FACTORS INFLUENCING MALE INTEREST IN THE USE OF FAMILY PLANNING: A COMPARATIVE STUDY OF RURAL AND URBAN COMMUNITIES IN MONZE DISTRICT OF ZAMBIA

By

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STATEMENT

I hereby certify that this study is in all entirely, the result of my own independent investigations carried out in rural and urban areas of Monze District. The various sources to which I am indebted are gratefully acknowledged in the text and in the references.

SIGNED BY: _____

(STUDENT)

DECLARATION

I hereby declare that the work presented in this study for the Master of Public Health (MPH) is my own work and has not been presented either wholly or in part for any other Master in Public Health degree and is not being currently submitted for any other degree.

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APPROVAL

This dissertation of Ms. Basila Irene Muzyamba is approved in partial fulfillment of the requirements for the award of the degree in Master of Public Health by the University of Zambia.

EXAMINERS' SIGNATURES	DATE
	10.12.03

DEDICATION

This study is dedicated to my beloved sons Macha , Moono, Bwalya and my mother Kasamba.

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ABBREVIATIONS

STD	-	Sexually Transmitted Diseases
ICDP	-	International Conference on Population and Development
FP	-	Family Planning
ZDHS	-	Zambia Demographic and Health Survey
FGD	-	Focus Group Discussion

ABSTRACT

This study examined and compared factors that influenced lack of male interest in the use of family planning between the urban and rural communities of Monze District in the Southern Province of Zambia. It discusses findings from married male respondents and participants of a focus group discussion.

Information was obtained from 380 men of which half (190) were from rural chief Choongo's area and another 190 were from Monze urban. To supplement the findings of the study, a focus group discussion of 12 men from rural were conveniently selected from Nteme Ward in chief Choongo's area while for the urban group, 12 men were conveniently selected from Monze Main Market. The overall total sample for the study was therefore 380 men. The study was conducted from February to April 2001 with the help of four (4) trained Midwives in data collection. An interview schedule was used as a data collection tool. Qualitative data was collected through 2 focus group discussions.

Key findings of the study included the following:

- Age, education, number of children and residence as some of the demographic characteristics that affect family planning services for both rural and urban communities.
- Knowledge on family planning services and contraceptive methods were high for both rural and urban.
- A gap still does exist between Zambian men's knowledge of family planning and their practice.

- Lack of access to family planning services, inadequate knowledge on family planning and desire for more children contribute to low use of family planning services.

- Some men do not accept available contraceptive methods due to fear of preconceived ideas about the side-effects.

- men who reported to be using modern methods of family planning rely predominantly on their wives to use these methods.

- The condom is the commonest male method used. The use is higher in urban than in the rural due to adequate media advertisement possibly in the hope of preventing HIV/AIDS.

- Inter-spousal communication was high for both rural and urban indicating a possible increase in family planning use in future.

- From a policy perspective men involvement in reproductive health and family planning should be viewed as desirable not only for equity reasons, but because programmes and health outcomes for both men and women are likely to improve. This can be done by ensuring appropriate male services and information in the existing facilities and to support research on male attitudes and practice as well as other socio-cultural factors that affect the use of family planning. Following research findings, it is imperative to apply effective interventions so as to increase male interest in the use of family planning.

CHAPTER ONE

1.0 BACKGROUND INFORMATION

Zambia is a landlocked, tropical country located in the South Central Africa, with an area of 752,614 square kilometers. Administratively, the country is divided into nine (9) provinces, namely: Northern, Southern, Eastern, Western, Copperbelt, Luapula, Central, Northwestern and Lusaka and has 72 districts.

Monze District is situated in Southern Province, about 200km south of Lusaka, the Capital City of Zambia. It covers an area of 6,687 square kilometers. Crop farming and animal husbandry on both commercial level and peasant scale are the main occupations for the rural population. Farming on peasant level has gone down due to frequent drought spells, which has hit the province since the early 1990s. Cattle rearing also have equally gone down due to corridor disease that kills many of animals each year. The population of Monze district is 220,451.[19] Out of this, there were 48,504 men above 15 years and 48,499 women in the childbearing age and the population below 15 years is 108,580, which is almost 50 percent of the total population. Monze District has 8,220 men from the Urban and 6,780 from Rural. The population growth rate (3.7 percent)[19] is slightly higher than that of the country (3.2 percent).[7] This may be attributed to low family planning use in the district as well as the traditional practice of polygamy among the Tonga people who value a big number of children. Polygamy is also regarded as a way of life and, to an extent, serves as a traditional method of family planning in this locality. The district is predominantly Catholic and this may influence the type of family planning method used in the area.[19]

Family planning is assisting individuals and couples to freely and responsibly make and fulfill decisions about the number of children they want and how to space them well. Family planning includes both the use of traditional and modern technologies of contraception and assisting those couples with problems of infertility. It is a key component of reproductive health, working in synergy with programmes involved in the prevention and treatment of reproductive related disabilities including sexually transmitted diseases (STDs).[5,23]

Family planning programmes have long been recognised for their importance in improving the health of women and children and in reducing population growth rates. However, Africa as a whole has lagged behind other world regions in the adoption and expansion of family planning. [24]Given the critical role African men play in family decisions, men's support and involvement are essential for family planning to become more wide spread.[23] If organised family planning and reproductive health programmes are to reach out to men, a better understanding of their reproductive intentions is essential. Exclusion of men from family planning services may contribute to low levels of use of contraception among couples and deprive men of an opportunity to exercise their reproductive responsibility.[15]

Men's participation describes men's active, positive involvement in achieving good reproductive health.[5] The term describes a complex process of social behavioral change that is needed for men to play more responsible roles in reproductive health. Most services have been targeted at women, arguably because it is them who get pregnant.[23]As a result of this, most modern contraceptives developed over the past few decades have been for women. Men's potential positive role in family planning

has often been ignored on assumption that they hold negative attitudes towards birth control.[8,22,23] However, historical evidence from many parts of Africa has shown that men on this continent have been actively involved in child-spacing through practicing abstinence, withdrawal and rhythm methods with their partners or spouse.[24]

Men's participation is a promising strategy for addressing some of the world's pressing reproductive health problems. The Human Immuno-deficiency Virus and Acquired Immuno-Deficiency Syndrome (HIV/AIDS) epidemic has been an important factor in bringing male involvement in family planning to the forefront of African Policy Agendas.[23] The spread of STDs including HIV/AIDS challenges African policy makers to develop strategies to promote condoms and other male and female methods for STDs and HIV protection. Men's involvement will be essential in condom promotion and other disease prevention activities.[15,20]

The 1994 International Conference on Population and Development (ICDP) in Cairo, Egypt and the 1995 Fourth World Conference on Women in Beijing, China, underscored the importance of men's roles in eliminating gender inequality and easing women's domestic burdens.[26,27] The newest generation of population policies and programmes is placing increasing emphasis on encouraging men to take an active role in all aspects of family life, including family planning. This will involve men as well in counseling services, Information, Education and Communication (IEC) programmes.[24]

Men in Zambia play a major role in decision-making at all levels. The need for men to practice safer sexual behaviour in this country is becoming even more urgent.[5]

Men now need to use condoms for both family planning and prevention of STDs and HIV/AIDS since they are more likely to transmit infections to women. Women are said to be more susceptible physiologically to the viral and bacterial agents that cause HIV and other STDs. For example, men are eight (8) times more likely to transmit HIV to a woman through repeated, unprotected sexual intercourse than women are to transmit the virus to men.[23]

Modern family planning in Zambia began in the 1960s through medical practitioners. In 1972, the Planned Parenthood Association of Zambia was formed and in 1979, family planning was integrated in the Ministry of Health's Maternal and Child Health (MCH) programmes as an essential element of Primary Health Care.[5,7] The Planned Parenthood Association of Zambia (PPAZ) and Family Life Movement of Zambia (FLMZ) also operate family planning clinics to supplement efforts of the Ministry of Health (MoH). The family planning in-service training programme for health workers began in 1981. In 1989, the Zambian Government adopted the National Development Population Policy as part of its fourth National Development Plan for 1989 – 1993. The emphasis on family planning then was on spacing of children and promoting healthy populations.[5,32]

However, despite these early activities, family planning service delivery remained difficult, and a few people, particularly men, had access to the modern family planning methods. Many women who want to avoid pregnancy are not using contraception because their husbands object to the use of family planning methods. On average, women with unmet need cited husband's disapproval as the main reason why they do not use contraception .[7]

The concentration of family planning services on women has not encouraged men to ultilise the available services. Duncan, in his study, "Oddman Out", cited unwelcoming atmosphere, long waiting time, being attended to by female advisers alone and lack of information on sources of family planning as discouraging factors for male participation .[11]

After realising that other groups of people like men were almost left out in accessing family planning services, the Government of the Republic of Zambia through Health Reforms, which began in 1992, saw the need to stress integration of services and provision of essential This basic health care package for all Zambians.[5] This is also in line with Roudi Faranzeneh, (1998), who found that recent research and programme experiences show that although services and information need to be different for men's and women's peculiar needs, it is possible to address both groups of needs through modest changes in the existing operations. The current population policy which is within the new economic recovery programme was revised in 1996 in order to take into account the new concerns which include HIV/AIDS, teenage pregnancy, poverty and gender issues. Its overall goal is to improve the standard of living and quality of life for all Zambians.[5]

From the foregoing, it is clear that involvement of men in family planning services does not only promote sharing of responsibilities in family planning practice, but it is also crucial in preventing millions of maternal deaths due to complications of pregnancy, child birth and unsafe abortions.

Therefore, ascertaining factors influencing male interest in the use of family planning

services in Monze district will help family planning programme planners, policy makers and service providers as they seek to improve men's approval and use of family planning. This in turn will help to reduce the population growth rate which is slightly higher in this district than the rest of the country.

1.2 STATEMENT OF THE PROBLEM

The high fertility rate figures referred to earlier suggest that there is underutilization of family planning services among men in Monze District. The preference for large families, tendency to practice polygamy and the low use of family planning methods among men in this locality may contribute to high fertility rate. The Christian churches also appear to influence male use of family planning in that, the only big hospital (Monze Mission) encourage use of natural scientific method only rather than other artificial family planning methods, as this is against the Catholic faith. The Zambia Demographic and Health Survey (ZDHS, 1996) also showed that there is underutilisation of modern family planning practice in the whole country. Considerable unmet needs exist among married women. Overall, 27 percent of these women need services – 19 percent for spacing their next birth, and 8 percent for limiting their births. Currently, only less than half of this "total demand" for family planning is being met. As a result of this, fertility in Zambia remains one of the highest in the sub-Saharan Africa (6.1 births per woman compared to about 4.3 births per woman in Zimbabwe).

In Monze District only 10 percent of the eligible potential users are practicing modern family planning.[19] Given the critical role Zambian men play in family decisions including fertility, male use of family planning will go a long way to reduce family size and other health problems related to reproduction. A large number of

children can only lead to an increase in the levels of poverty being experienced in the district and the country as a whole. Such children end up with little or no education, and this can in turn lead to a rise in unemployment, and a high crime rate. A preference for a large number of children in a family at a time when food output has become inadequate due to drought spells and cattle diseases will only add to the burden of malnutrition and death among children. Such problems, in turn, lead to a strain on financial and other resources in the district health sector.

By involving men in family planning, it can be easier for them to realise that traditional practices such as polygamy whether seen as a family planning method or not are not the best solutions, because in this modern era of rampant HIV/AIDS, if one spouse is infected, the rest of the other spouses also get it.

Concentrating on women clients alone and leaving out men will make them not engage in any form of family planning roles and continue discouraging their wives or partners to use contraceptives.

1.3 RATIONALE

The study seeks to unravel the factors at play in the situation so that hopefully, a solution may be found to improve male interest in the use of family planning in Monze District. This is in view of the fact that so many studies have been done on women concerning family planning issues and whose results have been used to improve contraception for both men and women.[23] Studies concerning men's attitudes on family planning are very few and none so far has been done in Monze. The few studies and surveys that have been done on men in Africa has shown that generally, African men know at least one method of modern or traditional family planning.[24]

Despite this knowledge, a wide gap exists between their knowledge and attitudes towards contraceptive use. For example, although the majority of married couples in Africa know about family planning, it is estimated that an average of 22 percent or 1 out of 10 couples practice either modern or traditional family planning.[24] The ZHDS of 1996 shows a similar picture for Zambian men. Except for condoms, vasectomy and natural family panning methods, knowledge on individual methods was found to be slightly higher among women than men.

This shows that even though issues concerning family planning are understood better than a decade ago, the picture is still incomplete. Men's concerns in family planning issues is an important aspect that needs to be considered by planners and policy makers in Zambia if men are to be fully involved in the matter. Lack of data on social, cultural and economic reasons that influence male interest in family planning has hindered their inclusion in these services.

