THESIS

EFFECTIVENES OF HEALTH EDUCATION FAMILY PLANNING GUIDELINE ON HEALTH BELIEF AND BEHAVIORS REGARDING FAMILY PLANNING METHODS AMONG MARRIED MEN IN MYANMAR

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MASTER DEGREE OF NURSING STUDY PROGRAM
FACULTY OF NURSING
UNIVERSITAS AIRLANGGA
SURABAYA
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THESIS SUPERVISOR APPROVAL SHEET

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This thesis is based on my original research and using citations and references from selected and current resources.

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PREFACE

This thesis is as a requirement for the Master Degree of Nursing in Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia. The title of this thesis is "Effectiveness of Health Education Family Planning Guideline on Health Belief and Behaviors regarding Family Planning Methods among Married Men in Myanmar".

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SUMMARY

EFFECTIVENESS OF HEALTH EDUCATION FAMILY PLANNING GUIDELINE ON HEALTH BELIEF AND BEHAVIORS REGARDING FAMILY PLANNING METHODS AMONG MARRIED MEN IN MYANMAR

By: Zay Yar Tun

Males are the most important members and care-takers of the family but they are considered to be un-co-operative when it comes to usage of family planning methods. Traditionally, family planning programs have focused primarily on women and most of the methods are designed for women considering that it is the women who become pregnant and it is easy to deliver reproductive health services as part of maternal and child health programs. The main objective of this study is to study the effectiveness of Health Education (HE) Family Planning Guideline on Health Belief and Behaviors regarding family planning methods among married men in Lay Myat Nar and Pin Ta Lae villages, Wundwin Township, Mandalay Region in Myanmar. The theoretical background of the study was health belief Model theory.

Quasi-experimental study designs was used to compare the results of the effectiveness of health education on health belief and behaviors regarding family planning methods among married men. Mann-Whitney test and Manova test were used to analyse data. In this study, each group have 45 married men whose wife were still within the age of female reproductive age. The data were collected from the sample population by conducting face to face interviews using structured interview questionnaire. All the instruments in Myanmar language were translated from English version.

The results also illustrated that there was a difference of health belief with p= 0.038, knowledge with p= 0.000 and attitude with p= 0.000 between intervention group and control group. The results of the analysis showed that the treatment group and the control group were different. It can be evaluated that provision of health education program has an impact on the improvement of health belief and behaviors regarding family planning methods in study group was significantly improved after intervention.

In hypothesis, the health education of family planning guideline program were significantly effect on health belief and behaviors regarding family planning methods.

Generally, Family planning was always thought to be a woman's prerogative and most of the studies on family planning in developing countries have long focused on women as the subject of interest. Very little work in this area has focused on men. Male are the most important members and care takers of the family. To improve health belief and behaviors regarding family planning methods among married men, male should be encouraged to participate in family planning program and should be promoted health education family planning guideline for men to improve their knowledge.

Finally, it is apparent that married men in the study group have got valuable advantages because of the effect of health education provided. Moreover, it could be also useful and informative to the health policy makers and health care planners to develop family planning program for married men.

ABSTRACT

EFFECTIVENES OF HEALTH EDUCATION FAMILY PLANNING GUIDELINE ON HEALTH BELIEF AND BEHAVIORS REGARDING FAMILY PLANNING METHODS AMONG MARRIED MEN IN MYANMAR

Abstract:

Introduction: Males are the most important members and care-takers of the family but they are considered to be un-co-operative when it comes to usage of family planning methods. Traditionally, family planning programs have focused primarily on women and most of the methods are designed for women considering that it is the women who become pregnant and it is easy to deliver reproductive health services as part of maternal and child health programs. The main objective of this study was to study the effectiveness of Health Education (HE) Family Planning Guideline on Health Belief and Behaviors regarding family planning methods among married men **Method:** Quasi-experimental study designs was used to compare the results of effectiveness of health education on health belief and behaviors regarding family planning methods among married men. Mann-Whitney test and Manova test were used to analyse data. **Result:** It was found that there was a difference of health belief with p= 0.038, knowledge with p= 0.000 and attitude with p= 0.000 between treatment group and control group. **Discussion:** There was an impact on the improvement of health belief and behaviors regarding family planning methods in study group was significantly improved after intervention. As the predetermined hypothesis, a difference was found between the knowledge, attitude and health belief of married men who received health education and those not received health education.

Keywords: Family Planning, Health Belief, Behaviors, Married Men

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INTRODUCTION

1.1 Background

Family planning is a way of thinking and living that is adopted voluntarily on the basis of knowledge, attitude and responsible decision by individuals and couples in order to promote health and welfare of the family, groups and thus contribute effectively to the social development of the country (WHO, 2011).It involves practices that will enable couples or individuals to determine the number of children they would like to have, when to have them, that is both the timing and spacing and most importantly, those they have the capability or the means with to cater for. (Fumilayo and Kolawole, 2000, Chidinma, 2014)

Males are the most important members and care-takers of the family but they are considered to be un-co-operative when it comes to usage of family planning methods. Traditionally, family planning programs have focused primarily on women and most of the methods are designed for women considering that it is the women who become pregnant and it is easy to deliver reproductive health services as part of maternal and child health programs. International Conference on Population and Development (ICPD) held in Cairo recommends that special efforts are required to actively involve men in reproductive health programs and emphasize their responsibility towards sexual and reproductive behavior, family planning and prevention of unwanted pregnancies if we have to control population (Alketa et al., 2011).

Despite global recognition of the importance of male involvement in family planning, Myanmar has not developed programmes in family planning that fully involve men. Most family planning programmes in our environment seem to focus on women only, the non- inclusion of men in various family planning programmes by program planners has made men not to know much about family planning and the benefits to their spouses and family especially in rural communities. Yet men can participate in family planning either as users of male methods or as supportive partners of users (Fumilayo and Kolawole, 2000, Chidinma, 2014).

In Global, 1,600 women and more than 10,000 new-born die from preventable complications during pregnancy and childbirth every day. Almost 99% of these maternal and 90% of neonatal deaths occur in the developing countries. As the first pillar of safe motherhood and an essential component of primary health care, family planning plays a major role in reducing maternal and new-born morbidity and mortality. Family planning enhances efforts to improve family health. However, traditional beliefs, religious barriers and lack of male involvement have weakened family planning interventions (WHO, 2012). The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries. There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural versus urban areas (WHO, 2015).

(Jafar et al., 2007) reported that most of the males were aware of at least one contraceptive method but awareness of modern methods was poor

(20%) which was increased after intervention (47%). Their willingness to allow their wives to use contraceptive also increased but the improvement was not statistically significant (p=0.08). (Gedefaw et al., 2014) stated that Only 44 (8.4%) respondents were using or directly participating in the use of family planning services mainly male condoms. The reasons mentioned for the low participation were the desire to have more children, wife or partner refusal, fear of side effects, religious prohibition, lack of awareness about contraceptives and the thinking that it is the only issue for women. Therefore, it is very important to get them involved in family planning in order to achieve better success. This will improve health of both themselves and their spouses.

Rapid population growth represents one of the major population concerns in Myanmar where the Population growth rate is 1.0% and is estimated to exceed 58.6 million in 2050. In 2014, the population of Myanmar was about 51 million people. The sex ratio of the total population is 0.93 comprising 93 males per 100 females (MOH, 2015). Relatively short life expectancy, as well as low level of education and poor health care, is prevalent in the population. Family planning (FP) refers to the anticipation and attention of individuals and couples regarding their desired number of children and the spacing and timing of their birth. FP plays one of the important roles to control the population growth rate of the country. In general, the consequences of a lack of access to FP are not only a high number of undesired pregnancies but also increased risk of sexually transmitted diseases and high number of abortions (WHO, 2014).

FP services in Myanmar are lacking and have not yet received the expected level of desired performance. The unmet need for FP in Myanmar stands at 19%, compared with only 3% in neighboring Thailand (MIO, 2014). A total of 70% of the population live in rural areas with little or no access to FP and maternal health services (MIO, 2014). Maternal mortality in Myanmar is 200 per 100,000 live births (MOH, 2015). The United Nations Population Fund reports that 87% of maternal deaths occur in rural areas, largely due to poor infrastructure and lack of reproductive health access and awareness (WB, 2013). The Myanmar Ministry of Health reports contraceptive use of the whole country at 46%, and hopes to increase to 50% (MOH, 2012). Though the maternal mortality ratio has declined steadily, with the low percentage of FP. FP can affect the number of maternal deaths in 2 ways. The most direct effect comes from the reduction in the number of births. With fewer births, the risk of maternal death is lower and the total number of deaths is lower. Also, the reduction of unintended pregnancies can also result in fewer abortions, which can carry a high mortality risk when there are complications (Siri & Munsawaengsub, 2016).

In Wundwin Township, total population is 235000, among them, total birth population is 3500, still birth is 50, abortion is 80, and maternal death is 5 in 2015. According to the 2015 report of Lay Myat Nar and Pin Ta Lae rual health center (RHC), total live-birth is 100 per 5158 population. Among them, there included 4 still-births, 15 abortion cases and 2 maternal deaths.

A rapid population growth is a burden on the resources of many developing countries. Unregulated fertility, can compromise the economic development and political stability of a country. Many international institutions and organizations have strongly advocated family planning for controlling the unregulated births. Even though many studies have been conducted in this field, the demographic research has focused on the determinants of contraception used by women. Family planning was always thought to be a woman's prerogative and most of the studies on family planning in developing countries have long focused on women as the subject of interest. Very little work in this area has focused on men. But the fact is that both men and women are equally responsible for planning and regulating the family size. It is now increasingly recognized that the actions required to achieve improvements in family planning should also encourage the active participation of men, hence exploring the role of husband's contraceptive practices is particularly important. Male involvement also includes the number of men who encourage and support their partner and peers to use family planning and who influence the policy environment to be more conducive to developing male-related programs (Rekha et al., 2015).

The male involvement includes not only male contraception but also all the other national program activities which works towards the awareness, acceptability and prevalence of family planning methods among the males. The usage of modern methods of contraception offer many advantages to the health and economy of both the couple and the country. The primary aim of family planning enables women and men to plan their families and space their

children through the use of modern contraceptives. However, family planning also embraces activities such as infertility, genetic counseling, contraception, abortion and sterilization (Rekha et al., 2015).

Men have rarely been involved in either receiving or providing information on sexuality, reproductive health, or birth spacing. They have also been ignored or excluded in one way or the other from participating in many FP programs as FP is viewed as a woman's affair. Traditionally, men are the heads of households and decision makers in all issues in their respective households. Men decide on FP and the number of children as well as how to use what is produced by the family. Also, findings have shown that since men were the decision makers, they were expected to initiate discussions on FP and the number of the children the couple want to have. Men were perceived as the sole providers for their family needs. Women were not considered decision makers, but implementers of what had been decided by men, without questioning men's decisions (Wambui et al., 2009).

In this study, health education will be given to married men in rural areas because health education is one of the ways to get the proper and sustainable knowledge regarding family planning methods among married men. By giving health education family planning guideline, the level of health belief and behaviors regarding family planning methods among married men will be improved. Therefore, health education will be given in this study as an intervention to enhance health belief and behaviors regarding family planning methods among married men.

1.2 Formulation of the Problem

Based on the description in the background of the formulation of the problem the researcher will determine the Knowledge and attitude regarding family planning methods among married men who lived in Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Region in Myanmar based on health belief model.

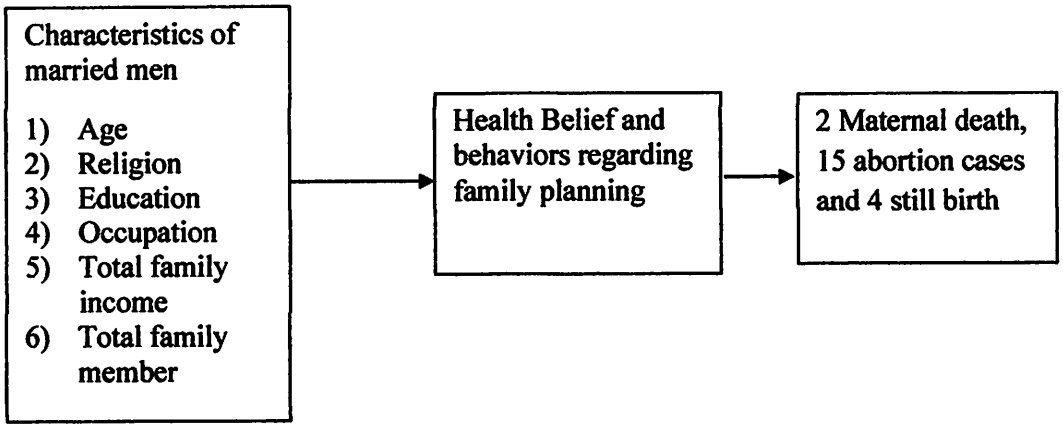

Figure 1.1 Identify the problem of health belief and behaviors regarding family planning methods among married men

Improved health belief and behaviors regarding family planning methods among married men tends to needed to support family planning service for men. Many factors may influence on health belief and behaviors regarding family planning methods among married men such as socio

demographic data: age, religion, education level, occupation, total family income and total family member.

Health Belief Model is an intrapersonal (within the individual, knowledge and beliefs) theory used in health promotion to design intervention and prevention programs (Evan Burke, 2013). Socio demographic data, factors as perceived susceptibility, perceived severity/seriousness, perceived benefits, perceived barriers and self-efficacy may affect the level of knowledge and attitude regarding family planning methods among married men. Therefore, this study will discuss the effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in Myanmar.

1.3 Research Questions

How is the effectiveness of Health Education (HE) Family Planning Guideline on Health Belief and Behaviors regarding family planning methods among married men at Wundwin Township, Mandalay Division in Myanmar?

1.4 Objectives

1.4.1 General Objective

To study the effectiveness of Health Education (HE) Family Planning Guideline on Health Belief and Behaviors regarding family planning methods among married men at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Division in Myanmar

1.4.2 Specific Objectives

1) To determine the effect of health education family planning guideline on health belief regarding family planning methods among married men
2) To determine the effect of health education family planning guideline on behaviors (knowledge and attitude) regarding family planning methods among married men

1.5 Benefits

1.5.1 Benefit for theory

The results of research can provide as a scientific reference regarding the health belief and behaviors regarding family planning methods among married men and displaying the relationships between variables of Health Belief and married men's knowledge and attitude regarding family planning methods.

1.5.2 Benefit for Practice

Health education family planning guideline on health belief and behaviors regarding family planning methods among married men may improve the level of health belief and behaviors of married men regarding family planning.

1.5.3 For Further Research

This study can be used as a preliminary study to identify the effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men.

CHAPTER 2
LITERATURE REVIEW

CHAPTER 2
LITERATURE REVIEW

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. Male involvement in family planning means more than increasing the number of men using condoms and having vasectomies; it also includes the number of men who encourage and support their partners in contraception and encourage 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 (Toure, 1996; Bruce, 2013).

A UNFPA report on male involvement observed that most reproductive health and family planning service delivery systems are almost entirely oriented toward women and provide little or no information about male contraceptive methods (UNFPA, 1997). Health workers are sometimes poorly trained in counseling men about safer sexual practices and male methods and may communicate negative rumours about them (Green et al., 1995) Many family

planning programs have now recognized that involving men and obtaining their support and commitments in family planning programs is of crucial importance because most decisions affecting family and political life are made by men. Men hold positions of leadership and influence from the family unit right through national level. Their involvements in family planning matters would therefore not only ease the responsibility borne by women in terms of decision making but would also accelerate the understanding and practice of family planning in general.

Involving men in family planning could increase contraceptive prevalence in several ways: By providing alternatives to couples dissatisfied with their current method; by increasing male contraceptive use; by promoting greater discussion between sexual partners; and by changing male attitudes regarding contraception.

2.1 Issues affecting Male Involvement in Family Planning

The lack of interest by men in family planning can be attributed to several factors including spousal communication. Men have a major role in the decision to use family planning methods and determining the number of children a couple should have. Spousal disagreement on reproductive matters relates to the ways in which men and women communicate their preferences. Spousal disagreement can be due more to the lack of communication between spouses than to be articulated opposition of one spouse to the other's desires (Omondi-Odhiambo, 1997; Bruce, 2013).

(Town et al., 2015) also conduct on Assessment of the Role of Men in Family Planning Utilization at Edaga-House Town, Tigray, North Ethiopia. In this study, community based analytical cross-sectional study design using pre tested self-administered questionnaires was carried out to collect the relevant information from 290 married men. Finding indicated that More than 99% of the subjects have heard about modern family planning methods/current contraceptive use. The most commonly mentioned 114(38.8%) of modern family planning methods was pills and followed by 91(30.9%) was inject able. The rate of current contraceptive use is significantly higher for those women with between 3-4 births or having between 1-3 live children (34.3%; n=101) and (25.5%; n=75) respectively. Of the participants 78(26.5%) were used Pills by need of 3-4 children ever born. The result shows that the more than half of the subjects (60.7%; n=176) did get married between 21-28 years old. The result shows that the more than half of the subjects (59%; n=170) had experienced in pregnancy terminated with Abortion (By asking Husband's experience of their wife). The majority of the subjects had never been involved themselves in FP with their wife and this may be attributed to negative perceptions recorded among them.

Determining male attitude and behavior on decision making and spousal communication in family planning: a study conducted amongst literate males of punjab, India was conducted by (Sood & Pahwa, 2014). In this study, cross-sectional descriptive study design using semi structured self-administered questionnaires was carried out to collect the relevant information from 225 males both married and unmarried. Finding showed that 95% of respondents were aware about condoms followed by Withdrawal (84%), Emergency contraceptive pills

(81%), and Tubectomy (79%) respectively. Out of all the available modern FP methods; Female and Male Sterilization usage is just around 19% and 1% respectively. In merely 23% cases, wives initiated discussion on Reproductive Health matters and for majority of the couples, FP discussions starts after the birth of 1st child. The major reasons for non-communication between couples on FP were "shyness" and "male perception that this is an unnecessary talk". Further it was found that only 65% men reported being comfortable if the female partner initiates discussion on the total number of children the couple should have.

(Berhane et al., 2011) studied on Men's Knowledge and Spousal Communication about Modern Family Methods in Ethiopia. In this study, cross-sectional study design using structure questionnaires was carried out to collect the relevant information from 738 married men. Finding showed that all 738 (100%) of the respondents had heard of family planning. About 558 (75.6%) mentioned the importance of using contraceptives for birth spacing and 457 (61.9%) to limit birth. Four hundred and forty-five (60.3%) of participants had ever discussed family planning with their wives. Thirty-three (33.0%) of the respondents reported that they were the sole decision makers in their families. About 597 (80.9%) approved the use of contraceptives. However, some participants did not discuss and approve family planning with their partner.

(Khamis, 2007) carried out a cross-sectional study including 400 married men. The finding revealed that More than 90% of husbands knew about pills, intra-uterine devices and condoms. Most of the husbands (89.3%) have positive attitudes towards family planning and agreed that modern methods are more effective than traditional methods. The majority of husbands (51.3%) agree that husbands should

also practice family planning. However, 172 husbands (43.0%) felt that family planning should be practiced only by the wife. About 282 husbands (70.5%) believed that the decision regarding practice of family planning should be decided by husbands and 225 (56.3%) felt the wife only should decide on practicing family planning.

(Dixit AM et al., 2013) studied on Assessment of knowledge regarding family planning methods and intended family size among men on urban slum, India based a cross-sectional study was conducted among 400 married men of age group 18-49 years. They found that Most commonly known methods of family planning were female sterilization (95.2%), condom (94.7%) and male sterilization (93.5%), IUCD (57%) was still not popularly known method of contraception. Emergency contraceptive pills (12.2%) and injectable (25.7%) were least known methods among men. On analysis present family size were 3.125 while desired family size was 2.63, it shown that tow child norm is not ideal to all.

Awareness, Attitude and Participation Rate of Men in Family Planning Programs in Iran was conducted by (Bani et al., 2014). In this study, descriptive study design was using semi structured self-administered questionnaires was carried out to collect the relevant information from 200 men and 200 women. Finding showed that the percentage of awareness, attitude and participation was 52.8%, 84% and 66.6% respectively. A significant relationship was observed between knowledge and participation ($r=0.293$, $p=0.005$) and attitude and participation ($r=0.328$, $p=0.005$). Awareness and participation of men in family planning program was not good, however; their attitude was acceptable.

A study on Knowledge, attitude and practices regarding family planning methods

among married men in urban field practice area of Ramnagar urban health center, Belagavi- A cross sectional study was done by (Chaudhary et al., 2015). It is cross sectional study included 320 married men. This study showed that only (19.1%) of married men had good knowledge about family planning methods while majority of men (58.4%) had average knowledge. Others (22.5%) had poor knowledge about the same. Only (10%) married men had positive attitude towards family planning while majority (64.4%) had average attitude. 25.6% men had negative attitude towards the same. Regarding practice, (33.1%) married men did good practice, (39.1%) men practiced negatively and (27.8%) were on an average. (Tilahun et al., 2015) carried out a quasi-experimental study including 811 married couples. The finding revealed that contraceptive use in both control and intervention households were similar. After the intervention, we observed among men in the intervention arm a significantly higher level of willingness to be actively involved in family planning compared to the men in the control arm ($p < 0.001$). In addition, the difference between spouses that discussed family planning issues was less reported within the control group, both in the case of men and women (($p = 0.031$) and ($p < 0.001$)) respectively.

