Addis Ababa University Faculty of Medicine
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THE INVOLVEMENT OF MEN IN FAMILY PLANNING AN APPLICATION OF TRANSTHEORETICAL MODEL IN WOLAITA SODDO TOWN SOUTH ETHIOPIA

By

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A Thesis Submitted To the School Of Graduate Studies, Addis Ababa University in the Partial Fulfilment Of The Requirement For The Degree Of Masters Of Public Health

June 2009, Addis Ababa

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Abstract

Introduction

Reproductive health in its broader sense should be a concern for all and not for just that of women, and reproductive health matters needs the attention of entire family and the society at large. Historically most reproductive health programs focused mainly on women and offered their services exclusively to women's. Most viewed women as the target group and paying little attention to the role that men might have with respect to women's reproductive decision making and behavior. The behaviors of husband and male sexual partners have significant impact on the contraceptive use of their wives and partners.This study explored the involvement of men in family planning by employing one of the health behavior models TransTheoretical model (TTM) in Wolaita Soddo town.

Objectives

To assess the involvement of men in fertility preference and contraceptive use by using of Tran theoretical model of behavior change

Methodology

Community based cross-sectional study was done in Wolaita zone, Soddo town Southern Ethiopia. Both qualitative and quantitative method was employed Focus group discussion was a qualitative method to complement the finding of the quantitative study. Data entry, data cleaning and analysis was done by SPSS version15 soft ware package. Ethical clearance was obtained from school of public health faculty of medicine.

Result

About 96% of the respondents were familiar with at least one family planning method the commonly known method pills (96%) Injectables (94.5%), condom (88.6%) Norplant (35.3%) and IUD (22.5%) Overall 65.5% of married men currently practice family planning method 77.5% approved use of contraception and about 60% of study participant discussed the issue of family planning. Behavioral stage of men in family planning method use, 26.7% were in the precontemplation Stage,7.8% contemplation,4.5% preparation,16.1% in the action stage 49.4% in maintenance stage.

Conclusion and recommendation

The study found high prevalence of knowledge of contraceptive methods among married men, but a relatively low utilization of male method. Discussion between spouses and their joint decision-making on contraceptive use was also found to be high. Most of behavioural stage of men was in maintenance/action stage. Targeted Stage based IEC intervention were recommended

Key Words

Family planning, Male involvement, Transtheoretical model, Stage of change,

Targeted Intervention

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ACRONYMS

AAU	Addis Ababa University
AIDS	Acquired Immuno Deficiency Syndrome
AOR	Adjusted Odds Ratio
CI	Confidence Interval
CPR	Contraceptive Prevalence Rate
EDHS	Ethiopian Demographic and Health Survey
FGD	Focus Group Discussion
FP	Family Planning
HBM	Health Belief Model
HIV	Human Immuno Deficiency Syndrome
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
O.R	Odds Ratio
SCT	Social Cognitive theory
SNNPR	Southern Nation and Nationalities People Region
SPSS	Stastical Package for Social Science
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
TFR	Total Fertility Rate
TTM	TransTheoretical Model
UNFPA	United Nations Population Fund
WHO	World Health Organization

1. Introduction

Reproductive health in its broader sense should be a concern for all not for just that of women and reproductive health matters needs the attention of entire family and the society at large (1). Historically most reproductive health program focused on family planning and in turn most family planning program offered their services exclusively to women. Most viewed women as the target group and paid little attention to the role that men might have with respect to women in reproductive health decision making and behavior (2). Family planning goals could be served by changes in patrichial male-female dynamics the social justice objectives of increasing equality the demographic objectives of lowering population growth rates and the public health goal of reducing disease especially sexually transmitted infection greater participation by men could thus contribute to the goal of reproductive health in variety ways (3).

In the 1990s many women's health programs began to acknowledge the fact that family planning must be viewed in the broader context of reproductive health. For instance the 1994 international conference on population and development in Cairo program of actions includes a statement on male responsibilities and participation (4).

'Special efforts should be made to emphasize men shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior including family planning, prenatal care, maternal and child health, and prevention of STDS including HIV prevention. Unwanted and high-risk pregnancies shared control and contribution to family income children education health and nutrition and recognition and promotion of equal values of children of both sexes (3, 4).

The same message was reinforced at the 1995 world conference on women in Beijing "shared responsibility between men and women in matters related to reproductive and sexual behavior is essential to improving women health" (3).

In 1997 the united nation population fund (UNFPA) published a booklet proposed that the agenda for men involvement "post Cairo and post Beijing" should be to change men so that they could play proactive role in the empowerment of women (3, 4).

The term male involvement includes two aspects namely male responsibility and male participation. Male responsibility stresses the need for men to assume responsibility to caring off offspring using contraceptive methods, practicing safe sexual behavior to protect self and partners from STI/HIV and unwanted pregnancy. While male participation emphasizes on active participation in family life, women special health, workplaces to promote gender equity and equality, girl education, women empowerment, sharing of households activities and child bearing and prevention of violence against women child. Participation also suggests more active role for men in both decision making and adopting behaviors such as sharing reproductive health decision making supporting partner's choices of family planning (5). Male involvement also includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which has the objective of increasing the acceptability and prevalence of family-planning practice of either sex (6).

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In patrichial society where household decisions are largely made by men, the need to include men in all matters that required joint spousal decision is critical in achieving key reproductive health goals. Despite this fact until recent year's men roles in couple's fertility decision making was ignored however since the past few years demographic studies examined the role of men in family planning and many of them showed the importance of involving husbands for couple's family planning adoption.

Ethiopia is one of the countries with an estimated population of 77.2 million, the second most populous country next to Nigeria in the continent (7). Ethiopians national health policy gives a high priority to the democratization and decentralization of the health service systems and emphasizes family planning services for optimal health of the mother; child and family. The population policy also emphasizes the expansion of family planning through clinical and community based services. It sets objectives to reduce TFR from 7.7 to 4.0 and increase CPR from 4% to 44% by the year 2015 (8). However the use of family planning services in Ethiopia is among the lowest in the world. According to Ethiopian demographic and health survey (EDHS), the contraceptive prevalence rate (CPR) in 2005 was 15%. The total fertility rate was 5.4. There has been decline of total fertility from 6.9 in 1990 to 5.4 in 2005 .a one child reduction decline in the past 15 years. Seventy eight percent of Ethiopian currently married women want to either stop or post phone child bearing .The unmet family planning need among married women in reproductive age group in the same year was 36% (9).

Studies from several nations has shown that reproductive health program are likely to be more effective for women when men are actively involved (Drennan1998) this is

evidence that a husband disapproval leads to reduction in contraceptive use. (Bongaaris and Bruce1995, kamal 2000) (10). Current literature also mention that four outcomes used as proxies to determine the success of involving men in family planning .these includes increase contraceptive use, decreased unmet need, correct use of Family planning method and decrease contraception discontinuation (4).

Failure to involve men in family planning programs can have a serious implication even when women are educated and motivated to practice contraception they may not do so. Because of opposition from their husbands in light of these finding some researcher question the validity of the estimates of unmet need derived from information collected only from women (11).

In the study conducted in the northern Gondor on the men knowledge attitude and practice of family planning methods out of the Sixty one percent of men knew at least one method of family planning (FP) and 64.3% of them approved the use of FP. 7.7% proposed that only men should use contraception 41.7% said only women should use them 32.3% said both should use them of all interviewed men (12).Similarly a study done by Terefe and Larson reported where couples receiving husband –wife counseling showed an increase in contraceptive use after one year compared to women who were counseled alone (Terefe and Larson,1993).

Contraceptive use is an instance of healthy behavior that requires behavioral change. The *adoption* of contraceptives may be addressed with in the framework of cognitive –social theories of behavioral change in particular the Transtheoretical models (TTM).

