

MALE INVOLVEMENT IN FAMILY PLANNING: WOMEN'S PERCEPTION

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ABSTRACT

Objectives: To assess the knowledge of mothers of under- five children brought to immunisation centres of contraceptive methods applicable by males and their perceptions of the roles of males in family planning.

Subjects and Methods: This cross- sectional descriptive study involved a questionnaire interview of mothers who came to immunise their children at five public immunisation centres in Port Harcourt. Data entry and analysis employed EPI-Info version 6.

Results: Amongst the 558 mothers interviewed, the contraceptive prevalence rate was 5.6% and 85.6% of them knew at least a family planning method for males. About 15.8% would depend on their spouses for choice of contraceptive methods and 52.7% would discontinue family planning if their spouses objected. About 33.5% of the spouses had used some form of contraception while only 22.1% of the females recognised that male involvement could impact on the acceptance rate of family planning services. Despite their knowledge of safe child spacing, about 53% of the respondents delivered within shorter intervals and had significantly more pregnancies/ children that they would have had if they were in ' control' of their reproductive health decisions. The spouses, despite being significantly older, more educated, with higher level jobs, and in-charge of the reproductive health decision in the home, did not contribute to the knowledge of the women and their practices of family planning.

Conclusion: Despite the advantaged position of males in family matters, their roles in family planning remains largely unutilised. If the acceptance of family planning must improve, males should also be targeted by family planning programmes.

Key Words: Male involvement, Women's perception, family planning

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INTRODUCTION

Historically, the predominant methods of preventing births in most parts of the world were those used by or requiring the cooperation of men. The oldest of these; *coitus interruptus* or withdrawal, was known to at least three ancient religious traditions,¹ and historical demography reveals that it was the principal method responsible for the demographic transition in Europe in the last century² It is still used by an estimated 35 million couples worldwide; and is the method most widely used in turkey³ a country with substantial access to modern methods. Nearly as many couples are thought to rely on periodic abstinence or the rhythm method.³ The advent of sexual revolution initiated by the pill undermined the role of men in family planning. Hormonal methods of contraception for women, beginning with the first oral contraceptive pill in 1960, and the subsequent development of intrauterine devices and modern surgical sterilization, led to the development of

Family planning services focused on women, often to the exclusion of men⁴ Today's challenge, as expressed by the 1994 International Conference on Populations and Development (ICPD) held in Cairo, is to enhance male responsibility for family planning by expanding services in ways that protect the reproductive health of both men and women, and by encouraging greater sensitivity to gender issues.⁵ Furthermore, in recognition of the role of the couple in family planning, one of the goals set at the 1990 World Summit for Children was to make 'Family planning education and services' 'available to all couples to empower them to prevent unwanted pregnancies and births which are too many and too close, and to women who are too young or too old'⁶ In Africa, men are the decision makers and therefore, studies have documented improvement in family planning acceptance and reduction in total fertility rates in areas where males have been involved in family planning.⁷ Studies have also shown that males tend not to discuss family planning issues with their spouses for various reasons such as uncertainty as to the

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number and sexes of children they would have and how many will survive; the feeling that such discussions will portray weakness of the supposed head of the family and lastly, there is difficulty in opening up a discussion on sexual matters which are considered taboo in Africa.⁸ Ignorance of family planning services has been identified as one of the constraints for its widespread acceptance in many developing countries.⁹⁻¹¹ Health education covering topics such as family planning is one of the activities carried out in the Primary Health Care settings. This study therefore aims at assessing women's perception of the role of men in family planning and their knowledge of the contraceptive methods for males.

SUBJECTS AND METHODS

The study was carried out at five immunisation centres in Port Harcourt. The centres were- University of Port Harcourt Teaching Hospital, Braithwaite Memorial Hospital, Churchill Health Centre, Comprehensive Health Centre, Orogbum and Potts Johnson Health Centre. Port Harcourt is the capital of Rivers State in the South- South geopolitical zone of Nigeria. Being a cosmopolitan city, data from these centres would largely reflect what obtains in other such cities in the country. Immunisation centres selected for study provided services for majority of the residents in Port Harcourt of all tribes and socioeconomic status. Although the immunisation days varied from centre to centre and no centre offered immunisation on daily basis, the days coincided in some sites for the study. Using a pre- tested questionnaire, after obtaining ethical clearance from the University of PortHarcourt Teaching Hospital Ethical Committee, trained year five medical students and some experienced public health nurses interviewed mothers who brought their children for immunisation and consented to participate in the study. Data collection lasted two weeks and occurred simultaneously at all sites. Care was taken to ensure that each woman was recruited only once into the study no matter the site she sought for care. Interviews were carried out in English language or Pidgin English which was commonly understood and spoken by the clients. During the pilot survey, it was noted that the sexes of the interviewers did not influence the responses of the clients. Consequently male and female interviewers were recruited for the study. The authors supervised data collection at all sites. Data collected from each client included, amongst others, the socio-demographic characteristics, the practice of family planning by the spouses, perceived family planning methods for males as well as their benefits. All data were entered into the data entry sheet using EPI-Info

version 6. Analysis was with the same package. Chi square test was used to compare the variables and a p value of 0.05 or less was considered statistically significant.

