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Factors Influencing Male Involvement in Family Planning in Ntchisi District, Malawi – A Qualitative Study

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Abstract

Malawi is among countries with the highest maternal mortality ratio (MMR) and fertility rate (FR) in Africa, among others caused by an unmet need for family planning (FP). In Malawi, FP is seen as a women's domain and because of this, male involvement in FP remains lower than wanted. This study aimed to explore influencing factors of male involvement in FP. In this qualitative study, 23 semi-structured interviews were held with 14 men, 5 women and 4 health surveillance assistants (HSAs) in Ntchisi District, Malawi. Transcribed data was analyzed through inductive content-analysis and generated five domains influencing male involvement: health behaviour motivation, gender relations, health behavioural skills, health behaviour information, socio-economic factors. Male involvement in FP could assist in reducing shame about going to the FP clinic, ignorance among men and in increasing understanding of the importance of shared decision-making and responsibilities in FP. This could eventually improve maternal and reproductive health within Ntchisi district. *(Afr J Reprod Health 2018; 22[4]: 35-43).*

Keywords: Male involvement, Family planning, Reproductive health, Malawi, Ntchisi

Résumé

Le Malawi fait partie des pays d'Afrique où le taux de mortalité maternelle et le taux de fécondité sont les plus élevés, notamment en raison d'un besoin non satisfait en matière de la planification familiale. Au Malawi, la PF est perçue comme un domaine réservé aux femmes et, de ce fait, la participation des hommes à la PF reste plus faible que souhaité. Cette étude visait à explorer les facteurs qui influent sur la participation des hommes à la PF. Dans cette étude qualitative, 23 entretiens semi-structurés ont été organisés avec 14 hommes, 5 femmes et 4 assistants de surveillance de la santé dans le district de Ntchisi, au Malawi. Les données transcrites ont été analysées à l'aide d'une analyse de contenu inductif et ont généré cinq domaines qui influent sur la participation des hommes: motivation du comportement face à la santé, relations de genre, compétences comportementales du point de vue santé, information sur le comportement face à la santé, facteurs socio-économiques. La participation des hommes à la PF pourrait aider à réduire la honte de se rendre à la clinique de la PF, l'ignorance chez les hommes et à faire mieux comprendre l'importance de la prise de décision partagée et des responsabilités en matière de la PF. Cela pourrait éventuellement améliorer la santé maternelle et de la reproduction dans le district de Ntchisi. *(Afr J Reprod Health 2018; 22[4]: 35-43).*

Mots-clés: Participation masculine, Planification familiale, Santé reproductive, Malawi, Ntchisi

Introduction

Family planning (FP) is essential to improve reproductive and maternal health through preventing unwanted pregnancies, reduction of unsafe abortion and the promotion of child spacing. In the last 20 years, almost 1.2 million maternal deaths were averted worldwide because of an increase in the use of contraceptives and FP services[1,2]. However, African countries are still characterized by a high number of unwanted pregnancies, unsafe abortions, high maternal mortality rates, low contraceptive prevalence rates and high unmet need for FP. In Malawi, the maternal mortality rate (MMR) is 439 per 100,000 live births, and with this Malawi is among the

countries with the highest MMR in Sub-Saharan Africa[3,4]. Although contraceptive prevalence rate has risen extensively in the past, the unmet need for FP is still relatively high, with 20.3% in Southern Malawi and 16.0% in Central Malawi[3]. Consequently, the fertility rate (FR) is at 4.4 births per woman. In Ntchisi District, central Malawi, both the MMR and the FR are higher than those of Malawi as a whole, respectively 728 per 100.000 live births and 7.2 births per woman[5,6].

Most policy programs regarding sexual and reproductive health in Malawi focus on mothers[7]. Women and girls are regarded as being 'primary clients' because they are the ones getting pregnant and suffering from complications during pregnancy, childbirth or abortion. This focus on women and the tendency to think about FP, pregnancy, and childbirth as a 'women's domain' has led to large differences between male and female involvement in FP in Malawi[8]. Since 2009, the Malawian Health sector has included strategies on the improvement of male involvement in their Sexual and Reproductive Health and Rights (SRHR) Policy[9]. Male involvement positively influences uptake and use of FP methods and services, which in turn could improve maternal and reproductive health[10,11]. However, these attempts have not been as successful as aimed for as male involvement remains low.

