FACTORS INFLUENCING MALE INVOLVEMENT IN THE UTILIZATION OF FAMILY PLANNING IN CHATO DISTRICT, GEITA REGION TANZANIA

FRANCIS DOTO FEDRICK

A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by the Open University of Tanzania, a thesis titled: Factors influencing male involvement in the utilization of family planning in Chato District, Geita ï Tanzania, in fulfillment of the requirement for the degree of Doctor of Philosophy

é é é é é é é é é é é é .
Prof. Emmanuel Kigadye
(Lead Supervisor)

é é é é é é é é é é ..
Date

é é é é é é é é é é é é é .
Dr. Harrieth G. Mtae
(Second Supervisor)

é é é é é é ..
Date

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DECLARATION

I, Francis Doto Fedrick, here by declare that this thesis is my original work and it has never been presented in any other learning for an award of any degree programme.

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Signature

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Date

DEDICATION

I dedicate this work to my mother in heaven Casilda Masele Peter Mpagama. Thank you mummy!

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ABSTRACT

Tanzania is one of the countries with the highest Total Fertility Rate in Africa of 5.2 and at 32% level of family planning utilization. Low involvement of men in family planning among others influences its utilization in many African societies. Males are observed to dominate in decision-making including issues of family planning. Though family planning is known to prevent maternal deaths, but some cultural norms, and service delivery factors make it difficult to achieve. This thesis documents the current level of family planning utilization among men and identifies the possible underlying factors influencing male involvement in the utilization of family planning. Using descriptive cross-sectional study compounded with quantitative and qualitative techniques, data were collected through a questionnaire administered to 496 participants in 4 wards of Chato District. Also Focused Group Discussions and Key Informant interviews were conducted from each of these areas. Data analyzed through SPSS, while using chi-square, bivariate analysis was done to assess the effect of individual factors on family planning utilization. Multiple logistic regression was then run to assess for the effect of potential confounding variables. The analysis revealed that there is very low level of family planning utilization among men (17.5%), which suggest that, there is low male involvement in the utilization of family planning in Chato District. There are many factors which contribute to this low utilization but the leading ones are said to be, distance to family planning clinics, menôs approval on utilization of family planning and side effects of family planning methods. The study recommends the need for family planning programme to adopt the approaches that integrate men into existing family planning services in order to improve family planning use and its sustainability.

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LIST OF ABBREVIATIONS

WHO	World Health Organisation
TDHS	Tanzania Demographic and Health Survey
FP	Family Planning Method
DHIS	District Health Information System
UMATI	Uzazi na Malezi Bora Tanzania
TFR	Total Fertility Rate
HIV	Human Immuno Defficiency Virus
SPSS	IBM SPSS statistical package
TRF	Total Fertility Rate
UN	United Nations
USAID	United States Agency for International Development
PNSR	Programme National la Sante de la Reproduction
CDC	Centre for Disease Control and Prevention
SDP	Service Delivery Points
MCH	Maternal and Child Health
GBV	Gender Based Violence
NBS	National Bureau of Statistics
DRCHCo	District Reproductive and Child Health Coordinator
KI	Key Informant
FGD	Focused Group Discussion

CHAPTER ONE

INTRODUCTION

1.1 Background to the Problem

Utilization of family planning (FP) is a human right that enables everyone to have the right to determine freely the number and spacing of their children and it includes selecting the means by which this may be achieved" without discrimination, violence and oppression, to have the necessary information and facilities for it, to access sexual and reproductive health services at the highest standard (WHO 2018). In other words it can be referred to as having children by choice and not by chance.

Utilization of FP is a global problem for the developed and non-developed countries, both in terms of total utilization and the types of methods utilized (WHO, 2015). The problem is more acute for developing countries where about 214 million women of reproductive age want to avoid pregnancy but are not utilizing FP (WHO, 2018). While for the developed countries FP utilization is some how better, where most women utilize FP thus recorded low abortion, especially unsafe abortion (WHO, 2018). However there are considerable efforts to encourage FP utilization in the countries, including the provision of education and public campaigns in communities.

Tanzania is among the first countries in Africa to introduce FP services through the independent Family Planning Association of Tanganyika (later Tanzania) (UMATI) (Williamson *et al*., 2009). Despite this, the national level of FP utilization has remained at 32% (TDHS, 2015-2016). This low utilization of FP is also reflected through an insignificant decrease of the total fertility rate from 5.8 in 1996 to 5.2 in

2016, and the maternal mortality rate has increased from 529 per 100,000 live births estimated in 1996 to the current 556 per 100,000 live births (TDHS, 2015-2016).

Low utilization of FP is also a case in Chato District. According to the DHIS, 2016, the utilization of FP in Chato District Council is 16.8%. Consequently, Chatoôs total fertility rate (TFR), or the average number of children per woman has stood high at 4.8 (District Health Information System (DHIS, 2016). The fertility rate in Chato is higher than its neighbouring districts. Muleba District has TFR of 3.5 and Bukombe is 4.0. Chatoôs TFR is also slightly below the National TFR which stands at 5.17 (TDHS, 2015-2016). The analysis made shows that the ratio of FP utilization among men is very low if compared to that of women. For example, in 2013, only 323 men utilized FP services while 4665 women were using the services. In 2014, men who utilized FP were 682 compared to 13,607 women.

However, in 2015, the number of men who utilized FP dropped to 470 while women were 12,103. The trend changed in 2016 where the number of men who utilized FP increased from 470 to 1456 used FP services while 14,797 women used FP services (TDHS, 2015-2016). This was an increase in men but still very low compared to that of women. The increase could be attributed by FP outreach services, social marketing, and behavior change communication which is done as part of integrated maternal services and increased National Distribution of FP commodities (USAID, 2018).

Low use of FP leads to high fertility in societies which is associated with maternal and child morbidity and mortality, as mothers are frequently exposed to risks of

child bearing and its complications, including heavy bleeding after delivery, gestational high blood pressure and diabetes, eclampsia and the risks of abortions which could result in death (Audet, 2008). FP utilization could help to reduce the exposure of mothers to the risks of child bearing and its complications (Tsui *et al*., 2010).

Other studies on FP by Yeakey *et al.* (2009) and Tanzania Demographic Health Surveys (TDHS) (2018) have also explained the association between high fertility rate and low FP utilization, high infant mortality rates, under five mortality rates and maternal mortality rates which is the case in Tanzania. These situational analysis are a base to encourage the efforts to promote FP and strengthen its utilization from the policy to the individual level taking on board the role of men in FP services. Effective utilization of FP can help address such emerging public reproductive health concerns and overall improve maternal and child health outcomes in general (WHO, 2015).

The low level of menôs involvement in FP needs an intervention because the practices of FP engage both men and women, and although the range of contraceptives includes methods for men, namely condoms, vasectomy and withdrawal that men use directly, and the Standard Days Method (SDM) that requires their participation, unfortunately FP programmes has primarily focused on women considering that, women are the ones who become pregnant and women use majority of the available contraceptive methods (Hardee *et al*. 2017). Further to this, there was a need to free women from excessive child bearing, and reduce maternal and infant mortality through modern methods of contraception (USAID, 2018). For

the same reason, the FP2020ôs goal explicitly targets to reach an addition of 120 million women and girls with family planning. This focus on women has reinforced the belief that family planning is largely a womenôs business, with the man playing a very peripheral role (Ramadhan, 2008).

It should be known that, in most societies, men are key decision-makers in almost all spheres of life, including the utilization of FP (Giddy *et al*., 2011; Ndinda *et al*., 2017); thus, there is a considerable need to include men more frequently in FP services. Men desire but, at the same time, do not use any FP methods due to many factors which could be at individual level, cultural characteristics or at health care service level (WHO, 2015). It has been reported that, when men are involved in family planning services, there are improvements in utilization of Family planning (Ndong *et al*., 1999). Enabling men to play a more active role in reproductive decisions has significant benefits to the acceptance of FP methods, the sustainability of the use of the methods, client satisfaction, and efficacy (Lundgren *et al*., 2012).

However, male involvement in FP services 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 partner and their peers to utilize FP and who influence the policy environment to be more conducive to developing male-related programs (Girum *et al*., 2017). The involvement of men in FP services would, therefore, not only easy the responsibility is borne by women in terms of decision making for FP matters, but would also accelerates the understanding and practice of FP in general (Undelikwo *et al*., 2013). Sometimes, there may be undisclosed FP utilization or non-utilization by females to achieve their fertility

desires when their husbands did not agree with their desires (Gipson & Hindin, 2009).

According to the Ghana Trend Report (2005), it was reported that 25% of married women were currently using a family planning method without any reference to their partners' involvement. However, domestic violence often occurs if there is utilization of FP by the women without approval by men (Kessy & Kuenning, 2007). Therefore, there is a need to recognize men instead of women alone in studies on fertility in order to improve overall FP utilization (Agadjanian, 2008).

1.2 Statement of the Research Problem

Despite the national efforts of universal access to reproductive health services, which include the utilization of FP, yet in Chato District, there is low utilization of FP methods. The record stands at 16.8% as compared to the national target of at least 60% (FP, 2020). The low utilization of FP use contributes to high fertility, which is associated with maternal and child morbidity, and mortality. This is because mothers are frequently exposed to the risks of child bearing and its complications, including heavy bleeding after delivery, gestational high blood pressure and diabetes, eclampsia and the risks of abortions which would result in deaths (Audet, 2008). Chato District experienced high maternal deaths in 2016, which was at 139 per 100,000 live births, due to low utilization of FP services where men contributed by only 1.6% of the total FP utilization in Chato District (DHIS, 2016).

Family planning saves the lives of women and children and improves the quality of life for all (WHO, 2010). Most of partners who use contraception rely on methods

requiring active male participation (Handelsman, 2019) and hence, the involvement of men in FP services can have significant benefits to the FP methods acceptance, continuation of utilization, client satisfactions and efficacy (Kabagenyi et al., 2014). However, access to FP is limited among men due to many factors which are not fully identified. Since the factors that made low contribution of men towards FP utilization in Chato District were not known, also the available data are for public FP clinics only, therefore a research was required for appropriate interventions to be made.

1.3 Research Objectives

1.3.1 Major Objective

To investigate the factors that influence maleôs involvement in the utilization of family planning in Chato District, Geita Region as a strategy to reduce maternal mortality.

1.3.2 Specific Objectives

i. To assess the proportion of men using family planning in Chato District Council.
ii. To assess the demographic factors that influence maleôs involvement in the utilization of family planning in Chato District.
iii. To assess the cultural factors that influence maleôs involvement in utilization of family planning in Chato District.
iv. To assess the health care system factors that influence maleôs involvement in utilization of family planning in Chato District.

1.4 Research Questions

i. What is the proportion of the men population utilizing family planning in the study area?
ii. What are the demographic factors that influence male involvement in utilization of family planning in the study area?
iii. How cultural factors influence male involvement in utilization of family planning?
iv. What are the health care systems factors influencing male involvement in utilization of family planning in study area?

1.5 Significance of the Study

The main purpose of this study was to establish the factors that influence maleôs involvement in the utilization of family planning in Chato District. The findings of this thesis are worth to be shared among professionals, the health care system from national level to local level and the community at large. The findings are expected to contribute to the existing body of knowledge regarding factors that influence maleôs involvement in FP utilization in Tanzania in terms of demographic, cultural and health care system factors.

The researcher is aware that FP involves both men and women but other studies conducted in this area had much of their focus on women only. This study sought to get information and views on the utilization of FP from men and fill the gap that exists in the literature on FP. The theory of collective action calls for equal opportunities between men and women in the use of FP. This thesis, then, provides

information on men which can be used along with those of women to improve collective action between men and women in the utilization of family planning.

Results from this study will be used as a reference for other researchers in other parts of Tanzania with similar demographic, cultural backgrounds, and health care system design. It is also expected that the information generated will be useful to planners and policy makers in the attempt to formulate effective policies that can help in making population projections. In turn, it would help to expand the availability of information that is useful for improving the quality of FP.

Health care system managers will use the results from this study to develop some strategies and interventions that will take into consideration the factors affecting male involvement in the utilization of family planning to improve maternal and child health and relieve the health care system which is overburdened by maternal services. Communities will benefit from sustained investments in family planning and maternal and child health programme as an important poverty reduction strategy in families and the community as a whole. Moreover, women will benefit from the proposed interventions which will enable them to increase FP uptake hence enables women to be healthier and have more equal opportunities to pursue an education, a career, and financial security.

The involvement of men in FP services is a promising strategy for addressing some of the worldôs most pressing reproductive health problems. Men can help millions of women to prevent unintended pregnancies, including the risks of abortions and reduce unmet needs for family planning; foster safe motherhood and practice

responsible fatherhood. This study complements the call from Tanzania Family Planning Research Agenda 2013-2020 to conduct researches on the factors influencing male involvement in Family planning utilization.

1.6. Scope of the Study

The scope of the study is limited to menôs involvement in the utilization of FP, all men with a sexual partner whether married, unmarried, cohabiting, widowed or separated were included in the study to avoid underestimation of FP utilization. The researcher was aware that single men also need to utilize FP as a component of reproductive health. Their status of FP utilization would help in making an intervention to single men.

1.7 Organization of the Thesis

This thesis is organized into five chapters. Chapter one introduces the concept of family planning, steps taken globally, in Africa and Tanzania in increased utilization of family planning and effects of low utilization of family planning which is also contributed by the low involvement of men in reproductive and child health services.

Chapter two contains literature review which highlights the status of family planning globally, in Tanzania and Chato District. The chapter also contains information on why FP utilization is beneficial to the health of women and children, family and nation as a whole. Different research publications are reviewed and show how family planning can be improved through maleôs involvement in reproductive health services. The factors influencing maleôs involvement in the utilization of FP services are broadly discussed by the help of literature. Research gaps in the use of family

planning among men were also identified.

Chapter three explains the methodology employed to guide the research process. This chapter explains the study area, participants, and how the sample was obtained and the strategies employed to make data analysis. Chapter four contains the results and its analysis while chapter five contains the discussion of the findings and recommendations in the form of proposed actions to be done from all levels of implementation for improving family planning utilization.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

In this chapter, key concepts of the study are defined and the supporting theories are critically reviewed in relation to the study. The status of family planning globally, in Africa, Tanzania and specifically in Chato District are discussed based on relevant studies. Further, the involvement of men in family planning is reviewed basing on the factors limiting the access to family planning among men which includes, demographic characteristics, culture related factors, and services related factors. These also include the review of national policies and different commitments concerning family planning and, finally, an analysis of the conceptual framework is done to provide a clear picture of dependent variable and several independent variables for this study.

2.2 Definition of Key Concepts

2.2.1 Family Planning Services

Family Planning services are defined by the U.S. Department of Health and Human Services Childrenôs Bureau (2000) as educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select how this may be achieved.

2.2.2 Family Planning Services Utilization

Family Planning Service Utilization refers to the use of family planning clinics, community-based distributors, pharmacies, or other sources of family planning methods (*PNSR Annual Report 2010).* Family planning utilization enables people to

make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (WHO, 2018).

2.2.3 Family Planning Method

Family Planning Method (FP) is a method, device or medication used to prevent pregnancy (WHO, 2015). FP methods are divided into two categories - modern and traditional methods. Modern methods are contraceptives whose effectiveness in reducing the probability of conception has been clinically proven. These include male sterilization, female sterilization, male condoms, female condoms, injectable hormone-based contraceptives (e.g. Depo Provera), combined oral contraceptive pills (also known as "the pill"), intra-uterine devices (IUD), and hormone-releasing contraceptive implants (e.g. Norplant).

In Tanzania, these methods can be obtained free of charge or for a fee at the local government clinics, private clinics, hospitals, pharmacies, medicine shops, mobile clinics, or from community health officers (Sedgh *et al*., 2007; Sullivan *et al*., 2006). On the other hand, traditional methods are FP strategies whose effectiveness has not been proven in clinical trials. These methods are part of the traditional lore passed on to younger generations by their older female and men. They include withdrawal, lactation amenorrhea (i.e., prolonged breastfeeding), periodic sex abstinence, and strategies that involve medicinal herbs or water or other items. Both users and

clinicians recognize that these methods are sub-optimal in preventing pregnancies, but they are still attractive options in many villages because they do not require money, traveling, or medical consultation (Sedgh *et al*., 2007; Sullivan *et al*., 2006).

In this study, traditional methods mentioned are those used locally by men or women in an attempt to prevent a woman from getting pregnant but they are not proven scientifically that they can serve the purpose. FP prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality (WHO, 2018)

2.2.4 Unintended Pregnancy

Unintended Pregnancies are pregnancies that are mistimed, unplanned or unwanted at the time of conception. Vaginal sexual activity without the use of contraception through choice or coercion is the predominant (Gipson *et al*., 2008). In developing world, unintended pregnancy can result in serious, long-term negative health effects including infertility and maternal death. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion.

2.2.5 Male Involvement

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 partner and their peers to use family planning and who influence the policy environment to be more conducive to developing male-related programs (Girum *et al*., 2017).

2.3 Critical Review of Theories

2.3.1 Collective Action Theory

Collective Action Theory for improvement of family planning programmes; in this perspective, utilization of family planning is seen as collective action for producing public good that will benefit the whole society in the long run. This theory of collective action was first published by Mancur (1965) in which he showed that any group of individuals attempting to provide a public good has troubles to do so efficiently. On the other hand, individuals have incentives to 'free -ride' on the efforts of others in certain groups and on the other hand the size of a group is of high importance and difficult to optimally determine. Family planning are public goods; a commodity or service that is provided without profit to all members of a society, either by the government or by a private individual or organization and bears the benefit or well-being of the public.

The theory of 'collective action' is applicable where birth control is necessary and collective action is in order like Chato District where family planning activities are given through reproductive health clinics. Decades of research have shown that better access to contraception helps people to avoid pregnancies they do not want, and to plan and space the pregnancies they do want. The purpose of family planning is to make sure that the desired resources are available for parents to give their children a better quality of life (WHO, 2010).

In this study collective action means equal opportunity between men and women in the utilization of family planning. This theory is in line with this study as the FP is a public good provided by the Government and other stakeholders but there are factors

influencing in reaching its desired results. That is why this study needs to investigate those factors for its rectification.

2.3.1.1 Strength of the Theory

The strength of collective action theory for studying family planning programme is a natural one: A family planning programme is a social intervention or social engineering programme. The type of collective actions that the theory examined are particularly appropriate for explaining individualôs participation in a social intervention, or social engineering programme, which can be a social movement or a family planning programme (Liao, 1994). A good family planning programme should ideally apply selective incentives, localize the costs and benefits, and invest in social capital. Collective action may help to explain why health behaviours tend to cluster at the community level and why, in the course of the program initiative, some collectives could not attain high coverage without resorting to social campaigns (Wang & Liao, 2019).

2.3.1.2 Weakness

The weakness of this theory is on the conflict between collective and individual best action where individual might utilize the public good or not after it has been obtained (Mancur, 1965). Another difficulty in collective action is that nobody is interested in bearing the expenses for the improvement; instead everyone is trying to profit from the public good greedily. The basic problem consists of the fact that within the scope of Mancurôs model individuals, acting economically do not have an interest in contributing to the provision of a public good. This provides a burden to

those who are providing the public goods, for this case the Government which has limited resources. Partners collaboration is highly needed in this situation.

2.3.2 Theory of Planned Behavior

Theory of planned Behaviour published by Ajzen (1985) states that attitude toward behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and behaviours. In family planning services it considers individuals as rational because they want to maximize their own interests regardless of the efforts by the society on controlling births through family planning. Mostly behaviours on family planning utilization are affected by social norms, language factors, poverty, embarrassment, culture and gender relations and factors related to quality of health services (Ajzen, 1985). In this study, planned behaviour theory is used as key success strategy whereby involvement of men in family planning services which could change the attitude of women to utilize more family planning methods. FP utilization is a voluntary action and acceptance is to be brought about by education and persuasion.

2.3.2.1 Strength of the Theory

The theory of planned behaviour is mostly used because of its main assumptions that intention is a strong predictor of behaviour and intention may be assessed by evaluating general attitudes, beliefs and preferences. An important feature of the Theory of Planned Behaviour is that it is not discipline-specific, or as its authors call it, it is a ócontent-freeô model of human behaviour (Ajzen, 2011), thus allowing to be applied to various different domains that study human behaviour.

2.3.2.2 Weakness

It is a good theory to be adopted but, the theory of planned behaviour does not explicitly consider the complexity of the dyadic nature of reproduction (Philipov 2011), nor does it describe the disagreement effects of a coupleôs decisional conflicts (Miller 2011a). The theory of planned behaviour while it considers normative influences, it still does not take into account environmental or economic factors that may influence a person's intention to perform a behavior. However, shortages in funding and access to Family Planning services remain a challenge in a developing country like Tanzania. USAID support Tanzania since 1980s to make Family planning services possible for everyone. In this study environmental factors (health care services and cultural) and economic factors (occupation) was also investigated to overcome this limitation.

