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ORIGINAL ARTICLE

Male Involvement in Family Planning: A Qualitative Survey of the Barriers and Facilitators amongst Married Men in Sokoto metropolis

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Keywords

Family Planning; Male Involvement; Qualitative; Sokoto

ABSTRACT

Background: Although large families are desired in Nigeria, women tend to want fewer children than men but are often unable to limit or space childbirth due to gender dynamics within relationships. Studies have identified men as a significant barrier to the use of contraceptives by their wives. The study explored married men's knowledge and perception on family planning (FP), involvement in FP, barriers and facilitators of male involvement (MI) in FP in Sokoto Metropolis.

Methods: A qualitative study was done among married men in Sokoto Metropolis in November 2017. Four focus group discussions were conducted among thirty-two men grouped based on educational status and age. Data was transcribed verbatim and a content analysis on emerging themes was done.

Results: All the participants were aware of FP and most of them said that it is beneficial to everyone in the community. Most of the participants perceived that FP is an issue for both men and women. All the participants said that men should be involved in FP. The barriers to MI in FP mentioned were lack of knowledge on FP and poverty while increasing awareness on FP, religious leaders and traditional rulers championing FP, and making FP free were the facilitators suggested.

Conclusion: The participants said that FP is beneficial to everyone in the community and men should be involved in FP. Traditional and religious leaders should be made the champions of FP in their various communities to improve acceptance and utilisation.

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INTRODUCTION

Although large families are desired in Nigeria, women tend to want fewer children than men but are often unable to limit or space childbirth due to gender dynamics within relationships.[1] Overall, Nigerian women have 0.7 children, more than their desired number of 4.8 children.[2] This implies that the total fertility rate (TFR) is 15% higher than it would be if unwanted births are avoided.[2] Sokoto State has a TFR of 7.0, which is amongst the

highest in the country and a contraceptive prevalence rate (CPR) of 2.3%, amongst the country's lowest.[2] Studies have identified a lack of male involvement (MI) in family planning (FP) as a significant barrier to the use of contraceptives by their wives.[3-5] For many years, men have been ignored or excluded in one way or the other from participating in many FP programmes as it is viewed as a woman's affair.[6] However, for more than two decades now, MI has remarkably increased because it was realized that men make decisions about everything, including decisions on their reproductive and sexual health, family size and the use of FP methods by women.[6-8] As a result, stakeholders in the field of FP have concluded that neglecting men in FP has grave implications for not only the men but for their wives and children.[8]

It has been shown that MI improves couples' knowledge and husband-wife communication about FP.[9] Studies done in Asia and Africa found that women perceive men's participation in FP as a support for them to use contraceptive methods that are highly efficient,[9-11] while partner opposition was found to cause an increase in unmet need and a shift in contraceptive mix favouring the use of traditional methods over the modern methods.[10] The barriers to MI in FP mentioned by the men in a study done in Southwest Nigeria were the perception that FP is a woman's activity, non-customary nature of male participation in FP, long waiting times at FP clinic, FP not male-friendly, the attitude of health workers and finance.[6] In a study done in Abakpa Nike, Enugu, South-eastern Nigeria, 66.7% of the respondents who were married men gave various suggestions on how men can become more involved in FP. About a quarter (25.5%) said by going to health centres and seeking expert advice, 7.8% said by raising awareness, 10% said via education, seminars, symposiums and workshops. Some of the respondents suggested that men could be involved through churches, community leaders, and men's societies, using a condom and reading about FP.[12]

This study is qualitative in nature as most of the existing studies are purely quantitative in approach.[4,7,8] There are limitations associated with such quantitative studies regarding understanding perception on FP and dynamics related to FP decision-making between husband and wife. This study will serve as a baseline survey, as there is no available published

study on this topic in Sokoto State to gain more insight that will help design and conduct future quantitative studies and advocacy visits that will address MI in FP. This study was carried out to explore married men's knowledge and perception of FP, their involvement in FP, barriers and facilitators of MI in FP in Sokoto Metropolis.

METHODOLOGY

Family planning services are provided by both the public and private facilities is Sokoto State and there are a total of 746 facilities providing family planning services in Sokoto State.[1] However, the sophistication of the service provided depends on the hierarchy of the facility. The frequency of running the FP clinics per week in the health facilities that provide the services vary; some run once a week. Aside the fact that Sokoto State has one of the lowest CPR in the country,[2] a community-based survey done among women in the State revealed that only 8.7% of the respondents made decision on FP together with their husbands.[13] The study was qualitative in design and was carried out in Sokoto metropolis in November 2017 among married men whose wives were within the reproductive age group. Men who were married for less than one year in the selected study area during the period of the study were excluded.

