

Factors influencing male involvement in family planning among married couples seeking maternity and pediatric services in Chuk

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ABSTRACT

Globally women have played a major role in household and decision making on their own health care and life through family planning. There has been tremendous improvement in utilization of family planning and reduced birth rates. However male involvement in family planning is still minimal with male playing a peripheral role. The aim of the study is to determine the factors influencing male involvement in family planning among married couples seeking maternity and pediatric services from January to June 2016 in CHUK. Cross-sectional study design was used. The study population comprised of 171 married couples seeking maternity and pediatric services in CHUK. The study sample size was 119 married couples systematic and randomly selected participated in the study. Data was collected using Interviewer administered semi-structured questionnaires. Study instrument validated by pilot testing and translating into local language and data collection lasted for a period of one month. Data was analyzed using SPSS for descriptive and inferential statistics at level of significance was set at $p= 0.05$. Findings were as follows: the socio-demographic characteristics that influenced male involvement in family planning with ($P < 0.05$) includes; participant's age, religion and residence. In like manner about 84 (70.6%) of study respondents had good involvement in family planning. Also spouse are not influenced by taboo when they understand benefits of Family Planning. A good number of the respondents knew condom and pills as family planning method However, only 27(22.7) knew withdrawal and 45(37.8%) aware of Tubal ligation as family planning. Inadequate health education by health care workers on Family Planning products/services may lead to low uptake of services ($P = 0.04$). Finally, study result showed low knowledge and influence of taboo. Way forward, to increase knowledge and improve attitude of males towards method of family planning and support their spouses' use of family planning.

Keywords:Family Planning, Male involvement, Married Couples, Maternity and Pediatric Services

INTRODUCTION

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 [1,2,3,4]. Most of the family-planning services were offered within maternal and child health (MCH) centers, most research and information campaigns focused on women and this has reinforced the

misconception that family planning is largely a woman's business, with the man playing a very peripheral role especially in a society where male supremacy is important [5,6]. Male involvement in family planning 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 partners in contraception and peers to

use family planning and who influence the policy environment to be more conducive to developing male related programs [7,8]. 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 effect of increasing the acceptability and prevalence of family planning practice of either sex [9]. The aim of family planning is to enable individuals and couples to anticipate and attain the desired number of children, spacing through use of contraceptive methods [10,12]. World fertility survey showed that utilization of family planning methods varied widely from 69% south-east Asia to 11% in Africa [13,14]. It is evident that the widespread adoption of family planning represents one of the most dramatic changes of the 20th century. Office of Population Affairs Clearing House [15], indicated that there is under development in reproductive health research on men compared to that of women [16]. As a matter of fact, males receive fewer reproductive services compared to their female counterparts. According to a survey conducted by OPAC in 2002, only 30% of men aged 20-44 received sexual health services, i.e., birth control advice/services. Conversely, the USA conducted an initiative in over half of its states dubbed "The X Project" under the Medicaid program, which was geared at extending family planning programmes to both men and women who had otherwise not been covered by Medicaid [17,18,19,20].

According to [21], Bangladesh has recorded poor utilization of family planning programmed services because all policies, activities, and projects are exclusively women centered. It was further noted that most family planning field service delivery systems were female focused [22]. [23] report that the study of male's role and involvement in family planning is a widely neglected area in India. However, in the previous 30 years the country had recorded a significant change in contraceptive use. In 1997, a study conducted by the Central Statistical Organization Yemen (CSOY), found that

family planning prevalence in Sana'a was 22% when both husband and wife approved of it, and in 12% of couples when the wife approves but the husband does not and in 4% when the husband approve but the wife doesn't [24]. There are many Yemeni women with unmet needs for family planning because the husband is still a significant barrier to family planning practice [25]. There is a misconception that the family planning adoption among the Muslim countries is low because of their religious opposition to contraceptive use [26]. [27], showed that men were highly inclined for using contraceptive though their wives were in opposition to use contraceptive because of religious beliefs and attitudes. The benefits of family planning is however not being fully achieved since most men are not getting involved in Africa with Ghana not being an exception [28]. The cause of low involvement of male in family planning is believed to be as a result of several factors. These factors include male's perception on family planning, their socioeconomic and demographic profiles, policies in place, mass media campaigns, inter personal communication from health workers, advice from family members, spousal communication and health systems in place [29]. Men play fundamental role and influences the couple's decision making process and reproductive health of couples depends on their attitude and level of knowledge on reproductive health [30]. Recent research show that expanding the availability of family planning services and working up on utilization of family planning services in developing countries could avert up to 42% of maternal deaths [31]. Use of contraceptives has given couples the ability to choose the number and spacing of their children, which, in turn, has prevented large numbers of unintended pregnancies and their consequences [32]. According to [33] there is an urgent need to increase male involvement in family planning decision making to improve family planning uptake. There is however low involvement of males in family planning in Ghana. Low levels of knowledge, social stigma, shyness, and

embarrassment and job responsibilities contribute to low involvement of males in family planning [34]. Over the past two decades fertility and family planning research programs have ignored men's roles and focused much on women's behavior [35]. The efforts to involve men began as early as the late 1970s, with attempts to make women-oriented family planning clinics more inviting to men but not much progress was realized in twenty years [36]. Family planning programs and campaigns focused on women leaving the men to play a very peripheral role [37]. According to [38], knowledge attitude and practice of men in Family planning was less prevalent only 39% of men being involved in Mukalla Yemen. In the same study 43% of the men felt that family planning should only be practiced by females. In the African context, men are key decision makers and soliciting their support in family planning is has been noted to be of paramount importance [39]. However their participation has been limited by a number of factors; Limited inclusion in family planning campaigns, attitudes of men towards family planning, perceived fear of side-effects, poor quality of available services, cultural or religious oppositions and gender-based barriers are some of the reasons for low utilization of family planning among male [40]. In Ethiopia [40] established that only 23% of the males used a contraceptive method which is still a low percentage. His study concluded that ignorance about various family planning methods designed for men and culture were the major deterrents [41]. The use of vasectomy in the world varies significantly by region and country. According to [42], almost three-fourths of the 37 million couples who use vasectomy live in Asia and only 0.1% or less in [43]. A study done in Kiambu County in Kenya showed that married men do not consent to modern methods of family and are limited to use of male condoms that are widely used. In Rwanda, modern contraceptive prevalence rate (CPR) more than quadrupled from 10% in 2005 (Rwanda Demographic and Health Survey [RDHS] 2005) to 45% in 2010. The total fertility rate decreased from 6.1 per woman in her lifetime in