Family Planning Knowledge, Attitude and Practice among Married Couples in Jimma Zone, Ethiopia was conducted by (Tilahu et al., 2013). In this study, quantitative and qualitative data collection techniques was using semi-structured questionnaires was carried out to collect the relevant information from 854 married couples. Finding showed that the concept of family planning was well known in the studied population. Sex-stratified analysis showed pills and injectable were commonly known by both sexes, while long-term contraceptive methods were

better known by women, and traditional methods as well as emergency contraception by men. Formal education was the most important factor associated with better knowledge about contraceptive methods (aOR = 2.07, p,0.001), in particular among women (aORwomen = 2.77 vs. aORmen = 1.49; p,0.001). In general only 4 out of 811 men ever used contraception, while 64% and 43% females ever used and were currently using contraception respectively.

(Nanji et al., 2015) also conducted on Comparative assessment of family planning knowledge and attitude of men in urban and rural areas of Anambra state, South-East of Nigeria. In this study descriptive, comparative cross-sectional study using a structured questionnaire was carried out to collect the relevant information from 388 males. Finding indicated that a high level of knowledge of the meaning of family planning, 98.5% and 92.8% for urban and rural respondents, respectively. The difference is statistically significant. Similarly, negative response to all artificial family planning cause infertility, 61.9% and 49.5%, for urban and rural population, respectively; family planning is necessary for good health of the family, 91.8% and 81.4% for urban and rural population respectively. Analysis of attitude towards family planning is positive as 96.4% and 76.3% urban and rural respondents, respectively believe that using contraceptive doesn't mean that one is wayward; birth control is not a sin, 75.3% and 59.3% for urban and rural populations, respectively; and family size has effect on well-being of the family, 85.6% and 69.6% for urban and rural populations, respectively.

2.2 Benefits of Family Planning

Family planning allows people to attain their deserved number of children and determine the spacing of pregnancies. It is achieved through contraceptive methods and treatment of fertility. It helps women to achieve life goals and when they decide to become mothers. The World Health Organization (WHO) and the United Nations Population Fund (UNPF) have identified some benefits to family planning and they include preventing pregnancy related health risk in women, reducing infant mortality, helping prevent HIV/AIDS, empowering people and enhancing education, reducing adolescent pregnancies and slowing population growth. Other benefits include reductions in anaemia and dysmenorrhoea, reduced risk of ectopic pregnancy, less demand for abortion, decreased need for surgical sterilization, reduced maternal mortality and fibrocystic breast changes (Burkman et al., 2004; Bruce, 2013).

Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia were conducted by (Tilahun et al., 2015). In this study, quasi-experimental study design was using semi-structured questionnaires was carried out to collect the relevant information from 811 married couples. Finding showed that contraceptive use in both control and intervention households were similar. After the intervention, we observed among men in the intervention arm a significantly higher level of willingness to be actively involved in family planning compared to the men in the control arm ($p < 0.001$). In addition, the difference between spouses that discussed family planning issues was less reported within the control group, both in the case of men and women (($p = 0.031$) and ($p < 0.001$)) respectively.

(Shahamfar et al., 2007) studied on Effect of Educational Intervention on male Participation in Family Planning in Iran. It is quasi-experimental study included 268 married men. This study shown that Most of the males were aware of at least one contraceptive method but awareness of modern methods was poor (20%) which was increased after intervention (47%). Their willingness to allow their wives to use contraceptive also increased but the improvement was not statistically significant (p=0.08). Use of contraceptive remains low in men even after intervention. Family planning education could increase the knowledge of men about modern contraceptives but the use of contraceptives by male may not increase which indicates that behavior change process may take longer time to have effect.

2.3 Getting Men Involved in Family Planning

In the past, family planning programs had focused on women because of the need to free women from excessive child bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family planning services were offered within maternal and child health (MCH) centers. Most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing peripheral role. But in a patriarchal society which still prevails in most countries, husbands make most of the important decisions for their families. It is necessary to have effective communication between husband and wife in order to ensure equal roles in matters of reproductive health. Such communication can also bring many advantages for growth of men's

consideration to participate in family planning (Population Council 1998, pp.27-28).

(Malkawi et al., 2016) studied on Men's perceptions of and participation in family planning in Aqaba and Ma'an governorates, Jordan. This study is based on cross-sectional descriptive design and was conducted among 104 married men. They found that 93.5% of the men had heard about family planning most commonly the intrauterine device (IUD) and oral contraceptives. Only 45.1% reported that they and their wife currently used it. Most men agreed about a minimum 2 years' child spacing (93.3%) and starting contraception after childbirth (71.2%) and that husband and wife should share decisions about family planning (90.2%) and the number of children (89.5%). Level of education significantly affected current use of contraception, while number of children significantly affected previous use of contraception.

(Rekha et al., 2015) conducted cross-sectional study on Married Men's Involvement in Family Planning: A Study from Coastal Southern India. This study was survey 156 married men using pretested semi-structured validated questionnaire. The finding revealed that 75.6% were aged between 26 and 34 years, 41.7% had one child, 92.3% subjects from upper and 86.9% from lower socio-economic status were aware about the male family planning services available in the market. Most husbands preferred that their spouse should be sterilized (53.8%). Family planning methods were actively practiced by 71.2%.

(Bayray et al., 2012) conducted community based descriptive cross-sectional survey in Ethiopia on Assessment of male involvement in family planning use among men in south eastern zone of Tigray, Ethiopia. This study was survey 574 married

men using semi-structured questionnaires. The finding revealed that 75% have reported that they were familiar with the concepts and benefits of family planning. About 62.9 % of the respondents explained that they had heard of at least two contraceptive methods. Thirty six percent of them did not know about male contraceptive methods. Overall, above 90% men have supported, approved using and choosing family planning. Majority, 75% of respondents or their wives used non-terminal contraceptive methods mainly injections 33% and pills 19.5% for child spacing. The study also revealed that none of the study participants used male terminal contraceptive methods.

A study on The Current States of Male Involvement on Family Planning and Factors Correlated with among Male Factory Workers in Bahir Dar City was done by (Walle & Alamrew, 2014). It is cross sectional study included 306 male factory workers. This study showed that 25.5% of male factory workers were involved in family planning practices. The study declared that educational status was a significantly predicts involvement on family planning (AOR=1.53, 95% CI: 1.08-11.14, 1.8= 95% CI: 1.31- 9.220, and 2.01= 95% CI: 1.51-7.76). Besides, respondents who stayed in marriage from 4 to 13 years were about 18 times more likely to be involved on family planning compared to respondents stayed more than 22 years (AOR= 18.06, 95% CI: 1.79-58.68). Moreover, number of living children in a family was associated with an outcome of interest (AOR= 11.01, 95% CI: 1.13- 106.9 and AOR= 7.40, 95% CI: 1.49- 36.64) respectively. Only one out of four respondents was involved in family planning. Besides, educational status, number of years in marriage, number of living children, and joint decision

on the number of children were statistically significant predictors of male involvement on family planning.

2.4 MALE CONTRACEPTION METHODS

2.4.1 Male Condoms

These are sheath or coverings that are placed on erected penis of a man and acts as a barrier to prevent sperm from meeting an egg and it is believed to be 98% effective in preventing pregnancy when used correctly and consistently, and the advantages are that it protects against sexually transmitted infections including HIV (WHO, 2015).

2.4.2 Male Sterilization (Vasectomy)

It is a permanent method of contraception where the vas deferens (tubes that carry sperms from the testicles to the ejaculatory duct) is cut or blocked. It works by keeping sperms out of the ejaculated semen, and is more than 99% effective after three months semen evaluation (WHO, 2015). The advantages of vasectomy are that it does not affect sexual performance (WHO, 2015) no hormones are used, it is permanent, the procedure is quick with few risks, and can be performed as an outpatient procedure in a clinic or doctor's office (Samra, 2014). However, the disadvantages are that, it may take three months to be effective as stored sperms may still be present (WHO, 2015), men may regret the decision later in life, and it does not prevent a man from getting sexually transmitted infections (Samra, 2014).

2.4.3 Withdrawal method

This is the method in which a man withdraws his penis from the partners' vagina and ejaculates outside to keep semen away from external genitalia. It is said to be 96% effective when used consistently and correctly, although it may require discipline and proper timing of withdrawal which may often be difficult to determine (WHO, 2015).

2.5 GENDER

Gender concerns the psychological, social and cultural differences between males and females. It is linked to "socially constructed notions of masculinity and femininity, and it are not necessarily a direct product of an individual's biological sex" (Giddens, 2001, p.107). The distinction between sex and gender is an important one, since many differences between males and female are not biological in origin. Sometimes people may find it difficult to distinguish gender from sex. Sex refers to the biological and physiological characteristics that define men and women (WHO, 2015). "Sociologists use the term sex to refer to the anatomical and physiological differences that define male and female bodies" (Giddens, 2001, p.107).

According to (Giddens, 2001), we all do gender ourselves in our daily social interactions and all aspects of our existence are gendered. Gender is a pattern in our social arrangement and in everyday activities or practices which those arrangement govern (Belmonte, 2012). Gender differences are culturally produced and not biologically determined, hence, gender inequalities are reviewed because men and women are socialised into different roles (Giddens, 2001).

2.6 Gender equality

Gender is said to interact with social factors and biological differences. The roles that women and men play are different and valued differently in different social contexts, and usually those associated with men are valued more highly. This therefore, is believed to affect the degree to which women and men have access to and control over, the resources and decision making needed to protect their health. "This results in inequitable patterns of health risks, use of health services and health outcomes. There are different factors that determine health and ill health for men and women. Mainstreaming gender in health is recognized as the most effective strategy to achieve gender equity. It is the strategy that promotes the integration of gender concerns in the formulation, monitoring and analysis of policies, programmes and projects, with the objective of ensuring that women and men achieve the highest health status" (WHO, 2001, online).

According to the mission statement of the 1995 Beijing conference for women, "the platform for action emphasizes that women share common concerns that can be addressed only by working together and in partnership with men towards the common goal of gender equality around the world. It respects and values the full diversity of women's situations and conditions and recognizes that some women face particular barriers to their empowerment" (UN, 1996, P.7).

2.7 Health Belief Model Theory

The Health Belief Model (HBM) is one of the first theories with a foundation in behavioral social sciences and the theory is widely used in nursing

practice today to promote healthy behaviors (Jones & Bartlett, 2013). In this study, I'm a Nurse, hence decided to use the Health Belief Model, because it is a Nursing Model that deals with issues of behavior. Behavioral change is expected to take place when someone has perceived some benefits from the actions one takes. Therefore, knowledge, attitude and practice regarding family planning methods is very important because it may need change of behavior for men to be wholly involved in family planning. The main strength of the HBM is its use of simplified health-related constructs that make it easy to implement, apply, and test (Conner, 2010) It offers the ability to understand the different behaviours or attitudes people may develop under the same condition by following or not following certain guidelines or requirements (Kartal & Ozsoy, 2007).

The model was originally developed by four psychologists, Hochbaum, Kegels, Rosenstock and Leventhal in the 1950s as a way to examine the reasons that prevented people from using free programs, which would detect or prevent diseases. The original model had four constructs; personal perception on the risk of acquiring a certain disease or condition (Susceptibility), personal perception of the seriousness of a certain disease, behaviour or condition (Severity), personal perceptions on the effectiveness and positive consequences when adopting a new behaviour (Benefits), personal perception of the obstacles that may prevent him/her to adopt a new behavior (Barriers) and supplemented later by more as follows; factors that trigger behaviour (Cues to actions) and personal perception on his/her ability to adopt a behaviour (Self-efficacy) (Rosenstock, 1966; Becker, Maiman, Kirscht & Haefner, 1977; Becker, 1990).

The model is an expectancy-value approach of decisions that are specifically related to an individual's health, and assumes that one's willingness to engage in preventive health behaviour depends on a two-step appraisal process which is the perceived threat of the situation under consideration, and the result of the cost-benefit analysis of the preventive behaviour. The model in this study was also used to see how men can have a healthier behaviour by seeing the importance of contraceptive use to prevent unplanned pregnancies (Bakkar, A.B et al., 1997).

2.7.1 Perceived Susceptibility

In order for people to adopt healthier behaviour, the most powerful perception is susceptibility or personal risks. The greater the risks, the greater the likelihood of engaging in behaviours to reduce the risks. For example, men who have a sexual partner with unknown HIV status, are most likely to use condoms in order to reduce susceptibility to HIV infection. Furthermore, it is logical that when people believe they are at risk of disease they will prevent themselves from getting infected. Although at times the opposite may happen, where unhealthy behaviours occur because people believe they have a low risk of susceptibility to infection. At times even when the perception of risk is high people usually don't adopt healthier behaviours. It is believed that when perception of susceptibility is combined with seriousness, the perceived threat is the result. Therefore, if the perception of the risk is to a serious disease for which there is real risk, there is often change of behaviour (Hayden, 2009).

2.7.2 Perceived Severity

The concept of perceived severity points to an individual's beliefs about seriousness or severity of the disease. On the other hand, perception of severity

may be based on medical information and knowledge, and it may also come from beliefs a person has about the difficulties the disease may create on them or the complications. For instance, flu is viewed as a relatively minor ailment, where if one gets it would stay home for a few days but this might not be so for someone who has asthma, because it could land the asthmatic person in hospital (Hayden, 2009).

2.7.3 Perceived Benefits

The construct of perceived benefits is a person's opinion of value or usefulness of a new behaviour in reducing the risk of disease development. Therefore, people might adopt healthier behaviours when they think the new behaviour will reduce their chances of disease development. Perceived benefits play a critical role in adoption of secondary preventive behaviours such as condom use in the prevention of sexually transmitted infections and pregnancy (Hayden, 2009).

2.7.4 Perceived Barriers

Since behavioural change is difficulty to attain to most people, the last construct of Health belief Model addresses the issue of perceived barriers to change. "This is the individual's own evaluation of obstacles in the way of him or her adopting a new behaviour. Of all constructs, perceived barriers are the most significant in determining behaviour change" (Hayden, 2009, p.33). For a new behaviour to be adopted, a person needs to believe the benefits of new behaviour, which must outweigh the consequences of continuing the old behaviour. This eventually enable adoption of new behaviour after overcoming the barriers (Hayden, 2009).

2.7.5 Cues to Actions

In addition to the four beliefs and modifying valuables, the health belief model suggest that behaviour is also influences by cues to action. The cues to action are events, people, or things that move people to change their behaviour (Hayden, 2009).

2.7.6 Self- Efficacy

Self- efficacy was added to the model in 1988 and it focuses on one's own ability to do something. It emphasises that people generally can only do something new when they believe they can do it. It further says that in situations where someone believes a new behaviour is useful (perceived benefit) but doubts his or her capability of doing it (perceived barrier), chances are that it will not be tried (Hayden, 2009). In summary, according to the Health Belief Model, modifying variables, cues to action, and self-efficacy affect our perceptions of susceptibility, seriousness, benefits, and barriers and, therefore, our behavior (Health Belief Model 2013 (ch 4) pp 32-34).

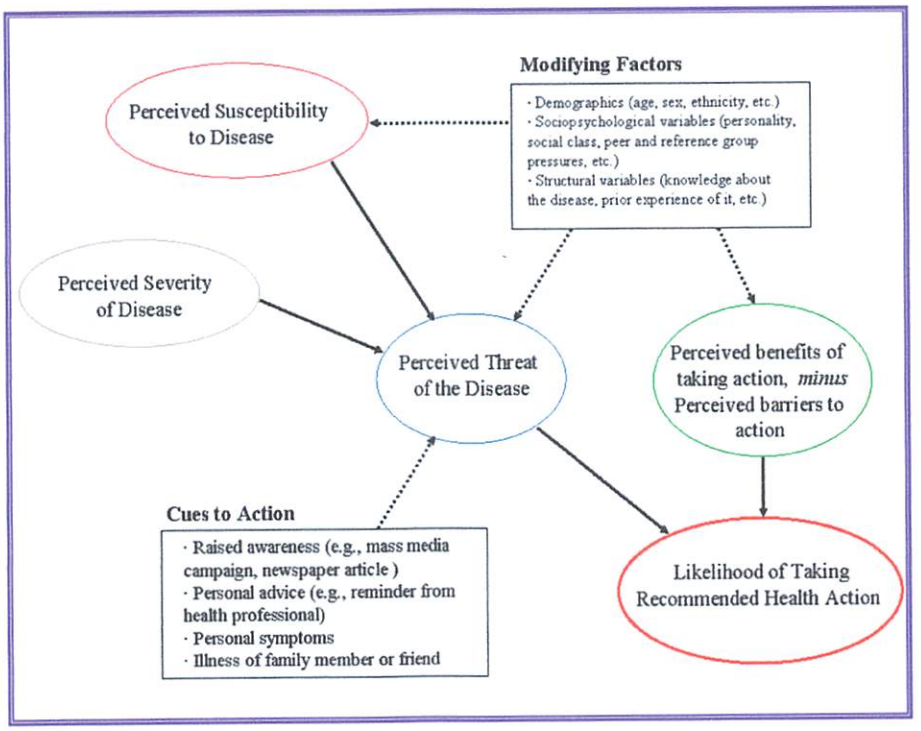

Figure 2.1 Construction of Health Belief Model (Jones & Bartlett 2013)

2.8 Theoretical Mapping

Review of original research regarding Awareness of male involvement in family planning and their influencing factors in the following table:

No	Title and Author	Variables	Types of Research	Results
1	Men's Knowledge and Spousal Communication about Modern Family Planning Methods in Ethiopia (Berhane, A., Biadgilign, S., Amberbir, A., Morankar, S., & Deribe, K., 2011) (Ethiopia)	- Socio-economic and socio-demographic characteristics of men - Married men's knowledge, approval and communication about family planning methods	Cross sectional study (738 married men)	All 738 (100%) of the respondents had heard of family planning. About 558 (75.6%) mentioned the importance of using contraceptives for birth spacing and 457 (61.9%) to limit birth. Four hundred and forty-five (60.3%) of participants had ever discussed family planning with their wives. Thirty-three (33.0%) of the respondents reported that they were the sole decision makers in their families. About 597 (80.9%) approved the use of contraceptives. However, some participants did not discuss and approve family planning with their partner.
2	Assessment of the Role of Men in Family Planning Utilization at	- Men's Socio-economic and socio-demographic	Community based analytical cross-sectional study design (290	More than 99% of the subjects have heard about modern family planning

	Edaga-Hamuse Town, Tigray, North Ethiopia (Town, U.E., & Ugwoke, U,M., 2015) (Ethiopia)	characteristics - Male involvement in family planning	married men)	methods/current contraceptive use. The most commonly mentioned 114(38.8%) of modern family planning methods was pills and followed by 91(30.9%) was inject able. The rate of current contraceptive use is significantly higher for those women with between 3-4 births or having between 1-3 live children (34.3%; n=101) and (25.5%; n=75) respectively. The majority of the subjects had never been involved themselves in FP with their wife and this may be attributed to negative perceptions recorded among them.
3	Knowledge, attitude and practice of husbands towards Modern family planning in Mukalla, Yemen Khamis, Y., & Almualm, A., 2007) (Yemen)	- Socio-demographic characteristics of men - Knowledge, attitude and practice of married men towards Modern family planning	A cross-sectional study (400 married men)	More than 90% of husbands knew about pills, intra-uterine devices and condoms. Most of the husbands (89.3%) have positive attitudes towards family planning and agreed that modern methods are more effective than traditional

				methods. The majority of husbands (51.3%) agree that husbands should also practice family planning. However, 172 husbands (43.0%) felt that family planning should be practiced only by the wife. About 282 husbands (70.5%) believed that the decision regarding practice of family planning should be decided by husbands and 225 (56.3%) felt the wife only should decide on practicing family planning.
4	Assessment of knowledge regarding family planning methods and intended family size among men on urban slum (Dixit, A.M., 2013) (India)	- Men's knowledge regarding family planning methods and family size - Men's socio-demographic characteristics	Cross-sectional study (400 married men of age group 18-49 years)	Most commonly known methods of family planning were female sterilization (95.2%), condom (94.7%) and male sterilization (93.5%), IUCD (57%) was still not popularly known method of contraception. Emergency contraceptive pills (12.2%) and injectable (25.7%) were least known methods among

					men.On analysis present family size was 3.125 while desired family size was 2.63, it shown that tow child norm is not ideal to all.
5	Comparative assessment of family planning knowledge and attitude of men in urban and rural areas of Anambra state, South-East of Nigeria (Nanji, G. A., Eze, P. N., Ugwoke, U. M., & Ifeadike, C. O., 2015) (Nigeria)	-	Men's socio-demographic characteristics - Family planning knowledge and attitude of men	Descriptive, comparative cross-sectional study (388 males)	Findings show a high level of knowledge of the meaning of family planning, 98.5% and 92.8% for urban and rural respondents, respectively. The difference is statistically significant. Similarly, negative response to all artificial family planning cause infertility, 61.9% and 49.5%, for urban and rural population, respectively; family planning is necessary for good health of the family, 91.8% and 81.4% for urban and rural population respectively. Analysis of attitude towards family planning is positive as 96.4% and 76.3% urban and rural respondents, respectively believe that using contraceptive doesn't mean that one is

					wayward ; birth control is not a sin, 75.3% and 59.3% for urban and rural populations, respectively; and family size has effect on well-being of the family, 85.6% and 69.6% for urban and rural populations, respectively
6	Knowledge, attitude and practices regarding family planning methods among married men in urban field practice area of Ramnagar urban health center, Belagavi- A cross sectional study (Chaudhary, B. K., Wantamutte, A. S., & Sah, J. K., 2015) (India)	-	Men's socio-demographic characteristics - Awareness of male involvement in Family Planning	Cross-sectional study (320 married men)	Only (19.1%) of married men had good knowledge about family planning methods while majority of men (58.4%) had average knowledge. Others (22.5%) had poor knowledge about the same. Only (10%) married men had positive attitude towards family planning while majority (64.4%) had average attitude. 25.6% men had negative attitude towards the same. Regarding practice, (33.1%) married men did good practice, (39.1%) men practiced negatively and (27.8%) were on an average.

