FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING PRACTICE IN MOSHI RURAL DISTRICT

BY

MRS MARY JOSEPH CHUWA (RN, BSc(N)

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH IN THE UNIVERSITY OF DAR- ES- SALAAM, SEPTEMBER 2001

DAR ES SALAAM * MEDICAL LIBRARY *

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the University of Dar- es- Salaam a dissertation entitled: Factors influencing male involvement in family planning practice in Moshi Rural District in partial fulfillment of the requirements for the degree of Master of Public Health.

Supervisor's Signature .....A Hussein.....

Dr. Asia Hussein (MD, Mmed)

Date: .....25/9/01.....



COPYRIGHT

All rights reserved. No part of this dissertation may be reproduced, stored in any form or by any means: electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the author or the University of Dar- es -Salaam in that behalf.

DECLARATION

I hereby declare that this dissertation is my original work and has never been submitted for a diploma or degree in any other University.

Candidate's Signature: .....

Mary J. Chuwa RN, BSCN (DAR)

Date: 25/9/01

DEDICATION

This dissertation is dedicated to my husband Joseph, parents Mr. Vincent Ottaru and my mother Catherine Makimaro whose beliefs in importance of education have contributed much in making me the way I am.

ABSTRACT

A descriptive cross sectional study was undertaken in Moshi Rural district, Kilimanjaro region during June- July 2001, to determine the factors influencing male involvement in family planning Moshi Rural district.

The communities within Moshi Rural District were selected using a multistage sampling technique involving wards and villages. Recruitment of respondents was carried out by inquiry at villages and household levels. Information on factors influencing male involvement in family planning practice was obtained using a structured questionnaire and in depth interview. A total of 218 men aged 18- 60 years were interviewed.

The results of this study indicated that respondents were highly aware of modern contraceptive (85.3%) but contraceptive use was low (47.0%). Respondents with no formal education were 2 times low in contraceptive use than those with primary education. Moreover the study showed that users and non-users have positive attitudes towards family planning practice. The study also identified lack of mutual agreement on issues pattern to family planning.

This study concludes that there are multifaceted factors that influencing male involvement in family planning practice. Recommendations for improvement of the situation and for further research are also provided.

ACKNOWLEDGEMENT

This dissertation is dedicated to all the staff of the Department of Community Health, Epidemiology and Biostatistics, Parasitology and Medical Entomology and Behavioral Sciences from whom the academic capability to do this work grew. The author owes many thanks to Dr. A. T. Kessy and Dr Asia Hussein who were devoted a lot of their time in discussing the proposal development and production of this dissertation.

I am also very grateful to the Ministry of Health/ DFID Eastern Africa (Tanzania- Dar es Salaam) for sponsoring me to undertake the Master of Public Health course. In this regard, I wish also to convey my sincere gratitude to Mrs. Mpembeni and Dr E. Mtumbuka for their statistical expertise rendered in data analysis. Thanks are also extended to Mr. T. Nyamhanga for encouragement and his continuous advice. I am indebted to all and to several other distinguished workers who gave very useful suggestions in the course of my study.

Sincere acknowledgement are also extended to all those who helped me with data collection in the field. I also wish to recall, with much appreciation, the cooperation received from Dr E.T. Ngomuo the District Medical Officer of Moshi Rural. I am also gratefully obliged to the Divisional and Ward Secretaries of Moshi Rural District for mobilizing the people in their areas. However I would like to thank all residents of Kindi and Kirima wards who participated in the study.

Last but not the least, I wish to pay special tribute to my husband Joseph, who tirelessly took care of the family during period of absence from home. I also thank my daughter Joyce and my sons Jackson and Johnson for the highest degree of moral support and encouragement throughout my studies.

Since it is difficult to mention by names, individuals who contributed in one way or another to the success of this work, to all of them I give my sincere gratitude. I am much indebted to all of them.

TABLE OF CONTENTS

ITEM	PAGE
Certification	ii
Copyright	iii
Declaration	iv
Dedication	v
Abstract	vi
Acknowledgement	vii
Table of contents	ix
List of tables	xi
List of Figures	x ii
List of Abbreviations	xiii
Chapter 1: Introduction	1
1.1 Statement of the problem	4
1.2 Objectives	6
1.3 Justification of the study	7
Chapter 2: Literature Review	8
Chapter 3: Methodology	14
3.1 Study area	14
3.2 Study design	16

3.3 Target population---------- ---------- 16

3.4 Study population---------- 16

3.5 Sample size estimation---------- 16

3.6 Sampling procedure---------- 17

3.7 Data collection methods and instruments---------- 18

3.8 Selection of research assistants and training---------- 19

3.9 Pre-test---------- 19

3.10 Data management and analysis---------- 19

3.10.1 Quantitative data analysis ---------- 20

3.10.1 Qualitative data analysis ---------- 21

3.11 Ethical consideration---------- 22

3.12 Limitation of the study---------- 22

3.13 Definition of terms ---------- 23

4.0 Chapter 4: results ---------- 25

4.1 Structured questionnaire ---------- 25

4.2 In-depth interview---------- 47

5.0 Chapter 5: Discussion ---------- 50

6.0. Chapter 6: Conclusion and recommendations---------- 56

7.0 REFERENCES ---------- 59

8.0 APPENDICES ---------- 62

8.1 English Version of Questionnaire ---------- 62

8.2. Swahili Version of Questionnaire ---------- 68

8.3. List of table ---------- 74

List of tables

Table 1: Percentage distribution of the study population by villages---------- 25

Table 2: Socio-demographic characteristic of the study sample---------- 27

Table 3a: Awareness of modern family planning methods---------- 28

Table 4a: Awareness of nearby place where FP services are offered.---------- 30

Table 4b: Distance to FP service delivery points.---------- 30

Table 8: Percent of respondent's level of contraceptive knowledge by marital status-- 34

Table 9: Source of information of modern Family Planning methods---------- 35

Table 10a: Percent distribution of respondents ever used modern FP methods --- 36

Table 10:b Percent of respondent's who currently use modern Family Planning methods 37

Table 11: Percent of respondent's who use modern Family Planning methods by level of education- 38

Table 12: Percentage of male who use modern Family Planning by marital status 39

Table 13: Percent of male who use modern Family Planning by religion ---------- 40

Table 14: Percent distribution of respondents who discuss FP issues by marital status 41

Table 15:Percent distribution of respondents who discuss FP issues by level of education-42

Table 16: Source of FP methods preferred by respondents---------- 43

Table 17: Service provider preferred by respondents---------- 44

Table 1: Shows the level of knowledge of specific contraceptive methods----------74

Table 2: Percentage of respondent's level of contraceptive awareness---------- 75

Table3: Percent of respondent's level of contraceptive knowledge by level of education 76

Table 4: Percent of respondent's level of contraceptive knowledge by age group-------- 77

Table 18: Scale for contraceptive knowledge---------- 79

LIST OF FIGURES

Figure 1:	Distribution of modern methods known by respondents----------	29
Figure 2:	Percent of respondents' level of contraceptive knowledge.----------	31
Figure3:	Percent of respondent's level of contraceptive knowledge by level of education-----	32
Figure4:	Percent distribution of respondent's level of contraceptive knowledge by age group	33

LIST OF ABBRIVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DHS	Demographic and Health Survey
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUCD	Inter Uterine Contraceptives Devices
IPH	Institute of Public Health
IPPF	International Planned Parenthood Federation
IEC	Information Education and Communication
MoH	Ministry of Health
MCH	Maternal and Child Health
NFPP	National Family Planning Programme
TRCHS	Tanzania Reproductive and Child Health Survey
STIs	Sexually Transmitted Infection
UMATI	Family Planning Association of Tanzania.

CHAPTER 1:

INTRODUCTION

Tanzania is among the most populous countries in Sub-Sahara Africa. According to the Demographic and Health Surveys (DHS 1996) the population has trebled, from 7.7 million in 1948 to 23.1 million in 1988 with a rate of 2.8% natural increase. Despite the facts that family planning services were provided as part of integrated programme. The prevalence rate continued to be low in the country. The contraceptive prevalence among men is 21 % (TRCHS, 1999). The contraceptive users rate for Moshi Rural was 15 %. The current contraceptive prevalence has increased up to 16 % in 1999 (TRCHS, 1999). A total fertility rate of 6.3 indicates that the population will continue to grow at a considerable pace in coming years. It had been projected that by the year 2000, the population would be about 33 million on an assumption of slight decline in fertility offset by the continued decline in mortality (Population Reports, 1990). Twenty percent of the population is women in their reproductive age, 15 to 44 years. Like other developing countries, Tanzania has a young based population structure. This implies that the country will continue to have high population growth for many years to come if serious and effective measures are not taken to reduce fertility.

Male involvement in family planning means more than increasing the number of men using condom and having vasectomies. It includes in addition men who encourage and support their partner and their peers to use FP and who influence the policy environment

to be more conducive 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 that have the objective of increasing the acceptability and the prevalence of FP practice of either sex.

