BARRIERS IN THE INVOLVEMENT AND PARTICIPATION OF MALES IN FAMILY PLANNING IN IRINGA MUNICIPAL, TANZANIA.

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MA, HPM Desertation

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By

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A dissertation Submitted in (Partial) Fulfilment of the Requirements for the degree of masters of arts in health policy and management of muhimbili university of health and allied sciences

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***Barriers in the involvement and participation of males in family planning***, in (Partial) fulfillment of the requirements for the degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences.

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Date: 11th November, 2010

Professor Graziella van den Bergh

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Date: 9.11.10

DECLARATION AND COPYRIGHT

I, *Kahale, Singwa Benjamin,* declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature..... Date..3rd Nov 2010

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DEDICATION

This work is dedicated to:

My fiancée *Hellen Arbogast Mbeiyererwa:* You missed my company for so long.

My beloved mother: *Mary George Nyakunga*: For your immense support and encouragement.

ABSTRACT

Background: In Tanzania the use of FP is still low. The use of contraceptives in married men of 15 – 65 years for any method is 68.3% while out of that 49.4% use condoms.

Objectives: The study intended to analyze barriers in the involvement and participation of male in FP.

Methodology: The study was a cross-sectional analytical study using quantitative and qualitative research methods. The study was conducted in Iringa region and the quantitative part of study involved 284 randomly selected male respondents aged 15 - 65 years and above. The qualitative part of the study involved 11 key informants who were Health care providers from both government and private health facilities in the study area. Quantitative Data were entered and analyzed using Epi Info version 3.5.1 while Qualitative data was analyzed using *Atlas it*.

Results: A total of 284 men responded to the questionnaires, most of them (44.4%) were between 25-34 years old. Findings showed that about 57% of respondents were involved in FP and 53% were participating in FP. Overall male involvement and participation was only 43%. Age, marital status and occupation were significantly associated with male involvement and participation. The study also revealed that men had positive attitudes towards FP. Among the reasons mentioned to hinder male participation in FP were religious beliefs being against use of FP, and Health facilities were found to be non male friendly

Conclusion: Male involvement and participation in FP is still very low. The barriers for the enrolment of men in FP were said to be: few contraceptive options for men and little knowledge about options by the community, an unfavorable social or religious climate and also FP clinic setups are unwelcoming to men.

Recommendation: The study recommends more information to men on FP methods and available FP option to them and use of different channels of communication in dissemination of FP information in a wide coverage. Increase in FP service accessibility and availability to men e.g. training of male FP providers to reach men.. The study also recommends strategies which might promote male involvement and participation in family planning like; Multi sectoral collaboration and revisiting FP policies, also considering FP as a cross cutting issue.

CONTENTS

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LIST OF ABBREVIATION

AIDS	Acquired Immune Deficiency Syndrome
BPA	Bachelor of Public Administration
CDC	Centre for Disease Control and Prevention
CPR	Contraceptive Prevalence Rate
FP	Family Planning
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HPM	Health Policy Management
HSM	Health Service Management
ICDP	International Conference of Population
IUCD	Intra uterine contraceptive device
MCH	Maternal and Child Health
MKUKUTA/ NSGRP	Mkakati wa kukuza uchumi na kupunguza Umasikini Tanzania/ National Strategy for Growth and Reduction of Poverty.
MoH	Ministry of Health
MA	Masters of Arts
MUHAS	Muhimbili University of Health and Allied Sciences
NBS	National Bureau of Statistics
NRCCS	National Reproductive and Child Health Communication Strategy

RH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
REDET	Research and Education for Democracy in Tanzania
SPSS	Statistical package for social sciences
TDHS	Tanzania Demographic and Health Survey
TNPP	Tanzania National Population Policy
UMATI	Chama cha malezi bora Tanzania (Tanzania family planning association)
USAID	United States Agency for International Development
WHO	World Health Organization
NPGRCH	National Policy Guidelines for Reproductive and Child Health service

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Family planning (FP) is considered a key constituent of basic health services and it benefits the health and well-being of women, men, children, families, and their communities (USAID, 2009). The aim of family planning is to enable individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births through the use of contraceptive methods and the treatment of involuntary infertility (WHO, 2009)

In Tanzania modern family planning dates back to the 1950s. Provision of modern family planning services in Tanzania started in 1959, when the Family Planning Association (UMATI) introduced services at urban clinics. The Government of Tanzania became actively involved in 1974, when it integrated family planning into maternal and child health services (MCH). In 1989, the government launched the first national family planning program, which included provision of family planning services by governmental, nongovernmental and faith-based organizations. Development partners supported the national program with funds, equipment, and supplies (Mwageni et al, 1998). In 2004 Tanzania has established National policy guidelines for reproductive and child health services, which stresses in making family planning services accessible, affordable and which encourages integration and/ or linkage with other RCH services (NPGRCH, 2004).

There are several family planning methods in Tanzania which have been approved and registered by the Ministry of health and social welfare and made available for use in the Health facilities (NPGRCH, 2004).

These family planning methods can also be categorized as permanent methods like male and female sterilization, also long term methods like IUCDs and Implants and also short term methods like the oral contraceptives. The most recent Demographic and Health Survey conducted in 2004/05 indicates that the most widely used method of family planning in descending order are Injectable (8.3%), oral contraceptives (5.9%), female sterilization 2.6%,

male condom (2%), Implants (0.5%), Intra Uterine Contraceptive Device (IUCD) 0.2% and male sterilization 0.05% (TDHS, 2004 – 5).