7	Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia (Tilahun, T., Coene, G., Temmerman, M., & Degomme, O., 2015) (Ethiopia)	- Male involvement in family planning - Men's socio-demographic characteristics	Quasi-experimental study (811 married couples)	Findings were compared within and between groups before and after intervention surveys. At the baseline, contraceptive use in both control and intervention households were similar. After the intervention, we observed among men in the intervention arm a significantly higher level of willingness to be actively involved in family planning compared to the men in the control arm ($p < 0.001$). In addition, the difference between spouses that discussed family planning issues was less reported within the control group, both in the case of men and women (($p = 0.031$) and ($p < 0.001$))
8	Married Men's Involvement in Family Planning – A Study from Coastal Southern India (Rekha, T., Unnikrishnan, B.,	- Socio-demographic characteristic of married men - Men's well aware about various family planning services	Cross-sectional study (156 married men)	75.6% were aged between 26 and 34 years, 41.7% had one child, 92.3% subjects from upper and 86.9% from lower socio-economic status were aware about the male

	Mithra, P. P., & Kumar, N., 2015) (India)			family planning services available in the market. Most husbands preferred that their spouse should be sterilized (53.8%). Family planning methods were actively practiced by 71.2%.
9	Men's perceptions of and participation in family planning in Aqaba and Ma'an governorates, Jordan (Malkawi, A. O., Sato, T., Hamaideh, S. H., & Hanouneh, S. I., 2016) (Jordan)	- Socio-demographic characteristic of married men - Knowledge, attitude and practices of male involvement in family planning	Cross-sectional, descriptive design (104 married men)	93.5% of the men had heard about family planning most commonly the intrauterine device (IUD) and oral contraceptives. Only 45.1% reported that they and their wife currently used it. Most men agreed about a minimum 2 years' child spacing (93.3%) and starting contraception after childbirth (71.2%) and that husband and wife should share decisions about family planning (90.2%) and the number of children (89.5%). Level of education significantly affected current use of contraception, while number of children significantly affected previous use of contraception.

10	Awareness, Attitude and Participation Rate of Men in Family Planning Programs in Iran (Bani, S., Hosseini, K., Hasanpour, S., & Valizadeh, S., 2014) (Iran)	- Awareness and participation of men in family planning - Socio-demographic characteristics of men and women	Descriptive study design (200 men and 200 women)	The percentage of awareness, attitude and participation was 52.8%, 84% and 66.6% respectively. A significant relationship was observed between knowledge and participation (r=0.293, p=0.005) and attitude and participation (r=0.328, p=0.005). Awareness and participation of men in family planning program was not good, however; their attitude was acceptable.
11	Assessment of male involvement in family planning use among men in south eastern zone of Tigray, Ethiopia (Bayray, A., 2012) (Ethiopia)	- Male involvement in family planning - Men's socio-demographic characteristics	Community based descriptive cross-sectional survey (574 married men)	75% have reported that they were familiar with the concepts and benefits of family planning. About 62.9 % of the respondents explained that they had heard of at least two contraceptive methods. Thirty six percent of them did not know about male contraceptive methods. Overall, above 90% men have supported, approved using and choosing family planning. Majority, 75% of respondents or their

				wives used non-terminal contraceptive methods mainly injections 33% and pills 19.5% for child spacing. The study also revealed that none of the study participants used male terminal contraceptive methods.
12	Determining male attitude and behavior on decision making and spousal communication in family planning: a study conducted amongst literate *males of punjab*, India (Sood, A., & Pahwa, P., 2014) (India)	- Male's Attitude about reproductive decisions making processes and family planning - Socio-demographic characteristics	Cross- sectional descriptive study (225 males; both married and unmarried)	95% of our respondents were aware about condoms followed by Withdrawal (84%), Emergency contraceptive pills (81%), and Tubectomy (79%) respectively. Out of all the available modern FP methods; Female and Male Sterilization usage is just around 19% and 1% respectively. In merely 23% cases, wives initiated discussion on Reproductive Health matters and for majority of the couples, FP discussions starts after the birth of 1st child. The major reasons for non-communication between couples on FP were "shyness" and

				"male perception that this is an unnecessary talk". Further it was found that only 65% men reported being comfortable if the female partner initiates discussion on the total number of children the couple should have
13	The Current States of Male Involvement on Family Planning and Factors Correlated with among Male Factory Workers in Bahir Dar City (Walle, Y., & Alamrew, Z., 2014) (Ethiopia)	- Men's socio-demographic characteristics - Male involvement in family planning	Cross sectional study (306 male factory workers)	The study revealed that 25.5% of male factory workers were involved in family planning practices. The study declared that educational status was a significantly predicts involvement on family planning (AOR=1.53, 95% CI: 1.08-11.14, 1.8= 95% CI: 1.31-9.220, and 2.01= 95% CI: 1.51-7.76). Besides, respondents who stayed in marriage from 4 to 13 years were about 18 times more likely to be involved on family planning compared to respondents stayed more than 22 years (AOR= 18.06, 95% CI: 1.79-58.68). Moreover, number of living children in a family

				was associated with an outcome of interest (AOR= 11.01, 95% CI: 1.13- 106.9 and AOR= 7.40, 95% CI: 1.49-36.64) respectively.
14	Effect of Educational Intervention on male Participation in Family Planning in Iran (Shahamfar, J., Kishore, J., & Shokhvash, B., 2007) (Iran)	- Male participation in Family planning - Men's socio-demographic characteristics	Quasi-experimental study design (268 married men)	Most of the males were aware of at least one contraceptive method but awareness of modern methods was poor (20%) which was increased after intervention (47%). Their willingness to allow their wives to use contraceptive also increased but the improvement was not statistically significant (p=0.08). Use of contraceptive remains low in men even after intervention. Family planning education could increase the knowledge of men about modern contraceptives but the use of contraceptives by male may not increase which indicates that behavior change process may take longer time to have effect.
15	Family Planning	- Socio-	Quantitative and	The concept of family

	Knowledge, Attitude and Practice among Married Couples in Jimma Zone, Ethiopia (Tilahu, T., Coene, G., Luchters, S., Kassahun, W., & Leye, E., 2013) (Ethiopia)	- demographic and reproductive characteristics of married couples - Knowledge, attitude and practice of family plannign	Qualitative data collection techniques (854 married couples)	planning was well known in the studied population. Sex-stratified analysis showed pills and injectable were commonly known by both sexes, while long-term contraceptive methods were better known by women, and traditional methods as well as emergency contraception by men. Formal education was the most important factor associated with better knowledge about contraceptive methods (aOR = 2.07, p,0.001), in particular among women (aORwomen = 2.77 vs. aORmen = 1.49; p,0.001). In general only 4 out of 811 men ever used contraception, while 64% and 43% females ever used and were currently using contraception respectively.

CHAPTER 3
CONCEPTUAL FRAMEWORK AND HYPOTHESIS

CHAPTER 3
CONCEPTUAL FRAMEWORK AND HYPOTHESIS

3.1 Conceptual Framework by Using Health Belief Model

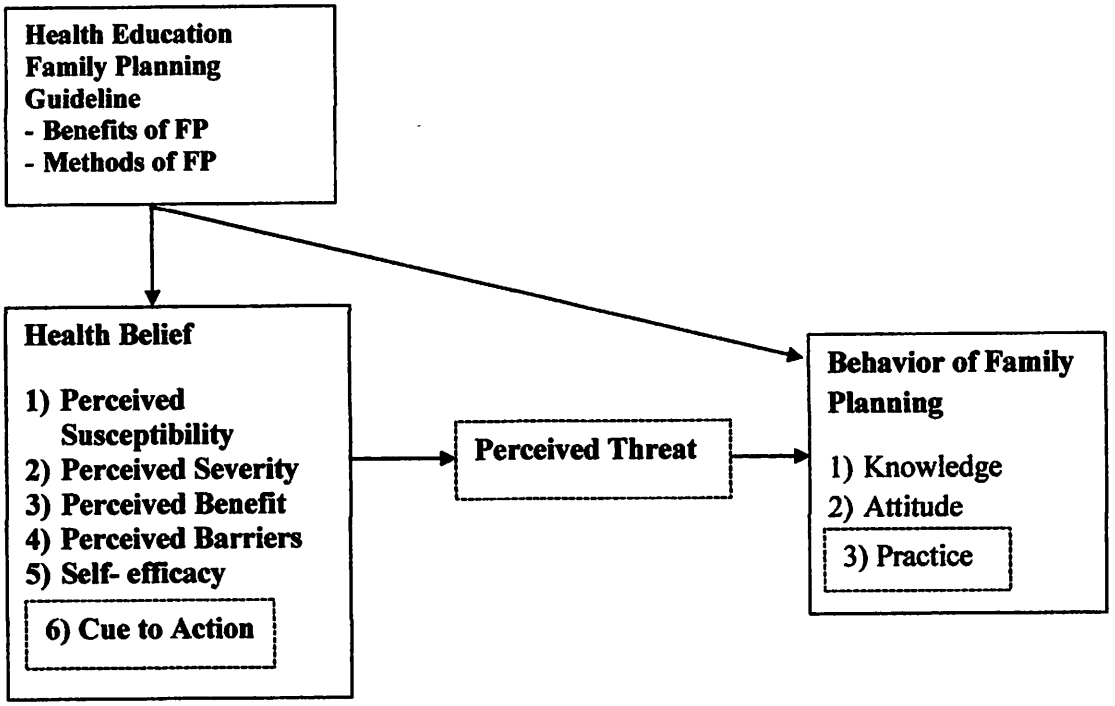

Figure 3.1 Model of the effecting factors on health belief and behaviors of Married Men's regarding in family planning on Health Belief Model

Health Belief Model (HBM) was originally developed by four psychologists, Hochbaum, Kegels, Rosenstock and Leventhal in the 1950s as a way to examine the reasons that prevented people from using free programs, which would detect or prevent diseases (Rosenstock et al., 1966). It is originally composed of the critical elements as perceived susceptibility, perceived

severity/seriousness, perceived benefits, perceived barriers and supplemented later by more as follows; factors that trigger behaviour (Cues to actions) and personal perception on his/her ability to adopt a behaviour (Self-efficacy) (as cited McEwen & Wills 2011, p.291). HBM is a conceptual famework used to understand health behavior and possible reasons for non-compliance with recommended health action (Becker & Rosenstick, 1984). HBM has been widely used and is considered as one of the most useful models in health care prevention and promotion (Roden, 2004). It offers the ability to understand the different behaviours or attitudes people may develop under the same condition by following or not following certain guidelines or requirements (Kartal, 2007).

In this study, Health Belief Model will be used to provide theoretical framework as Health Belief: 1) perception of susceptibility, 2) perception of severity, 3) perception of benefits, 4) perception of barriers 5) Cues to actions and 6) Self-efficacy and Behavior; knowledge, attitude and practice regarding family planning methods among married men. In the Health Belief Model, Perceived susceptibility is an individual's assessment of getting the disease and in my study, it is the individual's assessment of his chances of impregnating the partner by not getting involved in contraceptive use, while his perceived benefits could be his conclusion as to whether getting involved in contraceptive use is better or not. Then, perceived barriers would be his opinion on what would stop him from adopting the new behavior. The perceived seriousness or severity could be his judgment of the seriousness of not getting involved while his modifying variables are his personal factors that affect him whether he gets involved or not. His cues to action are those factors that will cause him to start to be involved in

contraceptive use as a way to support his partner. In addition, the self-efficacy would be his personal belief in himself to do something new, for instance, by supporting his partner in contraceptive use like reminding her to take the pill or himself getting involved directly by using condoms to prevent pregnancy or doing sterilization when he feels his family size has been attained.

When individuals think that they are old enough or they are sexually active, and they have the knowledge that getting involved in contraceptive use is an important thing, not only to prevent pregnancy but also to have a health family, they are likely to develop behavior that will be helpful to them. This will result into taking an action, when they know there are more benefits of those actions without looking at the barriers, which is then likely to bring about change of behavior. On the other hand, an individual's knowledge of being susceptible to sexually transmitted infections will make them use a condom every time they have sex, because getting an infection is their perceived threat and this brings about behavioral change. Furthermore, when a man believes that they can impregnate their partners, they may opt to use condoms or tell their partners to be on contraceptives, in order to prevent pregnancy. So, in this case, impregnating a partner is the perceived threat and the cue of action is the move one takes to use a condom or reminding a partner to take for instance, a pill and this eventually brings change of behavior.

Moreover, partners' social economic status can influence them to make a plan on number of children they want to have, which can be achieved by using contraceptives like condoms and sterilization for men. Pills, injections, as well as intrauterine devices for women can also be used in order to prevent pregnancy.

Health Belief Model is a model based on the interaction of the individual's readiness to comply with the behavior and the motivating and enabling factors that determine what the individual will do (Ross & Mico, 1980). Therefore, this study will analyze the effect of health education family planning guidelines on health belief and behavior regarding family planning methods among married men in Myanmar based on health belief model. It may be supported to develop and improve knowledge and attitude levels of family planning methods among married men.

3.2 Research Hypothesis

1. There is an effect of health education family planning guideline on health belief regarding family planning methods.
2. There is an effect of health education family planning guideline on behaviors (knowledge and attitude) regarding family planning methods.

CHAPTER 4
RESEARCH METHOD

CHAPTER 4
RESEARCH METHOD

In this chapter was conduct research design, study setting, target/study population, sample size, sampling method, research instruments, data collection method, data analysis, operational framework, pilot study and ethical consideration.

4.1 Research Design

The study design was a forum to answer research questions or test hypotheses expertise (Nursalam, 2008). This research was a quantitative study using quasi-experimental designs that provide treatment or intervention on the subject of the study and then the effect of the intervention was measured and analyzed. The design of the study is to approach pre-post test *group design* with a control group. This design was used to compare the results of effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in the group were measured before and after intervention. The study design can be diagrammed as follows:

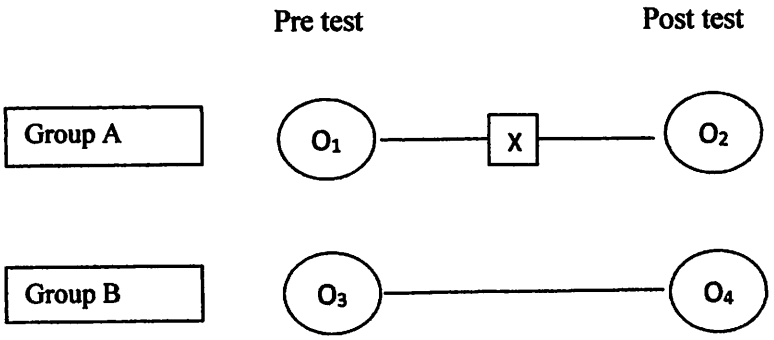

Figure 4.1 Study design of effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in Myanmar

Information:

O_1 = intervention group before education

O_2 = intervention group after education

O_3 = control group before education

O_4 = control group after education

X = education on knowledge, attitude and practice was given to the intervention group

4.2 Population, Sample and Sampling

4.2.1 Study population

(Polit and Beck, 2004) stated that "population refers to the aggregate or totality of those conforming to a set of specifications" (p.50). Therefore, married men whose wives were still within the age of 15-49 years (female reproductive age) from Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Division

in Myanmar was defined as study interest point because married men are representative for this study.

4.2.2 Sample size

(Polit, Beck & Hungler, 2001) stated that sample size refers to the number of studied participants in a sample. The optimum number in the sample depends on the characteristics of the study (Polgar & Thomas, 1995). The sample must meet the inclusion and exclusion criteria consisting of:

Inclusion Criteria

1. All married men who were living at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township.
2. All married men who were undergraduate level at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township.
3. All married men whose wives were still within the age of 15-49 years (female reproductive age) during the period of study.
4. All married men who were willing to participate in the study.

Exclusion Criteria

1. Married men who were medical personnel or working in the medical field.
2. Married men who have language barrier or poor communication.

Dropout Criteria

1. The respondent who were transferring to another place.
2. The respondent who do not want to participate in the study.

Large samples *(sample size)* using the formula estimated average (mean) in previous research is as follows:

$N = (1.96 / f)^2 (\sigma_1^2 + \sigma_2^2)$ (Smith & Morrow, 1991).

N = sample size

f = error factor = +/- 2.4

σ = standard deviation of the total knowledge scores in two groups = 5.5

$N = (1.96 / 2.4)^2 [(5.5)^2 + (5.5)^2]$

$= (0.8167)^2 (30.25 + 30.25)$

$= 0.6669 \times 60.5$

$= 40.35$(at least)

$= 40$

Therefore, sample size was 40 for each study and control group. However, each of 45 respondents were selected for the study and control group to cover the dropout rate.

4.2.3 Sampling Method

Sampling is the selection process for a portion of the population may represent the population (Nursalam, 2014). The samples in this study was conducted using systematic sampling technique, which is a technique determination of sample by choosing among a population sample in accordance with the desired researchers, so that the sample can represent the characteristics of the population that has been known previously. In this study, the lists of all married men whose wives were still within the age of 15-49 years (female reproductive age) was obtained firstly. According to the sample size calculation, 45 married men were selected by using systematic sampling method in considering the inclusion and exclusion criteria.

4.3 Research Variables

4.3.1 Independent Variables

Independent variables are variables that determine the value of other variables (Nursalam, 2014). Independent variables in this study are socio demographic data of married men in Lay Myat Nar village and Pin Ta Lae village such as age, education level, occupation, total family income and total family member, perceived susceptibility, perceived seriousness/severity, perceived benefits and perceived barriers.

4.3.2 Dependent Variables

The dependent variable is the outcome the research wants to predict or explain (Grove, Burns & Gray, 2013). Dependent variable in this study is knowledge and attitude regarding family planning methods among married men in Myanmar.

Table 4.1 Dependent and Independent variables of health belief and behavior regarding family planning methods among married men

Variables	Factors	Sub-Variables
(X_1) Independent variables	Health Education about Family planning guideline	X.1.1 Benefit of family planning X.1.2 Family planning Methods
(Y_1) Dependent variables	Factors from Health Belief	X.3.1 Perceived susceptibility X.3.2 Perceived seriousness/severity X.3.3 Perceived benefits X.3.4 Perceived barriers X.3.5 Self-efficacy
(Y_2) Dependent variables	Behavior regarding family planning methods among married men	Y.1.1 Knowledge Y.1.2 Attitude

4.4 Operational Definition

Table 4.2 Operational definitions of health belief and behaviors regarding family planning methods among married men in Myanmar

Variable Sub-variable	Definition	Parameter	Measurement of tools	Scale of data	Score
Independent Health Education Family Planning	Health education is the part of health care that is concerned with promoting healthy behaviors. It encourages behaviors that promotes health, prevents illness, cures diseases and facilitates rehabilitation	Consists of Education about 1. Benefit of family planning 2. Family planing methods	Health Education Family Planning Guideline (WHO, 2011)	-	-
Dependent					
Health Belief	Personal convictions that influence health behaviors	Consists of 1. Perceived Susceptibility 2. Perceived severity 3. Perceived benefits 4. Perceived barrier 5. Self-efficacy	Questionnaires	interval	a) 0-25 = Poor b) 26-50 = Enough c) 51-75 = Good d) 76-100 = Very good
Perceived susceptibility	Men's subjective perception of chance of being pregnant	Degree of personal perception to risk of pregnancy	(4) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-5 = Poor b) 6-10 = Enough c) 11-15 = Good d) 16-20 = Very good
Perceived severity	Men's perception of seriousness of contracting a pregnancy.	Degree of personal perception to severity of contracting a pregnancy	(4) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-5 = Poor b) 6-10 = Enough c) 11-15 = Good

Variable Sub-variable	Definition	Parameter	Measurement of tools	Scale of data	Score
					d) 16-20= Very Good
Perceived benefits	Men's perception of advantage of contraception to prevent pregnancy	Degree of personal perception to capability of family planning	(4) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-5 = Poor b) 6-10 = Enough c) 11-15 = Good d) 16-20 = Very good
Perceived barriers	Men's perception of obatacles on availability and accessibility of contraceptive method and contraceptive practices	Degree of personal evaluation of the obstracles	(4) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-5 = Poor b) 6-10 = Enough c) 11-15 = Good d) 16-20 = Very good
Self-efficacy for using family planning	Men's self-confidence on achievement of family planning use	Degree of personal perception on self-confidence of family planning use	(4) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-5 = Poor b) 6-10 = Enough c) 11-15 = Good d) 16-20 = Very good
Knowledge of family planning	Men's knowledge score on prescription of family planning	Personal knowledge of family planning - Benefit of family planning - Family planning methods	Questionnaires	interval	a) 0-5= Poor b) 6-10= Enough c) 11-16= Good
Attitude toward family planning	Men's attitude score towards family planning	Personal attitude toward family planning	(10) items of questionnaires will be measured by using Likert-scale;	interval	a) 0-27 = Positive Attitude b) 26-45 = Negative Attitude

4.5 Research Instruments

4.5.1 Development of Questionnaire

The questionnaire used in this study was constructed based from descriptive research studies conducted by (Tizta Tihahun, 2014) and (Myo Myo Mon, 2009). Then, questionnaire was developed in English and all questions were translated into the common local language of Myanmar and was checked by expert persons from each department. The questions was structured to be clear and simple. These questions was content validated by consulting with an expert researcher, a statistician and a health educator. Pretest was conducted with men who have same characteristics that living in different setting. Finally, the questionnaire was revised and modified based on the pretested results.