Two Local Government Areas (LGAs) out of the four LGAs in the metropolis were purposively selected (Sokoto South and Wamakko LGAs). Two wards from each LGA were purposively selected. One settlement from each ward was purposively selected. Thirty-two men were purposively selected to participate in the Focus Group Discussion (FGDs) from the selected settlements based on individuals' willingness to participate and give their views and were done with the aid of heads of the chosen settlements and their assistants. FGD participants were grouped based on age and educational status to remove any age-group limitation and allow free interaction. The groups were structured as follows: men 35 years old or less with formal education, men 35 years old or less with no formal education, men more than 35 years old with formal education and men more than 35 years old with no formal education.

Data was collected through FGD. Each group consisted of eight participants on the average, and four sessions were conducted in the four settlements selected within two weeks. An FGD guide was developed based on the study objectives

after extensive literature review.[3, 6, 14-16] There were ten major open-ended questions with probe questions to help elicit responses from the participants. The FGD guide was prepared in English, translated to Hausa, and back-translated to English by two scholars to ensure consistency of the translation. Two research assistants who were senior resident doctors in the Department of Community Medicine of Usmanu Danfodiyo University Teaching Hospital Sokoto and had participated in qualitative researches in the past were recruited. The FGD guide was pretested by the principal researcher and the trained research assistants in Sokoto North LGA (which was not one of the LGAs selected for the study) to check the feasibility of using the instrument. Adjustments were made based on the observations that were noted.

The principal researcher served as the moderator, and two research assistants served as the note-taker, and the other served as the timekeeper, conducted the FGD. The moderator led and guided the discussion using the FGD guide. At the same time, the note taker documented the major points made by participants, including the salient points and non-verbal cues that will add value to the information given by the participants. The sessions were audio-recorded to enable proper and complete documentation of each participants' contribution after obtaining permission from the participants before audio-recording of the sessions. The FGDs were conducted in places chosen by the participants in their environment that were convenient and provided privacy and confidentiality. Each of the discussions lasted for about 30-40 minutes and were conducted in the Hausa language. One FGD was done in a day, and if any observation was noted with regards to the ordering and framing of the questions, adjustment was made on the discussion guide before conducting another session.

The audio-recordings during the FGDs were transcribed into Hausa language, both the transcribed audios and the notes taken were translated into English immediately after a session, and content analysis was done along thematic lines. The findings were reported in narrative form. Ethical clearance (SKHREC/ 025/017) for the study was obtained from the Ethical Review Committee of the Sokoto State Ministry of Health. Permission was obtained from the LGAs authorities and the traditional ruler of each

settlement while verbal consent was obtained from the participants.

RESULTS

Socio-demographic characteristics of the respondents

Thirty-two married men took part in the FGDs, and their ages ranged from 26-66 years. Nine and seven of the participants aged >35 years had formal and informal education, respectively, while ten and six of the participants aged at most 35 years had formal and informal education, respectively. The major themes that emerged from the FGD were knowledge of FP, perception about FP, MI in FP, barriers and facilitators of MI in FP.

Knowledge of family planning

All the participants had heard about FP, and the local names they referred to it were "*tazarar haihuwa*" (birth spacing), "*hutun haihuwa*" (rest after birth) and "*maganin rurrutsa*" (medicine for poorly spaced birth).

"We call it tazarar haihuwa or hutun haihuwa." (47 years old participant, No formal education - FGD 3).

Participants all had similar views regarding the knowledge of the benefits of FP, with most of them saying it is beneficial to the mother, the child and the entire community. Some participants said:

"The benefits of FP are that first, a mother will get rest in her body, and then the child will have full health and enough breastmilk, thirdly the husband will have financial rest in terms of looking after the mother and the child." (37 years old participant, Formal education - FGD 1).

"FP adds to health not only to the family but to whole community for example if children have PEM, they get sick all the time, once the children are unhealthy, it is like the whole community is affected." (31 years old participant, Formal education - FGD 2).

The mention of irregular bleeding as a side effect of FP was recurrent in all the FGDs. Getting pregnant while still using a FP method and poor wound healing at the site of insertion of implants were also mentioned. Some of their responses were:

"My wife had irregular menstruation, and after she took drugs, she became okay. I even tell people whose wives have such side effects of visiting the hospital." (40 years old participant, Formal education - FGD 1).

"I have seen a woman who was injected and the injection did not expire but she got pregnant."