These two theories; the theory of collective action and the theory of planned behaviour complement each other in the sense that, there is provision of public good (family planning methods) for free in a collective manner and attitudes towards its use among people. In this study, both theories were used so that strengthening access (provision) and awareness (attitude) of family planning services utilization.

2.4 Empirical Analysis of Relevant Studies

2.4.1 Global Status of Utilization of Family Planning

Family planning utilization varies widely around the world, both in terms of total use and the types of methods used. In 2015, a total of 57.4% of married or in-union women of reproductive age worldwide were using some form of contraception. However, family planning utilization was much lower in the least developed

countries (40%) and was particularly low in Africa (28.5%). Among the other major geographic areas, family planning utilization was much higher, ranging from 61.8%, in Asia to 66.7% in Latin America and the Caribbean. Within these major areas there are large differences by region and across countries. While most women in more developed countries use family planning, in many of the poorest countries, fewer than one in five married women use a family planning (WHO, 2015).

Despite extensive global efforts and investments to reduce maternal mortality, this remains high in many developing countries (WHO, 2010). In developing countries, family planning utilization among young women, whether married or unmarried, involves a lot of experimentation and is inconsistent. Additionally, young women face many factors to the use of family planning, which include fear, embarrassment, cost, and lack of knowledge (Blanc *et al*. 2009). There is a wide gap which exists between African couples' knowledge and attitude toward family planning utilization; educated men are far more likely to approve of and use family planning than their less educated peers. There is considerable need to include men more frequently in family planning services (Ndinda *et al*. 2017).

2.4.2 Status of Family Planning in Tanzania

The level of utilization of modern family planning methods in Tanzania is 32% thus indicating an increase of 17% from that reported in 1996 (TDHS, 2015-2016). According to TDHS, (2015-2016) only 22% of women with informal education were using modern methods of contraception as compared to 52% of women with at least a secondary education. Total fertility rate (TFR) is 5.4 births per women, the TFR among rural women on the mainland is 6.1 higher than among urban women which

is 3.7 (TDHS, 2010). TDHS (2015-2016) shows that there has been a decrease in TFR from 6.3 in 1992 to 5.2 in 2016 due in part to an increase in use of contraceptives over the past two decades. On average, utilization of family planning services in Chato District Council is 16.8% if compared to targeted FP users and men are only 1.6% of the users (DHIS, 2016).

Tanzania is working hard on family planning services as a key to broad-based development and saving lives of women by reducing maternal morbidity and mortality. There is need to address the rapid population growth, however shortage in funding and human resources remain a challenge. USAID has been supporting Tanzania with the focus on increasing contraceptive uptake and providing instrumental in building Tanzaniaôs national program since 1980s (USAID, 2018). This aid has helped family planning programme to be integrated with other health services and contribute to the goals of reducing maternal mortality and improving child survival.

2.4.3 Demographic Factors of Family Planning

2.4.3.1 Age and Family Planning Utilization

Menôs sexual and reproductive health needs differ along the course of life depending on whether they are adolescents, beginning to explore sexual relationships, sexually active, newly married, first-time parents, growing or spacing their families, or have completed family size. Throughout different stages of life, men strive to fulfil roles and expectations while exhibiting behaviours that can facilitate or inhibit healthy sexual relationships.

Another study done in Asia on factors affecting FP use, indicated that age can influence utilization of family planning which includes use of contraceptive methods (Najafi *et al*. 2013). The study found that, women aged 20-24 have the highest contribution to the Total Fertility Rate and low fertility is observed among women aged 15-19 due to the introduction of free Universal Primary and secondary Education, which has kept girls in school, resulting in delayed marriages (Najafi et al, 2013). Program designers should specify behaviour outcomes they hope to affect, and use appropriate indicators to track changes in those behaviours over time. Keep in mind that social norms around sexuality and relationship are formed in early adolescence.

2.4.3.2 Marital Status and Family Planning Utilization

The state of being married or not married is used on official forms to ask if a person is married, single, divorced, or widowed. family planning use varies across different marital status as found by Blanc (2009) that, in developing countries, the use of contraceptives among young women, whether married or unmarried, involves a lot of experimentation and is inconsistency. The survival status of children is likely to affect the practice of contraception as, parents who have experienced death of the child may be less likely to use FP than others of the same parity (Palamuleni, 2013). This may arise from the desire to replace a dead child or to ensure against childlessness contributes to high fertility.

Women in a polygamous marriage are less likely to utilize FP than women who live in monogamous marriages (Audet *et al*., 2008). A lower frequency of intercourse for women in polygamous marriages can discourage them from using FP. Also, these

women are likely to adhere to traditional values and customs that encourage large families. Also, these women have a limited chance to space their births, since FP utilization within marriage is not expected (Audet *et al*., 2008).

2.4.3.3 Education and Family Planning Utilization

Educational stages are subdivisions of formal learning, typically covering early childhood education, primary education, secondary education and tertiary (or higher) education. A study done in Malawi by Palamuleni (2013) on family planning shows that, there is a positive correlation between contraceptive use and level of education other things being equal the higher the level of education the higher contraceptive use is expected to be. Although both the wives and husbandsô education are important there appears to be a consensus that the former is more important than the latter. Use of family planning is higher in urban than rural areas. Urban-rural difference in the adoption of contraception is the highest in Sub-Saharan Africa, where the rate is more than twice as high as among urban than among rural in all surveyed countries (Tsui, 2017). In Tanzania according to TDHS, (2015-2016) only 22% of women with informal education were using modern methods of contraception as compared to 52% of women with at least a secondary education. Family planning utilization increases rapidly as the number of living children increases, picking at 41% for women with 3 to 4 children.

2.4.3.4 Religion and Family Planning Utilization

Religious affiliation also affects contraceptive use (Palamuleni, 2013). Religions differ in their stand on fertility regulation and among the major world religions, Catholicism and Islam are widely regarded as pro-natalist in their ideology.

However, the relationship between religion and contraceptive use is much more complex than expected. In one study conducted in India, it was dis-covered that even though the average number of children born to a Muslim or Christian couple is higher than that born to a Hindu couple, the acceptance of sterilization to limit family size was greater among Muslims and Christians than Hindus (Palamuleni, 2013). A study of FP use in Bangladesh found that Muslim women were less likely to use FP than Hindu women (Hossain, 2018). The strength of oneôs religiosity or degree of oneôs adherence to the norms of a given religion may exert an influence on onesômode of life including reproductive behaviour.

In developing countries cultural practices and religious unacceptability of FP frequently emerged as an obstacle to use contraception (Randrianasolo, 2012). Sub-Saharan Africa may well offer greater resistance to fertility decline than any other world region. The reasons are cultural and have much to do with a religious belief system that operates directly to sustain high fertility but, that also has modeled the society in such a way as to bring rewards for high fertility (Mtae, 2015).

2.4.3.5 Occupation and Family Planning Utilization

The work status of women has also been linked to knowledge and utilization of FP. Employment can also be a source of empowerment for both women and men. It may be particularly empowering for women if it puts them in control of income. Women with gainful occupation are more likely to use FP than those with no gainful occupation (Mtae, 2015). Working women, particularly, those who earn cash incomes are assumed to have greater control over house-hold decisions and increased awareness of the world outside home. Consequently, they have more

control over reproductive decisions (Acharya *et al*., 2010). In sub-Saharan areas, where economic status is poor, studies shows that paid work also provides alternative satisfactions for women, which may complete with bearing and rearing children and may promote FP utilization (Palamuleni, 2013).

In US, the rates of unintended pregnancy are highest among women with low income. The study reveals that poor Latina women, and non-Hispanic black women are less likely to have access to family planning services but also, men are less likely to have access to and receive family planning services than women (Lawrence & Mia. (2016). There is a need to reach these groups of people through public outreach.

2.4.4 Health Services related factors to Utilization of Family Planning

2.4.4.1 Distance and Family Planning Utilization

Despite the fact that family planning is advantageous for maternal and new-born health and the services and commodities are free of charge, the reason of not using modern family planning methods is unclear in many places. A study done in Haiti by Wang reveals that living in limited proximity to a health facility offering a variety of contraceptive methods has impact on family planning use (Wang & Mallick 2019). Another study which was done in Ghana by Apanga (2015) found that, although most people are aware of the benefits of family planning, they complained that it was difficult to access family planning services as such services were provided by health facilities that were far from their homes. Improving access to a range of methods available at health facilities near where people live is critical for increasing contraceptive use in both urban and rural areas.

2.4.4.2 Side Effects and Family Planning Utilization

A side effect is usually regarded as an undesirable secondary effect which occurs in addition to the desired therapeutic effect of a drug or medication. Side effects may vary for each individual depending on the person's disease state, age, weight, gender, ethnicity and general health. Fear of side effects and the belief of being sterile were reported as the major reasons for not using any FP method in Pakistan (Sajid & Malik, 2010). A study done by Ochako *et al*., (2015) in Kenya also found that, the occurrence of side effects affected the continuation rates of FP methods. To enhance FP continuation rates, health service providers should continue counselling clients on the management of potential side-effects and ensure accurate information about modern contraceptives (Farmer *et al*., 2015).

2.4.4.3 FP Commodity Availability (Security) and Family Planning Utilization

Commodity security exists when clients can obtain and use essential health commodities when and where they need them (USAID, 2008). The Government of Tanzania (GOT), through MOHCDGE, is committed to ensuring reproductive health commodity security for all Tanzanians. This enables the people of Tanzania to choose, obtain, and use quality contraceptives and other reproductive health commodities whenever and wherever they need them across the country. FP methods are obtained free of charge across the country in all public health facilities and private for non-profit facilities (USAID, 2013).

Apart from health facilities Small commercial drug shops and pharmacies are often the first line of health care in Tanzania, especially in rural areas that have very few private or public FP clinics. Drug shops and pharmacies are an important source of

health services, products, and information that is particularly important in the context of high maternal mortality and morbidity and critical health-worker shortages (USAID, 2013). Ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, as well as supporting the health and development of communities (WHO, 2014).

2.4.4.4 Few Available FP Facilities (Access) and Family Planning Utilization

Poor accessibility for the FP services, the less likely they are to use family planning. Apart from convenient locations, outlets should be free of unnecessary restrictions on who can be served. Multiple Channels Increase Access and to make methods available to all potential users mix of service delivery point is important. Channels which can increase FP services includes; Clinics (public, NGO, or private, Community-based distribution (CBD), Private-sector providers, Mobile or temporary facilities (sometimes used in hard-to-reach communities). Private-sector retail outlets (such as pharmacies, drug shops, and kiosks that sell condoms and oral contraceptives, either at subsidized prices through social marketing or at full retail cost) (USAID, 2019).

2.4.4.5 Limited Family Planning Methods for Men and Utilization of Family Planning

Men are important supporters and clients of family planning. First, they can influence their partners in many ways concerning reproductive health. Men can either stand in their way or make decisions for them. Thus, menôs attitudes can determine whether women can practice healthy behaviours (WHO, 2018). Secondly, men are also important as clients. Important family planning methods like male

condoms and vasectomy, are used by men. Men also have their own sexual and reproductive health needs and concerns in particular regarding sexually transmitted infections (STIs), which deserve the attention of the health care system and providers (WHO, 2018).

Menôs choices remain limited to condoms, withdrawal and vasectomy. For men to share more equally the burdens as well as the benefits of family planning, more effective male contraceptive methods need to be available (Handelsman, 2019). Development of male-centered contraceptive drugs and injections has largely been abandoned due to concerns about side-effects and the belief that there is no market (Edwards, 2017). We need to shift the paradigm around this and build stronger commitment globally and nationally around men.

2.4.5 Cultural Factors of Family Planning

Engaging women and their partners in culturally-responsive family planning and contraception counselling is one essential element of preconception care, a primary care concept designed to reduce infant mortality and its associated racial/ethnic disparities (Ahmed et al. 2015). Number of Children has influence on family planning uptake, findings from a study done in the US by Sedgh (2007) shows that family size has influence on utilizing family planning methods and choice of the methods to use is changed over time, once the desired number of children is achieved, utilization of family planning increases. Parents are advised to use FP and have fewer children in a household at a given point in time to increase the availability of parental time and economic resources per child.

The discussion between couples on contraception is an important intermediate step along the path to eventual adoption and especially continuation of contraceptives uses. Since fertility involves participation of the wife and husband who may differ in their reproductive goals (in terms of number and timing of having the children), successful planning and decision making about fertility size and use of FP require effective communication of both partners (Mtae, 2015). When couples discuss contraception, they are more likely to make plans that they can carry out as seen in a study done in Yorubas Nigeria which support the fact that spouse communication has a significant role to play in the adoption of FP utilization (Ogunjuyigbe *et a*l., 2009).

In Tanzania 65% of women discuss with their husbands about family planning at least once and more than 50% of husbands approve family planning (TDHS, 2015-2016). Kessy (2007) shows that some women were using family planning methods secretly without the consent of their husbands, the women utilization of family planning services in secrecy exposed them to emotional or physical violence if discovered by their husbands (Ramadhan, 2008).

In fact, many men feel that it is menôs responsibility to allow women to use family planning methods, due to the fact that in many African societiesômen are decision ï makers in reproductive matters and women just follow without questioning what men tell them to do or not to do (Amrad, 2014). For this reason, it is important to involve men in family planning services as a way to prevent women who use family planning methods from domestic violence.

Studies suggested that perception is a main factor that affects utilization of family planning. Perception that many children is a sign of manhood, having many children is security at old age, having many children increases the working force and men preference to male child for inheritance deters contraceptive uptake (Amrad, 2014; Kerry *et al*., 2015). DHS survey by Kerry *et al*., (2015) also shows strong sex prevalence of 76% in Nigeria which also has highest number of children preferred by men of 8 children. In a study done in Mbeya, Tanzania, on the perceptions that affect men towards family planning use, revealed some factors influencing men to utilize the family planning. Those factors are lack of awareness on the importance of family planning services, worried about promiscuity among their partners if there is use of FP and having many wives with the desire to have many children (Wulifan *et al*. 2016).

Another study done in Switzerland on men contraceptive knowledge, attitudes and practices stipulated the factors. The study found that men believe termination of fertility is cultural contradiction. They should bear as many children as possible. In addition to that in Swiss culture one of the social securities for men in old age is having big numbers of children. Not only that but also male fertility is a sign of sustained manhood even during old age. The last perception found by Swiss study was men felt the family planning services were not user friendly to them (Lundgren *et al*. 2012).

Maleôs opposition to Family planning is another behaviour which influence the level of FP use. Mtae (2015) in her study in Kishapu and Mvomelo found that husband

approval of family planning has significant associations with contraceptive use. Another study done in Mwanza by Mosha *et al.,* in 2008 found that, menôs disapproval of family planning was cited as a reason for not using contraceptives by some women, while in Namibia, a study found that approval of family planning by both spouses was significantly associated with womenôs use of any modern method (Gebreselassie, 2007)

2.4.6 Community Awareness on Family Planning services in Tanzania

The gap between awareness and use may reflect the influence of a number of demographic, cultural behaviours and service related factors that hinder access to and acceptance of FP methods (Nettey *et al*., 2015). TDHS in 2018 indicate that, majority of community members are aware of the concept family planning and its importance, however not all members of the community supports use of family planning. Most men think family planning is for women, and the youth view family planning as a practice for adults who already have children.

Over 45 years of family planning program implementation in Tanzania, the level of utilization of modern family planning methods is 32% thus indicating an increase of 17% from that reported by TDHS in 1996. There is also an insignificant decrease of the total fertility rate from 5.8 in 1996 to 5.2 in 2016 (TDHS, 2015-2016). This situation puts pressure on already stretched social services such as health and education, as well as natural resources. There is a need for creating family planning knowledge in communities and ensure accessibility to family planning services especially in rural areas like Chato District Council.

Awareness on family planning services means the ability of the individual to name the methods or other practices and sources of services or supplies. According to the study done by Msovela (2016) in Tanzania, majority of men heard about family planning use. However, knowledge of proper use, risks and benefits of methods was lacking especially in the rural areas. This might be a case in Chato District which is more or less a rural district.

2.5 Policy Review

2.5.1 National Policies That Support the Provision and Expansion of Family Planning Services

i. National Population Policy 2006: Recognizes the need to educate women about the importance of family planning.
ii. National Health Policy 2007: Emphasizes the governmentôs commitment, in collaboration with the non-profit private sector and development partners, to continue to provide free health services for pregnant women, users of family planning services, and children under the age of five.
iii. The Health Sector Strategic Plan IV 2015-2020 (Tanzania Mainland): Family planning is prioritized to delay the age at first birth, to promote birth spacing and to give women the choice to decide on the number of children they have.
iv. One Plan II 2016-2020: Outlines a plan to respond to the need for and improve access to a full range of family planning services, with a special focus on rural and marginalized communities.
v. Five-Year Costed Implementation Plan for Family Planning 2018-2022 (Tanzania Mainland): Yet to be launched, the Plan sets targets for increased use

of all family planning methods and takes into consideration and builds on the substantial investments called for in other strategic plans. Family Planning Costed Implementation Plan 2017-2022 (Zanzibar): Aims to increase the uptake of family planning methods and identifies priority areas as well as the financial resources required.

vi. Vision 2025 (Tanzania Mainland): Details a road map for Tanzania to transition from a developing country to a middle-income country by the year 2025, with a high level of human development. It outlines the need for quality reproductive health services and a three quarters reduction in infant and maternal mortality rates from their current levels.

vii. The National Five-Year Development Plan 2016/17-2020/21 (Tanzania Mainland): National development aspirations articulated in the Vision 2025 are to transform Tanzaniaôs economy into a middle-income and semi-industrialized state by 2025, with family planning a component of public health interventions recognizing that continued rapid population growth could derail a potential demographic dividend.

Despite the Policy recognition of family planning by the policy, still there is low utilization of family planning services. FP utilization is low even though there is improvement of reproductive health due to limited knowledge to the public on various reproductive measures. Also the plans have failed for some extent because of the existence of myth and misconception, low male involvement, GBV, gender norms, inadequate skilled human resource, erratic supply of family planning method mix at health facility and community level.

All these shortfalls justified for the new National Health Policy 2017 and the fact that time has changed, there is a new fifth government political regime, increasing health sector challenges and new demands for drafting processes, format and contents of national sector policies in Tanzania. The new policy has the objective to improve reproductive, maternal, new-born, child and adolescent health services by strengthening services for infertility, family planning, pregnancy, sexually transmitted diseases, breast and cervical cancer; and strengthen gender sensitive programs for both men and women in provision of health services. This study aimed at improving family planning services in line with the objective of this policy.

2.5.2 Tanzania Commitments to FP (FP2020)

In the efforts to increase the uptake of contraceptives, and its recognition of a healthier population, Tanzania has strengthened the outreach services, engaging policy, and challenging traditional norms and family sizes. Recognizing that a healthier population leads to a more prospering nation, the Government of Tanzania committed to increasing the availability of modern contraceptive methods at all levels of the health system from 40% to 70% by 2020. With one of the highest child marriage prevalence rates in the world, the governmentôs commitment to reform key policies related to age of marriage, teenage childbearing, and scaling up youth friendly reproductive health facilities reflects its vision for a healthier development agenda for the nationôs girls and women.

2.6 Conceptual Framework of the Study

The process-context approach was developed after going through various researches concerning factors influencing FP programme to achieve desired results. The

utilization of FP is reported to be influenced by a complex interaction of many factors at individual (demographic), cultural and service delivery levels. It is modified from John Stover (1998) model as detailed in Figure 2.1. Since the research sought to establish the factors influencing male involvement in FP, Then FP methods use is the dependent variable which is expected to be influenced by independent variables (i.e. demographic factors - age, marital status, education level, occupation and religion), cultural factors which include number of children, many children as working force, many children as security at old age, many children improves male status, discussion about FP use (spouse, others), decisions on reproductive health and health care service factors which includes Distance to FP centre, Side effects after FP use, Availability of FP commodities and Availability of FP clinics). These variables can affect positively or negatively the fertility of individuals in the society.

Stover (1998) revised the framework from Bongaarts and Potter (1983) in light of new evidence, research, and data that have become available over the past three decades. Although, the model as originally conceived remains conceptually sound, and the general multiplicative nature of the main equation remain unchanged but new research allows some features of the model to be improved. In this framework the pathways by which reproductive health (RH) programs achieve their objectives are illustrated and it specifies how those who design the programme expect it to work to achieve results at both the program and population level. Moreover, the framework draws attention to the different aspects of programs (operational areas, access to services, and the quality of care) that must be working satisfactorily to achieve the desired end result.