Recently, encouraging efforts have been made to improve reproductive health and family planning in Tanzania. The national health policy (2003) attempted to address reproductive health and family planning in health sector reforms. The year 2005 marked the beginning of family planning's revitalization. Family planning was defined as critical in helping Tanzania achieve targets for the Millennium Development Goals in the Tanzania Vision 2025, and in the national strategy for growth and reduction of poverty (MKUKUTA)

Male involvement in family planning has been a concern for the health policy makers for quite some time. Increasingly, appreciation is growing that the involvement and participation of men in reproductive health (RH) as on Family planning matters is crucial indeed, because of their roles and responsibilities in decision making, and in providing support (NPGRCH, 2004). As male parents are also responsible for the rearing of children, it is expected that they should have a role in planning the size of the family, prevent HIV, sexually transmitted diseases and other health complications.

Involving men in Family planning might help Tanzania to achieve some major development goals, such as; a decreased infant and maternal mortality rate, increase in contraceptive prevalence rate which in return might reduce the rapid population growth. Indeed according to currently estimates projections by 2050, Tanzania will have 82.7 million inhabitants if population growth remains at 2.9% (Tanzania census, 2002).

The role of men in such matters is of great importance in Tanzania because the sole decision-makers in a vast majority of the Tanzanian families are males. Especially in the developing countries, women have a little or no say on matters which affect their reproduction or reproductive health. They need the consent of their husbands before accessing to health care or using contraception.

Both the ICPD held at Cairo in 1994 and the World Conference on Women at Beijing in 1995 highlighted the hitherto neglected area of need of male involvement in family planning and

reproductive health in the context of equity in gender relations and responsible sexual behaviour (ICPD, 1994. World Conference on Women Beijing, 1995)

Tanzania recognizes the benefits of the involvement and participation of males in family planning hence it is one among the nations which promote male involvement at the policy and service implementation levels and in Tanzania, Maternal and Child Health Clinics (MCH) are now known as reproductive and Child health Clinics (RCHC).

Although the political climate is favorable to including the involvement of men on the reproductive health policy agenda, involving men at the implementation level poses challenges as focusing on the general male population is not yet a priority for most health facilities in Tanzania, this is not to say that health facilities and agencies do not provide services for men rather the number of more specific initiatives directed at men are limited (Walston, 2005)

1.2 Statement of the Problem.

In Tanzania men have a key role socially and economically, first as a husband, then as a father in the formation of the family, in child education, and in the health and nutrition of the family members. As husband a man is required to be supportive on the decisions and needs concerning the reproductive health of his wife. Traditionally, men are the decision maker in almost all matters at family and community levels, including the number of children for a family and timing of pregnancies. Therefore failure to involve men in family planning initiatives is one among the major hindrances in the national efforts to increase family planning uptake and hence this means failure to address the problem of rapid population growth which is coupled with high infant and maternal morbidity and mortality rate.

Despite the availability of contraceptive methods, RCH care programs and several strategic plans, as of 2004-2005, when the last Demographic Health Survey (DHS) was conducted, the contraceptive prevalence rate (CPR) for modern contraceptives for women of reproductive age in Tanzania was 20% and the Total fertility rate remained as high as 5.7. In Iringa for example, the current use of modern contraceptive methods was 26.4%. At the same time, unmet need for family planning services among women of reproductive age 15 – 49 years was 22% among all Tanzanian women, this refers to women wishing to delay or postpone their

next birth for at least two years, or who do not want any more births, but who are not using a method of contraception. The use of contraceptives in married men of 15 – 65 years for any method is 68.3% while out of that 49.4% use condoms.

The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the understanding and practice of family planning in general.

However the involvement and participation of males in Tanzania is not much successful, since despite the facts explained above, till today in Tanzania there is no major efforts that have been made to include men as essential partners in reproductive health services. Hence this study which will be limited to Iringa Municipal District aims at analyzing barriers in involvement and participation of males in family planning.

Significance of the Study

The study might help in the identification of special issues which regard in the involvement and participation of males in family planning initiatives, challenges to the same and ways to overcome them.

Also, the study might be useful in analyzing some of the social factors which hinder male involvement and participation in family planning, and also those which may increase male awareness in family planning.

The study will help in developing new policies and reviewing the existing policies on Family planning issues; also will help in developing new approaches for increasing men's involvement in improving reproductive health. This will require a research agenda that is gender-sensitive, addressing the roles of both men and women.

1.3 Operational definition of terms

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their spouse and their peers to use FP and who influence the policy environment to be more favorable to developing male related programs. In this context "male involvement" should be understood in a much broader sense than male contraception,

and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice of either sex. (Toure, 1996)

Male participation in family planning In this study male participation in family planning is defined as to all respondents had ever used or now were using any of FP methods and had discussed about FP with their partners.

Contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time (WHO, 2008)

1.4 Research Objectives

1.4.1 General Objective

To analyze barriers in the involvement and participation of males in family planning

1.4.2 Specific Objectives

1. To examine the magnitude of the men's involvement and participation in family planning matters;
2. To determine attitudes of men towards family planning matters
3. To explore reasons that hinder men from effective participating in family planning matters
4. To determine factors that may encourage men to participate in family planning
5. To determine attitude of Family Planning service providers towards male involvement in family planning.

1.5 Research questions

1 To what extent are men involved and participate in family planning matters?

2 To what extent are men conscious of various family planning methods and how far do they support the use of contraceptives?