(1) Self-administered structured questionnaires, was used to assess health belief, knowledge and attitude regarding family planning methods among married men. It was consist with socio-demographic characteristics and (38) questions and divide into: Knowledge of family planning (9) items, Attitude towards family planning (9) items, Perceived susceptibility of pregnancy (4) items, Perceived seriousness/severity of pregnancy (4) items, Perceived benefits of contraceptive (4) items, Perceived barriers for using contraception (4) items, self-efficacy for (4) items.

(2) Structure of socio-demographic characteristics

The socio-demographic characteristics include age, religion, education, occupation, family income and number of children.

(3) Knowledge of family planning

A question as an instrument of knowledge of family planning was devised and modified from (Tizta Tihahun, 2014)developed an instrument to measure knowledge of family planning. It is composed of (9 items with 14 responses).

(4) Attitude towards family planning

A question as an instrument of knowledge of attitude towards contraceptive was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure knowledge of attitude towards contraceptive. It was composed of (9) items by using five-points Likert-type response.

(5) Perceived susceptibility of pregnancy

A question as an instrument of perceived susceptibility of pregnancy was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure the constructs of Health Belief. It is composed of (4) items by using five-points Likert-type response.

(6) Perceived severity of pregnancy

A question as an instrument of perceived susceptibility of pregnancy was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure the constructs of Health Belief. It was composed of (4) items by using five-point Likert-type response.

(7) Perceived benefits of contraceptive

A question as an instrument of perceived benefits of contraceptive was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure the constructs of Health Belief. It is composed of (4) items by using five-point Likert-type response.

(8) Perceived barriers for using contraception

A question as an instrument of perceived barriers for using contraception was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure the constructs of Health Belief. It was composed of (4) items by using five-point Likert-type response.

(9) Self -efficacy

A question as an instrument of self-efficacy for using contraception was devised and modified from (Myo Myo Mon, 2009).developed an instrument to measure the constructs of Health Belief. It was composed of (4) items by using five-point Likert-type response.

4.5.2 Instruments for Intervention

Full information regarding HE was prepared based on comprehensive guidelines from literature and expert persons before intervention. Health education regarding family planning and required information was provided to the respondents at the hall of rural health center of the village after four weeks of pre-intervention data collection. The village which had lesser obtained scores was chosen as study group and was decided to do intervention. The intervention was developed based on WHO's family planning guideline (2011). The family

planning education addressed the benefits of family planning, advantage and side effects of modern family planning methods (male condom, vasectomy and withdrawal). Health education program was held for one week and it was divided into two sections. Section (1) Benefits of family planning and male condom methods, Section (2) Advantage and side effect of vasectomy and withdrawal methods. Each meeting was last about 45 minutes. The responsible persons of the villages, midwife and other health care providers were invited to attend the session for sustainability of the information. After health education session, some present was given to all participants.

4.5.3 Instrument Testing (Validity and Reliability Tests)

Before conducting research, measurement tools was tested first. Test measuring instruments carried by spreading questionnaires to a number of participants were not the subject of this research and have almost the same characteristics with the study subjects. The trial results measuring devices was analyzed for validity and reliability. The results for validity are >0.514, it means all questions are validity. Reliability for knowledge instrument has cronbach's alpha 0.946, attitude instrument has cronbach alpha 0.911 and health belief instrument has cronbach's alpha 0.966. The results for reliability are >0.725 and all questions are reliability. In statistical analysis, all instruments is reliability. In this study, 20 married men from different sectors were requested to judge the degree of validity and reliability of the contents of the research instruments.

4.6 Location and Time Frame

4.6.1 Location/ Study area

This study was conducted at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Region in Myanmar. At that village, adequate numbers of sample population was available to study the effectiveness of educational intervention on health belief and behaviors regarding family methods. Moreover, the distance and transportation to this quarter was convenient for research work and also appropriate for the field management.

4.6.2 Time frame of the study (Gantt Chart)

The data collection and data analysis was done from February to April, 2017 in Lay Myat Nar village and Pin Ta Lae village, Wundwin Township in Myanmar. Time frame of the study was shown in table as follow;

Table 4.3 Time frame for study of health belief and behaviors regarding family planning methods among married men in Myanmar.

No	Activity	Months of Implementation activities								
		Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	April 2017	May 2017	June 2017	July 2017
1.	Preparing for proposal and praproposal exam	*	*							
2.	Proposal thesis exam			*						
3.	Data collection and analysis				*	*	*			
4.	Preparing for Thesis							*	*	
5.	Exam for results and thesis									*

4.7 Data collection method

Data was collected after obtaining the permission and approval from Research Ethics Committee of Faculty of Nursing, Universitas Airlangga and also from Research Ethics Committee of MINP. The permission was also obtained from the authorities of Lay Myat Nar village and Pin Ta Lae villages, Wundwin Township. After selecting sample population, all participants were explained about the purposes, procedures, benefits and the right of participants. After that, informed consent was taken from each respondent. In this study, data was collected from the sample population by conducting face to face interviews using structured interview questionnaire. The time of responding to the questionnaires was taken place 30 to 45 minutes. Pre intervention data collection of control group was carried out on February. Two days later, pre intervention data collection of intervention group was carried out. According to the results of pre intervention data collection, the village which had lesser obtained scores was chosen as study group and was decided to do intervention procedure. Health education program was carried out at four weeks after pre-test data collection. Health education program was held for one week and it is divided into two sections. Section (1) Benefits of family planning and male condom methods, Section (2) Advantage and side effect of vasectomy and withdrawal methods. Each meeting was lasted about 45 minutes. Health education program was prepared based on the WHO's Family Planning Guideline (2011). The family planning education addressed the benefits of family planning, advantage and side effects of modern family planning methods (male condom, vasectomy and withdrawal). For giving health education process, health talks or group teachings was conducted by using microphone as an

audio aid, LCD projector and screen and booklets as a visual aids. Before health education intervention, the intervention group was divided into three groups. Each group was involved 15 people. Health Education was held one group per day for section (1). For each group, health education section (2) was held after two days of section (1). The health education session was conducted at the hall of rural health center of the village after two weeks of pre intervention data collection. The responsible persons of the villages, midwife and other health care providers was invited to attend the session for sustainability of the information. After health education session, some present was given to all participants. One week after health education intervention, post intervention data collection was carried out. It was conducted in both study and control groups.

4.8 Data analysis

The statistical package for the social sciences (SPSS) version 16.0 was used to analyze the data. Knowledge and attitude scores was analyzed by descriptive statistics such as mean, median, standard deviation, minimum and maximum scores. Mann-Whitney test was used to compare the differences in the value of pretest and posttest both the treatment and control group. Furthermore, Manova test was used to analyze the effect of health education family planning guidelines on health belief and behaviors regarding family planning methods among married men.

4.9 Operational framework

Frameworks or operational framework are steps in the scientific activities, ranging from the establishment of populations, samples, and so on, namely the implementation of activities since the beginning of the study (Nursalam, 2014).

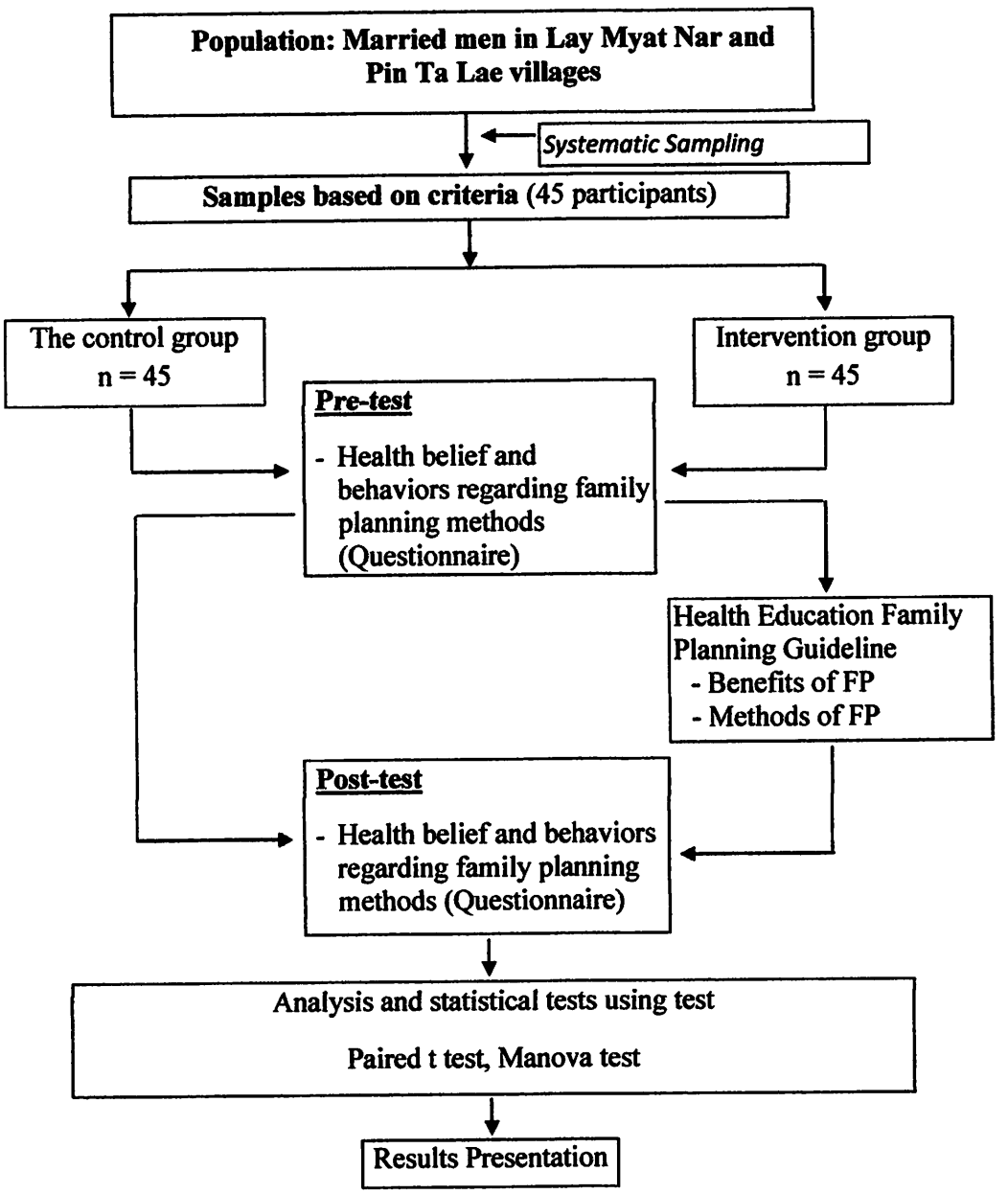

Figure 4.2 Operational Framework for Effectiveness of health education family planning guidelines on health belief and behaviors regarding family planning methods among married men in Myanmar

4.10 Pilot study

Questionnaire of health belief and behavior were drafted in a structured format and they were used in a pilot test before being distributed to the respondents enrolled in this investigation. It was conducted on 20 married men from Aung Min Thar village that same characteristic background. Refinement and modifications were done on the basis of pretest results. Furthermore, questionnaires was validated through expert validation by experts in the field of family planning.

4.11 Ethical consideration

Researchers apply ethical principles in this research through the steps to get a recommendation from educational institutions (Master Degree of Nursing University Press) of the Airlangga University, Surabaya, Indonesia. Also the approval and permission to conduct this study was taken from the Department of Medical Science, Department of Health, Ministry of Health, Nay Pyi Taw, Myanmar. Permission will be sought from the medical superintendent of RHC and all responsible persons. Protection of human subject is also being considered in this study. Measures will be taken to respect the participant's right to refuse participation, to refuse answering any undesirable questions, and to withdraw from the study prior to writing report.Verbal explanation about confidentiality and anonymity will be done as the subjects' name will be substituted with code numbers. The subjects will also be informed that they can withdraw at any time from the study if they wish. After the approval, the research is guided by the ethical issues that include:

4.11.1 Respect to Human

Before collecting the data, the participants was provided clear and concise information about the research objectives, procedure for data collection and confidentiality of information, potential benefits and their rights of participation. Signs on the written informed consent form will be taken from the participants who are willing to participate voluntarily in the study. Consent form is attached in (Appendix 2).

4.11.2 Beneficence and Non Maleficence

The objective of this study is to find out effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in Myanmar. This intervention study will promote health belief, knowledge and attitude regarding family planning methods among married men by providing accurate, correct and complete information to married men. Participating in the study may not affect in participant's life in the present or in the future. Participants will be asked some questions regarding family planning methods by pretested structured questionnaires and your responses will be recorded in answer sheets. Because it does not include invasive procedures such as treatments, drugs or laboratory tests etc, it cannot bear any risks on psychological and sociological aspects.

4.11.3 Anonymous and Confidentiality

Protection of human subject was also being considered in this study. The participants were informed that if they wish, they could withdraw from the study at any time and this would not effect on their job.

Confidentiality of the participants' information was strictly maintained as the participants' name was substituted with code numbers. The respondent's name was not included in the data collection sheets. It aims to maintain the confidentiality of respondents. The participation of respondents in the study was disguised in the form of coding on each sheet of data collection.

4.11.4 Autonomy and Freedoms

The participation of respondent in this study was voluntary and the respondent was entitled to resign at any time, without causing adverse consequences of respondents.

4.11.5 Justice

Married men in the control group were given Health Education Family Planning Guideline too, after the study was completed.

CHAPTER 5
FINDING AND RESULTS

CHAPTER 5
FINDINGS AND RESULTS

This chapter presents the research findings obtained from the analyses of the data generated by the descriptive and inferential statistics. Illustrative tables were used to demonstrate the findings. The results focused on pre and post-interventions knowledge, attitude and health beliefs scores within group and between groups. Firstly, data on background characteristics of two groups will be described. The results of knowledge, attitude and health beliefs scores before and after interventions were also compared.

5.1 General View of the Location of Research Area

Lay Myat Nar village and Pin Ta Lae village are located in Wundwin Township, Mandalay Region in Myanmar. These villages far 14 miles from Wundwin Township. In Wundwin Township, total population is 235000, among them, total birth population is 3500, still birth is 50, abortion is 80, and maternal death is 5 in 2015. According to the 2015 report of Lay Myat Nar and Pin Ta Lae rual health center (RHC), total live-birth is 100 per 5158 population. Among them, there included 4 still-births, 15 abortion cases and 2 maternal deaths. Therefore, researcher choose this location (Lay Myat Nar and Pin Ta Lae villages) for this research study.

5.2 Respondent Characteristics

5.2.1 Demographic characteristics of respondents

All respondents in this study were married men whose wives were still within the age of 15-49 years (female reproductive age) and lived in the study area. The characteristics of (45) respondents by using questionnaires as age, religion, education, occupation, total income and number of children in the first phase of this study were summarized in table 5.1.

Tabel 5.1 Distribution of respondents based on the characteristics of respondents in the treatment group and control group

Number	Characteristics	Intervention Group		Control Group	
		f	%	f	%
1	**Age**				
	< 25 years	4	8.9	4	8.9
	26 – 35 years	9	20.0	17	37.8
	36 – 45 years	20	44.4	18	40.0
	46 – 55 years	12	26.7	4	8.9
	56 or older			2	4.4
2	**Religion**				
	Buddish	45	100	45	100
3	**Education**				
	Illiterate			2	4.4
	Can read & write	2	4.4	4	8.9
	Primary school level	16	35.6	8	17.8
	Middle school level	15	33.3	13	28.9
	High school level	12	26.7	18	40.0
4	**Occupation**				
	Farmer	31	68.9	20	44.4
	Government employee	1	2.2	5	11.1
	Merchant	3	6.7	5	11.1
	Private employee	2	4.4	2	4.4
	Daily labourer	8	17.8	13	28.9
5	**Total Family income**				
	1 lakh and under	27	60.0	27	60.0
	100001 to 200000	13	28.9	15	33.3
	200001 to 300000	5	11.1	2	4.4
				1	2.2
6	**Having Child**				
	No	8	17.8	12	26.7
	Yes	37	82.2	33	73.3
7	**Child Number**				
	0	8	17.8	12	26.7
	1	9	20	10	22.2
	2	13	28.4	11	24.4
	3	11	24.4	7	5.6
	4	3	6.7	2	4.4
	5	1	2.2	2	4.4
	6			1	2.2
8	**Age**				
	1	10	22.2	21	46.7
	2	15	33.3	19	42.2
	3	20	44.4	5	11.1

Table 5.1 above shows that the characteristics of respondents in the intervention group based on the most respondent's age are between 36-45 years as many as 20 respondents (44.4%). Characteristics of all respondents are Buddhist religion as much as 45 respondents (100%). Most education level of respondents are primary

school level that is 16 respondents (35.6%). Characteristic based on occupation of respondents are farmer that is 31 respondent (68.9%). Characteristics of respondents based on the most total family income is 1 lakh and under as many as 27 respondents (60.0%). Most of the respondents have children that is 37 respondents (82.2%).

While in the control group showed that the characteristics of respondents in the control group based on the most respondent's age are between 36-45 years as many as 18 respondents (40 %). Characteristics of all respondents are Buddhist religion as much as 45 respondents (100%). Most education level of respondents are high school that is 18 respondents (40%). Characteristic based on occupation of respondent is farmer that is 20 respondent (44.4%). Characteristics of respondents based on the most total family income is 1 lakh and under as many as 27 respondents (60.0%). Most of the respondents have children that is 33 respondents (73.3%).

5.3 Data and Analysis of Research Variables

In this sub-chapter was discussed research variables include knowledge, attitude and health belief.

5.3.1 Difference the knowledge of respondents

The following was discussed on knowledge in the intervention group and control group in Myanmar that measured before and after Health Education (HE).

Table 5.2 Knowledge Scores

Variabel		N	Intervention Group		Control Group		
			Mean	SD	N	Mean	SD
Knowledge	*Pre test*	45	1.62	0.53	45	1.62	0.65
	Post test	45	2.47	0.50	45	1.36	0.57

Table 5.2 shows that the mean score of the intervention group in the pre-test was 1.62 and the post-test was increased to 2.47 while in the control group the mean score of the pre-test was 1.63 and post-test was 1.36. The results showed that the intervention group had a higher average knowledge value than the control group.

Table 5.3 Distribution of Knowledge (pre and post-test)

	knowledge	Group			
		Intervention		*Control*	
		Amount	%	Amount	%
Pre test	Poor	18	40	21	46.67
	Enough	26	57.78	20	44.44
	Good	1	2.22	4	8.89
	Total	45	100	45	100
Post test	Poor	-		31	68.89
	Enough	24	53.33	12	26.67
	Good	21	46.67	2	4.44
	Total	45	100	45	100

Table 5.3 shows that the knowledge of respondents in the intervention group in the pre-test were 18 respondents (40%) in the poor category, 26 respondents (57.78%) in enough category and 1 respondent (2.22%) in good category. In post-test, there were 24 respondents (53.33%) in enough category and 21 respondents (46.67%) in good category. In the control group, there were 21 respondents (46.67%) in the poor category, 20 respondents (44.44%) in enough category and 4 respondents (8.89%) in good category, and 31 respondents (68.89%) in poor category, 12 respondents (26.67%) in enough category and 2 respondents (4.44%) in good category in the post-test.

5.3.2 Differences the Attitude of Respondents

The following was discussed about attitude in the intervention group and control group in Myanmar that measured before and after Health Education (HE).

Table 5.4 Attitude Scores

Variabel		N	Intervention Group		Control Group		
			Mean	SD	N	Mean	SD
Attitude	*Pre test*	45	1.98	0.15	45	1.96	0.20
	Post test	45	2.00	0.00	45	1.93	0.25

Table 5.4 shows that the average attitude of the intervention group in pre-test was 1.98 and the post-test was increased into 2.00 while in the control group, the mean score of the pre-test was 1.96 and the post-test was 1.93. The results showed that the intervention group had a higher average attitude value than the control group.