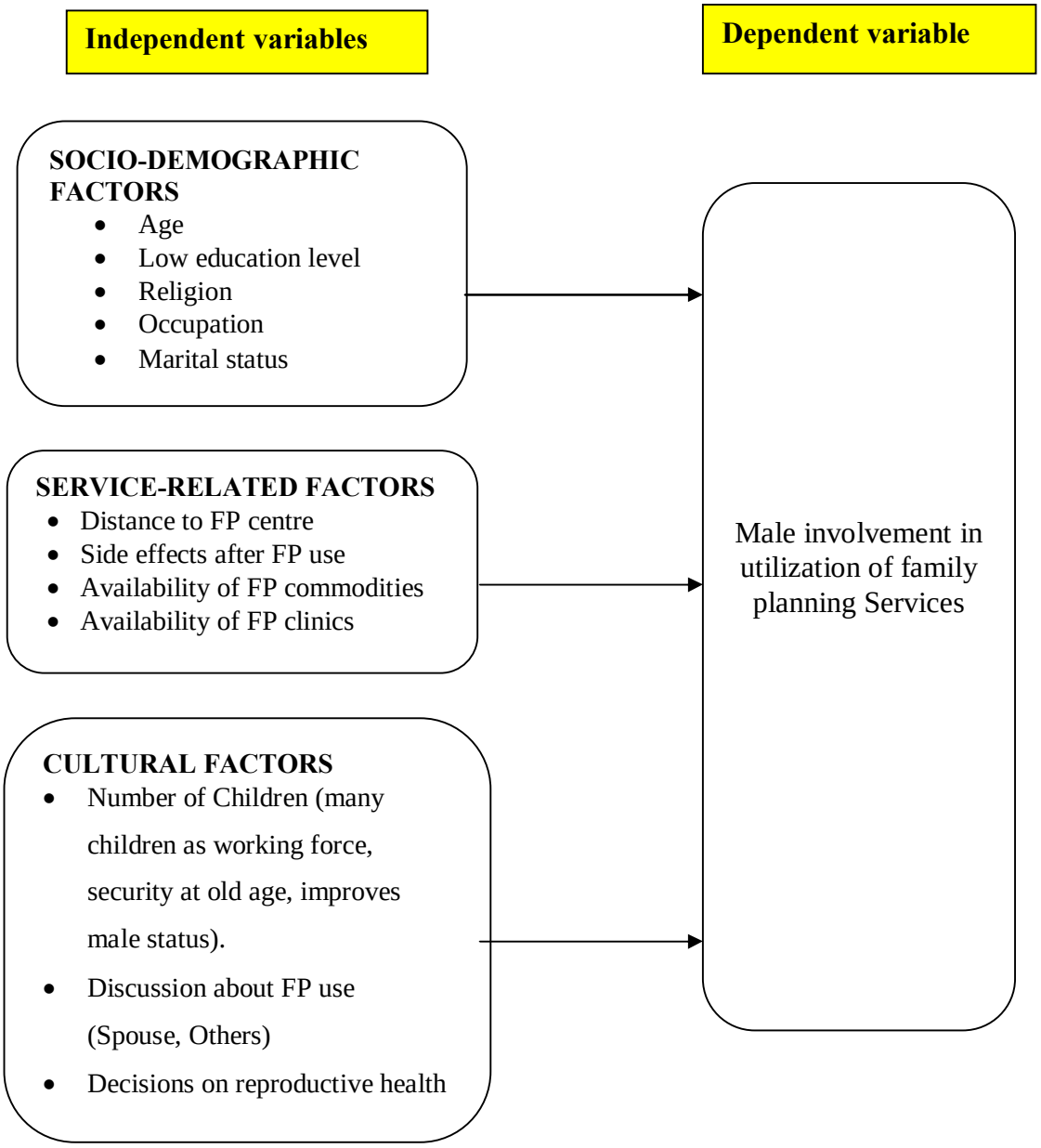

Figure 2.1: Conceptual Framework for the factors influencing male involvement in Utilization of Family Planning

Source: Modified from Stover (1998)

2.7 Research Gaps

There are very few researches which have been done regarding the aspect of men males in family planning, for most of studies reported that men view family planning as ñwomanôs domain,ò (Alege et al., 2016; Akintade et al., 2011; Blanc et al., 2009;

Funmilayo, 2017). This study intended to fill this gap by generating information from men regarding social demographic, cultural and services related factors in that influence their involvement in family planning utilization.

Though there are a few research on the subject at hand, Most of the studies on fertility which inform the National FP programme were done at the National level mostly by TDHS. Tanzania encompasses a great variety of ethnicities, cultures, histories, mores, and occupations within distinct geographical regions, also there is greater regional variation on fertility preferences (Mtae, 2015). This study fills this gap by providing information specifically to small areas of Tanzania with distant characteristics (Chato District).

A review of studies on FP since 2002 to 2012 indicate that, men influences family planning utilization since African men are often key figures in domestic decision making, particularly on fertility behaviour as reported by Tanzania Family Planning Research Agenda 2013-2020 (MOHCDGE, 2013). Malesô involvement is a research priority for the nation which this study intends to fill the gap by establishing key factors influencing maleôs involvement and how these factors can best be resolved to influence men to use or support FP services in Tanzania.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

In this chapter, there is description of the study area, the design of the study, sampling techniques, calculation of the sample size, data collection methods, ethical adherence, data analysis techniques and limitation of the study. The chapter, thus provides a detailed plan or framework used to collect information and data for making decisions that was later on interpreted and discussed as the findings of this research. The description of the methodology here, serves as a bridge between the research questions and execution of the research itself.

3.2 Study Area

The study was conducted in Chato District, of Geita Region which is located near lake Victoria. Chato is one of the six districts of Geita Region. It is bordered to the North by the Muleba District, to the South by the Shinyanga Region, to the East by Lake Victoria and Mwanza Region, to the West by the Ngara District, to the southwest by the Kigoma Region. According to the 2012 census, the District had an estimated population of 409,298 people in 2016, among whom 206,152 are females and 203,146 are males based on 4.8% annual growth. The number of households is 60,855 with an average of six members. The labour force in the district is 196,464 people, which is equivalent to 48 percent of the district population. The population density is estimated to be 115 people per square kilometre (NBS, 2016).

The District receives a reasonable amount of rains ranging between 82.95mm - 995.44mm. The rains make it possible for the district to produce a range of crops

including cash and food crops. The primary economic activity is subsistence farming without irrigation, using only rain. Common crops for local consumption are bananas, beans, maize, cassavas, and sweet potatoes. Commercial farming is not well developed, but cotton, tobacco, and coffee are grown for sale. Livestock rearing is usually an adjunct to farming, with some commercial ranches. Fishing is also commercial and for domestic use as Chato District neighbours Lake Victoria to the East (CHATO DC, 2016).

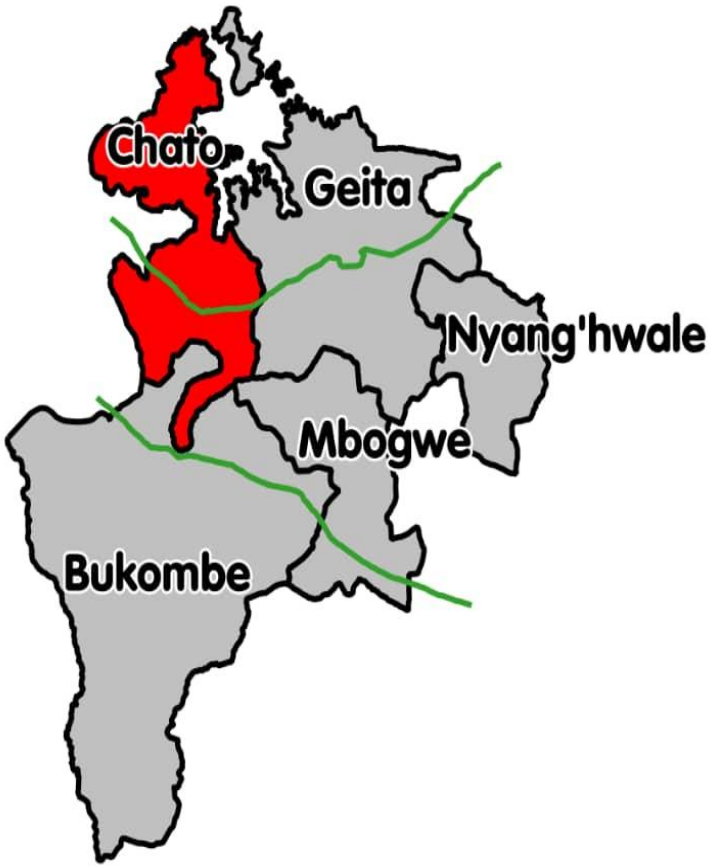

Figure 3.1: The Map of Chato DC showing Neighbouring Districts in Geita Region (CHATO, 2018)

Chato District is administratively divided into 23 wards; Chato, Bukome, Buselesele, Buziku, Bwera, Ichwankima, Ilemela, Kachwamba, Kasenga, Katende, Kigongo, Makurugusi, Muganza and Nyamilembe. The reason for selecting Chato district was

that, it is one of the new districts of Geita Region with unknown prevalence of family planning utilization. Chato is also second to the Geita Regional Hospital in terms of maternal deaths (DHIS, 2016).

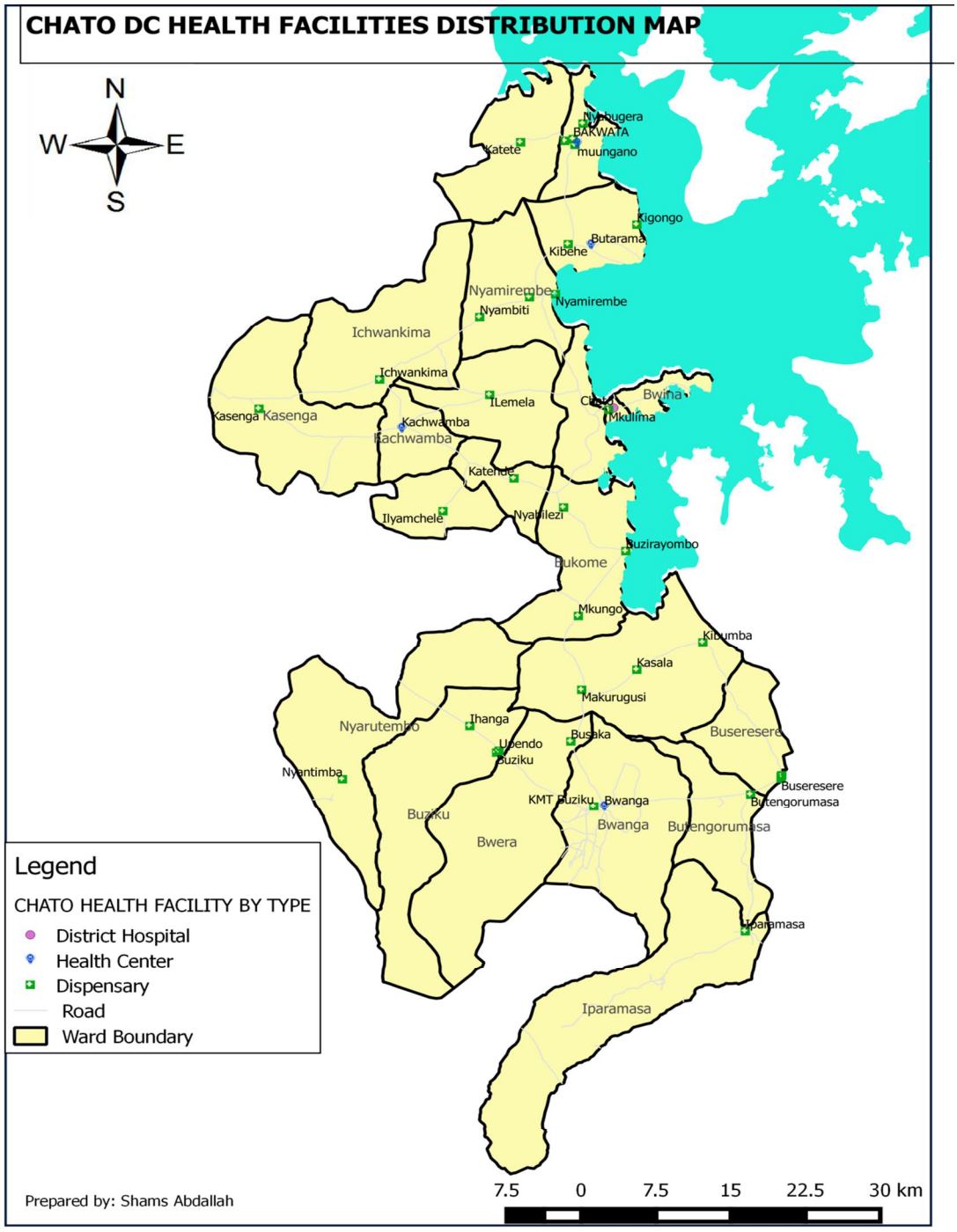

Figure 3.2: The Map of Chato DC Showing Distribution of Family Planning Services within Health Facilities in Different Wards (CHATO, 2018)

3.2.1 Ethnicity of Chato District

The main ethnic groups in Chato District are the Sukuma, Zinza, Subi, Jita, Kerewe, Ha, Kurya and Haya. The Sukuma dominates as it constitutes over 70 percent of the population. The rest of the groups constitute in various small proportions. They are mainly in Chato, Muganza and Buseresere wards of Chato District Council. The Jita and Zinza are mostly found in Muganza, Kigongo and Chato wards which are along the lake shores where they are mostly engaged with fishing activities (Chato, 2019). National policy gives very little importance to ethnic grouping as part of the efforts to consolidate the national identity and unity and information related to this issue is difficult to come by.

For the Sukuma society, cultural norms such as menôs dominance in decision-making, there is also a common adage in the society that a real man in Sukuma is he who has many children and large family. This thinking gives men social prestige which influences their family planning utilization (USAID, 2009). Zinza, Subi, Jita, Kerewe, and Haya societies have similar gender norms to that of Sukuma with regard to FP utilization since they are primarily of Bantu origin.

Despite that each of these ethnic group has unique language, social structure, and culture, there is a notable similarity on the pattern of behaviour between them (Sawe, 2019). The interventions focused on the role of cultural and gender norms in reproductive decision-making and contraceptive use among men and women in Tanzania is highly needed (Schuler, 2011). This is why, in this study, cultural factors among men were investigated in relation to FP utilization.

3.3 Study Design

Research design is a plan for collecting and utilizing data to obtain the desired information can be obtained with sufficient precision and answer each research question (Saunders, et al. 2009). The scientific integrity of the study and the credibility of the data from the study substantially depend on the study design (Parab & Bhalerao. 2010). Descriptive Cross sectional study design was used to assess the factors influencing male involvement in utilization of family planning in Chato district. The design is useful for measuring the cause and effect at the same time. This is the commonest study design used in general practice and research, in general and it is relatively easy to do, inexpensive and can be carried out in a short time frame (Olsen, 2004). The choice of this design was partly warranted by its ability to assess the burden of health needs of a population and informing the planning and allocation of health resources hence meeting the objectives of this study.

3.4 Study Population Characteristics

The participants of this study were men who aged from 19 years and above. These were heads of households who reside in Chato District. Most men at this age are engaged in sexual activities and so they provide the best information needed on family planning. Head of households in this context means those who are responsible for up keeping of a home and providing the primary support for a family. Keeping up a home for men means he is married or preparing to get married, hence, assumed to be in a certain state of sexual relationship and with experiences on family planning services themselves and/or in their communities. The sampling unit was men who live in a particular household. Also, various health care providers dealing with reproductive matters in the RCH clinics, District Reproductive and Child

Health Officer (DRCHO), religious leaders were interviewed for detailed information regarding family planning and social cultural issues.

3.5 Sample Size

For a known population, the minimum sample size was calculated using Yamaneô formula (Yamane, 1967)

Yamane = N / (1 + Ne2)

According to NBS (2016), the population of men aged 19 years and above was 79,580

Study population size N =79,580; Using 95% confidence interval, the error level is 0.05.

The calculation follows:

= 79,580 / (1 + 79,580 (0.0025)

= 79,580 / 1 +198.95

nå 400

To account for possible attrition and/or non-respondents, the number of participants was increased by 96 to become 496. This increase also aimed at getting at least two participants from all 48 hamlets selected. The sample size was 496 men aged between 19 years and above with stable family and residing in Chato District. There was equal distribution of participants from all the selected wards.

3.6 Sampling Procedures

Sampling is the act, process, or technique of selecting individuals or objects such that the selected group contains elements which are representative of the

characteristics found in the entire group. It is the process by which inference is made to the whole by examining a part of it (Mtae, 2015). Multistage sampling technique was used because the sample was drawn from 23 wards in Chato dDistricts. This technique was used because samples were drawn from a large and diverse population with defined geographical areas (clusters). In statistics, multistage sampling is the taking of samples in stages using smaller and smaller sampling units at each stage (Kaplan, 2013). In this study, wards, villages, and hamlets was were used as clusters. Simple random sampling was used to select eligible wards, villages, hamlets while systematic sampling method was used to select participants. These were preferred because Both both simple random sampling and systematic sampling methods provides equal opportunity for every member of a population to be selected. Each of these sampling practices is explained in the subsections below.

3.6.1 First Stage - Selection of Wards

At the district level, 4 wards were selected from 23 wards of Chato dDistrict by simple random sampling technique. Names of all 23 wards were written on small pieces of paper each and thrown into the box, the box was shaken and later on four pieces of paper with wards' names was picked from the box. The wards that became selected through this means are Muganza, Chato, Bukome, and Bwina. wards.

3.6.2 Second Stage - Selection of Villages

After the selection of the 4 wards, a list of all villages in each ward was prepared to obtain four separate boxes. From each box, with the name of the wards, three villages from each ward were selected through simple random sampling technique to obtain a total of 12 villages.

3.6.3 Third Stage - Selection of Hamlets

From each of 12 villages, a list of hamlets from each village was prepared to obtain 12 boxes for each village. Four (4) hamlets from each village were selected by using simple random sampling technique to obtain 48 hamlets.

3.6.4 Fourth Stage - Selection of Eligible Participants

In every selected hamlet, a list of all men aged 19 years and above was prepared (Sampling frame). This list was obtained from ward executive office/Village executive officer or ward chairperson. Then systematic sampling technique was used to pick 496 eligible men for the study.

3.6.5 Purposive Sampling

Key informants were selected purposefully to get the required information which could not be obtained through other means. Purposive sampling is a type of non-probability sampling that is most effective when one needs to study a certain cultural domain with experts. Purposive sampling may also be used with both qualitative and quantitative research techniques, based upon a variety of criteria which may include specialist knowledge of the researched issue, or capacity and willingness to participate in the research (Jupp, 2006). Key informants included one DRCHO, one Family Planning health provider from the selected wards (4), 4 elders and 4 religiousô leaders. Purposive sampling technique provided opportunity for the researcher to capture subjects of desired characteristics.

3.7 Recruitment and Training of Research Assistants

Five research assistants were recruited and trained in two days to assist in collection of data during data collection process. All 5 research assistants recruited were

oriented about the whole process and ethics. They were persons with a minimum qualification of ordinary level certificate. The research assistants were taught how best to ask questions, especially the in vernacular versions language of the contraceptive methods; how to fill in the questionnaires, display of good manners to respondents, conducting interviews in privacy and confidentiality and keeping the data obtained confidential, and there after taking care for of the completed questionnaires.

Figure 3.7: Research Assistants during Training Session and Distribution of Working Tools in Chato District
Source: Field work, 2019

3.8 Research Approach

3.8.1 Data Collection Techniques

Both quantitative and qualitative data were collected in order to obtain answers to the objectives of this study. A combination of techniques that gathers both quantitative and qualitative information was important to yield the most comprehensive results.

The data collection process started on 18th March, 2019, and ended on the 18th April, 2019. The researcher and 5 research assistants visited respondents at their homesteads under the guidance of hamlet leaders and village chairpersons, sometimes with village executive officers (VEOs). Data were derived from in-person (face to face), researcher-administered surveys of men. Structured questionnaire was used to obtain quantitative information (Appendix 2 and 3). Qualitative data were obtained through focus group discussions (FGDs) using a checklist (Appendix 4) and in-depth interviews using key informant interview guide (Appendix 5). The combination of quantitative and qualitative data was done for data triangulation to ensure validity of findings.

