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Male Involvement in Family Planning Services Utilisation and Associated Factors in Musanze District, Northern Rwanda

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Male Involvement in Family Planning Services Utilisation and Associated Factors in Musanze District, Northern Rwanda

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Abstract- Background: Male involvement in family planning services is critical for reducing unplanned pregnancies, unsafe abortions, maternal and child mortality. Men, being the primary decision-makers in the majority of African households, play an important role in women's usage and continuance of contraceptive methods. However, for a variety of reasons, their participation in family planning services remains limited. This study aims to determine the level of male involvement in family planning services utilization and associated factors in the Musanze district of Northern Rwanda.

Methods: A cross-sectional study design was carried out on 397 currently married men from June to August, 2023 in three sectors of Musanze district, Northern Rwanda. Simple random sampling technique was used to select participants of the study. Data were collected using Pre-tested interview-administered questionnaires. Multivariable logistic regression analysis was performed to identify variables associated with male involvement in family planning services utilisation. *Results:* In this study, the overall level of male involvement in family planning services utilisation was 36.7 % of males. The mean age of respondents was 38.103 (SD of ± 7.838). Logistic regression results suggested that age of respondents [AOR: 6.199, 95% CI: (1.727-22.251)] and being employed [AOR=2, 95% CI: (1.24-3.224)] were positively associated with male involvement in family planning services. Whereas, distance to family planning facility [AOR= 0.071, 95% CI: (0.009-0.579)], being educated [AOR=0.495, 95% CI :(0.229-1.072)] and being Muslim is negatively associated with male involvement in family planning services [AOR=0.226 95% CI: 0.041-1.237)].

Conclusions: In this study, the level of male involvement in family planning services utilization was low. Male involvement in FP services was predicted by age, education level, religion, occupation and distance to FP facility. Based on these findings, the study suggests integrating men into existing family planning services to enhance usage and sustainability.

Keywords: male involvement; family planning services; musanze district; northern Rwanda.

I. Introduction

Family Planning (FP) is a human right allowing everyone to space and determine the number of children using FP methods[1]. Family planning services have long been recognized as a fundamental component of public health programs worldwide, contributing to the improvement of maternal and child health, reduction of unintended pregnancies, and overall enhancement of reproductive health outcomes. While these services are often directed towards women, the role of men in family planning is increasingly acknowledged as a critical factor in its success and effectiveness [2].Globally, 1.1 billion women of reproductive age (15-49 years) in 2019 planned to utilize FP methods, yet 190 million women had an unmet need for FP, with rates greater in Sub-Saharan Africa (SSA) than elsewhere in the globe [3]. Despite significant progress over the years, many women worldwide want to prevent pregnancy but they and their partners are not using contraception. Some of the reasons for this unmet need include poor quality of service, a lack of a variety of methods, fear of opposition from partners, and concerns about side effects and health concerns among others [4]. One important element to consider is male involvement in family planning. Male involvement in family planning extends beyond the promotion of condom use and vasectomies as male contraceptive methods. It encompasses the active support provided by men to their partners in contraception, their advocacy for family planning within their social circles, and their efforts to shape policy environments that foster the development of programs aimed at male involvement [5]. Numerous studies have indicated that the acceptance and continuity of family planning services tend to be more successful for women when men actively participate[5,6].Traditionally, FP programs had focused primarily on women; however, men are regarded as primary decision makers about sexual activity and the desired number of children within most African communities and their involvement in FP is vital to the contraceptive methods acceptance and continuation [7,8]. The benefit of involving men in FP services could improve women's FP use and improve maternal outcomes, this could avert an estimated 830 daily maternal deaths in sub-Saharan Africa [9].The lack of male involvement in family planning is a contributing factor to low contraceptive usage and a high-unmet need for family planning in Africa. When men actively

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participate in family planning, it has the potential to reduce maternal mortality by 32% and child mortality by 10%. Despite the formation of FP policy initiatives, male participation in FP services utilisation is still considered low in the majority of SSA nations. According to the study done in Ethiopia, only 12.5% of men are involved in FP services. The reasons mentioned for low male involvement in FP include lack of knowledge of FP methods, fear of side effects, desire to have more children, cultural and religious prohibition [10]. Strengthening male participation in FP services utilization and reproductive health issues is an important public health initiative and key in achieving sustainable development goal target 3 (SDGs) of reducing maternal mortality. A study conducted in Uganda reported that when men are engaged in FP services utilization, women are likely to be motivated in FP acceptance, use and continuation. It was also discovered that 34.0% of women had insufficient partner involvement in FP, 80.6% believed that discussing FP with a partner has a good effect on their contraceptive use, and 93.5% thought that males play a role in FP [11].As a result, men must be consistently included in the use of FP services.