In the past, FP programs have focused attention primarily on women, because of the need to free women from excessive childbearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most FP services were offered within Maternal and Child Health (MCH) centers and most researches and information campaigns focused on women. This focus on women has reinforced the belief that FP is largely a woman's business, with the man playing a peripheral role.

Involving men and obtaining their support and commitment to FP is of crucial importance, especial in Africa, given their elevated position in the societies. Men make most decisions that affect political life, domestic and men hold positions of leadership and influence from the family unit right through the national level (IPPF 1984). The involvement of men in FP would therefore not only ease the responsibility borne by women in terms of decision–making for FP matters, but also accelerate the understanding and practice of family planning in general.

According to the1996 national survey there is an increase in the proportion of women and men who have heard of family planning methods (DHS, 1996). The proportion of all women who have heard of at least one method has increased from 74% in 1991–92 to

80% in 1994 and to 84% in 1996. The survey also revealed that the proportion of knowledge of any method of contraception increased form 72% in 1991–92 to 83% in 1996. Knowledge of specific method has also increased dramatically especially injectables. For men, the increase in the proportion that has heard of any method has been less steep than for women from 89% in 1996 to 93% in 1999.

Use of the modern male–oriented contraceptive methods-the condom and vasectomy-is low compared with use of other methods, but it is slowly increasing in some countries. In most countries traditional methods that require male cooperation-withdrawal and abstinence-also are little used (Population Reports, 1998). Some of information on condom use among unmarried population, observed to be higher among men than women. This might be due to the fact that this is the only method used by men and indicates motivation to avoid sexually transmitted infections especially HIV/AIDS (DHS, 1996).

Although there is an improvement in knowledge and use of family planning methods, married women who were interviewed, nearly half of them (46%) said they did not discuss family planning with their partners, for one reason or the other (DHS, 1996). This is an indication that apart from men's knowledge of contraceptives, their use or discussing with their spouses is still very low, thus there is a need to involve men in reproductive health program.

Although men in Tanzania influence policy and reproductive decision, including the decision on the size of the family and use of family planning by female partners,

strategies for involving them in program itself have been limited. Constraints militating against male involvement include: the provision of family planning services as an integral part of MCH services that are not attended by men, limited availability of men contraceptive methods and perceived roles by men in reproduction.

This research therefore, intends to determine factors influencing male involvement in FP practice and obtain information that can help to reach men with reproductive health services through approaches that are appropriate to them.

1.1 Statement of the problem

Effective FP requires mutual agreement between the spouses on the utilization of contraceptives. This is only possible if both partners have understood the concept of FP and methods used to avoid unintended pregnancies that could prevent one-fourth of all maternal deaths in developing countries (Population Report, 1998).

Men's support or opposition to their partners' practice of FP has a strong impact on contraceptive use in many parts of the world, including Tanzania. Within marriage in Tanzania, men typically have more say than women in decision to use contraception and in the number of children that the couple will have.

Historically, the FP Programme in Tanzania has never focused on men and youth for the reason that are not well documented. The setting and provision of MCH services exclude

men from playing an active role in fertility control. In most African cultures, such exclusion is likely to contribute to decreased contraceptive use since men are the main decision makers in many households and this include issues which relate to fertility control. Moreover, while there exists little information for male consumers, there are even fewer educational materials available for professionals and health care providers who deal with men's FP topics (Rogow, 1990). Most FP clinics are located within MCH centres and men do not feel comfortable going to those centres; most trained providers are female, trained to talk to women and may alienate men; the variety of modern methods are generally aimed at women, leading to an emphasis on female contraceptive methods.

A number of studies (DHS, 1991-92; DHS, 1994; DHS, 1996; WHO, 1998-1999) have indicated that men are mainly knowledgeable about men FP methods (condom, withdrawal, calendar and vasectomy) and some show that many couples do not know each other's views about FP. The practice on the above-mentioned methods among men is still low. For instance since Voluntary Surgical Contraception Programme started in 1988, only 367 men out of 3670 men exposed in the country have undergone this procedure (UMATI, 1999). The potential effect of HIV/AIDS may affect contraceptive use in regions where mortality from AIDS is high, couples may decide to have more children than they otherwise in order to increase the likelihood of a certain number surviving children. This resulting increase in the demand for births would lower the likelihood of couples adapting a contraceptive method to control their fertility. On the other hand efforts to prevent the spread of AIDS may result in increased condom use.

Under utilization of contraceptive services in Tanzania remains a problem. This is attributed to a multitude of factors including accessibility, lack of contraceptive information, religious opposition, and cultural mandate for large families and myths about contraceptives and sexual norms. However, policy makers and professionals agree that lack of male involvement in all areas of reproductive health may be a major contributing factor to low contraceptive use (MoH, 1994). It is in this context that this study seeks to determine factors influencing male involvement in Family planning practice and obtain information that will assist in instituting appropriate strategies to reach them.

1.2 Broad objective

To determine factors influencing involvement of male aged 18-60 years in family planning practice in Moshi Rural district.

1.2.0 Specific objectives

1.2.1 To determine the level of knowledge about methods for preventing conception among male aged 18–60 years in Moshi Rural district.

1.2.2 To determine the attitude of males aged 18–60 years towards FP methods in Moshi Rural district.

1.2.3 To determine the proportion of men who communicate with their partners on FP issues in Moshi Rural district.

1.3 Justification of the study

Like other developing countries, Tanzania is facing a rapid population growth (2.8%) and its associated problems. According to a country survey, current fertility levels a Tanzanian woman will have an average of 5.6 children by the end of her reproductive years (TRCHS, 1999).

When men and women are aware of each other's health needs, they are more likely to receive needed services. Strengthening communication between partners about FP and involving male in health promotion can lead to better health for the entire family. Family planning is often potrayed as a woman's concern, with the man playing a very peripheral role. For instance it has been established that some women use contraceptives without the awareness of their husbands (Mbuji, 1991). However their reasons behind using contraceptive methods secretly were not obvious.

This study intends to contribute to the understanding of the factors, which influence male involvement in FP practice, and obtain information that will assist to reach male with FP services through approaches that are appropriate to them. The result from this study will assist in instituting appropriate strategies for promoting FP practice through male involvement so as to increase use of contraceptive in the country.

CHAPTER 2:

LITERATURE REVIEW

Fertility regulation is basically aimed at changing the reproductive habits of a society, its sexual behaviour, the family life style, the roles and relative status of the two sexes. To be successful in getting the society adapt a new family planning method there must be a change in society's knowledge, attitude, beliefs and practice regarding human reproduction (Chipfakacha, 1993). Both men and women and particularly men have responsibility in initiating and maintaining these fundamental changes. Unregulated fertility is a health hazard, which has been recognized by man from time in memorial. This recognition has necessitated the search for ways of avoiding pregnancy when it is not desirable to conceive (Chanji, 1983). Many factors influence the fertility of individual and population. It is now widely accepted that control of fertility, like the prevention and avoiding death is a community responsibility.

Children are often seen as wealth and guarantee of continuity of life. The more precise reasons for wanting many children are to continue the lineage and commemorate the ancestral spirits to acquire labor force for physical protection and property. Also the need to have definite sex ratio among children strengthens the desire for more children (Moinos, 1973). Such strong desires for children strongly influence use of fertility regulation method either traditional or modern. Most Africans practice patriarchal cultural system. The male as a dominant member of the family determines all that takes place in his household including such personal issues as family planning.

In most developing countries men dominate decision making at family level including issues related to fertility control (World Bank Report, 1986). A positive relationship between partner communication on contraceptive issues and has been reported in several studies Nigeria (Oni and McCarthy, 1991), Ghana (Green 1992) and Zimbabwe (Shah, 1994). A study done in Zimbabwe on levels and trends in contraceptive use for example, reported that contraceptive use was relative higher where partners discussed with each other about fertility control (Shah, 1994) than where this was not the case. There is also a problem of beliefs and attitudes influencing contraceptive use. Some studies in Africa have shown that even where women are motivated to use modern FP, male attitudes towards such services may constitute barriers to contraceptive use (M0H, 1994). In addition study done in Mbeya region in Tanzania reported that 16.5% of women were using contraceptive without the awareness of their husbands (Mbuji, 1991). However, reasons behind using contraceptive method secretly were not given. In addition a study done in Jamaica shows that most men expressed a clear disapproval of permanent methods. 89% of men disapproved of tubal- ligations for their partners and 96% of men would not consider vasectomy. Twenty seven percent of men felt that the uncertainty of relationships made vasectomy too final an option. Others raised concerns that it would be against God's will (WHO, 1998-1999).

The husband's support is found to be a good predictor of future practice and continue use. There are studies done in the Philippines, which indicate that, the continuation rate among women whose husband support their contraceptive practice is much higher than among those who have no support from their husband (IPPF, 1984). In South Korea

researchers found that 71% of women whose husband approved FP had used contraception at some time, compared with 3% of women who husband did not approve (Population Reports, 1994). In Madagascar, Norplant continuation rates were higher after one year among couples in which the husband had been involved in the decision – making process, and among these couples, both wives and husband were more satisfied with Norplant than those in which only the wife was counseled. (Tapsoba et al, 1993).

