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Male Involvement in Family Planning Services for Population Development

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Abstract
This study sought to determine the relationship between male partner participation and the uptake of FP services. A descriptive cross-sectional survey of male partners was done where cluster sampling method was used to select the subjects. Structured questionnaires were used to collect data. Results indicate that majority of the respondents (89%) had the correct information except for a few who thought it to be a brutal method of denying women to bear children. The knowledge of men of what family planning is was high while practices were low, only 26% of male respondents accompanied their partners for FP services. FP clinics were not men friendly and many men perceived FP services to be for women only and most of the FP clinics were run by female health workers. The recommendation is that the government set up male friendly reproductive health clinics and set strategies for creating awareness that FP services are for both the man and the woman and also by emphasising a couple counselling approach. FP clinics to also include male health workers to serve the couples, this will help break the perception that FP is just a woman affair.

Keywords: male partner, male participation, awareness, attitude and practice, capacity building

INTRODUCTION

Family Planning (FP) services are an important component in reducing fertility and achieving population stabilisation and the overall well being of the family. Studies have shown that male partner participation in FP increases the uptake of the services.

Male involvement in family planning (FP) means more than just increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use FP for example accompanying mother to MCH/FP clinic, 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 have the objective of increasing the acceptability and prevalence of family-planning practice of' either sex.
In the past, family-planning programs have focused attention primarily 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 and 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 a very peripheral role.
Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life including the decision for family planning are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF, 2000). The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, this would also accelerate the understanding and practice of family planning in general (ibid).

In countries where men have participated in FP issues it has been noted that the contraceptive prevalence rate (CPR) tremendously improved and the total fertility rate (TFR) declined. For instance, a study done in the Islamic Republic of Iran showed that men's positive attitudes and beliefs regarding reproductive health (RH) have led to the success of

the family planning programme. The family planning (FP) and reproductive health (RH) programmes in Iran have reduced the population growth rate in the country and the maternal mortality rate has fallen below 100/100,000 live births, (WHO, 2006).

In Kenya despite the impressive achievement of the contraceptive program and it being actively addressed, the problems of guaranteeing predictable and sustainable contraceptive security persist. The unmet need of FP is significant and men are considered the dominant member in any family decision making process including decision to use FP methods. Therefore, men's behaviour and attitude have significant impact on the health of women and children, yet very few RH programmes have sought to involve men more. Most reproductive health services in Kenya have traditionally been provided in settings that are predominantly women oriented such as FP clinics (MOH, 2007). To support this, the existing FP structure does not prioritize contacting male partners on FP issues and women health care workers predominantly manage the structures.

In Butula district, the CPR stands at 29%, TFR at 5.6 children per woman. The infant mortality rate is estimated to be 80/100000 live births and maternal mortality ratio of 68/1000 and growth rate of 3.4% (AMREF, 2010; MOH, 2009).

PROBLEM STATEMENT

Worldwide more than 129 million women want to prevent pregnancy but they and their partners are not using contraceptives. Reasons for this are many. Fear of social disapproval or partners' opposition pose formidable barriers, as most decisions that affect family life are made by men. Worries of side effects and health concerns hold some people back; others lack knowledge about contraceptive options and their use. Services and supplies are not yet available everywhere, while the choices are also limited, (WHO, 2007). Worldwide 350million couples lack access to effective and affordable family planning 80,000 women die every year from unsafe abortion. Family planning can prevent 25 – 30% of all maternal deaths, (John Hopkins et al, 2007).

In Sub-Saharan Africa, the contraceptive prevalence rate (CPR) is very low estimated at 13% for married women, the total fertility rate (TFR) is 5.5 children per woman and the risk of maternal mortality ratio is 1:16, these factors compare unfavourably with developed countries where CPR is high, the TFR has declined to 1.6 and maternal death risk is 1:2800. The millennium development goals (MDGs) call for ¾ reduction of child mortality and maternal mortality rate in the years 2000 – 2015. In Kenya, use of FP is moderate, with 39% of married women using some form of contraception, unplanned pregnancies are still common and 24.5% women of reproductive age were found by KDHS to have unmet need for FP, (MOH,2007).

