



Patient education

Male involvement in family planning program in Northern Ethiopia: An application of the Transtheoretical model



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ABSTRACT

Objective: The objective of this study is to use the Transtheoretical behavioral model to assess male involvement in family planning.

Methods: A cross-sectional study was conducted in Angolela–Tera District of Amhara Region from February 15 to March 14, 2008 on married men. Multi-stage sampling technique was employed to select the 770 study participants. The relationship of stage of change and decisional balance, self-efficacy and processes of change was assessed by ANOVA tests.

Results: 225(30.5%) of the men were in the Precontemplation stage, 235(31.8%) were in the contemplation stage, 81(11.0%) were in preparation, 76(10.3%) were in action stage, and, 121(16.4%), were in the maintenance stage. Confidence increased across the stages while experiential and behavioral processes increased in the early stages and then decreased at a transition from action to maintenance stage. The pros were increased across the stages, the cons decreased and a crossover occurred prior to contemplation stage.

Conclusion: The findings suggest that counselors need to understand that behavior change is a process that occurs in a series of stages and therefore can facilitate behavioral changes with various strategies. Health educators need to develop educational components that match stages of change.

Practical implications: Based on our results, programs aimed at promoting contraceptive prevalence for contraception should seek ways and means for increasing the pros and for increasing self-efficacy.

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1. Introduction

Reproductive health programs have traditionally focused on women whilst, male involvement in family planning (FP) became a priority following the International Conference on Population and Development (ICPD) 1994 [1]. Limited research on male roles in Ethiopia and sub-Saharan Africa has consistently found that decisions regarding family size and contraception are dominated by husbands, who expect to have large families [2]. Contraceptive use is an instance of healthy behavior that requires behavior change. One of the most popular models for studying behavioral

determinants and informing interventions is the Transtheoretical model (TTM) of behavior change [3].

The TTM has been presented as an integrative and comprehensive model of behavior change [4], offers a relatively new approach for examining how and why people change their behaviors [5,6]. The stages that have been categorized in the behavioral change process include pre-contemplation, contemplation, preparation, action, and maintenance. An understanding of Prochaska's theory helps to explain the lack of success in increasing contraceptive usage. The model proposes that people have different stages to adopt any change, and the appropriate process or technique should be used to target behavioral change for people in a certain stage. This theory is important to intervene according to the levels of their stages of change [5]. Previous studies have been demonstrated the use of TTM in family planning behavior [7–9].

According to the 2007 Central Statistical Agency (Ethiopia) report, the population of the country stood at 73,918,505. Of

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whom, 36,621,848 (49.5%) were females [10]. The Ethiopia Demographic Health Survey (EDHS) 2005, reports that the contraceptive prevalence rate for Ethiopia was 14.7% while it was only 8.9% among currently married teenaged women between 15 and 19 years [11]. Fertility in Ethiopia declined from 5.9 to 5.4 per women within five years [12,13]. High risk births can be prevented through the use of family planning services [14,15]. In Ethiopian studies, when men were involved in home visit talks about family planning there was greater use of contraception and modern methods [2]. Tilahun et al. study found out that over half of the couples wanted more children (non willing to use contraceptive) and 30% of the spouses differed about the desire for more children [16]. In Alemayehu et al. study (2013) more than half of the married Ethiopian women had negative attitude towards using long acting and permanent contraceptive methods (LAPMs) (still 12% of the women used them, when the rest used other methods) [17]. Need for more children, husband approval, couple's discussion about family planning issues, monthly family income and number of living children were significantly associated with the use of modern contraceptives [18]. Factors that are associated with the use of modern contraceptive includes individual attitudinal, educational, cognitive, emotional and interpersonal barriers to uptake the FP, broader socio-cultural, and religious, and cultural norms and practices concerning the use of FP; geographic, administrative barriers as well as barriers relating to quality of care barriers; misinformation: – knowledge of different family planning methods: – fear of side effects (health concerns); husbands not supporting the use and fear of infertility after use [19,20].