RESULTS

Five hundred and fifty-eight (558) mothers were interviewed in the study. The respondents were aged 16- 43 years (mean- 26.192, mode 25- 29 years) while their spouses were aged 20- 54 years (mean- 32.213 years, mode 30- 34 years) (Table 1). Thirty three (5.9%) respondents and none of the spouses were teenagers. Of the 12 single women, 8 (66.7%) became acquainted with their partners as teenagers. The youngest ages at marriage and the birth of the first babies were 12 and 13 years, respectively (Table 2). The mean ages at first marriage and the birth of first babies were 21.3 and 22.5 years respectively, with the modal ages for both being 20- 24 years. The age at marriage correlated positively with that at the birth of the first baby while that at acquaintance did not (correlation coefficients at 95% confidence interval are 0.91 and 0.46 respectively). The educational level of the respondents and their spouses showed that about 16.2% respondents compared to 10.3% of their spouses had primary education and 27.0% respondents compared to 43.7% of their spouses were graduates (Table 3). The women were involved in lower level jobs than the males with 37.8% women being unemployed compared to 11.6% males (Table 4). The women were thus significantly younger, less educated and involved in lower level jobs/unemployment than their spouses ($\chi^2 = 398.156$, $df = 2$, $p = 000000$ for ages, $\chi^2 = 74.7025$, $df = 3$, $p = 000000$ for the educational levels and $\chi^2 = 199.142$, $df = 2$, $p = 000000$ for employment status). Although the women had a total of 1512 pregnancies and 1250 living children with a mean of 2.7, 2.2 respectively and 555 (99.5%) had heard of family planning, on their own, they would want to have more children than they currently had with 407 (72.9%) of them wanting to have 3- 5 children. Only 44 (7.9%) women would have wanted to have 0- 2 children. Furthermore, in spite of health services being the source of family planning information for 84.7% of these women, and 85.6% knowing at least a modern method for use by males, only 33.5% of their spouses had used some form of contraception (Figs 1- 2). Condom was the commonest method of contraception for males known by these respondents (60.2%) or used by their spouses (27.8%).

The perceived benefits of family planning to the males as perceived by the women were reduction of financial burden (35.3%), improved child care (11.5%) and planned parenting (10.8%), amongst others (Table 5). About 52.7% of the women would discontinue their contraception if their spouses objected and for 22.1% respondents, the males should participate in the choice of a contraceptive method for the females.

Table 1: Distribution of the Ages of the Respondents and Their Spouses.

Age Range (years)	Respondents		Spouses	
	Number	Percent (%)	Number	Percent (%)
	558	100	558	100
Not Known	4	0.7	29	5.2
15-19	3	5.9	0	0
20-24	160	28.7	16	2.9
25-29	231	41.4	74	13.3
30-34	99	17.7	203	36.4
35-39	29	5.2	150	26.9
40-44	2	0.4	56	10.0
45-49	0	0	21	3.8
50-54	0	0	9	1.6

Table 2: Distribution of the Ages of the Respondents at First Marriage or Acquaintances with Spouses and the Ages at the Birth of Their First Babies.

Age Range (Years)	Ages at first marriage/ acquaintance		Ages at the birth of the first babies	
	Frequency	Percent (%)	Frequency	Percent (%)
	558	100	558	100
Ages not known	4	0.7	4	0.7
<15	9	1.6	4	0.7
15- 19	165	29.6	115	20.6
20- 24	254	45.5	255	45.7
25- 29	119	21.3	158	28.3
30- 34	7	1.3	20	3.6
35- 39	0	0.0	2	0.4
TOTAL	558	100	558	100

Table 3: Educational Level of the Respondents and Their Spouses.

Educational Levels	Respondents		Spouses	
	Frequency	%	Frequency	%
Primary	90	16.2	57	10.3
Secondary	317	56.8	257	46.1
Tertiary	151	27.0	244	43.7
Total	558	100.0	558	100.0

Table 4: Occupation of the Respondents and Their Spouses.

Occupation	Respondents		Spouses	
	Frequency	%	Frequency	%
Unemployed	210	37.8	65	11.6
Public Servant	27	4.8	189	33.9
Trading/Business	113	20.3	64	11.5
Civil Servant	208	37.3	240	43.0
Total	558	100.0	558	100.0

Table 5: Perceived Benefits of Family Planning to the Males.

Benefits	Frequency	(%)
Reduction of Financial Burden	198	35.5
Improved Child Care	64	11.5
Planned Parenting	60	10.8
Happiness in the Home	38	6.8
Improved Care for the Family	28	5.0
Improved Health for the Father	28	5.0
Improved Health for the Family	22	4.0
Improved Health for the wife	9	1.6
Reduced Risk of Having Illegitimate Children	7	1.3

Figure 1: Perceived Family Planning Methods for Males by Subjects.