In Butula district the CPR is at 29% with TFR of 5.6 and growth rate of 3.4% and Marachi Central location being in the district has the same CPR and yet has 3 facilities offering the FP services, (DMOH, 2010).

According to these figures it shows that there is a problem in achieving the MDGs. And for them to be achieved the male partner must be involved in FP uptake to reduce the child and maternal mortality rate?

JUSTIFICATION

In Sub-Saharan Africa, FP research and intervention place a disproportionate emphasis on women and largely ignore the role of men; as a result, male participation in FP is low.

Kenya strives to meet the Millennium Development Goals (MDGs) number four; to reduce child mortality and number five ; to improve maternal health by the year 2015 (MOPHS , MOMS 2010). FP is one of the strategies in the Health Sector to achieve these goals. However, low involvement of male partner participation still poses a challenge in the implementation and success of its strategies. It is noted that such efforts will be in vein if male partners do not participate in FP services.

This study aimed to provide information to the District Health Management Team (DHMT) in order to plan for interventions related to promoting wider contraceptive practice among men in Marachi Central location and Butula District as a whole and reduce MMR.

The objective of this study was to determine the relationship between male partner participation in FP and the uptake of FP services.

LITERATURE REVIEW

Factors Influencing Male Involvement in Family Planning

Men's knowledge in Family Planning

Although the wife's education level was associated with the type of method used by the couple, the husband's education level has more influence on the use of male sterilisation and condoms. For example, men with any secondary or higher education were more likely than those with none to rely on either of these methods.

The study examining knowledge of men about family planning and its use by the convenience sample of men in Ghana showed that, socio – cultural factors contribute to ion level of male involvement. Factors like education, religion, type of marital relationship

and exposure to mass media increases knowledge, (Akafuah et al., 2008).

Access to information about RH services is important as it allows individuals to make decisions. The right to information is a human right and enables people to make informed decision. The government has an obligation to provide information, education and counselling about effective methods of contraception to men and women (IPPF, 2007).

The failure to include men in RH programmes leaves them less informed or misinformed about contraception, feeling incompetent or inhibited to discuss it with their partners. Studies show that when men are provided with information about RH, they are likely to be increasingly supportive of their partners. FP decisions and contraceptive use are dramatically higher among couples who have discussed family planning with each other, (Ndong et al., 1999). It is therefore beneficial to include men in RH programme to curb false information regarding contraceptive use or its effects on men or women and to encourage spousal communication about contraception.

Family planning knowledge in Kenya is almost universal, the male and female are able to develop a national approach to planning their families and therefore contraceptive use has sharply increased in Kenya. CPR was 18% in 1989, 27% in 1993, and 32% in 1998. Despite the achievement, much unmet need for FP persists. 24% of women that would like either to space or limit births are not using a method of FP, (KDHS, 2010).

The Kenya Vasectomy Promotion Project, sponsored by John Hopkins University and the Association for Voluntary and Safe Contraception (AVSC), was designed to increase potential acceptors' knowledge of vasectomy. Messages stress that the vasectomy procedure is simple and safe, that men who have vasectomies remain healthy and virile, and that "wives love it because they no longer fear an accidental pregnancy." Wives in the (femiplan) television commercials: "He's really strong . . We have great sex!" Radio, television, and newspaper adverts also direct men to visit Kencom House, the male-only clinic in Nairobi, where specially trained male service providers and counselors make men feel welcome

Attitudes Towards Family Planning

There is a strong belief that attitudes and biases held by policy markers, programme managers, health care workers and other types of providers can act as barriers to men's utilization of RH services. These barriers may exist because of the social or cultural values of providers, and include the belief that men are not interested in RH issues or simply the assumption that family planning is a woman's responsibility, (Wegner et al 1998).

In Nepal, sex preference can be another issue related to high fertility rate as preference for a son is held high because of continuity of the family name, performance of funeral rites and the expectation that sons provide security in old age.