3.8.1.1 Quantitative Data

Data from men were collected through structured questionnaires with both closed and open-ended questions translated in Kiswahili. The main advantage of using questionnaires is that a large number of people can be reached relatively easily and economically. A standard questionnaire provides quantifiable answers for a research topic. Questionnaires had 5 parts which were used to explore participantsô demographic factors, status of FP methods utilization among men, and factors

influencing male involvement in Family planning services utilization. A computer data screen was prepared for the study data entry using SPSS for windows.

3.8.1.2 Qualitative Data

3.8.1.2.1 Focused Group Discussions

A focused group discussion in this study involved gathering of the people from similar backgrounds or experiences together to discuss a specific topic of interest. It is a form of qualitative research where questions were asked about their perceptions attitudes, beliefs, opinion or ideas (Ogunbameru, 2003). A focus group approach was used to explore and examine what people think, how they think, and why they think the way they do about the issues of fertility and family planning without pressuring them into making decisions or reaching a consensus (Wilkinson, 2004).

A checklist was used to guide the moderator in leading the discussion (Appendix 4). Four (4) focused group discussions were held in each of the four selected wards. There was a mixture of female and males in the group discussions. A sample of 8 respondents participated in the FGD. According to Patton (2002), the average number of people who should participate in the discussion should be six to eight and the discussion should last for half an hour to the maximum of two hours. Random selection of eligible men and women for FGD based on their age and respondents were sub-grouped basing on their gender. These were men aged between 19 years and above who are in sexual relationship and women aged 15-49 who are also in sexual relationship. This sub-grouping was necessary to get the maximum freedom in expressing their views.

There was a moderator, and three trained research assistants who were responsible with taking notes - verbal and nonverbal, and one responsible with audio taping. The role of the moderator was to make everyone feel welcomed, at easy, ask questions, probe for more information and give all the participants enough time to answer questions. Inclusion of everyone in the discussion was very important to get views of each participant. The conversation was usually held indoors at a health facility near the village, or in a village building to show the participants that the focus group had the approval of the local authority. The discussions were conducted in Kiswahili by a trained moderator. Moderator started by describing the proceedings of a focus group then asked the questions. He encouraged all participants to air their views and probed for answers when some members were hesitant. Discussions for each focus group lasted between 50mins and 70mins.

3.8.2.1.2 Key Informant Interviews

The purpose of key informant interviews was to collect information from a wide range of people including health care providers, religious leaders, or residents who have first-hand knowledge about the community. Key informants were interviewed by the researcher, and one research assistant helped with recording both hand written and digital recording, in order to capture all the necessary details (Appendix 5). An in-depth interview guide was used, to make sure the discussion is on truck and in order to maintain consistency.

According to Guion (2006) the interview guide should be designed to help the interviewer focus on topics that are important to explore, maintain consistency across interviews with different respondents, and stay on track during the interview

process. In this study, an interview tool was prepared to guide the discussion (Appendix 4) and make sure the questions are answered. The key informant interview checklist contained an outlined script and a list of open-ended questions relevant to the topic discussed. Before beginning the interview, the researcher introduced himself and a brief introduction of the project. During introduction, the researcher explained the purpose for the interview and who is involved in the process. The researcher also explained why cooperation of participants was important in collecting the information needed, also explained to participants what will happen with the collected information and how the community will benefit. Questions were asked in such a way that draws upon the informant's expertise and unique viewpoint. After completing the interviews, the researcher sent out ñthank youò notes to the interviewees.

3.8.2 Data Analysis Strategies

3.8.2.1 Quantitative Data Analysis

Data compilation and processing started immediately after the end of the major field work. The questionnaires were properly filled by serial number, manually edited and entry was done by the principle investigator and one trained research assistant using SPSS. Entered data were cleaned for validation and consistency.

Data were analyzed differently according to the objectives; to address the first objective: Proportion of Men using Family Planning. This was reported as a valid percentage (%) in a frequency distribution table, where the numerator was the number utilizing FP and the denominator was the total number of respondents. Social demographic characteristics of the respondents were analyzed using

descriptive analysis and cross tabulation where frequencies and percentages were obtained.

To address the second objective: Demographic factors influencing male involvement in Utilization of Family Planning; bivariate analysis was carried out using frequency distributions and proportions were compared using chi-square at a confidence interval of 0.05, to look for any association between FP use (Dependent variable) with each of the potential demographic factors associated with FP utilization (independent variables).

To address the third objective: Cultural factors that influence utilization of family planning; Descriptive bivariate analysis was carried out using frequency distributions and proportions were compared using chi-square at a confidence interval of 0.05, to look for any association between FP use (Dependent variable) with each of the potential cultural factors associated with FP utilization (independent variables).

To address the fourth objective: Health Care System factors influencing utilization of Family Planning; Descriptive bivariate analysis was carried out using frequency distributions and proportions were compared using chi-square at a confidence interval of 0.05, to look for any association between FP use (Dependent variable) with each of the potential factors associated with FP utilization (independent variables).

In addition, multivariable analysis was performed using Binomial non-linear logistic regression analysis to compare strength of association between dependent variables with a set of independent variables which were significant at bivariate level. Factors

that were significantly associated with FP use at bivariate analysis ($p < 0.05$, those with p-values < or = 0.1) were considered in the logistic regression model. This was essential to control confounding factors that were not primary variables of interest but would possibly effect the association of other primary variables of interest with FP use. Their respective odds ratios (OR) associated with these potential factors were reported as a measure of strength, together with the respective 95% confidence intervals.

The model used was: Logit P (predictors of FP use) = Ŭ+ ϐ1 influence of number of children + ϐ2 influence of knowing FP clinic + ϐ3 distance to FP clinic + ϐ4 discussion between spouse on FP use + ϐ5 influence of menôs discussion with others apart from wife on FP + ϐ6 Menôs approval on spouse + ϐ7 influence of FP side effects.

3.8.2.2 Qualitative Data Analysis

Thematic analysis was employed to analyse data emanated from Focus Group Discussions (FGD) and key informants (KI). The moderation of the discussion by the researcher and research assistants and feedback from participants was done in the Kiswahili, the language which is best spoken by the participants. The feedback in Kiswahili was then translated to English by researcher and research assistants who were well versed with both Kiswahili and English language. Independent persons known to be well versed with both Kiswahili and English reviewed the translations to ensure that the meaning of participant responses had not been altered. The collected information was analyzed and coded by themes and sub-themes. Detailed notes were taken and then the discussions were audio taped for easy reference in the

future. For each FGD outcome of discussion and KI interview proceedings were summarized and used to supplement obtained quantitative information and verbatim quotations were used to illustrate responses on relevant issues.

3.9 Validity Checks of Instrument

Validity is the extent to which the interpretations of the results of a test are warranted, which depends on the particular use the test is intended to serve. In health care and social science research, many of the variables of interest and outcomes that are important are abstract concepts known as theoretical constructs. Using tests or instruments that are valid to measure such constructs is a crucial component of research quality (Kimberlin & Winterstein 2008). In other words, **Validity** determines whether the research truly measures that which it was intended to measure or how truthful the research results are (Golafshani, 2003).

Quality issues were addressed through the following measures to ensure that the data generated was complete, reliable and accurate. These measures contributed towards both internal and external validity of the study

i. Most of the contents of this questionnaire are obtained from similar studies done elsewhere. Content validity is also very important, and this can be obtained through other academiciansô reflections on their contents and structures (Bryman, 2008; Gass and Mackey, 2007).
ii. Training of the research assistants was done in a period of two days to familiarize them with the data collection process along with research ethics and safeguarding issues. The training focused on participant handling skills such as interviewing skills, content and meaning of questions, correct recording of

responses, how to conduct FGD and orientation to study objectives and procedures. They were trained on how to provide health education of Family planning service and they were given information on ethical issues such as the need to observe confidentiality and obtain informed consent from participants before administering study tools.

iii. Questionnaires was validated by peers and other professionals including supervisors and found to be a reliable tool for the collection of information pertaining to this study. During proposal presentation two discussants and other panel members went through it and gave their helpful and constructive comments.

3.10 Reliability Checks of Instrument

Reliability is defined as something reliable will perform in the future as it has in the past (whether the result is replicable) (Salkind, 1997). Reliability estimates, and evaluates the stability of measures, internal consistency of measurement instruments, and inter-observer reliability of instrument scores. Reliability reflects consistency and replicability over time and in this study was assured through the following measures.

i. The researcher pre-tested the questionnaire by distributing 20 copies of the questionnaire to the respondents with similar characteristics to targeted population of this study at Muungano ward and some modifications were done to the questionnaires.

ii. Every respondent was given with the same questions and in the same order as other respondents to ensure reliability, generalizability and validity. Reliability is

concerned with the ability of an instrument to measure consistently. It should be noted that the reliability of an instrument is closely associated with its validity (Tavacol et al., 2008).

iii. Data completeness and accuracy was checked every day and gaps identified were addressed with the respective research assistants.

3.11 Ethical Consideration

To ensure that the appropriate ethical standards are being upheld, ethical clearance was sought from the Open University of Tanzania. Permission to do the study in Chato District was obtained from the Regional Administrative Secretary of Geita Region and Chato District Executive Director. Permission to conduct interviews was also obtained from the head of households themselves. The consent process ensured that individuals are voluntarily participating in the research with full knowledge of relevant risks and benefits. Anonymity was maintained, as the respondents were not asked their names.

3.12 Study Limitations and Delimitation

i. Difficult in finding men at home was one of the problems encountered because all the data were collected by visiting respondents in their households during the day; since during the day, they go for economic activities like fishing and farming, also employed respondents were not found at home during day time on week days. This problem was solved by collecting data during the evening when most of men are back at home.

ii. Recall bias, participants might not remember well using family planning methods. This could result in miss classification, assigning wrong exposure or

outcome category, hence over or under estimation of the outcome. This was minimized by asking them to remember only within six months.

iii. Another form of responses bias could have arisen when assessing currently used FP methods and in particular condom use a form of FP method. This is because condoms are promoted not primarily for FP purposes but as a way to prevent STIs. This was addressed through asking men if they used condom for Family Planning intentions or STIs prevention, but also complimentary information of FGD minimized the error where participants were able to outline the frequently used methods.

CHAPTER FOUR

RESULTS

4.1 Overview

This chapter describes the frequency distribution on current FP utilization for all methods among males in Chato District and the factors that influence malesô utilization of FP. It describes the, respondentsô current age, general socio-demographic factors of respondents, including respondentôs awareness on FP use and socio-demographic factors, cultural factors, and service-related factors that influence FP utilization or non- utilization. The consequential factors to FP use are described at the end.

4.2 Proportion of the Current FP Use for all Methods

The proportion of men who reported using family planning methods themselves during the act of sexual intercourse for family planning purposes in the past six months before the research was 17.5%. Table 4.1 summarizes all the responses that were obtained from the field. Valid percentage was used because there are 38 respondents who were excluded because they genuinely did not respond to this question in the argument that they could not recall their utilization or non-utilization of FP in the past six months; thus, they were excluded from the analysis.

Table 4.1: Frequency Distribution of Family Planning Utilization

Characteristic		Frequency	Percent	Valid Percent
Used FP	Yes	80	16.1	17.5
	No	378	76.2	82.5
	Total	458	92.3	100.0
Missing	System	38	7.7	
Total		496	100.0	

Source: Field Data, 2019

4.3 Demographic Characteristics of the Respondents

4.3.1 Distribution of Men's Age

Figure 4.1 shows age of the respondents in which the minimum age was 19 years and maximum age of 70 years with mean age 35.98 (SD of ± 10.018).

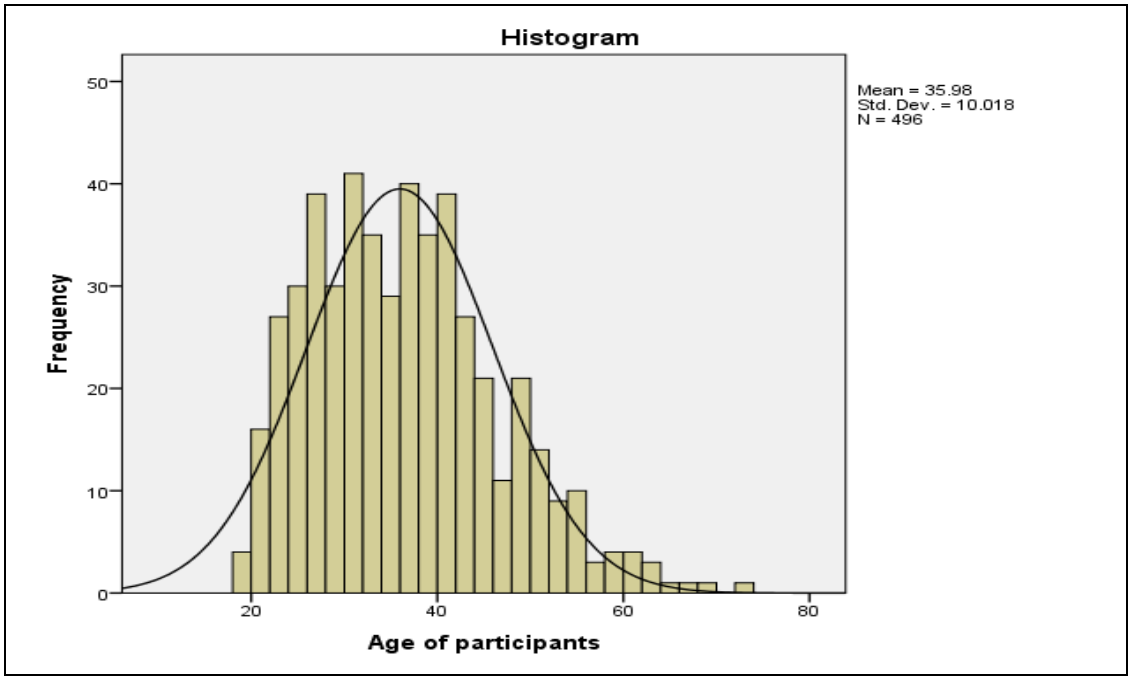

Figure 4.1: Age of Respondents
Source: Field Data, 2019

4.3.2 Distribution of Demographic Factors of Respondents

Table 4.2 shows the factors of each age group of men that were included in this study. It shows the menôs marital status, those with children, the number of children they have, number of wives they have, occupation, level of education, and their religion.

The major age group was 30-39 (36.3%) years of age. This means that the study employed a large majority of men who are in the active reproductive group and, therefore, they were expected to know and use different FP methods. With regard to marital status, most of the respondents were married (89.7% n=445) and about

95.8% (n=475) of the respondents had children. 83.3% (n=402) of men responded having two or more children; however, 86.2% (n=412) of the respondents had only one wife.

Table 4.2: Distribution of Demographic Factors of Respondents

Characteristics		Frequency	Percent
Age group	19	4	0.8
	20- 29	142	28.6
	30- 39	180	36.3
	40- 49	119	24
	50+	51	10.3
	Total	**496**	**100**
Marital Status	Not married	11	2.2
	Married	445	89.7
	Widowed	11	2.2
	Separated	18	3.6
	Cohabiting	11	2.2
	Total	**496**	**100**
Do you have any child	Yes	475	95.8
	No	21	4.2
	Total	**496**	**100**
Number of children	One	80	16.1
	Two or more	416	83.9
	Total	**496**	**100**
Number of wives	One	412	83.1
	Two	50	10.1
	Three	6	1.2
	Four	10	2
	Total	478	96.4
	Missing system	18	3.6
	Total	**496**	**100**
Occupation	Peasant	318	64.1
	Casual	25	5
	Employed	21	4.2
	Petty Business	93	18.8
	More than one occupation	39	7.9
	Total	**496**	**100**
Level of education	No formal education	59	11.9
	Adult education	12	2.4
	Primary Education	277	55.8
	Secondary Education	121	24.4
	College	26	5.2
	Missing system	1	0.2
	Total	**496**	**100**
Religion	Christian	397	80
	Muslim	60	12.1
	No religion	39	7.9
	Total	**496**	**100**

Source: Field Data, 2019

A majority of men who participated in the study were peasants (64.1% n=318), probably because Chato is still a rural district. A small minority of men had no formal education (11.9% n=59). The rest were educated from primary level (55.5%), secondary level (24.4%) and college education (5.4%). A large majority of the respondents (80% n=397) were Christians as compared to Muslims who were 12.1% (n=60) and non-religious which were 7.9% (n=39).

4.3.3 Distribution of Demographic Factors on Utilization of Family Planning

Table 4.3 provides the descriptive statistics about the utilization of family planning in the past six months by age, marital status, and level of education, occupation and religion. The results of the analysis indicate that, young men in the age group 30-39 (38.8%) followed by those in 20-29 age group (33.8%) tended to utilize more family planning methods than those older than them; i.e. of 40-49 (21.3%) and 50+ (6.3%). However, the difference was not statistically significant (p=0.625). These quantitative findings were supported by the findings of the FGD with the selected participants. The quote below was obtained from one of the FGDs.

> ñ*We young men are very reluctant and aggressive when asked to use FP because we marry to get children why then use FP". "Also, FP reduces sexual pleasure". (Masala Kulangwa, Male, 35years, Chato FGD group on 30th Mar 2019).*

Findings from this study reveal that married men who reported to use family planning were (92.5%), but also among those who reported not to have used family planning 92.6% were married compared to those who were single, widowed, separated or cohabiting. However, p value shows that utilization of family planning is not associated with marital status (p-value=0.901).

Further analysis revealed that, a majority of the men who were peasants (55% n 318) utilized more family planning than those with petty business (23.8%), casual labours (6.3%), employed (1.3%) and others with more than one occupation (13.8%). However, the p-value is 0.315 which shows that occupation is not associated with the utilization of family planning. With regard to the education level of the respondents, the results show that a majority of men who utilized family planning had primary (16.3%), and secondary education (32.5%) compared to those with informal education (11.3%). However, the level of education was not statistically associated with FP utilization (p-value =0.272). During KI interview a female respondent aged 38yrs from Chato town commented that:

> *I think some men don't want to participate in FP use because of lack of awareness. They do not know the best methods that can be used and some do not know where they can get such information'' said Mawazomengi, female, 38years, KI respondents on 15th April 201.*

With regard to the religion of the respondents, 83.8% of Christians used family planning methods and 11.3% of Muslims used family planning methods while 5% of those with traditional religions used family planning methods. However, the analysis of the difference among the religions shows that no statistically significant association between religion and FP utilization (p=0.670). In the interview with one of the religious leaders, it was argued that the followers are instructed to observe family planning for them to manage the needs of their children. The quote below serves to illustrate this point.

> *Life has changed, we don't teach our followers to get children they can't manage and end up being street children, Said Daima Mbele, Male, 65years, Religious leader (KI) on 17th April 2019.*

Table 4.3: Distribution of Socio-Demographic factors (Age, Marital Status, Level of Education and Religion) of Respondents and Utilization of Family Planning

characteristics		Did use FP during sex		Total	Significance
		Yes	No		
Age group	19 and bellow	0	3	3	Chi-Square=2.610 p-value=0.625
		0.00%	100.00%	100.00%	
		0.00%	0.80%	0.70%	
	20-29	27	106	133	
		20.30%	79.70%	100.00%	
		33.80%	28.00%	29.00%	
	30-39	31	138	169	
		18.30%	81.70%	100.00%	
		38.80%	36.50%	26.90%	
	40-49	17	96	113	
		15.00%	85.00%	100.00%	
		21.30%	25.40%	24.70%	
	50 +	5	35	40	
		12.50%	87.50%	100.00%	
		6.30%	9.30%	8.70%	
TOTAL		**80**	**378**	**458**	
Marital Status	Not married	1	9	10	Chi - Square=1.057 p-Value =0.901
		10.00%	90.00%	100.00%	
		1.30%	2.40%	2.20%	
	Married	74	350	424	
		17.50%	82.50%	100.00%	
		92.50%	92.60%	92.60%	
	widow	1	2	3	
		33.30%	66.70%	100.00%	
		1.30%	0.50%	0.70%	
	Separated	2	10	12	
		16.70%	83.80%	1000.00 %	
		2.50%	2.60%	2.00%	
	cohabiting	2	7	9	
		22.20%	77.80%	100.00%	
		2.50%	1.90%	2.00%	
Total		**80**	**378**	**458**	
Occupation	peasant	44	249	293	Chi-Square=5.912 p-Value =0.315
		15.00%	85.00%	100.00%	
		55.00%	65.90%	64.00%	
	casuals	5	20	25	
		20.00%	80.00%	100.00%	
		6.30%	5.30%	5.50%	
	Employed	1	1	2	
		50.00%	50.00%	100.00%	
		1.30%	0.30%	0.40%	

characteristics		Did use FP during sex		Total	Significan
	Petty business	19	67	86	
		22.10%	77.90%	100.00%	
		23.80%	17.70%	18.80%	
	More than one occupation	11	41	52	
		21.20%	78.80%	100.00%	
		13.80%	10.80%	11.40%	
Total		**80**	**378**	**458**	
Education level	No formal education	9	45	54	Chi-Square =6.373, P-value 0.272
		16.70%	83.30%	100.00%	
		11.30%	11.90%	11.80%	
	Adult Education	1	7	8	
		12.50%	83.30%	100.00%	
		1.30%	11.90%	11.80%	
	Primary Education	37	219	256	
		14.50%	85.50%	100.00%	
		16.30%	57.90%	55.90%	
	Secondary education	26	89	115	
		22.60%	77.40%	100.00%	
		32.50%	23.50%	25.10%	
	college	7	18	25	
		28.00%	72.20%	100.00%	
		8.80%	4.80%	5.50%	
Total		**80**	**378**	**458**	
Religious	Christianity	67	299	366	Chi-Square =1.1551, P-value 0.670
		18.30%	81.70%	100.00%	
		83.80%	79.10%	79.90%	
	Muslim	9	45	54	
		16.70%	83.30%	100.00%	
		11.30%	11.90%	11.80%	
	Non religion (Traditional)	4	34	38	
		10.50%	89.50%	100.00%	
		5.00%	9.00%	8.30%	
Total		**80**	**378**	**458**	

Key: Statistically Significant Difference Means (p<0.05)

Source: Field Data, 2019

4.3.4 Distribution of Family Planning Methods Utilized by Respondents

Figure 4.2 shows the distribution of the types of family planning methods used by respondents. Among the types of FP methods highly used by respondents in the past six months before the day of interview were condoms (32.5%), followed by natural methods (25%), implants (20%) and injectable (12.5%) respectively.

