Access to Family Planning Information and Contraception Methods Use among Tanzanian Men: A Cross-Sectional Study in Kibaha District

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Abstract

Continued evaluation of current health education and sensitization programs could help to inform and enhance men’s awareness and use of family planning services. This paper reports from a study undertaken to identify sources through which family planning (FP) information was obtained and their implications for FP practices among men in Kibaha District, Tanzania. A descriptive cross-sectional survey was conducted in April 2014, involving interviews with a random sample of 365 married men, using a structured questionnaire. Men reported to obtain FP information from their spouses (45.7%), mass media (27.6%), health facilities (18.1%), community health meetings (12.6%), and 26.8% received information from neighbours, friends, FP campaigns and billboards. Soga ward (rural) showed a larger proportion of men receiving FP information from health facilities than their counterparts in urban Mlandizi ward ($\chi^2 = 8.8923$, $p = 0.003$). Men who were exposed to family planning messages from different mass media at least once per week reported to use the methods with their spouses than those who were not exposed to such messages. Majority of men receive family planning information through their spouses. These findings suggest the need for more reliable sources of health information and methodologies for enforcing the messages.

Keywords: Family Planning; Information; Men; Kibaha

Abbreviations

ANC: Antenatal Care; AOR: Adjusted Odds Ratio; CHMT: Council Health Management Team; CHW: Community Health Workers; FP: Family Planning; HCW: Health Care Worker; HF: Health Facility; LRA: Logistic Regression Analysis; MCH: Maternal And Child Health; MUHAS: Muhimbili University of Health and Allied Sciences; NBS: National Bureau of Statistics; RH: Reproductive Health; STIs: Sexually Transmitted Infections; TDHS: Tanzania Demographic Health Surveys; TV: Television.

Introduction

Men in African cultures play an important role on family matters. They contribute to ideas, influence decisions and perform various activities including those related to reproductive health (RH). For example, they influence their spouses or personally participate in the adoption of family planning (FP) methods [1]. Reports show that male involvement in RH services contributes to increasing the support needed by their partners for matters related to their health, enhancing couple communication and increasing uptake of RH services. As evidence shows, men have in various ways been helping their spouses to attend clinic early and complete the recommended maternal and child health (MCH) clinics. Men have also been of assistance to women at delivery times, for instance, by escorting them to health facilities during the last moments of such women’s pregnancies. By assisting their spouses to do so, they get an opportunity to learn about FP methods including their use for prevention of unwanted pregnancies and sexually transmitted infections [2,3]. However, evidence shows that men’s participation in RH services remains low in most developing countries, Tanzania being one of them [4]. Of the factors commonly reported to contribute to lowering men’s participation in RH aspects are such conditions as their low level of education; low income earnings needed to support spouses or themselves when it comes to care seeking; social perceptions and values including those leading the men to believe that RH issues are a woman’s concern, and the latter being contributed by the prevalence of uncooperative gender norms and traditions [5,6]. Other factors include the limited awareness/knowledge of men about their duties in relation to RH as well as health facility (HF) institutional factors such as the attitudes and behaviours of service providers/health care workers (HCWs) [7]. Other factors include the perception on real or assumed side-effects of female contraceptive usage on grounds that such products are likely to reduce sexual pleasure between the partners and the sexual activity/performance of men (i.e. fear that men’s masculine ability to perform sex will be lowered by use of contraceptives); limited choices of male contraceptives due to shortage or absence of alternatives; fear from or concern about vasectomy (infertility among men); preference for large family sizes which are uninhibited by prolonged birth spacing; and concerns that women’s use of contraceptives will lead to extramarital sexual relations [8]. Moreover, lack of time and overall limited awareness regarding the specific role of men in RH, and traditionally FP programmes tending to focus on women do deter men’s meaningful involvement in issues related to fertility regulation [9–10]. Lack of access to RH information and services also contributes to low male acceptance of FP adoption [11].