In Ghana, the wife's attitude toward contraception is strongly influenced by her husband's attitudes and education (Bankole & Singh, 1998). A study done in Uganda showed that negative attitude derived from limited knowledge, misconceptions and myths surrounding the FP methods often prevent men and women from making a decision to adopt FP methods, (Kasedde, 2000). The author pointed out myths like vasectomy is equal to castration. Men and women in Uganda believe that vasectomy involves removal of the testicles and that it renders a man being unable to achieve an erection; they also believe that vasectomy means loss of manhood, a man who has undergone vasectomy would also be unable to ejaculate and so would suffer weight gain; possible shrinking of penis and loss of interest in sex. Still from Uganda another study was done using data from 2006 Uganda Contraceptive Prevalence Survey which interviewed women in 5 largest cities, found that husband's approval of contraceptive use and mainly intra uterine contraceptive device (IUCD) was the most important determinant. It was also found that the use of IUCD as contraception was higher among women whose husbands approved of their using contraception than for those whose husband did not (Joesoef et al., 2008).

Family planning methods are surrounded by myths and misgivings e.g. that (IUCD) may get lost in the womb or a child may be born with it stuck on the head. Health care providers have a professional obligation to provide care in a respective and non judgmental manner. Every interaction between health care staff and clients, from the moment they enter the health care setting until they leave should be non-judgemental and the health care provider should not have an attitude. This makes the client choose the right methods that suits her, (MOH, 2005).

FP Practices Among Men

In Haiti, it showed that FP practices were affected by many reasons. Among them, inconsistence supply of methods (particularly injectable)serious quality of care issues example long waiting times, poor counselling, interpersonal skills on the side of service provider, desire for additional children, method failure and contraceptive side effects, (WHO, 2007).
A study in Nigeria showed that all respondents were aware of contraception and only 69.9% were practicing a form of contraception with their spouse. The most commonly used method was condom at

46% Depoprovera injection, 27% IUCD, 11% oral pills, (Goret press, 2007). And a study conducted in Swaziland by Wallender, noted that men desired more children and considered a great number of children as ideal for Swazi family, (IPPFAR, 2000).

Unsafe abortion continues to be a major public health problem in many countries. A woman dies after every eight minutes somewhere in the developing countries due to complication arising from unsafe abortion. Global and regional estimates of the incidences of unsafe abortion and associated mortality (MOH, 2005).

Impact of Male Involvement in Family Planning

Decision Making

Terefe and Larson's report of a project for Ethiopian men is one of the very few studies to be actually concerned with evaluating the effectiveness of men's involvement as a health-promoting strategy (Terefe and Larson, 1993). It was designed to test whether involving men in family planning discussions with their wives made a difference to the use and uptake of modern contraception methods. An experimental group, which included 266 couples, was compared with a control group of 261 women. Both groups received home visits by female health assistants and traditional birth attendants. Subjects were questioned at baseline and at 2 and 12 months. At 12 months, almost twice as many experimental subjects were using a modern contraception method as controls. The fact that men were participating did seem to make an important difference to contraceptive uptake by their spouses.

Husband's Approval

According to Bankole and Singh, (1998) in their study in Ghana, the husband's attitudes and approval plays a big impact on the wife's attitude toward contraception use. A study in Kenya using 2010 KDHS also showed that husband-wife communication, particularly the wife's perception of her husband's approval of family planning, is highly associated with current contraceptive use (Lasse & Becker, 2007). In Kenya reproductive health services have been provided, but guaranteeing predictable and sustainable contraceptive security persists. The men's behaviour, attitude and availability of RH programmes that involve male have significant impact on men involvement in family planning. This is also reflected in Marachi Central.

METHODOLOGY

Study Design

This study was a cross – sectional descriptive design that has an advantage over the other types in that the subjects are interviewed at a single point in time, and this gives estimates of point prevalence.

Study Site and Target Population

Butula District is one of the twenty three districts in Western Province of Kenya and it is found in the Busia County. The district borders Mumias district in the North East, Nambale district in the North, Busia district in the North West, Samia district in the west and Ugenya district to the South. The district covers 247.2km^2. It is divided into 6 locations, 22 sub – locations with 131362 people.