This study, therefore needs to be done in Monze District in order to fill the gap concerning knowledge of factors hindering or influencing use of family planning services by men. By understanding their reproductive intentions, men can make better partners in solving reproductive health related problems not only in Monze District but in Zambia as a whole.

CHAPTER TWO

2.0 LITERATURE REVIEW

A growing number of family planning and other reproductive health care programmes and providers are seeing that men deserve more attention - for their own sake, for the women's sake, and for the health of their families and communities.[23] From this new perspective, men are potential partners and advocates for good reproductive health rather than by-standers, barriers, or adversaries.

This new attention contrasts with several decades of neglect that began in the 1960s after the development of modern contraceptive methods for women. Many family planning programs and other reproductive health care providers were accustomed to paying little attention to men except for the diagnosis and treatment of STDs.[8,20,24] Now, reproductive health programs are seeking better ways to understand men, to communicate with them, to engage them to help them take better care of themselves and their partners.

Family planning programs in the past have focused on women instead of men for several reasons: women bear the risks and burdens of pregnancy and child bearing; most modern contraceptives are for women; and many providers have assumed that women have the greatest stake and interest in protecting their own reproductive health. Reflecting on these assumptions, the clinic based service delivery design for family planning has made it difficult to include men.[3,11] Services have often been offered in MCH clinics. Many men see MCH clinics and their staff as serving only women and children and feel uncomfortable seeking information or services in that

setting.[24]

Some family planning programs have avoided men because they assume that men are indifferent or even opposed to family planning. Indeed men as a group are frequently blamed for many of the women's reproductive health problems. This was also confirmed at the 5th Seminar of the European society of contraception in Amsterdam. Objections were raised to focusing on men's needs including the concern that this may jeopardize reproductive health services for women and that men already have too much power over decisions affecting women's fertility and sexual health.[10]

Nevertheless, increasing evidence exists to show that ignoring the sex education and sexual health needs of men have important and wider social and health consequences. Men are a diverse group of individuals. They reflect the spectrum of humanity, from kind and caring to abusive and dangerous. It is therefore important that health programmes abandon stereotypes of men and learn more about their concerns and needs, especially when designing programs for different groups of men.[23]

Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. With HIV now spreading faster among women than among men in some regions, the AIDS pandemic has focused attention on the health consequences of men's sexual behavior.[20,23,28] Also, millions of pregnancies are unintended, and each year many thousands of women die as a result of these pregnancies.[5,24]

New information, new understanding, and new approaches promise to help men become full partners in better reproductive health. Men, as well as women, play key roles in reproductive health, including family planning, but increasing men's

participation has been difficult. Adopting new perspectives can help.[23]

Today's new perspectives recognise that:

- Men play important, often dominant roles in decisions crucial to women's reproductive health.
- Men are more interested in family planning than often assumed but need communication and services directed specifically to them.
- Understanding and influencing the balance of power between men and women can help improve reproductive health behavior.
- Couples who talk to each other about family planning and reproductive health can reach better healthier decisions.

2.1 INFLUENCE OF GENDER , COMMUNICATION AND DECISION MAKING.

Gender, the different roles that men and women play in a society and the rights and responsibilities associated with those roles is a powerful force.[23] Whether reproductive health programmes are for men or women, understanding gender is important. In many African countries including Zambia, men often dominate decision-making and so can seriously harm or help women's reproductive health. Programmes that recognize the widespread influence of gender, particularly how inequality between women and men affects their reproductive health, are better able to avoid reinforcing harmful gender roles. In recent years, several guidelines have been developed to help incorporate gender sensitivity into programmes design, implementation, and evaluation.

Many obstacles prevent men and women from talking about sexual and reproductive health issues. While research is slight, it suggests that a complex web of social and cultural factors impede such discussions. In many societies, sex is a taboo subject for men and women to discuss. Also, men and women are often afraid of being rejected by a sexual partner especially at the beginning of a relationship. Consequently they may feel uncomfortable to bring up issues, such as sexual history or use of contraception.[15,18,28]

Communication plays a key role in new approaches to equity between partners. It is an important intermediate step along the path to eventual adoption and sustained use of contraception. Lack of discussion may reflect a lack of personal interest, hostility to the subject or a customary reticence in talking about sex related matters. Encouraging couples to discuss contraceptive use and other reproductive decisions can lead to healthier practices. Messages in the mass media can address men's specific concerns and give men positive models to follow. At the same time, service delivery now recognizes men's distinct reproductive needs.[15,20,23]

2.2 ROLE OF RELIGION IN FAMILY PLANNING

Religion has a significant relevance in the demographic study of socio-economical groups. Religion prescribes a code of life, refers to a system of beliefs, attitudes and practices which individuals share in groups. According to Westoff, "the religious affiliation of the couple connotes a system of values which can affect the family via several routes: (a) directly by imposing sanctions on the practice of birth control or legitimizing the practice of less effective methods only, or (b) indirectly, by indoctrinating its members with a moral and social philosophy of marriage and family

which emphasizes the virtues of reproduction.[31]

A good example is the Catholic Church, which is known for its moral stand against the use of artificial family planning methods. The Pope bans all forms of contraception. This includes the use of condoms, the birth control pill, and if strictly applied would also include the natural rhythm method. Basically, contraception "before or after sexual act," at the moment is banned.[29] However, despite this ban on use of contraceptives in many catholic communities throughout the world, especially where AIDS is a threat, condoms have become readily available and used. For example studies have shown that Catholics in developing countries readily use contraceptives when they have access to them. In predominantly catholic developing countries, it is common for the majority of the population to use and/or support the use of contraceptives. This is true for countries such as Colombia, which is 93 percent Catholic, Mexico, which is 95 percent Catholic, and the Philippines, which is 84 percent Catholic.[25,30]

Most US catholic priests and religious sisters believe that it is not necessarily a sin to use contraceptives. A 1970 study by the National Conference of Catholic Bishops showed that more than 80 percent of the Catholic clergy did not insist on lay acceptance of the official birth control teaching in confessional.[30]

Demographic studies on the role of religion in fertility and family planning were carried out in India, where followers of different religions live side by side. Most of these studies revealed a higher fertility and lower family planning practice among Moslems than other religious communities such as the Hindus.[31]

2.3 SOURCE OF FAMILY PLANNING METHODS

Traditionally, most couples have obtained information on family planning from friends and families. Most people accepted any information on family planning because these practices of contraception were compatible with other traditional beliefs and practices, for example, post-partum sexual abstinence and lactation amenorrhea.[22,24] This information could have gaps or misleading since it was only based on hearsay and not on proven facts. According to ZDHS 1996, data indicated that most of the users of family planning methods, 60 percent obtain their methods from public (government) sources especially health centers; while 24 percent rely on private medical sources and 13 percent use other private sources such as shops, friends and relatives.

2.4 FAMILY PLANNING KNOWLEDGE

The majority of African men know at least one family planning method, either modern or traditional. In a number of countries, such as Egypt, Morocco, Kenya, Rwanda and Zimbabwe, knowledge of family planning among men is nearly universal.[24] In many countries, both men and women have at least a basic knowledge of modern family planning methods, but in some, men are more likely than women to have this knowledge. The gap between men's and women's knowledge of family planning is greater where the overall knowledge of family planning is lower. This may reflect the relative status of men and women and /or the scope of family planning programme development in those countries.[23]

In Zambia, knowledge of any contraceptive method among men aged 15 – 59 years was found to be almost universal too; only 4 percent of men reported that they did not know any method of family planning.[7] Except for the condom, male sterilisation and

natural family planning, knowledge of individual methods is slightly higher among women than men. It is also higher among married men than among all men. In general, men are more knowledgeable about modern contraceptives than about traditional methods. Four in five married men indicated that they had some knowledge about a traditional method. Knowledge about the condom in particular is almost high among the sexually active unmarried men than among married men. The least known method is the implant, (12 percent).[7]

2.5 ATTITUDES TOWARDS FAMILY PLANNING

Attitudes towards family planning determine whether or not it is practiced. While the majority of African men approve of family planning, there are much variations across the continent.[18,24] Generally men in West Africa, with the exception of Ghana are less likely to have a positive attitude towards family planning than men in other parts of Africa. In most countries, women are more likely than men to approve of family planning. The gap between men's and women's approval rates is wider where the male approval rate of family planning is lower. For example, the 1987 DHS in Mali showed that only 23 percent of husbands approved family planning compared to 71 percent of wives, despite the fact that husbands had considerably more knowledge of family planning than their wives.[15,24]

Education is the strongest predictor of men's attitude towards family planning. This is true as per selected social demographic characteristics of DHS1987 for Mali and Kenya where approval of family planning was more in better-educated men as are in monogamous marriages. In most countries men who live in urban areas approve of family planning more than their counterparts in rural areas; in some countries such as Kenya, there is almost no difference.[24]

The proportion of wives and husbands who approve of family planning use is slightly lower in the younger and older age groups. Urban residents are more likely to approve of contraceptive use than their rural counterparts. In Zambia approval of family planning use, is highest in Copper belt, Lusaka and Northwestern provinces as well as among those with the highest education.[7]

2.6 FAMILY PLANNING PRACTICE

Men's support affects the choice, adoption and continuation of the use of female methods. A wide gap exists between African couples' knowledge and attitude towards contraceptives and their use. Although the majority of married couples in Africa know about family planning, it is estimated that on average only about 22 percent of couples use either a modern or traditional method. For example, in countries where male survey was conducted in the early 1990s, family planning practice was found to be highest in Zimbabwe (60 percent), followed by Kenya (54 percent), and Egypt (51 percent). Family planning practice is found to be higher in the North and Eastern regions of Africa than West Africa, with the exception of Ghana.[15,24]

In general, urban men who are better educated and have had children are more likely to have a spouse using contraception than the less educated rural men. In many Zambian cultures family planning is only used when couples have already as many children as they want. However, as the concept of family planning gains acceptance, couples may begin to use contraception for spacing births as well as for limiting family size.[7]

2.6.1 DIFFERENCES IN FAMILY PLANNING PRACTICE BY SELECTED CHARACTERISTICS OF HUBANDS

DHS data reveal striking differences in family planning practices according to the following characteristics of husbands:

EDUCATION: Better-educated men are more likely than their less educated counterparts to practice or have a spouse who practices family planning. In Ghana for example, 61 percent of husbands that have completed secondary school or higher, practice family planning, compared to 35% of those husbands whose education did not go beyond primary school and only 10% of those with no education. This pattern is similar to what researchers have long observed with regard to women's education and their reproductive behavior.[23]

RESIDENCE: African men living in urban areas are more likely to practice family planning than those living in rural areas. This is in part because people in urban areas have better access to family planning services and information, and in part because they are more likely to be educated. In Morocco, where half of the population lives in urban areas, 51% of married men living in urban areas practice family planning compared to 30% of those living in rural areas.[23]

AGE: DHS do not show any particular age-related patterns of contraceptive use among married men. In some countries, such as Morocco and Tanzania, contraceptive practice is highest among husbands in their 30s; in other countries, such as Egypt and Ghana; it is highest among husbands in their 40s.[23]

TYPE OF MARITAL UNION: Family planning practice differs by type of union, and relationship varies from country to country. In Burkina Faso, Cameroon, Egypt

and Kenya practice is higher among men in monogamous marriages. In Malawi, Niger and Rwanda, the opposite is true. In Malawi 38% and 24% of husbands in polygamous and monogamous marriages, respectively reported that they were practicing family planning. In Morocco, Senegal and Tanzania, contraceptive practice is similar among monogamous and polygamous husbands.[23]

Reviewed literature had shown that men can participate in family planning in two ways by supporting their partner's decision to use family planning and /or by practicing male method of family planning themselves (condom, vasectomy, withdrawal or periodic abstinence).[23] Such findings suggest that men's reproductive health behavior is ready to change. If men are ready, why have some programmes to involve them fallen short? Some efforts may have been too weak and too brief or based on incomplete understanding of men's motivations, couple's interactions and what engages men to practice family planning.

Therefore, ascertaining factors influencing or hindering male interests in the use of family planning in Monze District, will help the policy makers, planners and implementers of family planning services to adopt strategies which would motivate men and improve their perceptions, approval and use of family planning services. This in turn would help to reduce the fertility rates.

2.7 CONCEPTUAL AND OPERATIONAL DEFINITIONS

Use of family planning – the ability and practice of an individual man to use family planning services. This is measured in this study by positive responses to questions in that regard.

Interest in family planning – is the drive or motivation of men to use family

planning services. In this study, this is determined by whether respondents' answer in the affirmative to questions as to whether they use or think they should use family planning.

Married men – males who have spouses and were married either under traditional or customary arrangements or by modern law.

Gender - refers to the different roles that men and women play in society and also to the rights and responsibilities that come with those roles.

Sex - refers to the biological and physical differences between men and women and as they get classified either to the group of 'male' or 'female'.

Fecundity - the physiological capacity of a woman, man or couple to produce a live child.