A wide spectrum of literature establishes that FP education and information is an important package needed for changing the attitudes of the target populations and their increased acceptance of the recommended FP methods. There are various sources from which men could receive FP information. Among the commonly reported ones are the interpersonal communications with FP service providers, mass media such as radio, television, newspapers, magazines as well as the use of adverts or promotions displaying messages and sometimes pictures on roadside billboards, posters fixed at various offices and houses in the streets, live drama shows, and community events [12,13]. In many developing countries, most of men as opposed to women have no common practice of visiting HFs for the purpose of seeking FP services. This is a lost opportunity since at these facilities they could receive information and counselling on FP issues. However, the level at which FP services are used differs from one country to another. For instance, reports from previous evaluations in Tanzania reveal men to have been more likely than women to get exposure to FP messages from different sources of the mass media [13]. In this regard, one would quickly jump to the conclusion that mass media were/are the most accessible and possibly effective source of FP information.
to men in a developing country’s context. However, more rigorous research and empirical evidence might be needed to support or refute this claim. Of course, some evidence has shown that there has been a positive association between mass media promotion and FP practices [14]. As noted in Kenya, Nigeria, Senegal, Nepal and Uganda, the promotion of FP using radios, televisions and print materials has shown to increase the number of people adopting and maintaining the use of FP in various countries [15–17]. It has also been established that the use of multiple channels of FP information widens the chance for individual adult people to access the information. That is to say, the number of channels connecting different mass media to which an individual person is exposed has had a positive impact on the knowledge, attitude and practices of such individuals in relation to FP methods. Therefore, use of multiple media communication channels remains evident as an opportunity for increasing coverage to specific community groups targeted and reinforces uptake of the messages that can potentially be translated into practice including an increased use of contraceptives [15,17]. To cite an example, mass media campaign involving radio, television, print materials and an advocacy forum with religious leaders contributed to a 24% increase in the number of first time FP users in sentinel clinics, while the number of continuing users increased to 37% [18].

On-going suggestions emphasise on the need for more studies to establish empirical evidence on the extent to which the FP topic is known, perceived, and how FP methods are accepted and practiced among the target populations including married women and men [8]. As argued, such studies would help the authorities to know the magnitude of knowledge on FP in respective communities and establish the extent of resistance towards the use of FP methods. At the same time, the authorities will be able to identify the main sources through which the target populations have been obtaining (or could better obtain) FP information. This could be taken as basis for packaging FP information and designing and implementing FP policies and interventions aimed at addressing the prevailing challenges in promoting FP among such groups and the entire adult population. In Tanzania, it has been documented that knowledge on, and acceptability and use of, FP methods are context-specific. Therefore, policy decision-making authorities and reproductive health program stakeholders need to be periodically updated with information on FP knowledge and practice statuses based on studies conducted in different socioeconomic settings [19]. Given the social-cultural and systemic diversities so far noted and contributing to the observed state of affairs when it comes to evaluation of FP information and use, the importance of evidence on access to and use of FP information among population groups at local context-specific levels in Tanzania is justified [20].

Methods

Study Site, Design and Sampling Approach

This study was carried out in Kibaha district, selected randomly among the six districts forming Pwani (Coast) region in Tanzania. Pwani region has been reported to experience an abrupt drop in the contraceptive prevalence rate. Thus, considering the justification made above regarding limited involvement of men in FP aspects, choice of the district for study was considered appropriate. Kibaha district consists of 11 administrative wards. A ward is a geographically defined administrative locality formed by at least three villages. Each village constitutes several hamlets (neighbourhoods) if the area is rural or streets if the area is urban. A hamlet is formed by several households that are close to each other [21]. According to the most recent national population census, Kibaha district has a total population of 75,899 and the prevalence of family planning use among married women is 34% [13].

At the time of the survey, Kibaha district health care system was supported by 24 health facilities (HFs), 17 of which were owned by the public (commonly referred to as government HFs) while the rest were run by the private sector (CHMT report, Unpublished).

The study was a cross-sectional survey and was conducted in the month of April 2014. To arrive at the sample needed for the study, starting from the district level, the 11 wards were stratified into urban and rural settings. From the two strata, two wards Mlandizi representing urban and Soga ward for rural setting were randomly selected. From the two wards, a random selection of three hamlets was done in Mlandizi ward and two villages from Soga ward. Finally, from each selected hamlet or village, a list of eligible men (aged between 18 and 60 years, married or cohabiting and had at least one child under the age of five years) was identified with the help of either the hamlet/village chairpersons or community health workers (CHWs). Thereafter, a random selection of respondents from the list in the respective localities was done leading to a total of 365 men. The sample size was calculated using a formula for single proportion [22] based on the contraceptive prevalence rate of family planning method of 34% in the region.