The introduction of family planning in Africa sidestepped this very important African rule. This of course was met with resistance from African patriarchal society causing problems for the service in African. In this lack of communication between husband and wife has been found to be the greatest obstacle to family planning.

Social anthropological studies indicate several traditional motives supporting the intense desire for children and the strong rejection of sterility by husband (DHS, 1992). Couples who talk about the number of children they want and about the family planning are more likely to use contraception than those who do not (Chipfakacha, 1993). It appears that the family planning providers took it for granted that African men were not interested in family planning and child spacing. Surveys done in Burkina Faso, Nigeria, Kenya and Sudan have however proven that men are generally interested in family planning and child spacing (DHS, 1992). In recent years, family planning services throughout the world have realized that it takes two partners for family planning to succeed. Hence many family planning programmes require both partners to come for counseling. In Africa not many men accompany their partner to family planning clinics

but nowadays males have started showing interest. Many countries such as Nigeria, Zimbabwe, Caribbean and Hong Kong have gone further and introduced programmes to encourage male involvement in family planning activities (Kapiga, 1995). Most of these programmes offer lectures, group discussions, and male counseling clinics and videos show. Studies done in Tanzania show that almost one-third 32% of all women age 15-49 and 39% of all men age 15-59 in Tanzania have used a method of family planning at some time in their lives. Eight percent of women have used withdrawal, condoms and the calendars rhythm method respectively. Other methods have been less widely used. Depo Provera Injections have been used by 3% of women, the IUD by 2% and female sterilization by 2%. More women have used Pills than any other method 13%. More men have used condoms than any other method 18%. Withdrawal and the calendar rhythm method have each been used by 13% of men. Nine percent recently of men have had partners who used the pill (Ngallaba et al. 1993). However, this data are urban oriented, it does not affect the rural community where majority of people live.

Also the Organization of Tanzania Trade Union (OTTU) in collaboration with Family Planning Unit has started a Project on male motivation at work place, which covers Dar es Salaam, Tanga and Kilimanjaro Regions. The main activity is counseling of peer group and offer Family Planning services at work site. Also, they have designed and produced IEC material targeting men. The clinics at work site are developed to provide more comprehensive family planning services, (UNICEF/ MOH, 1990). Despite these efforts, male involvement is still minimal, and more emphasis should be targeted in the rural areas where majority of the population live.

In sub-Saharan African despite the general low usage of contraceptive, an estimated 40% of those using contraceptives use a male oriented method that is condom, rhythm or withdrawal but not vasectomy, periodic abstinence is rarely praised since it requires the use of thermometer and knowledge of evaluator period. Many countries are targeting men for conception. In Honking the family planning association has been running programmes since 1960 catering for male only. There has been some male family planning practice in Tanzania such as vasectomy and condom use.

The exclusion of men from participating in reproductive health programmes is a worldwide phenomenon recognized at the 1994 Cairo conference. The conference called for gender equality as well as measures that enable men to take responsibility for their sexual and reproductive health behavior. There is now greater awareness of men's role in reproductive health, but more needs to be done to include them in service, to increase their use of family planning and to encourage their support for their partners' choice and use of contraceptive method (ICPD, 1994).

CHAPTER 3:

METHODOLOGY

3.1 Study area

The research was conducted in Moshi rural district in Kilimanjaro region. Moshi rural district is one of the six districts of the Kilimanjaro region. It lies between longitudinal 37.50 and 37.45 degrees East and latitudes 3.00 and 3.45 degrees South and covers a total land area of 3054 Sq.Km. the average mean temperature is 23.5°C and has annual rainfall ranging between 200 to 400 mm. In the Northern part it is boarded by Mt. Kilimanjaro, in South by Mwanga and Simanjiro districts. In the West by Hai district, and in the East by Rombo district.

Administratively, the Moshi Rural district is divided into four divisions (Hai, Kibosho, Vunjo East, and Vunjo West). It has 27 wards and 158 villages and with an estimated population of 342,553 of which 46.8% are males and 53.2% are females (Bureau of Statistics, 1988). The annual population growth rate for the region was 2.1 (Bureau of Statistics 1988) The indigenous people are mainly the Chagga and their main food crops are bananas, potatoes, beans, maize and a variety of fruits and vegetables. They also grow coffee and to a small extent pyrethrum as cash crops. Majority of the people are Christian and few Muslims.

The health facilities in the district include 6 hospitals (2 governmental, 3 voluntary agency, 1 parastatal); 6 health centers (4 governmental and 2 private); and a total of 97 dispensaries (31 governmental and 29 belonging to voluntary agencies and 37 private). There are 15 registered pre- primary schools and 194 primary schools (one private). And there are 37 secondary schools 24 are privately owned, 28 are "0" and 9 "A" level. There are 3 teachers colleges, Marangu, Mandaka and Singachini. The district has local brew shops as well as beer shops where people interact socially.

The study was conducted in Moshi rural district because of the fact that unmet need for family planning was relatively high compared to other districts in the country. Moreover the fertility rate was also high. Figures available for Moshi Rural are, contraceptive prevalence rate, which is 15% for men, and fertility rate of 6.3 children (TRCHS, 1999). However the national figure of contraceptive rate is 16% while the total fertility rate are 5.8 children. The MMR of Tanzania is still high that is 529/100,000 live births. Likewise, high parity, more than 5 pregnancies, is associated with increased risk of dying to both mothers and children (TDHS, 1999). The level of under-five mortality was 137/1000 live births in 1996 and 141/1000 in1991-1992. It is particularly high in rural areas compared to urban areas. Furthermore the investigator was familiar with the social-cultural setting of the area, and this familiarity was expected to ease the process of data collection especially on the sensitive issues.

3.2 Study design.

It was a descriptive cross-sectional community based study conducted in Moshi Rural district during the month of June 2001. The study involved males aged 18-60 years. This design was chosen because the study was conducted at one point and respondents were not followed up later.

3.3 Target population.

The target population consisted of all men aged 18-60 years living in Moshi Rural district.

3.4 Study population.

The study population consisted of all men aged 18-60 years living in the 4 randomly selected villages of Moshi rural district.

3.5 Sample size estimation

In order to calculate the sample size for the study, the prevalence of the current use of modern FP methods by men in Kilimanjaro region, 15% (TDHS 1996) was used. Therefore the estimated sample size would be calculated by using the following formula:

$$\frac{N = z^2 pq}{d^2}$$

Where,

N = The minimum number of participants required in the sample.

Z = the standardized normal deviate that corresponds to the 5% level of statistical significance, thus z was set at 1.96

d = 5% which was the precision of the result desired.

P = 15% proportion of the men using contraceptives in Kilimanjaro region.

q = 1- p (degree of accuracy 5%)

The sample size required was obtained by substituting the following figures:

Taking d = 0.05 and p = 15% then

$$N = \frac{1.96^2 \times 0.15 \times 0.85}{0.05^2} = 196$$

Therefore about 196 males were required in the study area, but 10% N was added to N, to take care of any attrition and therefore the sample size was 218.

3.6 Sampling procedure

The participants for the study were selected using a multistage random sampling technique. A list of all 27 wards of the Moshi Rural district was obtained from the district administrative office. Two wards were randomly selected. Thereafter Two villages were randomly selected from each of the selected wards, making a total of 4 villages. From each selected village a sampling frame of ten cell leaders was drawn and 5 out of 20 ten-cell leaders were selected from each village. All the households within the administrative areas of the ten cell leaders selected were included in the study. All

men aged 18- 60 years who had been living in the household for a period of at least six months prior to the day of interview were enrolled for the study.

3.7 Data collection methods and instruments

Data was collected using structured interview schedules and in-depth interview. The interview questions were both closed and open-ended. The in-depth interview was for assessment of attitudinal issues. In the study area 50 males were also interviewed in-depth. In each 50 household, one ten-cell leader was selected from each of 5 households in the district. The interview schedules were first designed in English and later translated into Swahili, which is the national language of Tanzania and is easily understood by the majority of the population. Apart from demographic characteristics, the interview schedule focused on participants' contraceptive knowledge, attitude, practice, and partner communication on fertility issues. (See appendix 8.1) Trained research assistants together the investigator conducted the interviews.

Explanatory variables are education level, socio-demographic characteristics, knowledge on contraceptives, attitudes towards contraceptives and source of information. Outcome variables are use of contraceptive methods, and communication between partners.

3.8 Selection and training of research assistants

Two research assistants were selected from service providers who were eligible for the interview if they provide either family planning or maternal health services to assist in administering the interviews. They were trained on the purpose of the study, how to establish good rapport with the study participants and how to conduct the interviews.

3.9 Pretest

Prior to the study pre-testing of the study instrument was done on 10 men in one village Shirimatunda of Moshi Rural district outside the research villages. The aim of the pretest was to test the feasibility of the study. In the process, problematic areas of the research instrument were identified and the necessary modifications done before embarking to the actual study. Following this exercise some open-ended questions were rephrased for easy understanding by the respondents.