Fertility - the actual output of births, as opposed to the potential output.

Attitude - is a feeling or a way of thinking for purposes of this study- towards discussion of family planning.

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

CHAPTER THREE

3. OBJECTIVES OF THE STUDY

1 General Objective

To compare factors influencing male interest in the use of family planning services between rural and urban areas of Monze District.

3.2 Specific Objectives

The study seeks to:

1. Identify demographic characteristics that influence men's use and approval of family planning services in Monze rural and urban study areas.

2. Determine the extent of family planning knowledge among rural and urban men.

3. Find out the attitude of urban and rural men towards family planning services.

4. Identify specific methods of family planning used in the areas of study.

5. Establish the social, cultural-gender issues that affect family planning in urban and rural areas of Monze

6. Identify the types of communication used in family planning in Monze District.

7. Make recommendations that will help policy makers and programme planners to encourage men to use family planning services in Zambia.

3.3 RESEARCH QUESTIONS

- What causes low male interest and participation in family planning?
- What are the family planning methods used?
- What is the knowledge, attitudes and behavior gap among men in Monze with regard to family planning.

CHAPTER FOUR

4.0 METHODOLOGY

4.1 STUDY DESIGN

For the purpose of this study, a descriptive cross-sectional and comparative study design was used to describe factors influencing male interest in the use of family planning services. The views, knowledge and practice of both urban and rural married men were compared for similarities and differences.

4.2 IDENTIFICATION OF VARIABLES

The dependent variable in this study was male interest in the use of family planning services, while demographic characteristics that influence male interest in use of family planning services, knowledge on family planning, attitudes towards family planning, specific contraceptive methods used, types of communication used, and cultural-gender related issues in the use of family planning services were the independent variables.

4.3 RESEARCH SETTING

This study was conducted in two (2) different settings (urban and rural communities) of Monze District. Monze is about 200 kilometers (km) south of Lusaka the capital city of Zambia. It is about 300mk north of Livingstone the Provincial Headquarters of Southern Province. The district has a population of 220,450.[7] The information was collected from a selected total population of 8,220 and 6,780 men for urban and rural areas respectively.[34]

The areas were chosen because the people found in the two settings differ in both

social and economic status and as such their views too were expected to be different.

4.4 STUDY POPULATION

The study sought to compare factors that influence male interest in the use of family planning services among the rural and urban married men. For this reason, the study population came from the two mentioned settings. The urban married men were selected from Monze township and the other group was from Monze rural in Chief Choongo's area.

5 SAMPLE SIZE DETERMINATION

A total sample of 380 married men were purposefully, but randomly selected for this study. The sample consisted of 190 urban men and 190 rural men from a total population of 8,220 men for urban and 6,780 men for the rural.[34] Monze rural is inhabited by Tonga people who are known to be traditionalists even with regard to reproductive health practices. The rural sample was randomly picked from Chief Choongo's area. Respondents were randomly selected from the six (6) Chiefs of Monze district, namely; Chiefs Monze, Mwanza, Chona, Ufwenuka, Hamusonde and Choongo. The urban sample was randomly selected from Monze town which is inhabited by a more mixed group of Zambian tribes whose conformity to traditional reproductive health practices is weaker. Respondents were randomly picked from the six (6) sections of Monze Township which is already demarcated by the local Council authority.

INCLUSION CRITERIA

Only married men aged 15 years and above for both rural and urban with different social backgrounds such as varying levels of education, occupations and religion were

eligible for this study.

EXCLUSION CRITERIA

- Single men aged 15 years and above.
- Married men out side the study areas.

To arrive at the sample size, a formula which gives a comparison between two proportions was used.

The calculations are as below:

$N=[(U+V)^2 [P_1(100-P_1)]+P_2(100- P_2)] /(P_1-P_2)$

Where V= SD(95%CI) or 1.96 and U= Power 80%=0.84

P_1=20% (proportion of urban men)

P_2 =10% (proportion of rural men)

$=[(0.84+1.96)^2 20(100-20) +10(100-10)]/(20-10)^2$

$=(2.76)^2 (1600 +900)] /100$

=7.6176 x25

=190 in each group.

6 SAMPLE SELECTION

The researcher purposefully, but randomly selected the two areas of study because the languages spoken in the two areas were understood and spoken fluently by her. Therefore communication was made easy for her.

Before the researcher started canvassing, all households in the two areas of study were listed in order to identify households with married men. The listing also enabled the

stratification of the eligible population into married men.

The married men from Monze urban (stratum 1) were given a serial number from one (N_{11}) up to the last number (N_{1i}), while the column for rural married men (stratum 2) was given a serial number from one (N_{21}) up to the last number (N_{2i}), where ($N_1 + N_2 = N$), the total number of all eligible respondents in the areas of study. In cases where there were more than one married man in the household, both of them were listed and given an equal chance of bearing selected into the sample. Later, the list was compiled and served as a sampling frame from which the sample for the area was drawn.

A sample size of n_1 and n_2 was then selected from stratum 1 and 2 proportionally using the circular systemic sampling design as follows:

K_1 and K_2 were the sampling intervals for stratum 1 and 2 respectively.

Choose a random stem R_1 and R_2 between one (1) and N_1 or N_2 whichever was the case.

Start with the random stem and proceed as follows:

$1, R_1, R_1 + K_1, R_1 + 2K_1, R_1 + 3K_1$.....

$[R_1 + (n_1 - 1) K_1 = n_1]^{th}$ respondent

$2, R_2, R_2 + K_2, R_2 + 2K_2 + 3K_2 \; R_2 + 3K_2$,.....

$[R_2 + (n_2 - 1) K_2 = n_2]^{th}$ respondent

When the sample was selected, canvassing begun too.

7 DATA COLLECTION

Data collection was carried over a period of two months and 20 days. Starting from the second (2nd) week of February 2001 to April 2001. Structured interview schedules with open ended and closed questions were used. Qualitative data was assembled through two (2) separate focus group discussions with men drawn from 2 different socio-economic backgrounds (rural and urban). The focus group discussions were used to supplement the data. These discussions, which lasted for about 30 minutes were tape-recorded.

Apart from tape recording grammatical errors, all transcriptions were verbatim in order to retain "the voices of the respondents. The languages used were a mixture of English (official language), Nyanja for the town respondents and Tonga, which the rural people use. Combining different techniques according to Achola (1998), reduces the chance of bias and increases the quality of data collection. A total of five (5) health personnel were used as research assistants (two for the urban and three for the rural areas). The research assistants for the rural area were selected from health center staff within the randomly selected study area while for the urban, the two were identified from Monze Hospital.

8 ETHICAL CONSIDERATION

Ethical approval was sought from the Research Ethics Committee of the University of Zambia. Permission to carry out the study was obtained from the relevant authorities in Monze.

Informed consent from the legible respondents was obtained and confidentiality was assured.

9 PRE- TESTING

Pre-testing of the study instruments was done before the main study to make sure that questions were clear, concise and consistent. All unclear questions were re-formulated and as for questionnaires, which were found to be rather long, the supposedly less relevant questions were deleted. The pilot study was conducted in the first week of November 2000 at Kabwata township an urban area and at Kanchomba, Pemba, a rural area. These two pilot areas are different from the residential area where the study was carried out.

10 QUALITY CONTROL CHECKS

During data collection at the end of each day, the researcher went through the filled in questionnaires to ensure that all the information was properly collected and recorded. Information was checked for completeness and internal consistency. This was to ensure collection of quality data as well as ensuring the statistical power of data when analyzed.

11 LIMITATIONS

The study had the following limitations:

- the sample size was relatively small, inevitably limiting the extent to which results could be generalized.

- The study is focused on married men's views, which may be relating to their spouses. Despite efforts to authenticate them, all responses from men relating to their spouses may need to be interpreted cautiously.

Data collection took longer than planned due to:

Non-Availability of Respondents

With the urban respondents, it was difficult to find them at their homes during *working days, so several trips had to be made for some of the respondents.*

For rural respondents, the majority of them were in the fields since the data collection coincided with the farming season. So longer distances had to be covered by following them to the fields.

Accessibility during rain season and distance

Some of the roads and bridges were impassable due to heavy rains in the months of February and March there by making it difficult to reach some of the respondents.

In rural areas, villages were far apart, needing more time to travel from one village to another.

Since the study was done in two areas (urban and rural) in which respondents had different socio-demographic backgrounds, it is likely that there may be bias due to ethnic/cultural differences.

Analysis and report writing took longer than it was supposed to due to restricted Accessibility to appropriate computer soft ware.

CHAPTER FIVE

5.0 PRESENTATION AND ANALYSIS OF DATA

5.1 INTRODUCTION

The data presented in this study was obtained from 380 married men in the Monze District of the Southern Province of Zambia. The study samples were from both Monze urban (190 men) and Monze rural (chief Choongo's area (190 men). The age range was from 15 years and above.

5.2 DATA PROCESSING AND ANALYSIS

Raw data collected from the interview schedules were checked for completeness and internal consistency before entering it into a spreadsheet. Responses from open ended questions were recorded as comments and later on were categorized, coded and entered on the spreadsheet.

Data was then analyzed using the Statistical Package for Social Sciences (SPSS) software.

5.3 DATA PRESENTATION

The study findings were presented in table form, figures and comments. The researcher found it suitable to use numerical description of data to summarise the results in a meaningful way to enable the reader to understand the author's intentions in the study.

The findings of male respondents were presented in Section A and Section B contained results from the Focus Group Discussion

SECTION A

Table 1

A Comparison of Socio-Demographic Characteristic of Rural and Urban Married Men

CHARACTERISTIC	RURAL n (%)	URBAN N (%)
AGE		
15 –24	15 (7.9)	11 (5.8)
25 – 34	79 (41.6)	78 (41.1)
35 – 44	44 (23 .2)	65 (34.2)
45 and above	52 (27.4)	36 (18.9)
EDUCATION		
None	3 (1.6)	3 (1.6)
Primary	97 (51.1)	59 (31.1)
Secondary	73 (38.4)	78 (41.1)
College	17 (8.9)	50 (26.3)
NUMBER OF CHILDREN		
1- 3	123 (64.7)	108 (56.8)
4 – 6	45 (23.7)	50 (26.3)
7 and above	20 (10.5)	28 (14.7)
None	2 (1.1)	4(2.1)
RELIGION		
Catholic	34 (17.9)	69 (36.3)
Protestant	37 (19.5)	64 (33.7)
SDA	118 (62.1)	45 (23.7)
Others	1 (0.5)	10 (5.3)
Non-believer	0 (0.0)	2 (1.1)
TOTAL	**190 (100.0)**	**190 (100.0)**

All respondents in this section were married men. since the study focused on comparing factors influencing male interest in the use of family planning services between rural and urban communities.

Table 1 shows that the majority of respondents 79(41.6%) from the rural and 78(41.1%) from the urban were in the age range of 25-34 years. The least age

group were young adults with 15(7.9%) from the rural and 11(5.8%) from the urban.

The level of literacy was high among respondents. Only 3 (1.6%) rural and 3 (1.6%) urban respondents did not attend school. A higher percentage 97(51.1%) from the rural had primary level while 78(41.1%) from the urban had secondary education. The majority 123 (64.7%) of the rural and 108 (56.8%) of the urban respondents had 1-3 children. Christianity was the only religion reported. The respondents were predominantly SDA 118 (62.1%) from the rural where as only 69(36.3%) of the urban respondents were catholics opposed to earlier assertion of Catholicism.

Table 2a

Respondents Use of Family Planning

DO YOU OR YOUR SPOUSE USE FAMILY PLANNING SERVICES	**RURAL N (%)**	**URBAN N (%)**
Yes	130 (68.4)	155 (81.6)
No	60 (31.6)	35 (18.4)
TOTAL	**190(100.0)**	**190(100.0)**

Table 2a shows that the majority of the respondents 155 (81.6%) from the urban and 130 (68.4%) from the rural were using family planning. (X^2 = 8.77, df = 1, P- value = < 0.003), indicating that there was no association between residence and the use of family planning.

TABLE 2b

Selected Demographic Characteristics that may influence Use of Family Planning Services by Residence

CHARACTERISTIC	RURAL n (%)	URBAN N (%)
AGE		
15 –25	8 (6.2)	8 (5.2)
25 – 34	48 (36.9)	63 (40.6)
35 – 44	34 (26 .2)	56 (36.1)
45 and above	40 (30.8)	28 (18.1)
TYPE OF MARITAL UNION		
Monogamous	101 (81.5)	132 (85.8)
Polygamous	29 (22.3)	22 (14.2)
EDUCATION		
None	3 (2.3)	3 (1.9)
Primary	65 (50.0)	53 (34.2)
Secondary	48 (36.9)	57 (36.8)
College	14 (10.8)	42 (27.1)
NUMBER OF CHILDREN		
1- 3	86 (66.2)	87 (56.1)
4 – 6	29 (22.3)	42 (27.1)
7 and above	15 (11.5)	25 (16.1)
None	-	1 (1.0)
RELIGION		
Catholic	28 (21.5)	53 (34.2)
Protestant	20 (15.4)	54 (34.8)
SDA	81 (62.3)	37 (23.9)
Others	1 (0.8)	11 (7.1)
TOTAL	**190 (100.0)**	**190 (100.0)**

Table 2 shows that more than half 155 (54.4%) of respondents from the urban and 130 (45.6%) from the rural were using family planning services.