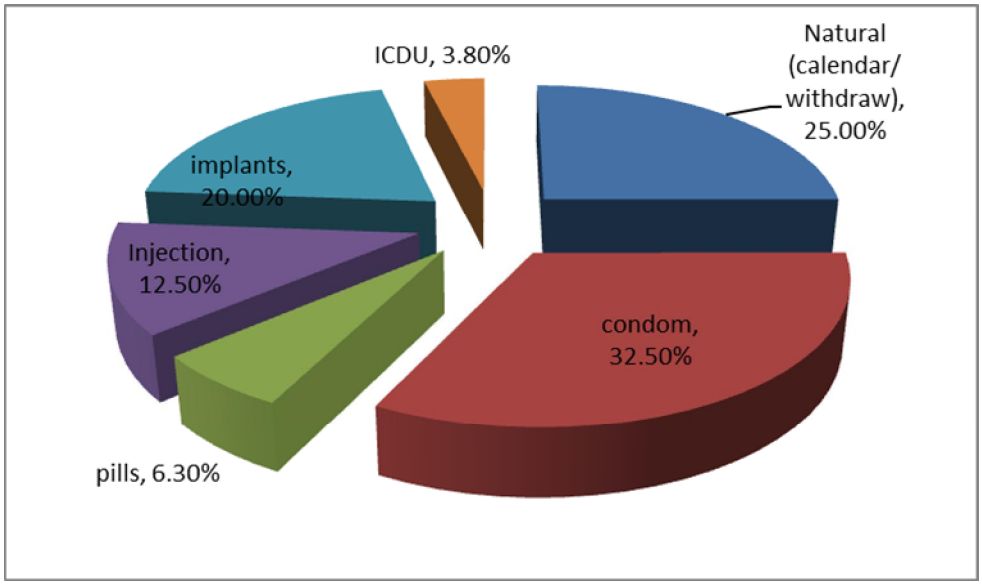

Figure 4.2: Distribution of Family Planning Methods Utilized by Respondents

Source: Field Data, 2019

Similar findings were obtained in the FGDs with the key informants who insisted that condom is the mostly used method and natural family planning methods. The following is one of the quotes from the FGDs with the selected participants.

> *''FP methods frequently used during sex were condoms. Some of us use natural methods, including herbal medicines of unknown names''. (Juakali, Male, 22years, Chato FGD on 30th Mar 2019).*

Another key informant added:

> *"We men we have limited number of family planning methods, but we always get condoms from the nearby shops or find them in lodges. The Government should think of bringing us some condoms at our houses because when we have them in our houses, it is convenient for us to use". Machozi, Male, 43years, (KI) on 17th April 2019.*

The interviews with the health practitioners involved in this study also confirm that condom is the leading family planning method that is mostly practised in Chato District.

> *''We always provide free condoms to our clients at every service delivery point free of charge and they are always available as compared to pills and injections. Condoms are available everywhere with less concern on their storage or technical know-how''. DRCHCo (KI) on 7th Apr 2019.*

The results in Table 4.4 shows that young men in the age groups of 20-29 and 30-39 had made use of condom more than the older men at 34.6% and 38.5% respectively. The percentage of utilization decreased with the age of the participant. There is higher utilization of condom among the married men (88.5% n 445) compared to the remaining groups. The results also show that Christians utilized condoms with highest percentage of 92.5 compared to Muslims and non-religious (Traditional) with 3.8% each.

Table 4.4: Distribution of Family Planning Utilization by Age, Marital Status and Religion

characteristic		**FP method use during sex**						
		Natural (calendar/ withdraw)	**condom**	**pills**	**Injection**	**implants**	**ICDU**	**Total**
Age group	20-29	6	9	1	2	8	0	26
		23.10%	34.60%	3.80%	7.70%	30.80%	0.00%	100.00%
		30.00%	34.60%	20.00%	20.00%	50.00%	0.00%	32.50%
	30-39	8	10	2	5	5	3	33
		24.20%	30.30%	6.10%	15.20%	15.20%	9.10%	100.00%
		40.00%	38.50%	40.00%	50.00%	31.30%	100.00 %	41.30%
	40-49	5	4	2	3	3	0	17
		29.40%	23.50%	11.80%	17.60%	17.60%	0.00%	100.00%
		25.00%	15.40%	%	30.00%	18.80%	0.00%	21.30%
	50+	1	3	0	0	0	0	4
		25.00%	75.00%	0.00%	0.00%	0.00%	0.00%	100.00%
		5.00%	11.50%	0.00%	0.00%	0.00%	0.00%	5.00%
Total		**20**	**26**	**5**	**10**	**16**	**3**	**80**
		25.00%	**32.50%**	**6.30%**	**12.50%**	**20.00%**	**3.80%**	**100.00%**
		100.0%	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Marital status	Not married	0	1	0	0	0	0	1
		0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	100.00%
		0.00%	3.80%	0.00%	0.00%	0.00%	0.00%	1.30%
	Married	20	23	5	9	15	3	75
		26.70%	30.70%	6.70%	12.00%	20.00%	4.00%	100.00%
		100.00%	88.50%	100.00%	90.00%	93.80%	100.00 %	93.80%
	Widowed	0	1	0	0	0	0	1
		0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	100.00%
		0.00%	3.80%	0.00%	0.00%	0.00%	0.00%	1.30%
		0	0	0	1	0	0	1

characteristic		FP method use during sex						
		Natural (calendar/ withdraw)	**condom**	**pills**	**Injection**	**implants**	**ICDU**	**Total**
	Separated	0.00%	0.00%	0.00%	100.00 %	0.00%	0.00%	100.00%
		0.00%	0.00%	0.00%	10.00%	0.00%	0.00%	1.30%
	Cohabiting	0	1	0	0	1	0	2
		0.00%	50.00%	0.00%	0.00%	50.00%	0.00%	100.00%
		0.00%	3.80%	0.00%	0.00%	6.30%	0.00%	2.50%
Total		**20**	**26**	**5**	**10**	**16**	**3**	**80**
		25.00%	**32.50%**	**6.30%**	**12.50%**	**20.00%**	**3.80%**	**100.00%**
		100.00%	**100.00%**	**100.00%**	**100.00 %**	**100.00%**	**100.00 %**	**100.00%**
Religion	Christian	15	24	5	7	15	2	68
		22.10%	35.30%	7.40%	10.30%	22.10%	2.90%	100.00%
		75.00%	92.30%	100.00%	70.00%	93.80%	66.70%	85.00%
	Muslim	3	1	0	3	0	0	7
		42.90%	14.30%	0.00%	42.90%	0.00%	0.00%	100.00%
		15.00%	3.80%	0.00%	30.00%	0.00%	0.00%	8.00%
	No religion	2	1	0	0	1	1	5
		40.00%	20.00%	0.00%	0.00%	20.00%	20.00%	100.00%
		10.00%	3.80%	0.00%	0.00%	6.30%	33.30%	6.30%
Total		**20**	**26**	**5**	**10**	**16**	**3**	**80**
		25.00%	**32.50%**	**6.30%**	**12.50%**	**20.00%**	**3.80%**	**100.00%**
		100.00%	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Source: Field Data, 2019

4.4. Distribution of Cultural Factors on Utilization of Family Planning

This study also examined the factors that might be associated with family planning utilization at a bivariate level of analysis, using the chi-square test. The analysis was made on the selected behaviors which yielded the results shown in Table 4.5. Men with more than one child frequently used family planning methods (85.7%) than those with one children (14.3%), p=0.036. Therefore, having many children is associated with utilization of family planning. Similar findings were obtained in the FGD with the participants. A close interpretation of the response also reveals that the instructions by religious leaders also contribute to this observation to ensure that parents have several children they can manage to take care. The following quote was

taken in one of the FGDs:

> *"Once you reach the desired number of children it is better to use FP otherwise you will not be able to support them". Mapinduzi, male, 39years, Bwina FGD on 1st April 2019.*

Another respondent from FGD also commented that;

> *"Most people prefer a small family of 4-5 because it is easy to take care of them especially now, but in the past people were after large families of 10-12 or until all the women eggs (ovum) finishes. This was done with the expectation that every child comes with own blessings to family". Imalamawazo, male, 26years, Chato FGD on 30th Mar 2019.*

The results reveals that, the spouse who talked to their partners about family planning had used family planning more (87.5%) than those who did not discuss with partners (12.5%) with p ' 0.001. Therefore, discussion among couples or partners is statistically significant associated with utilization of family planning.

The respondents reported that the use of contraceptives is very low because men do not want to hear about it and, sometimes, women use them in the absence of their spousesô awareness. If men were to discuss about FP use with their spouses, things could be different. The following quotes from FGDs were taken to reinforce this observation.

> *"Health care providers really want to help us to cope with the challenges of using FP. They also counsel on FP methods and how they work, but it would have been better if we were to be supported with our spouses because the counseling directly benefits only one partner in the relationship". Susu, female, 42years, (FGD) Chato on 30th March 2019.*

Respondents also pleaded on the importance of male involvement when it comes to issues concerning family planning as commented by this respondent;

> *''Some of our spouses want to have sex without considering FP since some of them don't visit with us in the FP clinics. They don't discuss with us when we share the benefits of using FP methods. Sometimes, it is difficult to use the*

> *PF methods in secret. It is not difficult to use the methods if we all visit the clinics and get trained on FP methods''. Pawawa, female, 32years, Chato FGD on 30th Mar 2019.*

According to the results, respondents who discussed about family planning services with other people apart from spouse or partner had used more family planning (77.5%) than respondents who did not discuss with others about family planning (22.5%) p ' 0.001. Therefore, the tendency to discuss about family planning with others apart from partners is significantly associated with utilization of family planning.

Men were also asked to say who should decide on getting another child in the family. The analysis of their responses show that 68.8% of respondents said both men and women, while men only were 30% and women only 1.2% (p ' 0.313). However, the difference was not statistically significant. Also, men who approved their partners use of family planning had used family planning more (92.5%) than those who did not approve their partners use of family planning (7.5%) with p-value ' 0.001. Therefore, approval of men on partners is significantly associated with family planning.

Similar findings were obtained from the discussions with some men showed a great concern of women using contraceptives without the permission of their spouse as commented by this respondent:

> *Most men do not approve the use of FP because they think that, when a women use FP, it is for extramarital purposes. A woman who uses FP methods can easily cheat on her husband since she cannot get pregnant, said Kasanda, female, 25years, Buzirayombo FGD on 9th Apr 2019.*

Gender violence was also reported when it comes to the use of FP without menôs approval. The following quote is taken from one of the interviewed respondents who emphasized on the existence of violence in some families were men become aggressive when their wives use FP without their consent.

> *ô'Some men do fight their wives (it is a very common practice), it occurs especially among the women who do not follow what their husbands are advising them…this is a very common practiceõõ. Igoko, male,39 years, Chato FGD on 30th Mar 2019.*

Some thinking, like the societyôs approval to utilize family planning (p=0.173), having many children is security at old age (p=0.70) and having many children increases manpower in the family (0.119) were found to be not associated with utilization of family planning.

Table 4.5: Utilization of Family Planning Methods by Cultural Factors

Characteristic		**Did Use FP during sex**		**significance**
		Yes	**No**	
Number of Children	one	11	62	Pearson Chi-Square=10.248 P-value=0.036
		13.7%	16.80%	
	More than 1	69	307	
		86.30%	83.20%	
Total		**80**	**369**	
Spouse talk about FP use	yes	70	212	Pearson Chi-Square =26.830, P-value <0.001
		87.50%	56.50%	
	No	10	163	
		12.50%	43.50%	
Total		**80**	**375**	
Have you ever talked to anybody else apart from your wife about FP	Yes	62	193	Pearson Chi-Square =18.707, P-value <0.001
		77.50%	51.10%	
	No	18	185	
		22.50%	48.90%	
		80	**378**	
Who should decide to get another child	Men only	24	124	Pearson Chi-Square =3.563, P- value 0.313
		30.00%	32.80%	
	Mother only	1	17	
		1.30%	4.50%	
	Both mother &women	55	232	
		68.80%	61.40%	
	other	0	5	
		0.00%	1.30%	
		80	**378**	
	Yes	74	242	Pearson Chi-

Characteristic		Did Use FP during sex		significance
Approve use of FP spouse		92.50%	64.20%	Square =24.791, P-value 0.001
	No	6	135	
		7.50%	35.80%	
In your tribe is FP use allowed?		**80**	**377**	Pearson Chi-Square =3.505, P- value 0.173
	yes	55	220	
		68.80%	58.50%	
	No	20	135	
		25.00%	35.90%	
	Donât know	5	21	
		6.30%	5.60%	
		80	**376**	
Having many children is security at old age	yes	27	179	Pearson Chi-Square =5.305, P- value 0.70
		33.80%	47.90%	
	No	47	172	
		58.80%	46.00%	
	Donât know	6	23	
		7.50%	6.10%	
		80	**374**	
Having many children increases the working force	Yes	19	135	Pearson Chi-Square =4.255, P-value=0.119
		23.80%	35.70%	
	No	58	230	
		72.50%	60.80%	
	Donât know	3	13	
		3.80%	3.40%	
		80	**378**	
Men prefer male child for inheritance	yes	17	123	Pearson Chi-Square =4.767, P- value =0.92
		21.30%	32.50%	
	no	59	230	
		73.80%	60.80%	
	Donât know	4	25	
		5.00%	6.60%	
		80	**378**	
Having many children improves status of males	Yes	12	118	Pearson Chi-Square =8.646, P- value=0.13
		15.00%	31.20%	
	No	66	254	
		82.50%	67.20%	
	Donât know	2	6	
		2.50%	1.60%	
		80	**378**	

Key: Statistically significant difference means (p’ 0.05)
Source: Field Data, 2019

4.5 Services Related Factors and the Utilization of Family Planning

The Analysis of the service provision related factors yielded the following results as shown presented = in Table 4.6. The respondents who knew more than one methods of family planning had 96.3% users during sex in the past six months and 3.7% non-users (p=0.950). However, the difference was not significantly associated with

utilization of FP methods. The results shows that, men who knew any family planning facility had used more (96.3%) family planning methods than those who didnâ t know (3.8%) and the difference was found to be statistically significant (p=0.008).

Respondents who resided within 2 km from family planning facilities (clinic) had used more family planning methods (78.5%) than those who are more than 2 km (19.4%) p=0.036. Therefore, distance to the FP facilities is associated significantly with utilization of family planning. The analysis of men who have had ever visited family planning clinic reveals that, 68.4% had used family planning methods more than those who have never visited (32.6%), p ' 0.001. Therefore, visiting a family planning facility is associated with utilization of family planning.

Furthermore, results show that, men or their partners who experienced any side effects after the use of family planning methods had less a low utilization of family planning methods (37.6%) than those who did not experienced side effects (62.4%) p=0.002. The difference was statistically significant. Side effects concerns were also observed during FGD and KI interview as commented by respondents as follows:

> *"I have used FP for the past five years and I was told which problems to expect and those problems of FP people talk about are just rumors and tend to discourage others, and I think they usually come if you have additional sickness, as for me I have no problem with FP and even if I were to get a problem I would go back and get treatment as I was told". Masangu, female, 32, Bwina FGD on 1st Apr 2019.*

The occurrence of side effects was also associated with scarcity of skilled human resource for health as commented by one of the respondents that:

> *"There is a shortage of trained FP health care providers. The few available*

often overworked because they also perform several other activities which has also affected the quality of FP services they provide, and contributed to low client satisfaction". "Also, we have few Doctors and equipment to provide long term methods to our clients". DRCHCo (KI) on 7th Apr 2019.

However, the results also shows that, missing family planning methods when visited family planning services providers did not affect the utilization of family planning (p=0.547).

Table 4.6: Service-Related Factors on Utilization of Family Planning

Characteristic		**Did use FP during sex**		**Total**	**Significance**
Family planning methods known	Pills	1	5	6	Chi-square =0.350, P-value =0.950
		16.70%	83.30%	100.00%	
		1.30%	1.50%	1.50%	
	Injection	1	3	4	
		25.00%	75.00%	100.00%	
		1.30%	0.90%	1.00%	
	Implants	1	1	2	
		50.00%	50.00%	100.00%	
		1.30%	0.30%	0.50%	
	More than one	77	319	396	
		19.40%	80.60%	100.00%	
		96.30%	97.30%	97.30%	
	Total	80	328	408	
		19.40%	80.60%	100.00%	
Knowing any FP facility (clinic)		100.00%	100.00%	100.00%	Chi-square =7.031 P-value= 0.008
	Yes	77	321	398	
		19.30%	80.70%	100.00%	
		96.30%	85.40%	87.30%	
	No	3	55	58	
		5.20%	94.80%	100.00%	
		3.80%	14.60%	12.70%	
	Total	80	376	456	
		17.50%	82.50%	100.00%	
		100.00%	100.00%	100.00%	
Distance from family planning facility (clinic)	Below 2km	62	217	279	Chi-square =6.655 P-value= 0.036
		22.20%	77.80%	100.00%	
		78.50%	64.80%	67.40%	
	2-5 km	11	93	104	
		10.60%	89.40%	100.00%	
		13.90%	27.80%	25.10%	
	6 km or more	7	25	32	
		19.40%	80.60%	100.00%	
		8.80%	7.50%	7.70%	
	Total	80	335	415	
		19.30%	80.70%	100.00%	
		100.00%	100.00%	100.00%	
Ever visited FP	Yes	54	88	142	Chi-square =61.441
		33.00%	62.00%	100.00%	

Characteristic		Did use FP during sex		Total	Significance
clinic in the past six months		68.40%	23.40%	31.20%	P-value= 0.001
	No	26	288	314	
		8.30%	91.70%	100.00%	
		32.50%	76.60%	68.90%	
		80	376	456	
		17.50%	82.50%	100.00%	
		100.00%	100.00%	100.00%	
Side effect after FP use	Yes	35	58	93	Chi-square =12.419 P-value= 0.002
		37.60%	62.40%	100.00%	
		50.00%	29.30%	34.70%	
	No	35	140	175	
		20.00%	80.00%	100.00%	
		50.00%	61.10%	57.80%	
	Total	70	198	268	
Miss FP methods when you visited family planning service provider	Yes	4	10	14	Chi-square =0.362 P-value= 0.547
		28.60%	71.40%	100.00%	
		5.60%	4.00%	4.30%	
	No	67	241	308	
		21.80%	78.20%	100.00%	
		94.40%	96.00%	95.70%	
	Total	71	251	322	
		22.00%	78.00%	100.00%	
		100.00%	100.00%	100.00%	

Key: Statistically significant difference means (p<0.05)
Source: Field Data, 2019

4.6 Multivariable Analysis

In an the attempt to explore further potential modifying variables accounting for variation in outcome in the data set, multivariable analysis was conducted. The variables included in the final logistic regression were, the number of children, knowledge of FP facility, distance to FP facility, discussions between partners, discussions with others apart from partner, menôs approval on use of FP and Side effects after of FP methods. These variables showed that there is a significant association at bivariate analysis. The logistic regression models that best predicts use of FP from the various predictors considered has p-value <0.05.