Transtheoretical model has been presented as integrative and comprehensive model of behavior change including contraceptive use (13). Previous studies on male involvement were not explained by health behavioral models. This study explained the involvement of men in family planning by TransTheoretical model of behavior change.

2. Literature review

2.1 Family planning and men

The continuing growth of the world population has become an urgent global problem Most of this growth is occurring in developing countries where the fertility rate is very high (14). A rapid population growth is a burden on the resources of many developing countries. Unregulated fertility, which contributes to such situations, compromises the economic development and political stability of these countries. . Therefore, many countries consider limiting population growth as an important component of their overall developmental goal to improve living standards and the quality of life of the people. This strategy is now enhanced by the availability of effective modern contraceptive methods

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

Recently family-planning associations recognized the importance of men's role and motivation in involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership

and influence from the family unit right through the national level (IPPF, 1984). The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the understanding and fertility decision making, particularly in Africa . But now that this has been recognized, the question is "what can family-planning and reproductive-health programs do to encourage men's cooperation?" (15).

Many studies have also suggested that family planning program in many African societies have been unsuccessful since they failed to take into account power relations between couples and patrichial nature of societies African men are not only head of the house hold but also are overall responsible for families also men have more influence on reproductive decision since they typically control the family asset. Not surprisingly African men generally desire longer families than do their wives as Caldwell observed African men want to have more children they gain socially economically from having a large number of children (16). men are proud of the number their children particularly sons because of the present and future benefit derived from them in the absence of social security program children constitute important source of old age support for their partners (17)

The role of male in fertility and family planning in sub-Saharan Africa is becoming increasingly important in the context of raising contraceptive prevalence and reducing levels of fertility. Fertility studies in the recent and past finding almost exclusively from women (Mbizvo and Basset 1995, Bankole1995 Adamedice and Adebag 1998) Regrettably policies and programs based on such finding have not had the expected

success in increasing contraceptive prevalence and simultaneously reducing overall fertility in sub Saharan Africa.Men involvement could assure an essentially prominent role in each couples family planning effort (18).

In Ethiopia family planning was initiated four decades ago. However even after such a long period of time family planning amongst the lowest in Africa CPR 15% and unmet need for family planning is very high 36% (19). Several factors are incriminated for the low coverage of family planning services. The reasons include desire to have more children, lack of knowledge about contraceptive use and where to find contraceptives, health concerns, religious prohibition, husband opposition and low involvement of men (20).

2.2 Knowledge and Attitude of men towards family planning method

Most sub Saharan Africa countries still have male dominated cultures. Ancestral customs give men right over women's procreative power. In such situation we would expect that the husband's approval may often be a precondition for a woman to use family planning.

How ever the women and men know of at least one family planning method and majority of them also approves of its use. But there is a large gap between Contraceptive knowledge, approval and practice (21).

Many men are poorly informed regarding sexuality and reproduction and need guidance on how to share decision making and negotiate on how choices with their partners in recent national DHS surveys in fifteen countries (most in sub Saharan Africa) three of four married men recognized at least one modern method of

contraception .The pill was the most recognized method followed by the condom and female sterilization except in a few countries most men had not heard vasectomy (15).

In Ghana, "despite the independent nature of some marital relationships, recent evidence indicates that men have the primary decision-making power in matters of FP." Both DHS data and focus-group research reveal that the husband is usually the effective decision-maker about fertility. Furthermore, husbands' family-planning attitudes and fertility goals usually are not influenced by those of their wives. And, when partners disagree on whether to use family planning, the man's preference usually dominates (1994). Also, "There is a reason to suspect that men comprehend FP messages differently than women do. Men felt that financial considerations were the primary motivation for FP use, whereas women reported that health and the need for women to 'rest' were the primary motivations for use (22). In East and North Africa, no significant difference in fertility desire was found. This shows the importance of targeting men with FP programs (Ezeh et al., 1996) however Population growth, remains around 2.7 percent annually, Making Ethiopia Africa's second most populous country with an estimated population of 77.4 million In 2005 (7), Misconceptions about contraceptive use are relatively more widespread among men with little or no education and men residing in rural areas. Men in Dire Dawa, Oromiya and Benishangul-Gumuz are most likely to think that contraception is women's business; men in Oromiya are also most likely to believe that using contraception might make a woman promiscuous, and men in Harari, Amhara and Benishangul-Gumuz are more likely than those in other regions to believe that women should be the ones to get sterilized, since they are the ones who get pregnant (9).

2.3 Health behaviors models

Theoretical models fundamentally guide both our Current and future understanding of health behavior, as well as providing direction for our research and Intervention development. Evaluation and comparison of the different theories reveals that they are not so different in terms of their differential predictions. Most differences really amount to emphasis on one construct over another. Cummings and colleagues conclude that theories which integrate ideas from other competing theories provide more explanatory power (23).

The common health behavior models are

1. Health Belief Model;

The Health Belief Model (HBM) has the longest history of all the theories reviewed. It was originally conceived by social psychologists in the public health arena as a way of predicting who would utilize screening tests and/or Vaccinations. According to the HBM, the likelihood that someone will take action to prevent illness depends upon the individual's perception that:

• They are personally vulnerable to the condition;

• The consequences of the condition would be serious;

• The precautionary behaviour effectively prevents the Condition; and

• The benefits of reducing the threat of the condition exceed the costs of taking action

The model's four key components are conceptualized as perceived:

1) Susceptibility, 2) severity, 3) effectiveness, and 4) cost

2. Theory of Reasoned action

The Theory of Reasoned Action (TRA) is a widely used behavioural prediction theory which represents a social-psychological approach to understanding and predicting the determinants of health-behaviour. Two basic assumptions that underlie

The TRA are: 1) behaviour is under volitional control,

2) People are rational beings

The TRA was designed to predict behaviour from intention, and proposes quasi-mathematical relationships between beliefs, attitudes, intentions, and behaviour.

- Behavior is direct results of INTENTION
- Intention made up of ATTITUDES and SUBJECTIVE NORMS
- Attitudes are based on BELIEFS
- Subjective norms derive from what one believes OTHERS THINK ONE SHOULD DO and MOTIVATION TO COMPLY

3. Theory of planned Behaviour

- Modification of the TRA with more emphasis on PERCEIVED BEHAVIORAL CONTROL OVER THE ACTION, and SELF-EFFICACY

4. Social Cognitive Theory

Bandura's Social Cognitive Theory (SCT), also referred to as Social Learning Theory. This theory goes well beyond individual factors in health behaviour change to include environmental and social factors. Bandura conceptualized influences on behaviour that involved the concept of *person* in terms of basic human capacities that are cognitive in nature. Key concepts associated with the person include: personal characteristics, emotional arousal/coping, behavioural capacity, self-efficacy, expectation, expectancies, self-regulation, observational/experiential learning, and reinforcement (22).

5. Health Promotion Planning Matrix - PRECEDE-PROCEED MODEL

Health Promotion Programs operate either at primary (hygiene and health enhancement), secondary (early detection) or tertiary (therapeutic) stages of prevention, it may accurately be seen as an intervention whose purpose is to short-circuit illness or enhance quality of life through change or development of health related behavior and conditions of living. The **PRECEDE** framework (*p*redisposing, *r*einforcing and *e*nabling *c*onstructs in *e*ducational / *e*nvironmental *d*iagnosis and *e*valuation) takes into account the multiple factors that shape health status and helps the planner arrive at a highly focused subset of those factors as targets for intervention. PRECEDE also generates specific objectives and criteria for evaluation. The **PROCEED** framework (*p*olicy, regulatory and *o*rganizational *c*onstructs in *e*ducational and *e*nvironmental *d*evelopment) provides additional steps for developing policy and initiating the implementation and evaluation process (23).