(39 years old participant, Formal education - FGD 1).

"There could be a wound which doesn't heal at the site of putting an Implanon." (27 years old participant, Formal education - FGD 2).

A few of the participants expressed the view that they were not aware of any side effects of FP.

"My wives have never told me of any side effects and they use injectables." (45 years old participant, No formal education - FGD 3).

Perception on family planning

The responses of the participants in the four groups on their opinion of FP being an issue for only the women varied, with most saying it is an issue for both men and women. A few said it is an issue for the women alone.

"It's an issue for both a man and a woman because if a man enters the issue, it is better. I know of a man who pays money so that his wife has her injectable contraceptive." (53 years old participant, No formal education - FGD 3).

"FP is only a woman's issue as she knows the pains and problems of pregnancy, she should be the one to talk to you about FP, your part as a man is just to have compassion for her, and some men do not even care." (47 years old participant, Formal education - FGD 1).

Their responses were almost evenly distributed with regards to who they think should decide whether to use the FP method. Some said it should be a joint decision, while some said the man should make the decision, yet some said it is the woman who should make the decision.

"It is the man that should take the decision because any problem that arises during childbirth will be taken care of by the man." (55 years old participant, No formal education - FGD 3).

"I don't agree that's it only the man that should decide because he may want it and she may not, or she may want it and he may not, that can lead to divorce. So, they should sit and talk about it." (37 years old participant, Formal education - FGD 1).

"The woman should be the one to decide because she is the one that takes care of the children and borne all the hardships. The husband goes out in the morning and comes back at night when the children are asleep." (46 years old participant, No formal education - FGD 3).

Participants had diverse opinions on willingness to use any FP method but an

overwhelming number were against vasectomy.

"Laughs! How will I agree for them to sterilise me? Nobody will sterilise me. I will not accept this one (vasectomy) but condom and withdrawal are OK. I will not accept sterilisation between me and God." (48 years old participant, No formal education - FGD 3).

"I would use condom because I think it is easy. Gaskiya (truth be told) in life, no one would allow himself to be sterilised because no one will want pain to be inflicted and secondly, you will become like a woman." (35 years old participant, No formal education - FGD 4).

However, one participant said he can use all the types of FP methods available to men.

"*Me, I can do any type of FP.*" (40 years old participant, Formal education - FGD 1).

Participants also had diverse opinions on willingness to allow their wives to use any FP method but an overwhelming number were against female sterilisation.

"*Eh! Two have a problem, female sterilisation and injections. Injections can make a woman bleed for three weeks. I am okay with implanon."* (36 years old participant, Formal education - FGD 1).

"I will allow my wife to use Implanon, but pills and IUCD release heat that can destroy the womb. As for implanon, it can be removed easily, and injectables go out of the body easily too." (36 years old participant, No formal education - FGD 3).

"I cannot stop my wife from giving birth so I would not let my wife's womb be tied. I can space births but I would not stop child birth because I do not know what God will bring later." (45 years old participant, No formal education - FGD 3).

One participant said he would let his wife do whatever method she so desires.

*"In my view, whatever my wife wants, even if it's to tie the womb, I will let her so that I will not infringe on her rights." (*30 years old participant, Formal Education - FGD 2).

Male involvement in family planning

All the participants in the four FGDs said they support the use of FP methods and some of them said they know a man in their community who does not support the use of FP methods. Some of these people who do not support the use of FP methods had formal education, whereas some don't, and their reason for not supporting FP was mainly religion. The traditional leaders, religious rulers, elder relatives and their parents were said to be in the best

position to talk to them regarding the acceptance of FP.

“They say that the Prophet said we should give birth so that he’ll be proud of us but the Prophet will not be proud of a wayward person and a villager.” (32 years old participant, Formal education - FGD 2).

All the participants said that men should be involved in FP and mentioned the activities that constitute their involvement as giving money to the wife for transport to the FP clinic, accompanying her to the FP clinic and discussing FP with the wife.

“Men should be involved in FP because that will make the thing to be smooth.” (60 years old participant, No formal education - FGD 3).

"I take my wife on a bike to FP clinic." (37 years old participant, No formal education - FGD 3).

Barriers to male involvement in family Planning

The barriers to MI in FP mentioned were ignorance, lack of knowledge and poverty. Some of the participants said:

“Lack of knowledge, ignorance and poverty makes men not to be involved in FP.” (50 years old participant, Formal education - FGD 1).

"It costs money even for transport to access it, and most people don't have it." (47 years old participant, Formal education - FGD 1).