Table 4.8 shows that, only three of the independent variables made a unique statistically significant contribution to the model, which includes distance to family

planning facility, menôs approval on use of family planning and the side effects after FP utilization. In the model the factors entered were those found to be significantly associated with utilization of family planning methods. The effect of each factor on the dependent variable (utilization of family planning during sex) was indicated by the odds ratio for each variable relative to the reference category.

The strongest contributing factor in this model of reporting utilization of family planning methods was menôs approval on the use of family planning methods with the odds ratio of 4.221. This means that the respondents who approved the use of family planning methods use were four times (OR =4.221, 95%CI =1.147-15.539) more likely to use family planning methods than those who disapproved it controlling for all other factors in the model. Similar findings were obtained in the interviews with the key respondents used in the study like this one;

> *"Most men do not accept use of family planning though women are willing to do so. Men disallow contraceptives because they are worried that their wives will have sexual relationship with other men, which is not true", Kalunde, female, 30years, Chato FGD on 30th Mar 2019.*

However, some men showed their concerns about the behavior of women once using FP methods as commented by this respondent: One of the interviewed key informant openly declared his resistance to FP methods with the argument, ñIf a woman stays longer without conceiving causes a woman to misbehave,ò said Mahindi, male, 29years, (KI) on 17th Apr 2019.

Distance to family planning services provider was also positively related to the utilization of family planning methods with the odds ratio of approximately 0.3. This indicates that those who are very close to family planning services providers were

approximately 2 times more likely to utilize family planning methods (OR=1.949, 95% CI=1.069-3.555) than those who are very far from family planning services providers, controlling for all other factors in the model. The FGD with selected respondents also substantiates this finding. The quote bellow serves to illustrate the point.

> *''FP services do not reach us in the villages. It is difficult to visit FP clinic frequently because it is located in a distant area''. Ng'wanakilala, female, 47years, Muganza FGD on 18th Apr 2019.*

The side effects from using some FP methods is positively related to non-utilization of family planning methods with odds ratio of 1.888 (95%CI =1.067-3.341). This means that the respondents who experienced side effects were approximately 2 times more likely to report non-utilization of family planning methods, controlling for all other factors in the model.

One of the interviewed women emphasized the following with regard to the side effects of the contraceptive pills.

> *''I missed my periods and I decided to stop FP injection because I was told that, if you continue missing my periods at a long time, it will be very difficult to conceive. I resumed FP methods after I explained my problem to my counselor and she told me that was a misinformation. She explained to me that it was an expected effect of the FP injection and it has nothing to do with fertility''. Ng'wanamaria, female, 34 years, Buzirayombo FGD on 9th Apr 2019.*

Another respondent added:

> *''These medicines are not good for us; they should be changed since there is a risk of getting obstetric cancer and some women get abnormal children". Ibobogelo, female, Buzirayombo FGD on 9th Apr 2019.*

Table 4.8: Logistic Regression Predicting Likelihood of Utilization of Family Planning Methods by Men

Characteristic	P-value	Exp(B)=OR	95% C.I.for EXP(B)	
			Lower	Upper
Number of Children	.423	1.091	.882	1.350
Knowing FP facility (clinic)	.388	.422	.060	2.994
Distance FP facility (clinic)	.030	1.949	1.069	3.555
Menôs discuss with spouse on FP	.108	2.188	.843	5.679
Menôs discussed with others on FP	.176	1.527	.827	2.821
Menôs Approve Spouse use of FP	.030	4.221	1.147	15.539
Side effects after FP use	.029	1.888	1.067	3.341

Key: Statistically significant difference means (p’ 0.05)
Source: Field Data, 2019

During focus group discussions for with the groups of both men and women, and the interviews with the key informants, there was were a mixed opinions on how to promote FP utilization among men and women. Some of the comments given by respondents were:

> *‘’Most men don’t know the benefits of using FP. Health education should be given priority for men because some of them once they discover a woman is using FP they start relationships with other women’’. Ng’wanaCharles, female 31years, Chato FGD on 30th Mar 2019.*

Another respondent added:

> *‘’Men say they don’t get pregnant why should it be their business to know about FP. Health education on FP services should be given priority to men”. Masangu, female, 28years, Health worker, (KI) on 17th Apr 2019.*

From Focused Group Discussion, five sub-themes were identified as the factors influencing menôs involvement in family planning utilization: (i) perceived side effects of female contraceptive methods which disrupt sexual activity, (ii) limited availability of family planning service delivery points, (iii) perceptions that family planning utilization was a womanôs business because they are the ones who get pregnant, (iv) preference for large family sizes which are uninhibited by prolonged

birth spacing; and (v) concerns that womenôs use of contraceptives will lead to promiscuity. Generally, knowledge of effective contraceptive methods was high. However, lack of time and the overall limited awareness regarding the specific role of men in reproductive health was also thought to deter menôs meaningful involvement in issues related to Family Planning.

4.7 Chapter Summary

The proportion of men who reported using family planning methods during the act of sexual intercourse in the past six months was found to be very low at 17.5%. For demographic characteristics, a large majority of respondents were young generation, married with one wife and having more than one child. Also, majority of respondents were peasants with at least primary education or more and practicing Christianity. All demographic characteristics had no significant association with FP utilization.

It was also found that despite low FP utilization, among the FP methods used condoms were highly used. Cultural factor which was found to be influencing FP use was menôs approval to contraception use. It was also found that, among the service-related factors, distance to FP services and side effects had influenced FP utilization. From Focused Group Discussions, five factors influencing menôs involvement to FP utilization was identified which includes; perceived side effects of female contraceptive methods, limited availability of family planning service delivery points, perceptions that family planning utilization was a womanôs business, preference for large family sizes which are uninhibited by prolonged birth spacing; and concerns that womenôs utilization of FP will lead to promiscuity.

CHAPTER FIVE

DISCUSSIONS

5.1 Overview

The objective of this study was to investigate the proportion of men utilizing family planning and the factors influencing male involvement in utilization of family planning. Therefore, in this chapter there are discussions on the current status of utilization of family planning methods, distribution of demographic factors of respondents, effects of demographic factors on utilization of family planning services, cultural influence and effects of service-related factors on utilization of family planning.

5.2 Current level of Utilization of Family Planning for all Methods

The level of utilization of family planning methods is one of the indicators which can be used to track the success of family planning activities. To get this information, men were asked if they utilized FP during sexual act in the past six months. In this study, the proportion of men utilizing family planning services was found to be 17.5%. This can also be referred to level of male involvement where respondents used or directly participated in the use of family planning. This implies that malesô involvement in the utilization of family planning services is still low. Therefore, there is a need of interventions to avoid unwanted pregnancies and increased maternal deaths due to abortions and complications of pregnancy.

Low male involvement was also found in a study done in Northwest Ethiopia where the proportion of men using or directly participating in the use of family planning

services was only 8.4% (Kassa *et al*., 2014). These results are also similar to a study done in the Democratic Republic of Congo which stands at 17% as reported by Kerry *et al*., (2015). However, results on male utilization of FP varies from place to place as seen from a study done in Moshi Rural District which was found to be at 47% as reported by Chuwa (2001) and Kassimu (2008) who reported 52.9% utilization of family planning by men in Kisarawe District, Tanzania. One possible reason for the difference is substantial variation of utilization of family planning services across the country by residence, region, and social economic factors (Mtae, 2015). Another possible reason for the differences could be the difference in the populations and difference in sample size.

Family planning service should be intensified in the whole nation as researches has demonstrated that FP can prevent up to one in every three maternal deaths by allowing women to avoid high risk pregnancies and abortions of unintended (DHIS, 2010). Unintended pregnancy is a concern to public health as it can lead to adverse social and health problems which includes fatal complications of pregnancy or likelihood of unsafe abortions (Yazdkhasti *et al*., 2015).

The findings reflect the current situation of male participation on family planning uptake and highlights the current efforts by the Governments through family planning programs which aims at scaling up contraceptive uptake. Great efforts are needed to achieve a significant reduction in maternal and infant mortality and their associated costs by investment in health care infrastructures and provision of quality services to improve quality and access of FP services to all.

5.3 Demographic Factors of Respondents

5.3.1 Distribution of Respondents' Demographic Factors

The mean age of respondents was 36 (SD of ± 10.018), and the a large majority of men of the study population were young generation aged between 20-29 and 30-39 years. This means Chato District is mostly occupied by young generation of men. This finding points out the need to develop effective strategies to educate young men in Chato District about reproductive health and FP, and also to improve their access to family-planning information and services, thus reducing the risk of unwanted pregnancies. At this age most men have just entered the stage of puberty or still have ability to sire more children unless they use various measures to control their fertility (Mtae, 2015).

For developing countries where men delay to marry at late ages with the purpose to achieve financial stability before marriage, there is increased risk of unsafe sexual activity practices if they are not provided with accurate information and appropriate FP services (DHIS, 2016). A lack of the necessary reproductive health information or services during this period will be obstacle of Family planning utilization (Blanc *et al*. 2009). Since family planning needs varies vary across different age groups, these findings highlight the need for family planning programs to cater services and messages toward specific age groups (Prata, 2016).

Marriage only takes place in such an instance when a love relationship exists between two different people. In this study, most of men were married (89.7%) meaning that, a large majority of the study population were aware of sexual practices. Marriage predispose couples to the risk of pregnancy hence the need to

control fertility (Mtae, 2015). FP gives married men and women an opportunity to avoid unwanted pregnancies, choose the number and spacing of their children and enjoy sexual intimacy which could lead to marital satisfaction. A study done in Zimbabwe on utilization of FP and marital status shows that, FP methods use (both traditional and modern) differs by their marital status (Adetunji, 2000).

These results suggest that, family planning services strategies should be taken as a whole by ensuring equitable access to family planning among all marital groups, (Kerry *et al*., 2015). Providing FP services in all walks of life, especially for married people, will encourage people with unfavourable perception the more (Adesola, 2014). Therefore, married people should have access to safe and voluntary family planning counselling and services which could expose them to importance of family planning.

Men who had children were 95.8% and 83.3% were reported having two or more children. Having children also should be considered as a factor influencing family planning due to different unmet needs between those without children and those with children (Kassa *et al*., 2014). A report by UN, (2004) revealed that more men than women have a desire for more children hence the low use of contraception among men is partly a well-reasoned decision, and not only a consequence of limited knowledge. The desire for children is one of the main reasons why most men and women get married and that's that is why sometimes, if a wife does not bear children, a man brings the second wife in search of children making FP use a problem if men are not well involved in FP services interventions.

Again, 86.2% of respondents had only one wife which indicate that, majority of Chato District men practice monogamous type of marriage. The need for FP use is different from polygamous community whose expectations is a high number of children (UN, 2004). The results for polygamous versus monogamous men suggest the nature of demand of family planning services activities in areas where polygamy is prevalent.

Most men were Christians (80%), however, this is because a large majority of men in Chato District are Christians. Still there are debates as to whether differences in fertility behavior are due primarily to religious processes or the interplay of socio-economic forces (Takyi et al., 2006), cultural influences (Mtae, 2018) and/or services related factors (Kassim, 2008). However, understanding these differences will help in providing more culturally competent delivery of care by health care providers (Pinter, 2016).

A majority men who responded were peasants, followed by those with petty business, casual labour and employed respectively. As for the education level, it is only a small minority of men who had no formal education (11.9% n=59). The rest were educated at least from primary level (55.5%), secondary level (24.4%) and college education (5.4%). FP utilization is associated with the economic activities of individuals as well as their level of education. These results help to understand the unmet need and the preferred choice of contraceptives (Mpuga, 2011). It is also observed that a majority of women with gainful occupation are more likely to utilize FP than those with no gainful occupation (TDHS, 2010).

5.3.2 Distribution of Demographic Factors on Utilization of Family Planning

The results of the current study indicate that, despite the differences in proportions among demographic characteristics, there was no relationship between demographic factors and the utilization of family planning services. This fact is contrary to the findings established by several studies which support strong association between family planning utilization and demographic factors;

A report by the USAID (2016), on population statistics in developing countries, shows that young men tend to utilize more family planning than other age groups. This is probably because, at this age, they are more sexually active. The findings are also contrary to those obtained in a study done in Northern Nigeria which revealed that FP utilization is more prevalent among the individuals in the middle age categories while older people are not inclined to the use of FP due to the lack of desire to do so (Mustafa et al., 2006). This was also featured during FGD that young men are stubborn and aggressive when it comes to FP use. Older men were concerned with having many children as the cost to raise children is not easy for them. Another study done in Luanda, Angola also reveals that FP is higher in use at the old age because most old people have attained the required number of children (Prata, 2016).

The results are also contrary to studies which reported that married men were the high users of family planning methods than those who were single, widowed, separated, or cohabiting as shown by a study done in USA by Kerry et al. (2015) which explains that never-married men usually have the highest contraceptive prevalence and currently married men have the lowest. Marital status has been found

to influence the use of family planning methods because both married women and men regard family planning methods to prevent pregnancy is associated with being unfaithful or promiscuity (Raine et al., 2010), which is contrary to the findings of this study. The fact that occupation is not associated with FP utilization is contrary to a study done by Ling, (2017) which found that family planning use was associated with occupation. Those with higher socio-economic class tended to use more FP methods than those with low socio-economic class.

This study revealed that education level of the people in Chato is not a factor that influences the use of FP. This is contrary to studies which came up with the conclusion that the level of education plays a very important role (Palamuleni, 2000; Agadjanian, 2015; Mekonnen & Worku, 2011). For example, Palamuleni (2000) conducted the study in Malawi that came up with an explanation that there is a positive relation between contraceptive use and the level of education, and mostly important being husbandsô education. The results are contrary to the findings of a study that was done in Mozambique which came up with a significant association between the level of education and FP utilization (Agadjanian, 2015). The study by Mekonnen and Worku (2011) also reported that the level of education influences FP utilization unlike results presented in this thesis.

This study also revealed that religion is not associates with FP utilization, meaning that malesô utilization of FP in Chato is not influenced by religious affiliation. Elsewhere, religion is seen influential to FP practices, especially the Catholicism and Islamic which are widely regarded as pro-natalist in their ideology (Palamuleni, 2013). Religion being not associated with family planning use is also contrary to a

study done in the US which revealed that there is a high religious attendance which is associated with less support on its provision (Barrett et al. 2014). However, there are some debates on whether differences in fertility behavior are primarily due to religious processes or the interplay of socio-economic forces (Takyi et al., 2006). Men during FGD clearly stated that life is so tough that everybody needs to control birth according to his capacity to serve well the family. This idea was also supported by religious leaders who revealed that religion does not instruct people to have many children who end up being street children; therefore, birth control is inevitable regardless of the belief.

The results of the current study indicate that, despite the differences in proportions among demographic characteristics, there was no relationship between demographic factors and the utilization of family planning services. This is a new knowledge developed from this study in Chato which could help to change the policy or strategies towards improving male involvement in utilization of Family planning.

5.3.3 Frequently Used Family Planning Methods

This study revealed that there is higher use of condoms (32.5%) than other methods and mostly among the young men in the age groups 20-29 (34.6%) and 30-39 (38.5%) had utilized condom more than older men at 5%. These findings compared to the results obtained in 2010 which came up with a conclusion that high use of condoms among young Tanzanians is probably due to the dual functions of the condom especially to protect a person from STIs despite its usefulness in family planning (TDHS, 2010).

There is higher utilization of condom among married men (88.5%) compared to other groups. In FGD men said, apart from family planning purposes, they often use condom for prevention of STIs, especially HIV and this is why condoms are highly used. A study done in Iraq on the use of condom suggested that the use of condom among the married men is for extramarital sexual relationship (Ismael *et al*., 2012). The results also show that Christians utilized condoms with highest percentage compared to other religious and those with no religion. This shows that there is changes happening in societies with regard to FP utilization and taking precaution against STIs, contrary to studies which suggest strong effect of religion on FP utilization (Takyi *et al*., 2006 & Barrett *et al*. 2014).

5.4. Factors Associated with Family Planning Utilization

5.4.1 Number of Children and Family Planning Utilization

The association between number of children and FP utilization was not statistically significant at multivariable analysis [p=0.42], but it was still positive [OR=1.09], meaning that of those who reported the influence of FP more than 80% were likely to use FP methods. The positive effect shown above means that, number of children of family size affect the choice to utilize or not to utilize FP. This means that, men in Chato has attitude towards many children. The findings are similar to a study done in the United States of America which shows that number of children has the influence on utilization family planning methods and choice of the methods to use is changed over time as the family size increases (Sedgh, 2007).

During Focused Group Discussions, men in Chato argued that, due to the nature of their socio-economical activities, they cannot have a few children. They need

children to support them in fishing, cultivation and livestock keeping. This tendency to have many children as a working force is seen to affect FP utilization in the area. Also, men had the belief that clan-ship is sustainably maintained when there are many children in a family and the fact that life is very short require them to quickly have many children to leave in the world before they die.

Women acknowledged the demand of many children from men but also expressed their grievances as men demand many children but at the end they run away once the burden of taking care of many children becomes heavy. Sometimes, if a woman uses FP in secret, men tend to go with other women to achieve their desires. In this situation, women remain with no choice unless men change their attitude. The families with limited number of children have more resources for each child and more can be accumulated for the parents to dedicate to each child.

The effect of number of children on FP utilization is quite important in correction of myths and misconceptions related to FP utilization which include that having many children is security at old age, many children increases the working force at family level and many children improves the status of males as was often reflected in the feedback from FGDs and KIs. Creating awareness of the various FP options for men to make their preferred choices of FP methods, and in addressing other FP related factors is very crucial as evidence suggests that women who have more than 4 children are at an increased risk of maternal mortality (WHO, 2018).

5.4.2 The Approval of Men and Family Planning Utilization

The association of approval of men and FP utilization was statistically significant at multivariable analysis where the approval of men was 4 times more likely to be

associated with FP use [OR=4.22, p<0.05]. These findings compared with to those of the study among women by Rob *et al*. (2007) that showed that partnerôs approval was more likely to be associated with utilization of FP in six countries that included Kenya, Malawi, Tanzania, Ivory Cost, Burkina Faso, and Ghana. For instance, partnerôs approval was 4 times more likely to be associated with FP utilization in Malawi [OR =3.59: 95% CI 2.93-4.39] and in Kenya [OR =3.49: 95% CI 2.73-4.46]. This is because most men who approve FP use with partner reported to utilize FP more than those who did not approve.

Traditionally men decide on FP utilization and the number of children as well as how to use what is produced by the family. This association is consistent with a study conducted in Nigeria which revealed that men were the reason that affect their wives to use family planning methods (Mairiga et al., 2010). Women acknowledged the reluctance of their husbands to utilizing FP due to ignorance, men believe that using FP makes a woman unfaithful, and if a woman uses FP without the husbandôs approve conflict in family happen.

Some women are fought by their husband in the societies around Chato when found using FP without the approval of their husbands. A study done in Ghana by Do and Kurimoto (2012), revealed that husbandôs disapproval of using FP was a common reason for the married women in Ghana not to use contraceptives in the fear that they would lose their husbandsô affection. Also, Mtae (2015), in Mvomelo Morogoro found that, many women use contraceptives covertly because their husbands object the use of FP and most of the time men are not ready to discuss.

Wolff, *et al.* (2000) in their study showed that partner opposition was found to account for as much as 20 percent of unmet need reported by women. It has been reported that most of African societies are largely patriarchal, Tanzania inclusive. In such societies, women face challenges such as partner opposition in making fertility preferences (Mtae, 2018). Kessy (2007) also shows that women utilization of family planning services in secret exposed them to emotional or physical violence in cases where they are discovered by their husbands. In fact, many men feel that it is menôs responsibility to allow women to use family planning methods, due to the fact that in many African societies men are decisionï makers in reproductive matters and women just follow without questioning what men tell them to do or not to do (Amrad, 2014). For this reason, it is important to involve men in family planning services as a way to prevent women who use family planning methods from domestic violence.

Although menôs approval had positive effects on the use of FP methods, FGD and KI revealed that some men disapproved FP utilization because it reduces sexual pleasure. Men revealed that using condom during sex is not pleasant. Further to this, other methods used by women make them sick and make sex unpleasant. For example, heavy bleeding after FP use affects frequent intercourse. This myth and misinformation makes men and women unable to use FP. This could be due to FP programs traditionally have focused on women as the primary beneficiaries and men have been considered as the silent partners of the services; hence, they remain ignorant when it comes to reproductive health which includes FP utilization (Hossain *et al.*, 2012). Tanzania Family Planning Research Agenda 2013-2020 also revealed that men need to be educated to understand the benefits of FP and approve its

utilization for the healthier family especially in Tanzania where the societies are largely patriarchal (male dominance), women face challenges such as partner opposition in making fertility related decisions (MoHCDGE, 2013).