6. TransTheoretical Model (TTM)

2.4 Trans theoretical Model (TTM)

Tran theoretical Model (TTM) is a model of intentional behavior change that has produced a large volume of research and service across a wide range of problem behaviors and populations. The TTM is a model of intentional change that focuses on the decision-making abilities of the individual rather than the social and biological influences on behaviour as other approaches tried. This model describes the relationships among: stages of change; processes of change; decisional balance, or the pros and cons of change; situational confidence, or self-efficacy in the behavior change; and situational temptations to relapse. This model has several advantages over other Models. First, it describes behavior change as a process, as opposed to an event. Then, by breaking the change process down into stages and studying which variables are most strongly associated with progress through the stages, this model provides important tools for

both research and intervention development individualized, stage-matched, expert system interventions (see below) that target those variables most predictive of progress for individuals at each stage of change. One aspect of this model that often goes unrecognized is that it is the processes of change that drive movement through the stages of change. Thus, although commonly referred to as the "Stages of Change Model" since "stage" is the core construct around which other model constructs are organized; this is a misnomer since it focuses attention on only one construct from this multidimensional model. Naturally, model-based interventions are multidimensional as well. TTM research has found remarkable similarities across different kinds of behavior changes. We have found repeatedly that the stages of change have predictable relationships with the pros and cons of behavior change, confidence in behavior change, temptation to relapse, and the processes of change. The largest numbers of TransTheoretical model related intervention studies have been for smoking and condom use (23).

2.4.1 Stages of Change

Individuals do not change their behavior all at once they change it incrementally or stepwise in stages of Change. The stages most commonly used across research areas include: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Individuals do not typically move linearly from stage to stage, but often progress and then recycle back to previous stage before moving forward again. This change process is conceptualized most meaningfully as a spiral, which illustrates that even when individuals do recycle to a stage they've been in before, they may still have learned from their previous experiences (22). Self efficacy is important for stage transition across all stage change (24).

Precontemplation describes individuals who for many reasons do not intend to change with in the next six months. Some of these individuals may want to change at some future time, but just not within the next six months. Others may not want to change at all and, in fact, may be very committed to their problem.

Contemplation describes individuals who are thinking about changing their problem behavior within the next six months. They are more open to feed back and information about the problem behavior than their counterparts in Precontemplation.

Preparation stages are committed to changing their problem behavior soon, usually within the next 30 days. These people have often tried to change in the past and/or have been practicing change efforts in small steps to help them get ready for their actual change attempt.

The *Action* stage includes individuals who have changed their problem behavior within the past six months. The change is still quite new and their risk for relapse is high, requiring their constant attention and vigilance.

Maintenance stage individuals have changed their problem behavior for at least six months. Their change has become more of a habit, and their risk for relapse is lower, but relapse prevention still requires some attention, although somewhat less than for individuals in Action stage.

2.4.2 Processes of Change

The processes of change describe the cognitive, emotional, behavioral, and Interpersonal strategies and techniques that individuals and/or change agents (therapists, counselors) use to change problem behaviors. The processes of change are also ideal tools for process-to-outcome research and in many ways provide the foundation for TTM expert system intervention. The processes of change are consistent with many SCT constructs and are quite similar to most conceptions of coping behaviors as well. Many studies across problem behaviors have found that the ten most used processes of change are Organized into two higher order clusters of processes: the experiential processes—Consciousness Raising, Dramatic Relief, Self-Reevaluation, Environmental Reevaluation, and Social Liberation; and the behavioral processes—helping Relationships, Counter conditioning, Reinforcement Management, Stimulus Control and Self Liberation (23).

2.4.3 Decisional Balance

Decisional Balance, or the pros and cons of behavior change, describes the importance or weight of an individual's reasons for changing or not changing. The pros and cons relate strongly and predictably to the stages of change. The pros are the positive aspects of changing behavior, or the benefits of change (reasons to change). In contrast, the cons include the negative aspects of changing behavior, or barriers to change (reasons not to change). These two dimensions have been consistently supported by studies across many different problem behaviors in TTM-based research. Characteristically, the pros of healthy behavior are low in the early stages and increase across the stages of change, and the cons of the healthy behavior are high in the early stages and decrease across the stages of change. The pros and cons are particularly useful when intervening with individuals in early stages of change

Decisional balance is an excellent indicator of an individual's decision to move out of the precontemplation stage. The TTM pros and cons constructs are quite similar to those also proposed by both the HBM (benefits/barriers) and the TRA/TPB (benefits/costs); and the evidence presented by Prochaska and colleagues across problem behaviors does provide some support for all three models.

2.4.4 Situational Confidence and Temptations

The self-efficacy construct utilized in the TTM integrates the models of self-efficacy proposed by Bandura, and the coping models of relapse and maintenance described by Shiffman. These variables have undergone considerable elaboration over time, with situational temptation to engage in the unhealthy behavior often viewed as an equally important companion construct to the more commonly used situational confidence measures. Confidence and temptation function inversely across the stages, and temptation predicts relapse better (23).

2.4.5 Self-Efficacy

The concept of self-efficacy is recognized as one of Bandura's most important contributions to psychology and the field of health behavior change in general. Self-efficacy refers to the *confidence* an individual has in his or her own ability to successfully carry out a behavior. The importance of self-efficacy for behavior change has been widely recognized across multiple behaviors relevant to health risk reduction. An individual with low self-efficacy is likely to have lower expectations of successfully performing the behavior and be more affected by situational temptations that are counterproductive to promoting and maintaining behavior change. In contrast, an individual who has High self-efficacy not only expects to succeed but is actually

more likely to do so. Several factors influence an individual self-efficacy, including persuasion by others, observing others' behavior (modeling), previous experience with performing the behavior, and direct physiological feedback Self-efficacy exerts such a strong influence on behavior change that confidence has been found to outperform past performance in predicting future behavior (23). According to Bandura (2002), self efficacy plays an important Role in the adoption of change and regulates human functioning through cognitive, motivational, affective and decisional processes. Therefore, assessment of the various socio-economic and cultural variables that contribute to low contraceptive practice is essential for promoting the use of contraception and lowering the birth rate (14).

2.5 Factors affecting involvement of male in family planning

Several factors may influence the attitude of men towards the use of contraceptive methods. There was strong association between literacy level and attitude of men towards contraceptive use (20). Other factors that affect involvement of men in family planning are religion, tradition, cultural value, access to media income and types of occupation (25).

Objective of the study

General objective

- To assess the involvement of men in fertility preference and modern contraceptive use by using Trans theoretical model (TTM) of behavior change

Specific objectives

- To assess the level of knowledge of married men for family planning
- To assess the attitude of men towards family planning methods
- To assess the level of involvement of men in the family planning use of their spouses
- To identify stage of male involvement using TransTheoretical models (TTM)
- To explore various factors associated with the behavior of men and involvement of men in modern contraceptive use.

4. Methods and Materials

4.1 Study area and source population

The study was conducted in Wolaita Soddo town, of Wolaita zone. This is one of the 13 zones in SNNPR. It is centrally located in the region, bordered by Kambata and Tembaro and Hadiya Zone in the north, Gamogofa Zone in the south, Dawro zone in the west, Sidama zone and Oromiya region in the east. The capital of the zone is Soddo town which is 385 kms south of Addis Ababa and 160kms west of the regional capital Awassa. Based on the 1994 National census the projected population of the zone in 2008/2009 had 1, 820 281. Out of which 95% of the Population residing in rural areas the rest 5% live in the town. The population density varies from 189/km^2 in less density populated woreda to 624/km^2 in highest density woreda, thus making the average density 234/km^2 (26). By the year 2008/2009, (2001G.C) there was one government hospital; one non government hospital and one private hospital, 14 health centers and 178 health posts are providing services for the community. Malaria, Tuberculosis, malnutrition and HIV/AIDS complicated by over crowding are the main health problems of the zone (27).

The total population of the town was 73,253 which were 37,986 are males 35,268 were females. The total number house hold was 14309 Wolaita Soddo town is structured in three kifle ketema and total of 11 urban dwellers association or kebeles in the town there were one government hospital and one NGO hospital one government health center, two higher clinics eight small clinics two pharmacies one drug distribution stores three drug stores eight drug vendors.

