ASSESSMENT OF MEN'S ATTITUDE, PRACTICE AND BARRIERS TOWARDS CONTRACEPTIVE UPTAKE IN MVOMERO DISTRICT

ASSESSMENT OF MEN'S ATTITUDE, PRACTICE AND BARRIERS TOWARDS CONTRACEPTIVE UPTAKE IN MVOMERO DISTRICT

By

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A Dissertation Submitted to the School of Public Administration and Management in Partial Fulfilment for the Award of Master's Degree of Health System Management (MHSM) of Mzumbe University

2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by Mzumbe University, a dissertation titled **"Assessment of Men's Attitude, Practice and Barriers towards Contraceptive Uptake in Mvomero District"** in partial fulfilment for the award of the Degree of Master of Health Systems Management of Mzumbe University.

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DECLARATION

I **Shabani H. Mapinda** declare that this dissertation is my original work and that it has not been presented to any other University for a similar or any other degree award.

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DEDICATION

This dissertation is sincerely dedicated to my mother Rukia Shabani Mndiga.

ACKNOWLEDGEMENT

The successful accomplishment of this report carries a lot of contributions from different people whom I would like to express my special thanks to them.

First of all, I thank God for making this dissertation successful, and I am so proud of my major supervisor Bertha Mwinuka, not only for approving my research but also for her efforts to equip me with knowledge and skills on research writing and report.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
CI	-	Confidence Interval
COC	-	Combined Oral Contraceptives
CPR	-	Contraceptive Prevalence Rate
ECPs	-	Emergency Contraceptive Pills
FH	-	Family Health International
FP	-	Family Planning
HCF	-	Health Care Facilities
HCW	-	Health Care Workers
HIV	-	Human Immunodeficiency Virus
IUCDs	-	Intrauterine Contraceptive Devices
LAM	-	Lactation Amenorrhea Method
MDGs	-	Millennium Development Goals
MHSW	-	Ministry of Health and Social Welfare
OR	-	Odds Ratio
PMTCT	-	Prevention of Mother to Child Transmission
POP	-	Progestin Only Pills
RCH	-	Reproductive and Child Health
SDM	-	Standard Days Method
SPSS	-	Statistical Package for Social Science
UK	-	United Kingdom
UMATI	-	Chama cha Uzazi na Malezi Bora Tanzania
WHO	-	World Health Organization

ABSTRACT

Involvement of men in family planning and contraceptive uptake is vital, as men are mentioned to dominate families' important decisions such as the number of children a couple to have and the spacing of those children(Mosha, Ruben, & Kakoko, 2013). Therefore, study aimed at assessing men's attitude, practice and barriers towards contraceptive uptake in Mvomero District. Data were collected from 110 respondents, whereby Cluster sampling and purposive sampling techniques were used to select respondents of this study. Data were collected using interviewer administered questionnaire, interview and Documentary review methods. Statistical Package for Social Science (SPSS) was used to analyze quantitative data while, qualitative data was analyzed by Content analysis.

The findings of this study showed that 34% of men use contraceptive, while 66% do not use any kind of contraceptives. Also, the results demonstrated that 71% of men are not supportive to their spouse/partners on the use of family planning they do not communicate with their female couples about family planning and 89% do not attend to RCH clinics with their spouse/partners where they would have got some knowledge on family planning services. It was also revealed that men consider family planning is necessary for their family wellbeing and its practice is not a blasphemy. However, men consider contraceptive uptake is a women practice, that it is not necessary for them to use due to their side effects and desire to have many children. This study also found out that knowledge, attitude, traditions beliefs, and religious beliefs are the barriers hindering contraceptive uptake among men. Furthermore, this study pointed out the strategies on place that can ensure male involvement in family planning. These strategies include; the Government commitment in extension of FP services; Provision of family planning products like condoms for free; Recruitment and distribution of adequate and competent health service providers in health facilities; Positive response of religious leaders and community leaders toward family planning; Intensive distribution of condoms in different outlets such as shops, super markets etc; and attendance of male partners in RCH clinics should be compulsory.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Family planning and contraceptive uptake is critical in helping couples and individuals realize their basic right to decide responsibly and freely if, when and how many children to have(Nations, 2015). Involvement of men and women in family planning is important because not only that the growing contraceptive uptake has resulted to improvements in health related outcomes including infant mortality and maternal mortality(Rutstein& Winter, 2015), but also improvement in economic outcomes and schooling, especially for vulnerable groups like girls and women(Joshi & Schultz, 2013). Both men and women have their own types of contraception. For instance, men commonly use male condoms, male sterilization or withdrawal method while women commonly use Oral Contraceptive Pills (OCP), Emergency Contraceptive Pills (ECPs), and Injectable, Implants, Intrauterine Contraceptive Devices (IUCDs), female condoms and female sterilization. The couples who prefer to use natural methods of family planning commonly use fertility awareness methods such as Standard Days Method (SDM), and Lactation Amenorrhea Method (LAM) (Allison & Foulkes, 2014).

People wish to have few children for different reasons including health and economic reasons such as food, shelter and paying school fees, however, the decision to uptake contraceptives seem to be hard especially for men. For instance, more than one in ten married or in-union women worldwide affirm that they want to stop or delay childbearing but are not using any method of contraception to prevent pregnancy; these are considered to have unmet need for family planning (United Nations, 2017). This situation is not good because the benefits of effective contraceptive utilization are overwhelming; the decision for not using family planning cannot be easily justified. For instance, approximately 1 million of the 11 millions of deaths per year of children younger than 5 years could be averted by increasing the birth intervals at least 24 months(Cleland et al., 2006).

In addition, the use of condoms prevents unwanted and unintended pregnancies at the same time reduce the chances of being infected by sexual transmitted diseases including HIV. For instance the reports suggest that contraceptive utilization prevents approximately 173,000 infections in the year (Welsh, Stanback, & Shelton, 2006).

Data on contraceptive use in 2017 demonstrated that 63 per cent of married or in-union women of reproductive age worldwide were using some form of contraception. Contraceptive use in 2017 was above 70 per cent in Europe, Latin America and the Caribbean, and Northern America, while being below 25 per cent in Africa (United Nations, 2017). Data on contraceptive use among men exclusively are still limited worldwide as family planning programmers still concentrate more on women of reproductive age than other groups such as men and youth. Regional difference in the use of some types of contraception is profound, of which in Africa and Europe, short-term and reversible methods like Injectables, pills and male condoms are more common, whereas long-acting or permanent methods such as implant, sterilization and IUCD are more common in Asia and North America(Nations, 2015). The fact the male condom is a common method of family planning in Africa, more concentration should be put on men, as it has been done for women in decades.

Globally, several initiatives had been taken so as to increase family planning and contraceptive utilization under the umbrella of Millennium Development Goals (MDGs). After the Millennium Development Goals reached its peak in 2015, United Nations General Assembly reaffirmed family planning commitments when it adopted the 2030 Agenda for Sustainable Development. There are two targets related to family planning in broader goals on health, gender equality and empowerment of girls and women (Nations, 2015).

Modern family planning in Tanzania started since 1950s, whereby in 1959 Family Planning Association (UMATI) introduced family planning services at urban clinics. Active involvement of Tanzanian Government in family planning started in 1974, when family planning became integrated into maternal and child health services (MCH). In recognition of the benefits of family planning, multiple initiatives were

done, firstly; the establishment of the guidelines for reproductive and child health services through National Health Policy (2003), secondly; family planning was given priority and defined as critical in helping Tanzania achieve targets in the national strategy for growth and reduction of poverty (MKUKUTA) and Millennium Development Goals in the Tanzania vision 2025.

According to Tanzania Demographic Health Survey(ICF Macro, 2011), the increase in the use of contraceptives over the past two decades has resulted to the decrease in Total Fertility Rate (TFR) in Tanzania from 6.3 in 1992 to 5.4 in 2010. It was estimated that 29 per cent of married and unmarried women in Tanzania use some contraceptive method, of which 24 per cent use modern methods of contraception including Injectables (9%), pills (5%) and condoms (4%). In addition, the use of some methods of contraception among married women increased from 10 per cent in 1992 to 34 per cent in 2010 (ICF Macro, 2011). Apparently, most men in Tanzania think family planning is for women, while the youth view family planning as a practice for adults, especially those who have children already(Mungure& Owaga, 2014). Thus, this study is looking forward to assess men's attitudes, practice and barriers towards contraceptive use. Since that contraceptive use in rural areas is lower than urban areas (for instance 46% of urban women use contraception while 31% of rural women use contraception), Mvomero district will be suitable to be the study area.

1.2 Statement of the problem

Empirical evidence suggest that contraceptive methods designed to be used by women such as Implant, pills, Injectable, IUCD, female sterilization account for more contraceptive use among couples (Nations, 2015). This is because contraceptive methods that require direct participation of men including male condom, male sterilization and withdrawal method accounted for only twenty one percent (21%) of contraceptive practice worldwide in 2015. It appears that male condoms and vasectomy are the only male contraceptive methods that have been

regularly improved (Hatcher et al, 2011). The low prevalence of male participation in contraceptive uptake cannot be explained by the fact that there is lack of new methods for men. For instance, despite the fact that male sterilization has few complications and less expensive than to perform female sterilization, still the performance of male sterilization is lower than the use of female sterilization (Shih et al, 2011).

There might be a problem with men's attitude and practice towards contraceptive use, as it was reported by Tao, (2015) that men are rarely family planning and contraceptive clients, however, in Tanzanian societies, men are mentioned to dominate families' important decisions such as the number of children a couple to have and the spacing of those children(Mosha, Ruben, & Kakoko, 2013).One of the factors associated with decision-making on contraceptive use, fertility and health care utilization were perception of husband's (Osuafor G, Maputle S,and Ayiga N. (2018) . Therefore, it is important to assess men's attitudes and practice towards contraceptive use. Not only that, but also it is important to identify barriers hindering men to use contraceptives, since in decades, most family planning programmes and projects have been offering these services exclusively to women compared to men (Kiogora, 2016), hence this study might bring more attention to men as a discrete group in family planning and contraceptive use because despite of having fewer options compared to women yet their uptake is very low.

1.3 Objectives

1.3.1 Main objective

To assess men's attitude, practice and barriers towards contraceptive uptake in Mvomero District

1.3.2 Specific objective

(i) To assess men's attitude towards contraceptive uptake

(ii) To assess the contraceptive practice among men

(iii)To identify barriers hindering contraceptive uptake among men

(iv) To assess the strategies on place to ensure male involvement in family planning

1.4 Research questions

1.4.1 Main research question

What are the men's attitude, practice and barriers towards contraceptive uptake in Mvomero District?

1.4.2 Specific research questions

(i) What is the attitude of men towards contraceptive uptake?

(ii) What is the contraceptive practice among men?

(iii) What are the barriers hindering contraceptive uptake among men?

(iv) What are the strategies on place to ensure male involvement in family planning?

1.5 Significance of the study

This study is enormous potential in turning up family planning and contraceptive utilization because men are important in making important family decisions like family planning use. Contraceptives that are designed for men including condoms are free from side effects compared to contraceptives that are designed for women. For instance, male sterilization is safer than female sterilization. Hence, bringing men on board using this study is very important.

