32 -35
	Non Acceptance	A score of 0-3 indicates non acceptance of F.P	

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Family planning is an important tool used to reduce fertility rate hence it reduces the population of the nation. Family planning has become vital on the agenda worldwide especially in developing countries where the population is growing at a very fast rate. Family planning awareness enables the users to gain on knowledge and the use of family planning increases thereby reducing Maternal and child Mortality.

Family planning use was reinforced at the United Nations International Conference in Geneva in 1984. All Governments were urged to give support to family planning as a measure to reduce on population and prevent maternal and child mortality and promote the health of women and children.

The literature review will comprise studies conducted on male involvement in family planning services. The review will focus on knowledge, attitude and practice of choice of contraceptive method. The purpose of this chapter is to avoid duplication of studies that have already been done by finding out what other researchers and scholars have done and reported on knowledge, attitude and practice of male involvement in family planning services. The Literature review will also help in refining the problem statement, study design and provides a further convincing argument why the research project is needed. The researcher has used Journals, books, unpublished research proposals, published research papers, clinical and hospital data, internet, government reports and records.

Studies on male involvement in family planning services have been done in different nations of the world and different findings and recommendations have been documented. The literature review will be organized according to variables influencing male involvement in family planning.

2.2 KNOWLEDGE

Male-involvement in family planning empowers men with knowledge on use of contraceptives and enhances reduction in fertility. Levy (2006) conducted a study on male involvement in family planning at the University of North Carolina at Chapel Hill as a fulfillment of acquiring a Master's Degree in Public Health. The study concluded that, when men are empowered with knowledge on family planning their involvement will be high.

Tsedeke et, al (2004) conducted a study on the role of men in contraceptive use and their fertility preference in Ethiopia. The study found that more women whose husbands were knowledgeable about contraceptives were utilizing the contraceptives compared to those whose husbands had no knowledge. Thus, family planning programs should not focus only on women, but they should also address men. Information, education and communication programs for promoting family planning methods should, thus, be strengthened (Tsedeke et, al 2004). The study concluded that increasing male utilization of family planning can be enhanced by intensifying IEC.

Luhana et al, (2005) conducted a case study in Lusaka, Zambia on male involvement in family planning as a measure to increasing contraceptive use and reducing fertility. Interviews were held with 31 key informants and group discussions were held with community volunteers. The studies found an association between knowledge and male participation in family planning. Therefore there is need to educate men on the importance of their involvement in family planning.

2.3 ATTITUDE

In Ghana, "despite the independent nature of some marital relationships, recent evidence indicate that men have the primary decision-making power in matters of family planning." Both Demographic Health Survey data and focus-group research revealed that husband were usually the effective decision-maker about fertility. Furthermore, husband's family-planning attitudes and fertility goals usually were not influenced by those of their wives. And, when partners disagree on whether to use family planning, the man's preference usually dominated (Population Reports, 2002). It was also discovered that men comprehend family planning messages differently than women did. The study further revealed that the mean ideal family size for currently married men is

higher than for married women. This difference is significant in West Africa, ranging from about two children in Burkina Faso to more than four children in Niger and Senegal (exception is Ghana, 0.6). In East and North Africa, no significant difference in fertility desire was found. This shows the importance of targeting men with family planning programs (Ezeh, 1998).

2.4 PRACTICE

The Population Reference Bureau (2010) states that, the ability to space children can increase the women's dependence and allow women and men greater control over their lives. The use of family planning also improves the health of the family. Globally, the uses of modern contraceptives are fueling the need for additional funding for family planning (Gribble, 2010). The Population Reference Bureau report also indicated that providing a variety of contraceptive methods, improves interaction between the health providers and clients and by providing information about contraceptives to clients enables the clients know the risks and benefits of family planning usage. This enables the couples achieve their reproductive goals.

The practice of modern male contraceptives methods such as the condom and vasectomy are still low in many countries worldwide though the situation is slowly improving in some countries. The withdrawal and abstinence are also less used in some countries. According to studies done in developing countries the use of condoms by married couples was at 4%, vasectomy was at 4% the use of vasectomy was only popular in few countries. The only country where vasectomy was widely used is South Korea at 12%, China at 10%, Nepal at 5% and India at 4% (Ezeh, 1998). The study concluded that a lot of effort is needed to increase awareness on male's usage of family planning.

Male involvement in regulating the family size has been a concern for the health policy makers for quite some time. The role of men in such matters is of great importance because decision-makers in vast majority of the Indian families are males. For instance a study conducted in Bangladeshi revealed men were not willing to undertake vasectomy and that women had a little or no say on matters that affect their reproductive health. The study showed that males were the sole decision makers in most of Indian families hence their involvement will enhance reduction in the population and promote health for women (Jayalakshimi et al, 2002). The study concluded that when men are not using the available contraceptives the population will continue to rise.

Nava and Field (2006) conducted a study on male involvement in contraceptive adoption as a means to reduce fertility at Chipata Health Centre in Lusaka, Zambia. The findings revealed that men had an influence on women's decisions on contraceptives use. This study evaluated the effect of male involvement on female contraceptive use through an experiment designed to remove the factors of insufficient supply, lack of information, misinformation, and divergent fertility preferences. Study participants include 1,994 married women who had given birth in the last two years living in compounds serviced by Chipata Clinic in Lusaka. Women in the study received vouchers that granted appointments with a family planning nurse at the local government clinic, without waiting more than one hour and with guaranteed access to the modern contraceptive method of their choice. An information session explaining all methods of family planning was also given to study participants at the time of voucher distribution. Women were randomized into two treatment groups. In the "individual" arm of the study, women were given these vouchers alone. In the "couples" arm, women were given these vouchers in the presence of their husbands. Take up of the voucher was high at 47%, indicating that women valued the substantial reduction in the time cost of an appointment associated with the voucher. However, evidence suggests that sharing information about family planning services with husbands reduces the couple's to utilize these services. Women who received the voucher in the presence of their husbands were 9 percentage points (18%) less likely to use the voucher to obtain an appointment at a family planning clinic. There was an even larger, 12 percentage point reduction in voucher use for couples where the husband reported wanting more children than their wives. Still a larger reduction in use was reported among younger couples, giving evidence for the hypothesis that differences in future preferences for fertility drive differences in demand for family planning services. Male knowledge of the voucher led to a substantial reduction in use of these services, suggesting that policies or technologies that shift relative control of contraceptive methods from men to women may significantly increase contraceptive use and reduce average fertility in some contexts. This is important to note given that an increasing number of policymakers have started to promote "male involvement" in family planning. It also suggests that take up of particular modern contraceptive methods may be sensitive to the amount of control women can exercise relative to their husbands in the use of these method

2.5 LEVEL OF EDUCATION

Levy (2006) conducted a study in which she concluded that men who had a higher level of education and came from a higher socioeconomic residence, their knowledge of contraception also was higher than those who their level of education was low.

2.6 ACCEPTANCE

According to a study done by Char et, al (2011) the acceptability of reproductive health information and contraceptives were relatively less developed in rural central India. Char and his colleagues conducted a cross sectional that used both qualitative and quantitative methods and participants included 38 unmarried rural men in four focus-group discussions .In addition a representative sample of 316 similarly profiled men, aged 17-22 years were recruited as participants in the study. Information was collected on the men's socioeconomic characteristics; awareness, knowledge, and perceptions of family planning; attitudes toward future contraceptive use; intra-family communication; knowledge about sexually transmitted illnesses and access and use of condoms. Content analysis for qualitative information and descriptive analysis for survey data were used to draw conclusions. The findings revealed those young unmarried rural Indian men's Sexual and Reproductive Health (SRH) knowledge and acceptance of the male contraceptives was limited, although the majority were familiar with condoms (99%). The young men identified electronic mass media (67%) as the prime source of reproductive health information, yet they lacked detailed knowledge of various contraceptives and felt ignored by health providers .It was found that young men were more concerned about avoiding infections and securing sexual pleasure and less concerned about avoiding potential pregnancies. For example, 68% of the young men were aware of condoms and their HIV/AIDS preventive role, but only about two-fifths mentioned that a condom can be used to prevent unwanted pregnancies. Although most young men (96%) knew where to access a condom, they felt uncomfortable or embarrassed doing so in their own villages or close by because of socio-cultural norms that prevented them from using contraceptives. Very few respondents (4%) disclosed using condoms themselves, but 59% said they knew someone from their peer group who had used them. The study concluded that though there are many health facilities providing male contraceptives few men are accessing and accepting the contraceptives.

2.7 CONCLUSION

The literature review has shown that not many studies have been conducted on male involvement on family planning. The few available studies have indicated that very few men were willing to undertake vasectomy as a family planning method and that the few available male contraceptives are not widely used by men in many countries. Lack of knowledge contributed to inability to access family planning by males therefore including men in family planning will ultimately reduce on fertility and knowledge about contraception use will increase. The males being the sole decision makers in most nations once involved in family planning will reduce on the fertility and the world population will be maintained to levels which will enable nations to eradicate poverty which comes about due to over population.

CHAPTER THREE

3:0 RESEARCH METHODOLOGIES

INTRODUCTION

This chapter gives a description of the research methodology that was used in the study. The purpose of the study was to determine the knowledge, attitude and practice of male involvement in family planning in Mpongwe District in particular Mpongwe Mission Hospital catchment area. The research methodology included the description of the study participants and the method used to select them, a description of tools and technique used to gather data and the research setting. The researcher has described how validity and reliability was ensured and the ethical considerations for carrying out the research. The chapter has a description of how the pilot study was done and how data was analyzed, plans for dissemination of findings, work plan schedule and Gantt chart.

3.1 RESEARCH DESIGN

Polit and Hungler (2001) defines research design as the overall plan for collecting and analyzing data ,including specification for enhancing the internal and external validity of the study .The design provides answers to the research questions or test the research hypothesis.

There are basically two broad types of research designs; non-interventional and interventional. Non-interventional studies involve description and analysis of research subjects or situations but no intervention is taken. While interventional studies involve manipulation of research subjects or situations and measures the outcome or results of the manipulation (Grove and Burns, 2005). In this study the researcher used a descriptive non-intervention research design. A descriptive research design is a study in which a data is collected, recorded and analysed. It involves a systematic collection and presentation of data to describe or refine characteristics of a phenomena or person as they naturally occur (Polit and Hungler, 2001).The research was descriptive as it involved identification and describing the knowledge and practice of male involvement in family planning in Mpongwe Mission Hospital catchment area.

3.2 RESEARCH SETTING

A research setting is a physical environment and conditions in which data collection takes place in a study (Polit and Hungler, 2001).