AGE: The main users of family planning services in the rural 48(36.9%) were found in the age group 25-34 years, followed by 40(30.8%) in the 45 and above age group whereas for the urban, the same age group 25-34 years were the major users 63(40.6%), and these, were followed by the 35-44 years age group 56(36.1%),(Table 2).

TYPE OF MARITAL UNION: A higher percentage of family planning users 133 (85.8%) from the urban and 105 (80.8%) from the rural were in the monogamous type of marriages.

EDUCATION.

In the rural area, majority of the respondents using family planning 65(50.0%) had primary education where as for the urban , the dominant users 57(36.8%) had secondary education. There was little difference in the use of the family planning services 3(1.9%) urban and 3(2.3%) rural among those with no education.

NUMBER OF CHILDREN: Most of the respondents 86 (66.2%) from the rural and 87 (56.1%) from the urban who used a method of family planning had 1 – 3 children.

RELIGION: The majority, 81 (62.3%) of the rural, respondents using family planning services were SDA where as only 54 (34.8%) of the urban were Protestants followed by the 53(34.2%) Catholics in spite of the restrictions imposed by the church in the use of contraception.

Table 3

Educational Level of Non-Users of Family Planning Services

EDUCATIONAL LEVEL	RURAL n (%)	URBAN n (%)
Primary	32 (53.3)	6 (17.1)
Secondary	25 (41.7)	21 (60.0)
College	3 (5.0)	8 (22.9)
TOTAL	**60 (100.0)**	**35 (100.0)**

Table 3 shows that the majority of non-users of FP 32 (53.3%) from the rural and 21 (60.0%)from the urban had primary and secondary levels of education respectively.

Table 4

Married men using Family planning services Against Knowledge of the Definition of Family Planning.

KNOWLEDGE OF DEFINITION OF FP.	RURAL n (%)	URBAN n (%)
Very knowledgeable	61 (46.9)	127 (81.9)
Moderate knowledge	23 (17.7)	28 (18.1)
Ignorant	46 (35.4)	0 (0)
TOTAL	**130 (100.0)**	**155 (100.0)**

The majority of the respondents 127 (81.9%) from the urban and 61 (46.9%) from the rural men currently using family planning were very knowledgeable on what family planning. was. Only 46 (35.4%) of rural and none of the in urban users were ignorant. There was an association between the use of family planning services and

knowledge of the definition of FP (X^2 =49.87 , df = 2, p – value =< 0.001).

TABLE 5

RESPONDENTS' KNOWN METHODS OF CONTRACEPTION

CONTRACEPTIVE	RURAL n (%)	URBAN n (%)
Pill	88 (46.3)	111 (58.4)
Condoms	38 (20.0)	70 (36.8)
Natural	14 (7.4)	2 (1.1)
Others	41 (21.6)	7 (3.7)
None	9 (4.7)	0 (0)
TOTAL	**190 (100.0)**	**190 (100.0)**

Table 5 shows that more than half 111 (58.4%) of the urban and only 88 (46.3%) of the rural respondents had knowledge of the pill as a method of contraception.

Table 6

RESPONDENTS INITIAL SOURCE OF FAMILY PLANNING INFORMATION AGAINST USE

INITIAL SOURCE OF FAMILY PLANNING INFORMATION	RURAL n (%)	URBAN n (%)
Friends	19 (14.6)	24 (15.5)
Relatives	6 (4.6)	10 (6.5)
Health workers	105(80.8)	107 (69.0)
School/media/church/ Christian books	0 (0)	13 (8.3)
Non of the above	0 (0)	1 (0.6)
TOTAL	**130 (100.0)**	**155 (100.0)**

In Table 6 the majority of the respondents 105 (80.8%) of the rural and 107 (69.0%) of the urban using family planning had health workers as their initial source of family

planning knowledge.

TABLE 7

Respondents Using Family Planning Services With Their Source

SOURCE OF FAMILY PLANNING SERVICES	RURAL n (%)	URBAN n (%)
Government hospital and health centres	99 (76.2)	105 (67.7)
Private medical sources	26 (20.0)	32 (20.6)
Others	5 (3.9)	18 (11.6)
TOTAL	**130 (100.0)**	**155 (100.0)**

Table 7 shows that the majority of respondents 99 (76.2%) from the rural and 105 (67.7%) from the urban obtained their family planning services from the public or government sources.

TABLE 8

Respondents Reasons For Not Using Family Planning

REASONS	RURAL n (%)	URBAN N(%)
Want more children	27 (45.0)	13 (37.1)
Lack of knowledge and sources of family planning	13 (21.7)	6 (17.1)
Wife menopausal, in fecund and infrequent sex	10 (16.7)	7 (20.1)
Opposition to use, fear of side effects and its up to the spouse	10 (16.7)	9 (25.7)
TOTAL	**60 (100.0)**	**35 (100.0)**

Table 8 shows that majority of the respondents 27 (45.0%) from the rural and 13 (37.1%) from the urban not-using family planning services stated that they wanted more children as a reason for not using family planning.

Table 9

Non- Users Of Family Planning Services Against Knowledge Of Family Planning definition

KNOWLEDGE OF FP DEFINATION	RURAL n (%)	URBAN n (%)
Very knowledgeable	25 (41.7)	23 (65.7)
Moderate knowledge	15 (25.0)	7 (20.0)
Ignorant	20 (33.3)	5 (14.3)
TOTAL	**60 (100.0)**	**35 (100.0)**

Table 9 shows that more than half 23 (65.7%) of the urban and 25 (41.7%) of the rural non-users of family planning services were very knowledgeable on what family planning was. About 20 (33.3%) rural and only 5 (14.3%) of urban did not know what family planning was (X^2 = 69.89, df =2, p-value = < 0.001), there was an association between knowledge and residence..

TABLE 10

Respondents Not Using Family Planning With The Number Of Children

NUMBER OF CHILDREN	RURAL n(%)	URBAN n(%)
1-3	37(62.0)	21(60)
4-6	16(27.0)	8(23.0)
7and above	5(8.0)	3(9.0)
None	2(3.0)	3(9.0)
TOTAL	**60(100.0)**	**35(100.0)**

Table 10 shows that more than half of the respondents not using family planning 37(62.0 %) from the rural and 21(60.0 %) from the urban had 1-3 children.

Table 11

Non-Users Of Family Planning Services Against Reasons For Future Intentions To Use Family Planning Services

REASONS FOR FUTURE INTENTIONS TO USE FAMILY PLANNING	RURAL n (%)	URBAN n (%)
To space children	17 (28.3)	12 (34.3)
For my spouse to remain healthy	3 (5.0)	7 (20)
If and when information on FP services was given to us.	7 (11.7)	6 (17.1)
Due to economic reasons i.e. have a manageable family	7 (11.7)	5 (14.3)
Wife is currently pregnant/ I am not living with my spouse now	3 (5)	5 (14.3)
No reason to use FP in future.	23 (38.3)	0 (0)
TOTAL	**60(100.0)**	**35(100.0)**

The majority of non-users of family planning 17 (28.3%) rural and 12 (34.3%) urban stated that the reason for future intention to use family planning services was to space their children. (Table 11).

Table 12

A Comparison of Selected Family Planning Issues between Rural and Urban Married Men

CHARACTERISITIC	RESIDENCE		
	RURAL n (%)	**URBAN N (%)**	**P – Value**
IS FAMILY PLANNING IMPORTANT?			
Yes	166 (87.4)	173 (91.1)	
No	6 (3.2)	12 (6.3)	< 0.001
N/A (do not know).	18 (9.5)	5 (2.6(	
FUTURE INTENTION TO USE FAMILY PLANNING SERVICES			
Yes	36 (18.9)	21 (11.1)	< 0.056
No	15 (7.9)	11 (5.8)	
Not applicable	139 (73.2)	158 (83.2)	
DO YOU HOLD TRADITIONAL BELIEFS ABOUT FAMILY PLANNING?			
Yes			
No	8 (4.2)	11 (5.8)	
	182 (95.8)	179 (94.2)	< 0.480
DO YOU DISCUSS FAMILY PLANNING WITH YOUR SPOUSE?			
Yes	144 (75.8)	154(81.1)	
No	46 (24.4)	36(19.0)	< 0.126

Table 12 (continued)

CHARACTERISITIC	RESIDENCE		
	RURAL n (%)	**URBAN n (%)**	**P – Value**
KNOWLEDGE OF FAMILY PLANNING SERVICES			
Very knowledgeable	86 (45.3)	150 (78.9)	
Moderate knowledge	38 (20.0)	35 (18.4)	< 0.001
Ignorant	66 (34.7)	5 (2.6	
SHOULD MEDIA CARRY OUT FAMILY PLANNING INFORMATION?			
Yes	176 (92.6)	170 (89.5)	
No	14 (7.4)	20 (10.5)	< 0.537
HEARD OF FAMILY PLANNING SERVICES?			
Yes	162 (85.3)	182 (95.8)	< 0.001
No	28 (14.7)	8 (4.2)	
TOTAL	**190(100.0)**	**190(100.0)**	-

Table 12 shows that the majority 166 (87.4%)of the rural and 173 (91.1%) of the urban respondents stated that family planning was important. (x^2 69.89, df = 2, p.-value < 0.001). There was an association between residence and importance of family planning. The table further shows that the current non-user of family planning services 36 (18.9%) from rural and 21 (11.1%) from urban intended to use these services in future (x^2 = 5.78, df = 2, p-value < 0.056).Hence there was no association between non use and future intention to use family planning services.

The majority of respondents 182 (95.8%) from the rural and 179 (94.2%) from the urban did not hold any traditional beliefs concerning family planning , (Table 12).

A higher proportion 144 (75.8%) of rural and 154 (81.1%) of urban respondents discussed family planning issues with their spouses (x^2 =4.146, df = 2, p-value <0.126), indicating no significant difference between the two groups, (Table 12). According to the same table 12, most of the respondents 124 (65.3%) from the rural and 185 (97.3%) from the urban were knowledgeable about family planning services. The majority of respondents 176 (92.6%) from rural and 170 (895 %) from urban felt that it was alright for the media to carry out family planning information. (Table 12). This same table, shows that a higher percentage 162 (85.3%) of rural and 182 (95.8%) of urban had at least heard about family planning, (X^2 = 12.27, df = 1, p-value = < 0.001), showing an association.

Table 13

Respondents' Specific Methods Used

CONTRACEPTIVE METHOD	RURAL n (%)	URBAN n (%)
Pill	106 (81.5)	118 (76.1)
Condom	6 (4.6)	18 (11.6)
Natural	6 (4.6)	13 (8.4)
Others	12 (9.2)	6 (4.6)
TOTAL	**130(100.0)**	**155(100.0)**

Table 13 shows that the majority, 106 (81.5%) of the rural and 118 (76.1%) of the urban use the pill (a female method) of contraception. There was an association between residence and the use of specific methods of contraception (X^2 59.79 df = 3 p-value = < 0.001).

Table 14

Respondents' Specific Method Used With Their Religion

METHOD	RURAL Total = 130 n (%)				URBAN Total = 155 n (%)			
	Catholic	Protestant	SDA	Others	Catholic	Protestant	SDA	Others
PILL	18 (13.8)	14 (10.8)	73 (56.2)	1 (0.8)	4 0 (21.1)	44 (28.4)	28 (18.7)	6 (3.2)
CONDOM	4 (3.1)	1 (0.8)	1 (0.8)	0 (0)	8 (25.8)	3 (1.9)	4 (2.6)	3 (1.9)
NATURAL	1 (0.8)	2 (1.5)	3 (2.3)	0 (0)	4 (2.6)	3 (1.9)	4 (2.6)	2 (1.3)
OTHERS	5 (3.7)	4 (3.1)	3 (2.3)	0 (0)	1 (0.6)	4 (2.5)	1 (0.6)	1 (0.6)
TOTAL	28(22.0)	21(16.0)	80(62.0)	1(0.8)	53 (34.0)	54 (34.8)	36 (23.5)	12 (7.7)

Table 14 highlights that the majority of the family planning users had the pill as the commonest method of contraception. Among these, more than half, 73 (56.2%) of rural were SDA, while 44 (28.4%) of urban were Protestants.