1.6 Scope of the study

This study focused firstly, on assessing men' attitude towards contraceptive uptake so as to know how men think of contraceptive uptake. Secondly, this study focused on determining the proportion of contraceptive uptake among men. This has added statistics on contraceptive uptake among men. Thirdly, this study focused on identifying the barriers facing men in contraceptive uptake. The study area for this research was Mvomero district, Morogoro region.

1.7 Limitations of the study

Like any other study, this research encountered some limitations that could threaten the validity and reliability of this study. However, the limitations were addressed so as to ensure the intended purpose of conducting this research is attained. This issue of collection of questionnaire that were completed by the respondents was hampered by several setbacks like on time return, some the respondents claimed to misplace their questionnaires, and others leaved blanks in some of the questions. However, the researcher ensured that all the questionnaires were return and completed completely since that the researcher was personally on the field distributing and collecting the questionnaires. For instance, those who left some blanks were given clarification so as to understand the questions, those who misplace the questionnaires were provided with other questionnaires to feel and the researcher reminded those who appeared to be late to return the questionnaires. On the side of health service providers, this research interfered with the working hours, however, when this was noticed, the researcher made some arrangements of the meeting with the sampled health service providers, of which it was decided that data collection done during the time of morning meeting at the bank before service hours begins. Also, male the respondents appeared to be unwilling to participate in this study, this provided a hard time for the researcher to convince the customers to respond to the questions.

1.8 Organization of the study

This study covers five chapters, which are; Introduction, literature review, methodology, presentation of findings and discussions, and the last chapter covers summary, conclusion and policy implications. This study started with the proposal that covered three chapters; Introduction, Literature review, and Methodology, of which the other two chapters; Presentation of findings and discussions, and summary, conclusion and policy implications followed after data collection from the field.

CHAPTER TWO

LITERATURE REVIEW

2.0 Theoretical literature review

2.1Definition of key concepts and theory

2.1.1Family Planning (FP)

Family planning is the ability of a woman or man to control the timing and number of their pregnancies (Pathfinder International Tanzania, 2008). FP plays a great role in reproductive health and it contributed to the efforts of meeting Millennium Development Goals by enabling women's participation in economic activities.

2.1.2Contraception

Contraception involves a deliberate use of artificial methods or other techniques to prevent pregnancy as a result of sexual intercourse. Main forms of artificial contraceptives are hormonal contraception (pills, injectable, and implants), intrauterine devices (IUDs), emergency contraceptive pills (ECPs), barrier methods (male and female condoms, spermicidal) and sterilization (Allison & Foulkes, 2014).

2.1.3 Male involvement in FP

Male involvement in family planning (FP) means more than enhancing the tendency of men using condoms as well as having vasectomies; male involvement also involves the tendency of men to encourage and support their wives/partner as well as their peers to utilize family planning and influencing the policy environment to match with male-related programs that are developed. Therefore, male involvement is more than the use of contraceptives among men, it involves also the contribution of men on enhancing acceptability and prevalence of family planning practice of both men and women (WHO, USAID &UCDavis, 2008).

2.1.4 Couple

According to Cambridge dictionary “couple” means two people who are married or in romantic or sexual relationship, or two people who are together for a particular purpose. In this study the term “couple” appeared many times representing the people who are married or have sexual relationship, either they are living together or not (Manlove et al, 2014).

2.1.5 Social-cognitive theory

Social-Cognitive Theory was the theory that impressed the researcher to conduct this study. This theory is based on understanding the risks and benefits of changing one’s behaviour, developing self-efficacy, and assessing outcome expectations of the change in behaviour. This theory establishes that human behaviour is determined by cognitive determinants, environmental determinants and behaviour determinants. Cognitive determinants (also called “personal factors”) includes knowledge, attitudes and expectations; behaviour determinants include skills, practice and self-efficacy; while environmental determinants include social norms, access in community and influence on others (ability to change own environment). In relation to this study, the researcher intends to explore men’s attitudes and practice towards contraceptive uptake and then look for the possibility to change their behaviour in case their attitudes and practice towards contraceptive uptake are found negative with the results of this study. Figure 2.1 demonstrates the concept of social-cognitive theory byNabavi (2012) as cited(Bandura, 2001).

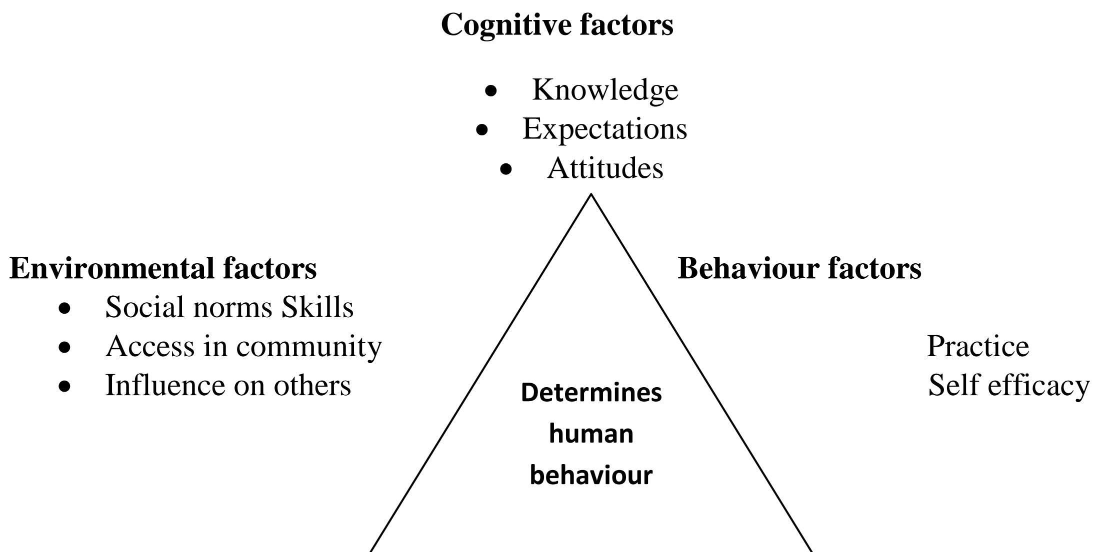

Figure 2.1: Social-cognitive theory
Source: (Bandura, 2001)

2.1.2 FP and contraceptive methods

Generally, there are two categories of family planning methods including natural methods and artificial methods of family planning. It appears that different people due to the number of reasons, particularly religious beliefs and side effects condemn the use of artificial family planning methods. Natural methods of family planning appear to be supported by different peoples including religious leaders and their followers, however, its effectiveness in birth control does not exceed that of artificial methods of birth control. In summary, the following are the methods of family planning and contraceptives based on their categories.

2.1.2 .1Natural methods of family planning

2.1.2.1.1Standard Days Method (SDM)

Standard Days Method (SDM) is a fertility awareness-based method of family planning that identifies a fixed fertile window for women with cycles that are between 26 and 32 days long. For women with cycles in this range, the method identifies day 8 through 19 as potentially fertile days.

According to Unseld M, Rötzer E, Weigl R, Masel EK, Manhart MD (2017) SDM is a well-accepted approach to family planning across the world. It is consistently viewed as being beneficial to couples' self-knowledge, their relationship, and satisfaction with frequency of sexual intercourse this is when used effectively and perfectly.

2.1.2.1.2Lactation amenorrhea method (LAM)

Lactation amenorrhea method (LAM) is a temporary contraceptive method that relies on exclusive breast-feeding. It can be used from birth up to six months afterwards. Producing milk is called amenorrhea; hence, this method of birth control is called lactation amenorrhea method-LAM. According to (WHO, USAID, & UCDavis, 2008), LAM is shown to be 98% effective for preventing pregnancy.

2.1.2.1.3Withdrawal method

Withdrawal methods known by different names including coitus interrupts, rejected sexual intercourse, pull-out method and that of withdrawal method. This is the method of birth control in which a man, during sexual intercourse, withdraws his penis from women's vagina prior to orgasm (ejaculation) and then directs his ejaculate (semen) away from a vagina in an effort to avoid insemination. Withdrawal method is highly applied by Muslims referring to the hadith of the prophet Muhammad May peace be upon him, it is estimated that withdrawal method has 73% effectiveness (WHO et al., 2008).

2.1.2.2Artificial methods of family planning

2.1.2.2.1Hormonal contraception:

Hormonal contraception refers to birth control methods that act on the endocrine system. Almost all methods are composed of steroid hormones, although in India one selective estrogens receptor modulator is marketed as a contraceptive. Examples of hormonal contraceptive methods are pills, Injectables and implants.

2.1.2.2.1.1Pills: - There are two kinds of pills including combined oral contraception (COC) that have oestrogen and progestin and Progestin Only Pills (POP) that have only progestin. The COC are anti-ovulation, meaning that they prevent ovulation of an egg; also they narrow or thicken the uterus wall and thicken cervical mucus. Majority of women can use this method except those who smoke, women who have got birth three weeks before, women who breastfeed children below 6 months, women with breast cancer, women who are expecting to get major operation recently, women with hypertension and women with liver disease and yellow fever. The side effects associated with COC includes nausea, headache, dizziness, weighing and breast ache. The COC have 99% accuracy when used perfectly by women who desire to use this kind of contraceptive method. Progestin Only Pills (POP) also prevents ovulation and thickens cervical mucus. Majority of women can use this method, however it is not recommended to women who have breast cancer, liver disease, tuberculosis, Epilepsy, and thrombosis. Side effects associated with POP includes headache, dizziness, missing menstrual, scanty bleeding per vaginum and breast ache. This method has 99% accuracy when used perfectly (MHSW, 2009).

2.1.2.2.1.2Implants: -this is the kind of hormonal contraception with a shape of plastic stick, which is inserted in woman's body. This method has one stimulate known as progestin. This method thickens cervical mucus and prevents male sperm to reach an egg, thus prevents pregnancy. Also this method is anti-ovulation, thus it prevents ovulation of woman's egg. Majority of women can use this method, however it is not recommended for women who have the history of breast cancer, have thrombosis, liver disease, pregnant women, women who breastfeed children below 6 months, women who use tuberculosis drugs, women who use anti epilepsy drugs, women who experience scanty bleeding per vaginum. Side effects associated with this method are; menstrual disorders, scanty bleeding per vaginum, headache, dizziness and breast ache. This method of family planning has 99% accuracy when used perfectly (MHSW, 2010).

2.1.2.2.1.3Injectables: - this is the kind of hormonal contraception that has progestin, provided after every three months by injections. This method prevents ovulation and thickens cervical mucus, which prevents women to get pregnancy.

Majority of women can use this method except women with diabetes for more than 20 years, women with vein thrombosis, liver disease, pregnant women, women who breastfeed children below 6 months, hypertension, breast cancer, scanty bleeding per vaginum. This method of family planning has 99% accuracy when used perfectly. Side effects associated with this method of family planning are; menstrual disorders, scanty bleeding per vaginum, gaining weight, nausea, temporary infertility recently after stopping the use of this method, headache, dizziness and also interferes with sex (MHSW, 2010).