4.2 Study period

The study was conducted from September 2008 upto April 2009, in Wolaita Soddo town

4.3 Study Design

Community based cross -sectional study employing both quantitative and qualitative data collection methods.

4.4 Study population

The study population comprises of those currently married men age 20-64 residing in wolaita soddo town who were selected from source population by using systematic sampling techniques.

4.4.1 Inclusion criteria; currently married men who lived in the study area more than Six Months, wives age 15-49 not currently pregnant and couples do not want to have a child in the next six months

4.4.2 Exclusion criteria; married men who lived in study area for less than Six months, pregnant wives and wives age greater than 49.

4.5 Sample size determination

The formula used for calculating the sample is

$$n = \frac{(Z\alpha/2)^2\ p(1-p)}{d^2}$$

Where

n=the desired sample size

p=proportion of couples both approve the contraceptive use (48.6%) (28)

Zα/2= critical value at 95% confidence level of certainty (1.96)

d= the margin error between the sample and the population =5% using the above formula sample size for single population proportion the desired sample size is 384.considering non response rate of 10% the total sample size used for the study was 423 married men

4.6 Sampling procedure

4.6.1 Quantitative Survey

Wolaita Soddo Town was divided into three areas based on existing Administrative unit (kifleketema) and eleven kebeles, from Arada and Mercato kifleketema two kebeles was selected. From Mehal kifleketmas one kebele was selected using simple random sampling techniques. The sampling fractions from each of the selected kebeles were determined proportional to the size of the total population of each kebele. Then systematic sampling method was employed to select the households from each kebele, where the sampling interval was the total number of households in each kebele divided by the corresponding number of households to be interviewed in each kebele. The first household to be interviewed was determined from the kebele house number register using simple random sampling method. The next household was identified by systematically (H/h^{th}) by going in a clockwise direction. If more than one eligible respondent were found in the selected household, only one respondent was chosen by lottery method (simple random sampling). In cases where no eligible was identified in the selected household, the interviewer to the next household in the clockwise direction was visited and included if eligible see in the (Figure1).

Figure 1 Showing Schematic Representation of Sampling Procedure February 2009

PPS=Proportionate Sampling SRS=Simple Random Sampling SS=Systematic Sampling

4.6.2 Qualitative survey

The qualitative data collection method was applied in order to generate information from health service providers, in the study area, currently married women, religious leaders and elders residing in the study town using focus group discussion (FGD) in order to supplement the result of the quantitative data that can not be quantified.

The FGD was conducted in the following manner:

- From currently married women two groups were selected
- From health service providers one group was selected
- From religious leaders and community leaders (elders) two groups were selected.

Discussion were made with five focus groups and each group consisted of 6-10 participants who was selected from the respective communities and facilitators, using Purposive non-probability sampling method

4.7 Tools for Data Collection

I. **Quantitative data collection**

The data for the quantitative section was collected using a structured questionnaire (See ANNEX II) prepared by addressing all-important variables. These questionnaires were adopted from different literature developed for similar purpose by different authors. It was reviewed to suit the local condition and translated to Amharic language and then back to English to ensure its consistency. The survey questionnaire was pre-tested in other kebele and the necessary modifications and correction was made to standardize and ensure its validity. Using the questionnaire, currently married men from the selected households were interviewed by trained diploma nurse data collectors with experience in data collection. The data collectors speak both Amharic

and the local language (wolaitigna). The interview was made by house-to-house visit in the presence of strong supervision.

II Qualitative data collection

Focus Group Discussion (FGD} was done separately in three homogenous group using an interview guide see (ANNEX III) .The FGD were facilitated by the supervisor who knows the local language and the principal investigator.

4.8 Data quality management

To ensure the external validity (generalizability) of the study, appropriate size and representative type of study units ware selected as described in the appropriate section above. And to ensure the internal validity (accuracy and precision) of the study, maximum effort was applied to minimize bias and errors using the following strategies:

a) During data collection process: - in order to enable proper functioning of the questionnaire as per the desired objectives, pre testing was conducted prior to data collection process. Then data were collected using the amended questionnaires by trained and experienced nurses.
b) Questionnaires prepared in English and translated in Amharic were translated to Amharic again to keep the consistency

4.9 Data Analysis procedures

Quantitative data was entered in SPSS soft ware package. Finally it was cleaned and analyzed based on the objectives of the study using the already planned explanatory and response variables using the mentioned computer soft wares (SPSS) and

Ms -Excel.

For the qualitative part; data collected by FGD facilitators through tape recorders were analyzed manually by the principal investigator. Some quotes from the qualitative data that best explain the involvement of male in family planning were identified and presented in the participants own words in parallel with the quantitative information to give more insight for the study.

Validity and reliability

The questionnaire will be first prepared in English then translated into Amharic back translated into English to assess its content validity. It was translated by the principal investigator; five experienced nurses and one sanitarian with BSc degree were recruited and trained for 2 days by the principal investigator on the method of data collection. Pretest was done for necessary correction done in the questionnaire

4.10 Study variables

Dependent variables

Family planning method use

Independent variable

- Spousal communication
- Approval of family planning
- Socioeconomic variables
- Socio cultural variables
- Knowledge and attitude men in family planning

4.11 Operational Definition

Currently use of contraception; those respondent who were using contraception once during the period of data collection

Ever use contraception; those respondents who were using contraception once in there life. It include those who were using contraceptive methods during the data collection period

Involvement of men ;participating in both fertility decision making and adopting behaviors such as sharing reproductive health decision making and supporting partners choices of family planning

4.12 Ethical considerations

Ethical clearance was obtained from the respective school of public health, and AAU Faculty of medicine ethical committees. A formal letter was submitted to all the concerned bodies to obtain their co-operation. All participants' right to self-determination and autonomy was respected. They were given any information they needed, verbally and in writing. Participation was voluntary and they can withdraw from the study at any time without explanation and without penalty or loss of benefit. The autonomy of each participant was assured unless they needed assistance in filling out the questionnaire. In such cases, confidentiality was assured and no personal details was recorded or produced on any documentation related to the study.

4.13 Dissemination of results

After the research paper is approved by the advisors and other responsible bodies, it will be disseminated to the graduate coordinator of the school of pubic health, and to those governmental (MOH) and non governmental organization that potentially benefited from the study. Finally the paper will be sent for publication to local or international journal.

5. Result

Socio-demographic Characteristics

All currently married men in the study 423(100%) responded to the questionnaire making the response rate 100%. The mean age of the respondent was 38.47 years. More than 2/3of the respondent with in the age range of 20-40 the rest constitute above age of 40. More than 85% of the study participants were Wolaita and Gammo by ethnicity other ethnic group constitute less than 15% (Table 1).

About (49.4%) of the respondents were Protestants, followed by Orthodox (40.4 %), Muslim (6.1%) and Catholics (3.8%). More than 75% of the respondent had received formal education, 14.9% were illiterate, and 2.8% were able to read and write but not attended formal education (Table 1).

About 1.9% of the study participants were unemployed, 3.3% were farmer, 24.1% were government employee, and 70.6% were private employees. The marital relationship of 97.6% was monogamous, while only 2.6% were polygamous (Table1).