Table 15

Respondents' Job of Their Wives with Discussion of Family Planning Issues

OCCUPATION OF THE SPOUSE	RURAL TOTAL = 190 n (%)		URBAN Total = 190 n (%)	
	YES	NO	YES	NO
Formal	5 (3.5)	2 (4.3)	19 (10.0)	5 (3.0)
Farmer	39 (27.1)	14 (30.4)	30 (16.0)	3 (2.0)
Self employed	69 (47.9)	23 (50.0)	66 (35.0)	12 (6.0)
Others	31 (21.5)	7 (15.2)	39 (21.0)	16 (8.0)

Table 15 shows that most of the respondent's spouses 69 (47.9%) from the rural and 66 (42.9%) from the urban who were self-employed discussed family planning issues with their husbands. (X^2 = 25.30, df 5 P-value =<0.001). Hence there is an association between 0ccupation of the spouse and discussion of family planning .

SECTION B

FOCUS GROUP DISCUSSION MATRIX FOR URBAN MARRIED MEN

INTERVIWEES	:	12 married men
TOPIC	:	Factors influencing male interest in the use of family planning
VENUE	:	Monze urban
DATE	:	2ND April 2001
TIME	:	10:30 hours – 11:05 hours
AGE GROUP	:	25 – 34 years
LEVEL OF EDUCATION	:	Grade 10 –12

FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS
	MEANING OF FAMILY PLANNING	
5 (men)	It is the control of the number of children by using contraceptives	-
2 (men)	It is the spacing of children and prevention of STD including HIV/AIDS	-
4 (men)	It is the limiting of the number of children due to the hard economic state of the country	-
FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS
	METHODS OF FAMILY PLANNING KNOWING	
6 (men)	Condoms and oral contraceptive pills	-
5 (men)	Withdrawal and injectables	-
1 (man)	Abstinence	-
FOCUS GROUP DISCUSSION NUMBER	TOPIC	REASONS
	MALE METHODS MOST PREFERRED	
10 (men)	Condom	Because a condom is easy to carry, use and store
1 (man)	Withdrawal	Because there is no need to carry anything. It is just natural
1 (man)	None	Because none of the male methods are reliable

FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS Explain a bit more
	WHY IS IT THAT SOME COUPLES DO NOT USE FAMILY PLANNING METHODS EVEN IF THEY KNOW THEM AND THEY WANT TO SPACE THEIR CHILDREN?	
3 (men)	Some couples are simply not interested. They feel that it's a sheer waste of time.	-
2 (men)	Some people have no love for their wives	Honestly, if one loves his wife, you would want her rest at intervals before another birth for her to be healthy
3 (men)	A lot of couples fear the side effects of the contraceptive methods	Sterility in women and impotence in men are common side effects of contraception which are feared most
4 (men)	Religious beliefs	A number of couples believe that God's plan for marriage is to procreate. Also traditionally, in case where a child dies, there is need for replacement, so in such cases, there is no need to use contraception

FOCUS GROUP DISCUSSION NUMBER	TOPIC	DO YOU FIND THIS HELPFUL?
	DO YOU DISCUSS FAMILY PLANNING ISSUES WITH YOUR PEERS OR OTHER OLDER MEN?	
11 (men)	Yes, we do this on quite a number of times	Of course it is very helpful especially this time of hard economic hardships. We get a great deal of good advice from these discussions.
1 (man)	No, I have never done it in my life, I mean I am speaking as an individual	Well after this fruitful discussion today I will also try to seek assistance from other peers
FOCUS GROUP DISCUSSION NUMBER	TOPIC	SOURCES
	HOW LONG DOES IT TAKE YOU TO REACH YOUR SOURCE OF FAMILY PLANNING SERVICES?	
3 (men)	About ten minutes	Hospital (mission)
9 (men)	About 5 minutes	Manungu Health Centre

FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS What are the issues you discuss?
	DO YOU DISCUSS FAMILY PLANNING ISSUES WITH YOUR SPOUSES?	
10 (men)	Yes we do	As breadwinners we tell our wives the number of children we want to have i.e. the number we can support. We tell them which method to use, normally it's the contraceptive pill which is easy for them to swallow.
2 (men)	No, we do not. This is because we have no time to discuss these issues with women. We can just tell them what to do, not matters of family planning because it's not their concern.	-

FOCUS GROUP DISCUSSION NUMBER	TOPIC	WHICH CHURCH DO YOU BELONG TO?
	WHAT IS YOUR CHURCH'S POSITION CONCERNING FAMILY PLANNING USE?	
5 (men)	For us the church allow, us to freely use family planning methods. There is even what they call Family Life Movement where couples can be counseled and have their queries answered	SDA
7 (men)	As for the church traditional teachings do not allow us to use artificial family planning except for natural family planning because the church believe that God want us to procreate. However, nowadays, we feel its up to individuals to make up their minds to choose which method of contraception to use because of economic hardships. To tell you the truth, we make informed choices and use whichever artificial method we want.	Roman Catholic

FOCUS GROUP DISCUSSION NUMBER	TOPIC	REASONS
	PREFERENCE BETWEEN TRADITIONAL AND MODERN FAMILY PLANNING METHODS	
12 (men	Prefer modern methods of contraception	Because these have a scientific proven mechanism of action
FOCUS GROUP DISCUSSION NUMBER	TOPIC	HOW SURE ARE WE OF THIS?
	WHY IS IT THAT SOME OF YOU DO NOT USE FAMILY PLANNING SERVICES?	
6 (men)	Well it 's due to lack of family planning knowledge among us	5 out of the six men said " we can confess that we have little knowledge on family planning"
4 (men_	Us men we don't like using condoms because their prolonged use can harm our male sexuality and cause sterility in our wives and other health concerns.	One man said, "I saw a wife of my friend become barren after using a pill. Another man said, "My own wife developed high blood pressure while in labour following use of oral contraceptives. Two of my friends are impotent.

FOCUS GROUP DISCUSSION NUMBER	TOPIC	WHY IS IT SO?
	IN YOUR HOMES, WHO DECIDES WHICH CONTRACEPTIVE METHOD TO USE AND THE NUMBER OF CHILDREN TO HAVE?	
11 (men)	Of course its us men and not the women	This is because us men we are the decision makers and breadwinners. The woman is there as a recipient to carry out orders and conceive babies only.
1 (man)	Both of us partners	This is so because we are equal partners and we need to agree not imposing this on the wife
FOCUS GROUP DISCUSSION NUMBER	TOPIC HOW ARE THE SERVICES PROVIDED AT YOUR SOURCE OF FAMILY PLANNING SERVICES?	WHICH IS YOU SOURCE
8 (men)	Generally we can say they are good. We can not complain at all.	Public or government
4 (men)	The services are very good although the price of contraceptives is a bit expensive	Private sources
FOCUS GROUP DISCUSSION NUMBER	TOPIC HOW DO YOU FEEL BEING ATTENDED TO BY A FEMALE HEALTH CARE PROVIDER?	EXPLAIN YOUR ANSWER
9 (men)	We feel its alright, we do not have any problem at all	Being attended to female health workers is alright because they are the majority and have always attended to us even when we have STDs. So why feel shy?
3 (men)	We feel shy and think its not good to be attended to by women health workers.	We say so because there are certain male issues which can be discussed in details with only male attendants who can understand us better.

FOCUS GROUP DISCUSSION NUMBER	TOPIC	EXPLAN WHY
	WHAT TYPE OF ENVIRONMENT WOULD YOU SAY YOU PREFER TO CONSULT OR SPEAK FREELY TO A HEALTH WORKER	
3 (men)	We would prefer a male only family planning clinic	Male only family planning clinics enable us freely to explain our problems and make us feel we are really involved in family planning.
9 (men)	Maternal Child Health Clinics (MCH) clinics are alright for us	This is because we can also be attended to there and we can get what we want too.

FOCUS GROUP DISCUSSION NUMBER	TOPIC WHICH DO YOU THINK IS THE BEST WAY TO MOTIVATE COUPLES WHO DO NOT USE FAMILY PLANNING SERVICES TO DO SO?	REMARKS
6 (men)	There is need to talk to both husband and wife concerning family planning services unlike in the past and even now where health workers only talk to our wives and ignore us.	-
2 (men)	There is need to introduce community based contraceptive distributors so that men can have easy access to family planning services and learn and use available methods after making informed choices.	-
4 (men)	Health workers should involve male (peer educators) if they want family planning services to become widespread, that is, if they want men to make a difference.	-
FOCUS GROUP DISCUSSION NUMBER	TOPIC WHICH IS THE BEST WAY TO PREVENT THE SPREAD OF SEXUALLY TRANSMITTED DISEASES AND HIV/AIDS INFECTION	REMARKS
2 (men)	Stick to one sexual partner	-
2 (men)	Use a condom when you have sex outside matrimonial home.	-
3 (men)	Abstinence for *widows/widowers and divorcees*	-
4 (men)	The church must take an active role in the prevention of STDs/HIV/AIDS by teaching family planning	-

FOCUS GROUP DISCUSSION MATRIX FOR RURAL MARRIED MEN

INTERVIWEES	:	12 married men
TOPIC	:	Factors influencing male interest in the use of family planning.
VENUE	:	Monze rural
DATE	:	10th April 2001
TIME	:	12:30 hours – 12:35 hours
RECORDING	:	Matthew Munahiba
AGE GROUP	:	25 – 34 years
LEVEL OF EDUCATION	:	Grade VII (7)

FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS
	MEANING OF FAMILY PLANNING	
7 (men)	It is a system put in place to space children	-
5 (men)	It is a way spouses use to prevent themselves from getting STDs, HIV/AIDS	-
FOCUS GROUP DISCUSSION NUMBER	TOPIC	REMARKS
	METHODS OF FAMILY PLANNING KNOWN	
3 (men)	Contraceptive pills for women	-
5 (men)	Condoms	-
1 (man)	Natural method	-
2 (men)	Abstinence	-
1 (man)	Withdrawal	-
FOCUS GROUP DISCUSSION NUMBER	TOPIC	WHY
	MALE METHODS MOST PREFERRED	
11 (men)	Condoms	Can be used to prevent STDs and easy to keep and carry.
1 (man)	Withdrawal	Because it's a natural method which does not need to be collected and stored

FOCUS GROUP DISCUSSION NUMBER	TOPIC WHY IS IT THAT SOME COUPLES DO NOT USE FAMILY PLANNING EVEN IF THEY KNOW THE METHODS AND WANT TO SPACE CHILDREN	EXPLAIN A BIT MORE
12 (men)	Its because they lack knowledge on family planning and access to sources of such services	The cause of this is because health facilities are only for women and children and men are not involved at all.
FOCUS GROUP DISCUSSION NUMBER	TOPIC DO YOU DISCUSS FAMILY PLANNING ISSUES WITH YOUR PEERS OR OTHER OLDER MEN?	REMARKS WOULD YOU SAY YOUR DISCUSSIONS ARE HELPFUL OR NOT
12 (men)	Yes we do. Actually on a good number of times we discuss these issues	They are very helpful because we tend to learn a lot through exchanging information with each other.
FOCUS GROUP DISCUSSION NUMBER	TOPIC HOW LONG DOES IT TAKE YOU TO REACH YOUR NEAREST SOURCE OF FAMILY PLANNING SERVICES	EXPLAIN A BIT MORE
9 (men)	Its about 21 km so when cycling it can take 2 hours but walking may be it can take 4 –7 hours	-
3 (men)	Its about 5 to 10km so it takes 1 hour to 3 hours	-

FOCUS GROUP DISCUSSION NUMBER	TOPIC DO YOU DISCUSS FAMILY PLANNING ISSUES WITH YOUR SPOUSE?	WHAT ARE THE ISSUES DISCUSSED? IF NOT WHY IS IT SO?
9 (men)	Yes, we discuss	We normally discuss issues pertaining to child spacing and limiting the number we can manage to take care of.
3 (men)	No. we actually don't do so	We feel there is no need to do so because all a man need is to just tell the woman to do what a man want her to do. For example you just tell her to collect contraceptive pills to swallow. If she refuses to carry out such orders then its an indication that she is not interested in her marriage any more.
FOCUS GROUP DISCUSSION NUMBER	TOPIC WHO DECIDES ON WHAT CONTRACEPTIVE METHOD TO USE AND THE NUMBER OF CHILDREN TO HAVE	WHY
1 (man)	It's the men because they are the decision makers, head of households and breadwinners.	Women are to be submissive to their husbands. They are recipients.
1 (man)	Both the husband and the wife decides on the best method to use and when to have the children and the number they want.	A husband who loves his wife need to give her chance to decide what is best for her and the family e.g. if she delivers by caesarean section, she needs to actively decide the type of method of family planning and the number of children to have.