3 What are barriers that hamper men from effective participating in family planning matters?

4 What are the strategies which may promote male involvement and participation in family planning?

5 What are the opinions of Family Planning service providers about male involvement in family planning?

1.6 Variables

Dependent/outcome variable

- Involvement and participation of males in family planning services

Independent variable

- Age, marital status, attitudes and occupation.

CHAPTER TWO

2.0 Literature Review

2.1 Introduction

In Tanzania, contraceptive use and effectiveness depend directly on men's involvement. There are several contraceptive methods available for men in Tanzania. Of all the contraceptive methods currently available to men, only one, vasectomy, is completely under male control. With the use of condoms and withdrawal, some extent of negotiation is involved, and cooperation is necessary for the method to be used effectively. The use of female-centered methods may be significantly influenced by male partners, in that men may mediate economic resources required to access these methods, or may either indirectly sanction or directly prohibit women's use of these methods (Green et al, 1995).

Traditionally, family planning programs have viewed women as their primary clients for three reasons: it is women who become pregnant; most contraceptive methods are designed for women; and reproductive health services can be offered conveniently as part of maternal and child health services (Green et al, 1995). Bayu Setiawan (2004) asserts that many countries have addressed women when it comes to family planning programmes while men have been excluded in many instances. The article makes reference to research carried out in the communities of Atoni/Dawan and Alor (West Timor) where the role of men in reproductive decision-making is explored. Setiawan concludes with several recommendations. Not only is it important to encourage male involvement in reproductive and family planning programmes but equally important is the commitment to developing broader social policies. He recommends that government policies should be strengthened regarding these issues and that reproductive health programmes, especially the family planning programme, should adopt a combined gender perspective in sexual health services. Involving men requires "significant changes in the structure of the programme as well as considerable adaptability and possibly re-education on the part of staff," according to Setiawan (Setiawan, 2004: vol 19 No 4)

Globally, men have not shared equally with women the responsibility for fertility regulation. While family planning efforts have been directed almost exclusively toward women, the lack of male involvement may also reflect the limited options available to men. The 1994 International Conference on Population and Development (ICPD), held in Cairo, reminded the world audience that good reproductive health is the right of all people, men and women alike, and that together they share responsibility for reproductive matters. By emphasizing gender (the prescribed roles men and women play in society) the conference drew attention to the fact that, if men are left out of the reproductive health equation, they are unlikely to be able to exercise responsibility.

At that meeting, 179 nations including the U.S. met and a worldwide consensus was reached to invest in and strive for goals such as universal access to family planning, reproductive health services, and education for men, women and adolescents as a whole. One of the most effective ways to address population growth and work to achieve larger global sustainable development goals is to increase access to voluntary family planning programs and services around the world (ICPD, 1994). Hence, as an outcome of the meeting calls have been made to increase the involvement of men in matters of reproductive health and family planning. Governmental and nongovernmental agencies and international health organizations all recognize the need to include men in reproductive health services and decision making, and make convincing arguments that doing so would benefit men and women alike (FHI, 2004), (UNFPA, 2003; WHO, 2002).

As interest in men's participation has grown, more studies and attention is being paid to learning knowledge of and attitudes about family planning and how to reach men effectively. A study by Akafuah, examines knowledge of and attitudes about family planning and its use by a convenience sample of men in Ghana. It considers socio - cultural factors such as spousal communication and cultural misconceptions about family planning that contribute to the low level of male involvement in use of contraceptives by men in Ghana. The findings indicate that demographic factors such as education, religion, types of marital relationship, and exposure to mass-media education have significant effects on the participants' increased

knowledge, changing attitudes, and practices of family planning and reproductive decision-making. The study identifies socio - cultural misconceptions resulting from lack of knowledge and education as the main deterrents for the use of different family planning methods including vasectomy. The study calls for further research and male-friendly programs that would clarify myths surrounding the use of contraceptive devices, their benefits and effects on the physiology of the users (Akafuah, 2008).

Also, from a study by Roudi (1996), it was revealed that in Africa men's contraceptive use is lower than might be expected, given their overall levels of approval and knowledge. Between one-quarter and two-thirds of men surveyed want no more children, yet neither these men nor their partners were using contraception (Roudi et al. 1996) The implication of such findings is that, if programs could find better ways to reach men as individuals and as members of couples, contraceptive use might rise considerably.

Additionally, a study was conducted by Kaida and others (2005) with married men and with family planning providers from both the government and private sector in Mpigi District, in central Uganda. The aim of this study was to determine men's perceptions about family planning and how they participate or wish to participate in family planning activities. The results indicate that men have limited knowledge about family planning, that family planning services do not adequately meet the needs of men, and that spousal communication about family planning issues is generally poor. However, almost all men approved of modern family planning and expressed great interest in participating. The positive change of the beliefs and attitudes of men towards family planning in the past years has not been recognized by family planning programme managers, since available services are not in line with current public attitudes. A more couple-oriented approach to family planning is needed. Measures could include, for example, recruiting males as family planning providers, offering more family planning counseling for couples, and promoting female-oriented methods with men and vice versa (Kaida et al, 2005).

2.2 Male use and approval of family planning

A study by Ndenzako (2001) conducted in Ngara, Tanzania, reported that according to the Demographic and Health Surveys (DHS), men are more likely to approve of family planning and to know about contraception than stereotypes about men suggest (Ezeh et al, 1996). While the majority of African men approve family planning, generally men in West Africa, except Ghana, are less likely to approve family planning and appeared to have less knowledge and low contraception use as compare to other regions in Africa. (Ezeh et al, 1996, Roudi and Ashford, 1996, Tanzania DHS, 1996).