The study was conducted at Mpongwe Mission Hospital Maternal Child Health (MCH) department and Mpongwe Mission Hospital outreach post. These outreach posts were Ntanda outreach post, Bwembelelo outreach post and Shingwa outreach post. Mpongwe Mission Hospital is situated in Mpongwe District on the Copperbelt Province. It caters for the catchment population of 18,260 people of which 9,111 are males (Mpongwe Mission Hospital Action Plan, 2011-2013). The institution has a bed capacity of 120 beds. The Hospital has four wards namely female medical/ surgical, male medical/surgical, Pediatrics and Maternity wards. It has an out -patient department were MCH department is found. Other department includes Laboratory, Pharmacy, Antiretrio viral Therapy department (ART), Laundry, mortuary and the Kitchen. The hospital is headed by Medical Superintendent and the Nursing part is headed by the Nursing Officer. Staffing levels are: 30 nurses with total of 60 professionals and 30 support staff. The outreach post are structures made by local people where health services are provided by nurses from Mpongwe Mission Hospital and are assisted by community Health workers.

Demographic Profile

The table below shows the demographic figures for Mpongwe Mission Hospital catchment area for 2011 Population based on the 2010 Census of Population and Housing.

Table 2: Mpongwe Hospital Affiliated Health Centre (HAHC) Population Categories

Category	Percentage	2011
Children 0- 11 months	4%	730
Children 12- 59 months	20%	3,652
Women of Child Bearing Age (15-45 years)	22%	4,017
Expected Pregnancies	5.40%	986
Expected deliveries	5.20%	950
Expected live births	4.95%	903
Total males (All ages)	49.90%	9,111
Total females (All ages)	50.40%	9,203
Totals	**161%**	**29552**

Source: Mpongwe District Health Management Team (DHMT) Action Plan 2011.

3.3 STUDY POPULATION

The study population consisted of men residing in Mpongwe Mission Hospital catchment area. The study units were men accessing MCH services at different selected four sites and they were expected to come from different social classes i.e. working class, business men and farmers.

3.4 SAMPLE SELECTION

Sample selection is the selecting of a portion of the population to represent the entire population (Polit and Hungler, 2001). Simple random sampling method was used at each selected health facility to select the 50 respondents. Simple random sampling is one in which every member of the population has an equal chance of being selected into the sample (Basavanthappa, 2006). At each site, sample frames of all the men accessing services at the selected site were given a number

written on a piece of paper. These pieces of paper with numbers were put in a box and the required numbers were picked at random. The advantage of random sampling was that it was quicker to study a sample than to study the whole population and findings were generalized because the selected samples were representative of the population

3.4.1. Inclusion Criteria

The inclusion criterion which is also known as eligibility criteria is defined as the criterion that specifies the characteristics of the population (Burns and Grove, 2005). The investigator only recruited men from 18years and above accessing family planning services at Mpongwe Mission Hospital and outreach posts residing in the study area to participate in the study. Only men who consented participated in the study.

3.4.2. Exclusion Criteria

An exclusion criterion is defined as a population that do not possess the required characteristics (Burns and Grove, 2005). In this study men accessing other reproductive health services at MCH department at Mpongwe Mission Hospital and selected outreach post were excluded from participating in the study and men who did not consent to participate in the study were also not recruited in the study.

3.5 SAMPLE SIZE

A sample size is the number of study participants (Polit and Hungler, 2001). The sample size for this study was fifty (50) i.e. 14 farmers, 10 Business men and 26 working class men from different departments. The participants were selected from men accessing Maternal Child Health services in particular family planning services. The relatively small sample size was considered by the researcher due to limited time, material and financial resources.

3.6 OPERATIONAL DEFINITIONS

1. Knowledge – The ability to define the term contraceptive correctly.

2. Attitude – The feelings people have towards the use of contraception.

3. Male involvement – This is the ability of males to fully participate in spacing the children being born.

4. **Practice** – This is when men access and use family planning methods.

5. Family planning - Ability to use the available contraceptives to prevent pregnancy.

6. Contraceptive – This is a method used to prevent pregnancy.

7. Contraceptive usage – The use of contraceptive at each sexual intercourse.

8. Accessibility – The ability to obtain contraceptives.

3.7 DATA COLLECTION TOOL

An instrument in research refers to the tool or equipment used to collect data. It may take the form of a questionnaire, an interview schedule, a projective device, or some other type of tool for eliciting information (Grove and Burns, 2005). Collection of data was carried out between 26th October and 22nd November 2011 from the four selected sites. A semi structured interview schedule is a tool which the researcher used to collect data. This tool was chosen because it was user friendly and it was applicable to both illiterate and literate males accessing family planning services. The advantages of using an interview schedule were that it gave room for respondents to ask questions and clarifications were given whenever necessary. The questions were standardized and a higher proportion of responses were corrected. The data collection tool had four sections: Section A: Demographic data, Section B: Knowledge of family planning, Section C: questions on Attitude , section D family planning practice among men and section E acceptability of F.P. The questions consisted of open ended and closed ended questions which were formulated in a questionnaire. Open ended questions permitted free responses which were recorded in the respondents' own words (Varkevisser et al 2003). These questions were useful in obtaining in-depth information which the researcher was not very familiar with or opinions, attitudes and suggestions of informants or sensitive issues. Closed ended questions had a list of possible options or answers from which the respondents had to choose possible answers. The interview schedule had the following advantages:

- Data for each interview was used during analysis of data
- Respondents remained unknown
- Effective in obtaining opinions, attitudes, values and perceived behaviour

- The researcher was able to gather data from a widely scattered sample
- Offered a simple procedure for exploring a new topic

DISADVANTAGES OF INTERVIEW

- The respondents could not give correct in the presence of the interviewer.
- The amount of information that was gathered is limited by the subject's available time and interest span. Usually respondents did not like to take more than 25 minutes to answer a questionnaire.
- Printing of the questionnaires was costly if the questions are lengthy and printed on high quality paper.
- Data were limited to the information voluntarily supplied by the respondents to the asked questions.
- The instrument was unable to probe a topic in depth without becoming unduly lengthy.
- Some items could have been misunderstood by the respondents

3.8 DATA COLLECTION TECHNIQUE

Data collection technique is the use of data collection tools to gather information needed to address a research problem (Polit and Hungler, 2001). It allows for systematic collection of information from respondents. In this study, data were collected by using an interview schedule at Mpongwe Mission Hospital MCH department and selected outreach post. The men were made to sit comfortably, permission to conduct the interview was got, consent was also obtained and confidentiality was assured. The semi structured interview schedule was structured or unstructured and verbal communication between the researcher and subject was done. In this type of interview, complete sets of well-defined questions were used. The researcher conducted five interviews per day. The procedure for data collection in this study was as follows:

- Before the interview the researcher/research assistant introduced themselves to the respondents.
- The purpose of the study was explained to the respondents.
- Respondent were reassured of confidentiality and anonymity.
- The respondents were informed on how the feedback will be provided

- After getting consent, the researcher/research assistant read out the questions to the respondents.
- The researcher then entered the responses as given by the respondents.
- At the end of the interview, the researcher went through the interview schedule to check for consistency in the answers provided and for completeness of the interview schedule.
- The interviewer asked the interviewee for any questions, comments or contributions regarding the study and then thanked the respondents for taking part in the study.

Each interview lasted for approximately 30- 45 minutes.

3.8.1 VALIDITY

This is the theoretical proposition, an accurate reflection of reality in a research (Burns and Grove 2005).

Validity is the degree to which an instrument measures what it is supposed to measure (Polit and Hungler, 2001). The researcher ensured validity by applying strategies that deal with threats to validity in the study. These strategies included , selection of the appropriate study design, random selection of participants, designing the data collection tools which was easy to administer and the pre-testing research instruments were used before the actual study was done. Validity was insured by conducting a pilot study where random selection of study participants was done to avoid bias in the representation of the target population. The study Supervisor at the Department of Nursing Sciences in the School of Medicine analysed the questionnaire and other selected tools for content validity.

3.8.2 RELIABILITY

Represent the consistency of the measure obtained from the research (Burns and Grove, 2005).

Reliability is the degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure (Polit and Hungler, 2001). The instrument used in one particular study should be able to bring out the accurate information even when the same instrument is used after some time it should produce similar results. . In this study the researcher ensured reliability by standardizing the instrument and the research tool was tested before the main study was done

by using a pilot study in the setting with similar characteristics as the setting where the main study was to be carried out hence stability of the data collection tool was ensured.

3.9 PILOT STUDY

A pilot study is a small preliminary investigation of the same general character as the major study, designed to acquaint the researcher with the problems to be corrected in preparation for the larger project (Grove and Burns, 2005). The researcher used a pilot study to determine and measure the clarity of the language, logical sequencing, and space for answers, need for further instructions, appropriateness, detection of errors and the duration for each interview. The pilot study was conducted at Ibenga Mission Hospital MCH Department. The pilot study consisted of five respondents representing 10% of the 50 sampled respondents. The five respondents in the pilot study were sampled using simple random sampling procedures. The investigator established a sampling frame for all males accessing family planning services. A sampling frame was established by giving the men numbers written on the pieces of paper and these papers were then placed in a box which was vigorously shaken and five papers were selected from the box one at a time. The investigator analyzed the results to find out if the respondents understood all the items indicated in the questionnaire. The pilot study also helped the researcher to exclude or include information in the questionnaire. Reformulation and additions to some questions was done. Question 14, 19, 20 were rephrased to enable respondents understand the question better.

3.10 ETHICAL AND LEGAL ISSUES

Ethics are a system of moral values that are concerned with the degree to which procedures adhere to professional, legal, and social obligations to the research subjects (Polit and Hungler, 2001). Any study being conducted should meet the ethical and cultural considerations to be acceptable by the respondents. Before conducting the study, the researcher obtained a written consent from District Medical Officer and Hospital Administrator of Mpongwe Mission Hospital and the additional personal consent were obtained from the men who participated in the study. The respondents were briefed about the purpose of the study and that they had the right to participate or withdraw from the study at any time. The respondents were assured of confidentiality of personal information shared with the researcher. No names of the respondents were indicated on the

interview schedule to ensure anonymity. The completed interview schedules were kept secured to avoid unauthorized access to the information contained in them.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

INTRODUCTION

The purpose of the study was to determine knowledge, attitude and practice of male involvement in family planning in Mpongwe. The study results were based on all the responses from fifty (50) men sampled randomly attending family planning clinics at (4) conveniently sampled Health Centres in the district namely MCH Department at Mpongwe Mission Hospital, Bwembelelo, Shingwa and Ntanda. The findings were entered on the data master sheet and analysed.

4.1 DATA ANALYSIS

Data analysis is the systematic organisation, synthesis of research data and the testing of research hypothesis using those data (Polit and Hungler, 2001).

All the interview schedules were edited for accuracy, completeness, uniformity and consistency. The responses from closed ended questions were entered on the data master sheet for easy manual analysis of data, while responses from open-ended questions were categorized according to similarity and then coded. Data was analyzed manually with aid of a scientific calculator.

4.2 PRESENTATION OF FINDINGS

The study findings were presented according to the sequence of sections and questions of the interview schedule.

The findings of the study were presented in frequency tables and pie charts. Cross tabulations of the variables helped to show clearly the relationship between variables.

4.2.1 DEMOGRAPHIC DATA

Table 3: Respondent's Age (n=50)

AGE	FREQUENCY	PERCENTAGE
20 – 30	14	28
31 – 41	25	50
42 -52	7	14
Above 53	4	8
Total	**50**	**100%**

Most 50% (25) of the respondents were in the age group 31-41, while 4 (8%) were above 53years.