FOCUS GROUP DISCUSSION NUMBER	TOPIC	WHICH CHURCH DO YOU BELONG TO?
	WHAT IS YOUR CHURCH'S POSITION ON FAMILY PLANNING USE?	
8 (men)	The church allow us to do so.	SDA
4 (men)	For us, the church does not allow that, but as individuals we still go ahead and use the prohibited methods because it's for our own good	Roman Catholic
FOCUS GROUP DISCUSSION NUMBER	TOPIC AMONG YOU MEN WHO ARE HERE WHAT ARE YOUR REASONS FOR NOT USING FAMILY PLANNING?	EXPLAIN FURTHER
4 (men)	We fear side effects	Sterility in women and partial impotence in men
2 (men)	We want more children	In case of deaths we have to replace children
2 (men)	We don't want to allow our wives to do so because they can become promiscuous	-
2 (men)	Our church's teaching is that God's plan for us is to procreate	-

FOCUS GROUP DISCUSSION NUMBER	TOPIC HOW DO YOU FEEL BEING ATTENDED TO BY FEMALE HEALTH CARE PROVIDERS AND HOW IS THE ENVIRONMENT AT THE FAMILY PLANNING SOURCE	IF NOT HAPPY WHY IS IT SO?
10 (men)	We have no problem. They are just alright for us. The MCH clinics are also alright for us.	-
2 (men)	We do not like to be attended to by females even just where we collect these methods, we prefer to have a separate place fo male only.	It is naturally just hard to explain all your problems to a female. You can't be free unless its your fellow man.
FOCUS GROUP DISCUSSION NUMBER	TOPIC HOW DO YOU THINK WE CAN ENCOURAGE MEN TO USE FAMILY PLANNING SERVICES?	
12 (men)	Teach men about family planning services. Reach men in all corners of the country including us in rural areas	-
FOCUS GROUP DISSCUSSION NUMBER	TOPIC WHICH IS THE BEST WAY TO PREVENT THE SPREAD OF SEXUALLY TRANSMITTED DISEASES AND HIV/AIDS INFECTION	
7 (men)	To be faithful to only one partner	-
5 (men)	To use condoms for most of us who cannot manage to have only one woman.	

discussion, only 12 rural and 12 urban respondents managed to attend.

6.2 DEMOGRAPHIC PROFILE OF RESPONDENTS

It is important to know the demographic characteristics of the respondents because it helps to assess the representativeness of the sample.The other reason is that, this could have a bearing on how the study subjects respond to family planning services.[7]

The study revealed that majority of the respondents fell in the age range 25-34 years. There was little difference between the rural, 79 (41.6%), and the urban 78 (41.1%), in this age group (Table 1). This age distribution gives a typical sexually active reproductive age group, implying that they are more likely to have more children in the future. than they have at the moment. The least age group were the young adults, 15 – 24 years with 15 (7.9%) from the rural and 11 (5.8%) from the urban. (Table 1).

The respondents included 5 (2.6%) men from the rural and 4 (2.1%) from the urban who were either widowed or divorced(Annex Table 22).The majority 151 (79.5%) from the rural and 162 (85.3%) from the urban were in the monogamous type of marriages.More of the rural marriages 35 (18.4%),were in polygamous marriages than 24 (12.6%) from the urban (Annex table 23).

The findings of the study have shown that more than half of the respondents 97 (51.1%) from the rural had primary education while the majority of the urban respondents 78 (41.1%) had secondary education,.Those who attained college level of education and above were only 17 (8.9%) from the rural while urban had more, 50 (26.3%), (Table 1).This is helpful for understanding family planning policies and their implications. While education still remains a strong predictor of men's attitude towards family planning, the findings of this study for the rural community disagree

<0.001) showing an association between knolewledge and residence.

All urban and the majority of rural respondents knew at least one method of contraception (both traditional and/or modern) except for 9 (4.7%) from the rural who did not know a single method (Table 5). The methods men were most likely to know were the pill (a female method of contraception, with more than half, 111 (58.4%), being from the urban while only 88 (46.3%) were from the rural. The condom was the commonly known male method with majority of the respondents, 70 (36.8%) being from the urban and 38 (20.0%) from the rural. The least known methods in the category of others were injectables, implants, foaming tablets, female sterilization and vasectomy. Other methods such as traditional male methods like periodic abstinence and withdrawal were least known, (Table 5).

The findings of this nature may imply that this knowledge on the male contraceptive (condom) among the urban respondents is due to wide media advertisement as a way of preventing HIV/AIDS and other STDs. Their rural counterparts could have less knowledge on condoms and other methods due to lack of access to media and limited family planning facilities, as well as their low education. Access to health facilities and media show a positive impact on men regarding family planning methods, especially the use of condoms with the emergency of the AIDS pandemic.

The study revealed that the majority of respondents using FP 99 (76.2%) from the rural and 105 (67.7%) from urban had government/public Hospital and health centers as their source of family planning services, (Table 7).

It is very important for the investigator to determine respondents' knowledge of specific methods, places where they can be obtained and the general accessibility of

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It is very important for the investigator to determine respondents' knowledge of specific methods, places where they can be obtained and the general accessibility of

these methods and services since it is a precondition for their use.This information is therefore very vital to family planning programme officers and policy makers.

6.4 FAMILY PLANNING COMMUNICATIONS

Most of the urban respondents, were well-informed about family planning services, 182 (95.8%) from the urban and 162 (85.3 %) of the rural had heard of family planning services,(Table 12). Their initial source of information were the health workers with 105 (80.8%) from rural and 107 (69.0%) from the urban. The other sources of information were friends/relatives and the media, (Table 6). These findings are contrary to other research results which have shown that women were often the source of family planning information to their partners.[11]

Respondents were also asked whether they consider it acceptable or not to carry out family planning messages over radios, Television or the Print media. 170 (89.5%)of the urban and 176 (92.6%) of the rural respondents, (Table 12), felt that it was alright to carry these messages on mass media because it helps to disseminate this information to wider areas including remote places.This information helps the researcher to assess the level of popular support for family planning education and advertising especially on the media.

6.5 INTERSPOUSAL FAMILY PLANNING COMMUNICATIONS

The study revealed that discussion of family planning between husband and wife was very high for both urban and rural communities, 144 (75.8%) rural and 154 (81.1%) urban (Table12).Inter-spousal communications is very important because it is a pathway to eventual adoption and sustained use of family planning.Lack of inter-

spousal discussion may reflect a lack of personal interest, hostility to the subject or a customary reticence in talking about sex related matters.

The findings also showed that there was an association between the occupation of the wife and discussion of family planning (x^2 =25.30, df = 5, p-value = <0.001), (Table 15). Most of the respondent's spouses, 69 (47.9%) of those in rural and 66 (42.9%) in the urban areas who were self employed, discussed family planning issues with their husbands. (Table 15). These findings are in line with the findings of the Population Reports (1998), which found that a woman who had some economic power also may be more likely to discuss family planning with her husband.[23] In Togo women who worked for cash and invested some of it in credit or savings plans reported the highest levels of communications with their husbands about family planning. The level was substantially higher than among women who worked for cash but did not invest or who did not work for cash at all.[23]

6.6 ATTITUDES OF MEN TOWARDS FAMILY PLANNING

The use of attitudinal information is not very suitable for precise or detailed interpretation because it does not uncover the depth of feeling or its origin. Although with regard to information on the wife's attitude, the husband may be wrong about his spouse's opinion, this perception is however important, since it may be a factor in shaping his behavior.

Nevertheless, this data does portray the general climate of opinion. Therefore, the information is useful in the formation of family planning policies, by indicating the extent to which further education and publicity is needed to gain acceptance of the principle of contraception.

According to the findings of this study, the majority of the respondents do approve of and use family planning. A higher proportion of the users, 155 (81.6%), were from the urban, while 130 (68.4%) were from the rural area, (Table 2a).

Those with higher education and those in the 30s are more likely to approve of and use family planning than others, (Table 2b).

Only 95 (25.0%) of the total respondents did not approve of the use of family planning. The majority of these, 60 (63.2%), were from the rural while only 35 (36.8%) were from the urban areas. The main reason cited by these for not using family planning services, 27(45.0%) of the rural and 13 (37.1%) of the urban respondents was that they wanted more children for labour and prestige, (Table 8).

The second reason advanced toward non-use of FP was lack of knowledge on family planning services and sources with 13 (21.7%)) from the rural and 6 (17.1%) from the urban, (Table8).

A higher percentage, 17 (28.3%) from the rural and 12 (34.3%) from the urban, among the non-users of FP stated that they intended to use family planning in future citing spacing of children as the main reason for the plans, (Table 11).

The majority of the respondents 166(87.4%) from the rural and 173 (91.1%) from the urban felt that family planning issues were important, because it helped couples to space and limit children, (Table 12). There was an association between importance of family planning and residence, ($x^2 = 69.89$, df = 2, p-value = < 0.001),(table 12).Despite not currently using family planning, a large number of non users of FP 37(62.0%) from the urban and all 35 (100%) from the rural intend to use family

planning for various reasons such as ,spacing children, for the wife to be healthy, (table 11).

The results of this study may imply that even though men do not fully use family planning services, they have a positive attitude in the use of family planning. This, therefore, means that they do support the use and appreciate their important roles in decision making pertaining to family planning, to family life, and the well being of their wives and children.

6.7 FAMILY PLANNING USE

The majority of the respondents, 155 (81.6%) from the urban and 130 (68.4%) from the rural, used family planning services, (Table 2a).The users mainly relied on modern methods of contraception.The contraceptive pill (a female method of contraception), was the most commonly used method by the spouses of the respondents, 118 (76.1%) from the urban and 106 (81.5%) from the rural, (Table 13). The condom was the commonest male method used by the respondents with 18 (11.6%) from the urban and 6 (4.6%) from the rural using it. (Table 13). The use of the condom may appear to be very low because men may avoid using them with their marital partners if they feel it decreases sexual pleasure. In addition, marital partners may be using more effective methods like the pill to prevent pregnancy. Thus the relevance of condom use within marriage may be limited.[11]

Most of the men using family planning methods, 99 (76.2%) from the rural and 105 (67.7%) from the urban, said that their major source of family planning services were public/Government sources with the least being served by others which include the traditional healers and other private sources, (Table 7).

Among currently married men who were not using contraceptives, 27 (45.0%) from the rural and 13 (37.1%) from the urban did not do so because they wanted more children, (Table 8). Contraceptive use was highest among respondents from the urban 155 (81.6%) than from the rural area 130 (68.4%), (Table 2a).

This was in part because people in urban areas have better access to family planning services and information and in part because they are more likely to be educated. In Morocco, where half the population live in urban areas, 51 percent of married men living in urban areas practice family planning compared to 30 percent of those living in rural areas.[24]

The majority of the family planning users were in their 30s. This is also in line with results of DHS of 1987 where in Tanzania and Morocco contraceptive use was found to be highest among those in the 30s than in the 40s. The lowest use was in the young age groups of 15 – 19 years. This may imply that young men who are starting a family did not use contraception because they wanted to have a certain number of children first. On the other hand, the use of contraceptives was more in the 30s for spacing children and suggesting that men above this age, having reached a desired number of children, may not be as interested as young men to use family planning services.

While knowledge on family planning services and contraceptive methods was high, the use of family planning was still quite low. This could partly be due to the fact that, despite these having high knowledge of family planning, they may still not really understand the issues behind family planning.

These findings demonstrate that people's perceptions of family planning affect whether they will use it/or not. Those who think that practicing contraception

provides health benefits are likely to use a method, as are those who perceive that family planning will help to improve their standard of living.

The study also shows the impact that social support network can have on contraceptive use. Individuals who have an influence on their spouses had a positive effect on their contraceptive behavior. Equally, health care providers who can influence their clients to use FP services can have a positive effect on their contraceptive behavior.

Therefore, it is important to identify those who can act as agents of social change and to increase their support for contraception. Their endorsement of family planning may help increase contraceptive use among their family and other community members.