Data Collection and Analysis

Data were collected using an interview administered questionnaire which consisted of mostly close-ended questions. The questions targeted to gather information related to the following elements that were treated as independent variables: individual respondent’s sociodemographic characteristics including residency, age, level of education, occupation and number of children; sources of FP information, exposure to three mass media channels (radio, television and newspapers) at least once per week, exposure to information on FP in the accessed mass media while the dependent (outcome) variable was FP use. Interviews were conducted mainly at the homes of the selected men, same for a few who preferred to be interviewed at their working places where they spent most of their time. Responses to open-ended questions were assigned codes for simplifying analyses requiring quantification for specific questions.

All data were checked for accuracy and consistency by double-entering by two independent data clerks. Epi-data version 3.1 (120106) software was used for data entry, whereas STATA version 11.2 statistical package was used for analysis. Descriptive analysis was done and presented in frequencies of the responses given to individual questions such as age, occupation, level of education and number of children; exposure to FP information and use of any FP method during the survey period. Chi-square test was done to determine whether or not there was any correlation or association between contraceptive use among men with their spouses and various factors such as exposure to FP messages in various sources of information including mass media. Main interest in the latter approach was to establish if there was any association between the individual respondents’ awareness of FP issues including methods recommended for FP and their practice as well as use or non-use of the methods. Logistic regression analysis (LRA) was conducted in the attempt to assess the odds of certain events or behaviours to be influenced by definite conditions. These included individual’s FP practices (including use of the methods) and access to FP information (as the latter was intuitively considered to have had an impact on individuals’ knowledge about the recommended FP methods). Also, some of the responses obtained from the use of the mentioned variables in the study questions were examined in terms of whether the respective respondent was residing in a rural or an urban area, with the aim of ascertaining any rural-urban differences in the results (e.g. access to FP information; use of FP methods). The first step in the LRA was to perform bivariate analyses
before moving on to a multivariate analysis, with adjustments being made for controlling for possible confounders among certain independent variables (age, education level, occupation, number of living children and place of residence). The associations were reported in odds ratios (ORs) while a 95% confidence interval (CI) was taken into account when regarding the observed difference as statistically significant at a p-value less than 0.05. Use of LRA in this study was found important since the response variables used in testing the associations were categorical or nominal in nature as recommended [23]. The second reason is that human behaviours may be influenced by more than a single factor. Therefore, reliance on Chi-square tests could not suffice in this case to better explain the statistical relationships between the outcome and independent variables than LRA could do.

Ethical Considerations

Ethical approval was obtained from the Research and Publications Committee of Muhimbili University of Health and Allied Sciences (MUHAS). Permission to conduct the study was obtained from the district and local authorities. All respondents were verbally informed about the study and asked to participate as respondents. Those who agreed were asked to sign an informed consent form as evidence of their willful participation. An individual was not enrolled into the study if he expressed reluctance to participate. Those who denied were assured of no penalty for their refusal or apology. Respondents who were willing to participate but were unable to read and write, they were asked for their thumb-print signatures as long as they consented. All individuals approached were assured that their names would be kept anonymous and that if they preferred part of the gathered information to be treated confidential would be treated so.

Results

Social Demographic Characteristics of Respondents

Of the 365 men who participated in the study, two thirds (65.5%) were living in urban settings of the study district. The mean age of all respondents was 35 years, although the majority (65.5%) were living in urban settings of the study district. The relative majority (41.1%) of the respondents were self-employed in the informal agricultural sector as small-scale farmers (Table 1).

Sources of Family Planning Information

Overall, close to half of respondents (45.7%) reported to have obtained FP information from their spouses. The other half received such information through other sources including mass media (27.6%); health facilities where they attended for care seeking (18.1%); community health meetings (12.6%), and others from neighbours, friends, campaigns and billboards (Table 2). Statistically, no significant difference was noted in terms of the proportions that obtained FP information from health facilities. For instance, Soga ward (rural) seemed to have a larger number of men reporting to have obtained FP information from health facilities than their counterparts reporting the same from Mlandizi.