Rwanda has made FP a central component of development and reducing poverty [12]. The government has been promoting FP through various strategies including; training providers, conducting mass media FP campaigns, strengthening health facilities by making contraceptives more widely available and affordable and increasing contraceptives funding and support from the government [13]. However, according to the 2019-2020 Rwanda Demographic and Health Survey (RDHS), only 64% of married women use family planning with 58% using modern methods and 6% using traditional methods [14]. On the other hand, the contraceptive discontinuation after one year of use is 30% and the unmet need for FP continues to be high with 14% [15]. There is high-unmet need for family planning hence the need to involve the male partner in FP programs.

A low level of male involvement in MCH services is a case in the Musanze district. According to Karamage in 2016, the level of male involvement in MCH services was still low as most of them thought that it was a woman's affair. In addition, men did not accompany their partners in MCH services including FP services due to fear of facing friends and relatives, behaviors of staff at health facilities, long waiting times, unavailability of physical space to accommodate men and low level of education been stated as barriers to male involvement in MCH services [16].Failure to involve males in FP services utilization can have serious consequences in a society like Rwanda, even if women are motivated to use FP methods, the non-involvement and opposition from husbands contribute to the high of unmet, low contraceptive use and discontinuation of FP methods [12]. However, access to FP among men is limited by many factors that are not fully identified. The level of male involvement in FP services and associated factors in Musanze district is not well identified, the only data available is for male engagement in MCH services. To address this gap, this study seeks to assess the level of male involvement in FP services utilization and associated factors in Musanze district, Northern Rwanda.

II. Methods

a) Study Design and Setting

A cross-sectional study was conducted from August to December 2023 in Musanze district, Northern part of Rwanda. Musanze district is one of the five districts of Northern Province. In north, it is bordered by Uganda and Gakenke district to the south, Burera district to the east and Nyabihu district to the west.According to Fifth Rwanda Population and Housing Census (2022), it has a population of 476522 people: 227340 males, and 249182 females with population density of 1154/ km^2. The district has both urban and rural areas with 234,258 people live in urban area while 242,264 live in rural area, and the district has an area of 530 km^2. It has 15 sectors, 68 cells and 432 villages. The population of men aged 21 years and above is estimated to be 74801 [17]. The district was selected because contraceptive prevalence rate ranks third lower (70%) in Northern province with only 66% using any modern FP method and 4% using the traditional method, the total fertility rate (3.5 children) [14].

b) Population and Eligibility Criteria

In this particular case, the target population consists of married men aged 21 years and older, who have partners of reproductive age and live in Musanze district. The researcher understands that men aged 21 and above are usually in committed relationships and are more likely to be involved in sexual and reproductive activities, which makes them a suitable group to gather information about family planning. The study participants were approached during a weekly community meeting held in the Musanze district every Tuesday. Inclusion criteria for participants in the study required voluntary consent, being married men aged 21 or older with a partner in the reproductive age group, and residing in specific sectors. Exclusion criteria involved being critically ill, unable to communicate or hear, reporting infertility, refusal to participate, or having a partner outside the reproductive age range (15-49 years).

c) Sample Size Determination

The sample size was determined using the Yamane formula for population (Yamane, 1967).

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

According to the National Institute of Statistics of Rwanda (NISR, 2023), the estimated population of males aged 21 and above was 74,801 [17]. Since, the study population (N) is 74801, by using a 95% confidence interval and sampling error of 0.05, the calculation becomes,

$$n = 74801/1+74801(0.05)^2 = 397$$

Where by
N: study population n: sample size e: sampling error

Therefore, the sample size in this study becomes 397.

d) Sampling Procedure

Three (3) out of 15 sectors were purposively selected in Musanze district, Northern Province based on the researcher's availability, geographical location, and financial resources. One sector was in an urban area, while the other two were in rural areas with different socio-demographic characteristics. The study included 397 men who were 21 years of age or older and met the study criteria. In this study, the participants were selected using a probability sampling technique known as simple random sampling. This means that each element in the larger population had an equal chance of being chosen for the sample. This ensures that the sample accurately represents the entire population, making it a reliable method for drawing conclusions and making statistical inferences. The process of selecting respondents began by assigning a unique identifier (ID) number to each married man in the population during data collection visits. Then, a computer program with a random number generator was used to generate a number within the range of the total study participants. This guaranteed that each married man had an equal opportunity to be selected. The randomly generated numbers were then matched with the unique identifiers assigned to the married men, and the individuals corresponding to these random numbers were included in the sample.