Table 4: Respondent's residence area (n=50)

Residence	FREQUENCY	PERCENTAGE
Mpongwe Hospital area	36	72
Bwembelelo	7	14
Shingwa	3	6
Ntanda	4	8
Total	**50**	**100%**

Majority 72% (36) of the respondent's lived in Mpongwe Hospital Catchment area, while 4(8%) lived in Ntanda

Table 5: Respondent's response on marital status (n=50)

VARIABLE	FREQUENCY	PERCENTAGE
Never married	1	2
Married	47	94
Separated	1	2
Divorced	1	2
Total	**50**	**100%**

Majority 94% (47) of the respondents were married while 1 (2%) were Divorced.

Table 6: Respondents' religious denomination (n=50)

Religious Denomination	FREQUENCY	PERCENTAGE
Catholic	7	14
Baptist	19	38
SDA	1	2
UCZ	4	8
Jehovah's Witnesses	19	38
Total	**50**	**100%**

Most 38% (19) of the respondents religious denomination was Baptist while 4 (8%) were UCZ.

Table.7: Respondents' level of education (n=50)

Level of education	FREQUENCY	PERCENTAGE
Never been	2	4
Primary	22	44
Secondary	19	38
Tertiary	7	14
Total	**50**	**100**

Most 46% (23) of the respondents had attained primary education level while 7(14%) attained Tertiary education.

Table 8: Respondent's occupation (n=50)

Occupation	FREQUENCY	PERCENTAGE
Formal Employment	26	52
Businessmen	10	20
Farmer	14	28
Total	**50**	**100**

Most 52% (26) of the respondents were in formal employment while 20% (10) were Businessmen.

Table 9: Respondents' responses on number of children (n=50)

Number of children	FREQUENCY	PERCENTAGE
1 – 2	19	38
3 – 4	18	36
5 -6	5	10
Above 7	8	16
Total	**50**	**100%**

Most 38% (19) of the respondents had children in the range of 1-2 children while 10% (50 had in the range of 5-6 children.

Table 10: Respondents' responses on age difference between two last children (n=50)

Age Difference last two children	FREQUENCY	PERCENTAGE
1 - 3	46	92
4 - 6	4	8
Above 7	0	0
Total	**50**	**100%**

Majority 92% (46) of the respondents' children's age difference between last two children ranged from 1-3 years while 8% (4) ranged from 4-6 years.

Table 11: .Respondent's tribes (n=50)

Tribe	FREQUENCY	PERCENTAGE
Lamba	24	48
Bemba	8	16
Namwanga	6	12
Tonga	4	8
Kaonde	8	16
Total	**50**	**100%**

Most 48% (24) of respondents were Lamba by tribe while 8% (4) were Tonga.

Table 12: Distribution of study variables (n=50).

Variable	Mean	Standard Deviation	Range
Knowledge	15.4	3.528	7 - 24
Attitude	7.42	0.758	6 – 8
Practice	5.96	0.856	5 - 7
Acceptability	4.36	0.802	2 - 5

Knowledge ranged from 7 -24 (mean = 15.4, SD = 3.528), Attitude ranged from 6 -8 (mean = 7.42, SD = 0.758), Practice ranged from 5 -7 (mean = 5.96, SD = 0.856), Acceptability ranged from 2 -5 (mean = 4.36, SD = 0.802).

4.2.2 KNOWLEDGE

Table 13: Respondents` response definition of Family Planning (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Having a child at an appropriate time	44	88
Spacing the children	4	8
Allowing only women seeking family planning services	2	4
Total	**50**	**100%**

Most 88% (44) of the respondents said that family planning was ''having a child at an appropriate time'' while 8% (4) said that it was ''spacing children.''

Table 14: Respondents' responses on the meaning of male involvement in Family Planning (n=50)

Meaning of male involvement in Family Planning	**FREQUENCIES**	**PERCENTAGE**
Men using condoms	11	22
Men supporting partners	28	56
Men escorting partners to access F.P services	3	6
No response	8	16
Total	**50**	**100%**

Most 56% (28) of the respondent's stated that male involvement in family planning was ''men supporting partners in family planning'' while 16% (8) gave no response.

Table 15: Respondent's response to if ever heard of Family Planning methods (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Yes	50	100
No	0	0

Majority 100% (50) of respondents had heard of family planning methods available.

Table 16: Respondents' knowledge on methods of Family Planning available (n=50)

RESPONSES	**FREQUENCIES**	**PERCENTAGE**
New 0-5 methods	20	40
New 6-11 methods	30	60
Total	50	100%

Majority 60% (30) of the respondents were able mention 6-11 methods of contraceptives while 40% (20) mentioned 5 and below.

17: Respondents' if ever heard of permanent method of Family Planning for men (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Yes	20	40
No	30	60
Total	**50**	**100%**

Majority 60% (30) of the respondents had never heard about permanent method of family planning while 40% (20) had heard about it.

Table 18: Respondents' responses on permanent Family Planning (n=50)

Vasectomy	FREQUENCIES	PERCENTAGE
Tie vans –deference to prevent sperm fertilizing the ovum	13	26
Permanent method of contraceptive for men	0	0
Wrong/no response	37	74
Total	**50**	**100%**

Most 74% (37) of the respondents were unable to state what vasectomy was and 26% (13) were able to state it correctly

Table 19: Respondents' responses on their source of information on Family Planning (n=50)

Source of information	FREQUENCIES	PERCENTAGE
Health workers	27	54
Friends	2	4
Wife	12	24
Parents	2	4
Newspaper/T.V or radio	7	14
Total	**50**	**100%**

Most 54% (27) of the respondents had source of information on family planning from the Health workers while 4% (2) got information from friends.

Table 20: Respondents' response on the benefits of using family planning (n=50)

Benefits of family planning	FREQUENCIES	PERCENTAGE
Well spacing children	33	66%
Children grow well	15	30
Maternal/child mortality prevented	2	4
Total	**50**	**100**

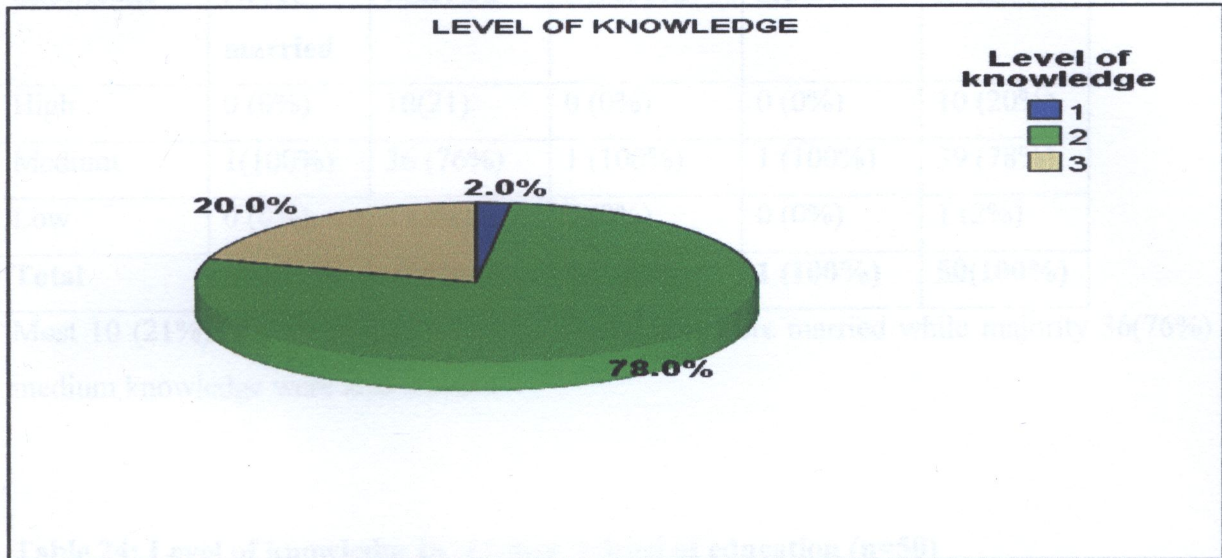
Majority 66% (33) of the respondents responded that there is spacing of children while 2 (4%) stated that family planning prevents maternal/child mortality.

Table 21: Respondents' responses on the disadvantages of not using Family Planning (n=50)

Disadvantages of not using Family Planning	Frequency	Percentage
Increase in unwanted pregnancies	40	80
Increase in abortions	4	8
Maternal/children mortality increased	4	8
Poor living standards	2	4
Total	**50**	**100%**

Majority 80% (40) of respondents stated that the disadvantage of not using family planning method was an increase in the number of unwanted pregnancies while 4% (2) stated that it leads to poor living standards.

Figure 3: Level of Knowledge



Majority of the respondents 78% (39) had high knowledge level about male involvement in family planning, 10 (20%) had medium knowledge and 2% (1) had low knowledge.

Cross tabulations on Relationships among knowledge and demographic variable

Table 22: Respondents' Knowledge on male involvement in Family Planning in relation to Age (n=50)

Level of knowledge	Age				
	20-30	**31-41**	**42-52**	**Above 53**	**Row Total**
High	2(14%)	6(24%)	2(29%)	0 (0%)	10 (20%)
Medium	12 (86%)	19 (76%)	4 (57%)	4 (100%)	39 (78%)
Low	0 (0%)	0(0%)	1 (14%)	0 (0%)	1 (2%)
Total	**14 (100%)**	**25 (100%)**	**7 (100%)**	**4 (100%)**	**50 (100%)**

Most 29% (2) of respondents with high knowledge on male involvement in Family Planning were aged 42-52 years while majorities 76% (19) with medium knowledge were aged 31-41years.

Table 23: Respondents' level of knowledge in relation to marital status (n=50)

Level of knowledge	Marital status				
	Never married	**Married**	**Divorced**	**separated**	**Total**
High	0 (0%)	10(21)	0 (0%)	0 (0%)	10 (20%)
Medium	1(100%)	36 (76%)	1 (100%)	1 (100%)	39 (78%)
Low	0 (0%)	1 (3%)	0 (0%)	0 (0%)	1 (2%)
Total	**1 (100%)**	**47 (100%)**	**1 (100%)**	**1 (100%)**	**50(100%)**

Most 10 (21%) of respondents with high knowledge were married while majority 36(76%) with medium knowledge were also married.

Table 24: Level of knowledge in relation to level of education (n=50)

Level of knowledge	Level of Education				
	Never been to school	**Primary**	**Secondary**	**Tertiary**	**Total**
High	1 (50%)	1 (5%)	3 (16%)	5 (71%)	10 (20%)
Medium	1 (50%)	20 (90%)	16 (84	2 (29%)	39 (78%)
low	0 (0%)	1(5%)	0(0%)	0(0%)	1(2%)
Total	**2 (100%)**	**22 (100%)**	**19 (100%)**	**7 (100%)**	**50(100%)**

Majority 71% (5) of the respondents with high knowledge had attained tertiary level of education while 84% (16) of the respondents with medium knowledge had attained secondary level of education.