Malawian policies on maternal and reproductive health lack locally informed research on men and masculinities[6]. In the last 6 years, studies on male involvement conducted in Malawi mainly focused on couples' communication, maternal health and maternity care[7,8,12–14]. USAID[15] conducted a study on the barriers of using contraception. However, they did not examine male involvement as a key focus[15]. This study represents one of the first attempts in Malawi (and in Ntchisi district in particular) to obtain information from men on their knowledge, perspective and attitude towards FP and male involvement. An increase in the use of FP (-services) through involving men could aid in improving maternal and reproductive health in Ntchisi. It is therefore of important to understand why male involvement has not increased to be able to improve these services.

Methods

The study was conducted in the rural villages surrounding the central trading area within Ntchisi district, Central Malawi. With a population of 225,000, Ntchisi is the fifth smallest district. The main tribe inhabiting Ntchisi is the Chewa tribe, the largest ethnic group in Malawi. Most people in Ntchisi speak the local language, Chichewa. Ntchisi has one hospital, 11 health centres and 1 dispensary. Individuals have accessibility to family planning (FP) methods and services in two ways. Firstly, inhabitants can go to health facilities to get FP methods, get information or education on FP (-methods) and get tested for pregnancy or sexual transmitted infections (STIs). Secondly, local health surveillance assistants (HSAs) living in villages surrounding the health facilities provide information on FP and the methods themselves. However there is still a large number of villages without an HSA present and the unmet need for FP lies at 20%[5].

After extensive desk-review on the topic, a qualitative study was conducted using semi-structured interviews, with a total of 23 respondents. Data collection was done by convenience sampling. The key population targeted were men of reproductive age living in Ntchisi district. 14 men that were (self-reported) sexually active were interviewed. The secondary target population consisted of 5 women of reproductive age (15-49yr) and 4 HSAs, which were included with the purpose of validation of the obtained data during the interviews with the key population.

The framework used for this study was based on two theories: the Information, Motivation, Behavioural skills (IMB) model and the WHO framework for Sexual and Reproductive Health and Rights[16,17]. The framework consisted of five factors which, according to both aforementioned models, influenced male involvement in FP: health behaviour information, health behaviour motivation, health behavioural skills, gender relations and socio-economic factors. These factors were used as thematic domains during the analysis and finally resulted in

the five domains as discussed in the Results section.

This study was part of the Standards Based Management–Recognition (SBM-R) study currently being undertaken by Amref Health Africa in Malawi, which is looking at improving the standard based management-recognition initiative to provide high quality, equitable reproductive and maternal health services in Malawi. The SBM-R study obtained ethical clearance from the College of Medicine Research and Ethics Committee (COMREC). Verbal consent was obtained at the start of the interview, recorded and transcribed afterwards.

Data collection consisted of three phases. In the first, the interview guides, containing validated questions derived from literature, for respectively men, women and HSAs were checked on translation issues and adapted accordingly. Secondly, pilot interviews were held according to the interview guide, analysed and adjusted accordingly afterwards. In the third phase, individual, semi-structured interviews were held with the respondents. Data was collected in the period of April and May 2017. During the interviews, a senior supervisor HSA served as a translator. The interviews had a length of 30 minutes on average and were recorded with a voice recorder.

The qualitative data collected through the semi-structured interviews, was transcribed verbatim and anonymized. Back translation was conducted to check for accuracy. The analysis took place in two phases. In the first, inductive content analysis was performed – using MS Excel – to interpret meaning from the transcripts. In the second phase, the emerged themes were compared to the used conceptual framework to see whether they could be placed back into the model and to see whether new concepts came up during analysis.

Results

Five domains emerged from the data analysis, based on the used conceptual framework: health behaviour motivation, gender relations, health behavioural skills, health behaviour information and socio-economic factors. Some themes overlap as they influence each other.

Health behaviour motivation

Within health behaviour motivation, two important subthemes arose: personal attitude and social influence. Within personal attitude, two important identified factors were attitude towards using FP methods and attitude about going to the clinic. Men acknowledge the importance of allowing their partner to use FP methods. Family planning assists in determining their ideal number of children, which according to the respondents is a positive thing. They also expressed that using FP methods feels good because they can have intercourse without having to fear another pregnancy. This does contradict the fertility rate (FR) in Ntchisi that is still high, which implies that knowledge does not always translate directly to practice. However, male respondents expressed they feel intimidated when surrounded by only women which makes them feel shy or ashamed to go to the FP clinic:

> *R: "…, when I go to the FP clinic, it's a lot of women than men that's why I feel shy […] yes, I would feel ashamed going to the clinic (male, 24)*

This result into the following: because there are never men present at the clinic, other men also feel that the family planning clinic is 'only female involvement' and there is no need for them to accompany their wives. Two female respondents also mentioned the fact that men are too shy to go to the clinic, and they confirmed that mostly only women are present.