Also, in seven of 15 countries surveyed in Africa, at least 90% of men approve the use of contraception. Within most of the countries men are less likely to approve family planning than women. This fact may in part explain why men are often pictured as an obstacle to contraception use. In all countries surveyed however, better-educated men express greater approval of family planning than do men with less education. Perhaps because the educated men understand the importance of family planning better and they might also more easily change their negative attitudes towards family planning (Green et al 1999, Loaiza et al 1998).

2.3 Men and family planning in Tanzania

The government of Tanzania through the Ministry of Health and Social Welfare has done a lot of effort to provide comprehensive health services to all citizens equally, I t has adapted to the Primary Health Care (PHC) approaches in which family planning and its components are basic services fundamental to provision of health for all. All men and women of reproductive age including adolescents irrespective of their parity and marital status, shall have the right to access to family planning information, education and services and the Ministry of Health shall insure a system of effective supervision and monitoring (National policy guideline and standard service and training in family planning, 1994).

Efforts have been made by the Ministry of Health to involve men in family planning however they were not sufficient. Few studies have been made of male involvement in family planning

in Tanzania (UMATI - 2000) and only recently the Tanzania and Demographic Health surveys have included men. Few NGOs have supported male oriented studies with regard to family planning. As reported in a study by Ndezako (2001) conducted in August – December 2000 in Ngara, Tanzania with men aged 15 – 59 years, male contraceptive prevalence was as low as 18%, with periodic abstinence as a common method in use (9%).

There are many problems which face family planning programs and hence this accounts for the low male contraceptive prevalence. A study by Mwageni (1998) conducted in Mbeya, showed that; low contraceptive prevalence is reportedly attributable to men's opposition to family planning. The study employed focus groups to explore the role of Tanzanian men in family planning. More specifically, it presented a rural - urban comparison of the attitudes of men in Mbeya region, to family size preference, sex composition, partners' communication on family planning matters and contraceptive behaviour. Findings indicate that men express positive attitudes towards family planning methods. There is, moreover, little rural - urban variation in male attitudes towards family planning in the study area (Mwageni, 1998)

Hence, there is an urgent need to understand in details the barriers in the involvement and participation of males in family planning in Tanzania.

The purpose of involving men in family planning

Men play important roles in regulating women's access to family planning services through control of finances, women's mobility and means of transportation, and health-care decisions, therefore the continued use or non-use of a family planning method is largely influenced by the man's decision. A study by Mistik at al (2003) carried out in Kayseri, Turkey explained that, as men play a prominent role in reproduction, it is therefore extremely useful to assess and encourage them to be involved in contraception, particularly in developing countries, where contraceptive goals have not been reached. The study also showed that men are not exposed much to family planning information. Therefore, in order to encourage men's involvement in family planning, the use of mass media and continual training programs, to try

to reach both men and women, could be very useful. Indeed when a man approves of his partner's use of contraception, it is most likely that there will be sustained use of contraception (Mistik et al, 2003).

Involving men in inter-spousal communication has also been found to be critical in the sustained use of family planning methods. For example, Demographic and Health Survey data from 14 African countries show that the percentage of women using contraceptives is consistently higher in the group that discussed family planning with their husbands (Roudi & Ashford, 1996).

Another purpose of involving men in FP is to increase the number of family planning users, since reproductive decision-making is a complex process that differs from one setting to the next and from one couple to the next, hence a shared responsibility is necessary. While men often have more say than women in the decision to use contraception, in some places women have more responsibility for family planning decisions than they do for other decisions (Mccauley, 1994). Sometimes women use contraception without telling their husbands. There is some evidence that things are changing. For example, in Tanzania a study found that younger husbands and wives increasingly agree that family interests and responsibilities should be shared (Larsen, 1996).

Also, the importance of addressing the issue of male involvement and participation on family planning is crucial to meeting unmet need. A research by Arwen Bunce conducted in Kigoma, Tanzania implied that, increased inclusion of men in family planning services and education programs is an important part of efforts to increase family planning uptake. Establishing separate spaces for men to learn about family planning would be an effective way of achieving this goal; these spaces could be created within outpatient departments or through community outreach activities at public gatherings. Alternatively, existing clinics should consider offering broader men's reproductive health services to enhance the appeal of family planning to men. Service delivery staff needs to be better trained to address men's reproductive health needs. And because some men indicated that they would prefer to receive service and information

from other men, an effort could be made to hire male staff and outreach workers hence decreasing unmet need (Arwen Bunce, 2007)

UNFPA (1995) lists the following reasons for the growing importance of male-involvement and participation in family planning:

- The advent of the AIDS epidemic has spurred intense interest in condom promotion;
- Men are more favourable to the general principle of family planning than has been assumed;
- Male support affects both the adoption and the correct use of female contraceptives;
- Male-involvement programs can be cost-effective if they are highly focused and offer male contraceptive methods directly or by referral;
- Men's role in the abuse of reproductive rights and sexual violence directed towards female partners and relatives should no longer be ignored; and
- The international consensus reached at International Conference on Population and Development in Cairo, Egypt has created a momentum for action.

Therefore, involving men in family planning for example in Tanzania will increase the contraceptive use, and also might encourage women's use of contraception, and improved continuation rates. In a paper by Pachauri (2001) it was observed that, if men are brought into a wide range of reproductive health services in such a way that they are supported as equal partners and responsible parents, as well as clients in their own right, better outcomes are expected in reproductive health indicators such as contraception acceptance and continuation, safer sexual behaviours, use of reproductive health services, and reduction in reproductive morbidity and mortality. Furthermore the paper concluded that gender inequality is a major barrier that must be overcome and improving the reproductive well-being of women and men requires freeing them both from restricted gender roles (Pachauri, 2001)

CHAPTER THREE

3.0 Research Methodology

3.1 Research design

A cross sectional analytical study using quantitative and qualitative research methods was used to explore barriers in the involvement and participation of males in family planning and strategies to involve men in the same. This study design was chosen because the study was meant to collect information once and there were no follow up of participants to the study.