Table 25: Level of knowledge in relation to occupation (n=50)

Level of knowledge	Occupation			
	Employed	**Business man**	**Farmer**	**Total**
High	7(27%)	1(10%)	2(14%)	10(20%)
Medium	19 (73%)	8 (80%)	12 (86%)	39 (78%)
Low	0 (0%)	1(10%)	0 (0%)	1 (2%)
Total	**26 (100%)**	**10 (100%)**	**14 (100%)**	**50 (100%)**

Most 27% (7) of the respondents with high knowledge were informal employment while those 10% (1) with low knowledge were business men.

4.2.3 ATTITUDE

Table 26: Respondents' responses on Nurses' reaction towards clients when providing Family Planning services at the health facility (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Positive	50	100%
Negative	0	0
Total	**50**	**100**

All 100% (50) of the respondents stated that nurse's reaction towards clients was positive.

Table 27: Respondents' reaction to poor Family Planning service from health workers (n=50)

Reaction to poor service	FREQUENCIES	PERCENTAGE
Still go back for reviews	47	94
Not attend reviews	3	6
Total	**50**	**100**

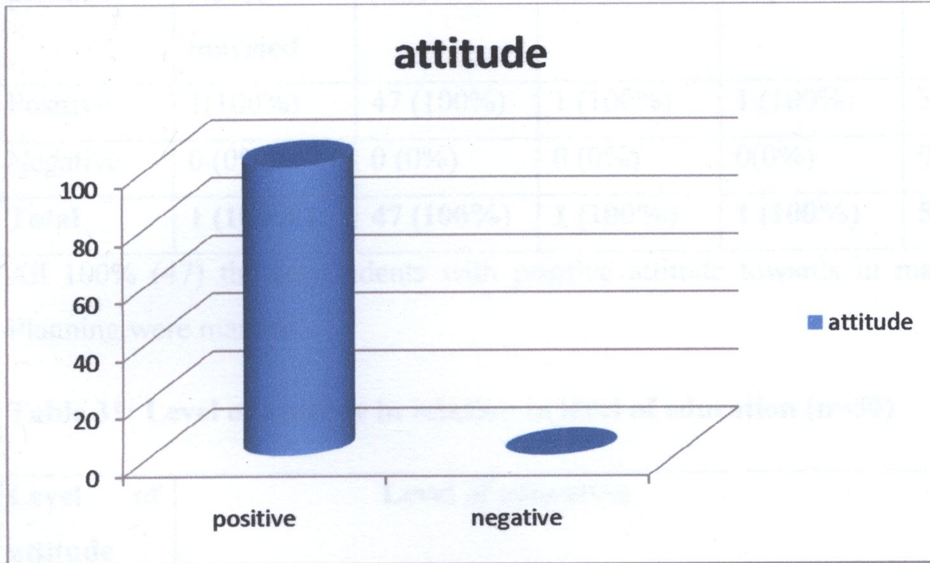
Majority 94% (47) of the respondent's stated that they would still go back for review even if they received poor Family planning services from Health workers while 6% (3) stated they would not attend reviews.

Table 28: Respondents' responses on who makes decision about Family Planning (n=50)

Decision on Family Planning	FREQUENCIES	PERCENTAGE
couple	40	80
husband	10	20
Total	**50**	**100%**

Majority 80% (40) of respondents stated that couples should make decisions on family planning together while 20% (10) stated Husbands should decide.

Figure 4: Level of Attitude (n=50)



All the respondents 100% (50) had a positive attitude towards male involvement in family planning.

Cross tabulation on Relationships among attitude and Demographic variable

Table 29: Level of attitude in relation to Age (n=50)

Level of attitude	Age				
	20-30	**31-41**	**42-52**	**Above 53**	**Total**
Positive	14 (100%)	25 (100%)	7 (100%)	4 (100%)	50 (100%)
Negative	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**14 (100%)**	**25 (100%)**	**7 (100%)**	**4 (100%)**	**50 (100%)**

All 100% (25) the respondents with a positive attitude towards use of male contraceptives were aged 31-41years.

Table 30: Level of attitude in relation to marital status (n=50)

Level of attitude	Marital status				
	Never married	**Married**	**Divorced**	**Separated**	**Total**
Positive	1(100%)	47 (100%)	1 (100%)	1 (100%)	50 (100%)
Negative	0 (0%)	0 (0%)	0 (0%)	0(0%)	0 (0%)
Total	**1 (100%)**	**47 (100%)**	**1 (100%)**	**1 (100%)**	**50 (100%)**

All 100% (47) the respondents with positive attitude towards in male involvement in Family Planning were married.

Table 31: Level of attitude in relation to level of education (n=50)

Level of attitude	Level of education				
	Never been to school	**primary**	**Secondary**	**Tertiary**	**Total**
Positive	2 (100%)	22 (100%)	19 (100%)	7 (100%)	50 (100%)
Negative	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**2 (100%)**	**22 (100%)**	**19 (100%)**	**7 (100%)**	**50 (100%)**

All 100% (22) the respondents with positive attitude towards in male involvement in Family Planning had attained primary level of education.

Table 32: Level of attitude in relation to occupation (n=50)

Level of attitude	Occupation			
	Employed	**Business men**	**Farmer**	**Total**
Positive	26 (100%)	10 (100%)	14 (100%)	50 (100%)
Negative	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**26 (100%)**	**10 (100%)**	**14 (100%)**	**50 (100%)**

All 100% (26) the respondents with positive attitude towards in male involvement in Family Planning were in formal Employment

4.2.4 PRACTICE

Table 33: Respondents' responses on accessibility of Family Planning services (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Hospital	45	90
Chemist	1	2
CHW	4	8
Total	**50%**	**100%**

Majority 90% (45) of the respondents accessed Family Planning services from the Hospital while 2% (1) accessed the services from Chemist.

Table 34: Respondents' responses on Distance to Health Facility (n=50)

Distance	**FREQUENCIES**	**PERCENTAGE**
Less than 5km	25	50
6-10km	17	34
11km and above	8	16
Total	**50**	**100%**

Most 50% (25) of respondents lived less than 5km from the Hospital while 16% (8) lived 11km and more from the Hospital.

Table 35: Respondents' responses on whether they had ever used male method of contraception (n=50)

Ever used male method of contraceptive	**FREQUENCIES**	**PERCENTAGE**
Yes	33	66
No	17	34
Total	**50**	**100%**

Majority 66% (33) of respondents said that they had used male contraceptive while 34% (17) had never used any method of contraception.

Table 36: Respondents' responses on method used (n=50)

Methods used	FREQUENCIES	PERCENTAGE
Condoms	28	56
Withdrawal	4	8
Abstinence	2	4
Never used	16	32
Total	**50**	**100%**

Most 56% (28) of respondents said that they had used condoms while 8 %(4) had used withdrawal method of contraception.

Table 37: Respondents' reason for non use of male method of contraceptive (n=50)

Non use of male method of contraceptive	FREQUENCIES	PERCENTAGE
Wife is on contraceptive	14	28
Women don't approve	3	6
Against religious belief	1	2
No response	32	64
Total	**50**	**100%**

Most 64% (32) gave no responses to why they were not using male methods of contraceptives and 2% (1) stated that it was against their religious beliefs to use contraceptives.

Table 38: Respondents' responses on whether their partner was using a Family Planning method (n=50)

RESPONSES	FREQUENCIES	PERCENTAGE
Yes	46	92
No	4	8
Total	**50**	**100%**

Majority 92% (46) of the respondent's partners were using a method of family planning while 8% (4) were not.

Table 39: Respondents' responses on method of contraceptive partner was on (n=50)

Contraceptive partner using	FREQUENCIES	PERCENTAGE
Injectable	21	42
Jadelle	5	10
Oral contraceptive	15	30
BTL	5	10
Not on any F.P	4	8
Total	**50**	**100%**

Most 42% (21) of the respondent's partners were on Injectable method of family planning while 30% (15) were on oral contraceptives.

Table 40: Respondents' responses on whether they were accessing Family Planning methods easily (n=50)

Accessing family planning	FREQUENCIES	PERCENTAGE
Yes	33	66
No	17	34
Total	**50**	**100%**

Majority 66% (33) of the respondents said that they were accessing family planning methods easily while 34% (17) were not.

Table 41: Respondents' reasons for accessing Family Planning methods (n=50)

Accessibility of family planning	FREQUENCIES	PERCENTAGE
Improves standards of living	50	100
No response	0	0
Total	**50**	**100%**

All 100% (50) of the respondents stated that accessing family planning methods leads to improvement of standards of living.

Figure 5: Level of Practice (n=50)

All the respondents 100% (50) had a satisfactory level of practice in family planning.

Cross tabulation on Relationship among Practice and Demographic variable

Table 42: Level of Practice in relation to Age (n=50)

Level of practice	Age				
	20-30	**31-41**	**42-52**	**Above 53**	**Total**
Satisfactory	14 (100%)	25 (100%)	7 (100%)	4 (100%)	50 (100%)
Unsatisfactory	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**14 (100%)**	**25 (100%)**	**7 (100%)**	**4 (100%)**	**50 (100%)**

All 100% (25) the respondents with a satisfactory level of practice in family planning were aged 31-41 years.

Table 43: Level of practice in relation to marital status (n=50)

Level of practice	Marital status				
	Never married	**Married**	**Divorced**	**Separated**	**Total**
Satisfactory	1 (100%)	47 (100%)	1 (100%)	1 (100%)	50(100%)
Unsatisfactory	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**1 (100%)**	**47 (100%)**	**1 (100%)**	**1(100%)**	**50(100%)**

All 100% (47) the respondents with a satisfactory level of practice of family planning were married.

Table 44: Level of practice in relation to level of education (n=50)

Level of practice	Level of education				
	Never been to school	**Primary**	**Secondary**	**Tertiary**	**Total**
Satisfactory	2 (100%)	22(100%)	19(100%)	7(100%)	50(100%)
Unsatisfactory	0 (0%)	0(0%)	0(0%)	0(0%)	0(0%)
Total	**2 (100%)**	**22(100%)**	**19(100%)**	**7(100%)**	**50(100%)**

All 100% (22) the respondents with a satisfactory level of practice in family planning had attained primary level of education.

Table 45: Level of practice in relation to occupation (n=50)

Level of practice	Occupation			
	Employed	**Business men**	**Farmer**	**Total**
Satisfactory	26(100%)	10(100%)	14(100%)	50(100%)
Unsatisfactory	0(0%)	0(0%)	0(0%)	0(0%)
Total	**26(100%)**	**10(100%)**	**14(100%)**	**50(100%)**

All 100% (26) the respondents with a satisfactory level of practice in family planning were in formal Employment.