2.1.2.2.2 Intrauterine Contraceptive devices (IUCDs):

Intrauterine Contraceptive Devices (IUCDs) is the method of family planning whereby an IUCD is placed into the women's womb to stop sperm and egg from surviving in the womb or fallopian tubes. It may also prevent a fertilized egg from implanting in the womb. Thus, an IUCD by definition is a small T shaped plastic and copper device that's inserted into the women's womb (uterus) by a special trained health provider including a doctor or nurse (MHSW, 2009). Apparently, IUD is a long-term method of family planning, having several benefits such as; it does not interfere with sex, immediately women can get pregnancy immediately after stopping using this method and also this method is not user-dependent. However, this method may increase menstrual bleeding and also may cause uterus perforation during insertion.

2.1.2.2.3Emergency contraceptive pills (ECPs)

Emergency Contraceptive Pills (ECPs) is the method of family planning whereby a woman is required to take a pill within 120 hours (5 days) after having unprotected sex (MHSW, 2009). This method of family planning delays ovulation thus reduces the chance of fertility after unprotected sex. All women can use this method especially those who were raped, women who use un sustainable method of family planning, women who had unprotected sex or accidents like condom blast. This method of family planning has 99% accuracy if used perfectly.

2.1.2.2.4 Barrier methods

The uniqueness of barrier methods from other methods of family planning is that it is used merely when you have sexual intercourse with your partner. Examples of barrier methods include male and female condoms, diaphragm, cervical cap, spermicidal foam, film and sponges (MHSW, 2009).

2.1.2.2.5 Sterilization

Sterilization is a permanent method of family planning that commonly applied by women in two ways/options; one procedure is tubal ligation and the second one is tubal occlusion. Tubal ligation is where clips are put on the fallopian tubes, and tubal occlusion is where a tiny a flexible device is put into= each tube (MHSW, 2010). However, this method requires medical cancelling and informed consent from professional staffs specialized in family planning and reproductive health. This method does not interfere with sex, does not chance sexual function, and also have no long-term side effects to users unless there were surgical complications.

2.1.3 Benefits of FP and contraceptives

There are so many benefits of family planning that the user can experience in spite of the notion that family planning has got its disadvantages including adverse health effects like severe bleeding of women during menstruation and distortion of menstrual cycle. In summary, the benefits of FP and contraceptives as provided by WHO, (1995) are mentioned below: -

To Women

- Better health
- Improved quality of life
- Less psychological/emotional strain
- Increased educational opportunities
- More energy for household activities
- Increased economic activities
- More energy for personal development

- More energy for community activities

To Children

- Better health
- Greater opportunity for emotional support from parents
- More food and other resources available
- Better opportunity for education

To Couple/ Family

- Freedom to decide when to have children
- Increased educational opportunities
- More energy for household activities
- Increased economic opportunities
- Less emotional and financial strain
- More energy for personal development
- More energy for community

To the Community

- Reduced strain on environmental resources
- Greater participation by individuals in community affairs
- Reduced strain on community resources (healthcare, education)

2.1.4 Family planning and reproductive health policy environment in Tanzania

In Tanzania, policies and strategies were established aimed at improving maternal and child health services through its National Health Policy (2007) that has made specific attempts to address maternal and new born and childbirth. The government decided to embark on issues concerning family planning and reproductive health following the increase of deaths of pregnant women from 529 in 1996 to 578 in 2005 (National Health Policy, 2007). In response to the fight against increased death of pregnant women in the country, the government of the United Republic of Tanzania in collaboration with private sectors decided to offer non-profit health services to pregnant women, children below five years and contraceptive users.

At the same time, the government also decided to embark on reproductive health of women, men and reproductive aged youths by developing strategies to implement family planning in the country.

For instance, family planning was given a priority in the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA I & II), which had three major interlinked clusters. One of the goals clearly outlined in the second cluster of the strategy was to improve the survival, health, and wellbeing of all children and women and of especially vulnerable groups. Also, by providing maternal education to pregnant women during clinic visits which their then advised by the physicians to go with their co-parents, postnatal education majorly basing on family planning, as part of the health sector reforms and included into the health sector strategic plan III (HSSPIII2009-2015). Currently, National Family Planning Cost Implementation Program (NFPCIP) serves as a foundation for the current One Plan II (2016-2020) that has family planning as one of the intervention. In addition, the Five Years Development Plan (2016-2021) anchored on Tanzania Development Mission-2025; all underscore the integral role of family planning in national development (Brosche, 2015).

2.2 Conceptual framework

In light of the objectives of this study, independent variables include men' attitude, practice and barriers, while dependent variable includes contraceptive uptake.Hence, figure 2.2 presents the conceptual framework of this study, of which attitude, practice and barriers are predictors of contraceptive uptake among men.

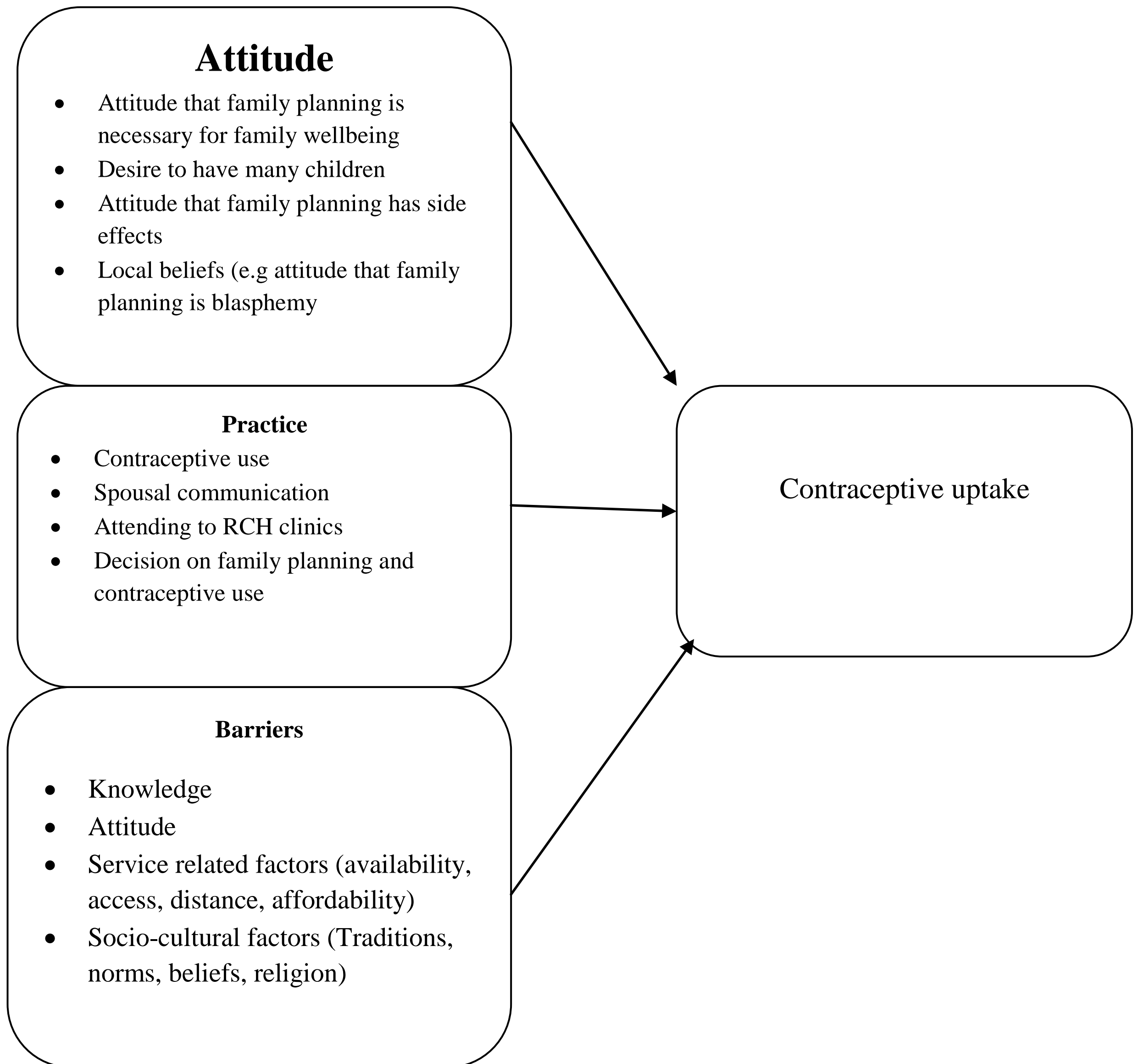

Figure 2.2: Conceptual framework

Source: Researcher's own construct (2018)

2.3 Empirical Literature Review

2.3.1 Male involvement in family planning

Manlove et al, (2014) conducted a study that aimed at estimating the impact of enhancing the prevalence and effectiveness of condom utilization among men who are sexually active on the incidence of non-marital pregnancy, rates of child poverty as well as abortion and child bearing. The paper started by recognizing the fact that nowadays researches and programs regarding males' involvement in family planning are apparently increasing, this shows that recently men are recognized and considered as a crucial part of family planning and contraceptive utilization in the world. The analysis of this study relied on the National survey of family growth (2006-2010).

The results of this study indicated that the number of pregnancies, births and abortions were substantially reduced by simulation to enhance condom use and effectiveness of condom use; non-marital birth rates declined from 23% to 47% for simulations that moved non users to users, and 11% to 36% for simulations that increases effectiveness of condom use among current users. Also, abortion rates decline ranged between 10% and 48% across the simulation. For these results, it was revealed that simulation-modeling developments in male contraceptive behavior has notably reduced child poverty, reduced non-marital births, and foremost increased male involvement in family planning.

USAID in collaboration with FHI360 and PROGRESS, (2012) conducted a study entitled "Increasing male involvements in family planning in Jharkhand, India." The purpose of this study was to develop a male based-family planning intervention and assess its influence on men's knowledge and attitudes towards family planning, couples' communication, and contraceptive use among a sample of young couples in Jharkhand, India.

This intervention study recruited 456 men from the age of 18 to 35 years old and female partners that were randomly selected from 38 villages involved in this study. Also the district of Jharkhand, India was involved in pre-post evaluation of this

project of male involvement in family planning. The key findings of this intervention study indicated that men are older than their female partners; mean ages were 24 for female partners and 28 for men. Also, it was revealed that couples were married for about 7 years and having about two children. The results obtained from this study also demonstrated that women were more illiterate than men were; 28% of men are illiterate while 44% of women are illiterate. Moreover, the primary religion in India was Hindu and primarily from the government category "other backward cates". At last, the increase in intended future utilization of family planning by sex revealed that; among female is 55% to 57% while among men is 56% to 65%.

Bruce (2013), conducted a study entitled "the involvement of men in family planning: A Case of 37 Military Hospital." According to the researcher of this study, there is a tendency especially in developing countries that data collected for policy and programme formulation generally relies on women. For a long time, men have been ignored on issues concerning family planning and contraceptive utilization, forgetting the fact that men are involved to make last decisions on the different family matters. Although women are responsible for getting birth, breastfeeding taking care of their little children, men are also involved in childbearing. If men are responsible in paying school fees, food, paying medical bills and taking care of many other responsibilities at home, they should also be involved in family planning. Hence, the purpose of this study was to explore involvement of men in family planning programs.