2005 (RDHS, 2005) to 4.6 children per woman in 2010 [30], underscoring the important role of FP in addressing population growth. Involving men in family planning has been recognized as important world over, globally men have not shared equally with women the responsibility of fertility regulation and planning for family [25]. Men's participation is crucial to the success of family planning programs and women's empowerment and associated with better outcomes in reproductive health such as contraceptive acceptance and continuation, and safer sexual behaviors, [40]. Limited choice and access to methods, attitudes of men towards family planning, perceived fear of side-effects, poor quality of available services, cultural or religious oppositions and gender-based barriers are some of the reasons for low utilization of family planning. [15], reports that in Kiambu County knowledge of FP among men stood at 22% compared to 78% of women hence an indication that FP initiatives have failed to target men in education and awareness creation. A study done in Limuru Sub County and Kenya found that only 18% of males were involved in FP initiatives and only 27% approved of their spouse use of family planning. A study on knowledge attitude and practice of male in Family planning carried out in Mukalla Yemen showed that the prevalence of male practice was only 39%. In the same study 43% of the men felt that family planning should only be practiced by females. The use of vasectomy in the world varies significantly by region and country. Vasectomy rates is almost 0.1% or less in Africa, despite the fact that vasectomy services have already been introduced in Sub-Saharan African countries like Ghana, Kenya, Malawi and Tanzania [8]. In a study carried out in Debremarkos Town, North west Ethiopia in 2013, 8.4% of the males use family planning services due to religious prohibition and lack of awareness about contraceptives. Men also feared that providers might pressure them into vasectomies or into disclosing extramarital sexual activity or HIV diagnoses to their wives. In Zambia male contraceptive methods are unpopular

except condoms which have become popular due to HIV/AIDS. About 1/3 of Zambian men know about vasectomy [17]. According to [18], various family planning campaigns have been rolled out in Rwanda with civic education on attitudes and backward cultural beliefs regarding men involvement in family planning being addressed. Child birth rates have been greatly improved with more families opting for fewer children. With increased literacy levels and social integrations, more men are now aware of the various FM methods that are not harmful; cultural stigmatization of men who undergo vasectomy is slowly fading away [20]. Despite these notable efforts and achievements by religious bodies, non-governmental agencies and the government of Rwanda, statistics revealed that the number of men involved in family planning was short of 2020 millennium goal, [19]. A study carried out in 24 health facilities in southern province of Rwanda showed that men rarely accompanied their spouses to FP clinics and believed that FP was only a woman issue [7]. Despite all efforts by the government, UN(United Nations) agencies, civil society and NGOs(Non-Governmental Organizations) in Rwanda, unmet need for FP is high: 38% of women have expressed need for FP, among them 25% to space births and 13% to limit them

but they remain unserved. This study therefore seeks to establish the factors that are associated with male involvement in family planning among married couples seeking maternity and pediatric services in CHUK. The study will provide the researcher with data on knowledge of men on FP and proportion of men who involve in FP and determine the factors that hinder male participation in family planning [9]. This research will help various stakeholders and institutions to design programs to increase knowledge and improve attitude of males towards method of family planning and support their spouse's use of family planning. This study will help policy makers and stakeholders to plan and implement strategies to integrate men into family planning. The study will motivate potential male clients to seek family planning services. The study will help to reduce maternal morbidity and mortality rate. To determine the factors associated with male involvement in family planning among married couples seeking maternity and Pediatric services in CHUK. To determine the proportion of men who practice family planning. To determine the socio-cultural factors that influence male involvement in family planning. To identify the barriers that influence male involvement in family planning.