3.2 Study Area

The study was conducted in Iringa region, in the Iringa municipality, Tanzania. Iringa region has seven (7) districts namely Iringa Municipal, Iringa Rural, Ludewa, Mufindi, Njombe, Kilolo and Makete.

Iringa Municipality is located in the southern highlands of Tanzania, it lies along latitude 7°49'south of the Equator, and longitude 35°39' east of the Greenwich Meridian and it covers an area of 162 km^2 and about 15 km^2 is water shade of little Ruaha Basin and its tributaries (REDET, 2007)

The indigenous inhabitants are the Wahehe. However, the municipality is by and large cosmopolitan even though the Wahehe are still a sizeable majority. The current population now consists of people from different districts of other regions of Tanzania.

Inhabitants of the municipality are mostly involved in petty businesses, poultry and small ruminant production. Some are working as civil servants in government and parastatals organizations.

Iringa Municipality is the administrative capital of Iringa Region and has got one (1) division, 14 wards and 162 streets and three villages. The size of the wards varies significantly. The 14

wards are: Kihesa, Mkwawa, Mwangata, Kitwiru, Ruaha, Mtwivila, Ilala, Makorongoni, Mivinjeni, Kitanzini, Mshindo, Gangilonga, Kwakilosa and Mlandege (REDET, 2007).

According to the 2002 census, Iringa Municipal has a population of 113,300 people on which 54,471 are males. Out of this population children of under five years are 22,675. The population is increasing at an annual rate of 4.6 against a national average rate of 2.9. (Population and Housing Census. 2002)

Moreover the municipality has two Hospitals and three health centers, two are government owned and one is private owned. There are 24 Dispensaries of which seven are government owned while the rest are private.

The municipality of Iringa is served by a small airstrip, which basically handles small aircrafts. It is connected to the outside world by a major road that connects Dar es Salaam, Morogoro and Mbeya to Zambia. Also, there is a road that links Iringa to Dodoma which is graveled and passable with difficulty particularly during the rainy season

3.3 Target population

The study involved men aged 15 - 65 years who are married or in a stable relation. The minimum age of 15 years was selected while official age at marriage for males in Tanzania is 18 years, this is because majority of youth become sexually active and start practising sexual activities in the age of 15 years in Tanzania, also this group was selected because chances that they were involved in making family planning decision were high.

The study also involved health providers from both government and private health facilities which provide family planning services in the study area.

3.4 Sampling techniques

A multi stage sampling technique was used to obtain study participants. The first stage sampling units were Health facilities, 10 health facilities out of 14 were selected randomly by lottery method. From each health facility 2 RCH health providers were selected as key informants.

At the community level, 6 wards were randomly selected from a list of 14 wards, and 5 streets in each ward were also selected randomly making a total of 30 streets. A total of 10 households were selected randomly and visited in each street making 300 households. Also 1 male respondent was recruited from each household. For households where there were more than 2 eligible respondents, 1 respondent were randomly selected by lottery hence everyone had equal chance to be recruited

Sample size estimation

The sample size was calculated from the following formula *(Altman D, 1991)*

$$N = \frac{z^2 (P (1-P))}{E^2}$$

Given that:

N= sample size

z=1.96 corresponding to 95% confidence level;

P= Prevalence of modern contraceptive use among males (estimated to be 49.4%)

(TDHS, 2004 - 5)

E = Maximum likely error to be 6%

Thus,

$$N = \frac{1.96 \times 1.96 (0.49 (1-0.49))}{0.06 \times 0.06} = \frac{3.8 \times 0.3}{0.004} = 285$$

$$N = 285$$

Hence minimum required sample size of **285** males is needed.

3.5 Data collection method

Two research assistants who had previous research experience were recruited. One day training and orientation on the overview of the study and the questionnaires to be used were conducted with the recruited research assistants.

Data collection tools

Data was collected using structured questions and key informant interviews. The interview schedule and the key informant interview guide were in English and then translated to Swahili which is the national language. The interview schedule contained both open and closed questions.

Pre testing of data collection tools: Pre-testing of the tools was done to check the clarity of the questions and to find out if the subjects had the same understanding of the questions as we had. During pre – testing mostly typing errors and repeated questions were the problems noted. These errors were identified and corrected before the main data collection.

3.6 Data analysis and processing

Quantitative data: Data entry and analysis was done using *Epi Info 3.5.1*. Descriptive statistics procedures were employed during the data analysis. Frequencies to see the overall distribution of the study subject with the variable under study was done. To measure the strength of association between explanatory variable and the dependent variable, bivariate analysis was used to assess variables which were involved in Male involvement in Family Planning issues.

Qualitative data: Analysis of the key informant interview included re-ordering of discussion topics, ordering of emerging issues in the discussions, transcriptions and making summaries. Analysis was done by using *Atlas – it software* where sorting and ordering of responses from key informant interviews were grouped into themes, the recurring statements and narratives were then summarized.

3.7 Data Reporting/Interpretation

Data was presented in both narratives (qualitative) and quantitative terms. Likewise chart, rates and percentages were used.