3.10 Data management and analysis

3.10.1 Quantitative data

Data was collected over a period of four weeks. Every evening the researcher checked the filled tools to find out whether they had been filled in completely and correctly. Corrections for minor mistakes/ omissions were made. Computer data entry was done at the Institute of Public Health, immediately after coming back from the field.

Questionnaire were coded and entered into a computer using EPI INFO (Centers for Disease Control and Prevention, Atlanta, GA, USA) statistical package. Data analysis was done following cleaning.

There were a total of 4 questions on family planning Knowledge (see appendix 8.1). Analysis of FP knowledge questions was done as follows: For each modern method spontaneously mentioned by the respondents a score of one point was given. The respondent was also given one point if he could correctly mention the mode of use of each modern contraceptive method. Respondents were also given one point if they had heard of any modern family planning method and another one point if they could explain where to get family planning supplies. The maximum number of scores that a respondent could get was 20 points. Those who scored less than 5 points were classified as having a low level of contraceptive knowledge, while those with 6-12 points were classified as having moderate knowledge. Those who scored 13 points or above were classified as having a high level of knowledge of family planning (see table 18 appendix 8.4).

Descriptive statistics mean, frequency, and percentages were used to analyze the quantitative data and help in subsequent interpretation of the same. Inferential statistics (chi- square) were also used.

3.10.2 Data analysis: Qualitative

The qualitative data were analyzed regarding the sub themes used. In the process of conducting in-depth interviews respondents were asked questions about attitude towards family planning practices. Respondents were asked to draw upon their personal experiences and opinions and to put forward as many ideas as possible, as these were recorded in the exercise book verbatim. Thereafter the investigator analyzed the information collected. Data analysis procedures involved the following:

- Each participant's responses was actively listened to and put down in writing.
- The transcription was read so as to identify shifts in participants' thoughts.
- The transcription was divided into thought segments (major ideas/ opinions).
- Specifying significant phrases (local concepts) of the respondents.

- Each significant phrase was distilled so as to express the central meaning of the segment, in the word of the investigator.
- Preliminary synthesis of central meanings of all thought segments for each participant with a focus on the essence of the phenomenon.
- Finally, synthesis of the essences that had surfaced in all participants' explanations resulted in an exhaustive description of the lived experience.



3.11 Ethical considerations: -

The study proposal was submitted for review and clearance to the ethical research committee of the Muhimbili University College of Health Sciences (MUCHS). Permission to carry out the study in Moshi Rural district was sought from the District Medical Officer (DMO) of the district. The eligible participants for the study were informed individually about the purpose of the study and explained that their participation was on voluntary basis. In addition the participants were assured of anonymity and confidentiality with the information they shared.

3.12 Study limitations: -

The limitations of the study were as follows: -

1. Obtaining good information about one's sensitive personal issues such as beliefs and perceptions is a delicate task. This is because, according to the African culture, open discussion on perception matters is considered immoral. The investigator tried to minimize this effect by establishing good rapport prior to conducting interviews. Also the participants were assured that the information, which they provided, would be kept confidential, and that no one except the investigator will have access to the interview schedules.

2. Finding people at home during normal working hours is an anticipated obstacle. Making follow up with appointment was done to minimize this problem.

3. Recall bias, especially when one is required to remember their age, contraceptive methods ever used was also another potential source of bias. An attempt was made in few cases where recall of age was a problem to use a calendar of major events in the area as a method to approximate their dates of birth.

3.13 Definition of terms:

Knowledge of FP: This was classified into 3 levels according to a score guide designed by the author. The scoring system takes into consideration individual awareness of different FP methods, their mode of use and awareness of FP delivery points. The minimum number of points that an individual could score was 20 points. If he scored less than 5 points – classified as not knowledgeable, 6-12 points –moderate knowledge and 13 and above highly knowledgeable.

Awareness: A man was taken as aware of FP methods if he could explain any one method he mentioned and mode of action correctly.

Attitude: Is defined as individual point of view towards modern Family Planning, if a person approved of modern FP he has positive

attitude, while if he disapproved or believed on rumors and misinformation's of modern FP he has negative attitude

Family Planning: Is defined as modern methods of birth control and child spacing

Family planning practice: Use of any modern family planning methods.

Male involvement: Means involving men from early stages of family planning, communication between partners, about family planning issues, consent to use methods of family planning male involvement also includes men who encourage and support their partners to use family planning.

CHAPTER 4 :

RESULTS

4.1 Structured questionnaire

The study included 218 men aged 18-60 years, living in Moshi Rural District. The study sample was obtained from Kindi and Kirima wards in Kibosho division. Kindi has an estimated population of 12,330, while Kirima has 8,559. From these two wards 4 villages were then randomly selected that are, Chekereni where 116 men (53.2%) were involved in the study, Kirima Kati 44 men (20.2%) were involved in the study, Kirima Masoka had 34 (15.6%) were involved in the study, and Kirima Juu where 24(11.0%) were involved in the study.

Table 1: Percentage distribution of the study sample by village

Village	No	%
Chekereni	116	53.2
Kirima Kati	44	20.2
Kirima Masoka	34	15.6
Kirima Juu	24	11.0
Total	218	100.0

The socio-demographic characteristics of the males interviewed are summarized in table 2. The majority (73.4%) of respondents were between the ages 25-44 years. More than three quarters of the study (77.6%) were married and the majority (82.1%) were Christian believers. The level of education attained by (63.3%) of the respondents was primary education, less than a quarter (23.8%) had secondary education and above while (12.8%) had no formal education. About a half of the respondents (53.2%) were peasants. Those who were involved in business were (23.4%) and (8.3%) were civil servants. (15%) were involved in other occupation, which include carpentry, tailors and masonry.

Table 2: Socio-demographic characteristics of the study sample

Characteristic	No	%
Age		
Less than 24 years	48	22.0
25- 34	60	27.5
35-44	52	23.9
45-54	35	16.1
More than 55 years	23	10.5
Total	218	100.0
Marital status		
Single	45	20.6
Married	169	77.6
Others[1]	4	1.8
Total	218	100.0
Religion		
Christian	179	82.1
Muslims	36	16.5
Pagans	3	1.4
Total	218	100.0
Education		
No formal education	28	12.8
Primary education	138	63.3
Secondary education and above	52	23.8
Total	218	100.0
Occupation		
Peasants	116	53.2
Business	51	23.4
Civil servants	18	8.3
Others[2]	33	15.1
Total	218	100.0

NB Others[1] = Separated/ Widowers/ Cohabitating/ Divorce
NB Others[2]= Carpentry/ Tailors/ Masonry

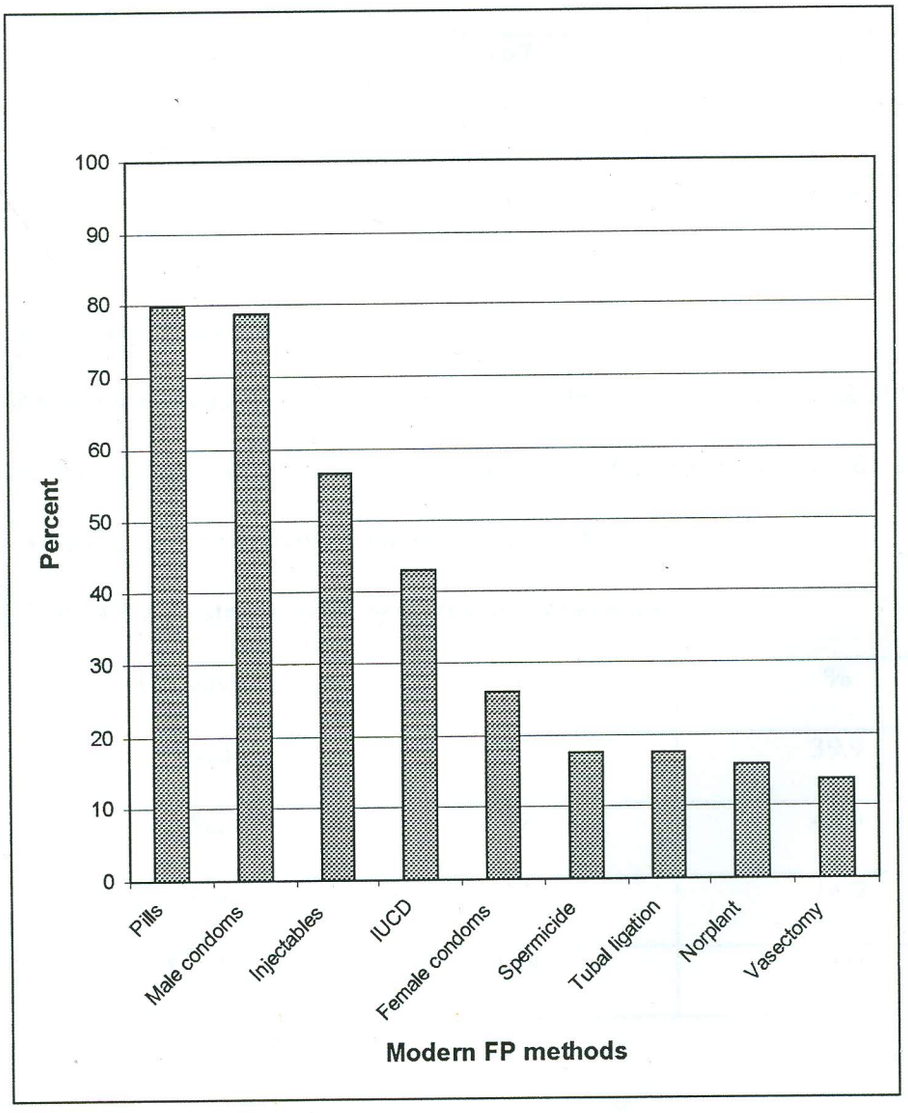
Respondents were asked if they had ever heard of any family planning method. Table 3a shows that a high proportion (85.3%)0f the respondents were aware of at least one modern FP method.