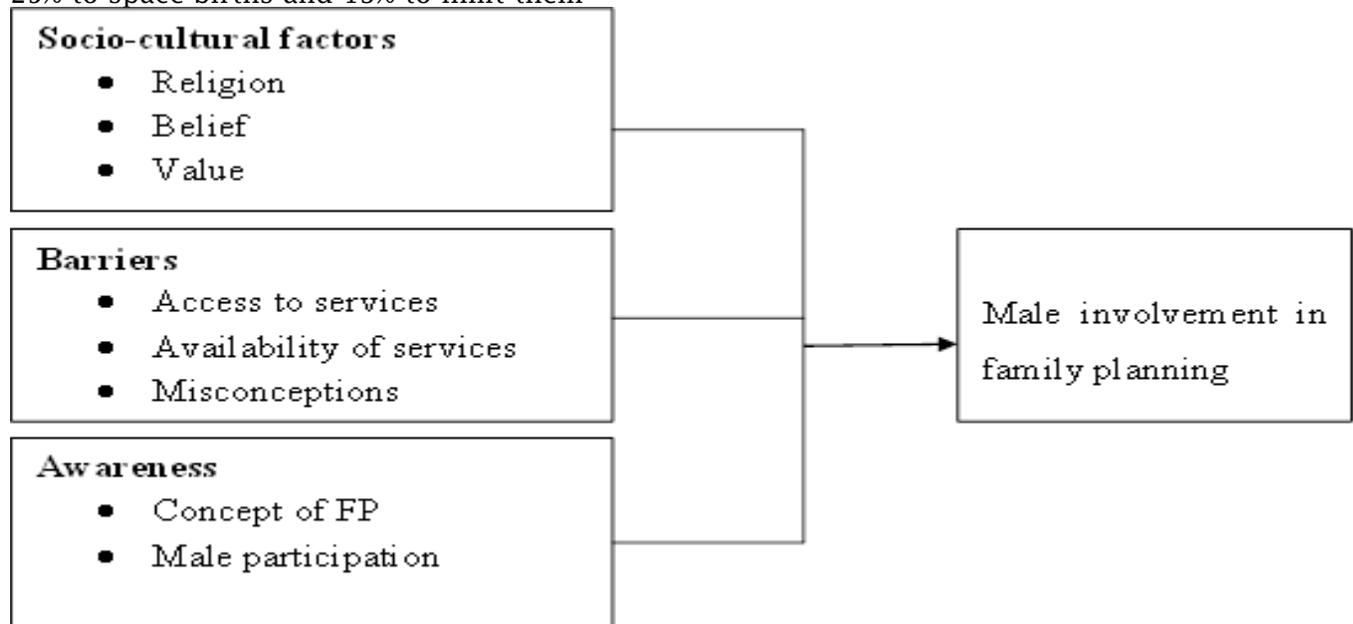


Figure 1: Conceptual framework

Social exchange theory focuses on rational assessment of self interest in human social relationships. The fundamental principle is that humans in social setting have tendency to choose behavior that maximizes their likelihood of meeting self interest in their enshrined situations [32]. Social exchange theory takes into account economic factors that make individuals rational. It argues that individuals have a tendency of choosing social relationships that are relatively cheap but with high payoffs. Thus the study used social exchange theory to assess the economic factors that impede male involvement in family planning making them rational consumers of family planning services. When there is a campaign on the use of contraceptives, men will embark on weighing the costs and benefits associated with the family planning method at their disposal. The theory, however, does not consider cultural factors thus making it limiting in that area. As such, the researcher settled on the importance of another theory that puts cultural factors into consideration. Bandura developed the social cognitive theory in 1986. This theory posits that the process through which people learn to adopt new behaviors' includes gaining knowledge of the risks and benefits of behavior change. Moreover, the theory suggests the importance of assessing outcome expectations, overcoming social and structural perceived impediments to health behavior change [12]. The social cognitive theory considers cultural aspects such as myths, taboos, and beliefs that communities embrace making them to adopt new and different behaviors. As such, the theory explains reasons of any abrupt behavioral changes. The theory states that when people observe a model performing a behavior and the consequences of that behavior, they remember the sequence of events and use this information to guide subsequent behaviors. Observing a model can also prompt the viewer to engage in behavior they already learned. In other words, people do not learn new behaviors solely by trying them and either succeeding or failing, but rather, the survival of humanity is dependent upon

the replication of the actions of others. Depending on whether people are rewarded or punished for their behavior and the outcome of the behavior, the observer may choose to replicate behavior modeled. This theory, therefore, was relevant to the study as it was useful in explaining the cultural factors that impede male involvement in family planning [18].

There is little empirical information on how the dynamics of interaction change when health care providers are faced with male clients [9]. In an editorial published by Population Council, [17] have discussed that "involving men" often means including them in counseling sessions, either alone or with their female partners". In an article that examined available literature and empirical data to highlight potential benefits of interaction with the male client [18], the author concluded that the health care providers need to be culturally sensitized to gender roles and ensure that involving men would in fact encourage joint responsibility, thus improving men's and women's reproductive health. This was also noted in another Indian study [20]. When both couple was involved in counseling for family planning, providers encouraged more communication among couples, as well as male responsibility for family planning [22]. Family planning is a deliberate effort by couples to regulate the number of children and spacing of births. It aims at improving family life at the micro level and contributing to sustainable development at the macro level. This is through fertility decline among other mechanisms. However, variables such as education, religion, socio - economic as well as cultural factors affect the effectiveness of family planning programs. One factor that deserves attention is the involvement of males in family planning. Men who are educated about sexual health issues are, for instance, more likely to support their partners in family planning decision-making and at the same time take up the responsibility of using contraceptives. Men need to share the responsibility for disease prevention, as well as the risks and benefits of contraception [15].

Male involvement in family planning 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 partners in contraception and peers to use family planning 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 effect of increasing the acceptability and prevalence of family planning practice of either sex [18]. One key finding relates to comments by participants that men's lack of involvement from fear and negative health beliefs stemmed from their overall lack of knowledge. This was attributed to the limited number of community-level reproductive health campaigns which targeted men. As a result, the emphasis on barriers related to harmful side effects may reflect heightened perceptions rather than actual experiences based on men's reliance on informal information sources, such as other male colleagues or relatives. Our findings are consistent with current research which points to a need to better educate men in the public sphere with appropriately tailored health messaging [30]. The concept of male involvement in family planning is broad in nature. The programme of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 emphasizes that special efforts should be made to emphasize on men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; pre-natal, maternal and child health prevention of STD and prevention of unwanted and high risk pregnancies. Use of male methods is one important aspect of male involvement in family planning. According to [18], family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. This contributes to growth of economy