3.8 Ethical considerations

Ethical clearance for this research was sought and acknowledged from the Muhimbili University (MUHAS) ethical clearance committee. Permission letters was obtained from Iringa Municipal District's administrative secretary, and at the ward level, permission was sought from the ward executive officer and village/street executive officer. All measures to maintain human rights including **informed consent;** the right to participate or not to participate in study, right to privacy and confidentiality and right to prevention from any type of harm was taken into consideration.

CHAPTER FOUR

4.0 Results

4.1 Demographic characteristics of respondents

A total of 284 men responded to the questionnaires, most of them (44.4%) were between 25-34 years old followed by those who were between 35-44 years old (20.8%). The calculated mean age was 33 years. Respondents were from six wards and among the 45 ethnic groups observed, 109 (38.4%) were the Hehe and the Bena constituted 14.1%.

Table 1: Demographic characteristics of respondents N=284

CHARACTERISTICS	RESPONDENTS	PERCENT (%)
Ward		
Gangilonga	47	16.5
Kihesa	50	17.6
Kitwiru	47	16.5
Kwakilosa	47	16.5
Mkwawa	64	22.5
Mtwivila	29	10.2
Age Group (Years)		
15 - 24	56	19.7
25 - 34	126	44.4
35 - 44	59	20.8
45 - 54	27	9.5
>55	16	5.6
Religion		
Christian	234	82.4
Muslim	50	17.6
Marital status		
Married	164	57.7
Stable relation	120	42.3
Occupation		
Student	44	15.5
Employees	74	26.0
Subsistence farmer	117	41.2
Petty business	49	17.3
Education level attained		
Completed primary school	77	27.1
No formal education	5	1.8
Primary school incomplete	14	4.9
Secondary or more	188	66.2

Data in table 1 also shows that, Majority (82.4%) of respondents was Christians and a larger percent (57.7%) were married while the rest cohabited. Also, 41.2% of respondents were subsistence farmers while 15.5% were students.

Eleven key informants were also interviewed. Among them, there was only 1 male participant and their age ranged from 28 years to 51 years on which five of them were below 34 years and the rest were above 35 years. Their professions were Nurse Officers, Nurse Midwives and Public Health nurses.

4.2 Magnitude of men's involvement and participation in family planning

Data in table 2 shows the magnitude of men's involvement and participation in family planning. In this study, male involvement was defined as to those men who have ever informed their partner about FP and supported their partners and friends on the use of FP. Findings from this study showed that, more than 70% had informed their partners on FP and 80% supported their partners on use of FP methods and the overall results showed that about 57% were involved in FP.

Furthermore in this study, male participation were defined as to all respondents had ever used or now were using any of FP methods and had discussed about FP with their partners and it was observed that 66.2% of respondents had reported using or having ever used male FP methods and more than 60% had ever discussed with their partner about FP methods hence on the overall about 53% were participating in FP. On top of that Male involvement and participation were considered when respondents were both involved and participated in FP, and it was observed that the magnitude of male involvement and participation was only 43%.

Table 2: Male involvement and participation in FP, N= 284

ITEM	RESPONDENTS	PERCENT (%)
Involvement		
Ever informed their partner to use FP methods	197	70.4
Support their partner in using FP methods	130	83.9
Support their friend in using FP methods	237	84.9
Male involvement	**162**	**57.0**
Participation		
Ever used or are using any FP methods	188	66.2
Ever discussed about FP with their partner	182	65.9
Male participation	**153**	**53.9**
Male involvement and participation	**122**	**43.0**

4.3 Attitude of men towards family planning

Data in table 3 shows findings concerning attitudes of men towards FP on which; More than 80% of respondents knew that family planning is important and approved the use of FP methods to themselves and by their partner/ spouse and majority of respondents acknowledged that there are advantages of using FP methods. Most of respondents accepted FP as more than 80% had never opposed their partners, friends and others on using FP methods; hence more than 50% of men have positive attitudes to FP.

Results from all key informants revealed that men has positive attitude towards FP as one of the respondents from Ngome health centre said that;

> *''male clients are very cooperative if they manage to attend at the FP clinic, their response are good, they are very attentive and they ask many questions during the visits''* (Nurse Officer – Ngome health centre).

Also another respondent argued that;

> *''sometimes men escorted their partners to FP clinics but they stay outside the clinic, and when you ask them inside they don't refuse''* (MCH aider – Iringa Regional hospital)

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Table 3: Attitude of men towards FP. N= 284

ITEM	RESPONDENTS	PERCENT
Importance of FP	244	89.4%
Approval of family planning methods use	247	89.2%
Approval of family planning methods use by partner/spousal	233	86.0%
Never oppose their friend or others of using FP methods	237	84.9%

4.4 Reasons that hinder men from effective participation in family planning

More than 90% of the respondents know well where to get FP services and information, and a majority mentioned that FP services can be accessed at Health facilities and there are no direct costs. Also health facilities are not far from their home settings as reported by the majority.

Among the reasons mentioned to hinder male participation in FP in this study as from respondents was that, religions do not support use of FP (50.5%), close relatives also do not support FP use. Also their tradition does not seem to support the use of FP methods since few support FP use by men. Also among the reasons mentioned by those who did not attend FP clinics were Myth and misconception e.g. 5.1% think that it is a duty of wife to attend FP clinics, 7.2% expected that the health workers may not be friendly and 4.3% mentioned that there might be too many clients at the FP clinics hence they will offer poor services. Some respondents (7.2%) seem to believe that they had enough knowledge on FP so they saw no use of attending FP clinics and 13% claimed to have no time for FP clinics. Moreover, 33.3% mentioned that was due to lack of knowledge about family planning and 28.3% mentioned that it was due to lack of knowledge about the existence of the service.