e) Study Variables and Measurements

The main outcome variable was level of male involvement in family planning services utilisation (high involvement or low involvement). The predictor's variables were socio-demographic factors (such as age, education level, religion, occupation, and marital status) and healthcare-related aspects such as proximity to FP facilities, concerns about side effects, and the availability of male contraceptive methods. Male involvement in FP was computed from the following six "Yes" or "No" questions: men's use of FP methods, accompanying partner to FP facility, discussing with a partner on FP issues, approving partner's use of FP, providing support to partner to access FP services, and encouraging the use of FP to partner. Based on the summative score of the question designed to determine male involvement through spousal communication and approval, men with scores 0-3 were considered as having low involvement in FP and 4-6 as high involvement.

f) Data Collection Procedure

A questionnaire, which was adopted by researchers [7,18] was used by the researcher to collect data from respondents. The questionnaire was primarily in English and was also translated into Kinyarwanda. It consists of both closed and semi-closed questions (refer to the questionnaire in the appendix). The questionnaire is divided into three sections, each addressing a specific objective. These sections provide quantifiable answers and investigate the level of male involvement in FP service utilization, as well as socio-demographic and health service-related factors among the participants. The advantages of using questionnaires are that they are cost-effective and user-friendly, and they facilitate accessibility to a large number of individuals.

g) Data Analysis

The analysis was performed using Stata software version 18. Descriptive statistics using frequency tables were used for categorical data, while mean and standard deviation were used to summarize numerical data. Multivariable logistic regression analysis was applied to identify factors associated with male involvement in family planning. Odds ratios with a 95% confidence interval were reported, and a p-value less than 0.05 was considered statistically significant.

h) Ethical Consideration

The study adhered to the principles outlined in the Declaration of Mount Kenya University. Initially, ethical approval was obtained from Mount Kenya University's ethical review committee (Reference number: MKU 04/PGS&R/0927/2023). Subsequently, the detailed objectives of the study were communicated to all participants, and written informed consent was obtained from each individual. All data collected from respondents were treated confidentially, with no names recorded on the questionnaire, and stored securely with password protection on a computer.

III. Result

a) Demographic Characteristics of Respondents

The study's respondents had a mean age of 38.103 years (SD ± 7.838). The largest proportion fell within the 32-42 age bracket (44.84%), followed by 27.5% between 43 and 53 years old. A notable 24% of male participants were aged 21-31, with 3.8% falling into the 54-64 age range. Demographic profiles varied: 46% had secondary education, 30% primary, 12% university, and 11% no education. Religious affiliations comprised 47% Catholic, 26% other Christian denominations, 20.6% Adventist, and approximately 6.05% Muslim. Regarding marital status, 57% were in an illegal

marriage, while 42.5% were legally married. Employment status showed 51.4% employed and 48.6% unemployed. In terms of children, 93.4% reported having 0-5, while 6.5% had 6-10. The summarized sociodemographic profile of the respondents can be found in [Table 1].

Table 1: Sociodemographic Characteristics of the Respondents

Variables	Frequency (n=397)	Percent (%)
Age group		
21-31	95	23.93
32-42	178	44.84
43-53	109	27.46
54-64	15	3.78
Education		
No education	44	11.08
Primary	122	30.73
Secondary	183	46.10
University	48	12.09
Religion		
Other	103	25.94
Catholic	188	47.36
Adventist	82	20.65
Muslim	24	6.05
Marital status		
Married illegally	228	57.43
Married legally	169	42.57
Employment status		
Employed	193	48.61
unemployed	204	51.39
Number of living children		
0-5	371	93.45
6-10	26	6.55

b) Level of Male Involvement in Family Planning Services Utilisation

Male involvement in family planning was assessed through a series of six yes-or-no questions outlined in [Table 2]. These questions aimed to gauge whether men utilized FP methods, accompanied their partners to FP facilities, engaged in FP discussions with their partners, approved of their partners' FP practices, provided support for accessing FP services, and encouraged FP usage. Scores were tallied based on the number of affirmative responses, ranging from 0 to 6. Men scoring between 0 and 3 were classified as having low involvement in FP, while those scoring 4 to 6 were considered to have high involvement.