4.2.5 ACCEPTANCE

Table 46: Respondents' responses on whether they approved family planning method to be used by their wives (n=50)

Approve of family planning	**FREQUENCIES**	**PERCENTAGE**
Yes	49	98
No	1	2
Total	50	100%

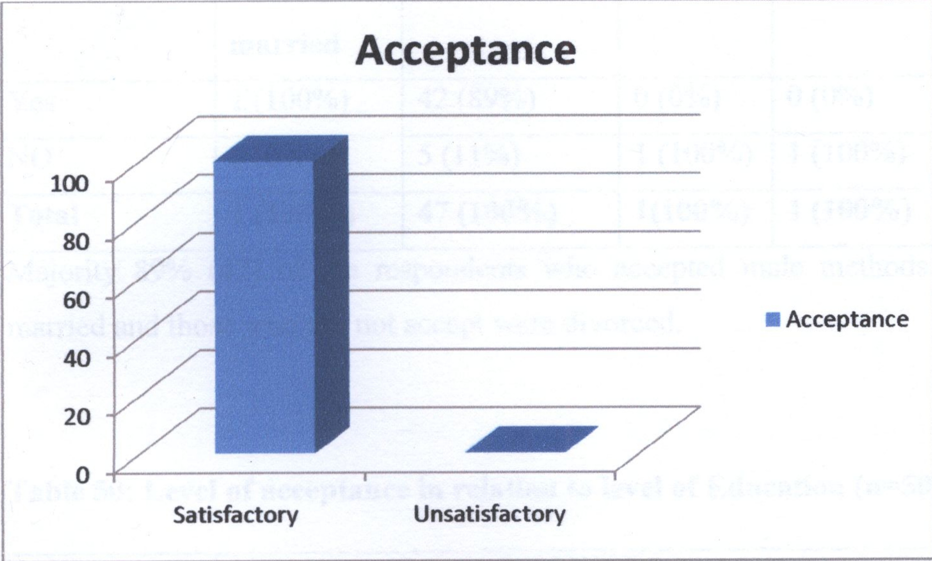
Majority 98% (49) of the respondents approved use of family planning by their wives while 2% (1) did not approve.

Table 47: Respondents' responses on whether their partner approved use of male methods of family planning (n=50)

Partner approved use of family planning	**FREQUENCIES**	**PERCENTAGE**
Yes	29	58%
No	21	42%
Total	**50**	**100%**

Most 58% (29) of the respondent's partners approved use of male method of contraceptive while 42% (21) respondent's partners did not approve the use.

Figure 6: Level of Acceptability (n=50)



All 100% (50) the respondents had a satisfactory level of acceptability of family planning.

Cross tabulation on Relationships among Acceptance and Demographic data

Table 48: Acceptance in relation to Age (n=50)

Acceptance	Age				
	20-30	**31-41**	**42-52**	**Above 53**	**Total**
Acceptance	12(86%)	23(92%)	6(86%)	3(75%)	44(88%)
NO	2(14%)	2(8%)	1(14%)	1(25%)	6 (12%)
Total	**14(100%)**	**25 (100%)**	**7(100%)**	**4(100%)**	**50(100%)**

Majority 92% (23) of respondents who accepted male method of contraceptives were aged 31-41 years and those who did not accept were aged 20-30years 14% (2).

Table 49: Acceptance in relation to marital status (N=50)

Acceptance	Marital status				
	Never married	**Married**	**Divorced**	**Separated**	**Total**
Yes	1 (100%)	42 (89%)	0 (0%)	0 (0%)	44(88%)
NO	0 (0%)	5 (11%)	1 (100%)	1 (100%)	6(12%)
Total	**1 (100%)**	**47 (100%)**	**1(100%)**	**1 (100%)**	**50(100%)**

Majority 89% (42) of the respondents who accepted male methods of family planning were married and those who did not accept were divorced.

Table 50: Level of acceptance in relation to level of Education (n=50)

Acceptance	Level of Education				
	Never been to school	**Primary**	**Secondary**	**Tertiary**	**Total**
Yes	2(100%)	18 (82%)	18 (95%)	6 (86%)	44(88%)
NO	0 (0%)	4 (18%)	1 (5%)	1 (14%)	6 (12%)
Total	**2(100%)**	**22 (100%)**	**19 (100%)**	**7 (100%)**	**50(100%)**

Majority 95% (18) of the respondents who accepted use of male contraceptives attained secondary level of education while 5% (1) with non acceptance also attained secondary level of education.

Table 51: Acceptance in relation to occupation (n=50)

Acceptability	**Occupation**			
	Employed	**Business men**	**Farmer**	**Total**
Yes	24 (92%)	9 (90%)	11(79%)	44 (88%)
NO	2 (8%)	1 (10%)	3 (21%)	6 (12%)
Total	**26 (100%)**	**10 (100%)**	**14 (100%)**	**50 (100%)**

Majority 90% (9) of the respondents who accepted use of male contraceptives were business men while 8% (2) who did not accept were in formal Employment.

4.2.5 RELATIONSHIPS AMONG KNOWLEDGE, ATTITUDE, PRACTICE AND ACCEPTANCE

Table 52: level of knowledge in relation to level of attitude (n=50)

Level of knowledge in F.P	**Level of attitude**		
	Positive	**Negative**	**Total**
low	1(2%)	0 (0%)	1 (2%)
medium	39 (78%)	0 (0%)	39 (78%)
High	10 (20%)	0 (0%)	10 (20%)
Total	**50 (100%)**	**0 (0%)**	**50 (100%)**

Most 20 %(10%) of respondents had high level of knowledge on male involvement in family planning and a positive attitude towards male involvement in family planning.

Table 53: level of knowledge in relation to level of practice towards family planning methods (n=50)

Level of knowledge of F.P	Level of practice		
	Satisfactory	**Unsatisfactory**	**Total**
Low	1(2%)	0 (0%)	1 (2%)
Medium	39 (78%)	0 (0%)	39 (78%)
High	10 (20%)	0 (0%)	10 (20%)
Total	**50 (100%)**	**0 (0%)**	**50 (100%)**

Majority 78% (39) of the respondents had medium level of knowledge on male involvement towards family planning and satisfactory level of family planning practice.

Table 54: level of knowledge in relation to level of acceptance towards family planning (n=50)

Level of knowledge of F.P	Level of acceptance		
	Acceptance	**Non acceptance**	**Total**
Low	1(2%)	0(0%)	1(2%)
Medium	35(78%)	4(80%)	39(78%)
High	9(20%)	1(20%)	10(20%)
Total	**45 (100%)**	**5 (100%)**	**50 (100%)**

Majority 78 %(35) of the respondents had medium level of knowledge on male involvement in family planning and had accepted the use of family planning.

Table 55: level of Knowledge in relation to source of information on family planning (n=50)

Level of Knowledge	Source of information on family planning					
	Hospital	**Friends**	**Wife**	**Parents**	**Newspaper**	**Total**
High	5(19%)	0(0%)	2(17%)	1(50%)	2(29%)	10(20%)
Medium	22(81%)	1(50%)	10(83%)	1(50%)	5(71%)	39(78%)
low	0(0%)	1(50%)	0(0%)	0(0%)	0(0%)	1(2%)
Total	**27(100%)**	**2(100%)**	**12(100%)**	**2(100%)**	**7(100%)**	**50(100%)**

Majority 81% (22) of the respondents with medium knowledge on family planning source of information was the hospital while those 50% (1) with low knowledge's source of information on family planning were friends.

Table 56: level of attitude in relation to level of practice towards family planning (n=50)

Level of attitude	Level of Practice		
	satisfactory	**Unsatisfactory**	**Total**
Positive	50 (100%)	0 (0%)	50 (100%)
Negative	0 (0%)	0 (0%)	0 (0%)
Total	**50 (100%)**	**0 (0%)**	**50 (100%)**

All 100% (50) the respondents who had a positive attitude towards family planning practice had a satisfactory level of family planning practice.

Table 57: level of attitude in relation to who makes decision on family planning (n=50)

Level of attitude	Decision on family planning			
	couple	Husband	wife	Total
Positive	40(100%)	10(100%)	0(0%)	50(100%)
Negative	0(0%)	0(0%)	0(0%)	0(0%)
Total	**40(100%)**	**10(100%)**	**0(0%)**	**50(100%)**

All 100% (40) of the respondents with a positive attitude towards decision on family planning were couples while 100% (10) were husbands.

Table 58: Methods of family planning used in relation to religious denomination (n=50)

Method used	Religious denomination					
	Roman catholic	Baptist	Seventh day Adv	UCZ	Jehovah's witness	Total
Condoms	0(0%)	9(47%)	1(100%)	3(75)	10(53%)	23(46%)
Withdrawal	1(14%)	2(11%)	0(0%)	0	1(5%)	4(8%)
Abstinence	5(71%)	0(0%)	0(0%)	1(25%)	1(5%)	7(14%)
Never used family planning methods	1(14%)	8(42%)	0(0%)	0(0%)	7(37%)	16(32%)
Total	**7(100%)**	**19(100 %)**	**1(100%)**	**4(100%)**	**19(100%)**	**50(100%)**

Most 47% (9) of the respondents who used condoms as a method of family planning were Baptist , while 71% (5) of Roman Catholics used Abstinence.

Table 59: level of attitude in relation to method of contraceptives used (n=50)

Level attitude	**Method of contraceptive used**				
	condoms	**withdrawal**	**Abstinence**	**Never used**	**Total**
Positive	27(100%)	5(100%)	2(100%)	16(100%)	50(100%)
Negative	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)
Total	**27(100%)**	**5(100%)**	**2(100%)**	**16(100%)**	**50(100%)**

All 100% (27) the respondents had a positive attitude towards use of condoms as a form of family planning method.

Table 60: level of practice in relation to distance to health facility (n=50)

Level of Practice	**Distance to health facility**			
	Less than 5km	**6-10km**	**11km and above**	**Total**
Satisfactory	26(100%)	18(100%)	6(100)	50(100%)
Unsatisfactory	0(0%)	0(0%)	0(0%)	0(0%)
Total	**26(100%)**	**18(100%)**	**6(100%)**	**50(100%)**

All 100% (26) the respondents with a satisfactory level of family planning practice resided less than 5km from health facility.

Table 61: level of Acceptance in relation to method of contraceptive partner is using (n=50)

Acceptance	Method partner is using				
	Injectable	**Oral contraceptive**	**Jadelle**	**Bilateral Tuba ligation (BTL)**	**Total**
Acceptance	19(90%)	13(93%)	7(78%)	4(80%)	43(88%)
No	2(10%)	1(7%)	2(22%)	1(20%)	6(12%)
Total	**21(100%)**	**14(100%)**	**9(100%)**	**5(100%)**	**49(100%)**

Majority 90% (19) of the respondents who accepted use of family planning method used Injectable, while 10% (2) did not accept use of Injectable as a method of contraceptives.

11km from the health facility's source of information on family planning was the radio, newspapers or Television.