Table 3(a): Percent of respondents who had ever heard of any modern family planning method.

Ever heard of any FP method	No:	%
Yes	186	85.3
No	32	14.7
Total	218	100.0

The three modern family planning methods most frequently mentioned to be known by the respondents were pills (79.8%), male condoms (78.9%), and injectables (56.4%). Norplant and vasectomy were the least known methods and were reported by (16.0%) and (13.8%) of respondents respectively. (See figure1 and appendix 8.3 table1)

Figure 1: Distribution of modern FP methods by known to respondents



Respondents were asked if they were aware of any nearby place where FP services are offered. (See table 4(a). Most of the respondents (78%) reported that were aware of nearby family planning delivery point.

Table 4(a): Distribution of respondents by awareness of nearby place where FP services are offered

Awareness of Place	No	%
Yes	167	78.0
No	47	22.0
Total	214	100.0

NB 4 missing responses

Respondents who were aware of FP service delivery points were asked to mention how far these places were from their home. Most of the respondents (85.2%)lived within 5kms of a service delivery point (see table 4(b).

Table 4(b): Distance to FP services delivery point

Distance	No.	%
< 2km	59	39.9
>2-5km	67	45.3
>5km	22	14.9
Total	148	100.0

Knowledge of modern contraceptive methods:

Respondent's level of knowledge of modern contraceptive method was determined by using a scoring scale (see section 3.10 pg 19). Over half of respondents (58.7%) were found to have moderate level of modern contraceptive methods and (28%) have low levels of knowledge, while (13.3%) had high level of modern contraceptive methods (see figure2 and appendix 8.3 table2).

Figure 2: Knowledge Of Modern Contraceptive Methods.

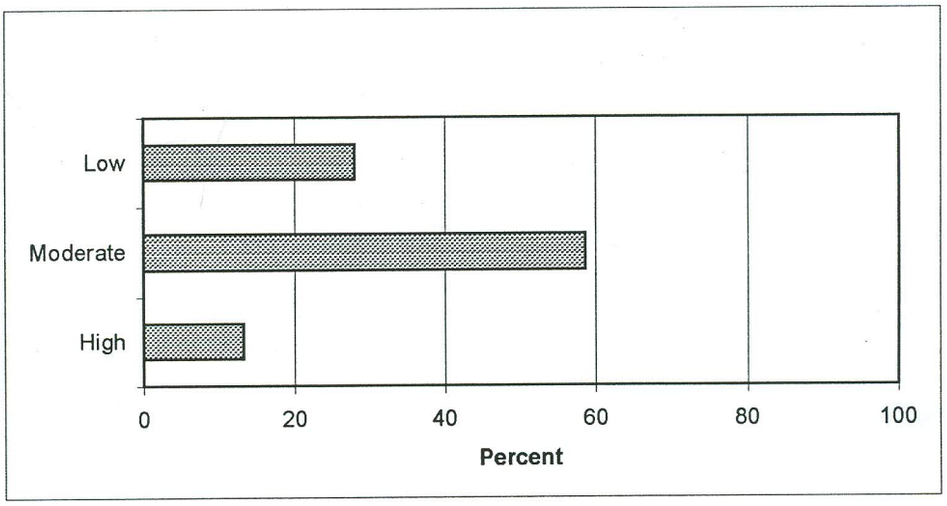
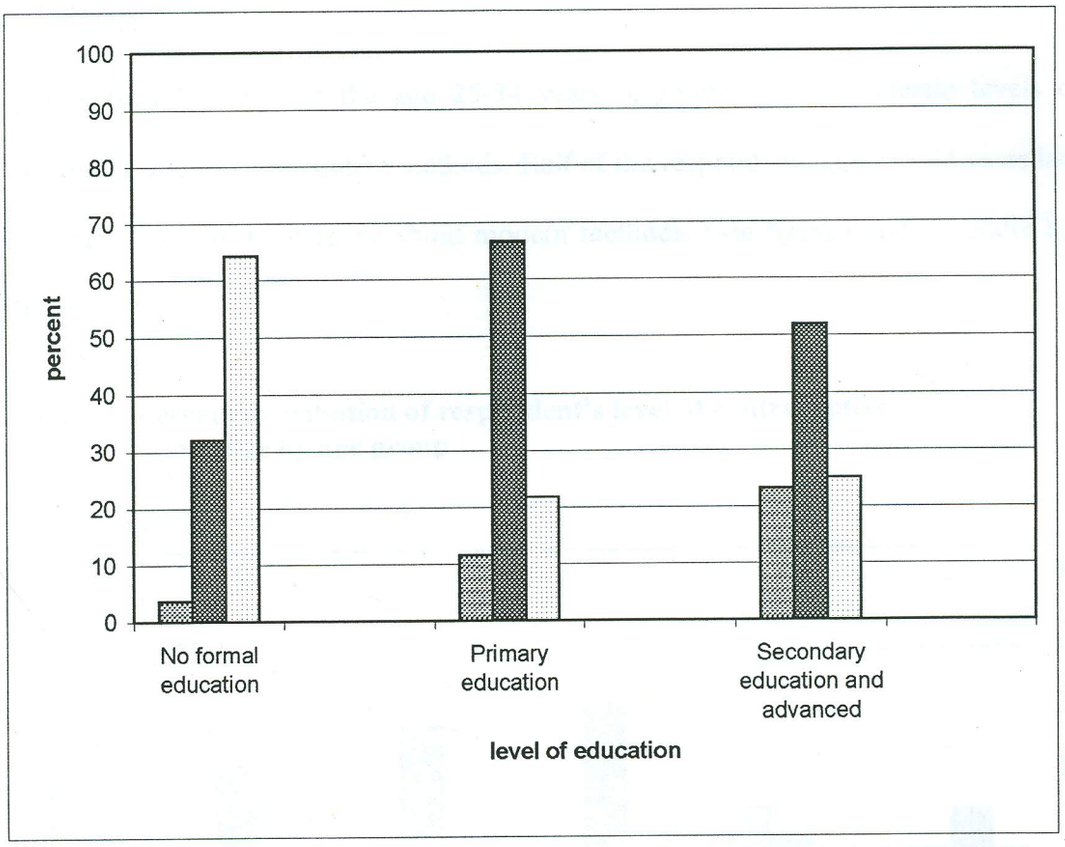


Figure 3 below compares respondent's level of contraceptive knowledge and their level of education. About two thirds (66.7%) of the respondents who had primary education had moderate level of knowledge on modern contraceptive methods, while (64.3%) of the respondents with no formal education had low level of modern contraceptive methods. (See figure3 and appendix 8.3 table3) The highest proportion of respondents with high level of family planning knowledge (51.9%) were among those with secondary education and above.