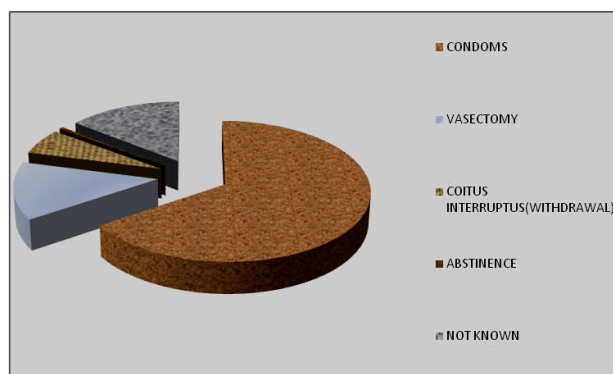
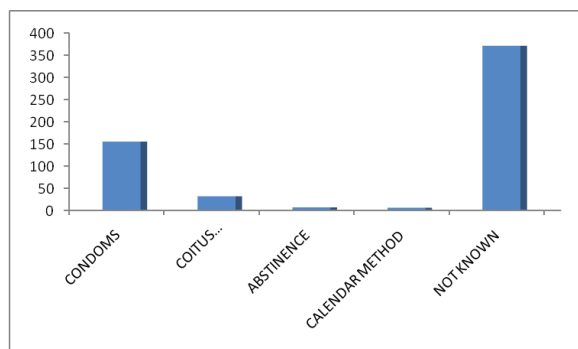


Figure 2: Family Planning Methods Used by Spouses.



DISCUSSION

Despite the advantaged position of males and their status as decision makers, their roles in family planning remain largely unrecognised. One major obstacle is men's reluctance to use family planning services. Men know little about their own or women's sexuality, communicate infrequently about sexuality in their relationships, and often believe many sexual myths. Many men are suspicious of family planning programmes because they see them as a conspiracy to undermine their power.¹² This is reflected in this study where less than half of the respondents used any form of contraception to the knowledge of the women. Focussing family planning programmes on women¹³ may have seemed pragmatic and cost effective at a time, but failed to take into cognisance the fact that men frequently had the final say in all family issues, including those that relate to contraception.¹⁴ In essence, ignoring the roles of men in this area may have contributed to the low uptake of contraceptive services in some parts of the world, including Nigeria, and has certainly led to a growing dissatisfaction among women about the disproportionate burden they have to bear for contraception. In our study the contraceptive prevalence among the respondents of 5.6% was similar to the 6% national prevalence at the time of the study and highlights the need for more intensive efforts to increase the acceptance of this important child survival strategy.¹⁵ Although the rate nationally has risen to 15.0%¹⁶ much remains to be done to reach the target set at the 1990 World Summit for Children. This poor acceptance of family planning is probably a reflection of the low level of involvement of men who are decision-makers in family planning. Lack of male involvement in family planning can be addressed immediately by a change in programme focus; by taking men into account and securing their support for their partners' decision to use a method, and encouraging males to use appropriate methods.¹⁷ Our study reflects the importance of men in contraceptive decisions since more than half

(52.7%) of the respondents would discontinue family planning if their spouses objected. Men who are educated about reproductive health issues may be more likely to support their partners' decision and encourage public policies that result in women receiving the reproductive health care they need.¹⁸ A project in rural Mali addressed this goal by using men to promote family planning in local communities. Many women reported that male community workers had changed their husbands' attitudes towards family planning and had generated more open communication between spouses about family planning.¹⁹ Similarly, a 1994 family planning campaign in Bolivia sought to increase communication, using a slogan "let's talk together." During the promotion, the numbers of new contraceptive users and men reporting their intentions to seek reproductive health services increased dramatically.²⁰ The perceived benefits of family planning to the males as reported by the respondents in our study are not different from what had been reported elsewhere. Fewer children with longer spacing will lead to reduction in financial burden, improved child care and planned parenting amongst others.²¹ These benefits may have led to the inclusion of family planning as one of the child survival strategies since it is likely to positively impact on child health and survival. Thus, failure to involve men in family planning implies a failure to access the potential acceptability of existing male methods. Having never explored the possibilities of fully engaging the male partner, the true acceptability of methods for men remains unknown. We therefore recommend that males get involved in family planning in the following areas:

- (i) Becoming the sources of family planning information to their less educated and less privileged wives.
- (ii) Becoming more responsible in reproductive health matters in the home: allowing the women to put into practice their desires and knowledge of the ideal interval between pregnancies and the total number of children desired. This should however be balanced on what is best in each family's situation.
- (iii) Encouraging the women to accept and practise various forms of contraception, and
- (iv) Accepting and practising contraception more freely.

CONCLUSION

Despite the advantaged position of males and their status as decision-makers in the family, their roles in family planning remains largely unutilised. If the roles of men had been recognised from the inception of family planning, the rate of its acceptance would have changed to the advantage of the family. If male involvement had been considered essential to the success of family planning programmes, and if women had been in policy and programmatic positions to demand that men share the burden for contraception

with them, the history of contraception might have been written differently.

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