Both qualitative and quantitative methods were used in this study. The findings obtained from this study demonstrated that; men play a supportive role to their wives/partners rather than using family planning themselves. Spousal communication influences the decisions about family size although men have more power to decide the number of children the couples should have.

Conclusively, taking consideration of the power of men in making strong decisions in families, particularly in African countries, male involvement in family planning is a critical move to enhance family planning and contraceptive utilization(Bruce, 2013).

Wiafe (2015), conducted a study entitled "Male involvement in family planning in Sunyani Municipality. This study was necessary in Ghana because only the little was known about male involvement in family planning within the country despite the fact that family planning started since 1956. The main objective of this study was to explore male involvement in family planning in the Sunyani Municipality, Ghana. The study design recruited in this study was a descriptive cross-sectional study, while the sampling technique used was systematic sampling, of which 403 adult the respondents were selected and interviewed using administered questionnaire technique. Data analysis was conducted using the Statistical Package for Social Sciences (SPSS version 20), of which the association between dependent and independent variables were determined using logistic regressions, while statistical significance was tested using Chi-Square Test.

The results obtained from this study revealed that; majority of the respondents (68%) were aged 18 to 34 years and 65.8% had at least completed secondary school. Foremost, merely 34.5% of males were involved in family planning. Logistic regressions indicated that basic education (OR=0.01, 95% CI, 0.01-0.1). There is significant association between having little or good knowledge of family planning and male involvement in family planning; (OR=0.1, 95% CI, 0.03-0.037) and (OR=0.4, 95% CI, 0.27-0.89) respectively. Conclusively, the study demonstrated that factors behind low male involvement in family planning include lack of education, religious beliefs and stigmatization. Lastly, training to men on family planning was recommended and emphasized so as to accelerate their involvement(Wiafe, 2015).

2.3.2 Attitude and practice of men in family planning

Chibwae, et al, (2018) conducted a study that aimed at determining the prevalence and factors affecting make partners' attendance to available reproductive health services. This study was conducted in lake zone Tanzania, whereby Shinyanga was the chosen district. Structured questionnaires and interviews were deployed for data collection, whereby structured questionnaires were distributed to randomly selected married men, while married men who found attending on RH services were interviewed so as to have in depth information. Data were collected from 204

married men who were randomly selected. The findings of this study indicated that 94.4% of men have escorted their partners to RCH clinic at least once, while 50.6% of them have escorted their partners to RCH at least thrice. The findings also indicated that three quarters (154/204) of men attended to RCH for HIV counseling and testing, while 63% attended antenatal care (ANC) services. Furthermore, it was revealed that less than 13% of men were reported to attend sexually transmitted infections (STIs/STDs), prevention of HIV transmission from mother to child (PMTCT), and reproductive health services.

Furthermore, the findings of this study revealed a significant association between age and RCH service attendance. This is because, male partners with age group between 25 and 34 had p-value < 0.001, while female partner invitation had p-value < 0.05. It was noticed that majority of men attend to RCH clinics not because they expect something better for the health of mother and child for their presence. This is because only 20% have attended to RCH because they believe that their presence have better health outcomes. Others attend to RCH for undefined reasons, it just happened they are there just escorting their partners. This study concluded that most men attend to reproductive health services following the invitation from their partners and their most focused services are ANC and VCT. Education on the importance of spousal communication and the health outcomes of attendance to RH services by either sex should be provided with much emphasis (Chibwae et al., 2018)

Chuwa (2012) conducted a study on male involvement in family planning practice. The aim of this descriptive study was to determine the factors influencing male involvement in family planning practices. Apparently, this study was conducted in Moshi rural district in Tanzania, and the sum of 218 men aged 18-60 years was recruited. The results obtained in this study indicated that awareness of men on family planning and contraceptive methods is high (85.3%), however, utilization of contraceptives is low (47%). Also most frequently used contraceptives in Moshi rural district includes, pills, implants, injectables, male condoms and IUCD.

It was also revealed that education have something to do with contraceptive utilization because people with formal education were more likely not to use

contraceptives compared with people with at least primary education. However, both users and non-users have positive attitude towards family planning, hence if more health promotions concerning family planning are directed to them, it will increase the use family planning methods (Chuwa, 2012).

Ijadunola, et al (2010) conducted a study that aimed at assessing men's awareness, attitude and practice of modern contraceptive methods; to determine the level of spousal communication and investigate men's opinion in family planning decision making. This descriptive cross-sectional study used a structured household questionnaire to collect information from 402 male study participants. The findings of this study indicated that 89% of men approved of the use of family planning while only 11% disapproved. Current users of male contraception were 56% while 80% of men had ever used contraception. About spousal communication on issues concerning family planning, the findings of this study indicated that it was quite poor. Further, it was revealed that socio-demographic factors including marriage type, religion, occupation and educational attainment are significantly associated with contraceptive use $p<0.05$. To wind up, this study reached to the conclusion that; male involvement in family planning decision is still poor and their support to family planning use by themselves or their partners is also low (Ijadunola et al., 2010).

2.3.3 Factors influencing men' participation in family planning

Sichana and Mbago, (2008) conducted a study that focused on investigating the factors influencing men's participation in family planning. This study was conducted in Mbeya region, of which data were collected from 568 respondents (married men with the age of 15-59 years old. The findings of this study indicated that contraceptive knowledge about methods of family planning among men in Mbeya region is high for condoms and low for diaphragm. Also, linear regression analysis and chi-square was derived and revealed that there is a significant relationship between modern contraception utilization among men and demographic factors such as education, age, desired number of additional children and number of living children.

2.3.4 Challenges and Barriers hindering male involvement in family planning

(Kahale, 2010)conducted a study that aimed at analyzing barriers in the involvement and participation of males in family planning. The study design recruited in this study was analytical cross-sectional study, while both qualitative and quantitative methods were used in this study. Simple random sampling technique was used to select 284 male the respondents aged between 15 to 65 years participated in this study. Eleven (11) key informants including health care workers (HCW) from both public and private hospitals were interviewed using qualitative approaches. Epi info 3.5.1 was used to analyze quantitative data while Atlas it was used to analyze qualitative data.

The findings indicate that, among 284 the respondents, 44.4% were aged between 25 years to 34 years old, of which 57% participants were involved in family planning, while 53% were participating in family planning. Generally, male involvement and participation in family planning was just 43%, of which age, occupation and marital status were significantly associated with male involvement and participation in family planning. In addition, it was revealed that one among the critical barriers of family planning and contraceptive utilization is religious beliefs.

To wind up this study concluded that, male involvement and participation in family planning in Tanzania is still very low, of which factors behind this situation includes;

- Little knowledge about family planning
- Few options of contraceptives for men
- Religious beliefs
- Social factors like age and marital status
- Family planning clinics are unwelcoming for men

The study recommended the following: -

- The use of different options and channels of communication to disseminate information regarding family planning in a wide range
- To enhance access and availability of family planning services for men
- To enhance male involvement and participation through;

a) Multi-sectoral collaboration
b) Revising policies
c) Considering family planning as a cross-cutting issue

Kiogora, (2016) conducted a study on barriers to male involvement in family planning in Kiambu county, central Kenya. The aim of this study was to explore barriers to male involvement in family planning. This descriptive cross-sectional study employed 60 the respondents who were married men aged between 18 and 55 years. These the respondents were purposely sampled, data was collected through semi-structured interviews and key informant interviews and analyzed through grounded approach in line with specific objectives. It was revealed that social factors including knowledge on FP, religion, spousal communication and gender roles influence male involvement in family planning. Further, the findings of this study indicated that majority of men in Kiambu country have never been involved in any FP project design activities, this implies that men are locked out from involvement. In addition, it was revealed that men do not allow the use of modern FP methods and they are only limited to condom use, a contraceptive method that is widely known and accepted by many. On the other side, economic factors including unmet need for FP and income also influence male involvement in FP, for instance, it was noticed that married men who earn less than KES 10,000 per month in Kiambu county find it too expensive to procure modern FP methods than prioritizing their income to other necessities.

(Adelekan, Omoregie, & Edoni, 2014) conducted a study that aimed at exploring the challenges and determined the way forward to male involvement in FP. This study used cross-sectional study design, and data were collected from 500 married men who were selected using a four-stage sampling technique. Semi structured questionnaire and focused group discussion (FGDs) methods were used to interview the respondents participated in this study. The findings of this study that was conducted in Nigeria indicated that; mean age of the respondents was 28.5 ± 10.3 years. It was also revealed that 37.9% of respondents' spouse had ever used family planning method, while 19% were currently utilize family planning. It was also found that merely 4.8% of study participants had ever been involved in family

planning. Several factors have been pointed out as barriers towards male involvement in family planning. Those barriers include; the perceptions that family planning is the women’ practice and it is not men’ custom to be involved in family planning. Several opinions were provided including male’s support interns of transport fare and other resources may be needed by their wives as a means of covering expenses involved in family planning utilization. It was also pointed out that majority of men do not support their wives in family planning uptake and had never being involved with FP practice for themselves. The government and non-government agencies have been advised to concentrate on preparing and conducting community sensitization programs.

2.3 Research gap

In the field of research in Tanzania, a lot have been said about family planning and contraceptive utilization among women, as a result policies and programs formulations relies on the data collected based on women. Men have been ignored for many years in matters concerning family planning and contraception; hence, this is the right time to conduct this study. On top of that, there is no doubt that contraceptive prevalence rate in Tanzania is still very low, hence, with joint involvement of both men and women in family planning could turn up the rate of FP and contraceptive utilization within the country. This study intends to study men’ attitude and practice towards contraceptive uptake. Not only that, but also this study sought to identify barriers facing contraceptive uptake against men

CHAPTER THREE

METHODOLOGY

3.1 Study design

This study used descriptive cross-sectional design to explore male involvement in family planning. A descriptive cross-sectional design is suitable because multiple units of the study were involved including health facilities, wards, streets and households (Kothari, 2004). Taking consideration the limited time available for accomplishment of this study, this design was suitable as it enabled the researcher conduct this study within a short period of time.

3.2 Study area

Area of the study refers to formal delineated geographical boundaries, (Msabila and Nalaila, 2013). The selected study area was Mvomero district, which is amongst the six districts under the administration area of Morogoro region. Specifically, two wards were included, which are Dakawa and Mzumbe of which three villages in each ward were selected. About the health facilities, Mvomero district hospital and Mzumbe health centre were involved. Mvomero district was suitable for this study because it is a rural area, which according to (Mungure & Owaga, 2014)majority of men found in rural areas are not in favour with the use of modern contraception, neither for themselves nor for their wives.

3.3 Study population

According to Mugenda and Mugenda (2008); study population should constitute individuals relevant to a particular study and have common observable characteristics. This study included male the respondents in the age between 18 to 50 years old. This means that female the respondents were not included in this study as the researcher targeted to get response about contraceptive uptake among men from male the respondents themselves.

3.4 Sampling techniques

Both probability and non-probability sampling techniques were used to select relevant samples in Mvomero district. The probability sampling technique was cluster sampling, while the non-probability sampling technique selected in this study was purposive sampling technique.