Figure 3: respondents' level of contraceptive knowledge by level of education



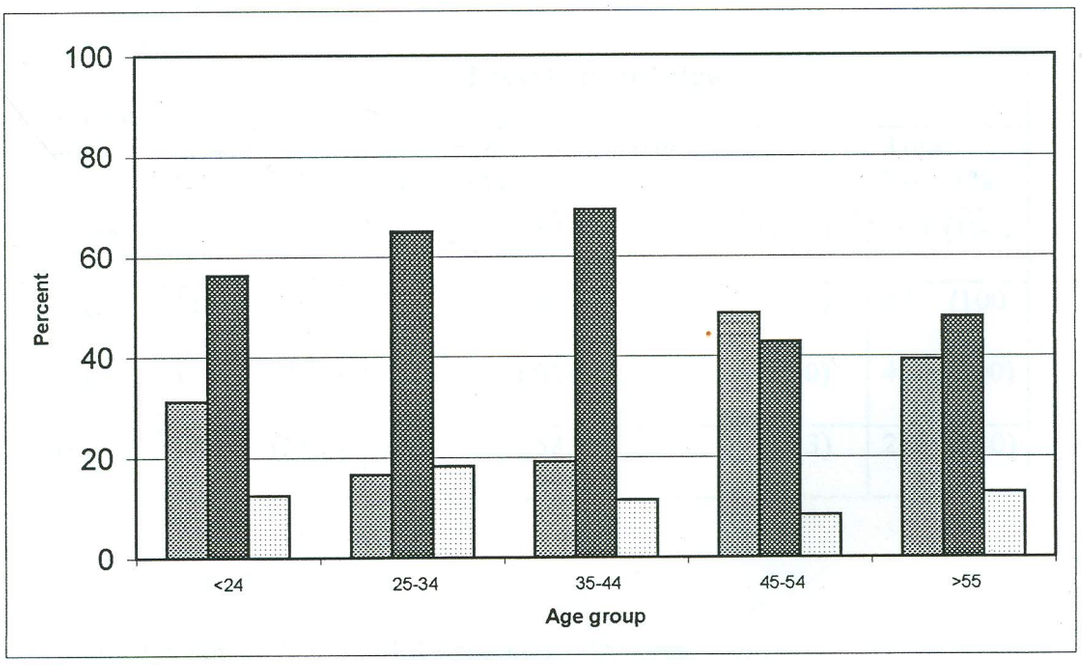
Key: Contraceptive knowledge

- High
- Moderate
- Low

The association between level of contraceptive knowledge and by age is summarized in figure 4 below.

As observed Figure 4 at the age 25-34 years respondents had moderate levels of knowledge about contraceptive methods. Half of the respondents aged 35-44 years had moderate levels of knowledge about modern methods. (see figure4 and appendix 8.3 table4).

Figure 4: Percent distribution of respondent's level of contraceptive knowledge by age group



Key: Contraceptive knowledge

- High
- Moderate
- Low

. When the level of contraceptive knowledge was examined across different marital status categories it is seen that the highest proportion of respondents who had a high level and those with a low level of contraceptive knowledge were from the other marital status category i.e. (25%) for both. The highest proportion of respondents with moderate level of family planning knowledge (64.4%) were the score, while the highest proportion of those who had low contraceptive knowledge (29.0%)were married (see table8)

Table 8: Percent of respondent's level of contraceptive knowledge by marital Status

Marital status	Level of knowledge							
	Low		Moderate		High		Total	
	No	(%)	No	(%)	No	(%)	No	(%)
Married	49	(29.0)	97	(57.4)	23	(13.6)	169	(100)
Single	11	(24.4)	29	(64.4)	5	(11.1)	45	(100
Others	1	(25.0)	2	(50.0)	1	(25.0)	4	(100)
Total	61	(28.0)	128	(58.7)	29	(13.3)	218	(100)

χ^2= 11.33; 2Df; p =0.003

* Others = Separated/ Widowed/ Cohabitating/ Divorce.

The source of information on family planning methods is shown in table 9 below. The most frequently reported source of information about family planning was reported to be radio (46.8%), then followed by health workers (33.9%). Those who received family planning information through friends were (25.7%), the least reported source of information was through television (2.8%).

Table 9: Source of information on modern family planning methods (N= 218)

Source	No	%
Radio	102	46.8
MCH workers	74	33.9
Friends	56	25.7
Magazine/books	41	18.8
Television	6	2.8

NB Multiple responses.

Practice of family planning:

Table 10(a) below indicates that (33.9%) of the respondents had ever used a modern family planning method, while (66.1%) of the respondents never used any modern family planning method. Respondents were asked if they have had ever used any modern FP methods (66.1%) of the study population had never use any modern methods of contraceptive, nevertheless (33.9%) of the respondents were using the methods before the time of study.

Table 10(a): Percent distribution of respondents by ever use modern FP methods

Use	No	%
Yes	74	33.9
No	144	66.1
Total	187	100.0

Table10 (b) below it seems that (47%) of the respondents were currently using a modern family planning method. (53%) of the respondents were not using modern family planning method nevertheless (47%) of the respondents were using the methods during the time of study.

Table10 (b): Percent distribution of respondent's who currently used modern FP methods

Use	No	%
Yes	102	47.0
No	116	53.0
Total	218	100.0

Table 11 below compares respondent's level of education and the contraceptive use. (47.1%) the respondents who were using contraceptive methods had primary education level, while (28.6%) who were using contraceptives had no formal education. Likewise (55.8%) 0f the respondents were using contraceptives had secondary education and above. Higher proportion of respondents with no formal education were non-users, while a higher proportion of those respondents with secondary education were using family planning methods i.e.71.4% and 55.8% respectively. This finding is statistically significant ($p<0.001$).

Table11: Percent of respondents' who use modern FP methods by level of education

Level of Education	Users		Non-users		Total	
	No	(%)	No	(%)	No	(%)
No formal education	8	(28.6)	20	(71.4)	28	(100)
Primary education	65	(47.1)	73	(52.8)	138	(100)
Secondary education and above	29	(55.8)	23	(44.2)	52	(100)
Total	102	(46.8)	116	(53.2)	218	(100)

$\chi^2= 108.17$; 3Df; $P< 0.001$

Family planning use by marital status

Table 12 below shows distribution of respondents who use modern family planning methods by marital status. Results from this study indicated that married men were reported using modern contraceptive (47.3%) compared to unmarried men (46.7%) who were using modern contraceptives during the time of study. Similarly proportion of married and single respondents reported to be using modern family planning methods (i.e.47.3%) and (46.7%). However the highest proportion of non-users (75%) were from others marital status category. This finding however not statistically significant (P <0.08).

Table 12: Percent distribution of study respondents by use of modern FP methods by marital status

Marital Status	Users		Non-users		Total	
	No	(%)	No	(%)	No	(%)
Married	80	(47.3)	89	(52.7)	169	(100)
Single	21	(46.7)	24	(53.3)	49	(100)
Others	1	(25.0)	3	(75.0)	4	(100)
Total	102	(46.8)	116.	(53.2)	218	100)

χ^2=3.01; 2Df; P = <0.08

NB Others = Separated/ Widowers/ Cohabitating/ Divorce.

Table 13 shows the percent of men who use modern FP by religion. (82.1%) of the respondents who were using contraceptives were Christians; while (9.8%) of the respondents were Muslims. Likewise (50.8%) of the respondents were Christians who were using contraceptives while Muslims were (27.8%) only. The low number of Muslims who participated in the study is because the area is Christian predominant

Table 13: Percentage distribution of study respondents by use of modern FP methods and Religion

Religion	Users		Non-users		Total	
	No	(%)	No	(%)	No	(%)
Christian	91	(50.8)	88	(49.2)	179	(100)
Muslim	10	(27.8)	26	(72.2)	36	(100)
Pagan	1	(33.3)	2	(66.7)	3	(100)
Total	102	(46.8)	116	(53.2)	218	(100)

Communication on family planning issues between partners:

Table 14 below shows percent distribution of respondents who discuss family planning issues by marital status.

Results from this study indicated that married respondents (65.6%) were found discussing issues pattern to family planning compared to single respondents (66.7%) during the time of study. Only 99/218 (65.7%) respondents reported that they discussed family planning issues with their spouses. Almost two thirds (65/99) of them discussed on family planning methods and their use. Generally a similar proportion of married respondents compared to single men reported to discussing family planning methods and their side effects to (9.7%) vs. (33.3%).

Table 14: Percent distribution of respondents who discuss FP with their partners by marital status

Issues discussed	Marital status				Total	
	Married		Single			
	No	(%)	No	(%)	No	(%)
FP methods	61	(65.6)	4	(66.7)	65	(65.7)
Side effects-FP	9	(9.7)	2	(33.3)	11	(11.1)
Others	23	(24.7)	0	(0.0)	23	(23.2)
Total	93	(100)	6	(100)	99	(100)

χ^2=0.44; 2Df; P =0.8

NB: others = Separated / Widowed / Cohabitating / Divorce.

Table 15: Indicates percent distribution of respondents who discuss FP issues by level of education. Over half of respondents who had primary, secondary education and above and half of respondents with primary education were found discussing issues pattern to family planning.

Table 15: Percent distribution of respondents who discuss FP by level of education

Level of education	Discuss on FP				Total	
	Yes		Not			
	No	%	No	%	No	%
No formal education	6	(21.4)	22	(78.6)	28	(100)
Primary education	67	(52.3)	61	(47.7)	128	(100)
Secondary education and above	26	(53.1)	23	(46.9)	49	(100)

$\chi^2 = 223.51$; 2Df; P<0.001

Respondents were asked to mention one source of family planning methods that they mostly preferred (see table 16). The most commonly reported place was a clinic (48.6%) and working places (37.6%).

Table 16: Frequency distribution of source of FP methods preferred by respondents

PLACE	No.	%
Clinic	106	48.6
Working place	82	37.6
Club/bar	23	10.6
*Others	7	3.2
Total	218	100.0

* Others = Football grounds/ Pharmacy shops

Majority of single respondents (55.6%) prefer to be served by anybody provided he/she has the experience on contraception compared to married respondents (47.3%),while (35.6%)vs.(38.1%) preferred to be given services by male providers and (9.0%) vs.(14.8) by female providers.