Table 1 Socioeconomic and demographic characteristics of currently married men in Wolaita Soddo town SNNPR

Respondent		
Variables	Frequency(N=423)	%
Age/year		
20-30	112	26.4
31-40	172	40.66
41-50	91	21..5
51-64	44	10.4
>64	4	0.94
Ethnicity		
Wolaita	268	63.4
Gammo	98	23.2
Amhara	26	6.1
Gurage	12	2.8
Siltie	11	2.6
Oromo	5	1.2
Others	3	0.7
Religion		
Protestant	209	49.4
Orthodox	171	40.4
Catholic	16	3.8
Muslim	26	6.1
Other specify	1	0.2
Educational status		
Illiterate	63	14.9
Read and write	12	2.8
Primary(1-6)	107	25.3
Junior high school(7-10)	107	25.3
preparatory(11-12)	24	5.7
Higher education	104	24.6
No response	6	1.4
Occupation		
Unemployed	8	1.9
Farmer	14	3.3
Government Employed	102	24.1
Private	299	70.6
Current living children		
0	7	1.7
1-2	143	33.8
3-4	137	32.33
>5	136	32.15
Marital relationship		
Monogamous	412	97.6
Polygamous	11	2.6

Men Reproductive health Characteristics

The mean age of study participant at first marriage was 25.2 year with a standard deviation 5.594 years. About 2/3 of study participant married at the age range of 20-29 but 11.8% of the study participant were in the age range between 15-19 years, and the rest 23.16% of the participant age 30 year and above (Table 2). The average number of living children per man was 3.68 and the average desired number of children was 3.82. Only 2.8% of the participant wished to have a child less than 2 year, 33.6% wished to have a child between 2-3 year, 23.2 % with in 3-4 year, and 29.3% wishes to have >4 year (Table 2).

Table 2 Reproductive health characteristics of the study participant, Wolaita Soddo Town, April 2009

Respondent		
Variable	Frequency(N=423)	%
Age at first marriage		
15-19	50	11.8
20-24	157	37.1
25-29	118	27.78
>30	98	23.16
Current living children		
None	7	1.7
1-2	143	33.8
3-4	137	32,4
≥5	136	32.1
Desired number of children		
1-2	129	30.4
3-4	177	41.8
≥5	117	27.8
Birth Spacing		
<2year	12	2.8
2-3 year	142	33.6
3-4 year	98	23.2
>4year	124	29.3
do not want to wait	12	2.8
do not know	35	8.2

Men knowledge of contraceptive use

About 96% of the respondents heard about family planning and familiar for at least one method. The most commonly reported family planning methods are pills (96%), injectables (Depo Provera) 94.5% condom 88.6%, Norplant 35.3% intrauterine device 22.5% Vasectomy 33.1% Tubal legation 33.1%, rhythm method 20.7%, Spermicidal 2.71% Other includes withdrawal method (Table.3)

Table 3 knowledge of study participant about modern contraceptive method Wolaita soddo Town 2009

Variable	Frequency(N=423)	%
Ever heard about modern contraceptive		
Yes	405	95.7
No	18	4.3
Knowledge of each method(N=405)		
Pills	389	96
Injectables	383	94.5
Condom	359	88.6
Norplant	143	35.3
IUD	91	22.5
Male Sterilization	134	33.1
Female sterilization	134	33.1
Rhythm method	84	20.7
Spermicidal	11	2.71
Other	1	0.24
Source of Information(N=405)		
Radio	340	83.9
Health worker	248	61.2
Poster	49	12.1
News paper	82	20.24
Parents	10	2.46
Others	49	12.1
Knowledge of sterilization (N=423)		
Yes	134	33,1
No	271	66.91
No response	18	4.44

*Multiple responses were given about knowledge of each method and source of information

Attitudes of men towards modern contraceptive

Married men were asked whether they have Desire to know more about family planning method 387(91.5%) of the respondent had desire to know more about family planning method 25(5.9%) of the respondent had no desire to know family planning method the rest 11 (2.9%) gave no response for this question. Married men were asked whether they approve or disapprove (both the male and female method) the use of family planning method about 328 (77.5%) of the married men approve the use of family planning at the time of the interview, while 80 (18.9%) disapprove the rest 3.5% gave no response for this question. The reason mentioned for disapproval 23(28.8%) were desire to have more children,21(26.3%) respondent refusal ,9(11.3%) wife or partner refusal, 9 (11.3) fear of side effect , 7(8.8%) religious prohibition,11(13.5%) were others about 59.5% of married men discussed family planning in the last 1 year of those who discussed family planning 187 (73.9%) had frequent discussion while 17(6.7%) and 49 (19.4%) had discussed the issue of family planning once and twice respectively (Table 4).

Table 4 Approval and Spousal Communication among currently married men in Wolaita Soddo town 2009

Variable	Frequency	%
Desire to know more about family planning method (N=423)		
Yes	387	91.5
No	25	5.9
No response	11	2.6
Approved use of contraceptive (N=423)		
Yes	328	77.5
No	80	18.9
I don't know	3	0.7
No response	12	2.8
Reason for Disapproval (N=80)		
Desire to have more child	23	28.8
Respondent refusal	21	26.3
Wife or partner refusal	9	11.3
Fear of side effect	9	11.3
Religious prohibition	7	8.8
Other	11	13.5
Discussion of Family planning (N=423)		
Yes	253	59.8
No	154	36,2
No Response	16	3.8
Frequency of Discussion (N=253)		
Once	17	6.7
Twice	49	19.4
Many Times	187	73.9

Table 5 Attitude of married men towards family planning methods Wolaita Soddo Town, Southern Ethiopia, April 2009

Married men Attitude	Strongly Agree No (%)	Agree No (%)	Neutral No (%)	Disagree No (%)	Strongly Disagree No (%)
Do you feel that too long a family size strains the family economic situation	218(51.5)	154(36.4)	16(3.8)	25(5.9)	10(2.4)
Too many children (a large family) makes a unhappy home	41(9.7)	278(65.7)	11(2.6)	76(18)	17(4)
Too many children have effect on the health of mother	158(37.4)	185(43.4)	19(4.5)	46(10.9)	15(3.5)
Family planning practice will make strong confidence between husband and wife	23(5.4)	98(23.2	56(13.2)	224(53)	22(5.2)
Men shares the responsibility of family planning	100(23.6)	233(55.1)	41(9.7)	36(8.5)	13(3.1)

Attitude score points
Strongly Agree = 5
Agree= 4
Neutral = 3
Disagree =2
Strongly Disagree= 1

Cutoff Points
above the mean attitude score== Positive Attitude
below the mean attitude score= Negative Attitude

From study participant 212(50.1%) have positive attitude while 211 (49.9%) had negative attitude. Married men who approved the use of family planning method were 3.713 times more likely to have positive attitude than men who didn't approved the use of family planning method (OR 3.713 95% CI(2,238,6.161). Married men who discussed family planning method were 1.835 times more likely to have positive attitude than men didn't discussed on family planning method (OR:1.835 95% CI (1.226,2.757).

Men use of Family planning with their partner

Overall 277 (65.5%) of Couples (married men and their wives) currently used family planning method and less than 5% of the respondent used male method (Vasectomy and condom) , about 36(8.5%) reported have used family planning at some time but not currently using it about 107(25.3%) reported never having used any family planning method.

The main reason reported for current use of family planning method Child spacing 207 (74.72%) limiting the number of children 70 (25.27%). About 158(71.4) reported joint spousal decision making on issue related to contraceptive use however 57 (20.5) decide contraceptive use alone. The decision made wife alone 21 (7.58%).

The rate of non use of family planning method among the study participant was 107 (25.3%). many reason were reported among non user desire to have more child 31(28.9%) husband opposed 15(14.01%), source of contraceptive not known 11(10.28%) wife opposed 10(9.34%) fear of side effect 9(8.41%) health concern 9(8.41%) religious prohibition 6 (5.6%) no response 8 (7.47%) others 8(7.47%) (Table 6).