Table 5.5 Distribution of Attitude (pre and post-test)

	Attitude	Group			
		Intervention		Control	
		Amount	%	Amount	%
Pre test	Positive	40	88.89	39	86.67
	Negative	5	11.11	6	13.33
Post test	Positive	45	100	38	84.44
	Negative	-	-	7	15.56

Table 5.5 shows that the attitude of respondents in the intervention group in pre-test was 40 respondents (88.89%) in positive attitude and 5 respondents (11.11%) in negative attitude. In post-test, all respondents (100%) were in positive attitude. In the pre-test of the control group, there were 39 respondents (86.67%) in positive attitude and 6 respondents (13.33%) in negative attitude while in the post test were 38 respondents (84.44%) in positive attitude and 7 respondents (15.56%) in negative attitude.

5.3.3 Differences the health belief of respondents

The following was discussed about health belief in the intervention group and control group in Myanmar that measured before and after Health Education (HE).

Table 5.6 Health belief scores

Variable		N	Intervention group		N	Control group	
			Mean	SD		Mean	SD
Perceived susceptibility	Pre test	45	13.22	1.91	45	13.02	2.76
	Post test	45	14.16	1.96	45	12.24	2.55
Perceived Severity	Pre test	45	14.20	2.35	45	14.40	2.00
	Post test	45	16.80	2.89	45	15.31	2.49
Perceived benefit	Pre test	45	14.91	2.89	45	14.27	2.18
	Post test	45	16.38	2.54	45	12.69	2.54
Perceived barrier	Pre test	45	13.09	1.98	45	12.80	2.02
	Post test	45	15.38	2.19	45	12.64	1.97
Self-efficacy	Pre test	45	14.22	2.18	45	14.38	3.86
	Post test	45	16.02	2.37	45	13.56	2.14

Table 5.6 shows that the mean score of perceived susceptibility in the intervention group of pre-test was 13.22 and post-test was increased into 14.16 while the pre-test mean score of control group was 13.02 and post-test was 12.24. Perceived severity mean score in pre-test intervention group was 14.20 and post-test was 16.80 while the control group pre-test mean score was 14.40 and post-test was 15.31. Perceived benefit mean score in pre-test of intervention group was 14.91 and post-test was increased into 16.38. The post-test perceived benefit mean score in control group was 14.27 into 12.69. Perceived barrier of the intervention group of pre-test was 13.09 and post-test was increased 15.38 while the pre-test mean score of control group was 12.80 and post-test was 12.64. The mean score of self-efficacy of the intervention group of pre-test was 14.22 and post-test was increased 16.02 while the pre-test mean score of control group was 14.38 and post-test was 13.56. The results showed that the intervention group had a higher value than the control group.

Table 5.7 Distribution of Health Belief Scores (pre and post-test)

Variable		Category	Group			
			Intervention		Control	
			Amount	%	Amount	%
Perceived susceptibility	Pre test	Poor	-		-	
		Enough	3	6.67 %	8	17.78%
		Good	37	82.82 %	28	62.22%
		Very good	5	11.11%	9	20%
	Post test	Poor	-	-	-	-
		Enough	-	-	8	17.78%
		Good	36	80%	31	68.89%
		Very good	9	20%	6	13.33%
Perceived Severity	Pre test	Poor	-	-	-	-
		Enough	4	8.89%	2	4.44%
		Good	27	60%	28	62.22%
		Very good	14	31.11%	15	33.33%
	Post test	Poor	-	-	-	-
		Enough	-	-	1	2.22%
		Good	14	31.11%	18	40%
		Very good	31	68.89%	26	57.78%
Perceived benefit	Pre test	Poor	-	-	-	-
		Enough	2	4.44%	-	-
		Good	20	44.44%	31	68.89%
		Very good	23	51.11%	14	31.11%
	Post test	Poor	-	-	-	-
		Enough	-	-	7	15.56%
		Good	14	31.11%	33	73.33%
		Very good	31	68.89%	5	11.11%
Perceived barrier	Pre test	Poor	-	-	-	-
		Enough	1	2.22%	3	6.67%
		Good	38	84.44%	36	80%
		Very good	6	13.33%	6	13.33%
	Post test	Poor	-	-	-	-
		Enough	1	2.22%	3	6.67%
		Good	18	40%	39	86.67%
		Very good	26	57.78%	3	6.67%
Self-efficacy	Pre test	Poor	-	-	-	-
		Enough	2	4.44%	5	11.11%
		Good	29	64.44%	28	62.22%
		Very good	14	31.11%	12	26.67%
	Post test	Poor	-	-	-	-
		Enough	-	-	4	8.89%
		Good	17	37.78%	34	75.56%
		Very good	28	62.22%	7	15.56%

Table 5.7 shows that the majority of respondents of perceived susceptibility in the intervention group in pre-test were good category and only three respondents were enough category. In the post-test, 9 respondents (20%) were increased into very good category. In the control group of the pre-test, the majority of respondents

were good category and 8 respondents (20%) in enough category. In the post test, three respondents were decreased from very good category into good category.

The majority of respondents in perceived severity in the intervention group in pre-test were good category and only 4 respondents were enough category. In post-test, 17 respondents were increased into very good category. In the control group of pre-test, the majority of respondents were good category and only 2 respondents were in enough category. In the post test, 11 respondents were increased into very good category.

The majority of respondents in perceived benefit of respondents in the intervention group in pre-test were very good category and only 2 respondents were in enough category. In the post-test, 8 respondents were increased into very good category. In the control group of pre-test, the majority of respondents were good category. In the post-test, 7 respondents was decreased into enough category.

The majority of respondents in perceived barrier of respondents in the intervention group in pre-test were good category and only one respondents in enough category. In the post-test, 20 respondents were increased into very good category and one respondent was still in enough category. In the control group of pre-test, the majority of respondents were good category and only 3 respondents were enough category. In the post test, 3 respondents were decreased from very good category into good category.

The majority of respondents in self-efficacy of respondents in the intervention group in pre-test were good category and only 2 respondents were in enough category. In the post-test, 14 respondents were increased into very good

category. In the control group of pre-test, the majority of respondents were good category and 5 respondents were in enough category. In the post test, 5 respondents were decreased from very good category into good category.

5.4 Mann-Whitney test for knowledge, attitude and Health belief

Table (5.8) The results of Mann Whitney test

Variables		Sig.
Knowledge	Post Intervention and Post Control	.000
Attitude	Post Intervention and Post Control	.000
Perceived Susceptibility	Post Intervention and Post Control	.000
Perceived Severity	Post Intervention and Post Control	.000
Perceived Benefit	Post Intervention and Post Control	.000
Perceived Barrier	Post Intervention and Post Control	.000
Self-Efficacy	Post Intervention and Post Control	.000

Table (5.8) shows that based on Mann Whitney test, significant $p< 0.05$ for all variables and sub-variables. There was differences between intervention and control group. Health education is effective on health belief.

5.5 Test results of health education influence on knowledge, attitude and health belief in Myanmar

The following is an analysis to fulfill the hypothesis test of the influence of health education on knowledge, attitude and health belief in Myanmar using MANOVA test.

Tabel 5.9 Test homogeneity between intervention group and control group

Box's M	F	Df1	Df2	*P value*
21.129	3.391	6	56107.472	0.06

Table 5.9 shows the covariance matrix between the intervention group and the control group is homogeneous ie p >0.05. This test results are in contradiction to MANOVA assumptions.

Tabel 5.10 Test the difference between the intervention group and the control group by using Manova Test

Effect		*Value*	F	Hypothesis df	*Sig*
HE	*Pillai's trace*	.661	55.962[b]	3.000	.000
	Wilk's lambda	.339	55.962[b]	3.000	.000
	Hotteling's trace	1.952	55.962[b]	3.000	.000
	Roy's largest root	1.952	55.962[b]	3.000	.000

Table 5.10 shows that in general, there were differences in average knowledge, attitude and health belief between intervention and control groups. Results show the value of hotteling's trace was sig. 0.000 which means smaller than α 0.05. So it is stated that there was difference of knowledge, attitude and health belief between intervention group and control group.

Tabel 5.11 The results of the analysis on the intervention group and the control group by using Manova Test

Variabel	df	*Mean*	F	*P value*
KNOWLEDGE	1	852.544	124.726	.000
ATTITUDE	1	915.211	37.500	.000
HEALTH BELIEF	1	3397.878	52.294	.000
PERCEIVED SUSCEPTIBILITY	1	122.500	22.777	.000
PERCEIVED SEVERITY	1	30.044	5.961	.017
PERCEIVED BENEFIT	1	380.278	51.103	.000
PERCEIVED BARRIER	1	313.600	60.402	.000
SELF EFFICACY	1	74.711	15.816	.000

Table 5.11 shows that there was difference of knowledge with p = 0.000 and attitude with p = 0.000, health belief with p = 0.000, perceived susceptibility with p = 0.000, perceived severity with p = 0.017, perceived benefit with p = 0.000, perceived barrier with p = 0.000 and self-efficacy with p = 0.000 between intervention group and control group. It can be seem that Health Education improves health belief, knowledge and attitude level among married men.

CHAPTER 6
DISCUSSION

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DISCUSSION

This section presents the discussion of the results that was already depicted in the previous chapter by comparing with the findings from previous researches related to research topic. Based on the objectives of the study, effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in Myanmar will be discussed.

6.1 Effect of health education on knowledge of the respondents

In this study, the majority of the intervention group have enough knowledge about family planning methods before health education. After giving health education about family planning guideline, most of the respondents 21 respondents were increased into good knowledge. In the control group, there were 21 respondents in the poor category, 20 respondents in enough category and 4 respondents in good category in pre-test and 31 respondents in poor category, 12 respondents in enough category and 2 respondents in good category in the post-test. In this study, most of the respondents knew the knowledge about contraceptive methods from their friends. Some respondents knew from health care provider and their wives.

Similar study conducted by (Chaudhary et al., 2015) showed that 19.1% of married men had good knowledge about family planning methods while majority of men (58.4%) had average knowledge. Others (22.5%) had poor knowledge about the same. (Berhane et al., 2011) revealed that most of male respondents had information about family planning. About 36.6% of the respondents knew more

than one method of family planning. (Nanji et al., 2015) stated that knowledge of family planning from urban respondents is higher than from the rural respondents. Family planning education could increase the knowledge of men about modern contraceptives but the use of contraceptives by male may not increase which indicates that behavior change process may take longer time to have effect (Shahamfar et al., 2007). (Mahamed, 2012) conducted that educational method is effective in increasing the knowledge and improving the attitude of family planning. The use of family planning method depends on the person's knowledge of the different family planning methods available and the willingness of both spouses to participate in the family planning program. In order to determine the interest of the participants in the subject of the family planning, the study sought to establish participants' general knowledge about the various family planning methods they were familiar with and used regularly (Sossou, 2008).

In this study, most of the respondents are primary and middle high school level. One third of respondents had poor knowledge level. Increased knowledge of respondents in the intervention group may be influenced by factors such as educational level, age and previous information on family planning guideline. As a result, health education was required to improve knowledge about family planning methods among married men. Health education about family planning guideline can also increase the score of knowledge in the treatment group. In this study, the researcher gave health education about family planning guideline with group teaching methods by using booklets and computer as a visual aids. The researcher assumed that the increase of knowledge score can be caused by giving health education two times with group teaching methods.

6.2 Effect of health education on attitudes of the respondents

The majority of the respondents of intervention group in attitude have positive attitude and five respondents have negative attitude before intervention. After intervention all respondents were increased into positive attitude. In the control group, the majority of respondents have positive attitude and six respondents have negative attitude. In post-test of the control group, the majority of the respondents have positive attitude and seven respondents have negative attitude.

(Khamis, 2007) stated that most of the husbands (89.3%) have positive attitudes towards family planning and agreed that modern methods are more effective than traditional methods. (Chaudhary et al., 2015) showed that only (10%) married men had positive attitude towards family planning while majority (64.4%) had average attitude. (25.6%) men had negative attitude towards the same. (Ayub et al., 2015) revealed that most of the respondents had positive attitudes towards family planning and appreciated the effectiveness of modern methods than traditional methods. (Mahamed, 2012) stated that there was a significant improvement in respondents' attitude after educational program in the experimental group. (Bani et al., 2014) revealed that more than half of men (52.8%) had good knowledge about family planning program. However most men (84.1%) had a positive attitude regarding family planning programs and also they had (66.6%) rate of participation. It will be noteworthy that attitude is a response that comes from knowledge and experiences. Attitude is consisting of three elements; cognitive, affective and behavioral. An affective domain is related to the bad or good, negative or positive, helpful or not helpful feelings in every individual. Behavioral aspect is the individual's readiness for action.

In this study, most of the respondents had positive attitude about family planning. It may be they have proper knowledge about family planning methods. However their information about family planning is inadequate. They do not know the different family planning methods, how and where they are inserted. In addition they do not know the side effects of the different family planning methods. In this study, the researcher mentioned benefits of family planning and advantage and side effects of male contraceptive methods to improve the attitude level and to decrease misconception of married men. Group teaching methods using booklets and laptop was effected in improving the attitude level of married men. Men's attitude are much more important in adaptation of family planning methods. So men should have good attitude level about family planning.

6.3 Effect of health education on health belief of the respondents

The majority of the respondents of intervention group in perceived susceptibility have good score before intervention and nine respondents were increased into very good score after intervention. In the control group the majority of the respondents in perceived susceptibility have good score in both pre and post-test. The majority of the respondents of intervention group in perceived severity have good score before intervention and 17 respondents were increased into very good score after intervention. In the control group the majority of the respondents in perceived severity have good score in both pre and post-test.

The majority of the respondents of intervention group in perceived benefit have very good score before intervention and eight respondents were increased into very good score after intervention. In the control group the majority of the

respondents in perceived benefit have good score in both pre and post-test. The majority of the respondents of intervention group in perceived barrier have good score before intervention and the majority of respondents were very good score after intervention. In the control group the majority of the respondents in perceived barrier have good score in both pre and post-test. The majority of the respondents of intervention group in self efficacy have good score before intervention and the majority of respondents were increased into very good score after intervention. In the control group the majority of the respondents in self efficacy have good score in both pre and post-test.

(Mahmoodi et al., 2011) stated that a significant difference between before and after education. The result of paired T test between before and after scores of perceived threat, perceived benefits and perceived barriers reveal that education improves the individuals perceptions about participation in family planning programs. In this study, married men from both group have good level about health belief and post-test of intervention group was increased significantly. In this study, the researcher gave health education program by using group teaching methods among married men. When giving health education, firstly the intervention group was divided into three group and each group involved 15 respondents. The researcher was used booklets and laptop for visual aids which for more effective in learning process. The researcher assumed that the increase of health belief score can be caused by giving health education with group teaching methods.

6.4 Limitations

There are some limitations that dictate caution in the interpretation of the results of this outcome data.

1) This study was conducted to married men. It was difficult to collect married men because they always busy with their job.
2) This is a quasi-experimental study, if possible focus group discussion should be carried out to explore their perception in future.
3) The interview guide was developed for this study as the standardized questionnaire was not available. However, validity was assured by consultation with an expert person, and a statistician.
4) This study was intended to rural population so it was not generalized for urban people.

CHAPTER 7
CONCLUSION AND RECOMMENDATIONS

CHAPTER 7
CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

A quasi-experimental study was conducted to reveal the effectiveness of Health Education (HE) Family Planning Guideline on Health Belief and Behaviors regarding family planning methods among married men at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Region in Myanmar.

1. Family planning is a very important intervention in reducing maternal and new born mortalities. So the results of this study will guide clinicians who counsel couples about family planning. It was concluded that married men need health education on family planning methods and health care providers were one of the most commonly used information sources.

2. . The results of the analysis showed that the intervention group and the control group were different. It can be evaluated that provision of health education program has an impact on the improvement of health belief and behaviors regarding family planning methods in study group was significantly improved after intervention. As the predetermined hypothesis, a difference was found between the knowledge, attitude and health belief of married men who received health education and those not received health education.
3. Finally, it is apparent that married men in the study group have got valuable advantages because of the effect of health education provided.

Moreover, it could also be useful and informative to the health policy makers and health care planners to develop family planning program for married men.

7.2 Recommendations

1. In this study, the existing knowledge of married men was poor and attitude level and health belief score were satisfactory. Especially, married men didn't know about male contraceptive methods. Further research should provide health education about male contraceptive methods among married.
2. Family planning program should involve men as well as women. Men involvement in family planning counselling will reduce opposition to family planning program and also encourage their wives to use contraceptive methods.
3. Male should be encouraged to participate in family planning program and should promote health education family planning guideline for men to improve their knowledge.
4. Generally, Family planning was always thought to be a woman's prerogative and most of the studies on family planning in developing countries have long focused on women as the subject of interest. Further studies should be carried out such as action research in rural setting for promoting the health belief and behaviors regarding family planning methods among married.

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APPENDIX

APPENDIX (1)
DOCUMENTATION PROOF OF ETHICAL CLEARANCE

KOMISI ETIK PENELITIAN KESEHATAN
HEALTH RESEARCH ETHICS COMMITTEE
FAKULTAS KEPERAWATAN UNIVERSITAS AIRLANGGA
FACULTY OF NURSING UNIVERSITAS AIRLANGGA

KETERANGAN LOLOS KAJI ETIK
DESCRIPTION OF ETHICAL APPROVAL

"ETHICAL APPROVAL"
No : 341-KEPK

Komite Etik Penelitian Kesehatan Fakultas Keperawatan Universitas Airlangga dalam upaya melindungi hak asasi dan kesejahteraan subyek penelitian kesehatan, telah mengkaji dengan teliti protokol berjudul :

The Committee of Ethical Approval in the Faculty of Nursing Universitas Airlangga, *with regards of the protection of Human Rights and welfare in health research, has carefully reviewed the research protocol entitled :*

"THE EFFECTIVENESS OF HEALTH EDUCATION FAMILY PLANNING GUIDELINE ON HEALTH BELIEF AND BEHAVIORS REGARDING FAMILY PLANNING METHODS AMONG MARRIED MEN IN MYANMAR".

Peneliti utama *Principal Investigator*	: **Zay Yar Tun**
Nama Institusi *Name of the Institution*	: Fakultas Keperawatan Universitas Airlangga
Unit/Lembaga/Tempat Penelitian *Setting of research*	:Lay Myat Nar village dan Pin Ta Lae village, Wundwin Township, Mandalay Region, Myanmar.

Dan telah menyetujui protokol tersebut di atas.
And approved the above-mentioned protocol

Surabaya, 8 Februari 2017
Ketua (*CHAIRMAN*)

Joni Haryanto, S.Kp.,M.Si.,Dr.Kep
NIP. 1963 0608 1994 03 1002

RESEARCH ETHIC COMMITTEE

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Reference No. 340/MNSc -Airlangga University/2017

Authorized Date. 3.3.2017

According to the considerations based on research ethic principles by the members of the Research Ethics Committee of Military Institute of Nursing and Paramedical Sciences, there are no controversial ethical issues involved in this project. Thereafter, following project is approved for conduction.

Project type: Master of Nursing Science Research

Project title: Effectiveness of Health Education Family Planning Guideline on Health Belief and Behaviors regarding Family Planning Methods among Married Men in Myanmar

Principal investigator: Lt. Zay Yar Tun

Supervisors: Prof.Dr. Nursalm, M. Nurs. (Hons.),
Dean of faculty of Nursing, Airlangga University
Dr. Tintin Sukartini, S.kp. M.Kes.
Head of Study Program (Master degree). Airlangga University

Secretary

3/3/2017

Chairperson
COL. MAY KHIN THEIN
BC-25513
M.B.,B.S, M.Med.Sc
Dr.Med.Sc (Radiology)
Dip.Med.Ed
Rector
Military Institute of Nursing and Paramedical Sciences

APPENDIX (2)
PARTICIPANT INFORMATION SHEET
ABOUT THE RESEARCH PROJECT

Research Title - Effectiveness of Health Education Family Planning Guideline on Health Belief and Behaviors regarding Family Planning Methods among Married Men in Myanmar

Research site - Lay Myat Nar village and Pin Ta Lae village, Wundwin Township in Myanmar

Supervisors - **Supervisor I**

Professor, Dr. Nursalam, M.Nurs. (Hons)

Dean of Faculty of Nursing

Airlangga University, Surabaya, Indonesia

- **Supervisor II**

Dr.Tintin Sukartini.S.Kp., M.,Kes

Head of the Study Program

Airlangga University, Surabaya, Indonesia

Researcher - Zay Yar Tun

Master Degree of Nursing Student (Medical & Surgical Nursing), Airlangga University, Surabaya, Indonesia

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This research project is aimed to study the effectiveness of health education family planning guideline on health belief and behaviors regarding family planning methods among married men in Myanmar. It is being conducted as the partial fulfillment of the requirement for the Master degree of Nursing (Medical & Surgical Program). The results of research (Information) will be helpfully supported in health belief, knowledge and attitude regarding family planning methods among married men in Myanmar. This research will be conducted at Lay Myat Nar village and Pin Ta Lae village, Wundwin Township, Mandalay Region in Myanmar. The study will last almost three months (February 2017 to April 2017).

If you agree to participate in this project, the research questionnaires will be distributed to collect the data for the first phase of study. When responding to the questions, you can answer freely and sincerely based on your actual knowledge, understanding, beliefs and feelings. The time of responding to the questionnaires will take place 30 to 45 minutes. You can ask the researcher for any unclear questions at any time when filling out the questionnaires. After identifying problem issue strategies, health education will be done for getting knowledge about family planning.