Within social influence, the most important identified factor was discussing family planning with friends and family. When men did not discuss family planning with their social environment, it was because of two reasons: either the topic of family planning was too sensitive, or some men believed it to be a private issue that is not to be talked about with others. Remarkable was the age difference in willingness to discuss

Table 1: Emerged themes during content analysis of factors influencing male involvement in family planning in Ntchisi District, Malawi

MAIN THEMES	DOMAINS	FACTORS
Health behaviour motivation	Personal attitude	Attitude towards using FP methods
		Attitude about going to the clinic
	Social influences	Discussing FP with friends and family
Gender relations	Responsibilities	Responsibility of avoiding pregnancy
	Decision making	The man as decision-maker within the household
Health behavioural skills	Male accompaniment	Status among other men
		Ignorance
	Self-efficacy	Feeling of already being involved (enough)
Health behaviour information	Level of knowledge	Lack of knowledge
		Misconceptions
		Strong link attitude and knowledge
	Accessibility to information	Different way of accessing information
Socio-economic factors	Accessibility	Accessibility of methods related to that of professionals
	Affordability	Related to distance and financial situation

family planning with others. In comparison to the younger male respondents in this study, the older male respondents found it less intrusive to talk about family planning within their environment. The older respondents mentioned they had to discuss and use family planning methods because they experienced “mistakes” such as an unwanted pregnancy. Younger male respondents had not been exposed to such experiences, and neither were they confronted with discussing family planning in school. According to all HSAs, information about FP is indeed not included in the primary or secondary school curriculum in Malawi. They do get a course called ‘Life skills’, which contains a ‘Sexual health’ part. However, this only focuses on bodily changes due to growing up, not on contraception and pregnancy. And since it is still a sensitive topic, especially among men, they do not talk to each other about it at a young age.

Gender relations

Men in Ntchisi are the main decision-makers within the household regarding the use of family planning methods and services, the used type of contraception and the number and spacing of their children. According to all male respondents, this is because the man is the one resourcing the money. All female respondents expressed they cannot decide on the type of contraceptives they use because 'the man finalizes every decision as head of the household'. However, women advise their husbands on which type they want to use, mainly because the women are the ones obtaining the information at the clinic as their husbands do not accompany them.

Even though men are the final decision-makers regarding FP and the number of children, they do not feel responsible for avoiding pregnancies. Almost all male respondents believe this is a woman’s responsibility:

> *R: "Yes, it's a woman's responsibility to avoid pregnancy […] caring is more about the woman at the household level, so that's why the woman needs to avoid another pregnancy" (male, 25)*

This opinion is reinforced by adverts about family planning on the radio, which contributes in shaping the male attitude towards FP. This information on the radio is mostly about female contraception, which incites the belief that ‘FP is a female domain’. All male respondents expressed that only their wives use (female) contraception and they do not use any male methods. Some male respondents (3/14) mention that because ‘all contraception is female’; it is the woman's responsibility to avoid pregnancy as well. In short: men have a seemingly contradictory role of making every decision regarding family planning

whilst at the same time being detached from family planning issues by distancing themselves from any responsibility towards getting the FP methods or knowledge about it.

Health behavioural skills

The two most important identified factors were male accompaniment and self-efficacy. Nine of fourteen respondents admitted they had never accompanied their wives, for which reasons vary. Men do not want their friends to think their wives control them instead of the other way around. Moreover, men mention they are often 'too busy with the land', 'resourcing money' or 'rather drink beer than wait around at the clinic'. Lastly, sometimes men have multiple partners. As they do not want to know the community to know about this, they refuse to go public by accompanying their partners to the clinic. Judging from the reasons for not joining their wives in going to a FP professional, men do not realize that their involvement is important for their wives' health. This might cautiously be regarded as ignorance. One female respondent mentioned that only knowledgeable men escort their wives to the clinic:

> *R: "I think the men are ignorant - they do not have enough information about FP issues. But those men who are educated, who have got enough knowledge, these are the only men that escort their partners" (female, 22)*

Regarding self-efficacy, half of the male respondents believe they are already involved in family planning and do not feel the need of changing their behaviour. Surprisingly, two female respondents also felt their husbands were already involved enough through allowing them to take contraception. If men feel as if they are already displaying the right behaviour, and this is confirmed by their wives and female-focused media adverts, there might be no intention to change their behaviour. Moreover, most of the male respondents felt like they had enough knowledge of FP and reproductive health as well. They chose not to obtain more knowledge as they felt knowing about the type their wife is using is enough.