SUGGESTIONS BY RESPONDENTS

Table 62: Respondent's suggestions (n=50)

SUGGESTIONS	FREQUENCY	PERCENTAGE
Massive sensitization to men about male involvement in family planning	20	40%
Hold meeting/workshops	17	34%
Form clubs/male clinic in family planning	10	20%
Formulation of family planning policy that couple access family planning together	3	6%
Total	**50**	**100%**

CHAPTER FIVE

5.0 DISCUSSION ON FINDINGS AND IMPLICATION FOR THE HEALTH CARE SYSTEM

5.1 CHARACTERISTICS OF THE SAMPLE

The demographic characteristics of the respondents which were relevant to this study included; age, marital status, occupation, residence, education level, religion, number of children, age difference between the last two children and tribe. The information on the demographic characteristic was essential for interpretation of study findings.

The sample comprised of men aged from 20 years to 53 years and above. Most 50% (25) of the respondents were aged between 31-41 years (Table 3). This shows that most of the respondents were in the middle age where one is expected to be married and use methods of contraceptives.

The study revealed that majority 72% (36) of the respondents resided less than 5km from the health facility (Mpongwe Hospital area) and 8% (4) resided above 11km (Table 4). Distance from health facility may affect accessibility of family planning services.

The majority 94% (47) of the respondents were married (Table 5). This indicates that marriage is still a valued institution in Zambia. Culturally men are expected to get married at a certain age.

Most of the respondents were either Baptist 38% (19) or were Jehovah's Witness 38% (19) (Table 6). Although there were more respondents who were Baptist and Jehovah's witnesses, all respondents were Christians who belonged to different religious denomination. This could be attributed to the fact that Zambia has been declared as a Christian nation.
Most of the respondents had attained primary education 44% (22), 14% (7) of the respondents had attained Tertiary education, while 38% (19) and 38% (19) had attained secondary school education (Table 7). Several studies have shown an association between education level and use of family planning methods, for instance a study conducted by Moronkola (2006) in Nigeria revealed that the majority of the respondents who attained secondary and tertiary education were utilizing family planning methods.

Most 52% (26) of the respondents were formally employed (Table 8). This finding is supported by the 2001 -2002 ZDHS report which revealed that the employment rate among Zambians is low.

Most 38% (19) of the respondents had 1-2 children and 16% (8) had 7 and above children (Table 9). The finding revealed a progressive decrease in contraceptive use as the number of children increased as evidenced by the fewer number of respondents who had more than 7 children. This finding could be attributed to the reduced total fertility rate (TFR) in the country which has resulted in couples having 1-2 children hence an indication that somehow family planning is being used by couples. According to the 2001-2002 ZDHS report, the current fertility level for Zambia as a whole (total fertility rate) is 5.9. This means that the average Zambian woman who is at the beginning of her childbearing years will give birth to 5.9 children by the end of her reproductive period if fertility levels remain constant at the level observed in the three-year period before the 2001-2002 ZDHS (CSO, 2003).

Majority 92% (46) of respondents had their last two children age difference of 1-3 years and 8% (4) had an age difference between 4-6years (Table 10). The recommended child spacing age is at least 2 years. This means that some of the respondents were not adequately spacing their children.

Most 48% (24) of the respondents were Lamba speaking people (Table 11). The high percentage of Lamba's who took part in the study could be attributed to the fact that the study was conducted in Lamba speaking people.

5.2 DISCUSSION OF EACH VARIABLE

The dependent variable was male involvement in family planning. The independent variables are discussed in relation to the dependent variable and they include practice, accessibility, knowledge and attitude.

Knowledge on male involvement in family planning

According to Levy (2006) when men are empowered with knowledge on family planning their involvement will be high. Appropriate knowledge on family planning is vital for men because they are decision makers in homes and have influence on women's contraceptives choice. Once men are

knowledgeable about family planning women will be fully supported on their choice of contraception.

In this study majority 88% (44) of the respondents were able to define family planning as having a child at an appropriate time while 4% (2) stated that family was allowing only women to seek family planning services (Table 13). There is need to educate all the men about family planning so that they are knowledgeable to increase on their involvement in family planning matters.

The men were also assessed as to whether they knew the meaning of male involvement in family planning. Most 56% (28) of the respondents stated that men supporting their partners in the use of family planning while 16% (8) gave no response (Table 14). When men are aware of the meaning of male involvement then they will be fully involved in family planning matters.

According to ZDHS (2001-2002) state that the knowledge on family planning was almost universal in Zambia. In this study All 100% (50) of the respondents had heard of family planning methods available in Zambia (Table 15). 60% (30) of the respondents were able to mention 6-11 methods of contraceptives while 40% (20) mentioned 5 methods and below (Table 16). This is an indication that men had knowledge on family planning methods available in health institutions.

The change in men's knowledge on vasectomy will enable men to access the service widely. According to the Study done by Jayalakshimi et al, (2002) knowledge on Vasectomy by men was low in many countries. In this study majority 60% (30) of the respondents had never heard about permanent methods of family planning while 40% (20) had heard about it (Table 17). Majority 74% (37) of the respondents were unable to state what vasectomy was while 26% (13) were able to state vasectomy correctly (Table 18). The low percentage of knowledge in vasectomy was due to inadequate knowledge by men on the method.

In this study, majority 54% (27) of respondents' source of information was the health workers followed by 24% (12) from wives (Table 19). The findings indicate health workers are providing IEC to clients at the health facilities and should be encouraged to continue doing so.

According to the Study done by Gallen et al, (2001) concluded that family planning when widely used the country's economy improves and women and children health is boosted. This is consistent with what the respondents stated on the benefits of using family planning. Majority 66% (33) of the respondents stated that children are well spaced while 4% (2) stated that family planning prevents maternal/ child mortality (Table 20).

The NCDP (1989) reveal that when family planning is not used the population increases leading to poor economy and there is increase in maternal deaths due to abortions as many pregnancies are unwanted. Majority of the respondents 80% (40) of the respondents stated that when family planning is not used it leads to increase in unwanted pregnancies while 4% (2) stated that it leads to poor living standards (Table 21). Therefore male involvement in family planning can enable family planning services to be widely used and promote good health to women and children.

With regard to the respondents' knowledge in relation to education attainment, the study showed that the majority 71% (5) of the respondents who had high knowledge on male method of family planning had attained Tertiary education while 84% (16) had attained secondary education (Table 24). Generally, respondents who had attained higher education (secondary and tertiary) had high knowledge on family planning. These finding are consistent with the findings of the study done by Levy (2006) which showed an association between men's education level and knowledge level.

The study revealed that the overall knowledge for men on family planning was high (fig 3). This assertion is in line with the 2001-2002 ZDHS report which showed that high knowledge on family planning was almost universal in Zambia.

5.2.1 ATTITUDE

The study done by Rashid et al, (2003) revealed that the attitude of males in the use of family planning is relatively positive when knowledge on family planning is enhanced by men. The findings of this study are in line with the findings done by Rashid. All 100% (50) of the respondents stated that nurse's reaction towards clients was positive when the family planning services are provided (Table 26). The nurses provide IEC to men on family planning issues hence knowledge is enhanced leading to positive attitude towards their involvement in family planning. The findings further revealed that majority 94% (47) stated that they will still seek family planning services even when they received poor services while 6% (3) stated they wouldn't seek the family planning services (Table 27).

Traditionally in Africa men decide on a number of children a couple should have. This notion is slowly changing, for example in this study 80% (40) of the respondents stated that a couple should make a decision on a family planning method to use while 20% (10) stated husbands should make a decision (Table 28). This is in line with study done by Shahriary (1999) which he concluded that

effective results on family planning are obtained when couples plan together on family planning matters.

The results of this study revealed that majority 66% (33) of the respondent were accessing family planning while 34% (17) were not accessing (Table 40). The findings indicated a positive attitude towards the use of family planning. The findings also indicated a positive attitude towards family planning regardless of education or marital status respondents had (Figure 4).

When men's attitude towards use of male method of contraceptive is positive then the male methods of contraceptives will be widely used. Most 66% (33) of the respondents had used male methods of contraceptives (Table 35). These findings indicate a positive attitude towards the use of male methods of contraceptives. This is consistent with the study done by Rashid (2003) in which he concluded that the use of family planning by men is dependent on positive attitude towards the available methods.

5.2.2 PRACTICE

According to the study done by Kerner et al, (2011) revealed that men facilitated contraceptive use for them to seek the contraceptive methods from health professionals. The results further revealed that, the intervention's content and its training in communication skills were essential mechanisms for successfully enabling men and their partners use contraceptives. Majority 90% (45) of the respondent's accessed family planning services from the Hospital while 8% (4) accessed from CHW (Table 33). All the sites where respondents accessed family planning provide education in family planning for men and their partners to access the service.

Distance to a health facility affect men accessing family planning services. The findings of this study indicated that most 50% (25) of the respondents resided 5km from the health facility while 16% (8) resided 11km and above from the health facility (Table 34). The low percentage to those who resided 11km and above could be attributed to the fact that most roads in these areas are bad and also public transport is a problem.

The study has revealed that most 56% (28) of the respondents had used condoms while 8%(4) had used withdrawal method of contraception (Table 36) .This could be attributed to the fact that there has been so much sensitization on condom used by HIV/AIDS prevention program. The finding is

also consistent with the study done by Nsemukila's B. et al (1998) which revealed that condoms were the most commonly used methods in Zambia.

Despite the centrality of religion and fertility to life in rural Africa, the relationship between the two remains poorly understood. According to the study done by Trinitapoli et al, (2008) concluded that religion has influences on contraceptive use. These findings are in line with findings of this study in that most 64% (32) of the respondents gave no responses to why they were not using male methods of contraceptives while 2% (1) stated it was against their religious beliefs to use contraceptives (Table 37).

According to the study done by Rashid et al, (2003) further revealed that decision making regarding use of contraceptives should be a joint process between couples. Majority 92% (46) of the respondent's stated that their partners were using family planning while 8% (4) were not (Table 38). The findings therefore, indicate that men were communication with their partners on contraceptive use for them to be aware of the methods their partners were on. Most 42% (21) of the respondent's partners were on Injectable method of family planning while 30% (15) were on oral contraceptives (Table 39)

The use of family planning bears more advantages to the users. In this study all 100% (50) of the respondents stated that accessing family planning methods leads to improved living standards (Table 41). When health professional provide quality family planning services male involvement in family planning is achieved. All the respondents 100% (50) had a satisfactory level of practice in family planning (figure 5).

5.2.3 ACCEPTANCE

Culturally men are decision makers in most African countries. According to the study done by Char et al, (2011) reveal that men dominate when a decision is to be made on type of contraceptives to be used as a couple. In this study majority 98% (49) of the respondents approved the use of family planning while 2% (1) did not approve (Table 46). The effectiveness of the use of family planning methods requires a couple to agree on the method to use. Most 58% (29) of the respondent's partners approved use of male methods of contraceptives while 42% (21) respondent's partners did not approve the use of male methods of contraceptives (Table 47).

The acceptance of use of male contraceptives may be dependent on the age of the user. In this study majority 92% (23) of the men who accepted the use of male methods of contraception's age ranged between 31 -41years old (Table 48). This could be attributed to the fact that the men in this study had an exposure to IEC regarding family planning. These findings are consistent with the study done by Char et al (2011) in which he concluded that when men are educated on family planning methods available on the market, the level of acceptance of the use of family planning is also higher.