Traditional position of men and women in the society at household level is largely maintained that is the man being the head of the house and the main decision maker. During the poverty eradication strategy paper of February 2001, it was acknowledged that the level of poverty could be lower if adult men and male youths played a role in agriculture. It was also observed that males invest less from sugarcane returns, (BDDP, 2008). The target population of this study were the males of reproductive age and sexually active in Marachi central location which had a population of 33,937 where males were 15,612 (46% of the total population).

SAMPLING METHODS AND INSTRUMENTS

The sampling method used in this study was cluster sampling since Marachi central location has many villages (46) and 6535 households and simple random sampling. A list of all the villages was compiled then 10 villages were randomly selected by picking the 5th village where by the last cluster picked the remaining village. The number of households in these villages was added cumulatively to reach the desired sample size of 421 which was distributed into the 10 villages' households per village. The instrument used in this study was a questionnaire comprising of structured questions and a Likert scale which was developed specifically for this study and pre-tested to ensure validity and reliability.

Data Collection Procedure

The major method of data collection used was questioning. The researcher used verbal questioning which involved researcher administered questionnaires to gather data from the respondents and was helped by trained community health workers (CHWs). Data collected was comprised of primary data for this study.

Reliability and Validity

The researcher pre-tested the questionnaire and used standardized protocol of asking questions for all respondents without changing their meaning so as to increase consistency of information collected hence ensuring reliability and validity.

Ethical Considerations

A high level of privacy and confidentiality was observed, identification of participants was kept

anonymous to the public and the findings of the study will only be submitted to the university and the District Public Health Nurse (DPHN's) and the chief.

LIMITATIONS

Culture, and language barrier affected questioning because most men believed that FP was a woman's affair. The questionnaire was written in English so when some of the questions were translated in the local language, it is likely that there may have been loose of the real meaning thus getting the wrong information.

Data Analysis and Proper Statistical Analysis

This study used both descriptive and inferential statistics. Raw data was coded and entered into the computer for analysis by use of EPI/excel/SPSS.

Descriptive statistics; this was used in the study to describe variability and dispersion of responses. Measures of central tendency were used to describe expected summary of statistics while measures of variability were used to describe distribution of results. Frequency distribution tables were used to present analysis of variables.

Inferential statistics; Two-way analysis of variance (ANOVA) was used to test interaction among variables of study. This is because the study had one dependent variable and three independent variables. Data was presented in graphs and charts.

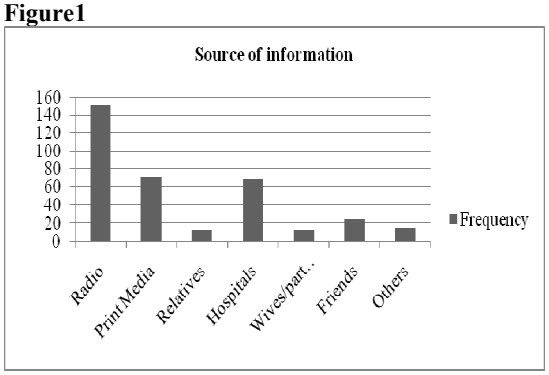
RESULTS AND DISCUSSION

Table 1: Demographic Data

DEMOGRAPHIC DATA			
Variables		**N**	**%**
Marital status	Married	237	66.9
	Single	73	20.6
Religion	Catholic	242	69
	Protestant	97	27
	Muslim	14	4
Level of education	None	9	2.5
	Primary	150	42.4
	Secondary	126	35.6
	College and above	68	19.2
Number of children	1 – 4 children	122	34.6
	Above 4 children	231	65.4

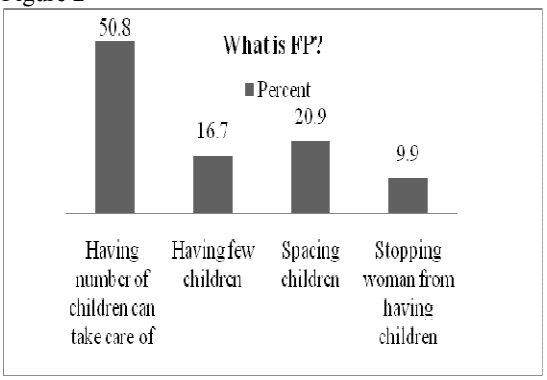
As per the data on the table above in the variable of marital status majority of the men were married at 66.9%, 20.6% were single while 12.5% comprised of divorced, cohabiting and widowers. For religion majority were catholic at 69%, protestant were 27% while 4% were Muslim. Level of education majority had primary education at 42.4% followed by secondary at 35.6%, college and above 19.2% and the least were who never stepped in a classroom at 2.5%. On the number of children the respondent had is one to four children was 34.6% while above four children had majority percentage of 65.4%