Table 4: Reasons that hinder men from effective participating in family planning, N = 284

ITEM	RESPONDENTS	PERCENT (%)
Lack of partner support towards use FP methods	174	64.2
Lack of close relatives support towards use FP methods	121	43.7
Religions against use of FP methods	139	50.5
Traditions against use of FP methods	81	29.3
Myth and Misconception	23	16.6
Lack of Time	18	13.0
Lack of knowledge about family planning	46	33.3
Lack of knowledge about the existence of the service	39	28.3

Among the reasons given by key informants were, that Health facilities are not male friendly as the majority of FP clients are women. One health providers said:

> *"when male client wants to access FP services from the clinics he might stay outside for long waiting people to clear out as he feels shy to queue with women waiting for service"* (RCH in charge - Iringa Regional Hospital)

Moreover, negative perception by men was among the reason mentioned as to hinder male participation in FP,

> *"Most men perceive that FP issues and taking care of children is a duty of women hence men do not show up in clinics either do not use FP methods"* (Nurse assistant - Sabasaba dispensary)

4.5 FP service provider's attitude towards male involvement

All key informants who were FP providers, showed positive attitude towards male involvement since they claimed that FP is very important to men. As one said;

> *"Male involvement in FP is very important because it will reduce misunderstanding between couples as when one is aware of his partner use of FP methods, will give*

freedom to women not to hide those methods as some hide pills so as not to be seen by their spouse" (Public health nurse – Ipogoro health centre)

4.6 Factors that may encourage male participation in FP

Data in table 5 shows that 50% of the respondents suggested provision and dissemination of family planning IEC materials to men and FP service providers in both rural and urban setting as an alternative approach in increasing the involvement and participation of males in family planning matters. Others suggestions included awareness creation (28.0%), FP service demand creation (12.7%) and advocacy (7.4%) to men through community sensitization and FP campaign e.g. mass media campaign and door to door campaign.

Table 5: Suggestions in increasing male participation in FP, N = 284

ALTERNATIVE APPROACH	RESPONDENTS	PERCENT (%)
Provision of IEC materials	144	50.7
FP awareness creation	85	28.0
FP service demand creation	36	12.7
Advocacy on FP	21	7.4

Key informants suggested that in order to increase male participation in FP the communities have to be sensitized;

"In order to increase male participation, communities have to be informed about FP services especially FP methods to men through campaigns, radio and television in both urban places and in villages" (Nurse Officer – Mkwawa health centre)

Also they suggested that vasectomy service have to be provided closer to the people so as to increase use by men.

> *"Males in need of vasectomy has to be referred to Iringa Regional Hospital, sometimes these referrals for vasectomy cause male client to change their mind and then give up since they are kept waiting for service providers who had skills and for sure they are very few especially here in Iringa municipal"* (Nursing officer – Mkwawa health centre).

Additionally men have to be educated on FP in both urban and rural areas, as commented by one of the female key informants;

> *"Most of men are in darkness concerning the advantages of FP, they don't know anything they just think FP is all about pills and for women only so they are not concerned at all"* (Public health nurse – Ipogoro health centre).

Moreover it was suggested that, there should be a continuous supply of FP methods in the clinics since shortage of FP methods in the clinics hinder the utilization.

> *"There have to be a continuous supply of FP methods to health facilities as when there are shortages people tend to drop out from utilization"* (Centre manager – Marie Stopes Iringa)

A key informant from Igumbilo health centre suggested that the government should propose FP planning policies which are comprehensive. She said the following;

> *"The government should take a look on our existing policies on FP and they should revise them or make new policies which will emphasize on male involvement and if possible FP should be taken as a cross cutting issue just like HIV and AIDS"*

CHAPTER FIVE

5.0 Discussion

The study assessed the barriers in involvement and participation of men in family planning in Iringa municipal.

Findings from this study showed that, more than 70% had informed their partners on FP and 80% supported their partners on use of FP methods and the overall results showed that about 57% were involved in FP. Furthermore, it was observed that 66.2% of respondents had reported using or having ever used male FP methods though the qualitative finding was against this idea as it revealed that the average daily attendance were one man per month. Common FP method being used by a majority of men was Condom as nearly to 70% used it and very few went for vasectomy. This also was reported by the study done in Hosanna and Gondor, Ethiopia which showed that male methods such as vasectomy were utilized poorly (Ismail, 1998; Tularo *et al.*, 2006).

In this study we found that overall magnitude of male involvement and participation was 43% and there is statistical association between male involvement and participation in family planning with age, marital status and occupation. This finding was also reported by Daka, 1986 who saw several factors like age, religion, marital status, tradition value, access to media, and types of occupation to influence the involvement and participation of men in family planning (Daka, 1986). Men in older age have completed their family sizes and so are more likely to accept FP to avoid unwanted pregnancies. Employed men are likely to be of higher level of education and hence are more knowledgeable of FP methods compared to the uneducated counterparts.

Men showed positive attitude since more than 80% of respondents knew that family planning is important and approved the use of FP methods to themselves and by their partner/ spouse and more than 80% had never opposed their partners, friends and others on using FP methods, similar results were reported in the study by Ezeh, 1996, the report analyzes 17 surveys of

nationally representative data on men and examines indicators including fertility levels, fertility preferences, knowledge and use of contraception, and intentions to use in the future. Of the 17 surveys covered the report by Ezeh, 7 were conducted in West Africa, 6 were in East Africa, 2 were conducted in North Africa, and 2 were in Asia, the study revealed that men are more likely to approve of family planning and to know about contraception than stereotypes about men (Ezeh et al, 1996). Furthermore, since family planning programs and services become more focused on involving the male population, researchers are finding that men who have knowledge about family planning are more likely to have positive attitudes regarding contraception and therefore support their partners' use of family planning methods (Wegner, 1998, Oni, 1991).