6.8 SUMARRY OF FOCUS GROUP DISCUSSIONS

A COMPARATIVE SUMMARY OF FOCUS GROUP DISCUSSION FOR RURAL AND URBAN COMMUNITIES

TOPICS DISCUSSED

TOPIC ONE

i. DEFINITION OF FAMILY PLANNING

Most of the respondents defined family planning as a way of spacing and limiting the number of children using contraceptives, (9 men urban Vs 7 men rural). A good number of rural men and few urban (5 men Vs 2 men) defined family planning as a way of preventing Sexually Transmitted Diseases including HIV/AIDS. These findings were a bit similar to the interview results where all the urban respondents knew the definition while more of their rural counterparts did not.

ii. METHODS OF FAMILY PLANNING KNOWN

Six (6) urban men and 5 rural men knew of the condom. The same 6 urban men knew of the oral contraceptives while only 3 men in rural knew of the oral contraceptive pill. Five urban men reported withdrawal and injectables and only 1 rural reported knowing withdrawal. Two (2) men (one urban Vs one rural) reported the knowing the abstinence method. The other method reported by the rural respondents was natural scientific method (1 man).

iii. MALE METHOD MOST PREFERRED

The majority of the respondents (10 men urban Vs 11 men rural), preferred using condoms, citing that they were easy to carry, use and store. A total of 2 men (1 urban Vs 1 rural) preferred the withdrawal method because they felt that it was natural. Only one (1) man from the urban preferred none of the male methods because he felt that all male methods were unreliable.

iv. REASONS FOR LOW UTILIZATION OF FAMILY PLANNING SERVICES AMONG MEN

All the 12 rural men stated that the low use of family planning among men was because of lack of knowledge and access to source of family planning services. Urban men had varied reasons why they felt that men did not adequately utilize family planning services. These were, (3 men), that some couples were simply not interested. Four men cited religious and cultural beliefs, i.e. the belief that God's plan for marriage was to procreate. Also traditionally, in case a child dies, there is need for replacement. Three men, cited fear of side effects of contraceptives i.e., contraceptive pills causing sterility in women and condom use causing impotence in men. Two men indicated the lack of love for their wives by not giving them ample time to rest between births. The response from the 12 rural men (lack of access and knowledge on family planning) also emerged as a major reasons why men seem uninterested in the use of family planning from the interview results. The other reasons advanced by the urban men such as fear of side-effects, demand for more children, as well as religious reasons like God' need for procreation, also came up as part of the reasons for low utilization of family planning services among rural men..

v. DISCUSSION OF FAMILY PLANNING ISSUES WITH PEERS OR OTHER OLDER MEN

Almost all urban respondents, (11 men), admitted discussing family planning issues with their peers or other older men because these discussions were helpful in order to plan for their family welfares. Only one man stated that he has never discussed these issues with peers but from there onwards promised to do so because he realized the benefits. For rural men, all the 12 agreed discussing these issues with other men as they learnt a lot from the exchange of these information.

vi. DISTANCE TO FAMILY PLANNING SERVICES

The urban men stated that it only took them about 5 minutes (9 men) and 10 minutes (3 men) to reach their family planning source. Their rural counterparts had to take more time to reach their source of service, i.e. about 4 – 7 hours (9 men), and take 1 – 3 hours walking for (3 men)

vii. PREFERENCE BETWEEN TRADITIONAL AND MODERN METHODS

All the 12 urban men stated that they preferred using modern methods of contraception because these have a proven scientific mechanism of action. For the rural respondents, only 4 men had the same line of thought with their urban counterparts. The majority of the rural group, (8 men), preferred to use traditional methods because they had proved that it works. They further cited that traditional methods were free from side effects unlike the pill. And worse still, the condoms, which could burst any time while in use.

viii. DECISION ON CONTRACEPTIVE METHODS AND THE NUMBER OF CHILDREN TO HAVE

An Equal number of both urban and rural men ,(11), in both groups stated that men

are the breadwinners, decision makers and heads of the households. Therefore, they are the people who decide what method of contraception to use and what number of children to have and when. This is so because women are just recipients and therefore have to be submissive to their husbands. The remainder (1 man rural and 1 man urban), stated that it was the duty of both partners to make joint decisions on the method of contraception to use and the number of children to have because they are all equal. The rural man went ahead to say he felt that the woman also needed to take part in such kind of decisions. For example if her deliveries were all by caesarean sections, she needed to actively take part in deciding the best method and the number of children to have because it is her health which matters.

ix. PREFERRED SEX OF HEALTH PROVIDER

The majority of urban men (9) felt that it was alright to be attended to by female care providers because they are the majority and have always attended to them even in cases of STDs. Ten (10) of the rural men agreed with this line of thinking. Three urban men however, felt that they preferred to be attended to by fellow males because they feel shy with female attendants, and 2 rural men agreed with the latter.

On the environment or source of Family Planning Services, 3 urban men and 2 rural men preferred a male -only clinic, where as the majority, 9 of the urban men and 10 of the rural men felt that Maternal and Child Health Clinics were alright for them to obtain their family planning services. These results were similar to the interview findings where most of the men did not mind to use the same existing health services for family planning.

x. HOW TO ENCOURAGE MEN TO USE FAMILY PLANNING SERVICES

All the 12 rural men felt that there was need to teach men about family planning services in all corners of the country, including those in the rural areas.

Urban men had various ways to motivate men in the use of family planning services. These were: six men said there was need for health workers to discuss family planning issues with both wife and husband unlike in the past and even now where husbands are ignored and the talk is only given to the wife. Two men suggested the introduction of community-based distributors for men to have easy access so that they can learn about and use the available methods after making informed choices. Four men said health workers need to involve peer educators for these services to become widespread, i.e. they want men to make a difference. These results were also similar to the suggestions obtained from the interview findings. Thus, family planning awareness programmes have had and may continue to have an influence on Zambian men's contraceptive behaviour. The importance of intensifying these programs ,especially in rural areas, can not be over -emphasized.

6.9 IMPLICATIONS OF THE STUDY

The study findings have shown that substantial numbers of Monze men are actually using family planning services directly or indirectly through their spouses, and they have expressed their desire to become even more actively involved in all matters involving family planning services.

Lack of information on family planning services and access to sources of supply are some of the major factors identified as hindrances to full utilization of family planning services. The desire for more children - despite men's high knowledge on family planning and contraceptive methods - may still affect their use to some extent.

It is encouraging to find out that inter-spousal communication is high for both urban and rural men,(table 14). These findings show that men are moving away from traditional cultures where male dominance was a major obstacle to spousal communication about family planning. From a policy perspective, men's involvement in reproductive health and family planning should be viewed as desirable not only for equity reasons but because programmes and health outcomes for both men and women are likely to improve as a result.

CHAPTER SEVEN

7.0 CONCLUSION

Adequate information on socio-cultural factors that influence male approval and use of family planning is essential for developing programmes relating to family planning services. This study has identified some of the factors and needs that appear to influence men's use of family planning.

It is a common belief that men in general do not show any interest in using or supporting their partners to use family planning. The study findings, however, dispute this notion. Instead, the findings show that men are in fact interested and are actively involved in the use of family planning and encourage their spouses to do so.

According to this paper, factors such as age, residence, education, number of children, family planning and contraceptive knowledge and specific methods used may predict male interest in the use of family planning, which need to be taken care of or borne in mind when implementing family planning programmes.

7.1 RECOMMENDATIONS

- Service providers need special training in male counseling and inter –spousal communication issues since they play a big role in breaking down barriers to men's' involvement in family planning use.

- Men still need information on family planning issues and need more access to these services. To cater for this, policy makers need to ensure that this is provided through the existing services and make them more male-friendly.

- The gap between knowledge and practice need to be seriously looked into in

order to reduce the existing gap.

- Male involvement initiatives should be encouraged and reinforced through peers, group discussions and the media.

ANNEXES

ANNEX 1: REFERENCES

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ANNEX 2: QUESTIONNAIRE

Confidential

Questionnaire No:

QUESTIONNAIRE FOR MARRIED MEN ON FACTORS INFLUENCING MALE INTEREST IN THE USE OF FAMILY PLANNING SERVICES

AREA CODE:DISTRICT: DATE

NAME OF INTERVIEWER:

INSTRUCTIONS TO RESEARCH ASSISTANTS

1. Always introduce yourself before beginning the interview.
2. Explain the purpose of the study and ask for permission to do the interview.
3. Make the respondent sign the consent form before you start.
4. Assure confidentiality.
5. Do not force a respondent to participate, pull out politely where the respondent is reluctant or unwilling to take part.
6. Do not write the name of the respondent on the questionnaire.
7. Write the appropriate response in the space provided.
8. Remember to thank the interviewee at the end of the interview.

QUESTIONNAIRE

Section 1: Respondent's Background For official use only

1. Sex
   1. Male
   2. Female
2. How old were you on your last birthday?
   _____ Years.
3. Residence
   1. Rural
   2. Urban
4. What tribe do you belong to?

   _____
5. Marital status
   1. Married
   2. widowed
   3. Divorced
   4. Separated
6. If you are married, how many wives do you have?

   _____
7. What is your denomination?
   1. Catholic
   2. Protestants
   3. Muslim
   4. Any Other, please specify _____
8. Level of education
   1. None
   2. Primary
   3. Secondary
   4. college

9. Occupation of the man
   1. Managerial
   2. Teacher/clerical/civil servant
   3. Driver/cleaner/security guard
   4. Farmer
   5. Self-employed

10. Do you usually do this job?
   1. Throughout the year
   2. Half of the year
   3. Seasonally
   4. Once in a while

11. If you do not do this job throughout the year, explain why.

_____

12. How much do you earn, per month? Kwacha _____

13. What do you mainly do during your leisure time?
   1. Drinking beer
   2. Just at home
   3. With friends
   4. Sports
   5. Any other (specify) _____

14. What does your wife do?
   1. Managerial
   2. Teacher/clerical/civil servant
   3. Farmer
   4. Self-employed
   5. Others

15. Do you have any children?

1. Yes
2. No

16. If yes to Q15, how many children do you have?

1. 1 – 3
2. 4 – 6
3. 7 and above

SECTION B: FAMILY PLANNING USE

17. Have you ever heard of family planning methods?

1. Yes
2. No

18. If yes to Q 17, what was your initial source of your family planning knowledge?

1. Friends
2. Relatives
3. Health worker
4. Any other, specify

19. What is family planning?

1. Using contraceptive pills
2. Having few children
3. Using contraception to space children
   can have them at the time you want
4. Others

20. If yes to Q 17, which method (s) or ways have you heard about?

1. Pill
2. Condom
3. Natural scientific
4. Others

21. Do you think it is important to use any family planning method?

1. Yes

2. No

22. Give reasons for your answer

_____

_____

23. Do you or your spouse use any family planning method?

1. Yes

2. No

3. Not sure

24. If yes to Q 23, which method do you use? _____

25. What is the source of your contraception?

1. Government

2. Private medical sources

3. Other private sources (specify)_____

26. What do you think of the services provided at your source of family planning method?

27. For those who are not using a method of contraception, to avoid pregancy now, what is your main reason?(check Q 23).

(a) Fertility Related Reasons:

1. Not having sex

2. Infrequent sex

3. Wife menopausal/hysterectomy

4. Wife subfecund/infecund

5. Post partum/breastfeeding

6. I want more children

7. Wife pregnant

8. On separation with my wife

(b) Opposition to Use

1. Respondent opposed

2. Wife/partner opposed

3. Others opposed

4. Religious prohibitions

(c) Lack of Knowledge

1. Knows no method

2. Knows no source

(d) Method Related Reasons

1. Health concerns

2. Fear of side effects

3. Lack of access/too far

4. Cost too much

5. Inconvenient to use

6. It interferes with body's normal process

7. Up to the woman to use

8. Others, specify _____

28. If No to Q 23, do you or your spouse think you will use a method of family planning to delay or avoid pregnancy in future?

1. Yes
2. No

29. Give reasons for your answer

30. Do you have any traditional beliefs or taboos concerning family planning?

1. Yes
2. No

31. If yes, explain.

32. Do you discuss any family planning issues with your wife?

1. Yes
2. No

33. If yes to Q 32, which are the main issues of contraception do you discuss?

34. Do you accept information on family planning to be Provided through mass media (that is radio, television or newspaper and magazines)?

1. Yes
2. No

35. Give reasons for your answer.

36. In your own opinion, why do you think men seem uninterested to use family planning services?

37. Give suggestions on how best men can be encouraged to utilize family planning services.

_____

_____

_____

_____

END OF INTERVIEW

ANNEX 3: INFORMED CONSENT

Dear Participant,

Data is required from you on your views concerning the use of family planning. The objective of the study is to determine factors that influence male interest in the use of family planning:

1. Participation in this study is voluntary. You are free to withdraw at any stage of the interview if you want.

2. Be rest assured that all information you give will be highly confidential.

3. The information you give will be used by family planning policy makers and programme planners to motivate men to use or encourage their spouses to use family planning in order to improve reproductive health of families and the community at large. Benefits to the participants are long term.

I, ... hereby called participant understand the guidelines of this study and that I am willing to be interviewed. I hereby consent to participate.

Dated this..... day of .....year.....

Signed.....
Participant

Signed.....
Interviewer

Note to the interviewer: If the participant does not know how to read and write, indicate "Agreed" on the space provided for the participant's signature.

ANNEX 4

EXTRA TABLES

Table 16

RESPONDENTS' LEISURE ACTIVITIES WITH THEIR USE OF FAMILY PLANNING

LEISURE ACTVITIES	RURAL n (%)	URBAN n (%)
Drinking beer	29 (22.3)	91 (58.7)
Sports	36 (27.7)	51 (32.9)
Reading, listening to the radio	12 (9.2)	5 (3.2)
Sitting at home	25 (19.2)	5 (3.2)
Church work/gardening business i.e. photocopying	28 (21.5)	3 (1.9)
TOTAL	**130(100.0)**	**155(100.0)**

Table 16 shows that the majority of family planning users among the urban respondents, 91 (58.7%), drunk beer during their leisure activities where as for rural respondents, the majority, 36 (27.7%) were involved in sports..