The findings of this project will be presented at medical/nursing conferences and published in health related journals. But your name and address will not be disclosed and be maintained confidentiality. With the exception of the researcher participating in this research project and his supervisors, no other one will be allowed to look at your information. Your name will not be described either on the research questionnaires or on the thesis paper. The researcher takes a responsibility that your participation in this project will not disturb to your job. You have a right

to withdraw from the project at any time if you have no desire to involve in the study. Your information will be kept confidentiality.

Approval and permission to conduct this research project had been already granted from Ethical Approval Committee on Faculty of Nursing of Airlangga University, Surabaya, Indonesia as well as from the Department of Health Professional Resource Development and Management and the Department of Health, Ministry of Health, Nay-Pyi-Taw, Myanmar. Also, the researcher had obtained permission to collect the required data for this research thesis from the authorized person of the villages.

If you have any questions regarding this research project, you can ask freely to the researcher using above e-mail addresses and phone number. I would like to say thanks you for your willingness.

Zay Yar Tun

Master Degree of Nursing Student

(Medical &Surgical Nursing)

Airlangga University, Surabaya, Indonesia

APPENDIX (3)
CONSENT FORM TO INVOLVE IN RESEARCH PROJECT

Name .....; Age .....year; Address - No .....;

Village .....; Township .....;

Ph. No. .....

This is to certify that I ---------- agree to participate as the participants in this research. I have known the purpose and process of this study. I have read and understood the above information regarding to the research project entitled "Effectiveness of Health Education Family Planning Guidelines on Health Belief and Behavior regarding Family Planning Methods among Married Men in Myanmar". Any questions that I have asked to the researcher have been answered to my satisfaction. I agree to participate in this research project voluntarily. I agree that the information obtaining for this study to be used in writing thesis, submitting at medical/nursing conferences and publication in health related journals, if my name and address remain strictly confidential.

Signature of participant .....

Name.....

Date .....

Signature of witness .....

Name .....

Date .....

Signature of researcher .....

Name .....

Date .....

APPENDIX (4)
DEMOGRAPHIC QUESTIONNAIRE

Nobody knows who answers on this questionnaire. Your personal data and responses to the questions will not be shared to any other persons. The information obtained from this questionnaire will be used only in this research project, and will not be explored in any other places with any reasons. The researcher will protect the respondent's personal information. Please answer to the questions frankly and truly based on your actual knowledge, understanding, beliefs and feelings. Please answer all the questions as your participation in this procedure will offer valuable information to improve knowledge and attitude regarding family planning methods among married men.

1	Age	1.≤25 2. 26-35 3. 36-45 4. 46-55 5. 56 or older
2	Religion	1.Buddish 2.Hindu 3.Islam 4.Christian 5.Others (Specify) _____
3	Education	1. Illiterate 2. Can read and write 3. Primary School 4. Middle School 5. High School
4	Occupation	1. Farmer 2. Government employee 3. Merchant 4. Private employee 5. Daily labourer 6. Non-government organization employee

		7.Has no job 8.Others (specify) _____
5	Total family income per month	----------Kyats
6	Do you have children?	1.Yes 2.No (Skip 7)
7	How many children you have?	----------(number of children)

APPENDIX (5)

Knowledge of family planning

1	Family planning is to avoid unwanted pregnancy and help to bring about wanted births.	1. Yes 2. No
2	Have you heard of any ways or methods that men can use to avoid pregnancy?	1. Yes 2. No
3	If you answered yes to 2, Which ways or methods have you heard about? Circle code for each method mentioned spontaneously and then proceed down column For methods not mentioned spontaneously ask "Have you ever heard of (Method)?"	
i	MALE STERILIZATION: can men undergo operation not to have any more children?	1. Yes 2. No
ii	CONDOM: can men put a rubber sheath on their penis before sexual intercourse for a reason of family planning?	1. Yes 2. No
iii	WITHDRAWAL: can men be careful and pull out before climax?	1. Yes 2. No
iv	Have you heard of any other ways or methods than the above mentioned in which men can use to avoid pregnancy?	1. Yes 2. No
v	If you answered yes to Q1 (xii), What is the method?	(Specify)_____ ----------
4	If your answer is yes to any of the above questions, do you know how to use any of the methods described above?	1. Yes 2. No
5	Do you think using contraception has any side effects?	1. Yes 2. No (Go Q 6)
6	If your answer is yes to the above question, what are the side effects?	(Specify)_____ ----------
7	Do you know of a place where you can obtain a method of family planning from?	1. Yes 2. No (Go Q 8)
8	If your answer is yes to Q7, Where is it from?	1.Public or private Hospital 2.MCH center

		3.RHC/sub-center 4.Private clinics 5.Drug shop 6.Others _____
9	From which source did you know about the contraceptive methods?	1.Health care providers 2.Friends 3.Wife 4.Media 5.NGO/INGO 6.Others _____

APPENDIX (6)

Attitudes towards family planning

No	Attitudes towards family planning	SA	A	N	D	SD
1	Contraceptive use is against the human nature.					
2	Advantages of contraception outweigh the side effects.					
3	Condom is comfortable to use.					
4	Condom has fewer side effects the other methods.					
5	It is important to practice family planning so as to acquire a sound and happy family life.					
6	Man is also responsible for the family planning.					
7	Everybody need not know contraceptive methods.					
8	Contraceptive method must be applied to prevent unmet pregnancy.					
9	It is not a shameful to use condom.					

APPENDIX (7)

Factors concerning Health Belief

No		SA	A	N	D	SD
Perceived susceptibility						
1	My wife has no chance to get pregnant.					
2	It is easy for my wife to get pregnant.					
3	My wife can get pregnant any time she wants.					
4	My wife is not ready to get pregnant.					
Perceived severity						
1	Being pregnant is a normal situation for all women.					
2	It will disturb my social life if my wife gets pregnant.					
3	Being pregnant is a danger for my wife.					
4	Life-threatening induced abortion will happen if my wife have unintended pregnancy.					
Perceived benefits						
1	Contraception can help my wife to prevent unintended pregnancy.					
2	Using or not using contraception will not effect on my wife getting pregnant.					

3	Contraceptive helps me to plan my desired family size.					
4	Contraceptives methods are more harmful than beneficial for my health.					
Perceived barriers						
1	My wife/I can get contraceptive methods any times we want.					
2	We cannot pay for contraception despite its availability.					
3	My wife and I have no any problems related to contraception.					
4	My wife and I do not know how to use contraception					
Self-efficacy						
1	My wife can decide by herself to use contraception.					
2	If my wife decides to use contraception, she can use it successfully.					
3	I am not sure whether I can use contraception.					
4	The decision on contraceptive use depends on my wife.					

APPENDIX (8)

HEALTH EDUCATION FAMILY PLANNING GUIDELINES MEETING I

Highlights: Benefits of Family Planning and Male Condom Method

Day/date :

Time: 18:00 pm (allocation of 45 minutes)

Venue: Hall of rural health center at Lay Myat Nar village, Wundwin Township, Mandalay Division, Myanmar

Target: Married men whose wives were still within the age bracket of 15-49 years (female reproductive age)

Meeting I

A. Purpose

1. General Instructional Objectives

After getting health education, to enhance knowledge about benefits of family planning and male condom methods.

2. Specific Instructional Objectives

After getting health education, the client understands:

1) Benefit of family planning

2) Male condom methods

3) How to use male condom methods

4) Advantage and side effect of male condom methods

B. Target group

Married men whose wives were still within the age bracket of 15-49 years (female reproductive age) in Lay Myat Nar village, Wundwin Township, Mandalay Division, Myanmar.

C. Equipment and Materials

1. LCD and projector screen
2. Laptop, slide presentations
3. Booklets
4. The room should have covered with sufficient ventilation and lighting

D. Method

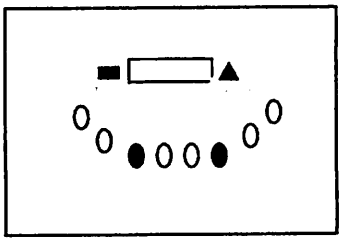
Presentation, discussion, and question and answer

E. Setting

1. Time Setting

Phase	Time	Activities	Participants Activities
Introduction	17.00 - 18.00	Prepare participants, tools and room	Participants prepare in the provided place
Intervention	18.00 - 18.05	Opening 1. Greetings 2. Self Introduction 3. Explanation of research purpose	Listen to the opening
	18.05 - 18.35	Materials Presentation : 1) Benefit of family planning 2) Male condom methods 3) How to use male condom methods 4) Advantage and side effect of male condom methods	Listen and give feedback on the material presented.
	18.35 - 18.50	Question and answer session and evaluation of results	- Ask questions about the material which is poorly understood. - Answering questions.
Closing	18.50 - 18.55	Closing	Participants preparing to leave the room

2.Place Setting



Information:

: Speaker/ researcher

: Facilitator

: Observer

0 **: Participants**

: LCD

Evaluation Form

Meeting I

No of Respondent: Date:

No	Activities	Client	
		Yes	No
1.	Agree on contract activity		
2.	Understand the materials presented		
3.	Active in activities		
4.	Ask questions about the presented material		
5.	Answering the questions		

APPENDIX (9)

HEALTH EDUCATION FAMILY PLANNING GUIDELINE MEETING II

Highlights: Family Planning Methods (Vasectomy and Withdrawal)

Day/date :

Time: 18:00 pm (allocation of 45 minutes)

Venue: Hall of rural health center at Lay Myat Nar village, Wundwin Township, Mandalay Division, Myanmar

Target: Married men whose wives were still within the age bracket of 15-49 years (female reproductive age)

A. Purpose

1. General Instructional Objectives

After getting health education, to enhance the knowledge about the advantage and side effects of family planning methods (Vasectomy and Withdrawal)

2. Specific Instructional Objectives

After getting health education, the client understands:

1) Family planning methods (vasectomy and withdrawal)

2) How to use vasectomy and withdrawal methods

3) Advantage and side effect of vasectomy and withdrawal methods

B. Target group

Married men whose wives were still within the age bracket of 15-49 years (female reproductive age) in Lay Myat Nar village, Wundwin Township, Mandalay Division, Myanmar.

C. Equipment and Materials

1. LCD and projector screen
2. Laptop, slide presentations
3. Booklets
4. The room should have covered with sufficient ventilation and lighting

D. Method

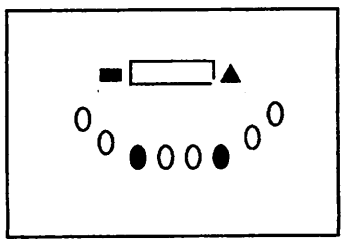
Presentation, discussion, and question and answer

E. Setting

1. Time Setting

Phase	Time	Activities	Participants Activities
Introduction	17.00 - 18.00	Prepare participants, tools and room	Participants prepare in the provided place
Intervention	18.00 - 18.05	Opening 4. Greetings 5. Self Introduction 6. Explanation of research purpose	Listen to the opening
	18.05 - 18.35	Materials Presentation : 1) Family planning methods (vasectomy and withdrawal) 2) How to use vasectomy and withdrawal methods 3) Advantage and side effect of vasectomy and withdrawal methods	Listen and give feedback on the material presented.
	18.35 - 18.50	Question and answer session and evaluation of results	- Ask questions about the material which is poorly understood. - Answering questions.
Closing	18.50 - 18.55	Closing	Participants preparing to leave the room

2.Place Setting



Information:

: Speaker/ researcher

: Facilitator

: Observer

: Participants

: LCD

Evaluation Form

Meeting II

No of Respondent: Date:

No	Activities	Client	
		Yes	No
1.	Agree on contract activity		
2.	Understand the materials presented		
3.	Active in activities		
4.	Ask questions about the presented material		
5.	Answering the questions		

APPENDIX (10)
STATISTICAL ANALYSIS FOR RELIABILITY TESTS

(1) Reliability Knowledge

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	15	100.0
	Excluded[a]	0	.0
	Total	15	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.946	14

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Family planning is to avoid unwanted preg;	6.6000	26.114	.540	.947
Have u heard of any ways or methods that men can use...	6.8000	25.171	.736	.942
If u answer Yes to 2, which ways u heard	6.6667	25.524	.648	.944
Male sterilization: can men undergo operation.....	6.8000	24.886	.796	.940
Condom: can men put a rubber sheath on their penis	6.4667	25.838	.671	.944
Withdrwal: can men be careful and pull out before climmix	6.5333	25.695	.655	.944
Have u heard any others ways of methods than the above....	6.6667	25.238	.707	.943
if u answer yes to K3d, what is ...(specify)	6.8000	24.743	.827	.939
If u answer is yes, do u know how to use...	6.8000	25.171	.736	.942
Do u think using contraception , side effect?	6.6000	25.400	.688	.943
If u answer is yes, side effect?	6.5333	25.552	.685	.943
Do u know a place where u can obtain mtd of FP	6.8000	24.600	.858	.939
If u answer yes to K7, where it is from?	6.8000	24.743	.827	.939
From which source did you know about the contraceptive methods?	6.7333	24.924	.772	.941

(2) Reliability Attitude

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	15	100.0
	Excluded[a]	0	.0
	Total	15	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.911	9

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Contraceptive use is against the human nature	21.6667	19.238	.800	.895
Advantages of contraception outwigh the side effect	21.8000	16.457	.632	.925
Condom is suitable for contraception	21.6000	17.829	.813	.892
Condom have fewer side effect the other methods	21.0000	21.143	.573	.910
It is important to practice FP so as to nice family life	21.7333	18.924	.841	.892
Men is also responsible for FP	21.7333	18.781	.870	.890
Everymarried men need not know contraceptive methods	21.6667	19.524	.742	.899
Contraceptive method must be applied to prevent unmet pregnancy	21.4000	19.257	.680	.902
It is not a shameful to use condom	22.0667	21.067	.637	.907

Reliability Health Belief

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	15	100.0
	Excluded[a]	0	.0
	Total	15	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.966	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
My wife has no chance to get pregnant	66.0667	118.924	.772	.964
It is easy for my wife to get pregnant	66.0667	118.210	.702	.965
My wife can get pregnant any time as she want.	66.2000	116.743	.709	.965
My wife is not ready to get pregnant	66.0000	118.000	.853	.963
Being pregnant is normal situation for all married women	66.2000	116.743	.709	.965
It will distrub my social life if my wife get pregnant	66.0000	118.000	.853	.963
Being unwanted pregnant is danger for my wife	66.2000	119.600	.731	.964
Lifethreating induce abortion will happen if my wife unintentde preg...	66.0000	118.000	.853	.963

Contraception can help my wife to prevent unintented pregnancy	66.0667	118.781	.783	.964
Using / not using contraception will not effect on my wife getting pregnant	66.4000	118.400	.659	.965
Contraceptive hely me to plan my desire family size	66.4000	118.400	.659	.965
Contraceptive methods are more harmful than benicial for my health	66.0667	116.210	.833	.963
My wife and I can get contraceptive methods any time we want	66.1333	117.552	.876	.963
We can not pay for contraception despite if availability	66.2000	119.314	.637	.965
My wife and I have no any problem related to contraception	65.8667	115.981	.701	.965
My wife and I do not know how to use contraception	66.0667	121.210	.603	.966
My wife can decide by herself to use contraception	66.0667	117.495	.749	.964
If my wife decide to use contraception, she can use it successfully	66.1333	115.552	.774	.964
I am not sure whether I can use contraception	66.2000	117.743	.872	.963
The dicision on contraceptive use depend on my wife	66.0667	111.924	.896	.962

VALIDITY KNOWLEDGE

Correlations

		Family planning is to avoid unwanted preg;	Have u heard of any ways or methods that men can use...	If u answer Yes to 2, which ways u heard	Male sterilization: can men undergo operation.....	Condom: can men put a rubber sheath on their penis ....
Family planning is to avoid unwanted preg;	Pearson Correlation	1	.389	.327	.389	.431
	Sig. (2-tailed)		.152	.234	.152	.109
	N	15	15	15	15	15
Have u heard of any ways or methods that men can use...	Pearson Correlation	.389	1	.764**	.722**	.185
	Sig. (2-tailed)	.152		.001	.002	.510
	N	15	15	15	15	15
If u answer Yes to 2, which ways u heard	Pearson Correlation	.327	.764**	1	.764**	.342
	Sig. (2-tailed)	.234	.001		.001	.211
	N	15	15	15	15	15
Male sterilization: can men undergo operation.....	Pearson Correlation	.389	.722**	.764**	1	.492
	Sig. (2-tailed)	.152	.002	.001		.062
	N	15	15	15	15	15
Condom: can men put a rubber sheath on their penis	Pearson Correlation	.431	.185	.342	.492	1
	Sig. (2-tailed)	.109	.510	.211	.062	
	N	15	15	15	15	15
Withdrwal: can men be careful and pull out before climmix	Pearson Correlation	.577*	.289	.472	.577*	.853**
	Sig. (2-tailed)	.024	.297	.075	.024	.000
	N	15	15	15	15	15
Have u heard any others ways of methods than the above....	Pearson Correlation	.055	.491	.464	.764**	.645**
	Sig. (2-tailed)	.847	.063	.081	.001	.009
	N	15	15	15	15	15
if u answer yes to K3d, what is	Pearson Correlation	.389	.722**	.491	.722**	.492

...(specify)	Sig. (2-tailed)	.152	.002	.063	.002	.062
	N	15	15	15	15	15
If u answer is yes, do u know how to use...	Pearson Correlation	.389	1.000**	.764**	.722**	.185
	Sig. (2-tailed)	.152	.000	.001	.002	.510
	N	15	15	15	15	15
Do u think using contraception , side effect?	Pearson Correlation	.722**	.389	.327	.389	.739**
	Sig. (2-tailed)	.002	.152	.234	.152	.002
	N	15	15	15	15	15
If u answer is yes, side effect?	Pearson Correlation	.577*	.289	.189	.289	.853**
	Sig. (2-tailed)	.024	.297	.500	.297	.000
	N	15	15	15	15	15
Do u know a place where u can obtain mtd of FP	Pearson Correlation	.667**	.722**	.764**	.722**	.492
	Sig. (2-tailed)	.007	.002	.001	.002	.062
	N	15	15	15	15	15
If u answer yes to K7, where it is from?	Pearson Correlation	.389	.722**	.491	.722**	.492
	Sig. (2-tailed)	.152	.002	.063	.002	.062
	N	15	15	15	15	15
From which source did you know about the contraceptive methods?	Pearson Correlation	.218	.600*	.339	.600*	.564*
	Sig. (2-tailed)	.435	.018	.216	.018	.029
	N	15	15	15	15	15
TotalKNOW	Pearson Correlation	.605*	.777**	.702**	.829**	.717**
	Sig. (2-tailed)	.017	.001	.004	.000	.003
	N	15	15	15	15	15

Correlations

		Withdrwal: can men be careful and pull out before climmix	Have u heard any others ways of methods than the above....	if u answer yes to K3d, what is ...(specify)	If u answer is yes, do u know how to use...	Do u think using contraceptio n , side effect?
Family planning is to avoid unwanted preg;	Pearson Correlation	.577*	.055	.389	.389	.722**

	Sig. (2-tailed)	.024	.847	.152	.152	.002
	N	15	15	15	15	15
Have u heard of any ways or methods that men can use...	Pearson Correlation	.289	.491	.722**	1.000**	.389
	Sig. (2-tailed)	.297	.063	.002	.000	.152
	N	15	15	15	15	15
If u answer Yes to 2, which ways u heard	Pearson Correlation	.472	.464	.491	.764**	.327
	Sig. (2-tailed)	.075	.081	.063	.001	.234
	N	15	15	15	15	15
Male sterilization: can men undergo operation.....	Pearson Correlation	.577*	.764**	.722**	.722**	.389
	Sig. (2-tailed)	.024	.001	.002	.002	.152
	N	15	15	15	15	15
Condom: can men put a rubber sheath on their penis	Pearson Correlation	.853**	.645**	.492	.185	.739**
	Sig. (2-tailed)	.000	.009	.062	.510	.002
	N	15	15	15	15	15
Withdrwal: can men be careful and pull out before climmix	Pearson Correlation	1	.472	.289	.289	.866**
	Sig. (2-tailed)		.075	.297	.297	.000
	N	15	15	15	15	15
Have u heard any others ways of methods than the above....	Pearson Correlation	.472	1	.764**	.491	.327
	Sig. (2-tailed)	.075		.001	.063	.234
	N	15	15	15	15	15
if u answer yes to K3d, what is ...(specify)	Pearson Correlation	.289	.764**	1	.722**	.389
	Sig. (2-tailed)	.297	.001		.002	.152
	N	15	15	15	15	15
If u answer is yes, do u know how to use...	Pearson Correlation	.289	.491	.722**	1	.389
	Sig. (2-tailed)	.297	.063	.002		.152
	N	15	15	15	15	15
Do u think using contraception , side effect?	Pearson Correlation	.866**	.327	.389	.389	1
	Sig. (2-tailed)	.000	.234	.152	.152	
	N	15	15	15	15	15