and ensures a healthy population. FP reduces adolescent pregnancies, reduces infant mortality and reduces cases of sexually transmitted diseases. High population growth rate increases demand for resources and can lead to over exploitation of available natural resources. Recently, family-planning associations have recognized the importance of men's role and motivation in fertility decision making, particularly in Africa. The concern now is what family-planning and reproductive-health programs should do to encourage men's cooperation? [22]. According to [8] in his publication spousal communication and family planning in Amasaman, low level of practice of family planning among the people is due to inadequate spousal communication. Women point their male partners resistance to family planning as a significant barrier to uptake and continuation, resulting in decisions to use contraceptive methods covertly or not at all [12]. [17], established that spouse communication is positively associated with contraceptive use: DHS data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) show that the percentage of women using modern contraceptives is consistently higher in the group that had discussed Family Planning with their husbands in the year before the interview than in the group that had not. Health workers are sometimes poorly trained in counseling men about safer sexual practices and male methods and may communicate negative rumors about them [25]. There is little empirical literature on how the dynamics of interaction change when health care providers are faced with male clients [20]. In an editorial published by Population Council, [27] opines that involving men often means including them in counseling sessions, either alone or with their female partners. Ringheim(2002), concluded that the health care providers need to be culturally sensitized to gender roles and ensure that involving men would in fact encourage joint responsibility, thus improving men's and women's reproductive health. Men who have knowledge about family planning are

more likely to have positive attitudes regarding contraception and therefore support their partners' use of family planning methods [7]. In addition limited number of community-level reproductive health campaigns which targeting men heightened negative perceptions pointing the need to better educate men in the public sphere with appropriately tailored health messaging [12]. Men typically have more say than women in the decision to use contraception and in the number of children that the couple will have, [8]. According to the 1984 Zimbabwe Reproductive Health Survey 42% of married women stated that it was the husband's responsibility to decide whether his wife should use FP methods, Piotrowet [8]. Spouse education level is positively associated with contraceptive use. According [15], his research on effect of education level on the use of contraceptives among men revealed that men who have at least secondary level education have knowledge about various FP methods and participate more than their counter parts who have below secondary level education. In Rwanda there are still taboos regarding discussions on FP between spouses. According to [18], 29.7% of Rwandan women have not discussed contraception with their husbands during 12 months preceding the survey. The survey revealed the power of the man in decision-making regarding contraception, among 11% of all couples who have diverged opinion on contraception, women approve but their husbands don't, and the reverse is true in only 1 percent of couples. Despite all efforts by the government, UN (United Nations) agency, civil society and NGOs (Non-Governmental Organizations) in Rwanda, unmet need for FP is high; 38% of women have expressed need for FP, among them 25% to space births and 13% to limit them while only 28% men express the need [12].

A study conducted by [18] in Uganda indicates that a commonly reported disincentive among men to support their partner's use of contraceptive methods related to perceived side effects which were blamed for reducing sexual pleasure and increasing women's risks of infertility

and illness. According to the study, men reported being frustrated by several observed side effects, most notably irregular and prolonged bleeding, as well as vaginal dryness, and decreases in sex drive or libido. Excessive bleeding in particular was seen as having detrimental effects on marriages as long periods of blood loss reportedly led to women's general fatigue and dampened their interests in sexual intercourse. Bleeding was also attributed to limiting the number of opportunities for men to have sex with their partner, thus a precursor and motivation for developing extramarital sexual relations. Men's fertility intention is closely related to adopt couples contraceptive method. In Bangladesh, [8] found that husband's preference for more additional children were decreasing the probability to use family planning method. [19], points out that men have a strong desire for large families and a prevalence of many sons, who are regarded as their heirs. In a study conducted in South Korea, [6], sought to investigate the factors that influenced utilization of FP among men in blue-color and white-color jobs. Data was collected using questionnaire and the analyzed; the results revealed that 74% of men in white-color jobs were involved in FP compared to 37% of men in blue-color jobs. The study further revealed that men with white-color jobs had more disposable income that enabled them to access family planning services. A study carried out in Uganda showed that religious barriers are quite evident in African in that about 20% of the population is composed of Catholics whose doctrine emphasizes that sexual acts are for recreational purpose. Therefore, Catholics oppose any form of artificial methods [9]. Married women in the urban areas are more likely to use contraceptive methods than married women in the rural areas [9]. According to [14], couples living in the city were involved in FP compared to those living in the slums. This was attributed to the difference in level of income among the two groups. Studies have identified barriers to modern FP use in Malawi including poor knowledge of how to use FP methods and

misconceptions about some of them; side effects from some methods; inadequate counseling; disapproval of FP use by men and community leaders; poor partner communication; the need to travel long distances on foot to access FP services; and unaffordable costs of these services in some settings [7,17,19].

Many factors, of course, affect women's and men's contraceptive use, but there are three key elements which deserve to be highlighted. Men's support or opposition to their partners' practice of family planning has a strong impact on contraceptive use in many parts of the world, including Africa. Within marriage in Africa, men typically have more say than women in the decision to use contraception and in the number of children that the couple will have. For example, according to the 1984 Zimbabwe Reproductive Health Survey 42% of married women stated that it was the husband's responsibility to decide whether his wife should use FP methods. Focus groups conducted by Zimbabwe Nation Family Planning Council(ZNFPC) and a private research agency suggested that men were the ultimate decision makers on family size and FP matters in Zimbabwe" [9]. Spouse communication is positively associated with contraceptive use: DHS data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan and Togo) show that the percentage of women 'using modern contraceptives is consistently higher in the group that had discussed FP with their husbands in the year before the interview than in the group that had not. Men's lack of access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most FP clinics cater to women, so men are uncomfortable about going to these clinics. Men must be reached in other ways. This testimony from a Kenyan is a good illustration of 'that need: After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with the natural methods we were using. Her blood pressure immediately shot up, and

she was advised to stop it. It was duty, too, to take part in family planning.