Table 17

RESPONDENTS' OCCUPATION WITH THEIR USE OF FAMILY PLANNING

OCCUPATION	RURAL n (%)	URBAN n (%)
Managerial	6 (4.6)	13 (8.4)
Civil servant/ clerical / teacher	12 (9.2)	38 (24.5)
Driver/cleaners/ security guard	62 (47.7)	43 (27.7)
Farmer	45 (34.6)	29 (18.7)
Self employed	5 (3.8)	32 (20.6)
TOTAL	**130(100.0)**	**155(100.0)**

The table shows that the main users of family planning were in the formal sector of employment, 62 (47.7%) of these in the rural and 43 (27.%) from the urban.

Table 18

RESPONDENTS' INCOME WITH USE OF FAMILY PLANNING SERVICES

INCOME PER MONTH	RURAL n (%)	URBAN n (%)
Less than K100,000	110 (84.6)	76 (49.0)
K100,000 – K199,000	14 (10.8)	43 (27.7)
K200,000 – K299,000	1 (0.8)	13 (3.0)
K300,000 – K399,000	1 (0.8)	6 (3.9)
K400,000 – K499,000	-	5 (3.2)
K500,000 and above	4 (3.1)	12 (7.7)
TOTAL	**130(100.0)**	**155(100.0)**

Table 18 sows that the majority of respondents, 110 (84.6%)of the rural and 76 (49.0%) of the urban users of family planning fell in the least income group of below K100,000 per month.

Table 19

RESPONDENTS USE OF FAMILY PLANNING SERVICES WITH THE TYPE AND QUALITY OF SERVICES PROVIDED

TYPE AND QUALITY OF SERVICES PROVIXED	RURAL n (%)	URBAN n (%)
Good – excellent	118 (90.8)	143 (92.3)
Long waiting time	2 (1.5)	2 (1.3)
Erratic supplies	6 (4.6)	2 (1.3)
Some methods unavailable/expensive	3 (2.3)	6 (3.9)
Inadequate knowledge about family planning by providers	1 (0.8)	2 (1.3)
TOTAL	**130(100.0)**	**155(100.0)**

Table 19 shows that the majority, 118 (90.8%) of the rural and 143 (92.3%) of the urban respondents stated that their quality of service was good to excellent.

Table 20

REASONS WHY MEN SEEM UNINTERESTED TO USE FAMILY PLANNING IN GENERAL..

REASONS	RURAL n (%)	URBAN n (%)
Want more children for labour and prestige	75 (39.5)	71 (37.0)
Simply not interested	2 (1.0)	1 (0.5)
Fear of side effects	4 (2.0)	20 (10.5)
Lack of knowledge about family planning	18 (9.5)	6 (3.0)
Lack of access	70 (36.8)	51 (26.8)
Fear that husband/ wives may become promiscuous	5 (2.6)	15 (7.9)
Fear of unknown	15 (7.9)	12 (6.3)
Fear that prolonged condom use may harm male sexuality	1 (0.5)	1 (0.5)
Culture/ religious beliefs	0 (0)	13 (6.8)
TOTAL	**190(100.0)**	**190(100.0)**

Table 20 shows that the majority, 75 (39.5%) of the rural, and 71 (37.0%)of the urban respondents mentioned that men seem uninterested in the use of family planning services because they want more children for labour and prestige.

Table 21

SUGGESTIONS ON HOW TO IMPROVE MALE INVOLVEMENT IN FAMILY PLANNING

SUGGESTIONS	RURAL n (%)	URBAN n (%)
Target men at workplace and teach them	82 (43.2)	62 (33.0)
Encourage group discussions	6 (3.2)	17 (9.0)
Provide family planning clinics for males only	1 (0.5)	2 (1.1)
Encourage male involvement in family planning clinics and activities	8 (4.2)	28 (15.0)
Inform all people the importance of family planning	93 (48.9)	75 (39.5)
Sensitize all men the need for a small family especially in rural areas	0 (0)	1 (0.5)
To have male instructors in family planning	0 (0)	1 (0.5)
Have men who have succeeded to use family planning talk to other men	0 (0)	2 (1.1)
Advocate for sex education at both primary and secondary school	0 (0)	1 (0.5)
TOTAL	**190(100.0)**	**190(100.0)**

Table 21 shows that the majority,93 (48.9%) rural, and 75 (39.5%) urban respondents stated that informing all people on the importance of family planning was one of the ways to encourage male involvement in the use of family planning.

TABLE 22:

RESPONDENTS' MARITAL STATUS

MARITAL STATUS	RURAL n(%)	URBAN n(%)
Married	185 (97.4)	186 (97.9)
Widowed/ divorced	5(2.6)	4(2.1)
TOTAL	**190(100.0)**	**190(100.0)**

Table 22 shows that the majority of the respondents were married, 185 (97.4%) rural, and 186 (97.9%) urban.

TABLE 23:

RESPONDENTS' TYPE OF MARITAL UNION

TYPE OF UNION	RURAL n(%)	URBAN n(%)
Monogamous	151 (79.5)	162 (85.3)
Polygamous	35 (18.4)	24 (12.6)
Others	5 (2.6)	4 (2.1)
TOTAL	**190(100.0)**	**190(100.0)**

Table 23 shows that the majority, 151 (79.5%) rural, and 162 (85.3%) urban respondents were in the monogamous type of marriages.

ANNEX 5

FOCUS GROUP DISCUSSION GUIDE FOR MARRIED MEN

INTRODUCTION

1. Welcome the participants warmly.
2. Introduce yourself and the recorder to the group, then ask participants to introduce themselves too.
3. Explain the purpose of the discussion.
4. Assure participants of confidentiality and encourage them to feel free in the discussion.

TOPICS FOR DISCUSSION

1. Definition of family planning.
2. Methods of family planning known.
3. Among the male methods you mentioned, which one do you prefer and why?
4. Why is it that some couples do not use family planning methods even when they know about them and want to space their children?
5. Discussion of family planning issues with peers other than adult men.
6. Accessibility to source of family planning services.
7. Among the given methods, which ones do you prefer (traditional or modern)?
8. Who decides what contraceptive to use and the number of children to have? Give reasons.
9. Views towards attendance by female health workers.
10. Suggestions on how to motivate men to use family planning.

THE UNIVERSITY OF ZAMBIA

Research Ethics Committee

Telephone: 252641
Telegram: UNZA, Lusaka
Telex: UNZALU ZA 44370

Fax: + 260-1-250753

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Your Ref:
Our Ref:

26th October 2000

Ms Irene Basila Muzyamba
MPH student
Community Medicine Department
UTH LUSAKA

Dear Ms Muzyamba

The following research proposal presented to the Research Ethics Committee on 30th August was approved. Congratulations!

Title of research proposal: **"Factors influencing lack of male interest in the use of family planning (FP) in Monze District".**

Please keep the Committee informed on the progress of your research.

Yours sincerely

Signed:.....
PROF K S BABOO MBBS MMED FRSH DABTM
CHAIRPERSON, RESEARCH ETHICS COMMITTEE

All communications should be addressed
to the District Director of Health and not
to individuals

Telephone 50111/50798/50734/50724

Fax: 50700

In reply please quote:
No:.....

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

Monze District Health Office
P.o Box 660144
MONZE.

1ST DECEMBER 2000

Ms BASILA IRENE MUZYAMBA
UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE,
DEPARTMENT OF COMMUNITY MEDICINE,
P.O BOX 50110
LUSAKA.

Dear Ms. Muzyamba,

RE: CONDUCTING RESEARCH STUDY.

I am writing in response to your request for conducting a research study on factors influencing lack of male interest in the use of family planning in Monze District. We have no objection in your carrying out the study, but would you please provide us with your research proposal before you start. We will also be grateful if you give us a report on your study.

I hope that you will get all the co-operation you need during the study.

Yours sincerely,

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
MONZE DISTRICT HEALTH OFFICE
0 4 DEC 2000
DISTRICT DIRECTOR OF HEALTH
P.O. BOX 660144 MONZE

DR. I. HANSINGO
ACTING DISTRICT DIRECTOR OF HEALTH
MONZE DISTRICT HEALTH OFFICE

CC. Manager Administration
CC. Manager Planning & Development.

REPUBLIC OF ZAMBIA

MONZE DISTRICT COUNCIL

STRICT COUNCIL SECRETARY
lephone: 50433/50434
C.S. Direct Line 50066
legraphic Address
ISCOSEC"
X: 50061

P.O. Box 6601
MONZE
Zambia

MDC/112/32/18

5th January, 2001

Ms. Basil Irene Muzyamba
University of Zambia,
School of Medicine,
Department of Community Medicine,
P.O. Box 5110,
LUSAKA.

Dear Madam,

re: REQUEST TO CONDUCT RESEARCH STUDY.

Reference is made to the letter dated 24th October, 2000, in which you had requested for permission to conduct a research study in the District.

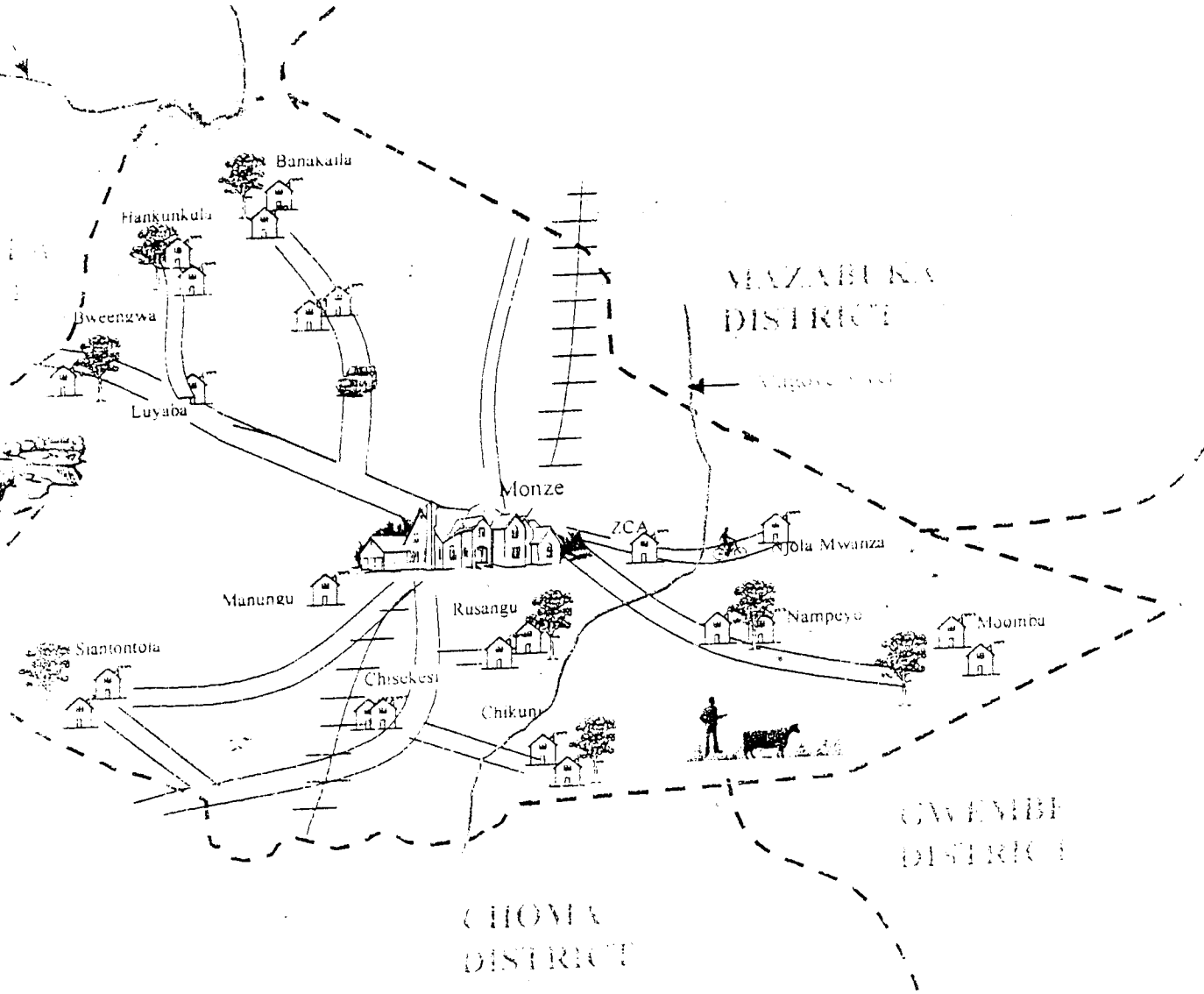
Iam happy to inform you that permission has been granted.

Yours faithfully,

Y. SIMPAMBA
COMMITTEE CLERK
for/COUNCIL SECRETARY
MONZE DISTRICT COUNCIL

/czs*

MONZE DISTRICT MAP



Y

District Boundary

Road

Rail line

River

Hospital

Health Centre