5.4.3 Discussion between Partners (Spouse) and Family Planning Utilization

Although there were statistical insignificant association between discussion between men and partner with Family planning utilization, the odds remained positive and greater than 1 (OR=2.18). This means that there is positive association despite weak in its strength. This positiveness is true because Family planning is when both the husband and wife together discuss and mutually decide how many children they would like to have and when to have them. They can give sufficient love, care, attention and good education to each of their children (USAID, 2018). The results are similar to those reported by Kaida et al. (2005) that men who discus with women about family planning are predisposed towards the use of family planning services.

Another study done in Yorubas Nigeria also support the fact that discussion between men and partner has a significant role to play in the adoption of Family planning utilization (Ogunjuyigbe et al., 2009). Most women are still unable to discuss with their spouse on issues related to reproductive matters as shown by a study conducted in Morogoro Municipality in Tanzania by Mtae (2012) on married women, showed that only a quarter (25.2%) of respondents reported to discuss with their spouses. Discussions between partners is expected to increase the utilization of FP as discussions because they are a means to exchange knowledge on the benefits of FP between couples.

During interviews, women expressed the lack opportunities of discussion with their partner on FP due to their busy schedule; hence, they lacked opportunity to exchange knowledge on FP. This influences their desire to use FP methods since the use of FP without the knowledge of partners is associated with promiscuity in Chato society. Men also disagreed to discuss on FP with women partners because they believed that, when a women is left for a long time without conceiving, there is a possibility of a women to have extramarital affairs. FP utilization is the responsibility of both men and women; hence, they need to discuss when and how many children to have in the family.

5.4.4 Discussion of Men with other People (Peer, Close Relatives, Distant Relatives and Friends) and Family Planning Utilization

Although the discussions with other people apart from partners was more than 50% OR=1.53) likely to be associated with the use of FP, the strength of the association was not statistically significant [p=0.18] at multivariable analysis. The findings indicated that discussions between men with other people apart from spouses or partners (peers) is not significantly associated with FP use. Although Kassimu, in Kisarawe, found that discussions with other people means getting additional information on family planning services and the methods to use along with other experiences from users (Kassimu, 2008).

It is easy for non-users of FP to be influenced with users and so to increase adoption rate and can also address the influence towards discussions between partners on reproductive matters as well as family size (Mtae, 2015). Despite this insignificant association, the interviews with men in this study revealed that some men get

confidence on the effectiveness of the methods towards FP. Through discussions with fellow men, they get to know the best methods preferred by many men and also learn how best to use particular family planning methods. In order men to utilize FP effectively and consistently, they must encounter more encouragement to do so from other people (their peers) apart from their partners or spouses.

5.4.5 Knowledge of Family Planning Facilities (FP Clinics)

Although knowing FP facility was associated with FP utilization at bivariate analysis, the strength of association was not significant at multivariable analysis with odds ratio below 1 (OR =0.42). This means that, in Chato, knowing where to get FP services is not significantly associated to utilization of Family planning. This is in contrast to a study done in rural Uganda which shows that the lack of knowledge of where to acquire correct FP information and methods affects the eventual uptake of FP (Alege, 2016). However, during the interviews, it was revealed that some men were not aware if there is modern FP methods that could be used by men which means promotion messages on Family planning has not reached all community members in Chato District probably due to under-utilization of FP facilities. Women reported to know where to get information and family planning methods because they frequently visit health care providing facilities as they are in charge of taking care of family health related issues including frequent clinic visits.

Traditionally, men are not engaged in FP hence remain unaware of the availability of the services. Family planning clinics play a big role in sexual and reproductive health behaviors, outcomes of risk perception regarding the use of FP. This is true because family planning services usually include counseling, since counseling

provides an opportunity to discuss the advantages of preconception care (Klerman, 2006). However, the potential of family planning services to promote its utilization is limited by the under-utilization of these clinics (Alemayehu, 2017). During interviews, some men expressed their feelings that family planning clinics are mainly for women and it is embarrassing for a man to visit them. The time to wait for services at clinics is a waste for the men who are required to provide for the family. Women acknowledged how it is difficulty to convince men to accompany her to FP clinics. It is, therefore, important to come up with a low to force men to utilize FP services in case there is no mutual consensus and the women wish to do so.

5.4.6 Distance to Family Planning Facilities (Clinics) and Family Planning Utilization

The results also showed that residing in close to FP service delivery points is significantly associated with the utilization of family planning than those who are far. We found, in this study, that men who lived beyond the walking distance of facilities with family planning services (more than 2 kilometers walking distance) were significantly less likely to use modern FP methods compared to those who lived within 2 kilometers from family planning services.

Chato is still a rural District with the majority of occupants being peasants with low economic income as seen from the demographic results. This results are similar to a study on FP among men done in Kisarawe which also revealed that the distance to FP services beyond 2 kilometer influenced FP utilization nearly 2 times more than those residing within 2 kilometer due to poor social economic status which makes

men leaving far from FP services providers unable to pay fare or due to poor infrastructure (Kassimu, 2008).

This result is also supported by Kaida et al. (2005) in Uganda who also reported that the distance from family planning service providers as a significant barrier to the utilization of family planning services. Distance is negatively associated with utilization of family planning as those leaving far away from the services tend not to use FP methods due to poor accessibility (Agadjanian, 2015). During interviews, it was also revealed that men are discouraged to use FP due to distance as they have so many family issues to take care. Therefore, family planning becomes less important because of this discouragement. Men emphasized on the importance of FP services to reach them in villages where they live and suggested that, the Government should provide more FP service delivery points to make access to FP easy for all.

5.4.7 The Side Effects of Family Planning Utilization

The analysis of the data obtained revealed that the side effects after the utilization of FP significantly influence the utilization of FP. The side effects had significant effects on the use of family planning methods. This means that those respondents who experienced side effects were more likely to report non-utilization of family planning methods. This observation is also reported by Ochako *et al*. (2015) in Kenya where fear of side effects was found to be influencing utilization of family planning methods. There is a need of research focused on the behavioural outcomes but also health outcomes (morbidity). Clients are more likely to quite utilization of FP to avoid problems or staying away from the complications associated with the utilization of FP methods (Sir Lewis, 2001; Alvergne *et al*., 2017).

During interviews, the side effects were mentioned as the factors that influence FP utilization. The side effects which were mentioned by respondents included; heavy bleeding after FP utilization, becoming fat, change of the colour of the skin, stomach aches, and headaches while utilizing FP. Negative perceptions about FP were also recorded during the discussions both from FGD and KI, in which it was revealed that there is misinformation association among respondents between Family planning use and infertility, abnormalities of unborn babies specifically hydrocephalus was mentioned, cervical cancers and changing of hair colour.

Although the side effects was mentioned as a factor influencing FP utilization some of the respondents from FGD acknowledged the importance of dissemination of information about FP by skilled health workers to control the side effects. As well, every individual should be informed of the FP methods according to need and health status. They should also receives proper counselling on the proper use of the methods to avoid or counteract side effects.

5.5 Chapter Summary

The use of family planning methods among men was found to be very low in this study because there are some obstacles towards the use of FP. Therefore, there is a need of quick intervention to overcome the problem. However, the status varies across regions in the country as evidenced by other similar studies. The majority of respondents were of the young generation, married to one wife and had more than one child. Also, majority of respondents were peasants with at least primary education or more and practicing Christianity. Demographic factors showed no significant association with FP utilization due to continued efforts on FP services by

the Government and partners.

Despite that, for more than four decades, Tanzania has been offering family planning services while creating and adopting different strategies, this research revealed that the utilization of family planning services has remained low, at unacceptable level as has been shown by this study. In Chato District, the utilization of FP is declining due to many factors, such as menôs disapproval on utilization of family planning methods, distance to the family planning facilities and fear of the side effects. These results give an implication that there is a need to involve men in FP services as well as improve access to FP services. These services need to be provided by skilled health workers to encourage the utilization of family planning methods.

CHAPTER SIX

SUMMARY, CONCLUSION, AND RECCOMENDATIONS

6.1 Overview

This is the first study to be carried out in the study area using men as proxy for utilization of family planning services. There is no information on any other similar study which has been done in the lake zone. This will add knowledge in the professional arena.

6.2 Summary of the Study Population

A majority of men of the study population were young generation aged between 20 and 39 years. At this age most men have just entered the stage of puberty or still have ability to sire more children unless they use various measures to control their fertility. In this study, a large majority of men involved in the study were married men. This would mean that the majority of the study population had been engaged into sexual practices. Also, most of men reported to have two or more children. Therefore, there were different unmet needs between those without children and those with children; thus, differences in the utilization of family planning methods.

Most of the respondents were married to one wife. Further analysis observed differences in the utilization of FP between the polygamous versus monogamous men which suggest the nature of demand of family planning services in the areas where polygamy is prevalent. More than half of men who informed this study were peasants meaning that Chato District is mainly occupied by people who are largely practicing agriculture and livestock keeping.

6.3 Conclusion

6.3.1 Objective 1: The Proportion of Men Using Family Planning in Chato District

In this study, it has been revealed that a large majority of men who were involved in the study do not utilize FP. Condom was the most frequently reported FP method that was predominantly utilized. However, it is important to note that condom is primarily for FP purposes but also a means of prevention against STIs. Thus, the high use of condom could be because of the intention to prevent STDs than for FP. The current level of utilization of FP for all methods was at 17.5%. This low level of male involvement could be due to the lack of information, and inaccessibility to the services men do face. All stakeholders with the Government in the front line should ensure family planning programs incorporate the responsibility and roles of males in the uptake of family planning.

6.3.2 Objective 2: The Social Demographic factors Affecting Male the Involvement in the Utilization of Family Planning Services in Chato District (Age, Marital status, Level of Education, Occupation and Religion)

This research has demonstrated that demographic characteristics do not influence male involvement in the utilization of FP in Chato District; however, do not necessarily translate to FP utilization. This situation calls for more innovative strategies for the promotion of FP, and education on the importance of FP methods utilization engaging wider community. Also, accessibility should be considered by increasing SDP, as there might be no barrier but the services are hard to reach.

6.3.3 Objective 3: The Influence of Cultural Factors on Male Involvement in the Utilization of Family Planning

The results of the study also show that the use behaviour is strongly associated with maleôs approval on utilization of FP. A majority of men in Chato District do not approve FP utilization. In such situation, family planning programs should engage with wider community through mass and peer campaign strategies. The strategies used to create the awareness on male involvement in FP issues should be given priority at the facilities and community levels, to increase the number of adopters of male involvement in FP.

6.3.4 Objective 4: The Health Care System factors influencing Male Involvement in Utilization of Family Planning Services among Men in Chato District

The findings revealed that the distance from FP facilities and the side effects affect use of family planning significantly. Therefore, improving utilization of family planning services also needs interventions by the health sector. Most reproductive health influencing factors cannot be addressed in the absence of quality, accessible health services, and medical knowledge and skills across all FP facilities.

6.4 Appraisal of Theoretical Framework

It has been well established that, family planning contributes to reducing maternal mortality by reducing the number of births and, thus, the number of times a woman is exposed to the risk of mortality. Generating knowledge through researches on the factors influencing FP utilization and development of strategies to address them will contribute to improvements in maternal health.

According to Stover (1998), Family Planning Utilization is influenced by various independent factors. The investigation of the factors influencing male involvement in Family Planning Utilization were three. The first observation is Demographic factors which includes age, marital status, education level, occupation and Religion . The second is cultural factors which include number of Children, discussion about FP use (spouse, others), decisions on reproductive health and health care. The last factor is service related factors which includes distance to FP centre, the side effects after FP use, availability of FP commodities and the availability of FP clinics. These factors can affect positively or negatively the fertility of individuals in the society through utilization of family planning.

This study showed that menôs approval on FP use distance to FP service delivery points and side effects after FP have direct and indirect influence on male involvement in Family Planning use. Therefore, the findings from this study showed that most components in the model were relevant and helpful in explaining the factors influencing male involvement in FP utilization.

Despite its strong theoretical contribution, Stoverôs model has its own limitation. Stover believed that the use of contraceptives can also control fertility but he failed to realize that contraception does not protect women from pregnancy unless couples use the method which they have chosen effectively and consistently and for this to happen the access and utilization of family planning services accordingly is very important, and this should include proper ways of handling contraceptives side effects. The framework was intended to aid the analysis and explanation of the factors influencing FP utilization, by focusing interest on the links between

dependent variable (Family Planning Utilization) and each of the demographic, cultural and service related factors. Therefore, variations in the level of FP utilization is expected due to variations on the factors within the framework or others as observed in this study.

6.5 Recommendations

The recommendations are proposed to Government, FP service providers, health managers and other direct programme implementers for improving use of FP services among men and women.

6.5.1 Government Level

i. Male involvement is crucial to improved utilization of family planning, programs at all levels should be guided in a manner that it reaches both men and women with family planning information and services and provides a space for couples to discuss fertility intentions and contraception.

ii. Allocation of adequate financial resources at all levels will help access for FP services for all.

iii. Deployment of skilled health workers across the country to provide the right information on FP methods and provide FP methods according to individual needs in the quest to reduce unnecessary side effects of FP methods.

iv. Governmental Policies should incorporate the responsibility and role of males in the uptake of family planning services. Policies and strategies which mention men, offer strong opportunities for male involvement at implementation level (service level).

v. Continuous Monitoring and evaluation of FP programs and provide necessary support

6.5.2 Programme Level

i. Service quality ï Service Delivery Points has geographical proximity to individuals and individuals cost of reaching FP facilities is within their economic means.

ii. Provision of sustained advocacy for use of family planning services at community level through conducting seminars to community leaders and promotion adverts in media/leaflets. This will make individuals free from social-demographic and cultural behaviours in seeking FP services

iii. Training of the available health staff providing FP services to improve their capacity on family planning services provision, and increased commitment.

iv. Making sure there is FP commodity security by timely and adequate supply of contraceptives to both service providers and clients.

v. Integration of services to reach every men with FP services information

6.5.3 Individual Level

i. Recruiting males as family planning providers. This is very important given that although clinic staff might be respected for their technical competence, the experiences of fellow men are far more influential, male providers acts as peer motivators

ii. Offering more family planning counselling for couples at home. Couples using contraceptive methods could be invited to contribute to family planning education talks in the community to promote use of FP methods for

men and women

6.6 Recommendations for Further Researches

i. Feasible ways to increase contraceptive continuation rates must be identified.

ii. Research directed toward improving training programme and supply logistics should be undertaken.

iii. Views from health care workers on what should be done to promote FP use among men.

iv. There is a need to assess the benefits of involving both partners in the contraceptive counselling process

v. Longitudinal studies like cohort study to establish causal effect between the factors and utilization of family planning service.

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APPENDICES

APPENDIX 1: RESEARCH LEARANCE

THE OPEN UNIVERSITY OF TANZANIA
DIRECTORATE OF RESEARCHAND PUBLICATIONS

Kawawa road, Kinondoni
Municipality
P.O. Box 23409,
Dar es Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445
Ext.2101
Fax: 255-22-2668759,
E-mail:drp@out.ac.tz

Our Ref:RP/06/2018 Date: 14th December, 2018

TO WHOM IT MAY CONCERN

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No. 55 in the official Gazette. The act was however replaced by the Open University of Tanzania charter of 2005, which became operational on 1st January 2007. In line with the later, the Open University mission is to generate and apply knowledge through research.

To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance,on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology,to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Mr. Francis Doto Fedrick (REG. NO. PG 201608386) who is a Ph.D. student at the Open University of Tanzania.**

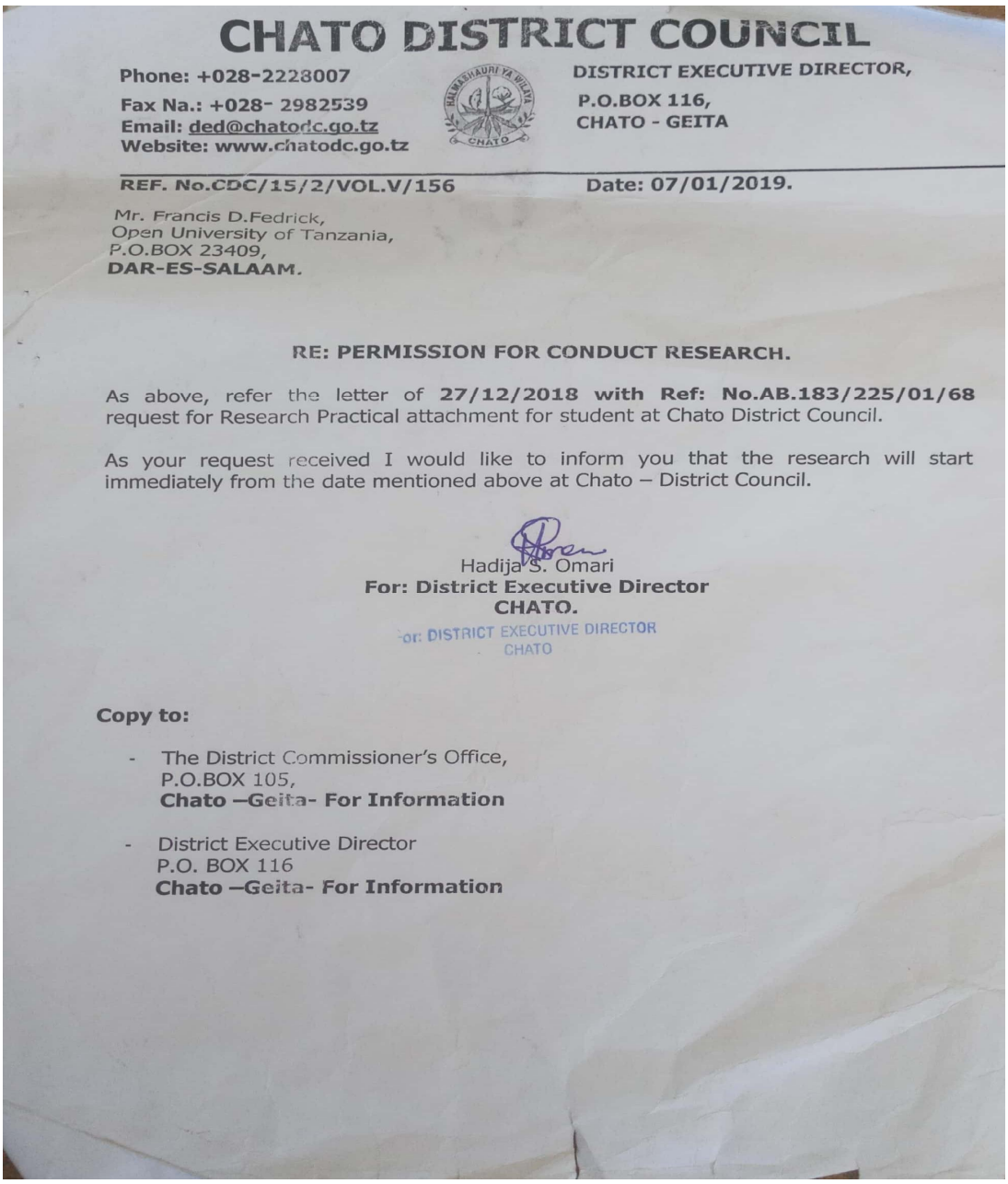
We here by grant this clearance to **Mr. Francis Doto Fedrick** to conduct a research titled

"factors to Family Planning Services Utilization among Men in Chato District, Geita Tanzania''.

Incase you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O. Box 23409, Dar es Salaam. Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

Yours sincerely,

Prof Emmanuel Kigadye
For: VICE CHANCELLOR
THE OPEN UNIVERSITY OF TANZANIA



CHATO DISTRICT COUNCIL

Phone: +028-2228007
Fax Na.: +028- 2982539
Email: ded@chatodc.go.tz
Website: www.chatodc.go.tz

DISTRICT EXECUTIVE DIRECTOR,
P.O.BOX 116,
CHATO - GEITA

REF. No.CDC/15/2/VOL.V/156 Date: 07/01/2019.

Mr. Francis D.Fedrick,
Open University of Tanzania,
P.O.BOX 23409,
DAR-ES-SALAAM.

RE: PERMISSION FOR CONDUCT RESEARCH.

As above, refer the letter of **27/12/2018 with Ref: No.AB.183/225/01/68** request for Research Practical attachment for student at Chato District Council.

As your request received I would like to inform you that the research will start immediately from the date mentioned above at Chato – District Council.