If u answer is yes, side effect?	Pearson Correlation	.700**	.472	.577*	.289	.866**
	Sig. (2-tailed)	.004	.075	.024	.297	.000
	N	15	15	15	15	15
Do u know a place where u can obtain mtd of FP	Pearson Correlation	.577*	.491	.722**	.722**	.667**
	Sig. (2-tailed)	.024	.063	.002	.002	.007
	N	15	15	15	15	15
If u answer yes to K7, where it is from?	Pearson Correlation	.289	.764**	1.000**	.722**	.389
	Sig. (2-tailed)	.297	.001	.000	.002	.152
	N	15	15	15	15	15
From which source did you know about the contraceptive methods?	Pearson Correlation	.378	.875**	.873**	.600*	.491
	Sig. (2-tailed)	.165	.000	.000	.018	.063
	N	15	15	15	15	15
TotalKNOW	Pearson Correlation	.705**	.753**	.855**	.777**	.735**
	Sig. (2-tailed)	.003	.001	.000	.001	.002
	N	15	15	15	15	15

Correlations

		If u answer is yes, side effect?	Do u know a place where u can obtain mtd of FP	If u answer yes to K7, where it is from?	From which source did you know about the contraceptive methods?	TotalKNOW
Family planning is to avoid unwanted preg;	Pearson Correlation	.577*	.667**	.389	.218	.605*
	Sig. (2-tailed)	.024	.007	.152	.435	.017
	N	15	15	15	15	15
Have u heard of any ways or methods that men can use...	Pearson Correlation	.289	.722**	.722**	.600*	.777**
	Sig. (2-tailed)	.297	.002	.002	.018	.001
	N	15	15	15	15	15
If u answer Yes to 2, which ways u heard	Pearson Correlation	.189	.764**	.491	.339	.702**
	Sig. (2-tailed)	.500	.001	.063	.216	.004
	N	15	15	15	15	15

Male sterilization: can men undergo operation.....	Pearson Correlation	.289	.722**	.722**	.600*	.829**
	Sig. (2-tailed)	.297	.002	.002	.018	.000
	N	15	15	15	15	15
Condom: can men put a rubber sheath on their penis	Pearson Correlation	.853**	.492	.492	.564*	.717**
	Sig. (2-tailed)	.000	.062	.062	.029	.003
	N	15	15	15	15	15
Withdrwal: can men be careful and pull out before climmix	Pearson Correlation	.700**	.577*	.289	.378	.705**
	Sig. (2-tailed)	.004	.024	.297	.165	.003
	N	15	15	15	15	15
Have u heard any others ways of methods than the above....	Pearson Correlation	.472	.491	.764**	.875**	.753**
	Sig. (2-tailed)	.075	.063	.001	.000	.001
	N	15	15	15	15	15
if u answer yes to K3d, what is ...(specify)	Pearson Correlation	.577*	.722**	1.000**	.873**	.855**
	Sig. (2-tailed)	.024	.002	.000	.000	.000
	N	15	15	15	15	15
If u answer is yes, do u know how to use...	Pearson Correlation	.289	.722**	.722**	.600*	.777**
	Sig. (2-tailed)	.297	.002	.002	.018	.001
	N	15	15	15	15	15
Do u think using contraception , side effect?	Pearson Correlation	.866**	.667**	.389	.491	.735**
	Sig. (2-tailed)	.000	.007	.152	.063	.002
	N	15	15	15	15	15
If u answer is yes, side effect?	Pearson Correlation	1	.577*	.577*	.661**	.732**
	Sig. (2-tailed)		.024	.024	.007	.002
	N	15	15	15	15	15
Do u know a place where u can obtain mtd of FP	Pearson Correlation	.577*	1	.722**	.600*	.882**
	Sig. (2-tailed)	.024		.002	.018	.000
	N	15	15	15	15	15
If u answer yes to K7, where it is from?	Pearson Correlation	.577*	.722**	1	.873**	.855**
	Sig. (2-tailed)	.024	.002		.000	.000
	N	15	15	15	15	15

From which source did you know about the contraceptive methods?	Pearson Correlation	.661**	.600*	.873**	1	.809**
	Sig. (2-tailed)	.007	.018	.000		.000
	N	15	15	15	15	15
TotalKNOW	Pearson Correlation	.732**	.882**	.855**	.809**	1
	Sig. (2-tailed)	.002	.000	.000	.000	
	N	15	15	15	15	15

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

VALIDITY ATTITUDE

Correlations

		Contraceptive use is against the human nature	Advantages of contraception outwigh the side effect	Condom is suitable for contraception
Contraceptive use is against the human nature	Pearson Correlation	1	.552*	.821**
	Sig. (2-tailed)		.033	.000
	N	15	15	15
Advantages of contraception outwigh the side effect	Pearson Correlation	.552*	1	.537*
	Sig. (2-tailed)	.033		.039
	N	15	15	15
Condom is suitable for contraception	Pearson Correlation	.821**	.537*	1
	Sig. (2-tailed)	.000	.039	
	N	15	15	15
Condom have fewer side effect the other methods	Pearson Correlation	.395	.288	.428
	Sig. (2-tailed)	.145	.298	.112
	N	15	15	15
It is important to practice FP so as to nice family life	Pearson Correlation	.915**	.495	.905**
	Sig. (2-tailed)	.000	.061	.000
	N	15	15	15
Men is also responsible for FP	Pearson Correlation	.732**	.495	.763**
	Sig. (2-tailed)	.002	.061	.001
	N	15	15	15

Everymarried men need not know contraceptive methods	Pearson Correlation	.625*	.357	.676**
	Sig. (2-tailed)	.013	.191	.006
	N	15	15	15
Contraceptive method must be applied to prevent unmet pregnancy	Pearson Correlation	.439	.901**	.474
	Sig. (2-tailed)	.102	.000	.074
	N	15	15	15
It is not a shameful to use condom	Pearson Correlation	.590*	.377	.599*
	Sig. (2-tailed)	.021	.166	.018
	N	15	15	15
TotalATTITD	Pearson Correlation	.843**	.766**	.865**
	Sig. (2-tailed)	.000	.001	.000
	N	15	15	15

Correlations

		Condom have fewer side effect the other methods	It is important to practice FP so as to nice family life	Men is also responsible for FP
Contraceptive use is against the human nature	Pearson Correlation	.395	.915**	.732**
	Sig. (2-tailed)	.145	.000	.002
	N	15	15	15
Advantages of contraception outwigh the side effect	Pearson Correlation	.288	.495	.495
	Sig. (2-tailed)	.298	.061	.061
	N	15	15	15
Condom is suitable for contraception	Pearson Correlation	.428	.905**	.763**
	Sig. (2-tailed)	.112	.000	.001
	N	15	15	15
Condom have fewer side effect the other methods	Pearson Correlation	1	.463	.694**
	Sig. (2-tailed)		.082	.004
	N	15	15	15
It is important to practice FP so as to nice family life	Pearson Correlation	.463	1	.821**
	Sig. (2-tailed)	.082		.000
	N	15	15	15
Men is also responsible for FP	Pearson Correlation	.694**	.821**	1
	Sig. (2-tailed)	.004	.000	
	N	15	15	15
Everymarried men need not know contraceptive methods	Pearson Correlation	.632*	.732**	.915**
	Sig. (2-tailed)	.011	.002	.000
	N	15	15	15

Contraceptive method must be applied to prevent unmet pregnancy	Pearson Correlation	.485	.417	.578*
	Sig. (2-tailed)	.067	.122	.024
	N	15	15	15
It is not a shameful to use condom	Pearson Correlation	.533*	.642**	.642**
	Sig. (2-tailed)	.041	.010	.010
	N	15	15	15
TotalATTITD	Pearson Correlation	.638*	.877**	.900**
	Sig. (2-tailed)	.010	.000	.000
	N	15	15	15

Correlations

		Everymarried men need not know contraceptive methods	Contraceptive method must be applied to prevent unmet pregnancy
Contraceptive use is against the human nature	Pearson Correlation	.625*	.439
	Sig. (2-tailed)	.013	.102
	N	15	15
Advantages of contraception outwigh the side effect	Pearson Correlation	.357	.901**
	Sig. (2-tailed)	.191	.000
	N	15	15
Condom is suitable for contraception	Pearson Correlation	.676**	.474
	Sig. (2-tailed)	.006	.074
	N	15	15
Condom have fewer side effect the other methods	Pearson Correlation	.632*	.485
	Sig. (2-tailed)	.011	.067
	N	15	15
It is important to practice FP so as to nice family life	Pearson Correlation	.732**	.417
	Sig. (2-tailed)	.002	.122
	N	15	15
Men is also responsible for FP	Pearson Correlation	.915**	.578*
	Sig. (2-tailed)	.000	.024
	N	15	15
Everymarried men need not know contraceptive methods	Pearson Correlation	1	.439
	Sig. (2-tailed)		.102
	N	15	15
Contraceptive method must be applied to prevent unmet	Pearson Correlation	.439	1
	Sig. (2-tailed)	.102	

pregnancy	N	15	15
It is not a shameful to use condom	Pearson Correlation	.590*	.281
	Sig. (2-tailed)	.021	.311
	N	15	15
TotalATTITD	Pearson Correlation	.796**	.754**
	Sig. (2-tailed)	.000	.001
	N	15	15

Correlations

		It is not a shameful to use condom	TotalATTITD
Contraceptive use is against the human nature	Pearson Correlation	.590*	.843**
	Sig. (2-tailed)	.021	.000
	N	15	15
Advantages of contraception outwigh the side effect	Pearson Correlation	.377	.766**
	Sig. (2-tailed)	.166	.001
	N	15	15
Condom is suitable for contraception	Pearson Correlation	.599*	.865**
	Sig. (2-tailed)	.018	.000
	N	15	15
Condom have fewer side effect the other methods	Pearson Correlation	.533*	.638*
	Sig. (2-tailed)	.041	.010
	N	15	15
It is important to practice FP so as to nice family life	Pearson Correlation	.642**	.877**
	Sig. (2-tailed)	.010	.000
	N	15	15
Men is also responsible for FP	Pearson Correlation	.642**	.900**
	Sig. (2-tailed)	.010	.000
	N	15	15
Everymarried men need not know contraceptive methods	Pearson Correlation	.590*	.796**
	Sig. (2-tailed)	.021	.000
	N	15	15
Contraceptive method must be applied to prevent unmet pregnancy	*Pearson Correlation*	.281	.754**
	Sig. (2-tailed)	.311	.001
	N	15	15
It is not a shameful to use condom	Pearson Correlation	1	.691**
	Sig. (2-tailed)		.004
	N	15	15

TotalATTITD	Pearson Correlation	.691**	1
	Sig. (2-tailed)	.004	
	N	15	15

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

VALIDITY FOR HEALTH BELIEF

Correlations

		My wife has no chance to get pregnant	It is easy for my wife to get pregnant	My wife can get pregnant any time as she want.	My wife is not ready to get pregnant	Being pregnant is normal situation for all married women	It will distrub my social life if my wife get pregnant	Being unwanted pregnant is danger for my wife	Lifethreating induce abortion will happen if my wife unintende preg...
My wife has no chance to get pregnant	Pearson Correlation	1	.561*	.377	.918**	.377	.918**	.494	.918**
	Sig. (2-tailed)		.030	.165	.000	.165	.000	.061	.000
	N	15	15	15	15	15	15	15	15
It is easy for my wife to get pregnant	Pearson Correlation	.561*	1	.325	.638*	.325	.638*	.729**	.638*
	Sig. (2-tailed)	.030		.237	.010	.237	.010	.002	.010
	N	15	15	15	15	15	15	15	15
My wife can get pregnant any time as she want.	Pearson Correlation	.377	.325	1	.464	1.000**	.464	.491	.464
	Sig. (2-tailed)	.165	.237		.082	.000	.082	.063	.082
	N	15	15	15	15	15	15	15	15
My wife is not ready to get	Pearson Correlation	.918**	.638*	.464	1	.464	1.000**	.607*	1.000**

pregnant	Sig. (2-tailed)	.000	.010	.082		.082	.000	.016	.000
	N	15	15	15	15	15	15	15	15
Being pregnant is normal situation for all married women	Pearson Correlation	.377	.325	1.000**	.464	1	.464	.491	.464
	Sig. (2-tailed)	.165	.237	.000	.082		.082	.063	.082
	N	15	15	15	15	15	15	15	15
It will distrub my social life if my wife get pregnant	Pearson Correlation	.918**	.638*	.464	1.000**	.464	1	.607*	1.000**
	Sig. (2-tailed)	.000	.010	.082	.000	.082		.016	.000
	N	15	15	15	15	15	15	15	15
Being unwanted pregnant is danger for my wife	Pearson Correlation	.494	.729**	.491	.607*	.491	.607*	1	.607*
	Sig. (2-tailed)	.061	.002	.063	.016	.063	.016		.016
	N	15	15	15	15	15	15	15	15
Lifethreating induce abortion will happen if my wife unintentde preg...	Pearson Correlation	.918**	.638*	.464	1.000**	.464	1.000**	.607*	1
	Sig. (2-tailed)	.000	.010	.082	.000	.082	.000	.016	
	N	15	15	15	15	15	15	15	15
Contraception can help my wife to prevent unintented pregnancy	Pearson Correlation	.826**	.410	.512	.918**	.512	.918**	.671**	.918**
	Sig. (2-tailed)	.000	.129	.051	.000	.051	.000	.006	.000
	N	15	15	15	15	15	15	15	15
Using / not using contraception will not effect on my wife getting pregnant	Pearson Correlation	.346	.546*	.757**	.321	.757**	.321	.408	.321
	Sig. (2-tailed)	.207	.035	.001	.244	.001	.244	.131	.244
	N	15	15	15	15	15	15	15	15
Contraceptive hely me to plan my desire family size	Pearson Correlation	.346	.546*	.757**	.321	.757**	.321	.408	.321
	Sig. (2-tailed)	.207	.035	.001	.244	.001	.244	.131	.244

	N	15	15	15	15	15	15	15	15
Contraceptive methods are more harmful than benicial for my health	Pearson Correlation	.561*	.483	.789**	.638*	.789**	.638*	.729**	.638*
	Sig. (2-tailed)	.030	.068	.000	.010	.000	.010	.002	.010
	N	15	15	15	15	15	15	15	15
My wife and I can get contraceptive methods any time we want	Pearson Correlation	.570*	.791**	.566*	.671**	.566*	.671**	.741**	.671**
	Sig. (2-tailed)	.027	.000	.028	.006	.028	.006	.002	.006
	N	15	15	15	15	15	15	15	15
We can not pay for contraception despite if availability	Pearson Correlation	.576*	.496	.539*	.521*	.539*	.521*	.705**	.521*
	Sig. (2-tailed)	.025	.060	.038	.046	.038	.046	.003	.046
	N	15	15	15	15	15	15	15	15
My wife and I have no any problem related to contraception	Pearson Correlation	.522*	.450	.547*	.562*	.547*	.562*	.460	.562*
	Sig. (2-tailed)	.046	.093	.035	.029	.035	.029	.084	.029
	N	15	15	15	15	15	15	15	15
My wife and I do not know how to use contraception	Pearson Correlation	.826**	.410	.243	.918**	.243	.918**	.318	.918**
	Sig. (2-tailed)	.000	.129	.384	.000	.384	.000	.249	.000
	N	15	15	15	15	15	15	15	15
My wife can decide by herself to use contraception	Pearson Correlation	.561*	.741**	.325	.638*	.325	.638*	.729**	.638*
	Sig. (2-tailed)	.030	.002	.237	.010	.237	.010	.002	.010
	N	15	15	15	15	15	15	15	15
If my wife decide to use contraception, she can use it successfully	Pearson Correlation	.839**	.607*	.434	.921**	.434	.921**	.569*	.921**
	Sig. (2-tailed)	.000	.016	.106	.000	.106	.000	.027	.000
	N	15	15	15	15	15	15	15	15
I am not sure whether I can use contraception	Pearson Correlation	.494	.729**	.764**	.607*	.764**	.607*	.643**	.607*
	Sig. (2-tailed)	.061	.002	.001	.016	.001	.016	.010	.016

	N	15	15	15	15	15	15	15	15
The decision on contraceptive use depend on my wife	Pearson Correlation	.699**	.602*	.641*	.765**	.641*	.765**	.592*	.765**
	Sig. (2-tailed)	.004	.018	.010	.001	.010	.001	.020	.001
	N	15	15	15	15	15	15	15	15
Total Health Belief	Pearson Correlation	.795**	.735**	.744**	.867**	.744**	.867**	.756**	.867**
	Sig. (2-tailed)	.000	.002	.001	.000	.001	.000	.001	.000
	N	15	15	15	15	15	15	15	15

Correlations

		Contraception can help my wife to prevent unintended pregnancy	Using / not using contraception will not effect on my wife getting pregnant	Contraceptive hely me to plan my desire family size	Contraceptive methods are more harmful than benicial for my health	My wife and I can get contraceptive methods any time we want	We can not pay for contraception despite if availability	My wife and I have no any problem related to contraception	My wife and I do not know how to use contraception
My wife has no chance to get pregnant	Pearson Correlation	.826**	.346	.346	.561*	.570*	.576*	.522*	.826**
	Sig. (2-tailed)	.000	.207	.207	.030	.027	.025	.046	.000
	N	15	15	15	15	15	15	15	15
It is easy for my wife to get pregnant	Pearson Correlation	.410	.546*	.546*	.483	.791**	.496	.450	.410
	Sig. (2-tailed)	.129	.035	.035	.068	.000	.060	.093	.129
	N	15	15	15	15	15	15	15	15
My wife can get pregnant any time as she want.	Pearson Correlation	.512	.757**	.757**	.789**	.566*	.539*	.547*	.243
	Sig. (2-tailed)	.051	.001	.001	.000	.028	.038	.035	.384
	N	15	15	15	15	15	15	15	15

My wife is not ready to get pregnant	Pearson Correlation	.918**	.321	.321	.638*	.671**	.521*	.562*	.918**
	Sig. (2-tailed)	.000	.244	.244	.010	.006	.046	.029	.000
	N	15	15	15	15	15	15	15	15
Being pregnant is normal situation for all married women	Pearson Correlation	.512	.757**	.757**	.789**	.566*	.539*	.547*	.243
	Sig. (2-tailed)	.051	.001	.001	.000	.028	.038	.035	.384
	N	15	15	15	15	15	15	15	15
It will distrub my social life if my wife get pregnant	Pearson Correlation	.918**	.321	.321	.638*	.671**	.521*	.562*	.918**
	Sig. (2-tailed)	.000	.244	.244	.010	.006	.046	.029	.000
	N	15	15	15	15	15	15	15	15
Being unwanted pregnant is danger for my wife	Pearson Correlation	.671**	.408	.408	.729**	.741**	.705**	.460	.318
	Sig. (2-tailed)	.006	.131	.131	.002	.002	.003	.084	.249
	N	15	15	15	15	15	15	15	15
Lifethreating induce abortion will happen if my wife *unintentde* preg...	Pearson Correlation	.918**	.321	.321	.638*	.671**	.521*	.562*	.918**
	Sig. (2-tailed)	.000	.244	.244	.010	.006	.046	.029	.000
	N	15	15	15	15	15	15	15	15
Contraception can help my wife to prevent *unintented* pregnancy	Pearson Correlation	1	.202	.202	.711**	.570*	.576*	.522*	.826**
	Sig. (2-tailed)		.471	.471	.003	.027	.025	.046	.000
	N	15	15	15	15	15	15	15	15
Using / not using contraception will not effect on my wife getting pregnant	Pearson Correlation	.202	1	1.000**	.546*	.663**	.601*	.605*	.058
	Sig. (2-tailed)	.471		.000	.035	.007	.018	.017	.838
	N	15	15	15	15	15	15	15	15
Contraceptive *hely me to plan*	Pearson Correlation	.202	1.000**	1	.546*	.663**	.601*	.605*	.058

my desire family size	Sig. (2-tailed)	.471	.000		.035	.007	.018	.017	.838
	N	15	15	15	15	15	15	15	15
Contraceptive methods are more harmful than benicial for my health	Pearson Correlation	.711**	.546*	.546*	1	.791**	.496	.667**	.410
	Sig. (2-tailed)	.003	.035	.035		.000	.060	.007	.129
	N	15	15	15	15	15	15	15	15
My wife and I can get contraceptive methods any time we want	Pearson Correlation	.570*	.663**	.663**	.791**	1	.485	.741**	.395
	Sig. (2-tailed)	.027	.007	.007	.000		.067	.002	.145
	N	15	15	15	15	15	15	15	15
We can not pay for contraception despite if availability	Pearson Correlation	.576*	.601*	.601*	.496	.485	1	.395	.273
	Sig. (2-tailed)	.025	.018	.018	.060	.067		.145	.325
	N	15	15	15	15	15	15	15	15
My wife and I have no any problem related to contraception	Pearson Correlation	.522*	.605*	.605*	.667**	.741**	.395	1	.396
	Sig. (2-tailed)	.046	.017	.017	.007	.002	.145		.144
	N	15	15	15	15	15	15	15	15
My wife and I do not know how to use contraception	Pearson Correlation	.826**	.058	.058	.410	.395	.273	.396	1
	Sig. (2-tailed)	.000	.838	.838	.129	.145	.325	.144	
	N	15	15	15	15	15	15	15	15
My wife can decide by herself to use contraception	Pearson Correlation	.561*	.422	.422	.741**	.941**	.365	.667**	.410
	Sig. (2-tailed)	.030	.117	.117	.002	.000	.181	.007	.129
	N	15	15	15	15	15	15	15	15
If my wife decide to use contraception, she can use it successfully	Pearson Correlation	.839**	.288	.288	.607*	.634*	.372	.375	.839**
	Sig. (2-tailed)	.000	.299	.299	.016	.011	.172	.169	.000
	N	15	15	15	15	15	15	15	15
I am not sure whether I can	Pearson Correlation	.494	.846**	.846**	.729**	.918**	.552*	.716**	.318

use contraception	Sig. (2-tailed)	.061	.000	.000	.002	.000	.033	.003	.249
	N	15	15	15	15	15	15	15	15
The decision on contraceptive use depend on my wife	Pearson Correlation	.699**	.645**	.645**	.812**	.886**	.508	.630*	.577*
	Sig. (2-tailed)	.004	.009	.009	.000	.000	.053	.012	.024
	N	15	15	15	15	15	15	15	15
Total Health Belief	Pearson Correlation	.804**	.697**	.697**	.853**	.888**	.675**	.740**	.638*
	Sig. (2-tailed)	.000	.004	.004	.000	.000	.006	.002	.010
	N	15	15	15	15	15	15	15	15