Table 6 practice of family planning method and reason for not use married men and their partner Wolaita Soddo town, April 2009

Variable	Frequency	%
Family planning method use(N=423)		
Currently used	277	65.5
Ever used	36	8.5
Not used	107	25.3
Reason for Current use(N=277)		
Child spacing	207	74.72
Limiting the number of child	70	25.28
Decision on family planning method use(277)		
My self	57	20.5
Both of us	198	71.4
My wife	21	7.58
Reason for not using family planning method (N=107)		
Desire to have more child	31	28.9
Respondent opposed	15	14.01
Source of Contraceptive not known	11	10.28
Wife opposed	10	9.34
Fear of side effect	9	8.41
Health concern	9	8.41
Religious prohibition	6	5.6
No response	8	7,47
other	8	7.47

Injectable (Depo-Provera) was the commonly used family planning method 190(68.6%), followed by Oral contraceptive pill 35(12.63%), Norplant 27 (9.74%), Rhythm method 10 (3.61) Condom 6(2.16%) others 5(1.9) (Figure 2).

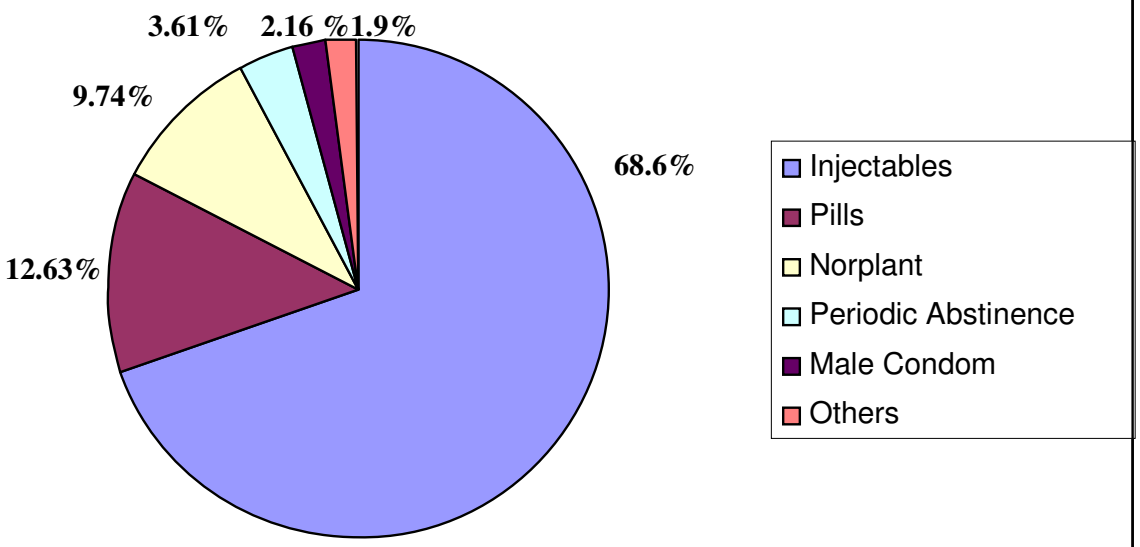

Figure 2 Couple Family planning Method Use

Behavioral Stage of Men in Contraceptive Use in Wolaita Soddo Town

From the study participant 113(26.7%) had no intention to take family planning method in the future (*precontemplation stage*), 33 (7.8%) intend to take family planning methods within the next 6 months (*contemplation stage*), 19(4.5%) intend to take family planning method with in the next 30 days, 68 (16.1%) starts to practice family planning method with in the past six month (*action stage*). The rest 209 (49.4%) of the participant used family planning method in the past and plan to practice in the future.

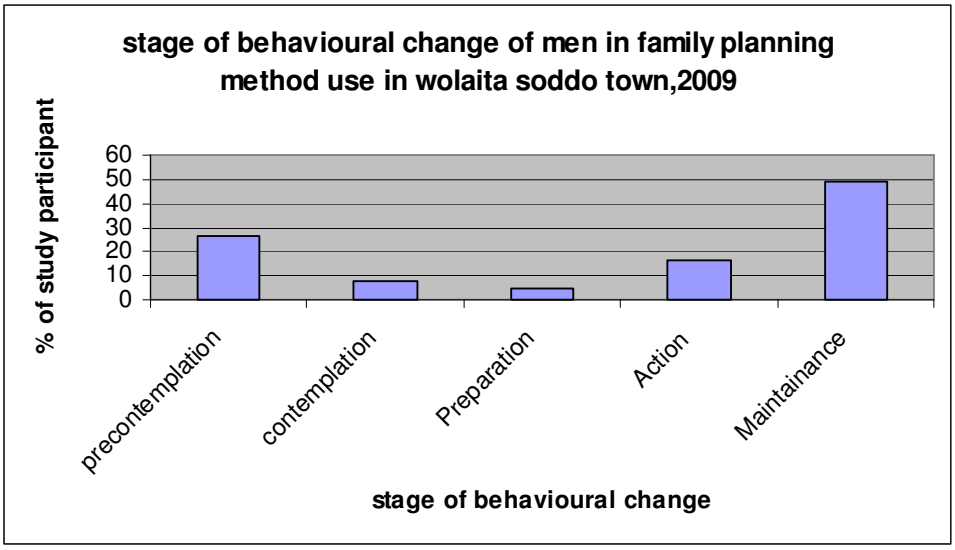

Figure 3 Stage of Behavioral change in family planning

Table 7 Sociodemographic characteristics versus Behavioral stage of men in family planning use of study participant Wolaita Soddo town 2009

Variable	Behavioral Stage of men				
Age	**Precontemplation N=113**	**Contemplation N=33**	**Preparation N=19**	**Action N=68**	**Maintenance N=209**
20-30	25	12	6	18	57
31-40	22	17	11	38	95
41-50	31	2	1	9	50
51-64	31	2	1	3	7
>64	4	0	0	0	0
Religion					
Protestant	45	25	15	31	109
Orthodox	53	8	4	27	82
Catholic	7	0	0	3	6
Muslim	8	0	0	7	11
Other	0	0	0	0	1
Ethnicity					
Wolaita	63	20	11	40	146
Gammo	33	1	7	16	37
Amhara	6	11	1	3	16
Gurage	2	0	0	4	6
Siltie	6	0	0	3	2
Oromo	2	0	0	2	1
other	1	1	0	0	1
Occupation					
Employed	98	32	18	65	200
Unemployed	13	1	1	1	7
No response	2	0	0	2	2
Educational status					
Educated	73	28	16	58	184
Uneducated	39	5	3	7	23
No response	1	0	0	3	2

Determinant of family planning use by the study participant

Analysis of the independent variables in relation to current use of family planning method showed that exposure to media, approval and discussion about family planning issue among spouses were found to have significant impact on contraceptive use (Table 8). Odds ratio(OR) with their corresponding 95% confidence interval (CI) were adjusted for educational status, occupation, having radio/Television, discussion about family planning with wife and approval/disapproval of contraceptive use.

Men who had a radio 2.167 times more likely to practice family planning method than those with no radio/Television (OR= 2.167 CI 1.065-4.410) men who had television in his home practice family planning method 2.25 than men had no television/radio (O.R=2.25 CI 0.479-10.569). Men who had both Television and radio 2,855 times practice family planning method than men who had no Television/radio (O.R 2.855 CI 1.299-6.273). Men who had discussions with their wives about family planning matters were 4.091 times more likely to practice family planning method than men who had no discussion (O.R=4,091, 95% CI 2.273-7.364,) and men who approved of the use of family planning method were 4.091 more likely to practice than men did not (O.R 16.58 95% CI 7.69-35.77).