The study showed that only 42% of the respondents had ever gone to health facilities for advice or service.

Among the reasons mentioned to hinder male participation in FP in this study are, religions do not support fully FP use. This is in contradiction with the online Oxford Dictionary of Islam (2010) which reported that in contrast to Christian traditions who prohibit contraceptive use, from earliest times family planning and contraception found acceptance in Islamic tradition although the *Quran* contains no clear or explicit text regarding birth control. However, the traditions *(hadith)* of Muhammad do. Though some traditions forbid birth control, the majority permit it. (Online Oxford Dictionary of Islam, 2010)

Another reason mentioned to hinder male participation was wrong perception by men as they perceive it is a duty of wife to attend FP clinics. This was also reported from a study by Drennan, 1998, which showed that family planning programs traditionally viewed women as their main clients because it is women who become pregnant, most contraceptive methods are designed for women, and reproductive health services can be conveniently offered as part of maternal and child health services (Drennan, 1998). Moreover, most viewed women as the target group and paid little attention to the role that men might have with respect to women in reproductive health decision-making and behavior (RHM, 2009). Also in study by Setiawan (2004) reported that

many countries have addressed women when it comes to family planning programmes while men have been excluded in many instances. Moreover, in a 1995 study of 25 family planning clinics in United states of america reporting a male client share of at least 10%, the researchers found that the most frequently cited barrier to providing reproductive health services to men was the perception (by men) that family planning clinics are female organizations that serve only women (Shulte & Sonenstein, 1995).

The study also revealed that there are limited FP methods for men which was among the stumbling block towards male involvement and participation in FP, hence majority use condom as male FP method, this was reported in a recent assessment of urban health needs by Thwin, 1996, that men expressed a need for the development of "more male methods" in the style of injectable or pills and went on to state that men "...should have full information on the merits and demerits of contraceptive use either through the media (i.e. newspapers, etc.) or by other means." Men from urban slums indicated "...a need for male involvement with reasons that they have the responsibility to decide on family size limits (Thwin et al. 1996).

Additionally, qualitative finding also supports this finding as among the reasons given by key informants were, that Health facilities are not male friendly as the majority of FP clients are women

CHAPTER SIX

6.0 Conclusions and recommendations

6.1 CONCLUSION

Most men have information, knowledge and positive attitude towards FP, and some encourage their wives to use a family planning method. The majority of men shared decision making on family issues, including family planning with their wives.

However male involvement and participation in FP is still very low, and the more markedly barriers for the enrolment of men in FP are as follows:

- Unlike the female contraceptive options, the men contraceptive options are few, including condom and are not widely known by the community.
- Unfavorable social or religious climate. Hence men lack full support from society, relatives and religious leaders.
- Most FP and reproductive health services are designed to meet women's or children's needs, and as a result men were less informed concerning FP. Providers lack the training or skills necessary to meet men's FP needs and men may be embarrassed about visiting a facility that primarily serves women.
- FP clinic setups are among the barriers as most of them are inconvenient or unwelcoming to men.
- On top of that there is a shortage of FP methods/devices, FP service providers and Facilities which also are among the stumbling block towards male involvement and participation in FP.

In conclusion, an effective intervention for boosting male involvement and participation in FP requires partnerships between health providers, religious and community leaders, parents, and media. A community oriented and multi sectoral approach holds great promise for removing the barriers to male involvement and participation in FP.

6.2 RECOMMENDATIONS

The following recommendations are made directly based up on this study;

1 In order to influence the overall magnitude of male involvement and participation men should be well informed on FP methods and available FP option to them, also myth and misconception hence this have to be cleared to men concerning FP use by men e.g. some people had in mind that FP methods like Vasectomy cause impotence. Different channels of communication should be used to disseminate FP information e.g. through Community Sensitization and advocacy to the religious leaders, government leaders and influential people. FP campaigns e.g. door to door campaign and mass media campaign. Additionally men should be reached through work place training programs, in school FP programs, FP peer education programs.

2 Since men showed positive attitude towards family planning, then the government and other stakeholders should increase FP service accessibility and availability e.g. increase health facilities and making them male friendly, training of male FP providers, also should strengthen outreach services and provide youth friendly services. Additionally FP service providers have to be trained further on FP so to increase and update their knowledge hence increasing availability of FP services.

3 However recommended strategies which might promote male involvement and participation in family planning includes; Multi sectoral collaboration where governments, nongovernmental organizations (NGOs), donors' agencies and relevant stakeholders team up and hence widening up the coverage and ensure sustainability of FP services particularly for males since this ensures an addition of resources. More over FP policies should be revised and the issue of FP should be considered and as a cross cutting issue.

4 Condom use is among the FP methods for men and also helps in prevention against HIV and other Sexual transmitted disease and in the study condom use was observed to be the choice of many respondents there for the government and other stakeholders should promote and ensure availability and accessibility of condoms in both rural and urban settings.

7.0 Area for future researches

- More research is needed on the policy implication in the expansion of male involvement and participation in FP and RH services use in Tanzania.
- Also more research is needed on Social, cultural, political and economic factors which prevent men from benefiting from family planning in Tanzania.

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