"One morning we went together to our local family planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, of women and their babies. This was a woman's world and I felt totally lost." [8]. This confirms the assumption that no matter how many men want to know about and utilize contraception, most family-planning programs have not yet given adequate facilities to serve them. There are still taboos regarding discussions on FP between spouses. Study in Rwanda showed 29.7% of Rwandan women have not discussed contraception with their husbands during 12 months preceding the survey. This is a serious issue and understanding why could help the increase of contraceptive prevalence. The survey revealed the power of the man in decision-making regarding contraception. In fact, among 11% of all couples who have diverged opinion on contraception, in 10% of couples, women approve but their husbands don't, and the reverse is true in only 1 percent of couples. 59% of couples have the same opinion and both partners approve contraception. Most studies done indicates that culturally, most communities render it hard for a male to be involved in family planning because contraception would lead to sexual unfaithfulness among the taker. Despite all efforts by the government, UN (United Nations) agencies, civil society and NGOs(Non-Governmental Organizations) in Rwanda, unmet need for FP is high: 38% of women have expressed need for FP, among them 25% to space births and 13% to limit them but they remain un served. The literature reviewed covered global, regional and local perspectives on the concepts of family planning, male involvement as well as the factors associated with male involvement in family planning. The researcher reviewed literature extensively on the correlation between FP method, FP project designs, level of education, gender, religion, spousal communication, knowledge on FP, Unmet needs for FP, level of income, perceptions and fertility preference on male involvement on family

planning. Basing on the literature reviewed, social, cultural and economic factors are associated with men involvement in family planning. The study was carried out in Kigali city which is divided into three districts; Gasabo, Nyarugenge and Kicukiro. It has an estimated population of One Million people. Nyarugenge district was chosen randomly for the study and it has one referral hospital i.e. CHUK (University Teaching Hospital of Kigali) which was purposively chosen for the study. The hospital is located in Kigali city, Nyarugenge district. The hospital gets patients from all over the country with minimum total of 300 patients seen in outpatient department. The hospital has many departments and specialties to include Obstetrics and gynecology, Pediatrics, Surgery, Internal Medicine, and Radiology etc. The hospital has a total

staff of 576. The researcher used cross-sectional study using quantitative approach. This study design examines the relationship between a variable and other variables of interest as they exist in a defined population at a single point in time or over a short period of time, [8]. Cross-sectional studies provide providing snapshot of the frequency in a population at a given point in time. Cross-sectional studies are used to assess the burden of disease or health needs of a population and are particularly useful in informing the planning and allocation of health resources. Target population is a set of people households that are being investigated [18]. The target population was 171 married couples seeking maternity and pediatric services in CHUK. According to CHUK maternity and pediatric report an average of 80 people seek these services per month.

Table 1:

Month	Maternity	Pediatrics
January	22	13
February	19	17
March	25	9
April	19	15
May	11	7
June	9	5
TOTAL	171	

SOURCE: CHUK Health Records Department.

Those who were included in the study were married couples seeking maternity and pediatric services in CHUK to participate in research study. The exclusion criteria were the unmarried males and females seeking maternity and pediatric services in CHUK but were too

weak to participate in the study, and also those who were not willing to participate or those who did not consent. Sample size determination: The sample size was determined using the Slovincs formula (1991) for sample size determination.

$$n = \frac{N}{1 + (Nxe^2)}$$

Where: n-sample size, N- Population size, e- margin of error (0.05)²

$$171/1 + (171 * 0.0025) = 119$$

Systematic sampling was used to select respondents in the study. Systematic sampling is a probability sampling method in

which sample members from a larger population are selected according to a random starting point and a fixed periodic interval. This interval, called the sampling interval, is calculated by dividing the population size by the desired sample size, [6]. The married couples who come for the health services were selected with an interval of every odd number to participate in the study. Data was collected using interviewer administered semi-structured questionnaires seeking information on social-demographic, socio-cultural, social-

Data management and analysis

Data collectors were trained to collect data through interviews and the use of semi-structured questionnaire for respondents who were able to read and write daily for a period of one month. Data collectors were trained on how to collect data. The data collected was processed using SPSS version 20. Descriptive statistics will be conducted and presented in frequency tables, charts and graphs. Analysis was done by both descriptive and inferential statistics. Chi square was used for correlation relationships. Approval of the study was

The findings are presented and interpreted based on the objectives of the study. A total of 119 males with their spouses were consented to participate in the study. The results are presented in tables and graphs form. A total of 119 questionnaires were administered. The completed questionnaires were edited for completeness and consistency. 119 questionnaires were returned. This represented a response rate of 100 %. This conformed to [19] who recommended that for simplification a response rate of 50% is sufficient for scrutiny and exposure, 60% is good and a response rate of 70% and over is excellent. Male involvement in family planning: Results shows factors

economic and involvement of male in family planning. The questionnaire will be translated to Kinyarwanda for easy understanding. Pretest of the data instrument was carried out in King Faisal Hospital and this helped to improve the instrument reliability. Validity is defined as the accuracy and meaningfulness of inferences, which are based on the research results [15]. To ensure validity the questionnaire was translated into Kinyarwanda to ensure respondents understood the content. Pilot study was done at King Faisal Hospital.

sought from CHUK ethical committee. Consent was obtained from the respondent and no names were required to ensure confidentiality of information from respondents. The information gathered during the research was used for study purposes and was treated as discrete and confidential. The information collected was kept in a safe place to ensure confidentiality of information. The respondents were explained to that they have a right to give or not give information.

RESULTS

related to male involvement in family planning. Most of the respondents 95(79.8%) were discussing with the spouse about Family Planning while the remaining 24(20.2%) indicated otherwise. However, 108(90.8%) reported that they have never attended family planning clinic with the spouse. Majority 107(89.9%) strongly agreed that they support their spouse on right choice of family planning. 49(41.2%) of the respondents strongly disagreed that family planning practices should be left to women only though considerable number 14(11.8%) strongly agreed with the statement.