Figure 6 illustrates that all the respondents had a satisfactory level of acceptability of family planning use. This finding is consistent with the findings of a study done by Patel et al (2000) which revealed that men who were knowledgeable and had accepted the use of contraceptives were utilizing the family planning services than those who were not knowledgeable and did not accept the use of family planning.

Religious beliefs can have strong influence on the men's choice of contraceptive method. The study has revealed that the majority 100% (1) of the seventh day Adventists respondents' accepted condoms as family planning methods while 14% (1) of the catholic respondents' did not accept use of family planning method (Table 58). This could be attributed to the social stigma associated with condom use where most people thinks that condom promote immorality.

5.3. SIGNIFICANCE TO NURSING

5.3.1 Nursing Practice

According to Mayor et al (2006), practice may be defined as a way of doing something, especially as a result of habit, custom, or tradition. Practice is the actual performance of an activity in a real situation. The study revealed that level of knowledge did not interfere with men's practices in family planning and that practices in family planning was not any way influenced by occupation one had. Nursing practice should be tailored to embrace certain rights that are already recognized in the national laws and the new knowledge that is generated from various researches should be incorporated into nursing practice to improve the service delivery. Counselling should be the appropriate tools to assist men make decisions and access family planning for them to be more involved in family planning matters. The developed Guidelines and protocol for family planning should be developed, monitored and evaluated regularly to ensure that the standards of practice in

nursing are maintained for the benefit of the clients and the nation as a whole. Nurses are the majority of health workers in the health care system in Zambia who plays an important role in providing counseling and giving health education on family planning maters.

5.3.2 Research

The knowledge and determinants of the choice of contraceptive are dynamic because of changes in the environment emanating from medical and technological advancements and innovations and require constant research to foster improvement in the delivery of family planning services. More studies are needed to assist in developing new tools which can be used to disseminate information for men to be involved in family planning. Research is also needed to explore areas which hinder men from actively participate in family planning. When men are involved in family planning the nation can benefit as the population reduces to levels which the nation can manage.

5.3.3 Administration

The study revealed a knowledge deficit on vasectomy as a method of contraception among men. The Nursing administrators should therefore put measures to educate men on available methods of contraceptives offered in Mpongwe District. For the success of male involvement in family planning, stocks of male methods of contraceptives should always be available therefore Family planning administration should order the stocks and monitor the usage. Although the study had revealed a large number men accessing family planning services at the health facility 34% (17) were not. This calls for deployment of more staff to the reproductive health Department in order to improve coverage to 100%.

5.3.4 Education

The study revealed that most of the respondent's source of information on family planning was the health facility which revealed that the health professionals were providing the services in family planning. The Health professionals should be commended for the good work they are doing and should be encouraged to continue their good works. However, it is prudent that the curriculum for nursing be regularly reviewed to accommodate new information on reproductive health so as to enable the health training institutions produce knowledgeable, skillful and competent health

workers who are ready to provide a quality service to the clients in need of reproductive health services.

5.4 CONCLUSION

Once the proposal was done, the researcher went ahead and sought permission from the District Director of Health (Mpongwe District) and data was collected from 50 men who were randomly selected. The data was then edited for completeness and errors and no omissions were found. Data was then coded using numerical values. Open ended responses were categorized and coded as well. After that, the data was entered manually on a data master sheet. Data was presented using frequency tables and figures for easy analysis. Cross tabulations were also used to show relationships between variables. Calculations were done using a calculator. The purpose of the study was to assess the knowledge, practice and attitudes of men towards male involvement in family planning in Mpongwe District. The study findings revealed that 50% (25) of the respondents were within the age group 31 to 41 years, 72% (36) resided in Mpongwe Hospital area (within 5km from health facility) and 94% (47) were married. Most 38% (19) of the respondents were Jehovah's Witness.44% (22) had attained primary level of education and 52% (26) were in formal employment. Most 38% (19) of the respondents had children in the range of 1-2, 92% (46) had children's age difference between last two ranging from 1-3 years and 48% (24) were Lamba by tribe. The study further revealed the influence of religion on family planning use, 28% (14) of the respondent's religious denomination accepted the use of condoms as a method of family planning while 2% (1) of the respondent's religious denomination did not accept condoms as a family planning method.

5.5 RECOMMENDATIONS

The researcher made the following recommendations in view of study made:

5.5.1. TO THE MINISTRY:

1. The government through Ministry of Health should make a policy which will enable couples to access family planning together this will make men to be more involved in family planning.

2.The MOH should train, trainers of trainer in male involvement in family planning in all provinces of Zambia so that massive education could be provided in form of meetings with men, sensitization through drama, workshops and production of materials which contain information on male methods of contraception.

3.The Ministry of Health should intensify the training and capacity building programs for health providers on latest information on contraceptive technology for men so that a highly competent health provider will effectively interact with the men and inform them about the risks and benefits of contraceptive use and this will help men to achieve their reproductive goals.

5.5.2. TO DISTRICT HEALTH OFFICES:

1. The District Health Management Team should ensure contraceptive security at all levels of service delivery through improved logistic management to ensure consistence supply of male methods of contraceptives. When there is consistence with the supply of various contraceptive methods, everyone who wants to use family planning would be able to choose and use contraceptive method of their choice.

2. The District Health Management Team should continue to sensitize men on the availability of permanent family planning for men (vasectomy) at Mpongwe Mission Hospital and St Theresa Mission Hospital so that men could access the service.

5.5.3. TO OUT- REACH CENTRE'S (THE STUDY INSTITUTION)

1.Family planning providers to fully use men who are actively involved in family planning to educate other men so that more men are aware of male methods of contraception.

2. There is need to have three to four nurses during out-reach days, this is to intensify Health Education on family planning in order to increase coverage.

5.6 DISSEMINATION OF FINDINGS

According to Polit and Hungler (2001), dissemination of findings entails the measures that would be undertaken to communicate the findings from the study to other people. The researcher will make a presentation on the findings of the study to Mpongwe District Health Management Team

and Mpongwe Mission Hospital management. A copy of the summary of research findings will be provided to the health centre's (study locations) where the study participants will access the information about the research findings. Other copies will be made available to key stakeholders; the University of Zambia through the School of Medicine library and the Department of Nursing Sciences.

5.7 LIMITATIONS TO THE STUDY

The limitation of the study was that the sample size of 50 respondents was too small to generalize the findings onto the general population of Mpongwe District. The criteria used to determine the sample size was the availability of resources such as period of time in which the study was to be conducted, manpower and finances. The sample was drawn from men who accessed family planning which created a bias to those who never accessed the service (family planning).

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APPENDIX 1

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

STRUCTURED INTERVIEW SCHEDULE

TOPIC: MALE INVOLVEMENT IN FAMILY PLANNING SERVICES IN MPONGWE MISSION HOSPITAL CATCHMENT AREA

Serial No. [ ]

Date of Interview..

Place of interview..

INSTRUMENTS TO INTERVIEWER

1. Greet the respondent and introduce your self
2. Explain the purpose of the interview
3. Write serial numbers on interview schedule and not names
4. Get verbal and written consent from the respondents
5. Tick responses in the space provided [ ] for answers with alternatives
6. Write responses in the blank space provided for questions that require explanations
7. Reassure the respondents of confidentiality about their responses
8. Thank the respondents at the end of each interview

For Official use

SECTION A: DEMOGRAPHIC DATA

1. How old were you on your last birthday? ....

2. Where do you stay?..

3. What is your current marital status?

   1. Never married [ ]
   2. Married (monogamous) [ ]
   3. Married (polygamous) [ ]
   4. Separated [ ]
   5. Divorced [ ]
   6. Widowed/ widower [ ]
   7. Co-habiting [ ]

4. What is your Religious denomination?

   (a) Roman catholic [ ]

   (b) Baptist [ ]

   (c) Seventh day Adventist [ ]

   (d) United Church of Zambia [ ]

   (e) Others specify..

5. What is your highest level of education?

   a. Primary education [ ]
   b. Secondary education [ ]
   c. Tertiary education [ ]
   d. Never been to school [ ]

6. What is your occupation?

a) Employed full time [ ]

b) Farmer [ ]

c) Business man [ ]

7. How many children do you have?

....

8. What is the age difference between the last two?

....

9. What is your tribe?

....

SECTION B: KNOWLEDGE OF FAMILY PLANNING

10. In your own understanding what is family planning? (Choose the most accurate /correct answer)

a) Having a child at an appropriate time and a method of contraceptive is used to prevent pregnancy. [ ]

b) Spacing the children [ ]

c) Allowing only women to seek family planning service` [ ]

11. In your own understanding what is male involvement in family Planning?

....

....

....

....

....

12. Have you ever heard of family planning methods?

a) Yes [ ] b) No [ ]

13. If yes which type of family planning method do you know?

1. Oral contraceptives [ ]
2. Abstinence [ ]
3. Loop [ ]
4. Diaphragm [ ]
5. Condoms [ ]
6. Vasectomy [ ]
7. Withdrawal [ ]
8. Natural [ ]
9. Injectable [ ]
10. Jadelle [ ]
11. Female sterilization [ ]

14. Tick methods of contraceptives used by males?

a.) Condoms

b) Withdrawal

c) Abstinence

d) Oral contraceptive

e) Vasectomy

15. Have you ever heard of permanent family planning for men?

a) Yes [ ] b) No [ ]

16. If your answer in Q 15 is yes elaborate on the method

....

……………………………………………………………………………………

……………………………………………………………………………………

17.Tick one source of information on family planning use?

1. Hospital [ ]
2. Friends [ ]
3. Wife or girlfriend [ ]
4. Parents [ ]
5. Newspapers, T.V or radio [ ]

18. What are the benefits of using family planning?

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

19. In your opinion what are the disadvantages of not using family planning?

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

SECTION C: ATTITUDE TOWARDS FAMILY PLANNING

20. When you go to access family planning from a health facility, how do Nurses react?

1 Good [ ]

2 Fair [ ]

3 Poor [ ]

21. What is your reaction when not happy with family planning?

Service received at the health facility?

a) Go back when review date is due [ ]

b) a) Not go back to health facility [ ]

22. In your own opinion who should decide on the number of child

ren a couple should have?

1. Husband [ ]
2. Wife [ ]
3. In-laws [ ]
4. Couple [ ]

SECTION D: FAMILY PLANNING PRACTICES AMONG MALES

23. Where do you get your method of contraception?

1. Hospital [ ]
2. Clinic [ ]
3. Chemist [ ]
4. Work place [ ]
5. Community health workers [ ]
6. Trading Shops [ ]

24. How far is your home from the health facility?

a) Less than 5km

b) Between 6 and 10 Km

c) 11 Km and above

25. Have you ever used any male method of contraception?

i) Yes [ ] ii) No [ ]

26. If your answer in Q 25 is yes, what type did you use?

....

27. If your answer in Q 25 is no give reasons?

....

....