Table 8 Result of Multivariate Analysis Current use of family planning with selected explanatory variable

Variable	Current use of Family planning		Crude Odds ratio	95% Confidence Interval	Adjusted Odds ratio	95% confidence Interval
	yes	No				
Education						
Educated	242	100	3.630	(2.16-6.09)*	1.352	(0.648-2.823)
Uneducated	30	45	1		1	
Occupation						
Employed	265	130	3.567	(1.46- 8.72)*	0.988	(0.28-3.44)
Unemployed	8	14	1			
Do you have TV/Radio						
Radio only	121	56	2.701	(1.573 -4.638)*	2.167	(1.065-4.410)**
TV Only	9	6	1.875	(0.610-5.759) *	2.25	(0.479-10.569)
Both TV and radio	111	39	3.558	(2.011- 6.292)*	2.855	(1.299-6.273)**
None	36	45	1		1	
Approval of family Planning						
Approved	266	62	32.762	(16.49-65.09)*	16.587	(7.69-35.77)**
Not Approved	8	75	1		1	
Discussion on the issue of family planning						
Yes	217	36	10.549	(6.52- 17.08)*	4.091	(2.273-7.364)**
No	56	98	1		1	

* shows significance odds ratio unadjusted, p<0.05

** shows significance odds ratio adjusted, P<0.05

Summary of focus Group Discussion

Five focus group discussions were done in order to supplement the findings of quantitative result.

The FGD were conducted among the following groups: from currently married women two groups was selected, from health service provider's one group was selected and from religious leaders and community leaders (elders) two groups was selected.

Overall focus group discussion are summarized in the following four thematic areas

1. Benefit of Family planning method

The participant reported advantages of family planning were:

- Improves the household income through creating Opportunities to women to engage in labour force this improves overall income of the family.
- Improves the health of mother and children. Participants said abortion-related and obstetric-related mortality and morbidity could have been averted by use of effective contraception by women wishing to postpone or cease further childbearing. Also they said family planning also brings large potential health and survival benefits for children, mainly as a result of wider interval between births.
- Improves the socio economic status of women. Family planning provides better opportunity to women's education and to engage in non domestic income generating activities.
- Improves the quality of life and nutritional condition of the family. If a mother had better education &economic condition she would satisfy the nutritional need and demand of the family

2. Spousal communication and attitude of male towards family planning method

Participant from currently married women, religious and community leader said that previously spousal communication in family planning was minimal. Most men perceived that family planning was the issue of women But now this was improved , they discuss the issue of family planning with their wives they made joint decision on the use of family planning method. One currently married female participant said to improve our life I and my husband jointly discussed the benefit of family planning method she said in wolaitigna (*deoa madenawe teleya ekeyoga loo eseppe zooretede haseyetede eketesse*") participants from health care provider also agreed that the attitude of male towards contraceptive methods know improved compare to previous time majority approves the use of contraceptive method and they discuss family planning method with their wives (Partners). But still there was a fear to visit health institution among men. The reason cited by the health care provider initially the family planning service provision starts along with Maternal and child health services and health facilities availing limited male method the only male method that was found in health facility was condom. Participant from community leader's and one kebele leader said that I will be ashamed personally, to visit to take male method of family planning method and also had a great fear to vasectomy.

3. Barriers to spouses on practice of family planning method

Cultural barrier

The entire participant of focus group agreed that there was a culture that encourage many number of children and that provides great social value for large family. Even one participant said the parent of large family benefited from their children said in wolaitigna ("*Derro natte deyo keetaye getta nattuppeka madetese''*) this culture inhibit spouses to practice family planning methods. Other cultural barrier that was

explained by study participant was perception of community children as an asset socially and economically gain from having a large number of children, fear and low desire by men to practice family planning method, fear among females to disclose the benefit of family planning, gender-based power imbalance in the issue of sexual and reproductive health, low Habit in spousal discussion, and family planning rumors in the community such as contraception causes sterility. But the discussant perceived that this should be changed.

Institutional barrier

Participant from health care provider said that health institutions availing female method of Family planning .the only method that was available in health facility was condom even in hospital vasectomy were not performed

Low level of education

Level of education of both husband and wife was also a factor to practice family planning method. Participants said that Low awareness of men in reproductive health and family planning was a factor that inhibits the use family planning method. Education forebear's modern ideas of small family size as it means better standard of living. It also ensures greater knowledge about various methods of contraceptive and their effectiveness.

Religious barrier

Participant from currently married women, health care provider and community leader said that previously most of the religious leader both in Christian and Muslim strictly opposed the use family planning but know this was changed most religious

leader advocate communication between husband and wife. Even if there is a change in attitude of religious leader towards family planning method still some religious leader opposed the use of family planning method

4. Participant suggestion to improve male involvement in family planning use

Participant from married women recommends that health worker should work in educating males and involving males in family planning counseling session and educating males on the benefit of family planning. Participant from married women and community leaders recommend that health worker should work with Model household benefited from family planning program educate the community, sensitize the community leader and religious leader through work shops seminar on the issue of reproductive health and family planning.

Participant from health care provider suggest that community conversation should be done to improve awareness of male towards family planning method and reproductive health, and key decision maker should work on incorporation of the family planning method and responsible parenthood into school curriculum

6. Discussion

The study assesses the involvement of men in family planning method utilization in Wolaita Soddo town. Involving men and obtaining their support and commitment to family planning is of crucial for family planning service utilization. This paper focuses the importance of involving men in influencing the utilization of family planning method and highlighted the potential insights into men's behavior where family planning interventions could be made. There are variations in the types of family planning method that are practiced in the study area. Male method such as vasectomy and condom were utilized poorly, which is consistent with study done in Hosanna and Gondor (12,20).Desire to have another child, the participant opposition, respondent and their wife perception source of contraceptive not known fear of side effect, health concern and religious prohibition are among the reasons reported for low utilization of family planning. Men knowledge on family planning is very high compare to previous study. In this study 96% of married men know at least one method of family planning this might be the result of intervention by the health sector and increase exposure to media.

The average living children per men was 3.68 and the desired number of children was 3.82 which are lower than a study done in Hosanna by Tularo eta'l this could be explained by high knowledge of family planning by the study participant and improvement in practice of family planning method (20).

Only 2.8% of the participant wishes to have a child with 2 year,33.6% wishes to have a child between 2-3 year, 23.2 % 3-4 year ,29.3% wishes to have after four year This shows high number participant practice family planning method for birth spacing than limiting which is in agreement a study done in Ethiopia and other developing countries. (20, 15)

In this study 26.7% of the study participant no intention to practice family planning method in the future (Precontemplation stage).Which is Comparable to Vietnam study. 25.8% of the men were in the precontemplation stage. In this study 7.8% of the study participant had intention to practice family planning method in the next six months (contemplation stage) which includes those that was prepared to practice family planning method which is in agreement with Vietnam study (9) 4.5% of men in this study are preparing themselves to practice family planning method with in the next 30 days, which is higher than Vietnam study. This might be a study done in Vietnam was rural this study was urban and the Vietnam study was only for IUD but this study was for all methods of family planning .The rest 65.5% of the study participant were in action /maintenance stage which is comparable with Vietnam study(9) .

From this study we can classify study participants those in the behavioral stage in precontemplation, contemplation and preparation stage currently not practiced family planning method. But those in action and maintenance stage currently practiced family planning method.

A study revealed that educated men more likely to practice family planning method than uneducated once adjusted odds ratio 1.352 CI (0.648-2.823) but not stastically significant P-value> 0.05. A study conducted in northern Ethiopia showed that men have greater desire for more children than women. A desire for more children decreases as the level of education increases. Education forebear's modern ideas of small family size as it means better standard of living. It also ensures greater knowledge about various methods and their effectiveness.

In this study we found that there is no stastical association between family planning practice and religion. The impact of religion on contraceptive use of now diminished. Family planning method was practiced in both Muslim and Christian Society. The qualitative finding also supports this idea.