(i) Cluster sampling

This sampling technique was used to select respondents to participate in this study from two clusters, which were Dakawa ward and Mzumbe ward. This sampling technique involves grouping the population in clusters and select relevant clusters or groups rather than individuals for the inclusion in the sample. This method was applied to select 100 respondents from the study area. This sampling technique was suitable for this study because the researcher has done many interviews in different locations (Kothari, 2004).

(ii) Purposive sampling technique

This sampling technique was used to select 10 key informants (health staffs) to participate in this study. This is because health staffs from RCH clinics have reliable knowledge about male participation in family planning. This sampling technique was suitable for the study because it included samples that had reliable information, less costly, more convenient and can be used in both qualitative and quantitative studies (Freedman et al., 2007).

3.5 Sample size

The sample size of 110 enabled the researcher to gather information that was useful for this study and draw a valuable conclusion. One hundred samples (male respondents) was obtained quantitatively by the formula provided by Slovin, (2007). On the other hand, 10 samples (health workers from RCH clinics) was obtained qualitatively based on the researcher's own judgement. Since that health care workers were purposively selected, and the number of sample was also purposively. As Malhotra and Dash, (2011) established that non-probability sampling relies on the

personal judgment of the researcher rather than chance for the sample elements to get selected.

n = N / (1+N (e) 2)

Whereas;

n = sample size

N = Population of the study

e = Error of prediction

N = 260, 525

e = 0.1

n =?

Thus,

n = 260, 525(1+260, 525(0.1)2

n = 260, 525/1+ 260, 525 (0.01)

n = 260, 525/1+2605.25

n = 260,525/2606.25

n = 99.96

n=100

3.6 Data collection method

Three data collection methods were deployed including administered questionnaire, interview and documentary review methods.

3.6.1 Questionnaire

Is the method of data collection which consisting list of questions and other prompts given to people in order to collect facts or opinions about something. This data collection method was preferred since it is cost effective, quick and less intrusive, lacks interviewer bias, and offers the possibility of anonymity and privacy to inspire more respondent's responses on sensitive matters (Fox & Bayat, 2007:88). Also questionnaire method was employed because it is simple, cheap and enabled the

researcher to reach a large number of the respondents within a short time. Questionnaires were distributed and filled by 100 Respondents. The set of questions aimed to get information on men's attitude, practice and barriers towards contraceptive. The respondents were asked to choose, rate and fill the blank spaces in the questionnaires.

3.6.2 Interviews

Yin (2009) contends that interview is a conversation with a purpose tailored to the achievement of researcher's objectives. This method or technique of data collection used to obtain information from 10 key informants who included health workers from RCH clinics available in Mvomero district hospital and Mzumbe health centre. This methods was used to solicited information on men's attitude, practice and barriers towards contraceptive and specifically to get an insight about male involvement in family planning.

3.6.2 Documentary review method

This method enabled the researcher to gather data from the secondary sources such as documents, books, articles, as well as pamphlets, manuals and polices concerning male involvement in family planning (Ndunguru, 2007). Tanzania Health Management Information System (HMIS) was visited so as to see data set report of Mvomero district council regarding family planning use. This method helped the researcher to compare the results to be obtained in this study and the existing information concerning male involvement in family planning. This data collection technique enabled the researcher to obtain secondary data from secondary sources of data including websites, books, manuals and policies.

3.7 Plan for data analysis

Data were analysed qualitatively and quantitatively. In particular, qualitative data were analyzed using content analysis and quantitative data were analyzed using Statistical Package for social Science (SPSS version 21.0). Descriptive statistics was derived whereby the findings were presented in frequencies and percentages. The

scale used was likert scale, of which respondents were required to respond to questions by indicating whether they strongly agree, agree, neutral, strongly disagree or disagree. This scale was applied all variables involved in assessment of men' attitudes, practice and barriers towards contraceptive uptake.

3.8 Reliability

The tools for data collection including questionnaires and interview guide were tested before the actual data collection. This pilot test ensured reliability of data that was collected in the field.

3.9 Validity

Validity is the extent to which data adequately reflects the real meaning of the concept or issues under consideration Kumar, (2005). The researcher designed tricky questions that can be referred to as follow up questions so as to ensure the validity of the collected data.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This study's main research objective was to assess men's attitude, practice and barriers towards contraceptive uptake in Mvomero district. The specific research objectives were: To assess men's attitude towards contraceptive uptake; to assess the contraceptive practice among men; to identify barriers hindering contraceptive uptake among men; and to assess the strategies on place to ensure male involvement in family planning. The purpose of this chapter is to present the results of the study response about men's attitude, practice and barriers towards contraceptive uptake. The presentation follows the sequence of the objectives; however, the presentation starts with the highlights of the sample and its characteristics.

4.2 Sample Size and its Characteristics

Data for the study were collected from a sample size of 110 the respondents of which 100 individual male the respondents who were given questionnaires and 10 health service providers. The sampled male the respondents were aged between 18 years and 49 years old. Age was considered important due to the fact that individual's attitudes and perceptions are likely to be influenced by age groups as peers. Forty three percent of the respondents had primary education, followed by 25% who had secondary educationwhile, 21% never attended to school and 11% had college/ university education. Education level was considered because empirical evidence established that education is associated with family planning utilization (Wiafe, 2015). Also, 46% of the respondents were farmers, 20% entrepreneurs, 19% were employed, and 15% were livestock keepers. Occupation was considered in this study because occupation might affect the use of family planning depending on the nature of particular occupation.

The sampled male the respondents were also asked to disclose their religion because religious beliefs were considered to be the influencing factor in family planning and contraceptive utilization because some religious teachings like Roman Catholics and fundamental Muslims condemn modern contraceptive utilization (Pauline et al, 2015). The results indicated that 43% of the sampled male the respondents were Christians, 39% were Muslims and 18% were paganism. The type of tribes of the sampled male the respondents was also considered in this study due to the influence that tribes have in various social issues including education and health. The results indicated that 26% of the sampled male the respondents were Ruguru, 21% were Ziguas, 19% were Kaguru, 18% were Maasai and 4% were Mang'ati.

This study also included 10 health service providers who were aged between 18 years and 52 years old; 40% were doctors and 60% nurses; 40% holding bachelor degree, 30% holding certificate, 20% holding diploma and 10% holding master's degree. Also, 80% of the sampled health service providers had the work experience above 5 years, while 20% had the experience between 1 to 5 years. Work experience was considered on the side of health service providers because the experienced ones were expected to provide reliable information regarding the factors affecting male involvement in family planning at Mvomero district. These findings are as summarized in table 4.1

Table 4.1: Characteristics of the respondents

Variables	Variable categories	Frequencies	Percentage
Age	Male the respondents		
	18-25	23	23
	26-33	32	32
	34-41	35	35
	42-49	10	10
Total		100	100
	Health service providers		
	18-25	1	10
	26-33	2	20
	34-41	5	50
	42-49	1	10
	Above 49	1	10
Total		10	100
Education level	Male the respondents		
	Not attended to school	21	21
	Primary	43	43
	Secondary	25	25
	College/University	11	11
Total		100	100
	Health service providers		
	Certificate	3	30
	Diploma	2	20
	Degree/Advance diploma	4	40
	Postgraduate degrees(masters/PhD	1	10
Total		10	100
Occupation	Male the respondents		
	Livestock keeping	15	15
	Farmer	46	46
	Entrepreneur	20	20
	Employed	19	19
Total		100	100
	Health service providers		
	Doctor	4	40
	Nurse	6	60
Total		10	100
Work experience	Male the respondents		
	1-5 years	37	37
	Above 5 years	63	63
Total		100	100
	Health service providers		
	1-5 years	2	20
	Above 5 years	8	80
Total		10	100
Religion	Male the respondents		
	Christians	43	43
	Muslims	39	39
	Paganism	18	18
Total		100	100
Type of tribe	Male the respondents	10	10
	Maasai	4	4
	Mang'ati	19	19
	Kaguru	26	26
	Ruguru	21	21
	Zigua	6	6
	Sagara	14	14
	Other tribes		
Total		100	100

Source: Field data (2019)

4.3 Men's attitudes towards contraceptive uptake

Attitude of people towards something is a big predictor of people's decision towards something, especially on social and health issues like family planning use. This means that attitude of people towards family planning can predict the decision of family planning use.

Therefore, on this study five variables were considered in assessing men's attitude towards contraceptive uptake. The respondents were asked to disclose their opinions whether firstly; family planning is necessary for their family wellbeing, secondly; family planning is not necessary for people who desire to have many children, thirdly; family planning is not good because it has side effects, fourthly; family planning practice is a blasphemy, and fifthly; family planning is necessary for women, not for men.

In case of the first categories the respondents were asked to disclose their opinions as **to iffamily planning is necessary for family wellbeing.**The data from the questionnaire showed that 42% agreed that family planning is necessary for their family wellbeing. This was followed closely by 38% who strongly agreed that family planning is necessary for their family wellbeing. However, 9% disagreed, 5% strongly disagreed while 6% were neutral. This is because family planning enables people to have a desired number and space of children, decreases mortality rate among pregnant women and promotes women's health and gender equality through increasing access to education and women's ability to participate in income generating activities.Since that the respondents were in favour that family planning is necessary for family wellbeing and the results from the study done by Sedgh & Hussain, 2014 also indicated that, it implies that men can accept family planning for their family wellbeing, which is good as family planning has both health-related benefits and socio-economic related benefits

Family planning plays multiple tasks more than reducing the number of children; it also enables people to have a good interval of childbirth. However, there is an attitude of men that family planning is not necessary for people who desire to have

many children. That is why in this study, the respondents were asked to disclose their views regarding this attitude. The findings of this study showed that 36% of the respondents agreed that family planning is not necessary for people who desire to have many children. Also, 14% strongly agreed on this, however the remaining the respondents had different opinions, as 32% disagreed, 8% strongly disagreed and 10% was neutral. This implies that men have negative perceptions towards family planning, as they think that the aim of family planning is only to reduce the number of children. This means that men overlook the point that family planning not only reduces the number of children, but also reduces mortality rate among pregnant women and plays a great role in improving mother and child health. As empirical evidence established that; family planning increases the survival rate for mother and child and brings about improvements in maternal and child health pregnancy (Global Health eLearning Centre, 2018).

The next question to be asked was; **family planning is not good because it has side effect.** The question was asked because family planning issues has side effects across the community; hence, it was important to include this variable in this study. From the study findings indicated that, 39% of the respondents agreed that family planning is not good because it has side effects. Also, 22% had almost the same opinions as they strongly agreed that family planning is not good because it has side effects. Other the respondents had different opinions on this variable as 18% disagreed, 8% strongly disagreed and 13% were neutral. This means that side effects are amongst the factors that hinder men's involvement in contraceptive uptake. However, empirical evidence suggests that severity of side effects of contraceptives as well as environmental issues do not exceed the effects of not using any family planning method for birth control or child spacing. This is because pregnancy interval of less than 6 months are associated with 150 percent of increased risk of maternal death, 70 percent of elevated risk of third trimester bleeding, 70 percent increase of premature rupture of membranes, and 30 percent increased risk of postpartum endometrit is in the next pregnancy (Adelekan, Omoregie, & Edoni, 2014).