Health behaviour information

Within health behaviour information, two important factors were identified: knowledge of FP and accessibility of information. When looking at the content of what the male respondents knew, they could name different types of contraception, whether the contraceptive prevents pregnancy, STIs or both and they could name the frequency in which their wives needed to take them. However, the men did not know how contraceptives work: they often had misconceptions on how they affect the female body. 12 out of 14 respondents could not name more than 3 types of contraception. When looking at variations within the study sample, one big difference came forward: 1 respondent did not know any types of contraceptives while another respondent knew at least 5. When those two respondents are compared, there clearly was a difference between them about the main themes in this study. As shown in Table 2, there was a strong link between attitude and practices regarding FP.

Accessibility of information plays a big role in the level of knowledge of the respondents. People in Ntchisi mostly access information through radio, HSAs, in the hospital and in the health clinic. However, as the information provided by media like radio is mostly about female contraception, as mentioned before, this keeps reinstating the belief that 'FP is a female domain'. Moreover, the HSAs have a passive role in providing information. Community members must act by visiting the HSAs to obtain information instead of the HSAs visiting the community members in their houses.

Table 2: Comparison between 2 male respondents about male involvement in family planning in Ntchisi District

	Respondent 5 (male, 24 years)	**Respondent 14 (male, 28 years)**
Knowledge	Does not know any type of contraception	Knows at least 5 types of contraception
Education/ Profession	Primary school, 'cowboy' (forced to be as this was his father's occupation)	Primary school, farmer (did not finish school due to poverty)
Attitude	Feels ashamed going to the FP clinic	Feels like going to the clinic is a good decision
Behaviour	Never goes to clinic/never accompanies wife	Goes to clinic "*Due to take knowledge, I want to have relevant, current information about FP".* Sometimes accompanies wife
Gender relations	Contraception is woman's responsibility. "*Because it is the woman who can take the injection, not the man. That's why it is the responsibility for the woman to avoid pregnancy"*	Feels like contraception it's the responsibility of both. "*If you come across the challenges of not taking FP methods, you two also you will be involved into solving those issues".*
Social influence	Doesn't talk about contraception with his friends	[no information]

Socio economic factors

Important factors were accessibility and affordability. According to all respondents in this study, the accessibility of FP services and methods in general should be easy due to the existence of HSAs and the district hospital. Moreover, in Malawi, FP methods are for free which means there are no financial barriers to obtain them. However, in practice, especially in hard-to-reach rural areas, people do get charged for FP methods by the bike-couriers, sent by outreach clinics that deliver them. The money is in turn used for bike-maintenance. When there is no HSA in the area, often these couriers are the only way to obtain FP methods. This leads to the fact that when people do not want to pay for FP methods, inhabitants of rural areas still often do not have access to FP methods. Accessibility of methods is thus also related to the accessibility of professionals: when there is no HSA living in the catchment area, it is a lot harder for respondents to access the FP methods. People are forced to go the nearest clinic or hospital for counselling and getting their FP methods. This can cause problems, as the respondents mentioned they never know whether the medical personnel will be present during the day they are planning on visiting the clinic:

> *R: "….one day when we went to the clinic, we found that one of the medical personnel's relative had died. As such, all staff including those involved with FP services went to the funeral. Under such circumstances, people get pregnant because they fail to access the FP methods since no one is available to attend to them." (male, 25)*

Moreover, in the situation of no HSA present in the village, distance and financial factors do play a big role when the hospital is far away as this might cause men to stay at home as paying for transport for one person is less expensive than paying for two. Moreover, most respondents mentioned it is a long walk to the district hospital. Often, they are not able to walk due to a restriction of resources to buy food along the way.

Discussion

In this study, men are aware of the possible side-effects but do not mind them as taking contraception prevents unwanted pregnancy, which is more important to them. In contradiction, Kabagenyi *et al.*[18] stated that a lack of male involvement is caused by male opposition towards contraceptive use. Three factors herein were

described: fear of side effects, male preference for a large sized family and fear of promiscuity[18]. These findings are supported by several other studies on male involvement in reproductive health[19,20]. The difference could be explained through the fact that both male and female respondents in this study expressed a preference for a small-sized family due to shortage of land and resources. They are aware of their restriction in means and resources. They realise that their children, when they would have many, might be deprived of food and education. Both male and female respondents explained that they would rather endure side-effects than having to fear another pregnancy every time they have intercourse. Men also do not have a fear of promiscuity of their partner as they firmly stated that women cannot have multiple partners. According to one male respondent, the fact that men can, and women cannot have multiple partners is proclaimed by the Malawian law. All in all, almost all male respondents stated that it feels good to use FP methods because it feels secure and protected. Moreover, they did not display any fear of side-effects, promiscuity or preferred a large family.