In this study Approval of family planning method use by the study participant was 77.5% lower than a study done in Hossana and Bangladesh and Kenya. But higher in a study done in Gondor this might be a difference in sociocultural norms such as male/Husband dominance and opposition to the use of contraceptive of study participant. Approval of men in contraceptive use was highly associated with current use of contraceptive use adjusted odds ratio 16.5 CI (7.69-35.77) P<0.001

Husband-wife communication, as measured in particular by each spouse's attitude toward family planning, the wife's perception of her husband's approval of family planning, interspousal power, gender role in the sphere of marital life. Spousal discussion about matters related to reproduction and family planning is viewed as being successful to the extent that it directly increases the use of contraception and favourable attitudes towards contraception among couples. Through discussion a couple can come to a mutual decision on whether or not to use contraception to plan when to have children and how many to have (14).In this study we found 59.8% married men discuss the issue of family planning with spouses. A study done in Hosanna town 66% of married men discussed the issue of family planning the difference between two studies explained by cultural difference between two communities but a study done in Gondor 14 year back by Ismail.s. Only 23.9% of

married men have discussed family planning with their wives, which is lower than this finding. In this study men who were discussions with their wives about family planning matters 4.09 times to practice family planning method than men who had no discussion (O. R 4,091 95% CI 2.273-7.364,) in agreement with a study done in Hosanna (20) The qualitative finding also supports this finding participants said there is improvement in discussion between husband and wife in the issue of family planning.

Husbands who had Radio, Television, and both have more likely to practice family planning than those they don't have because media influences the knowledge and attitude of the study participant.

In this study, the CPR was found to be 65.5% is higher than other urban centre in the country. This might be due to an increased awareness and knowledge of the community about contraception, increased access to family planning services, or increased involvement of NGOs, private and religious organizations in the advocacy and provision of family planning service Male method of contraception such as vasectomy and condom poorly practiced by the study participant. There in no men in the study participant that undergone Vasectomy and only 6 (2.16%) of study participant practiced condom and 0.36% withdrawal method. These results are in agreement with DHS Ethiopia and other developing countries studies (7.15)

7. Strength and limitation of the study

Strength of the study

- This study used qualitative method to supplement the result and also to explore ideas that are not addressed by quantitative survey

Weakness of the study

- Since the study was cross-sectional does not show causual relationship
- Presence of very limited studies for comparison purpose could be considered as a constraint factor for the study
- Social desirability bias could not be ruled out in responses to questions

8. Conclusion

The study found high prevalence of knowledge of family planning methods among married men, improvement of men attitude towards family planning methods, high family planning method utilization by married women, low utilization rate of male method and low level health institution readiness to provide the service for married men. Discussion between spouses, approval of family planning method by men and joint decision making on family planning method use found to be high. This also in agreement with qualitative finding done with marred women participants.

Behavioral stage of men on family planning method use around half of the study participant on maintenance or adoption stage significant proportion on the action stage this shows that there were an improvement on behavioral change of men on family planning method use. Various factor affect the involvement of man in modern contraceptive use the impact of religion on family planning method use was reduce but education, exposure to media, spousal Communication has significant effect on family planning method use.

9. Recommendation

Based on the study finding the following recommendation are made

- Family planning methods use among married men is very low (e.g., condom 2.16%). For this purpose, governments, nongovernmental organizations (NGOs), donors' agencies and relevant stakeholders should ensure availability, accessibility and sustained advocacy for use of condom for protection against unwanted pregnancy
- The health provider should help men to communicate with their partners and make contraceptive choices together
- Health institution should improve the availability of men family planning method through resource mobilization from partners(NGOs) and different actors
- Information, education and communication programs for promoting family planning methods should, be strengthened in local media
- Targeted, stage based IEC intervention should be implemented to change the knowledge and attitude of married men in family planning method
- This study focuses on only staging the behaviour of change of men further study was recommended by looking through the effect of other construct of TransTheoretical behaviour model (Self efficacy, Decisional balance, process of change and situational temptation)

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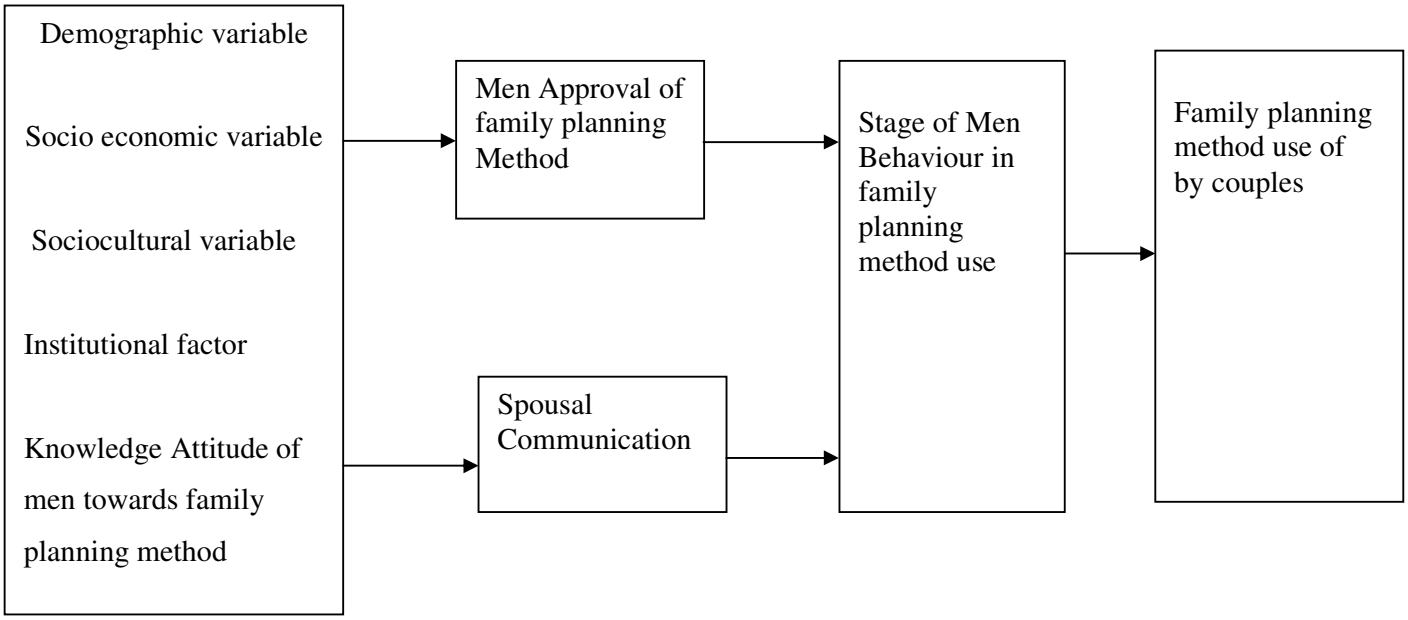
ANNEX I Conceptual Framework for the Study of Involvement of Male in Contraceptive use by the Application of Trans theoretical Model



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Annex III Focus Group Interview Guide for community& religious leaders

INTRODUCTION; I would like to ask you the involvement of male in family Planning in this community

1. What is the advantage of family planning to this community?
2. Who decide on family planning use in the family? How?
3. How do you discussed about family planning with your partner?
4. How men can support his wife in family planning use?
5. What are the cultural factors that affect men to use family planning method?
6. What you heard rumors in the use of family planning?
7. is there religious prohibition in contraceptive use?
8. What are the factors that inhibit communication with your partner?
9 . What you suggest to improve communication between husband and wife

Focus Group Interview Guide for currently married women

INTRODUCTION; I would like to ask you the involvement of male in family Planning in this community

1. How do you decide on family planning use in the family?
2. How men can support his wife in family planning use?
3. How do you communicate with your husband in sexual and reproduction issue Specifically Family planning
4. How cultural factors affect the use of family planning methods in your area?
5. How can we improve the communication specifically with the issue of sexual and Reproductive Health specifically family planning?

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Focus Group Interview Guide for government health provider

INTRODUCTION; I would like to ask you the involvement of male in family Planning in this community

1. How the communities express his opinion towards health service provided?
2. Who is your potential client – men?
   Women
3. How do you look the attitudes of men towards modern contraception and overall Fertility ?
4. What are the obstacles to use men methods of contraception's?
5. Is there couple counseling secession in family planning services? How it has been given
6. What are the reasons men can't visit for family planning to the health facility?
7. How we can improve partners Discussion in reproductive health and family Planning

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