Table 2: Distribution of Male Involvement in Family Planning Services

Variables	Frequency n=397)	Percent (%)
Using any FP method(s)		
Yes	47	11.84
No	350	88.16
Discussed FP with your partner		
Yes	193	48.61
No	204	51.39
Support for your partner to access FP services		
Yes	148	37.28
No	249	62.72
Approve FP use by partner		
Yes	170	42.82
No	227	57.18
Accompany your partner to the FP facility		
Yes	58	14.61

No	339	85.39
Encourage the use of FP by partner		
Yes	141	35.52
No	256	64.48

According to the study, only 36.78% (146 out of 397) of the married men surveyed exhibited high involvement in FP service utilization. Conversely, 63.22% (251 men) demonstrated low involvement [Table 3]. These findings suggest that the level of male engagement in FP service utilization among men in Musanze district falls below average, with the majority of respondents scoring below four points out of a maximum of six. Regarding the types of FP methods employed by the respondents, only 11.8% (47 men) reported using male FP methods. Among these 47 men, the predominant method utilized was condoms, chosen by 74.5% (35 men). Other methods included withdrawal (12.8% - 6 men), vasectomy (8.5% - 4 men), and miscellaneous methods (4.3% - 2 men).

Table 3: Level of Male Involvement in Family Planning Services Utilization

Male involvement in family planning	Freq.	Percent
Low	251	63.22
High	146	36.78
Total	397	100.00

c) Socio-Demographic Factors Associated with Male Involvement in Family Planning Services Utilisation

The analysis of [Table 4] revealed a significant statistical relationship between male involvement in FP and age (p-value = 0.0006). Moreover, a similar observation was made regarding participants' educational level, religion, marriage status, occupation, and their level of male involvement in FP (p-value = 0.0048, p-value = 0.0306, p-value = 0.0068, respectively). However, no statistically significant relationship was found between male involvement and the number of children (p-value = 0.1340).

Table 4: Socio-Demographic Factors Associated with Male Involvement in Family Planning Services Utilisation

Variables	Male Involvement in Family Planning		Chi-	P-value
	Low	High		
Age group				
21-31	77	18		
32-42	105	73	17.46	0.0006
43-53	61	48		
54-64	8	7		
Education				
No education	24	20	12.94	0.0048
Primary	87	35		
Secondary	119	64		
University	21	27		
Religion				
Other	63	40	8.90	0.0306
Catholic	116	72		
Adventist	50	32		
Muslim	22	2		
Marital status				
Married illegally	157	94	7.32	0.0068
Married legally	71	75		
Employment status				
Employed	136	115	8.47	0.0036
unemployed	57	89		
Number of living children				
0-5	231	20	2.25	0.1340
6-10	140	6		

d) Services-Related Factors Associated with Male Involvement in Family Planning Services Utilisation

The study unveiled significant statistical correlations between various factors and male involvement in FP. Firstly, there's a notable correlation between proximity to a health facility and male engagement in FP (p-value = 0.0004). Men residing within close proximity (less than 5 km) to a health facility demonstrate a higher rate of high involvement in FP compared to those residing farther away (more than 5 km). Furthermore, the study highlighted a statistically significant link between male involvement in FP services and apprehension regarding side effects (p-value = 0.01365). Men who do not harbor fears of side effects exhibit a higher rate of high involvement in FP compared to those who do. However, the study found no significant association between the availability of FP services in the community and male involvement in FP (p-value = 0.1029). While there appears to be a slightly elevated proportion of high involvement among men in communities with accessible family planning services, the disparity is not statistically significant. This suggests that mere service availability may not strongly influence male involvement in FP [Table 5].

e) Multivariable Analysis of Factors Associated with Male Involvement In Family Planning

The strongest contributing factor of male involvement in FP is the age group with an odd ratio of 6.199. This means that the respondents who were in the age group (54-64 years) were 6 times more likely to have high involvement in FP compared to the 21-31 years age group (OR=6.199, 95% CI: 1.727-22.251). Again, the participants who had primary education were more likely to have high involvement in FP (OR=0.331, 95% CI: 0.147-0.745) compared to those with no education. It was shown that employment status has a positive association with male involvement in FP; employed respondents were 2 times more likely to have a higher involvement in FP compared to unemployed (OR= 2, 95% CI: 1.24-3.224). Distance to a health facility was also associated with male involvement in FP with the odds ratio of approximately 0.071. Men living very close to a health facility are more likely to have high involvement in FP (AOR= 0.071, 95% CI: 0.009-0.579) than men living very far from FP facilities. Fear of side effects is also associated with male involvement in FP with an odds ratio of 3.444 (95% CI = 0.087-14.202). This means that men who experienced fear of side effects were approximately 3 times less likely to have higher involvement in FP than respondents who did not fear side effects. To summarize, age, employment status, education, distance to health facilities and fear of side effects collectively contribute to increased probabilities of male involvement in FP services (Table 6).