However, as discussed in several studies, personal attitude is always affected by or derived from environmental influences like culture[21,22]. In African countries, community expectations often influence an individual's decisions, especially with regard to FP[23]. According to the WHO, social norms affect families, whole communities and even societies and therefore are intrinsically linked to the shaping of individual's sexual lives and their use of FP[24]. The question is whether the personal negative attitude resembles what the respondents feel or reflects what the community feels. This is not accurately examined within this study, and future research should therefore focus on differentiating between personal attitude and social attitude.

Secondly, regarding gender relations, in this study it was found that men make the final decisions about the number and spacing of their children and the use of contraceptives. However, at the same time, they distance themselves from any responsibility regarding avoiding pregnancy through gaining knowledge or getting the FP methods at the clinic. This is consistent with existing literature[7,25]. A contradictory finding however is one reported by Kululanga *et al.*[8], who found that women are often unwilling to have their husbands participate and that they are the main barrier for male involvement in reproductive health. This study however shows that women are positive about their husbands' accompaniment to the FP clinic, but they do not feel the freedom to discuss this with their husbands. These findings are consistent with two other quantitative studies conducted in Mozambique and Nigeria, which state that men have important and dominant roles within the household and have more decision-making power with regard to their wives behaviour concerning contraceptive uptake[26,27].

With regard to an explanation of the discrepancies in this study, firstly, some of the mentioned studies have been conducted in different countries: Nigeria, Kenya, Nepal, Ethiopia, and Mozambique. Each of these countries has its own culture, sometimes even more than one, which influences sexual and reproductive health behaviour[28,29]. Secondly, the inconsistencies between the studies done by Kululanga *et al.*[8] and this study might be explained by the fact that they were conducted in different parts of Malawi. The Northern, Southern and Central parts of Malawi differ significantly with regard to maternal health[3]. The results of this study should therefore be interpreted with caution for this was a case study focused on one district in Central Malawi. Lastly, the fact that this study did not find a negative attitude towards contraception among men might be the result of the increase in communication and service delivery on FP in Malawi. The findings in this study show that most respondents had good accessibility to FP providers because oftentimes there was an HSA living in their village or outreach clinics to visit them on a regularly basis. Because recently FP methods have become more easily accessible and providers are living within the communities, it might have become normal to use FP methods which could

explain the recent shift in attitude from negative towards positive.

One limitation was the social desirability bias: the researcher was a foreigner, from a different gender and often a different age category in comparison to the male respondents. This resulted in the fact that men e.g. quoted radio-commercials to display their level of knowledge instead of giving their own, personal opinions on the matter. Attempts to minimize the bias involved sitting next to the respondents instead of directly facing them and by gaining the trust of the village headmen before interviewing the community members. A second limitation was the language barrier. To translate from English to Chichewa, the translator used simplified versions of the question, which could have triggered different answers. Moreover, due to the use of a translator it was impossible to directly probe to respondents' answers. Sometimes a respondent answered in an emotional state and by the time the translation reached the researcher, the respondent would have lost that feeling and their answers to a probed question would be relatively static.

This qualitative case study only consisted of semi-structured interviews and was focused on one district within Central Malawi: Ntchisi district. However, according to the Demographic and Health Survey (DHS) of Malawi[3], the Northern, Central and Southern parts of Malawi differ in the field of maternal and reproductive health. To come up with nation-wide recommendations on increasing male involvement in FP, it is advisable to conduct a bigger study, involving mixed methods with on the one hand a quantitative component to test whether the found factors that influence male involvement are not only applicable to Ntchisi district, but to Malawi as a whole. On the other hand, there should be a qualitative component in the form of a cross-sectional case study between several districts throughout Malawi.

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Contribution of Authors

Study idea and design: Astrid A. Dral with input from all authors; Data collection: Astrid A. Dral; Data analyses: Astrid A. Dral with input from all authors; Article drafting: Astrid A. Dral; Revision and final approval of article: all authors.

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