28. Is your partner currently using any family planning method?

i) Yes [ ] ii) No [ ] iii) Don't know [ ]

29. If yes to Q 28 which method is she using?...

30. In your own opinion do men easily access family planning services?

i) Yes [ ] ii) No [ ]

31. If the answer to Q 30 is yes elaborate?...

....

SECTION E: ACCEPTABILITY OF FAMILY PLANNING

32. In your own opinion are you able to approve and use family planning?

a) Yes [ ] b) No [ ]

33. What does it benefit the nation when Family Planning is widely used?

....

....

34. Does your partner approve use of male method of contraceptive?

a) Yes [ ]

b) No [ ]

35. What recommendations can you make to actively involve men

In family planning services?..

....

....

THANK YOU FOR PARTICIPATING

University of Zambia

P.O BOX 5011

Lusaka

17th October, 2011.

The District Director of Health

Mpongwe District

P.O. Box 55

Mpongwe.

UFS: The Hospital Superintendent

Ibenga Mission Hospital,

Mpongwe.

Dear Sir/Madam,

REF: PERMISSION TO CARRY OUT A PILOT STUDY

Iam a 4th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a degree in Nursing.

As a partial fulfillment of this programme, Iam required to conduct a research study. The Topic of my study is ''Male involvement in Family Planning services''. I therefore write to request for permission to carry out the pilot study at your institution. I intend to conduct this pilot study on the 28th October 2011 at Maternal Child Health Department (MCH).

Yours Faithfully

Kasoka Ruth.

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

P.O BOX 5011

Lusaka

17th October, 2011.

The District Director of Health

Mpongwe District

P.O. Box 55

Mpongwe.

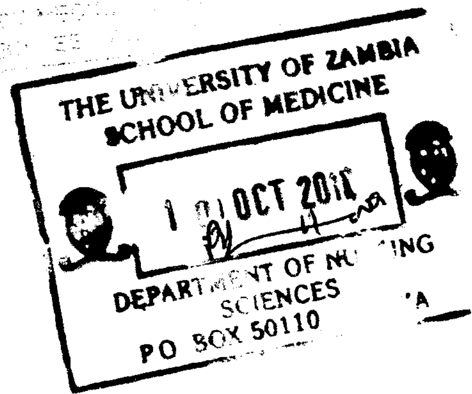
UFS: The Hospital Superintendent

Ibenga Mission Hospital,

Mpongwe.

No objection

DMO



Dear Sir/Madam,

REF: <u>PERMISSION TO CARRY OUT A PILOT STUDY</u>

Iam a 4th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a degree in Nursing.

As a partial fulfillment of this programme, Iam required to conduct a research study. The Topic of my study is ''Male involvement in Family Planning services''. I therefore write to request for permission to carry out the pilot study at your institution. I intend to conduct this pilot study on the 28th October, 2011 at Maternal Child Health Department (MCH).

Yours Faithfully

Kasoka Ruth.

University of Zambia

P.O BOX 5011

Lusaka

17th October, 2011.

The District Director of Health

Mpongwe District

P.O. Box 55

Mpongwe.

UFS: The Head,

Department of Nursing Sciences,

UNZA.

Dear Sir/Madam,

REF: PERMISSION TO CARRY OUT A RESEARCH

Iam a 4th year student at the University of Zambia, School of Medicine in the Department of Nursi
Sciences pursuing a degree in Nursing.

In a partial fulfillment of this programme, Iam required to conduct a research study. The Topic of n
study is ''Male involvement in Family Planning services''. I therefore write to request for permission
carry out the study at Mpongwe Mission Hospital, Ntanda outreach post, Bwembelelo outreach post a
Shingwa outreach post. I intend to conduct this study from 20th October, 2011 to 24th November, 2011

Yours Faithfully

Kasoka Ruth.

C.C. The Hospital Superintendent, Mpongwe Mission Hospital.

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

P.O BOX 5011

Lusaka

17th October, 2011.

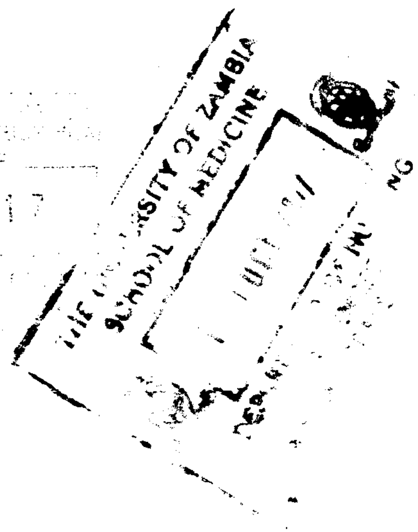
The District Director of Health

Mpongwe District

P.O. Box 55

Mpongwe.

No objection
DMO



UFS: The Head,

Department of Nursing Sciences,

UNZA.

Dear Sir/Madam,

REF: PERMISSION TO CARRY OUT A RESEARCH

Iam a 4th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a degree in Nursing.

In a partial fulfillment of this programme, Iam required to conduct a research study. The Topic of my study is ''Male involvement in Family Planning services''. I therefore write to request for permission to carry out the study at Mpongwe Mission Hospital, Ntanda outreach post, Bwembelelo outreach post and Shingwa outreach post. I intend to conduct this study from 20th October, 2011 to 24th November, 2011.

Yours Faithfully

Kasoka Ruth.

C.C. The Hospital Superintendent, Mpongwe Mission Hospital.

APPENDIX III: WORK PLAN

Activity	Time	Frame	Responsible Person
	Dates	Duration	
Development of Research Proposal	15/06/11-22/06/11	Continuous	Researcher
Data collection tool preparation	08/09/11-16/09/11	8 days	Researcher
Finalize Research Proposal	17/09/11-22/09/11	4 days	Researcher
Clearance letter from authorities	12/10/11-17/10/11	5days	Researcher
Pilot study	20/10/11- 21/10/11	2 days	Researcher
Collection Tool Amendments	22/10/11-23/10/11	2 days	Researcher
Training Research Assistant	24/10/11- 25/10/11	2days	Researcher
Data Collection	26/10/11-9/11/11	10 days	Researcher
Data Analysis	1011/11-24/11/11	10 days	Researcher
Report Writing	25/11/11-8/12/11	10 days	Researcher
Draft Report To DNS Supervisor	09/12/11-16/12/11	6 days	Researcher
Finalize Report	19/12/11-12/03/12	55 days	Researcher
Publication of Results	13/03/12-23/03/12	10 days	Researcher

Appendix IV: Research Budget

Item	Unit Cost	Unit	Total Cost
STATIONARY			
Note Books	5000	2	10,000
Reams of Paper	30000	2	60,000
Pens	1000	10	10,000
Erasers	2000	4	8,000
Tipex	10000	2	20,000
Stapler	15,000	1	15,000
Perforator	50,000	1	50,000
Manila Paper	2,000	6	12,000
Diary	15,000	1	15,000
Pins	500	50	25,000
Scientific Calculator	80,000	1	80,000
Flip Charts	20,000	3	60,000
Markers	7,000	4	28,000
Staples	30,000	1 box	30,000
Box File	30,000	1	30,000
Folder Clips	500	10	5,000
Small Folder	1,000	10	10,000
Field Bag	50,000	2	100,000
Memory Sticks	120,000	1	120,000
SUBTOTAL			688,000
SECRETARIAL MATERIAL			

Questionnaire Typing	2,000	8 pages	16,000
Research Proposal Typing And Binding	2,000	50 pages	100,000
Questionnaire Printing	1000	8	8,000
Research Report Writing	50pagesx2,000	1	100,000
Photocopying Of Final Research Document	250 x 50 pages	6	75,000
Binding Of Research Document	80,000	6	480,000
SUBTOTAL			K779,000
HUMAN RESOURCE EXPENSES			
Transport During Pilot Study	20,000x2 people	x 2days	40,000
Transport (fuel)	40,000	x15 days	600,000
Lunch Allowance For Researcher	50,000x2	15 days	1,500,000
Refreshments For Respondents	5,000	50	250,000
SUBTOTAL			K2,390,000
INFORMATION DESSEMINATION			
Hire For venue	100,000	1 day	100,000
LCD Hire	100,000	1 day	100,000
Refreshments	5000	15 day	75,000
SUBTOTAL			K275,000
TOTAL			K4,827,000
CONTINGENCY 10%			K413,200
GRAND TOTAL			K4,545,200

BUDGET JUSTIFICATION

This research proposal budget has taken into consideration the aspects of stationary, human resource expenses, secretarial services and contingency.

Stationary

Stationary will be very much needed for me to be able to carry out this research with no difficulties. I would need reams of paper for the formulation, amendments and production of pilot study questionnaires which are not included under the costs for the final questionnaires. Memory sticks will be needed for storage of vital information and documents such as questionnaires and analysis of data final data. This is to ensure confidentiality and safety of information collected; a bag will be needed with a zipper for securing data.

Secretarial Material

For the research to be carried out successfully I will need material to be procured such as reams of paper, as well as to have the research findings typed, photocopied and bound at the prevailing rates in the area as captioned in the budget.

Human Resource Expenses

In order to enable the researcher move from point of residence to points where data will be collected during pilot study and final collection of data, transport will be needed and it can either be use of motor bike or Hospital land cruiser since there is no public transport available in those areas. The researcher will also need to have money for lunch for the sake of uniformity; current government rate of missing lunch allowance will be used.

Information Dissemination

At the end of the research the findings will need to be presented to stakeholders that are, the district health office and Mpongwe Mission Hospital.

Contingency Fund

This is 10 percent of the total budget which has been added to cover for unforeseen extra costs and to cushion inflation that might occur in the due course of the research process.

APPENDIX V: GANTT CHART

TASK PERFORMED	RESPONSIBLE PERSON	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Development of research proposal	Researcher										
Finalizing research proposal	Researcher										
Clearance from Authority	Researcher										
Pilot study	Researcher										
Data collection	Researcher										
Data analysis	Researcher										
Report writing	Researcher										
Submission of draft research report to DNS	Researcher										
Finalizing of report	Researcher										
Dissemination of results	Researcher										

Appendix VI: Informed Consent

Dear participant,

My name is Ruth Kasoka; I am a student from the University of Zambia in the School of Medicine, pursuing a Bachelor of Science in Nursing in the Department of Nursing Sciences.

In partial fulfillment of the degree of Bachelor of Science in Nursing, I am required to undertake a research project. My study topic is on Male involvement in Family Planning at Mpongwe Mission Hospital and outreach posts (Ntanda, Bwembelelo and Shingwa).

You have been randomly selected to participate in this study and I wish to inform you that participation in this study is voluntary and you are free to withdraw at any stage of the study if you so wish. You will be asked some questions on knowledge, attitude and practice of family planning. Any information you give me will be kept confidential and no name will be written on the interview schedule.

You will not receive direct benefits from the study or monetary gain. The information you will give will help develop better understanding of male involvement in family planning.

If you have any questions, please contact the head of department of the nursing sciences department of the school of medicine at the University of Zambia Box 50110 Lusaka.

I .... here by called the participant understands the guidelines of this study and I am willing to participate in the study.

Date...

Signature/thumb

Respondent...

Signature Interviewer..

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