Access to Different Mass Media Channels and Exposure to Family Planning Information

Majority of respondents were exposed to at least one type of mass media and 82.7% of them reported to have listened to radios while a slightly lower proportion (n = 85, 28.1%) claimed to have received FP information through community meetings. For those reporting to have had seen or heard of FP messages by watching TVs, they were additionally reading newspapers. Overall, more than half of the respondents reporting to have been watching TVs also attested to have been reading newspapers at least once per week (Table 3). Of those who listened to the radio, 78.1% confirmed to have heard FP messages as compared to more than half (65.7%) of respondents who got such messages by watching TVs. Moreover, about half of respondents (48.4%) reported to have had access to newspapers through which they could get FP messages. For those reporting to have had seen or heard of FP messages through the mass media, they specified that the contents of the messages were related to such issues as child spacing, types of recommended FP methods, importance of using the methods, their safety and male involvement in FP services.
Exposure to Different Sources of Information and Family Planning Use

Chi-square test of association between use of FP method(s) and access to FP information via different sources indicated the following results: no significant difference in the use or non-use of FP methods by men who had received FP information (i) from their spouses and those who had not ($\chi^2 = 0.046, P = 0.830$); (ii) from health facility staff and those who had not ($\chi^2 = 0.6902, P = 0.406$); (iii) through mass media sources and those who had not ($\chi^2 = 0.0941, P = 0.759$); and (iv) through community meetings attended and those who had not ($\chi^2 = 2.3103, P = 0.129$). However, further analysis shows association between men use of FP methods with their spouses and exposure to FP messages in the three mass media channels.

Sixty-eight percent of respondents who were exposed to FP messages in the radio reported to have been using any FP method with their spouses ($\chi^2 = 18.0016, P = 0.001$). Likewise, 67.2% ($\chi^2 = 4.41, P = 0.03$) of the men who reported to have seen an FP message on TV had used a FP method with their spouses. Seventy percent of men who read newspapers at least once per week reported to use FP methods with their partners ($\chi^2 = 6.55, P = 0.01$). As shown on Table 4, unadjusted odds ratios show that exposure to radio, television and newspapers had strong association with whether a man uses any FP method with his partner. After adjusting for education level, marital status, residency, occupation and number of children, men who were not exposed to FP messages in the radio (AOR = 0.37; 95% CI: 0.24–0.59, $p = 0.00$); television (AOR = 0.60; 95% CI: 0.37–0.97, $p = 0.04$) and newspapers (AOR = 0.51; 95% CI: 0.30–0.87, $p = 0.01$) were less likely to use FP methods as compared to their counterparts who were exposed to those media.

**Discussion**

As shown from this study, the majority of men reported to receive FP information from their partners apart from mass media channels and health care facilities that were used as a source of information by only 18% of the respondents. This finding is similar to what was reported in the last Tanzania Demographic Health Survey (TDHS). The latter survey found that only a few men received information through interpersonal communication with health care providers [13]. The reason behind these observations may be diverse, but in the present study we argue that as few men seemed to visit HFs as compared to women in relation to RH services [6,24], the HFs might not be most suitable place for targeting men with FP education. Otherwise, there is a need to ensure that more deliberate and concerted interventions are launched so as to encourage men to visit HFs in which various health education information (including FP messages) giving programs are instituted to serve the respective clients. By doing so, men can get an opportunity for asking questions for clarification from health service providers to clear their doubts and misconceptions.

Receiving FP information from sexual partners or spouses might be viewed as an uncertain means of reaching men with FP information in the event the partner does not clearly understand what she was informed by the HCW at the HF. Sometimes, the spouse’s ability to deliver the right message to her partner in the right manner might be low. On the other hand, HCWs may limit the words they give to their female clients regarding the behaviour of men on sexual and RH matters, and therefore, when it comes to passing the messages about use of certain FP methods, the female clients will automatically fail to give it correctly. By visiting HFs themselves, men may be sensitised on FP and then persuaded themselves, men may be sensitised on FP and then persuaded about their need to use certain FP methods. This would increase the number of men eventually complying to adopt the methods. It might not be strange to find women who have reservations onFP methods recommended for men, and therefore, expressing shyness at talking openly about issues aimed to influence or encourage men to use FP methods. As experts have noted, interpersonal
communication, for example between service providers and male clients might help to clear existing rumours and misinformation about FP which are widespread in many developing countries [25].