Table 2: Male involvement in family planning

Variable	Frequency (n=119)	Percent (%)
Whether discussing about Family Planning with the spouse		
Yes	95	79.8
No	24	20.2
Ever attended Family Planning Clinic with the spouse		
Yes	11	9.2
No	108	90.8
Supporting their spouse on right choice of Family Planning		
Strongly Agree	107	89.9
Agree	9	7.6
Not Sure	1	0.8
Disagree	1	0.8
Strongly Disagree	1	0.8
Family Planning practices should be left to women only		
Strongly Agree	14	11.8
Agree	1	0.8
Not Sure	5	4.2
Disagree	50	42
Strongly Disagree	49	41.2

Overall score of male involvement on family planning: The overall score of male involvement on family planning was determined by using a score of responses. Four (4) variables presented in Table 4.5 were considered together and scores were structured. The maximum attainable total score was 12 and the minimum was 2. The mean was generated (9.0) and those who scored mean and above (9.0) were classified as having adequate male involvement and those who scored below the mean (9.0) were classified as inadequate male involvement on family planning. As indicated in Figure 2, majority of the respondents 84(70.6%) had adequate male involvement on family planning while the remaining 35(29.4%) had inadequate male involvement on family planning.

Socio-demographic attributes of the respondents: The findings show that the highest percentage 48 (40.3%) were within the age group of 31-40 years followed by 20-30 years 45(37.8%). However, above 40 years were only 26(21.8%). Regarding level of education, about half of the respondents attended tertiary education 59 (49.6%), secondary education was 53(44.5%) while there were only 7(5.8%)

attended primary school. Most of the respondents 98 (82.4%) were Christian followers whereas the remaining were Muslims 21(17.6%). Respondents were asked about their employment status and more than half 66(55.5%) were employed and about a quarter 28(23.5%) were self-employed followed by 25 (21.0%) who were unemployed. Majority of them 88 (73.9%) were urban settlements.

Table 3: Socio-demographic attributes of the respondents

Variable	Frequency (n=119)	Percent (%)
Age		
20 – 30	45	37.8
31 – 40	48	40.3
Above 40	26	21.8
Educational Level		
Primary	7	5.8
Secondary	53	44.5
Tertiary	59	49.6
Religion		
Christian	98	82.4
Muslim	21	17.6
Employment Status		
Self Employed	28	23.5
Employed	66	55.5
Unemployed	25	21.0
Residence		
Urban	88	73.9
Rural Kigali	31	26.1

Association between socio-demographic characteristics and male involvement in family planning. Cross-tabulation analysis of the association between socio-demographic characteristics of respondents and male involvement in family planning is summarized in Table 4.6. There was significant association between age group and male involvement where respondents aged 20 to 30 years were significantly higher to involve in family planning adequately (84.4%) than those aged above 40 year (53.8%) [$\chi^2=8.03$;

$df=2$; $P=0.018 < 0.05$]. Christian respondents were significantly more likely to involve in family planning adequately (75.5%) compared to Muslims (47.6%) [$\chi^2=6.48$; $df=1$; $P=0.011 < 0.005$]. The proportion of adequate male involvement in family planning was higher among respondents resided in rural Kigali (83.9%) than those living in urban Kigali (65.9%). However, this was not significant [$\chi^2=3.56$; $df=1$; $P=0.059 < 0.005$].

Table 4. Association between socio-demographic characteristics and male involvement in family planning

Variable	Adequate Male involvement		Inadequate Male involvement		chi square value	df	p value
	N	%	N	%			
Age							
20 - 30	38	84.4%	7	15.6%	8.03	2	0.018
31 - 40	32	66.7%	16	33.3%			
Above 40	14	53.8%	12	46.2%			
Educational Level							
Primary	4	57.1%	3	42.9%	3.61	2	0.165
Secondary	42	79.2%	11	20.8%			
Tertiary	38	64.4%	21	35.6%			
Religion							
Christian	74	75.5%	24	24.5%	6.48	1	0.011
Muslim	10	47.6%	11	52.4%			
Employment Status							
Self Employed	17	60.7%	11	39.3%	1.76	2	0.414
Employed	49	74.2%	17	25.8%			
Unemployed	18	72.0%	7	28.0%			
Residence							
Urban	58	65.9%	30	34.1%	3.56	1	0.059
Rural Kigali	26	83.9%	5	16.1%			

Socio-cultural factors affecting family planning practice

The results show descriptive analysis of socio-cultural factors affecting family planning practice. Majority 94(79.0%) of the respondents strongly agreed that spouse knowledge of family planning is important to acceptance of practice. 49 (41.2%) agreed with the statement of spouse who visit health facility are likely to accept service. However, considerable percentage 44(37.0%) disagreed with the statement. Nearly half of the respondents 59(49.6%) did not agree that spouse are not influenced by taboo when they understand benefits of Family Planning. About half of the respondents 60(50.4%)

strongly agreed with spouse who understand family planning should support partner. Similarly, 67 (56.3%) strongly agreed that knowledge of family planning enable a man to support a partner on family planning. Majority of the respondents 79(66.4%) strongly agreed with the statement that religious practices should not prevent the acceptance and practice of Family Planning among spouses. Most of them 103(86.6%) also strongly agreed that condom use protects against diseases and unwanted pregnancy.