Table 5: Health Services-Related Factors Associated with Male Involvement in Family Planning Services

Variables	Male Involvement in Family Planning		Chi-	P-value
	Low	High		
Distance to a health facility				
Very close(less than 5 km)	227	145	12.33	0.0004
Very far (more than 5 km)	24	1		
Fear of side effects				
Yes	9	14	6.10	0.0136
No	242	132		
Availability of FP in the community				
Yes	12	133	2.26	0.1029
No	239	13		

Table 6: Multivariable Analysis of Factors Associated with Male Involvement in Family Planning Services Utilisation

Male involvement	Odds Ratio	St. Err.	t-value	p-value	95% CI	Sig
Age group						
21-31	Ref					
32-42	3.134	1.021	3.51	0.000	1.656-5.934	***
43-53	5.201	1.889	4.54	0.000	2.553-10.599	***
54-64	6.199	4.042	2.80	0.005	1.727-22.251	***
Education level						
No education	Ref					
Primary	0.331	0.137	-2.67	0.008	0.147-0.745	***
Secondary	0.495	0.195	-1.78	0.075	0.229-1.072	*
University	0.937	0.455	-0.13	0.894	0.362-2.426	
Religion						
Other	Ref					

Catholic	0.902	0.252	-0.37	0.711	0.522-1.558	
Adventist	1.002	0.341	0.00	0.996	0.514-1.953	
Muslim	0.226	0.196	-1.71	0.086	0.041-1.237	*
Marital Status						
Married illegally	Ref					
Married legally	1.148	0.276	0.57	0.565	0.716-1.841	
Occupation						
Unemployed	Ref					
Employed	2	0.487	2.84	0.004	1.24-3.224	***
Children						
0-5	Ref					
6-10	0.42	0.228	-1.60	0.11	0.145-1.217	
Distance to the health facility						
Very close (less than 5 km)	Ref					
Very far (more than 5 km)	0.071	0.076	-2.47	0.013	0.009-0.579	**
Fear of side effects						
Yes	3.444	2.489	1.71	0.087	0.835-14.202	**
No	Ref					
Availability of FP in the community						
Yes	0.916	0.663	-0.12	0.904	0.222-3.78	
No	Ref					
Constant	0.297	0.145	-2.49	0.013	0.114-0.773	**

Significance: *** p<0.01, ** p<0.05, * p<0.1. Ref: Reference.

IV. Discussion

This study aimed to determine the level of male involvement in FP services utilization and associated factors in Musanze district, Northern Rwanda. Determining the level of male involvement in FP services is crucial for evaluating the effectiveness of FP initiatives. The findings indicated that only 36.78% of men demonstrated a high level of involvement in FP. This high level of involvement includes using FP methods, accompanying their partners to FP facilities, discussing FP matters with their partners, approving their partners' use of FP, providing support in accessing FP services, and encouraging their partners to use FP.

These findings are consistent with previous studies conducted in Ethiopia, where a similar percentage (39.9%) of male involvement in FP services utilization was observed [19] and Bangladesh (40%) Indicating a comparable level of male involvement in FP. However, it contrasts sharply with more recent surveys reporting lower rates, such as 17.5% in Tanzania [8], 12.5% in Ethiopia[10], 17% in the Democratic Republic of Congo[20]and 8% of Indonesia [21] In Indonesia, there is a widely held belief that FP is mainly the responsibility of women. This perception is further reinforced by the focus of national FP programs on women. Furthermore, the significant differences in the use of FP services throughout the country can be explained in part by factors such as place of residence, region, and socioeconomic status. Another potential factor that might contribute to these differences could be the variations in populations and the differences in sample sizes. Unexpectedly, 74% of men surveyed who used contraception relied solely on condoms, indicating a remarkably low adoption of alternative male contraceptive methods. This finding is in line with the study conducted by Frederick in Kenya [7]. This inclination could be linked to the limited availability of male contraceptives in rural communities. Therefore, it is imperative to enhance initiatives focused on promoting awareness and accessibility to permanent FP options, especially for those unequivocally committed to avoiding future parenthood.