Table 17: Service provider preferred by respondents

Provider	Married		Single		Others		Total	
	No	(%)	No	(%)	No	(%)	No	(%)
Any	80	(47.3)	25	(55.6)	1	(25)	106	(48.6)
Male	64	(38.1)	16	(35.6)	3	(75.0)	83	(38.1)
Female	25	(14.8)	4	(9.0)	0	(0.0)	29	(13.3)
Total	169	(100)	45	(100)	4	(100)	218	(100)

4. 2 In-depth interviews

Attitudes, perceptions and beliefs towards modern family planning.

In-depth interviews were conducted for 50 respondents in order to obtain their beliefs and attitudes towards modern family planning. Overall the results of this study show that people in Moshi Rural district, their attitude towards modern FP was positive for both users and non-users. They perceived users as people who have come to terms with reality and are trying to minimize financial difficulties by having small families. One respondent said, *" family planning users have healthy families, and they are generally happy people"*, in contrast, children belong to non-users' were reported *"do not eat well, did not attend school, do not dress well and do not get medical care."* Non-users shared these attitudes. In fact half of respondents said they intended to become users at some unspecified time in the future. Four respondents said. After their wives get four children would be closed (tubal legation) they want nothing else.

Most couples reported not discuss about family planning until they were married, or had several children, and were beginning to feel economic pressures. One respondent reported the following. *"It is me who brought the discussion. I checked my children's ages, and then I looked at my wife. We must plan."* Some men non-users had never discussed family planning with their spouses because they did not yet have enough children. However, customs are changing, and according to one man aged 59 years, who mentioned that during our time, we did not discuss such things our time was different.

Non-users are afraid of side effects associated with modern contraceptives and are more influenced by rumors and misinformation. One man said, "*if his wife used a modern method, I think her life would be in ruins because of the side effects.*" Another respondent uses family planning reported, *"I head that if you take the pill continuously you can have a two-headed child."*

Most men, both users and non-users, "*prefer to receive information and services at their working place from health workers" "Health workers are experts. They are people I can trust"* They stressed the importance of home visits: *"Home visits are very important because we have women and men who fear going to the hospitals or public places, especial FP clinics; they think people will laugh at them".*

A substantial majority of the participants disapproved of FP, mostly on religious grounds. They felt it was wrong to plan your family because a child is given to some one though God's will Roughly one-third the participants said that Islam does not support family planning. Two respondents reported that: "*Mohammed asked his followers to have many children so that in the next world his followers will be the majority. This is only possible by having the number of children has destined rather than limiting it".*

Because of widespread rumors about modern contraceptives, some of respondents do not use family planning even though they are aware of its advantages: preventing unwanted pregnancies, spacing birth, limiting the number of children, reducing household

expenses, improving maternal and child health and preventing sexually transmitted infections (HIV/AID/STIs). According to one respondent *" I have noticed that a man with a woman who use modern methods have fewer children, are solid, and look healthy. Those who have too many children are quickly, look tired and are worn out"*. Participants were dissatisfied with abstinence; the most widely practiced traditional contraceptive method. Sexually active man (18years), for example, frequently commented, *"abstinence is too difficult to use"*. Despite the recognized advantages of family planning, participants perceived that the disadvantages outweighed them. Rumors and misinformation about modern methods are widespread. People fear that modern methods cause serious side effects, including sterility, multiple births, heavy bleeding, varicose vein and cancer of the cervix. Moreover participants also worry that their wives will be sexually promiscuous if they have access to effective contraceptives. Contraceptive safety is an important issue that can be addressed in information education and communication (IEC) campaigns with specific audiences about safety and benefits of family planning. Unmarried men, for example, may be most interested in preventing pregnancies and STIs.

Married men may be interested in an alternative to abstinence and may be sensitive to the economic benefits of family planning. Women need to be sure that family planning protects their own and their children's health. Respondents wanted to know more about modern methods. Nearly all respondents wanted more information on contraceptives. Most respondents agreed that the mass media were the appropriate channels for the information. Furthermore they felt that health professionals are the most credible source

of information. Majority of respondents favor contacts with health workers and experienced contraceptive users. Given the pattern of responses generated in this section, it appears fears and misconceptions regarding modern contraceptive methods do not have much to do with the belief system in the community.

CHAPTER 5:

5. DISCUSSION

Findings of this study have revealed that the majority of male respondents (85.3%) in Moshi Rural District are aware of modern family planning methods, but a small proportion of them (47%) used family planning. This gap between contraceptive knowledge and use had also been reported from studies conducted in other parts of the country (Mbunda et al 1991; Ngallaba et al 1992). Similar findings have also been reported from studies outside Tanzania (Population Report, 1994). Educational level was found to have a bearing on knowledge about family planning i.e. all respondents who had secondary education and above had moderate (51.9%) knowledge about modern FP methods;(66.7%) of those with primary education had moderate knowledge and those with no formal education (64.3%) had low level of knowledge about FP methods. Interestingly, however, the results obtained from this study differ much from those obtained from a study done by Chipfakacha, (1993) in Botswana, which indicated that, there was no difference in family planning knowledge among learned and unlearned individuals. However, this figure is slight lower than Tanzanian national figure, which is 93%.

Analysis of specific contraceptive methods known in the study area revealed that three modern FP methods most frequently known by the respondents were pills (79.8%), male condoms (78.9%), and injectables (56.4%). The Norplant and vasectomy were the least known methods and these results were not surprising given the way family planning services are promoted in the country. In most cases the pills is the most widely used method because there are few known modern methods when promoting different FP practice. Of late the condom is also widely known and used due to HIV/AIDS prevention campaigns. Although Norplant has been introduced into the country, few respondents appeared to be aware of it. The findings again reflect how this method is being promoted. Emphasis is in the urban areas probably due to the need for health personnel in the initial phase of introducing Norplant. Vasectomy, which is also, one of the few male contraceptive methods available was known to about (13.8%) of the respondents.

The extent to which respondents were aware of family planning service delivery points was examined. The results revealed that (78.0%) of the respondents were aware of places where family planning services can be obtained.

The observed low contraceptive use rate in the study area was not surprising due to various reasons, first, as noted elsewhere, raising the level of reproductive knowledge does not necessarily mean use rates of contraceptive method will also increase. Circumstances, which facilitate use behaviour, include improving

quality of service delivery. A recent report from Kenya showed that improving the quality of care in family planning service delivery from the perspective of both clients and providers significantly improved use rates (MoHK, 1995). Quality of care was defined using six elements: choice of methods, information given to users, technical competence, inter-personal relations, follow-up and appropriate constellation of services. Experience of the author in Moshi Rural District showed that few of this quality of care elements are appropriately taken into account during family planning services due to variety of reasons; for example, lack of FP method mix, lack of instruments, lack of rooms for counseling and so on. Men's support or opposition to their partner's practice of family planning has a strong impact on contraceptive use in Moshi Rural District, including Tanzania. Within marriage in Tanzania, men typically have more say than women in the decision to use contraception and in the number of children that the couple will have.

Apart from quality of care and support from men, exclusion of men from family planning services could have also contributed to low contraceptive use. In Tanzania Family planning services are targeted to women through MCH services leaving men outside the system. Moreover, while there exists little information for male consumers, there are even fewer educational materials available for professionals and health care providers who deal with men's family planning topics (Rogow, 1990).

The lack of male involvement in family planning programmes not only provides limited exposure to men; it also excluded men from playing a role on fertility control. These findings were supported by Finger (1992), who established that providing family planning services to married women alone was a barrier to effective fertility control, since such policies isolated sexually active clients including men.

Findings of the current study show that, despite a low rate of partner communication (65.7%) on fertility related issues, use behaviour was also low. The possible explanation to such observation in the current study could have been attributed to a lack of mutual agreement between partners on who should decide on whether to use contraceptive or not, and who should be responsible for procurement of contraceptives. Such discussions were reported in all age groups. However, the extent of such discussions varied by marital status, level of education. Such discussions were found to be not differing much when compared to married (65.6%) and among single respondents (66.7%). A slightly higher proportion (53.1%) of respondents with secondary or more advanced education discussed such issues than those without formal education (21.4%).

However, the result obtained from this study differ much from those obtained from a study done by Green, (1992) which indicated that high partner communication has been associated with high contraceptive use.

The majority of respondents (82.1%) were Christians and the Catholic Church is a major influencing factor to beliefs and practices regarding family planning. Literature reveals that Roman Catholic believers are among the least users of modern contraceptive methods. Religion has a powerful influence on morals of an individual. The Catholic Church owns several health units in the study area including Kibosho hospital. This may weakens the ability of such units to promote contraceptive use due to the stand of church on the fertility control issues. It will be rather difficult to achieve set targets of contraceptive use prevalence due to barriers arising from the influence of the Catholic Church (UMATI, 1999). In contrast study done in Mbeya indicated that Muslims were 2.7 times more likely to use contraceptives than Christians were (Mbuji, 1991).