This study also addressed the attitude of men that family planning is a blasphemy, as in the society, some beliefs like this are given a priority as a result in some way they affect important things like family planning. Therefore, the respondents were asked **if family planning practice is a blasphemy**. .The findings of this study demonstrated that the respondents do not consider family planning practice as a blasphemy as 42% disagreed and 30% strongly disagreed on that. Only few had different opinions as 8% and 4% of men respectively agreed and strongly agreed that family planning practice is blasphemy, while 16% were neutral. This is similar to the study conducted by Wiafe, (2015), which demonstrated that beliefs like family planning is blasphemy reduces family planning uptake among men.

The attitude that family planning is a practice for women and not for men was also addressed in this study by asking the respondents to disclose their views on the statement "family planning is necessary for women, not for men". The findings of this study implies that men consider family planning practice is necessary for women not for men, as 37% and 31% of men respectively agreed and strongly agreed on that. Only 9% and 8% of men respectively disagreed and strongly disagreed on that, while 15% were neutral. This is similar to the findings from other previous studies, for instance the findings from the study conducted by Tao, (2015) indicated that men especially in Africa consider family planning as a women practice, which is why men are rarely family planning clients. They would rather play a supportive role through spousal communication in encouraging their spouses/partners to uptake contraception than using family planning method themselves (Bruce, 2013).

These findings with regards to the attitudes of men towards contraceptive uptake have been summarized in table 4.2

Table 4.2: Men's Attitude of towards contraceptive uptake

Variable/Questions	Strongly agreed		Agreed		Strongly disagreed		Disagreed		Neutral		TOTAL	
	n	%	n	%	n	%	n	%	n	%	n	%
Family planning is necessary for family wellbeing	38	38	42	42	5	5	9	9	6	6	100	100
Family planning is not necessary for people who desire to have many children	14	14	36	36	8	8	32	32	10	10	100	100
Family planning is not good because it has side effects	22	22	39	39	8	8	18	18	13	13	100	100
Family planning practice is a blasphemy	4	4	8	8	30	30	42	42	16	16	100	100
Contraceptive uptake is special for women, not for men	31	31	37	37	8	8	9	9	15	15	100	100

Source: Field data, (2019)

4.4 The contraceptive practice among men

The second objective of the study was intended to understand the Contraceptive practice among men. This is because family planning involves both Men's and Women's as men have their own related family planning methods to include condoms and male sterilization. Respondents were asked to answer whether they use contraceptive or not. And further they required mentioning and tick kind of contraceptive they are using for family planning. Furthermore, the involvement of men in family planning through spousal communication and attendance to family planning clinics was also assessed so as to find out if men are playing a supportive role to their spouses/partners on the use of family planning.

4.4.1 Contraceptive uptake among men in Mvomero district

In the first category respondents were asked to say whether they use any kind of contraceptive method or not. A total of 100 respondents were involved and the findings of this study as presented in figure 4.1 below showed that 34% of the

respondents use some family planning method, while 66% do not use any family planning methods. These findings are in line with the study conducted by Tao, (2015) that men are rarely use family planning methods hence it is difficult for them to take control and plan on the number of children's to give birth with his wife.

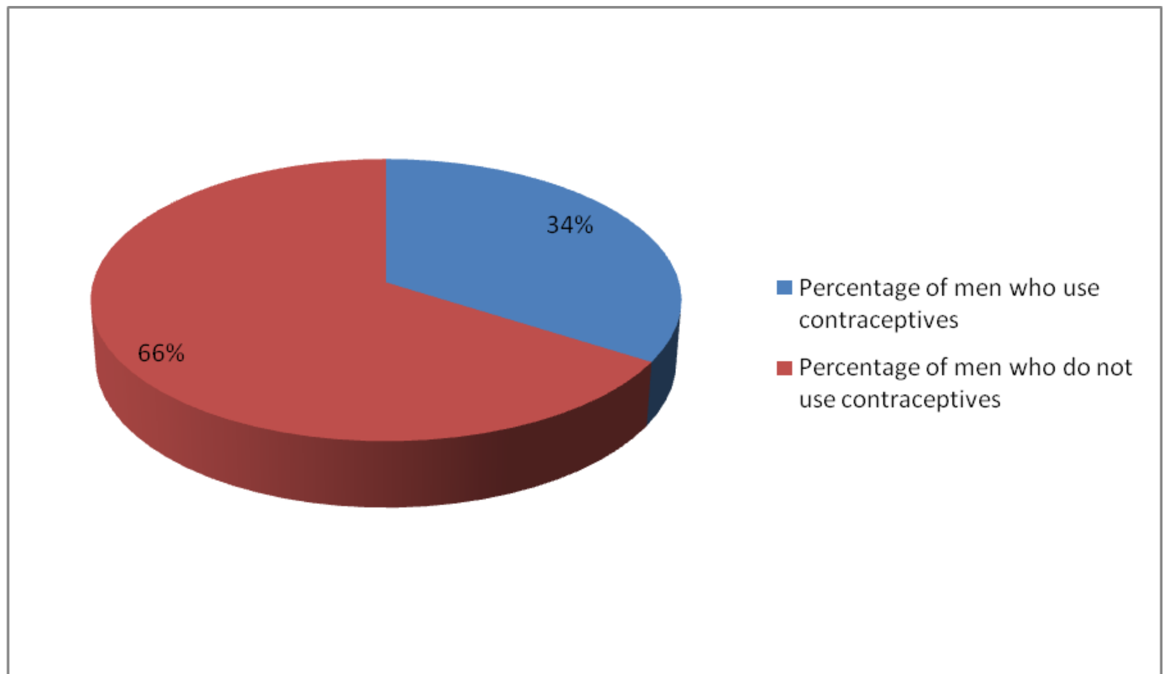

Figure 4.1: Contraceptive uptake among men in Mvomero district
Source: Field data, (2019)

On the useful interview with the respondents, researcher revealed that most of the men were not using family planning methods due to t many common contraceptive side-effects and misconceptions about side effects, such as increased risk of infertility and birth defects. One of the participants said:

> *…….To be honest these family planning is not our culture that we heritage from our ancestors it is new thing that need to be taken into precautions because I hear from other complain the side effects to us like risk of infertility, this increasing fear to me for using it since we need to have more children for our future…….*

Furthermore another respondents add that: *"the rumors has been spreading and they say if you are taking the family planning, your children will be lame, your children will grow up with big heads, and so on and whatever, trying to discourage people from taking the family planning."*

4.4.2 Family planning methods used by men in Mvomero district

The study also wanted to know the methods of family planning specifically used in the study area by men. A total of 100 respondents were distributed with the questionnaire. The respondents were asked to disclose the family planning methods they commonly use, and the findings indicated that among thirty four percent (34%) of the respondents who use some kind of family planning method, 100% said they use condoms. Hence, it appears that condom is the common family planning method used by men in Mvomero district. This means that other methods of family planning like male sterilization are not commonly used. These results are similar to the study conducted by Manlove et al, (2014), who suggested that condom is the common contraceptive method used by men; therefore, family planning programmers should create easy accessibility of condoms.

4.4.3 Spousal communication

Spousal communication is vital on issues concerning family planning and contraceptive utilization. This study addressed this variable by asking the the respondents (men) to disclose whether they communicate with their spouse/partners about family planning uptake or not. The results of this study indicated that 71% of men do not communicate with their female couples about family planning, while only twenty nine percent (29%) of men communicate with their female couples about family planning. This is similar to the empirical evidence established by Bruce, (2013), who demonstrated that men are more willing to play a supportive role to their spouse in encouraging them to use family planning instead of using it themselves

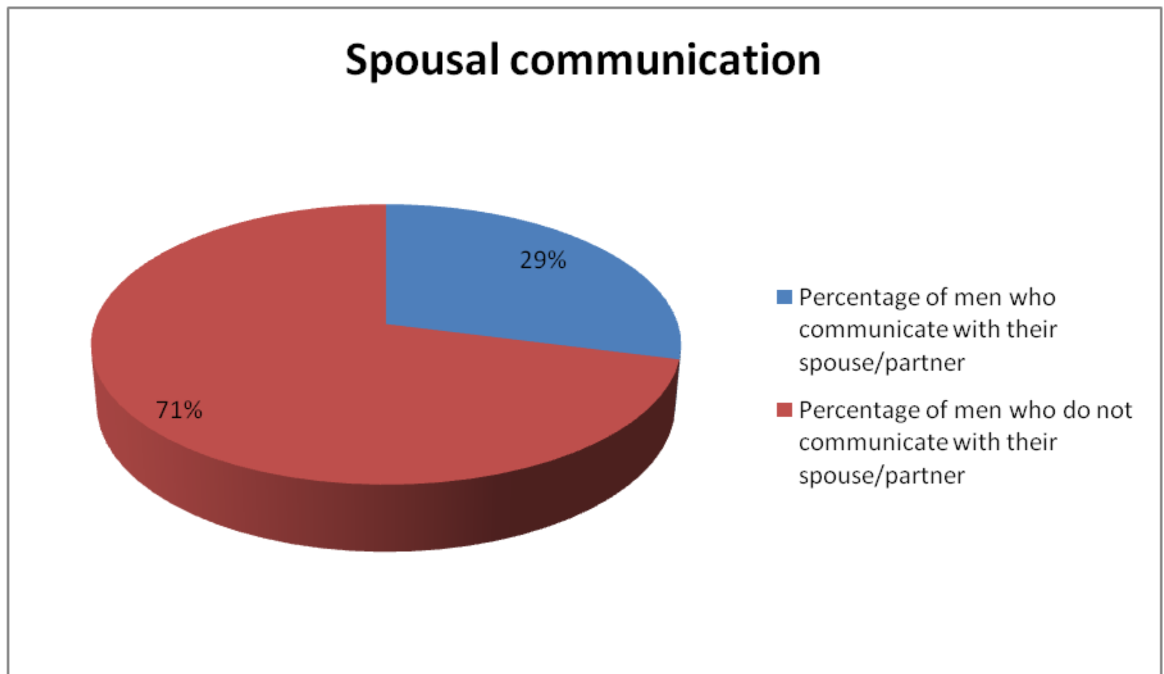

Figure 4.2: Spousal communication
Source: Field data (2019)

4.4.4 Attendance of men at Reproductive and Child Health clinics

The researcher wanted to find out participation of Men's at Reproductive and Child Health clinics especially in Family Planning. Both questionnaire and interview data collection methods were used to collect information. In case of questionnaire 100 respondents were involved and results revealed that only 11% of the respondents attend to RCH clinics, while 89% do not attend to RCH clinics. The finding implies that; men attendance to the RCH clinics is low and most of them perceive it as female responsibility role. The findings are in line with some of the scholars that, the proportion of male participation in these programmes in Sub-Saharan Africa remains low (Peltzer et al., 2011; Haile & Brhan, 2014).Also Anasel &Mlinga, (2014) add that Family planning is still perceived as the responsibility of women despite improving household couple's discussions on the same.