Men's lack of access to information and services is a barrier to using a family planning method [21]. Despite reported high knowledge of family planning in the EDHS 2005, married adolescents report very limited use of contraception methods [11]. Investigating the male factors that affect the reproductive health of the women including family planning is of great importance and is currently receiving increased attention. So this study aimed to identify demographic and attitudinal characteristics of men associated with different TTM stages of contraceptive use so as to better tailor future interventions.

2. Methods

2.1. Study setting

The study area was Angolela-Tera District, one of the 22 districts in North Shoa Zone, Amhara Region of Amhara. It is located 110 km north of the capital Addis Ababa and 656 km South East of the regional capital Bahir Dar Chacha is the capital town of the district. The district has an estimated total population of 97,287 that resides in the 20 kebeles. The district has two health centers, and seventeen health posts. The study was conducted from February 15 to March 14, 2008 in Angolela Tera district, Amhara Region, Ethiopia. Family planning services, such as, injectables, pills, condoms, and intrauterine devices (IUD) are offered free of charge at the district health institutions [22]. The target population were all married males residing within the district. Therefore, the study population were married males living in the selected areas of the district with inclusion criteria of men (ages 15–59) with a wife within the reproductive age group (that is the wife's age should be between 15 and 49 years) and in union for more than six months and exclusion criteria of couples where husband stayed for more than six months from home and men or women who were perceived infertile or pregnant during the study period. Study subject who didn't meet the inclusion criteria were ineligible for participation in the study.

2.2. Sample size and sampling technique

A sample size of 770 was required by calculating proportion of men who approved use of contraceptives 62.9% [23] and 95% CI with a design effect of 2 and 10% allowable error for absenteeism and refusal to participate in the study. The kebeles were stratified based on urban and rural. From the 20 kebeles, six (five rural and one urban) kebeles were selected randomly in the district. Census was carried out to produce a complete list of all married males who fulfill the inclusion criteria in the selected kebeles. During the census, subject's name, age of husband and wife, perceived pregnancy, perceived infertility and address of the eligible married males were included. Census result showed that a total of 7732 married men lived in the selected six kebeles. Of those 7732 married men, 7483 were eligible for the study (6463 from rural and 1020 from urban). Once we got the lists of eligible married males, simple random sampling technique was used to select the 770 study participants. The number of study participants to be sampled from the selected kebeles was determined using proportionate-to-population size. The selected married man was interviewed. If the selected married man was absent or closed his house during data collection the interviewers revisited the household (HH) three times at different time intervals and if interviewers failed to get that study participant, the study participant was excluded from the survey.

The stages of change and processes of change instrument were adopted from other studies [4,24] and were revised after examining the relevance of scale items, through which a structured questionnaire was developed. The questionnaire was first prepared in English and translated into Amharic and retranslated to English to check for consistency.

2.3. Measurements

The outcome variable was behavioral stages of male involvement in contraception use and the explanatory variables were background variables (demographic, social, and economic variables), desire for children: decisional balance, self-efficacy and processes of change measures.

The processes of change on modern contraception were measured by statements using 5 point Likert scale format which was adopted from other study [24]. Self-efficacy in convincing the wife to use contraception was assessed using seven Likert scale questions. Seventeen decisional balance scale items were included in the questionnaire. A checklist of pros and cons for general contraception was used to assess the decisional balance. Participants were asked to determine whether they agreed or disagreed with giving responses that ranged from 1 to 5. For the pros and the cons a total score for a scale was calculated by adding the numerical numbers associated with responses to each item. When they made their decision about contraception use the summation of all pros and cons was calculated as the decisional balance score. Based on this coding, a zero score meant that the participant had equal pros and cons, whereas a negative score meant that the participant had more cons than pros, and a positive score mean that the pros outweigh the cons.

In this study we defined precontemplation as: no intention to take contraception within the next six months, contemplation as: intention to take contraception within the next six months, preparation as: intention to take contraception within the next 30 days and has taken some behavioral steps in this direction, action as: use contraception for less than six months, maintenance as: use contraception for more than six months.

Decisional balance as: the balance between the perceived advantages of using contraception (the pros), and the perceived disadvantages or barriers to using contraception (the cons).

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