As also noted from the present study, a greater proportion of the men who had access to radios and TVs and nearly half of those who had access to newspapers confirmed to have heard of FP. The proportions reported are higher than the ones documented from a previous study which showed that about 50% of the men had access to FP messages through radio while 20% of the same group had accessed FP information through TVs and newspapers [13]. The higher proportion of men who were exposed to FP information through mass media could be due to the fact that recently the emphasis on FP issues has increased in the reproductive and child health (RCH) arena in Tanzania. This has gone hand in hand with the campaigns for behaviour change communication, both for FP and for the prevention of sexually transmitted infections (STIs) through different mass media channels; as confirmed by experience from different sites within a country and in different countries [26]. The present study findings also reveal that exposure to FP messages through radio; television and newspapers did not differ between the rural and urban settings. This evidence differs from what the TDHS reported before, showing that exposure to FP messages was significantly higher in urban than in rural areas, for all types of the mass media [13]. The reason for this could be due to improvement in social economic status over time and hence increased access or ownership of radios and television sets in rural settings.

Further, the findings from this survey have shown that mass media influence attitude and FP practices among men. Men who were not exposed to FP messages from any media were less likely to use FP methods with their partners. However, the low coverage of FP messages reaching men might not bring great impact on the general community. In addition, we argue that since mass media, unlike interpersonal communications do not offer opportunity to ask questions directly, there is a need to design mechanisms that could facilitate a two-way communication approach. For example, we could include question-and-answer sessions for clarification in order to clear various myths and misconceptions that may deter men in adopting and supporting FP use.

Despite the interesting findings presented from this study, there are several methodological limitations that are important to spell out as guidance to future researchers who may wish to investigate more on the same subject area. The immediately noted limitation is related to the study size, and this includes both the study area covered and study population if one looks at these from a study representation viewpoint. The methods used for data collection may also raise another concern due to lack of qualitative data that would help to strengthen the inferences made out of the findings presented. While the use of a structured questionnaire may seem appropriate for the objectives and scope of the present study, one can underscore the general lack of representation of qualitative information such as perceptions of the respondents that could be better captured using qualitative data collection and analysis. Some of the respondents might/could have given different answers when responding to the same set/types of questions if they were given a room to express themselves rather than confining them to structured questionnaires as was the case in the present study. The use of different data gathering and analysis techniques might bring about more holistic and even some controversial or inconclusive results [27]. In connection to employing different research methods in one study, some questions that were not answered in the current study that could be further researched on include whether men thought to have enough information on FP in general (or on FP methods), where they would like to receive FP information, what sources they felt were trustworthy and compelling, what information they would like to receive and from whom and whether they would like information on male methods in addition to the female ones. We further argue that, had women been one of the target groups for this study probably they could give responses and experiences that are different from those given by their male counterparts on certain aspects.

Conclusion

This study has shown various sources of family planning (FP) messages among men, including health service providers (HCWs) in health facilities, spouses, mass media and community meetings. The majority of the respondents mentioned their spouses as their main source of the FP information, indicating that, to these men, spouses were the main source of the information and therefore could be relied upon as an effective channel for passing FP message to men. However, any attempt to increase men’s health facility visit behaviour especially making men accompany their spouses to attend ANC and other RCH services could make a difference in FP education to both women and men. The findings from the present study, however, despite the limitations, suggest further research on factors influencing men’s participation in FP aspects in developing countries whereby the health systems are always constrained by various factors. Information is power, and therefore, based on the available information, health program authorities, including those dealing with FP programming and interventions can make use of the available information to review their programmes as need might be depending on how useful the evidence created seems to be for them for the time being. By learning from the experience on what the situation is in given local contexts, new insights can be developed and trapped to make things much better and use the evidence to evaluate whether the existing programmes are effective or not and therefore allowing authorities to take the desired courses of action.

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Conflict of Interest Declaration

The authors declare no conflict of interest related to this work.

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