The questionnaire findings are supported with interview results that, men's number in RCH clinics for Family planning was very poor due to various individual reasons

and perceptions such as negativity of health workers and lack of space for men in RH clinics and long waiting time, fear of HIV status disclosure and perceived side effects of the services or treatments for example of women over bleeding and loss of fertility when using modern contraceptives. One health provider who participated in this study quoted saying that:

> *"the attendance of men at RCH clinics for family Planning is not convincing, many of them do fear to attend due to various factors which make them believing that RCH clinics is not made for them and some of them thinking that attending in these clinics is wasting of time and* fear of HIV status disclosure*, while those few who attend to the RCH clinics mostly do not come here looking for family planning services, they are commonly here for other services like anta natal services, postnatal services and immunization services."*

This is consistent with other studies in developing countries, which reported low participation rates among men in RCH clinics for Family planning services (Tilahun &Mohamed, 2015).

On the other hand the study established that, 11% of the respondents who attend RCH clinics for Family Planning they did so to satisfy their wives and Some of the men reported that they accompanied their partners so as to learn directly from the RHC clinic service providers about the pregnancy and the health of the mother. One participant said: "*I wanted to know the condition of the baby and if my wife had any problem* "and

Another one commented that *"I attended to know my health status as we talked with my wife on the need to test for HIV. I also wanted to get more explanation concerning the pregnancy, and in case of any problem we will know how it can be solved".*

Some reported to have attended the RCH services because they wanted to understand their HIV status and that of their wives. One man stated

> *"I attended VCT with my wife, the reason being need to know our HIV status because there are many risks. Knowing our status was important to both my wife and myself and I feared that, if I had the virus without my knowledge, then realize after being sick, my health condition could worsen. So I have to regularly come to the VCT for testing and share results with my wife".*

4.5 Barriers to contraceptive uptake among men

On this study, assessing the barriers to contraceptive uptake among men in Mvomero district was among the objectives of the study. On this objective nine variables were considered. These variables are knowledge, attitude, availability, accessibility, distance, traditions, norms, beliefs, and religious beliefs.

4.5.1 Knowledge about family planning and contraception

This study addressed the knowledge of men about family planning because knowledge is a big predictor of family planning uptake. People with knowledge about family planning can realize the benefits of family planning easily and possibly use. This is different to people with limited knowledge about family planning as their chances of family planning use decreases because they are unable to realize the benefits of using family planning. The findings of this study indicated that 38% of the respondents agreed that little knowledge on family planning hinder contraceptive uptake among men, while 32% strongly agreed. Other the respondents had different opinions as 13% disagreed, 8% strongly disagreed, while 9% were neutral. Since that 38% of the respondents agreed that little knowledge on family planning and contraception hinder contraceptive uptake among men, this implies that knowledge is the barrier towards contraceptive uptake among men. This is in line withWiafe, (2015) that knowledge about family planning is the big predictor of family planning use, this is because those who have little knowledge about family planning in most

case ignore the use of FP, compared to those with enough knowledge. Thus, knowledge of men about family planning reflects family planning use among men.

4.5.2 Attitude towards contraceptive uptake

Attitude of men towards family planning predicts the decision to use family planning, this is the rationale of addressing this by asking the respondents to disclose whether negative attitude towards family planning hinders contraceptive uptake among men. The findings indicated that 40% of the respondents (men) agreed that negative attitude towards contraceptive uptake hinders contraceptive uptake among men. Also, 34% strongly agreed on that, however, 14% disagreed on that, 7% strongly disagreed, while 5% were neutral. Hence, these findings demonstrate that attitude is amongst the barriers hindering contraceptive uptake among men. Similar to the study conducted by Bruce, (2013) that established that attitude of people towards family planning is the big influencing factor towards contraceptive uptake. Examples of these attitudes are; men consider family planning is a women practice rather than men, family planning is not necessary for people who desire to have many children, and family planning is not good because it has side effects.

In interview some men complained about the healthcare providers attitude contributing them not attending for family planning services and reported that negative attitudes such as shouting, scolding, not allowing clients to explain their side effect experiences, and giving preference to socially accepted family planning services user groups like the married women, existed in some of the health facilities. Respondents said that:

> *"To be frank some healthcare providers are bad-mannered, very impolite. That is the major complaint with many men in our area here. That is why even most men not attending health facilities and as result, they choose purchasing family planning equipment from drug supplies in private shops instead of going to clinics.*

4.5.3 Availability of family planning commodities

Availability of family planning services was considered as a barrier hindering contraceptive uptake among men because not all wards and streets at Mvomero district have their own health facilities. However, the findings of this study indicated that 39%) of the respondents (men) disagreed that little availability of contraceptives hinder contraceptive uptake among men. Also, 28% strongly disagreed on that, however, 11% agreed, 7% strongly agreed, while 15% were neutral. This implies that availability of contraceptives is not amongst the barriers hindering contraceptive uptake among men. This variable was considered because empirical evidence suggests that; the use of modern contraception increases when more methods become available. For instance, in Taiwan modern contraceptive use increased as a result of provision of multiple methods in family planning programs, and it was revealed that addition of one method would increase total contraceptive use by about 12 percent, hence if contraceptive prevalence is 40% then it would rise to 52% (Ross and Stover, 2009).

4.5.4 Accessibility of family planning commodities

Family planning services might be available but not accessible, hence even though the variable of availability of services was included in this study, it was important to assess whether the accessibility of services in any way hinder male contraceptive uptake among men. The findings indicated that 41%disagreed that limited accessibility of family planning hinder contraceptive uptake among men. Also, it was revealed that 33% of the respondents strongly disagreed on that, however others had different opinion as 12% agreed, 6% strongly agreed and 8% were neutral. This implies that accessibility of contraceptive commodities is not the barrier hindering contraceptive uptake as these commodities are subsidized by the government can be accessed at the RCH clinics all over the country. Ross and Stover, (2009) also established that accessibility of family planning also affects family planning uptake.

4.5.5 Distance from health care facilities

Distance between health facilities and residential areas were considered in this study because in some ways some people may be denied of family planning services due to distance. The study uses both questionnaire and interview data collection methods. A total of 100 respondents were given questionnaire and the from the study area indicated that thirteen percent (13%) of the respondents agreed that long distance from health facilities hinders contraceptive uptake among men. This is followed closely by 11% who strongly agreed on that, however, 42% disagreed and 23% strongly disagreed on that, while 11% were neutral. This implies that distance is not the barrier hindering contraceptive uptake among men. These findings are in line with other researcher that distance is not a significant factor affecting family planning use because people can look for important services regardless how far they are (GHeLC, 2018).

The questionnaire findings were supported by interview response that, distance is not a problem for them to pay a visit to health facilities for RCH clinics for family planning. One of the respondents elaborating that:

> *…….I don't think distance and accessibility of health facilities like dispensary in our village is a problem some men regardless most of them are living very far away but the time is fixed for provision of family planning and contraceptive methods such that when they want to use, they can access the services. They are told not to forget the date and they are insisting to come on time. So this is not a problem for me…*

4.5.6 Traditions

Tradition was addressed because there are some tribe have traditions that are not favourable or supportive to family planning uptake. For instance, tribes like Maasai and Mng'ati who were involved in this study have traditions that marriage is all about having children without any limits as long as they are blessed to have children. Also, one Maasai respondent was interviewed and provided that

> *"The traditions of Maasai and Mang'ati, women are not allowed to use methods that do not fit to their cultural values and norms. Family planning is among the health services that are unfit with their values, and if a woman by any means use family planning with or without the consent of the husband can be subjected to a divorce"*

In questionnaire the findings indicated that 45% of the respondents agreed that traditions hinder contraceptive uptake among men. Also, 38% strongly agreed on that, however, 11% disagreed on that, 2% strongly disagreed, while 4% were neutral. Hence, these findings demonstrate that traditions are amongst the barriers hindering contraceptive uptake among men. Similar to the study conducted by Wiafe, (2015) who found out that tradition affects contraceptive uptake among men.

4.5.9 Religion

Religious beliefs were addressed in this study because they have a big contribution to the decision to use or do not use contraceptive methods. This is because there are some religion/denominations openly condemn the use of contraception. Both questionnaire and interview were used. From the findings the result indicated that 46% of the respondents agreed that religious beliefs hinder contraceptive uptake among men, while 30% strongly agreed. Other the respondents had different opinions as 10% disagreed, 3% strongly disagreed, while 11% were neutral. Since that majority of the respondents agreed that religious beliefs hinder contraceptive uptake among men, this implies that religious beliefs is the barrier towards contraceptive uptake among men. This proves findings from Wiafe, (2015), who suggested that religious beliefs affect family planning uptake among men.

From the interview, Public described that some of the religious beliefs were hurdles to delivery and use of family planning services, for the reason that they disheartened societies from using any technique. Certain faiths assumed that the use of contraception was equal to committing abortion, which is considered sinful. In addition, delivery of family planning services to single users was commonly measured to be unsuitable as it was thought to be encouraging promiscuity and sex before marriage in society.

> *"In our faith we are discussing about family planning issues but in negative way since the issue that came out strong was that, family planning is taken as sinful and not allowed to our religious beliefs by saying that the use of family planning medicine, it will make you abort. They keep insisting that the function of a pill is to abort the pregnancy each time you get pregnant. So, it is not right for us to abort because abortion is murder."*

The above explained findings about barriers hindering contraceptive uptake among men are as summarized in table 4.3 below.

Table 4.3: Barriers to contraceptive uptake among men

Variable/Questions	Strongly agreed		Agreed		Strongly disagreed		Disagreed		Neutral		TOTAL	
	N	%	n	%	n	%	n	%	n	%	n	%
Little knowledge about contraception hinders contraceptive uptake among men	32	32	38	38	8	8	13	13	9	9	100	100
Negative attitude about contraception hinders contraceptive uptake among men	34	34	40	40	7	7	14	14	5	5	100	100
Limited availability of contraceptives hinders contraceptive uptake among men	7	7	11	11	28	28	39	39	15	15	100	100
Limited access to contraceptives hinders contraceptive uptake among men	6	6	12	12	33	33	41	41	8	8	100	100
Large distance from health facilities hinders contraceptive uptake among men	11	11	13	13	23	23	42	42	11	11	100	100
Traditions hinders contraceptive uptake among men	38	38	45	45	2	2	11	11	4	4	100	100
Norms hinder contraceptive uptake among men	34	34	36	36	5	5	15	15	10	10	100	100
Unsupportive beliefs hinder contraceptive uptake among men	31	31	35	35	4	4	23	23	7	7	100	100
Religious beliefs hinder contraceptive uptake among men	30	30	46	46	3	3	10	10	11	11	100	100

Source: Field data (2019)

4.6 Strategies on place to ensure men's involvement in family planning and contraceptive uptake

For the men to be involved in family planning, the respondents were asked to propose the strategies that can enhance male involvement in family planning. Therefore, from the study, the respondents have suggested six strategies to ensure male involvement on family planning. These strategies include; (i) provision of family planning products like condoms for free, (ii) recruitment and distribution of adequate and competent health service providers in rural health facilities; (iii) Positive response of religious leaders and community leaders toward family

planning; (iv) Intensive distribution of condoms in different outlets such as shops, super markets etc; and (v) Attendance of male partners in RCH clinics should be compulsory. The findings were as summarized in Table 4.9

4.6.1: Provision of family planning products such as condoms for free in health facilities all over the country

This strategy is important and has provided some positive outcomes because provision of condoms for free can act as a reminder for men, they can realize the necessity of condoms. Men's response on the statement *"Provision of family planning products like condoms for free ensures male involvement in family planning"* indicated that 39% agreed, 35% strongly agreed, 14% disagreed, 8% strongly disagreed while 4% were neutral. This was also recommended by Man love et al, (2014), who established that since that condom is a commonly used contraceptive method, it should be provided for free.