Hadija S. Omari
For: District Executive Director
CHATO.

For: DISTRICT EXECUTIVE DIRECTOR
CHATO

Copy to:

- The District Commissioner's Office,
  P.O.BOX 105,
  Chato –Geita- For Information
- District Executive Director
  P.O. BOX 116
  Chato –Geita- For Information

APPENDIX 2: QUESTIONNAIRE (ENGLISH VERSION)

This questionnaire consists of 43 questions, just respond according to the best level of your understanding and experience on the factors affecting utilization of family planning services. This is not an examination; all answers are true.

PART I: For official use only

1. Questionnaire No é é é é é é . 2. District of the client é é é é é é é é é

3. Ward é é é é é é . 4. Village é é é é é é é é .5. Hamlet é é é é é é é

6. Date of interview é é é é é é é 7. Name of intervieweré é é é é é é é é .

PART II: Background information

8. Age (in years) é é é é é é

9. Marital status

1. Single
2. Married
3. Widowed
4. Separated
5. Divorced
6. Cohabiting

If the answer is married, go to the question no. 10

10. How many wives do you have?

1. One
2. Two
3. Three
4. Four
5. Others (specify) é é é é é é é é é é é é .

11. What is your current occupation? é é é é é é é é é é

    1. Peasant
    2. Daily wage labour
    3. Employed
    4. Petty business
    5. Others (specify) é

12. What is your highest level of education? é é é é é é é é é é é é .

    1. No formal education
    2. Adult education
    3. Primary education
    4. Secondary education
    5. College

13. What is your religion?

    1. Christian
    2. Muslim
    3. No religion
    4. Other (specify)é é é é é é é é é é .

14. Do you have children?

    1. Yes
    2. No

If the answer is yes, go to question no. 15

15. What is the number of your children?

    1. One
    2. Two

3. Three

4. Four

5. More than four

16. Have you heard of family planning methods?

1. Yes

2. No

If the answer is yes, go to question no. 17

17. Mention the methods you know é é é é é é é é é é é é é é é é é é

é é é é é é ..é é

é é é é é é é

PART III: **Family planning methods utilization**

18. Have you had sex with your partner in the past six months?

1. Yes

2. No

If the answer is yes, go to the question no. 19

19. In the last time you had sex; did you or your partner use any Family Planning Methods?

1. Yes

2. No

If the answer is yes, go to question no. 20

20. Mention the method you used é é é é é é é é .é é é é é é é é é é é .

PART IV: **Utilization of Family planning services**

21. Have you ever gone to the health facilities to seek health care in the past six months?

1. Yes ☐

2. No

22. Do you know any facility which provides family planning services?

1. Yes ☐

2. No

If the answer is yes, go to question no. 22

23. What is the distance to the nearest facility you know which provides family planning services?

1. 2 to 5 km ☐

2. 6 to 10 km

3. 11km and above

24. Have you ever used family planning services in the past six months?

1. Yes ☐

2. No

If the answer is yes, go to question no. 25 and if the answer is no, go to question 27

25. What was the reason(s) that made you to use the family planning services? (**You can choose more than one response**)

1. To accompany my partner to obtain the family planning methods ☐

2. Looking for male oriented family planning methods ☐

3. Looking for family planning information ☐

3. To seek the treatment of STI ☐

4. Others (Specify)é .

If the reason is to accompany your partner go to the question no. 26

26. When you accompany your partner to the family planning services do you stop at the door of the family planning clinic without entering inside the clinic?

1. Yes ☐
2. No

If the answer is yes, go to question no. 27

27. Why did you not enter in the family planning clinic?

é é

é é

28. Have you talked about family planning with your partner?

1. Yes ☐
2. No

If the answer is yes, go to the question no. 28 and if the answer is no, go the question no. 29

29. How often do you talk about family planning with your partner in a week?

1. Once
2. Twice ☐
3. Three
4. More than three

30. Have you discussed family planning with any other person?

1. Yes ☐
2. No

31. On your own view, who should decide to have another child?

1. Husband only

2. Wife only ☐

3. Wife and Husband

4. Other (specify)é ..

32. Do you approve your partner to use a contraceptive method to prevent pregnancy?

1. Yes ☐

2. No

PART V: factors TO THE UTILIZATION OF FAMILY PLANNING SERVICES

33. In your tradition, is the control of fertility allowed?

1. Yes ☐

2. No

34. Children provide social security for the parents at old age?

1. Agree

2. Disagree ☐

3. Undecided

35. The status of males improved and gained enhanced respect from their peer and the community when they have many children

1. Agree

2. Disagree ☐

3. I donôt know

36. The big number of children is important for labour and social security

1. Agree

2. Disagree

3. I donôt know

37. Most men preferred for son over daughter because boys become members of fatherôs clan.

1. Agree

2. Disagree

3. I donôt know

38. The competition between wives in the polygamy for a husbandôs love is often played out with the number of children, most importantly sons borne by each woman

1. Agree

2. Disagree

3. I donôt know

39. Did you get any side effect after using a family planning method?

1. Yes

2. No

40. If yes, what was the side effect(s) ----------?

41. Did you miss family planning methods when you visited family planning services providers?

1. Yes

2. No

Thank you

APPENDIX 3: QUESTIONNAIRE (KISWAHILI VERSION)

Maelekezo

Hili dodoso lina maswali 43, tafadhali jibu kutokana na unavyoelewa na uzoefu wako juu ya vikwazo vinavyoathiri huduma za uzazi wa mpango. Huu siyo mtihani, majibu yote ni sahihi

SEHEMU YA I: Taarifa kwa matumizi ya ofisi tu

1. Namba ya dodosoé é é é é é . 2. Jina la wilayaé é é é é é é é é é .

3. Jina la Kata é é é é é é é é é .4. Jina la kijiji é é é é é é é é é é é

5. Jina la kitongojié é é é é é 6. Tarehe ya usailié é é é é é é é é

7. Jina la msaili é é é é é é é é é é é ..

SEHEMU YA 2: Takwimu za msailiwa

8. Umri wako ni miaka mingapi? é é é é é é é é é é é é é é é é

9. Hali ya ndoa ya sasaé é é é é é é é é é .

1. Hajaoa
2. Ameoa
3. Nimefiwa na mke
4. Wametengana na mke
5. Nakaa na Kimada

Kama jibu ni nimeoa nenda swali namba 10

10. Una wake wangapi?

1. Mmoja
2. Wawili
3. Watatu

4. Wanne

5. Nyingine (tafadhari taja) é é é é é é é é é é é é ..

11. Unafanya kazi gani kwa sasa? é é é é é é é é é é é ..

1. Mkulima

2. Kazi za kibarua ☐

4. Nimejiajiri

5. Mfanyabiashara

6. Nyinginezo, taja é ..

12. Kiwango chako cha juu cha elimu ni kipi? é é é é é é é é é é é é ..

1. Sikusoma

2. Elimu ya watu wazima ☐

3. Elimu ya msingi

4. Sekondari

5. Elimu ya Chuo

6. Nyingineyo, tajaé ..

13. Dini yako ni ipi?

1. Mkristo ☐

2. Muislamu

3. Sina dini

4. Nyingineyo taja é é é é é é é é é

14. Je una watoto?

1. Ndiyo ☐

2. Hapana

Kama jibu ni ndiyo nenda swali namba 15

15. Una watoto wangapi?

1. Mmoja
2. Wawil
4. Wanne
5. Zaidi ya wane

16. Umeshawahi kusikia njia za uzazi wa mpango?

1. Ndiyo
2. Hapana

Kama jibu ni ndiyo nenda swali namba 17

17. Taja njia za uzazi wa mpango unazozijua

é é

SEHEMU YA TATU: Matumizi ya njia za uzazi wa mpango

18. Je umefanya tendo la ndoa katika kipindi cha miezi sita iliyopita?

1. Ndiyo
2. Hapana

Kama jibu ni ndiyo, nenda swali namba 19

19. Mara yako ya mwisho kufanya ngono wewe au mwenza wako mlitumia njia yoyote ya afya katika kipindi cha miezi sita iliyopita

1. Ndiyo
2. Hapana

Kama jibu ni ndiyo, nenda swali la 20

20. Taja njia mliyotumiaé é

SEHEMU YA NNE: **Matumizi ya huduma za uzazi wa mpango**

21. Je umeshawahi kwenda kwenye kituo cha afya kupata huduma yoyote ya afya katika kipindi cha miezi sita iliyopita

1. Ndiyo ☐
2. Hapana

22. Je unajua kituo chochote kinachotoa huduma ya uzazi wa mpango?

1. Ndiyo ☐
2. Hapana

Kama jibu ni ndiyo, nenda swali namba 23

23. Kuna umbali gani kutoka kituo cha karibu unachokijua kinachotoa huduma ya uzazi wa mpango?

1. Chini ya 2 km
2. Kati ya 2 km na 5 km ☐
3. 6 km au zaidi

24. Je umewahi kwenda kwenye kituo kinachotoa huduma ya uzazi wa mpango katika kipindi cha miezi sita iliyopita?

1. Ndiyo ☐
2. Hapana

Kama jibu lako Ni ndiyo nenda swali namba 25 Na Kama jibu Ni hapana, nenda namba 28

25. Nini ilikuwa sababu iliyokufanya wewe kwenda kwenye kituo cha uzazi wa mpango? (**unaweza kutoa jibu zaidi ya moja**)

1. Kumsindikiza mwenzangu kwenda kupata huduma ya uzazi wa mpango ☐
2. Kupata njia za kiume za uzazi wa mpango ☐

3. Kupata habari za uzazi wa mpango

4. Kutibiwa magonjwa ya ngono

5. Nyingine (Taja) é é é é é é é é é é é é é é é é ..

Kama sababu yako ni kumsindikiza mwenzako, nenda swali namba 26

26. Wakati umemsindikiza mwenza wako katika kituo cha uzazi wa mpango. Uliingia ndani?

1. Ndiyo

2. Hapana

Kama jibu lako ni ndiyo, nenda swali namba 28

27. Kwanini hukuingia ndani? é

28. Umeshawahi kuongea kuhusu uzazi wa mpango na mwenza wako?

1. Ndiyo

2. Hapana

Kama jibu lako ni ndiyo nenda swali namba 29 na kama jibu ni hapana nenda namba 30

29. Mara ngapi huwa unaongea na mwenza wako kuhusu uzazi wa mpango katika wiki?

1. Mara moja

2. Mara mbili

3. Mara tatu au zaidi

30. Umewahi kuongea na mtu mwingine yeyote kuhusu uzazi wa mpango?

1. Ndiyo

2. Hapana

31. Kwa mtazamo wako ni nani aamue kupatikana kwa motto mwingine?

1. Baba peke yake
2. Mama peke yake
3. Baba na mama kwa pamoja
4. Mwingine (Mtaje) é é é é é é é é é é é é é é é ..

32. Unakubali mwenzi wako atumie njia za uzazi wa mpango kuzuia ujauzito?

1. Ndiyo
2. Hapana

SEHEMU YA TANO: VIZUIZI VYA KUTUMIA HUDUMA ZA UZAZI WA MPANGO

33. Katika mila yako kuzuia uzazi kunaruhusiwa?

1. Nakubali
2. Nakataa
3. Sijaamua

34. Kuwa na watoto kunatoa uhakika wa kutunzwa kwa wazazi wakati wa uzee?

1. Nakubali
2. Nakataa
3. Sifahamu

35. Hadhi ya mwanaume inaongezeka kutoka kwa wanaume wenzake na jamii kwa ujumla kama ana watoto wengi

1. Nakubali
2. Nakataa
3. Sijaamua

36. Idadi kubwa ya watoto ni muhimu kwa ajili ya kupata watu wa kufanya kazi.

1. Nakubali
2. Nakataa
3. Sijui

37. Wanaume wengi wanapenda watoto wa kiume kwa sababu watoto wa kiume wanakuwa ni wa ukoo wa mwanaume.

1. Nakubali
2. Nakataa
3. Sijui

38. Ushindani wa wake walio kwenye ndoa ya mitala (uke wenza), kwa penzi la mme huwa mara nyingi unakwenda sambamba na kushindana kwa idadi ya watoto hasa watoto wa kiume waliozaliwa na kila mama

1. Nakubali
2. Nakataa
3. Sijui

39. Je ulipata madhara/maudhi yoyote baada ya kutumia njia za uzazi wa mpango

1. Ndiyo
2. Hapana

40. Kama ndiyo, ni madhara/maudhi gani ulipata ?----------

41. Je ulishawahi kukosa njia za uzazi wa mpango hata pale ulipotembelea watoa huduma za uzazi wa mpango?

1. Ndiyo
2. Hapana

Aksante kwa ushirikiano

APPENDIX 4: CHECK LIST FOR FOCUS GROUP DISCUSSION

1. Attitudes towards family size and awareness on FP

Do you know about family planning services? Also explain its benefits

Are you aware of any traditional and/or modern contraceptive methods which have been used by men or women in this community? Mention which you know

It is said that some women/men are interested in having many children as a workforce, or security especially at old age

a) What are your views on this aspect?

b) What is the exact number of children that women/men find it to be ideal in this community?

c) Is there any taboo, cultural belief or religious beliefs guiding this?

2. Attitudes towards family planning services utilization

In general, what are the views of women/men towards family planning methods use?

What are the circumstances do women/men feel they should use or not use contraceptives?

What do you say about availability of family planning services in this community?

In your community, how is the woman viewed if she uses modern contraceptives?

3. Attitudes towards husband and wife communication on family planning services utilization

In most African households husbands have power to control and make decisions on various issues including contraceptive use

Do women/men normally discuss about reproductive issues in this community?

Do they discuss about child spacing and delaying births?

Do they also discuss about specific methods of delaying or postponing births

Is it a common practice in this community for husbands/wives to beat their wives/husbands? What is your opinion on this?

For those who do not discuss, what are their main reasons for not doing so?

4. factors affecting utilization of family planning services

Why do some woman/men prefer not to use contraceptives in this community?

Are there any myths or misconception about use of family planning services?

Is access to FP services a barrier in this community?

Is religion a barrier in this community towards utilization of FP?

5. Promotion of family planning use among women and men

What are your views in general on what should be done to promote use of contraceptives among men and women?

THE END

APPENDIX 5: KEY INFORMANT INTERVIEW GUIDE

1. Attitudes towards family size and awareness on FP

Do you know about family planning services? Also explain its benefits

Are you aware of any traditional and/or modern contraceptive methods which have been used by men or women in this community? Mention which you know

It is said that some women/men are interested in having many children as a workforce, or security especially at old age

a) What are your views on this aspect?

b) What is the exact number of children that women/men find it to be ideal in this community?

c) Is there any taboo, cultural belief or religious beliefs guiding this?

2. Attitudes towards family planning services utilization

In general, what are the views of women/men towards family planning methods use?

What are the circumstances do women/men feel they should use or not use contraceptives?

What do you say about availability of family planning services in this community?

In your community, how is the woman viewed if she uses modern contraceptives?

3. Attitudes towards husband and wife communication on family planning services utilization

In most African householdsô husbands have power to control and make decisions on various issues including contraceptive use.

Do women/men normally discuss about reproductive issues in this community?

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Is it a common practice in this community for husbands/wives to beat their wives/husbands? What is your opinion on this?

For those who do not discuss, what are their main reasons for not doing so?

4. factors affecting utilization of family planning services

Why do some woman/men prefer not to use contraceptives in this community?

Are there any myths or misconception about use of family planning services?

Is access to FP services a barrier in this community?

Is religion a barrier in this community towards utilization of FP?

5. Promotion of family planning use among women and men

What are your views in general on what should be done to promote use of contraceptives among men and women?

THE END

APPENDIX 6: INFORMED CONSENT FORM (ENGLISH VERSION)

INFORMED CONSENT FORM

THE OPEN UNIVERSITY OF TANZANIA

CONSENT FORM

ID ï NO

Consent to participate in study

Greetings! My name is é , I am a doing research on **factors AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG MEN AT CHATO DISTRICT.**

Purpose of the study

To determine factors hindering Men to utilize Family Planning services in Chato District.

What participation involves

If you agree to join this study, you will be required to answer a series of questions that have been prepared for the study through questionnaire in order to obtain the intended information regarding the utilization of family planning services among men.

Confidentiality

All collected information will be kept confidential and will only be used for study purposes. Identification numbers will be used instead of names.

Risk

We do not expect any harm to happen to you because of participating in this study

RIGHTS TO WITHDRAW AND ALTERNATIVES

To participate in this study is completely voluntary. You can free choose not to participate in this a study, and even if you will have already accepted to participate in the study you can quit at any time if you feel so. No penalty or loss of any benefits upon refusal to participate or withdrawal from the study.

BENEFITS

There will be no direct benefit in participating in this study. However, the information we gather from this study will help to improve the provision of family planning services among men in the district as well as other places in the country.

IN CASE OF INJURY

We do not anticipate that any harm will occur to your family as a result of participating in this study. There will be no compensations to you or your family.

WHO TO CONTACT

If you have questions about this study, you should contact the study coordinator or the Principal Investigator **FRANCIS DOTO FEDRICK** of PO BOX 116 Chato ï Geita - 0784888559

If you have questions which need further clarification, as participant you have a right to

Prof Emanuel Kigadye, Director Research and Publications of the Open University of Tanzania PO Box 23409, Dar es Salaam, Tanzania. Mobile +255754373756

SIGNATURE

Do you agree?

Participants agreesé é é é é Participant does not agreeé é é é é é é é é é .

I é é é é é é é é é é é é é é . have read the contents in this form.

My question has been answered. I agree to participate in this study.

Signature of participanté é é é é é é é é é é é é é é é é .

Signature of Research Assistanté é é é é é é é é é é é é é é é é

Date of signed consenté é é é é é é é é é é é é é é é é é

APPENDIX 7: INFORMATION CONSENT FORM (KISWAHILI)

INFORMED CONSENT FORM

Namba ya utambulisho ☐ ☐ ☐

Ridhaa ya kushiriki kwenye utafiti

Hujambo! Ninaitwa é é é é é é é é é é ..nafanya utafiti wa **VIKWAZO VINAVYOZUIA WANAUME KUTUMIA HUDUMA ZA UZAZI WA MPANGO KATIKA WILAYA YA CHATO.**

Madhumuni ya Utafiti

Utafiti huu unalenga kuainisha **VIKWAZO VINAVYOZUIA WANAUME KUTUMIA HUDUMA ZA UZAZI WA MPANGO KATIKA WILAYA YA CHATO**

Nini kinahitajika ili kushiriki.

Ili kushiriki katika utafiti huu inabidi kukubali na kujiunga kwa kujibu maswali toka kwenye dodoso la maswali yaliyotungwa kwa ajili ya utafiti huu.

Usiri

Taarifa zitakazokusanywa kupitia dododso hili zitakuwa siri hakuna mtu yeyote atakayeambiwa ulichosema. Taarifa zitaingizwa kwenye ngamizi kwa kutumia namba ya utambulisho.

Hatari

Hatutegemei hatari yeyote kupata kwa sababu ya kushiriki kwako katika utafitii huu. Hivyo hatutakuwa na fidia yeyeote kwako au familia yako.

Nani wa kuwasiliana naye

Kama una maswali kuhusiana na utafiti itakubidi kuwasiliana na Mtafiti Mkuu **FRANCIS DOTO FEDRICK** wa Chuo Kikuu Huria cha Tanzania S. L. P 116

Chato ï Geita,. Kama una maswali ambayo yatahitaji maelezo zaidi una haki ya kumpigia simu Pro. **Emmanuel Kigadye,** Mkurugenzi wa utafiti na uchapishaji, Chuo Kikuu cha Afya ya Sayansi na Tiba Muhimbili, S. L. P 65001, Dar es salaa, Simu +255754373756

Sahihi

Je umekubali?

Mshiriki amekubali é é é é Mshiriki hajakubali é é é é é é é é é é é é .

Mimi é .nimesoma maelezo ya form hii. Maswali yangu yamejibiwa na nimeridhika. Nakubali kushiriki katika utafiti huu

Sahihi ya mshirikié .

Sahihi ya shahidi (kama Mshiriki hawezi kusoma/kuandika) é é é é é é é é é

Sahihi ya mtafiti msaidizi é é é é é é é é é é é é é é é é é é é .

Tarehe ya kutia sahihi ya kushiriki é é é é é é é é é é é .

Faida

Hakutakuwa na faida moja, hata hivyo taarifa zitazokusanywa kutokana na utafiti huu zitasaidia uboreshaji wa utoaji wa husuma za uzazi wa mpango kwa wanaumme katika wilaya na sehemu zingine nchini.

Endapo utapata madhara

Hutegemewi kupata madhara yeyote kutokana na ushiriki wako katika utafiti huu