The study revealed a significant association between male involvement in FP and age (p-value < 0.05). Men in the age group of 54-64 years were found to be almost six times more likely to be involved in FP services compared to those in the age group of 21-31 years. However, this finding contradicts the study by Green and J. Chens (2014) on male involvement in reproductive health in Indonesia. Their study did not identify any association between the age of the respondents and involvement in contraceptive uptake. Instead, they found that confounding variables such as education and age influenced involvement [22]. The finding of this study showed that a higher educational status of the husband was positively associated with male involvement in FP (p-value < 0.0048). The possible explanation is that educated men are more likely to have good knowledge of family planning, which initiates their involvement. This aligns with a study conducted in Mozambique, which found a significant association between the level of education and FP utilization [23].The results indicated that legally married men had approximately twice the odds of being involved in FP compared to their counterparts in illegal marriages (OR=2; 95% CI: 0.716-1.841). This finding is consistent with prior research suggesting that married men tend to

utilize FP methods more than those who are single, widowed, separated, or cohabiting, as evidenced by Kerry et al.'s study conducted in the USA in 2015 [20]. Likewise, employment status demonstrates a significant association with male involvement in family planning. Employed men exhibited two times higher odds of involvement in FP (OR= 2, 95% CI: 1.24-3.224) compared to unemployed. The fact that occupation is associated with FP utilization aligns with a study conducted by Ling (2017), which found that FP use was associated with occupation[24]. The findings suggest that residing closer to FP service delivery points is significantly associated with increased engagement and utilization of FP services, in contrast to those living further away. Men living more than 5 km away from health facilities showed markedly reduced odds of male involvement compared to those residing within 5 km [AOR] = 0.071, 95% CI: 0.009-0.579). These findings are similar to the study conducted in Tanzania where the distance from FP facilities significantly affects the use of FP[8]. It is also supported by the study conducted in Mozambique where men living far away from the clinics tend not to use FP methods due to poor accessibility [23]. This finding is also supported by Ochako et al. (2015) in Kenya, who similarly highlighted distance from FP service providers as a significant obstacle to the utilization of FP services. The negative association between distance and FP utilization is consistent, as individuals residing far from these services often face challenges accessing them, resulting in decreased usage of FP methods[25]. As a result, the discouragement diminishes male involvement in FP services. The analysis of the data revealed that the fear of side effects affects male involvement in FP. Respondents who experienced fear of side effects were less likely to have high involvement in FP compared to respondents who had no fear of side effects. Francis (2019) in Tanzania where fear of side effects was found to be influencing utilization of FP methods also reports this observation [7]. Again, a similar observation was reported from the study done in Uganda where some men believe that they cannot support their partners to use FP methods because using FP is associated with bleeding[26].

a) Strengths and Limitations of the Study

The study aims to assess male involvement in family planning services utilisation and associated factors in Musanze district, Northern Rwanda, and identify associated factors. The findings will inform the district administration about the level of male engagement in FP services and factors influencing it, crucial for developing appropriate measures. These insights can guide the design and implementation of programs to enhance FP service utilization, potentially reducing unmet FP needs and maternal and child mortality. Scientifically, the study fills gaps in knowledge on male involvement in FP services, serving as a reference for similar contexts in Rwanda. Participants will gain awareness, leading to better decision-making and support for FP utilization. Despite its contribution, the study's limitation lies in its focus on one district, limiting generalizability. Future research recommendations include nationwide studies. Challenges encountered include obtaining reliable responses due to cultural factors, addressed through confidentiality assurances and consent procedures.

V. Conclusion

The study concluded that the level of male involvement in FP services utilization in Musanze district was low, at 36.7%. It emphasized the critical role of FP in reducing maternal mortality by limiting births and reducing mortality risks for women. The study focused on sociodemographic factors like age, marital status, education, occupation, and religion, as well as health service-related factors such as distance to FP centers, limited male contraceptive options and side effects of FP use. These factors can affect fertility through FP utilization. Factors like age, education, occupation, distance to FP centers and fear of side effects were found to influence male involvement in FP. Male condom use was predominant. Addressing these factors and developing strategies to improve them is crucial for promoting FP utilization and improving maternal health.

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