4.6.2: Recruitment and distribution of adequate and competent health service providers in rural health facilities

Rural areas are said to have unmet needs for family planning, and one of the factor causes that is shortage of human resource for health who can create awareness to the community about family planning and can ensure availability and accessibility of family planning services. Men who participated in this study were asked to disclose their views on the statement *"Recruitment and distribution of adequate and competent health service providers in rural health facilities ensures male involvement in family planning".* The findings indicated that 35% agreed, 36% strongly agreed, 15% disagreed, 5% strongly disagreed, while 9% were neutral. Chuwa, (2012) insisted that rural health facilities lack health practitioners, hence recruitment and distribution of adequate and competent health service providers in rural health facilities is highly recommended.

4.6.3: Building positive response of religious leaders and community leaders toward family planning

Religious leaders and community leaders are very influential on different matters concerning the community including family planning. Hence, this strategy is important because it focus on involving religious leaders and community leaders on matters concerning family planning. On the statement *"Positive response of religious leaders and community leaders toward family planning ensures male involvement in family planning"* 44% of the respondents agreed, 31% strongly agreed, 12% disagreed, 9% strongly disagreed, while 4% were neutral. Grisanti (2012) also suggested that religious leaders have high influence in family planning matters, hence they need to change their stand so as to enhance family planning uptake.

4.6.5: Government commitment to extending family planning services

Respondents in the study area explained that government should show commitment towards FP services provision in Mvomero district. They reported that the increased number of new health facilities and healthcare personnel being deployed would improve access to contraceptive services. In questionnaire respondents were asked about strategies to improve effectiveness of FP in Mvomero District. The Findings indicated that 38% of sampled men agreed, 40% strongly agreed, 5% disagreed, 3% strongly disagreed, while 14% were neutral.

On the other hand the respondents in the useful interview said that:

> *"For the family planning to be effectives, the government should opening up more health facilities, especially the health posts. This will contributing to reducing the physical distance that most men have to travel to access family planning services and will ensure availability and accessibility of various contraceptive methods.*

4.6.6: Compulsory attendance of male partners in RCH clinics put in practice

Attendance of male partners to the RCH clinics is vital because it simplifies male involvement in family planning. Hence making it compulsory for men to attend to RCH clinics is a good strategy. Men's response on the statement *"Attendance of male partners in RCH clinics should be compulsory so as to ensure male involvement in family planning"* 38% of the respondents agreed, 27% strongly agreed, 26% disagreed, 7% strongly disagreed, while 2% were neutral. This was also suggested by USAID, (2006) that family planning should be included in Prevention of mother-to-child transmission (PMTCT) sites.

Table 4.4: Strategies on place to ensure men's involvement in family planning and contraceptive uptake

Variable/Questions	Strongly agreed		Agreed		Strongly disagreed		Disagreed		Neutral		TOTAL	
	n	%	n	%	n	%	n	%	n	%	n	%
Government commitment to extending family planning services	35	35	39	39	8	8	14	14	4	4	100	100
Recruitment and distribution of adequate and competent health service providers in rural health facilities ensures male involvement in family planning	36	36	35	35	5	5	15	15	9	9	100	100
Positive response of religious leaders and community leaders toward family planning ensures male involvement in family planning	31	31	44	44	9	9	12	12	4	4	100	100
Intensive distribution of condoms in different outlets such as shops, super markets etc ensures male involvement in family planning	40	40	38	38	3	3	5	5	14	14	100	100
Attendance of male partners in RCH clinics should be compulsory so as to ensure male involvement in family planning	27	27	38	38	7	7	26	26	2	2	100	100

Source: Field data, (2019)

CHAPTER FIVE

SUMMARY, CONCLUSSIONS AND RECOMMENDATIONS

5.1 Summary

This study aimed at investigating the attitude of men towards contraceptive uptake. The study was guided by four specific objectives. A sample of 110 respondents were involved whereby the researcher used both probability and non-probability sampling to select sample. The study used questionnaire, interview and documentary review as data collection methods.

From the study first objectives, the findings indicated that men consider family planning as; (i) family planning is necessary for their family wellbeing; (ii) family planning is not necessary for people who desire to have many children; (iii) family planning is not good because it has side effects; (iv) family planning practice is not a blasphemy; and (v) family planning use is necessary for women, not for men.

Secondly, this study assessed the contraceptive practice among men. It was revealed that majority of the respondents and was using Condom as main family planning method, and on the other than the study revealed that majority of the men do not communicate with their female couples about family planning. Finally the findings of this study indicated majority of the men do not attend to RCH clinics for family planning service.

Thirdly, this study also assessed the barriers hindering contraceptive uptake among men. The findings indicted that knowledge, attitude, traditions, and religious beliefs are the barriers hindering contraceptive uptake among men.

Lastly, the study revealed that strategies on place to ensure male involvement in family planning Were: Provision of family planning products like condoms for free; Recruitment, government commitment in extending FP services, Positive response of religious leaders and community leaders toward family planning; and Attendance of male partners in RCH clinics should be compulsory.

5.2 Conclusion

This paper concludes that there is slight contraceptive uptake among men in Mvomero district as only 34% of sampled men uptake contraceptives, while 66% do not uptake contraceptives. Also, it appears that men in Mvomero district are not supportive to their spouse/partners on the use of family planning as; seventy one percent (71%) of men do not communicate with their female couples about family planning and 89% do not attend to RCH clinics with their spouse/partners looking for family planning services. About the men's attitudes towards contraceptive uptake, men consider contraceptive uptake is a women practice, that it is not necessary for men to use contraceptives because of side effects and their desire to have many children. However, men consider family planning is necessary for their family wellbeing and its practice is not a blasphemy. This study also concludes that knowledge, attitude, traditions, norms, beliefs, and religious beliefs are the barriers hindering contraceptive uptake among men. Further, this study pointed out the strategies on place that can ensure male involvement in family planning. These strategies include; Inclusion of family planning services in Reproductive and Child Health (RCH); Provision of family planning products like condoms for free; Recruitment and distribution of adequate and competent health service providers in rural health facilities; Positive response of religious leaders and community leaders toward family planning; Intensive distribution of condoms in different outlets such as shops, super markets etc; and Attendance of male partners in RCH clinics should be compulsory.

5.3 Recommendations

In supporting the government's efforts and other stakeholders including international agencies, NGOs, CBOs and private sectors in promoting male involvement in family planning, this study came out with the following recommendations: -

i. The government should emphasis on recruitment and distribution of adequate and competent health service providers in rural health facilities. This could

enable percentage increase of contraceptive uptake among men is rural areas all over the country.

ii. To emphasize on community based family planning programs such as mobile outreach, since that people who do not seek for family planning at RCH clinics for different reasons including distance and little awareness still lack contraceptives' information and choices.

iii. Family planning services providers and all other stakeholders should concentrate more on changing men' stand towards voluntary participation in family planning because the findings of this paper demonstrated that there is a potential to change men' view as men consider family planning is necessary for their family wellbeing.

iv. Family planning service providers and other stakeholders like NGOs and CBOs should look for a better way to reach and possibly change the people who are against family planning utilization because of socio-cultural factors.

v. Family planning services should be integrated with other services including HIV related services like the way family planning services are integrated with reproductive and child health. This is enormous potential in enhancing male involvement in family planning as it brought positive effects to men.

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APPENDICIES
QUESTIONNAIRE

No	Question	Response	Code
	A:Characteristics of respondents		
A1	Age		
A2	What is your education level	Informal Primary Secondary College/University	1 2 3 4
A3	What is your occupation		
A4	What is your work experience		
A5	What is your tribe?		
A6	What is your religion?	Muslim Christian	1 2
	B: Attitude of men towards contraceptive uptake		
B1	Family planning is necessary for family wellbeing	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
B2	Family planning is not necessary for people who desire to have many children	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
B3	Family planning is not good because it have side effects	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
B4	Family planning practice is a blasphemy	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
B5	Contraceptive uptake is special for women, not for men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5

	C: Men's involvement in family planning and contraceptive uptake		
C1	Do you use any method of FP?	No Yes	0 1
C2	If yes, mention the kind of FP or contraceptive method you use		
C3	Do your spouse/partner use any method of FP	No Yes	0 1
C4	If yes, mention the kind of FP or contraceptive method your .spouse/partner use		
C5	Do you communicate with your spouse/partner about FP	No Yes	0 1
C6	Do you attend to the clinic of FP and reproductive health	No Yes	0 1
C7	If yes, mention the name of the clinic		
	D: Barriers hindering contraceptive uptake among men		
D1	Little knowledge about contraception hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D2	Negative attitude about contraception hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D3	Limited availability of contraceptives hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D4	Limited access to contraceptives hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D5	Large distance from health facilities hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D6	Traditions hinders contraceptive uptake among men	I strongly agree I agree I strongly disagree	1 2 3

		I disagree Neutral	4 5
D7	Norms hinder contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D8	Unsupportive beliefs hinder contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
D9	Religious beliefs hinder contraceptive uptake among men	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
	E: Strategies on place to ensure male involvement in family planning		
E1	Government Commitment in extension of the service	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
E2	Provision of family planning products like condoms for free ensures male involvement in family planning	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
E3	Recruitment and distribution of adequate and competent health service providers in rural health facilities ensures male involvement in family planning	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
E4	Positive response of religious leaders and community leaders toward family planning ensures male involvement in family planning	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
E5	Intensive distribution of condoms in different outlets such as shops, super markets etc ensures male involvement in family planning	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5
E6	Attendance of male partners in RCH clinics should be compulsory so as to ensure male involvement in family planning	I strongly agree I agree I strongly disagree I disagree Neutral	1 2 3 4 5

INTERVIEW GUIDE

INTERVIWEE INFORMATION

Gender: Male / Female
Age:
Your position:
Number of years in your position:

OBJECTIVE OF THE STUDY

The main objective of the study is to assess men's attitude, practice and barriers towards contraceptive uptake in Mvomero District

QUESTIONS

1. Tell me about yourself.
2. Tell me about your experience as a health provider in family planning and reproductive health
3. How do people of Mvomero district understand family planning?
4. What is the attitude of men towards family planning?
5. Which is the commonly used method of family planning by the people who attend to the clinic?
6. In your experience working at this health facility, tell me about the attendance of men in family planning clinic.
7. In your experience working at this health facility, what is the co-problem affecting participation of men in family planning?
8. In your experience working at this health facility, what are the other factors affecting participation of men in family planning?
9. Over all in your opinion, what is the level of male involvement in family planning at this health facility?