From this study it clearly shows that most men got information about family planning from radio (46.8%), followed by health workers (33.9%), friends (25.7%), and from newspaper (18.8%). The least reported source of information was through television (2.8%)

Men's lack of access to information and services has been a barrier to family planning use. Men cannot share responsibility for family planning if services and information do not reach them. Encouraging men's co-operation can start with understanding their point of view rather than relying on their partner's perception of their views. Contrary to popular belief, men want information about contraceptive methods for both partners. Most family planning information,

education, and communication (I E C) campaigns have assumed that men are not interested, therefore focused only on women rather than on couples. Some campaigns have blamed men and portrayed them as irresponsible, adversaries, and a barrier to be overcome in accessing FP services. These types of IEC programmes may have been the very barrier that prevents men from learning more about sexually and family planning. There is a need for more positive images and messages about the role of men, such as the recent information education and communication.

Both users and non-users had positive attitudes towards modern contraception, but they don't use them because of some reasons. Out of 50 respondents whom the in-depth interviews were conducted (60%) were showing fear of permanent sterility (20%), cancer of cervix and varicose veins (20%). Substantial majority of respondents disapproved of family planning, mostly on religious grounds. The other reason was to maintain the ancestral heritage and security; some associate the modern family planning methods with promiscuity among their wives. The respondents however, felt that female contraceptives were safe if well chosen but could predispose women to other diseases. This suggests a high level of knowledge of contraceptives.

However a good proportion of those who are married and those who have at least one child have positive attitude towards modern FP. Few respondents of the study population did not know that is approve or disapprove any modern family planning methods.

Result from this study indicated that married respondents were more likely to report using modern contraceptive (47.3%) compared to single (46.7%). Contraceptive use among men was low generally decreased with age. The use of modern methods is lowest among men aged less than 24 years, gradually increased, and then decrease again toward the end of reproductive years. Use is highest among men aged 24- 45years. This observation is partly due to age since older respondents in the study sample are not only more likely to have many children, but they are also likely to be less educated than younger respondents. However the highest proportion of non-users (75%) were from the others marital status category.

CHAPTER 6:

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study showed that the Tanzanian male readily accepts and has a good knowledge of child spacing. However, a lot more needs to be done especially regarding family planning counseling whereby only women seem to be concerned. Male should also be advised that family planning methods are not only for women, but they should participate fully. Moreover be encouraged to move from high level of awareness to high level of support and acceptance and improve communication between couple about family planning issues. On the other hand men in the study area had favorable attitude towards family planning. Men in the study area preferred to be counseled on FP as couples, but currently obtain their information on contraception from friends, mass media, news paper/magazine and health workers.

6.2 RECOMMENDATIONS

Basing on the findings of this study it is recommended that:

1. Close the knowledge- practice gap:

As in many population programmes seeking to change behaviour, male involvement programmes display a classic KAP-gap. There is a gap between knowledge and practice, between what people know they should do and what they actually do. Motivational campaigns, IEC activities, print media, and operations research all these approaches have been used to increase men's share in parental responsibility. Condom social marketing has been used, leading often to increased condom mostly for STI/AIDS prevention. These strategies have generated high level of awareness of FP; however, acceptance rates have remained relatively low. Therefore, addressing this gap should be the next step future programme.

2. **Develop appropriate service delivery strategies:**

Design programmes that give men accurate information about contraceptives and FP as well as enable men to communicate with their partners about these issues, which encourage shared decision-making. The focus of family planners should be on how partners may be assisted to communicate openly and have common agreement on fertility issues. Therefore it might be advisable for many services to integrate male reproductive health care services including FP, impotence, STIs, infertility and other conditions. This broader definition of male health would make it easier for Tanzanian men walk into a clinic.

3. **Target messages to men:**

Special messages should be targeted to men, to foster responsible and caring attitudes and to encourage men to discuss FP with their partners. Family planning messages that emphasize the economic benefit of having fewer children and portray responsible men as those who discuss family size and contraception with their partners should be designed for a male audience. In future campaigns, care should be taken to emphasize the need for the spouses to share decisions.

4. Leave aside the widespread myths, misinformation and false rumors about family planning and contraception by creating factual messages based on research results.

5. Finally it is recommended that a national survey be carried out to determine the appropriateness of the present integrated MCH-FP facilities for use by men. Moreover greater effort on information, education and services should be targeted to areas where there is a high influence from the church as there will be always people who want to use modern family planning methods.

Suggestions for further Research:

Research is needed to establish the extent of under-or over reporting of current contraceptive use by men and women. Also research should be on non-users of modern contraceptive methods.

7.0 REFERENCES

1. Bureau of Statistics, [Tanzania] and Macro International Inc. 1997. *Tanzania Demographic and Health Survey 1996.* Calverton, Maryland: Bureau of Statistics and Macro International.

2. Bureau of Statistics, (1994). *Tanzania Knowledge, Attitude and Practice Survey* Dar es Salaam: Tanzania.

3. Bureau of Statistics, President's Office- Planning Commission. 1988 Population Census, Kilimanjaro Region Profile 1988 Dar es Salaam, December 1990.

4. Biennial Report (1998-1999) Reproductive Health Research WHO: A New Beginning.

5. Chanji, A.G. (1983). Methods of Family Planning, Bugando Hospital Association of Gynaecologists and Obstetricians of Tanzania Proceedings of Scientific Conference 3.

6. Chipfakacha, V.G. (February 1993). Attitudes of Males on Contraceptive. A KAP Survey, East African Medical Journal 70(2).

7. "Encouraging men co-operation" *Population Reports* XXII (1): 25-29, July 1994.

8. Finger, William R. (1992). "Pilot Programs Increase Men's Involvement." Network. 13(1): 8-9. Family Health International.

9. Green, Cynthia P., Sylvie I. Cohen, and Dr. Hedia Belhadj-El Ghoayel. Male Involvement in Reproductive Health, Including Family Planning and Sexual Health" *Technical Report*, UNFPA.

10. International Planned Parenthood Federation (1984). Male Involvement in Family Planning 73-76, 79-80.

11. Johns Hopkins Center for Communication Programmes, Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects, Working Paper No. 3, Johns Hopkins Center for Communication Programmes/ Population Communication Services/Population Information Programme, Baltimore, Maryland. January 1997.

12. Molnos, A. (1973) Cultural Source Material for Population Planning in East Africa Review of Cultural Research 1 EAPH Nairobi 1978.

13. Ministry of Health, (1994). National Family Planning Progrmame: Plans of Operation 1989/93 Dar es Salaam: Tanzania.

14. Mbuji. P.K.L (1991). Contraceptive Prevalence Rate and Factors Related to Contraceptive use among childbearing women in Mbeya Urban, Tanzania.

15. "Men- New Focus for Family Planning Programmes" *Population Reports,* XIV (33): 913. November- December (1986).

16. Men: Key Partners in Reproductive Health. A Report on the First Conference of French-Speaking African Countries on Men' s Participation in Reproductive Health March-April, 1998 Ouagadougou, Bukina Faso.

17. Ngallaba S, Kapiga SH *et al. Tanzania Demographic and Health Survey 1991/1992.* Bureau of Statistics, Planning Commission, Dar es Salaam and Macro International Inc. Colombia MD, USA, June (1993).

18. National Bureau of Statistics [Tanzania] and Macro International Inc. 2000 *Tanzania Health and Reproductive Child Health Survey 1999.* Calverton, Maryland: National Bureau of Statistics and Macro International Inc.

19. Parkin D.J. (1972). Luo Living in Kampala, Nairobi and Central Nyanza: Kenya EAPH.

20. Population Council and the Family Planning Association of Kenya. (1995). *Increasing Male Involvement in the Family Planning Association of Kenya (FPAK) Family Planning Programme.*

21. Population Planning Unit, Planning Commission, (1993). Population and Development in Tanzania, Dar es salaam.

22. Population Dynamics of Sub-Saharan Africa. (1993). Factors Affecting Contraceptive Use in Sub-Saharan Africa.

23. Weinstein, Kia I, Sylvester Ngallaba, Anne R. Cross, and F. M. Mburu. 1995 *Tanzania. Knowledge, Attitudes and Practices Survey, 1994.* Calverton, Maryland: Bureau of Statistics, Planning Commission and Macro International Inc.

24. Topsoba et al (1993) *"Involving Husbands to Increase the Acceptability* of NORPLANT *in Antanarivo, Madagascar*. Paper Presented at the annual meeting of American Public Health Association, San Francisco, CA, October 1993.

25. Swartz, M.C. Religious and marginal rights of Bantu women in Tanzania. PHD thesis reprint 1966.

26. UNICEF/MOH, (1990). Women and children situation analysis. Dar es salaam.

27. UMATI (1999) Clinical services July 1998 to December 1999.

28. Rogow, Debbie. (1990) "Man/Hombre/Homme: Meeting Male Reproductive Health. Care Needs in Latin America." Quality, No. 2. The Population Council.

29. World Bank Report, (1986a): World Development Report 1986:65 Geneva.