Table 5:Socio-cultural factors affecting family planning practice

Statements	Strongly agree, n(%)	Agree, n(%)	Not sure, n(%)	Disagree, n(%)	Strongly disagree, n(%)
Spouse knowledge of Family Planning is important to acceptance of practice	94(79.0%)	18(15.1%)	0(0.0%)	5(4.2%)	2(1.7%)
Spouse who visit health facility are likely to accept service	20(16.8%)	49(41.2%)	3(2.5%)	44(37.0%)	3(2.5%)
Spouse are not influenced by taboo when they understand benefits of Family Planning	25(21.0%)	13(10.9%)	8(6.7%)	59(49.6%)	14(11.8%)
Spouse who understand Family Planning will support partner	60(50.4%)	28(23.5%)	9(7.6%)	21(17.6%)	1(0.8%)
Knowledge of FP enable a man to support a partner on FP	67(56.3%)	25(21.0%)	8(6.7%)	18(15.1%)	1(0.8%)
Religious practices should not prevent the acceptance and practice of Family Planning among spouses	79(66.4%)	17(14.3%)	7(5.9%)	7(5.9%)	9(7.6%)
Condom use protects against diseases and unwanted pregnancy	103(86.6%)	12(10.1%)	0(0.0%)	2(1.7%)	2(1.7%)

Association between socio-cultural factors and male involvement in family planning
 The association between socio-cultural factors and male involvement in family planning is summarized below. The strongly agree and agree were combined into agree and not sure, disagree and strongly disagree were combined into disagree. The proportion of adequate male involvement in family panning was

significantly higher among respondents who agreed that condom use protects against diseases and unwanted pregnancy 83(72.2%) than those who indicated otherwise 1(25.0%) [$\chi^2=4.14$; df=1; P=0.042<0.005]. However, there was no significant association between the other variables.

Table 6 :Association between socio-cultural factors and male involvement in family planning

Variable	Adequate Male involvement		Inadequate Male involvement		chi square value	df	p value
	N	%	n	%			
Spouse knowledge of Family Planning is important to acceptance of practice							
Agree	80	71.4%	32	28.6%	0.65	1	0.421
Disagree	4	57.1%	3	42.9%			
Spouse who visit health facility are likely to accept service							
Agree	46	66.7%	23	33.3%	1.22	1	0.270
Disagree	38	76.0%	12	24.0%			
Spouse are not influenced by taboo when they understand benefits of Family Planning							
Agree	23	60.5%	15	39.5%	2.72	1	0.099
Disagree	61	75.3%	20	24.7%			
Knowledge of FP enable a man to support a partner on FP							
Agree	62	67.4%	30	32.6%	2.00	1	0.158
Disagree	22	81.5%	5	18.5%			
Religious practices should not prevent the acceptance and practice of Family Planning among spouses							
Agree	67	69.8%	29	30.2%	0.15	1	0.697
Disagree	17	73.9%	6	26.1%			
Condom use protects against diseases and unwanted pregnancy							
Agree	83	72.2%	32	27.8%	4.14	1	0.042
Disagree	1	25.0%	3	75.0%			

Factors related to family planning use

All respondents had ever heard of family planning. Similarly, all the respondents indicated that family planning method was accessible as per the choice and also all were aware on the place to get family planning services. The main methods of family planning used by the spouse were

IUCD 54(45.4%) followed by Injection 26(21.8%), condom at 16(13.4%) and pills at 15(12.6%). Most of the respondents 99 (83.2%) reported that they were using condoms as male family planning method.

Table 7 Factors related to family planning use

Variable	Frequency (n=119)	Percent (%)
Ever heard of Family Planning		
Yes	119	100
Whether Family Planning method are accessible as per the choice		
Yes	119	100
Awareness of the place to get Family Planning services		
Yes	119	100
Family planning methods used by spouse		
Condom	16	13.4
Pills	15	12.6
Injection	26	21.8
Withdrawal	8	6.7
IUCD	54	45.4
Types of male family planning methods use		
Condom	99	83.2
Withdrawal	20	16.8

Association between types of family planning use and male involvement in family planning. Findings show the relationship between types of family planning use and male involvement in family planning. However, there was no any significant association observed between the variables.

Table 8: Association between types of family planning use and male involvement in family planning

Variable	Adequate Male involvement		Inadequate Male involvement		chi square value	df	p value	Interpretation
	n	%	N	%				
Family planning methods used by spouse								
Condom	11	68.8%	5	31.3%	5.599	4	0.231	insignificant
Pills	11	73.3%	4	26.7%				
Injection	21	80.8%	5	19.2%				
Withdrawal	3	37.5%	5	62.5%				
IUCD	38	70.4%	16	29.6%				
Types of male family planning methods use								
Condom	72	72.7%	27	27.3%	1.298	1	0.255	insignificant
Pills	12	60.0%	8	40.0%				

Knowledge on the methods of family planning
 All the respondents knew condom as family planning and almost all 118(99.2%) knew pills as family planning method. Regarding IUCD, Injection and Vasectomy

majority of the respondents 106(89.1%) 93(78.2%) and 69(58.0%) respectively indicated that they knew them. However, only 27(22.7) knew withdrawal and 45(37.8%) knew Tubal ligation as family planning.

Barriers to practice of family planning

Results show the factors related to barriers of practice of family planning. Generally most of the respondents agreed with the statements. About three quarter 92(77.3%) of the respondents strongly agreed that the attitude of health staff affect male practice of family planning. Likewise, majority 93(60.5%) agreed that distance of health facility influence attendance of Family Planning Clinic. Most of the respondents strongly agreed

that Family Planning Clinics are oriented mostly to women 93(78.2%) hence low male involvement, Inadequate health education by health care workers on Family Planning products/services may lead to low uptake of services 73(61.3%), side effects of Family Planning contributes to low utilization of services or products (75.6%) and inadequate knowledge on FP affects the practice and choice of services among spouses (78.2%).