Figure1



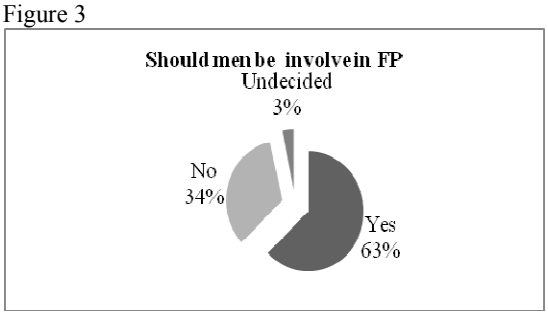
The source of information on family planning was got mostly from the radio 150 respondents followed by print media like newspapers and posters at 70, hospitals came in third with 68 respondents got information from them. The rest of the respondents got information from relatives, spouses, friends and others at 52respondents

Figure 2



The respondents had the knowledge on what FP was, according to this graph 50.8% knew the definition of FP as having the number of children you can take care of, spacing of children was at 20.9%. Having few children and stopping woman from having children was at 26.6%

Figure 3



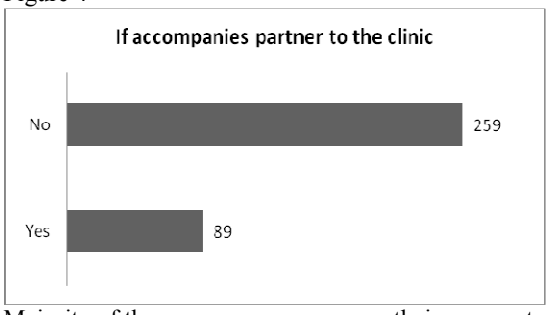
According to their responses the majority were of the idea that men should be involved in FP at 63% while 34% thought that men should not be involved in FP citing it's a woman affair.

Table 2

Attitudes on FP				
Variables				
	Agree		**disagree**	
	N	**%**	**N**	**%**
Spouse seek FP services without permission from husband	196	56.3	152	43.6
Men who accompany wife to clinic are bewitched	79	22.4	269	76.0
Men should accompany their partners to FP clinics	89	25.5	260	74.7
Its taboo for men to discuss with women about FP	249	70.3	99	27.9
Men and women should undergo counseling at the same time	147	41.5	201	56.8
FP clinic are for children and women	118	33.4	230	65.0
FP information first given to men then women	254	71.8	94	26.6

According to the likert scale the men have an attitude towards family planning for instance the ones who agreed to accompany their spouse to FP clinic is only 25.5% while a whole 70.3% think it's a taboo to discuss with women about FP. If we check the number of women seeking FP services without permission from their spouse is high at 56.3%

Figure 4



Majority of the men never accompany their women to the FP clinic at the rate of 259(73.4%) while those who accompany them are a mare 89(25.2%).

CONCLUSION

- The knowledge of men concerning FP was high while practices were low based mainly on culture and religion and the lack of understanding of the advantages of FP on the family and the Nation as a whole.
- FP clinics are not men friendly and most men perceive FP services to be for women only.
- The attitude of men on FP is poor. Majority of African men perceive FP as a woman affair and if they accompany their wives to the FP clinic they will be perceived as weak or over ruled by their women

RECOMMENDATIONS

- Population and development policies require putting in place IEC strategies to address male attitudes whose decision making undermine women rights on areas that directly affect their health. A well-designed and well-focused IEC campaign can have a positive impact on men by increasing their knowledge and improving their attitudes toward FP; this impact, in turn, will increase. joint decision-making.
- The government should setup male friendly reproductive health clinics and encourage men to be involved in FP services, then most families will have the number of children they can take care of and this will help in eradicating poverty in the community.

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