Correlations

		My wife can decide by herself to use contraception	If my wife decide to use contraception, she can use it successfully	I am not sure whether I can use contraception	The decision on contraceptive use depend on my wife	Total Health Belief
My wife has no chance to get pregnant	Pearson Correlation	.561*	.839**	.494	.699**	.795**
	Sig. (2-tailed)	.030	.000	.061	.004	.000
	N	15	15	15	15	15
It is easy for my wife to get pregnant	Pearson Correlation	.741**	.607*	.729**	.602*	.735**
	Sig. (2-tailed)	.002	.016	.002	.018	.002
	N	15	15	15	15	15
My wife can get pregnant any time as she want.	Pearson Correlation	.325	.434	.764**	.641*	.744**
	Sig. (2-tailed)	.237	.106	.001	.010	.001
	N	15	15	15	15	15
My wife is not ready to get pregnant	Pearson Correlation	.638*	.921**	.607*	.765**	.867**
	Sig. (2-tailed)	.010	.000	.016	.001	.000
	N	15	15	15	15	15
Being pregnant is normal situation for all	Pearson Correlation	.325	.434	.764**	.641*	.744**

married women	Sig. (2-tailed)	.237	.106	.001	.010	.001
	N	15	15	15	15	15
It will distrub my social life if my wife get pregnant	Pearson Correlation	.638*	.921**	.607*	.765**	.867**
	Sig. (2-tailed)	.010	.000	.016	.001	.000
	N	15	15	15	15	15
Being unwanted pregnant is danger for my wife	Pearson Correlation	.729**	.569*	.643**	.592*	.756**
	Sig. (2-tailed)	.002	.027	.010	.020	.001
	N	15	15	15	15	15
Lifethreating induce abortion will happen if my wife unintentde preg...	Pearson Correlation	.638*	.921**	.607*	.765**	.867**
	Sig. (2-tailed)	.010	.000	.016	.001	.000
	N	15	15	15	15	15
Contraception can help my wife to prevent unintented pregnancy	Pearson Correlation	.561*	.839**	.494	.699**	.804**
	Sig. (2-tailed)	.030	.000	.061	.004	.000
	N	15	15	15	15	15
Using / not using contraception will not effect on my wife getting pregnant	Pearson Correlation	.422	.288	.846**	.645**	.697**
	Sig. (2-tailed)	.117	.299	.000	.009	.004
	N	15	15	15	15	15
Contraceptive hely me to plan my desire family size	Pearson Correlation	.422	.288	.846**	.645**	.697**
	Sig. (2-tailed)	.117	.299	.000	.009	.004
	N	15	15	15	15	15
Contraceptive methods are more harmful than benicial for my health	Pearson Correlation	.741**	.607*	.729**	.812**	.853**
	Sig. (2-tailed)	.002	.016	.002	.000	.000
	N	15	15	15	15	15
My wife and I can get contraceptive methods any time we want	Pearson Correlation	.941**	.634*	.918**	.886**	.888**
	Sig. (2-tailed)	.000	.011	.000	.000	.000
	N	15	15	15	15	15
We can not pay for contraception despite if availability	Pearson Correlation	.365	.372	.552*	.508	.675**
	Sig. (2-tailed)	.181	.172	.033	.053	.006
	N	15	15	15	15	15
My wife and I have no any problem related to	Pearson Correlation	.667**	.375	.716**	.630*	.740**

contraception	Sig. (2-tailed)	.007	.169	.003	.012	.002
	N	15	15	15	15	15
My wife and I do not know how to use contraception	Pearson Correlation	.410	.839**	.318	.577*	.638*
	Sig. (2-tailed)	.129	.000	.249	.024	.010
	N	15	15	15	15	15
My wife can decide by herself to use contraception	Pearson Correlation	1	.607*	.729**	.812**	.777**
	Sig. (2-tailed)		.016	.002	.000	.001
	N	15	15	15	15	15
If my wife decide to use contraception, she can use it successfully	Pearson Correlation	.607*	1	.569*	.774**	.802**
	Sig. (2-tailed)	.016		.027	.001	.000
	N	15	15	15	15	15
I am not sure whether I can use contraception	Pearson Correlation	.729**	.569*	1	.839**	.885**
	Sig. (2-tailed)	.002	.027		.000	.000
	N	15	15	15	15	15
The dicision on contraceptive use depend on my wife	Pearson Correlation	.812**	.774**	.839**	1	.911**
	Sig. (2-tailed)	.000	.001	.000		.000
	N	15	15	15	15	15
Total Health Belief	Pearson Correlation	.777**	.802**	.885**	.911**	1
	Sig. (2-tailed)	.001	.000	.000	.000	
	N	15	15	15	15	15

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

APPENDIX (11)
STATISTICAL ANALYSIS FOR RESEARCH INSTRUMENTS

Descriptives

Intervention

Descriptive Statistics

	N	Minimum	Maximum	Sum	Mean	Std. Deviation
Ktotalpre	45	1.00	3.00	73.00	1.6222	.53466
Ktotalpost	45	2.00	3.00	111.00	2.4667	.50452
Atotalpre	45	1.00	2.00	89.00	1.9778	.14907
Atotalpost	45	2.00	2.00	90.00	2.0000	.00000
Ptotalpre	45	3.00	4.00	141.00	3.1333	.34378
Ptotalpost	45	3.00	4.00	166.00	3.6889	.46818
Valid N (listwise)	45					

Control

Descriptive Statistics

	N	Minimum	Maximum	Sum	Mean	Std. Deviation
Ktotalpre	45	1.00	3.00	73.00	1.6222	.64979
Ktotalpost	45	1.00	3.00	61.00	1.3556	.57031
Atotalpre	45	1.00	2.00	88.00	1.9556	.20841
Atotalpost	45	1.00	2.00	87.00	1.9333	.25226
Ptotalpre	45	3.00	4.00	142.00	3.1556	.36653
Ptotalpost	45	3.00	4.00	140.00	3.1111	.31782
Valid N (listwise)	45					

Crosstabs
Intervention group

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Ktotalpre * Ktotalpost	45	100.0%	0	0.0%	45	100.0%

Ktotalpre * Ktotalpost Crosstabulation

Count

		Ktotalpost		Total
		enough	good	
Ktotalpre	poor	9	9	18
	enough	15	11	26
	good	0	1	1
Total		24	21	45

Atotalpre * Atotalpost Crosstabulation

Count

		Atotalpost	Total
		enough	
Atotalpre	poor	1	1
	enough	44	44
Total		45	45

Ptotalpre * Ptotalpost Crosstabulation

Count

		Ptotalpost		Total
		good	very good	
Ptotalpre	good	13	26	39
	very good	1	5	6
Total		14	31	45

Crosstabs
Control group

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Ktotalpre * Ktotalpost	45	100.0%	0	0.0%	45	100.0%

Ktotalpre * Ktotalpost Crosstabulation

Count

		Ktotalpost			Total
		poor	enough	good	
Ktotalpre	poor	20	1	0	21
	enough	9	10	1	20
	good	2	1	1	4
Total		31	12	2	45

Atotalpre * Atotalpost Crosstabulation

Count

		Atotalpost		Total
		poor	enough	
Atotalpre	poor	1	1	2
	enough	2	41	43
Total		3	42	45

Ptotalpre * Ptotalpost Crosstabulation

Count

		Ptotalpost		Total
		good	very good	
Ptotalpre	good	34	4	38
	very good	6	1	7
Total		40	5	45

1. HEALTH EDUCATION AND HEALTH BELIEF MODEL

A. UJI normalitas

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
HE_HBELIEF	.132	45	.047	.953	45	.066
CONTROL_HBELIEF	.103	45	.200*	.962	45	.145

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

b. Equality test using independent t test

Group Statistics

	CATEGORY	N	Mean	Std. Deviation	Std. Error Mean
NUMBER	HE HBELIEF	45	78.7333	9.05137	1.34930
	CONTROL HBELIEF	45	66.4444	6.93003	1.03307

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
NUMBER	Equal variances assumed	4.415	.038	7.231	88	.000	12.28889	1.69936	8.91176	15.66602
	Equal variances not assumed			7.231	82.392	.000	12.28889	1.69936	8.90856	15.66922

2. Health education and knowledge
   a. Normality Test

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	*df*	*Sig.*	*Statistic*	*df*	*Sig.*
HE_BKNOWLEDGE	.141	45	.024	.945	45	.032
CONTROL_BKNOWLEDGE	.147	45	.016	.962	45	.151

a. Lilliefors Significance Correction

b. Equivalence test using mann whitney

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of KNOWLEDGE is the same across categories of KNOWLEDGE.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

3. Health education and attitude
a. Normality Test

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	*df*	*Sig.*	*Statistic*	*df*	*Sig.*
HE_BATTITUDE	.117	45	.144	.926	45	.007
CONTROL_BATTITUDE	.078	45	.200*	.981	45	.655

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

b. Equality test using mann whitney

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of ATTITUDE is the same across categories of ATTITUDE.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

1. Normality Test of health belief using Kolmogorov-Smirnov

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Pre susceptibility intervention & control	.140	90	.000	.968	90	.025
Pre severity intervention & control	.178	90	.000	.947	90	.001
Pre benefit intervention & control	.119	90	.003	.965	90	.017
Pre barrier intervention & control	.259	90	.000	.892	90	.000
Pre self efficacy intervention & control	.099	90	.028	.978	90	.136

a. Lilliefors Significance Correction

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Post susceptibility intervention & control	.171	90	.000	.945	90	.001
Post severity intervention & control	.102	90	.021	.975	90	.085
Post benefit intervention & control	.123	90	.002	.940	90	.000
Post barrier intervention & control	.159	90	.000	.937	90	.000
Post self-efficacy intervention & control	.110	90	.009	.974	90	.067

a. Lilliefors Significance Correction

Based on Kolmogorov-Smirnov test, It means that the data distribution are not normal for both pre and post group.

2. Mann-Whitney test

Pre intervention and control group.

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of pre_suspec_intcont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.954	Retain the null hypothesis.
2	The distribution of pre_severity_intcont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.614	Retain the null hypothesis.
3	The distribution of pre_benefit_intcont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.177	Retain the null hypothesis.
4	The distribution of pre_barrier_intcont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.358	Retain the null hypothesis.
5	The distribution of pre_selfeff_intcont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.702	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

Post intervention and control group

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of post_suspec_cont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.
2	The distribution of post_severity_cont is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.009	Reject the null hypothesis.
3	The distribution of post_benefit_co is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.
4	The distribution of post_barrier_cor is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.
5	The distribution of post_selfeff_con is the same across categories of Heducation.	Independent-Samples Mann-Whitney U Test	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

T-Test

Group Statistics

	Group	N	Mean	Std. Deviation	Std. Error Mean
K_pre_test	interention group	45	1.6222	.53466	.07970
	control group	45	1.6222	.64979	.09686
K_post_test	interention group	45	2.4667	.50452	.07521
	control group	45	1.3556	.57031	.08502
A_pre_test	interention group	45	1.9778	.14907	.02222
	control group	45	1.9556	.20841	.03107
A_post_test	interention group	45	2.0000	.00000	.00000

P_pre_test	control group	45	1.9333	.25226	.03761
	interention group	45	3.1333	.34378	.05125
P_post_test	control group	45	3.1556	.36653	.05464
	interention group	45	3.6889	.46818	.06979
	control group	45	3.1111	.31782	.04738

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
K_pre_test	Equal variances assumed	2.822	.097	.000	88	1.000	.00000	.12544	-.24929	.24929
	Equal variances not assumed			.000	84.853	1.000	.00000	.12544	-.24941	.24941
K_post_test	Equal variances assumed	.035	.853	9.789	88	.000	1.11111	.11351	.88553	1.33669
	Equal variances not assumed			9.789	86.710	.000	1.11111	.11351	.88549	1.33673
A_pre_test	Equal variances assumed	1.374	.244	.582	88	.562	.02222	.03820	-.05369	.09813
	Equal variances not assumed			.582	79.683	.562	.02222	.03820	-.05380	.09824

	Equal variances assumed	14.580	.000	1.773	88	.080	.06667	.03761	-.00807	.14140
A_post_test	Equal variances not assumed			1.773	44.000	.083	.06667	.03761	-.00912	.14245
	Equal variances assumed	.353	.554	-.297	88	.767	-.02222	.07491	-.17109	.12665
P_pre_test	Equal variances not assumed			-.297	87.641	.767	-.02222	.07491	-.17110	.12666
	Equal variances assumed	26.016	.000	6.849	88	.000	.57778	.08435	.41014	.74541
P_post_test	Equal variances not assumed			6.849	77.450	.000	.57778	.08435	.40982	.74573

4. MANOVA Test

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	HBELIEF	3397.878[a]	1	3397.878	52.294	.000
	KNOWLEDGE	852.544[b]	1	852.544	124.726	.000
	ATTITUDE	915.211[c]	1	915.211	37.500	.000
Intercept	HBELIEF	474223.211	1	474223.211	7298.407	.000
	KNOWLEDGE	12366.944	1	12366.944	1809.262	.000
	ATTITUDE	108368.100	1	108368.100	4440.305	.000
HE	**HBELIEF**	**3397.878**	**1**	**3397.878**	**52.294**	**.000**
	KNOWLEDGE	**852.544**	**1**	**852.544**	**124.726**	**.000**
	ATTITUDE	**915.211**	**1**	**915.211**	**37.500**	**.000**
Error	HBELIEF	5717.911	88	64.976		
	KNOWLEDGE	601.511	88	6.835		

	ATTITUDE	2147.689	88	24.406		
Total	HBELIEF	483339.000	90			
	KNOWLEDGE	13821.000	90			
	ATTITUDE	111431.000	90			
Corrected Total	HBELIEF	9115.789	89			
	KNOWLEDGE	1454.056	89			
	ATTITUDE	3062.900	89			

a. R Squared = .373 (Adjusted R Squared = .366)

b. R Squared = .586 (Adjusted R Squared = .582)

c. R Squared = .299 (Adjusted R Squared = .291)

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	post_suspec_cont	122.500[a]	1	122.500	22.777	.000
	post_severity_cont	30.044[b]	1	30.044	5.961	.017
	post_benefit_cont	380.278[c]	1	380.278	51.103	.000
	post_barrier_cont	313.600[d]	1	313.600	60.402	.000
	post_selfeff_cont	74.711[e]	1	74.711	15.816	.000
Intercept	post_suspec_cont	16187.211	1	16187.211	3009.736	.000
	post_severity_cont	19536.400	1	19536.400	3875.959	.000
	post_benefit_cont	19565.878	1	19565.878	2629.323	.000
	post_barrier_cont	18951.511	1	18951.511	3650.194	.000
	post_selfeff_cont	18835.600	1	18835.600	3987.436	.000
Heducation	post_suspec_cont	122.500	1	122.500	22.777	.000
	post_severity_cont	30.044	1	30.044	5.961	.017
	post_benefit_cont	380.278	1	380.278	51.103	.000
	post_barrier_cont	313.600	1	313.600	60.402	.000
	post_selfeff_cont	74.711	1	74.711	15.816	.000
Error	post_suspec_cont	473.289	88	5.378		
	post_severity_cont	443.556	88	5.040		
	post_benefit_cont	654.844	88	7.441		
	post_barrier_cont	456.889	88	5.192		
	post_selfeff_cont	415.689	88	4.724		
Total	post_suspec_cont	16783.000	90			
	post_severity_cont	20010.000	90			
	post_benefit_cont	20601.000	90			
	post_barrier_cont	19722.000	90			
	post_selfeff_cont	19326.000	90			
Corrected Total	post_suspec_cont	595.789	89			
	post_severity_cont	473.600	89			
	post_benefit_cont	1035.122	89			
	post_barrier_cont	770.489	89			
	post_selfeff_cont	490.400	89			

a. R Squared = .206 (Adjusted R Squared = .197)

b. R Squared = .063 (Adjusted R Squared = .053)

c. R Squared = .367 (Adjusted R Squared = .360)

d. R Squared = .407 (Adjusted R Squared = .400)

e. R Squared = .152 (Adjusted R Squared = .143)

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.990	2881.133[b]	3.000	86.000	.000
	Wilks' Lambda	.010	2881.133[b]	3.000	86.000	.000
	Hotelling's Trace	100.505	2881.133[b]	3.000	86.000	.000
	Roy's Largest Root	100.505	2881.133[b]	3.000	86.000	.000
HE	Pillai's Trace	.661	55.962[b]	3.000	86.000	.000
	Wilks' Lambda	.339	55.962[b]	3.000	86.000	.000
	Hotelling's Trace	1.952	55.962[b]	3.000	86.000	.000
	Roy's Largest Root	1.952	55.962[b]	3.000	86.000	.000

a. Design: Intercept + HE

b. Exact statistic

Box's Test of Equality of Covariance Matrices

Box's M	21.129
F	3.392
df1	6
df2	56107.472
Sig.	0.06

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + HE

Normality Test Result

Variabel	*Shapiro – wilk (sig)*
Health belief of intervention group	0,047
Health belief of control group	**0,200**
Knowledge of intervention group	0,024
Knowledge of control group	0,016
Attitude of intervention group	**0,144**
Attitude of control group	**0,200**

Equality of knowledge, attitude and health belief based on pre-test in the treatment group and control group

Variabel	Group	N	*Mean*	SD	P *value*
Knowledge	Intervention	45	1,62	0,53	1,000
	Control	45	1,62	0,65	
Attitude	Intervention	45	1,98	1,15	0,562
	Control	45	1,96	0,21	
Health Belief	Intervention	45	3,13	3,34	0,767
	Control	45	3,16	3,37	

Equality of knowledge, attitude and health belief based on post-test in treatment group and control group

Variabel	Group	N	*Mean*	SD	P *value*
Knowledge	Intervention	45	2,47	0,50	0,000
	Control	45	1,36	0,57	
Attitude	Intervention	45	2,00	0,00	0,083
	Control	45	1,93	0,25	
Health Belief	Intervention	45	3,69	0,49	0,000
	Control	45	3,11	0,32	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
HE_HBELIEF	45	100.0%	0	0.0%	45	100.0%
CONTROL_HBELIEF	45	100.0%	0	0.0%	45	100.0%

Descriptives

			Statistic	Std. Error
HE_HBELIEF	Mean		78.7333	1.34930
	95% Confidence Interval for Mean	Lower Bound	76.0140	
		Upper Bound	81.4527	
	5% Trimmed Mean		78.8457	
	Median		81.0000	
	Variance		81.927	
	Std. Deviation		9.05137	
	Minimum		60.00	
	Maximum		94.00	
	Range		34.00	
	Interquartile Range		15.00	
	Skewness		-.381	.354
	Kurtosis		-.826	.695
CONTROL_HBELIEF	Mean		66.4444	1.03307
	95% Confidence Interval for Mean	Lower Bound	64.3624	
		Upper Bound	68.5265	
	5% Trimmed Mean		66.1420	
	Median		66.0000	
	Variance		48.025	
	Std. Deviation		6.93003	
	Minimum		54.00	
	Maximum		84.00	
	Range		30.00	
	Interquartile Range		9.00	
	Skewness		.637	.354
	Kurtosis		.180	.695

General Linear Model

Between-Subjects Factors

		Value Label	N
HE	1.00	HE	45
	2.00	NOHE	45

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.990	2881.133[b]	3.000	86.000	.000
	Wilks' Lambda	.010	2881.133[b]	3.000	86.000	.000
	Hotelling's Trace	100.505	2881.133[b]	3.000	86.000	.000
	Roy's Largest Root	100.505	2881.133[b]	3.000	86.000	.000
HE	Pillai's Trace	.661	55.962[b]	3.000	86.000	.000
	Wilks' Lambda	.339	55.962[b]	3.000	86.000	.000
	Hotelling's Trace	1.952	55.962[b]	3.000	86.000	.000
	Roy's Largest Root	1.952	55.962[b]	3.000	86.000	.000

a. Design: Intercept + HE

b. Exact statistic