Table 9:Barriers to practice of family planning

Statements	Strongly agree, n(%)	Agree, n(%)	Not sure, n(%)	Disagree, n(%)	Strongly disagree, n(%)
Attitude of health staff affect male practice of Family Planning	92(77.3%)	22(18.5%)	1(0.8%)	2(1.7%)	2(1.7%)
Distance of health facility influence attendance of Family Planning Clinic	30(25.2%)	72(60.5%)	5(4.2%)	11(9.2%)	1(0.8%)
Family Planning Clinics are oriented mostly to women	93(78.2%)	22(18.5%)	1(0.8%)	3(2.5%)	0(0.0%)
Inadequate health education by health care workers on Family Planning products/services may lead to low uptake of services	73(61.3%)	40(33.6%)	2(1.7%)	4(3.4%)	0(0.0%)
Side effects of Family Planning contributes to low utilization of services or products	90(75.6%)	23(19.3)	2(1.7%)	3(2.5%)	1(0.8%)
Unavailability of services for males affects male involvement in Family Planning	32(26.9%)	31(26.1%)	30(25.2%)	22(18.5%)	4(3.4%)
Inadequate knowledge on FP affects the practice and choice of services among spouses	93(78.2%)	18(15.1%)	2(1.7%)	2(1.7%)	4(3.4%)

Association between barriers to practice family planning and male involvement in family planning.

The results show the association between barriers to practice family planning and male involvement in family planning. Respondents who agreed inadequate health education by health care workers

on family planning products/services may lead to low uptake of services were significantly more adequately involve in family planning 82(72.6%) than those who indicated otherwise 2(33.3%) [$\chi^2=4.22$; $df=1$; $P=0.040<0.005$].

Table 10: Association between barriers to practice family planning and male involvement in family planning

Variable	Adequate Male involvement		Inadequate Male involvement		chi square value	df	p value
	n	%	n	%			
Attitude of health staff affect male practice of Family Planning							
Agree	80	70.2%	34	29.8%	0.22	1	0.637
Disagree	4	80.0%	1	20.0%			
Distance of health facility influence attendance of Family Planning Clinic							
Agree	73	71.6%	29	28.4%	0.33	1	0.565
Disagree	11	64.7%	6	35.3%			
Family Planning Clinics are oriented mostly to women							
Agree	81	70.4%	34	29.6%	0.04	1	0.844
Disagree	3	75.0%	1	25.0%			
Inadequate health education by health care workers on Family Planning products/services may lead to low uptake of services							
Agree	82	72.6%	31	27.4%	4.22	1	0.040
Disagree	2	33.3%	4	66.7%			
Side effects of Family Planning contributes to low utilization of services or products							
Agree	80	70.8%	33	29.2%	0.05	1	0.829
Disagree	4	66.7%	2	33.3%			
Unavailability of services for males affects male involvement in Family Planning							
Agree	42	66.7%	21	33.3%	0.99	1	0.319
Disagree	42	75.0%	14	25.0%			
Inadequate knowledge on FP affects the practice and choice of services among spouses							
Agree	78	70.3%	33	29.7%	0.08	1	0.777
Disagree	6	75.0%	2	25.0%			

Appendix xx: Overall score on male involvement on family planning
The following elements were used to assess the overall score of male involvement on family planning;

- Whether discussing about Family Planning with the spouse (Yes=1; No=0)
- Ever attended Family Planning Clinic with the spouse (Yes=1; No=0)
- Supporting spouse on right choice of Family Planning (Strongly Agree=5; Agree=4; Not Sure=3; Disagree=2; Strongly Disagree =1)

The study was conducted to establish factors that influence male involvement in family planning among married couples who were seeking pediatric and maternity services in CHUK. The study found out about knowledge on family planning, socio-cultural factors that

- Family Planning practices should be left to women only (Strongly Agree=1; Agree=2; Not Sure=3; Disagree=4; Strongly Disagree =5)

The overall score was generated by aggregating the scores. The maximum attainable total score was 12 and the minimum was 2. The mean was generated (9.0) and those who scored mean and above (9.0) were classified as having adequate male involvement and those who scored below the mean (9.0) were classified as inadequate male involvement on family planning.

DISCUSSION

influence involvement and other barriers to practice. Family planning should be planned and organized to target both men and women to help achieve sustainable impact. Spousal support leads to positive attitude towards use of family planning and reproductive health. According to the

first objective on social cultural factors that affect male involvement, the more knowledge a man had on family planning the higher the possibility of involvement and support to spouse and is in line with study by [17]. The spouse who understood family planning was highly able to support their spouse use of FP and was not affected by their taboos on practice of FP. The spouse who accompanied their partners to FP clinics were likely to accept services. The study found out that spousal support was fundamental in success FP practice. The respondents strongly agreed that family planning should not be left for women only which are not in line with study by [20]. Majority of the partners discussed with their spouse about family planning which is contrary to study done in Uganda

by [17]. On barriers to family planning, the study found out that staff attitude at the health facility led to low uptake and is in line with a study by [30], access to FP services and lack of sufficient education at the clinic lead to low uptake of FP services. Since most FP services are women oriented, the unavailability of male services contributes to low male involvement. There was strong association between inadequate education by health workers and low uptake of family planning. Majority of the respondents had knowledge on family planning and agreed that condoms prevented unwanted pregnancy which is in line with a study done by [9] and the different methods that are available. They were also aware of the places to get services.

CONCLUSION

The study concludes that there was adequate male involvement in support of spouse to practice and use services but the men did not accompany their spouses to the family planning clinics. Due to shortage/few services for men, it led to

low uptake of family planning. The success of male involvement should involve partnership between health sector coordinators health providers, religious leaders and community empowerment.

RECOMMENDATIONS

1. Ministry of Education and Ministry of Health should provide training and equip reproductive health service providers with enough information for the success of FP through the curriculum.
2. Health stakeholders to involve men in the whole cycle of maternal health to promote male involvement
3. Ministry of Health should promote vasectomy among males.

Suggestion for further study

1. Study on male involvement to cover other districts for better generalization.
2. Study on attitude and practice of vasectomy

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