“Men are not fully involved in FP because women are the ones who give birth.” (28 years old participant, No formal education - FGD 4).

“Some men don’t know about it. Some men don’t even allow their wives to go to the hospital.” (66 years old participant, Formal education - FGD 1).

Facilitators of male involvement in family planning

Concerning factors that could make the males to be more involved in FP, increasing awareness on FP, religious leaders and traditional rulers championing the issue, home visits by health workers, making FP free (without collecting money for even consumables) and giving incentives to users of FP were mentioned.

“If people get exposed and attend meetings like this, they’ll be more aware of FP and get involved.” (40 years old participant, No formal education - FGD 3).

“There are ways men can be more involved. Traditional rulers and religious leaders can talk to men and make them more involved.” (48

years old participant, No formal education - FGD 3).

"*There should be more community participation, and more religious leaders should also participate, improved education for women and even transport the women to the health facility.*" (52 years old participant, Formal education - FGD 1).

"Give financial incentives." (60 years old participant, No formal education - FGD 3).

DISCUSSION

This study explored the married men's knowledge and perception of FP, involvement in FP, barriers and facilitators of male involvement in FP in Sokoto Metropolis. In this study, it was not surprising to find out that all the participants were aware of FP as FP is a popular health topic of discourse on mass media, especially the radio. Although awareness does not translate to the utilisation of FP methods, it is the first step along the pathway. A survey done in Sokoto revealed that 96.8% of married men in both the urban and rural areas were aware of FP.[17] Birth limiting was not mentioned as a benefit of FP, and this did not come as a surprise as people in North-western Nigeria buy into the idea of birth spacing more than birth limiting and the dislike of both male and female sterilisation methods by almost all the participants further buttressed this point. This has grave implications as people will continue to give birth to the number of children that they cannot adequately cater for whom may end up on the streets and may be lured into banditry, kidnapping and other vices thus increasing the security challenges. Prevention of sexually transmitted infections was also not mentioned as a benefit of FP, thus highlighting the need to increase information on the benefits of FP.

Side effects of FP methods serve as deterrents to the utilisation of FP methods although sometimes their gravity is exaggerated by people especially when trying to discourage others from utilising them. It is note-worthy that some of the participants considered contraceptive failure as a side effect of FP which sometimes might be due to improper usage of the contraceptive methods like not taking the injectables as at when due or delay in taking them by a few days or weeks. This calls for adequate counselling of clients by the health workers providing FP services so as to reduce the failure rate to the barest minimum. Insertion site wound was also noted as a side effect of FP

which may arise as a result of poor infection prevention practices during the insertion procedure thus highlighting the need for training and re-training of health workers providing FP services on these aspects so as to decrease the incidence of the occurrence of insertion site wound. It was heartening when a participant remarked that the irregular bleeding could be treated in the hospital and he even suggest that to other people.

Taking a decision jointly by the husband and wife on the adoption of FP methods enhances the utilisation and continuation of FP method use. Although most of the participants in this survey thought that FP is an issue for both men and women, a much smaller number had the opinion that the decision on the usage of FP methods should be made jointly by the couple. This implies that most of the participants have the opinion that FP decision should be made by either the husband or the wife alone thus highlighting the need for increasing the awareness on the importance of optimum participation of both the husbands and wives in FP decision making.

The preference of temporary methods over the permanent methods was not surprising because as mentioned earlier, birth limitation was not listed as a benefit of FP by any of the participants. This may be due to the fact that men have a higher desire for large family size compared to women.[2, 17] The public health implication is that people will continue to give birth to more children than they can adequately cater thus resulting in overpopulation, poverty and insecurity.

In this survey, all the participants said that they support FP and that men should be involved in FP. This is not in synchrony with the fact that Sokoto State has the lowest CPR in the country,[2] although what people say may not actually be what they practice. Lack of knowledge on FP and poverty were identified as the barriers of men's participation in FP and, increasing awareness on FP, religious leaders and traditional rulers championing the issue were some of the facilitators mentioned by the participants in this study. The importance of the religious leaders and traditional rulers can assume in championing the issue of FP cannot be over-emphasized due to the roles they play in their communities. It is expected that making them champions of FP could increase the acceptance and utilisation of FP methods just like the acceptance of

polio vaccine especially in Northern Nigeria was enhanced by them.

Limitations of the study: The study was qualitative; hence it cannot be generalised to the population. There may be deliberate withholding of information by some participants because they are in a group. An attempt was made to reduce this bias by segregating the groups along with age and educational level.

Conclusion: The participants said that FP is beneficial to everyone in the community and men should be involved in FP. The barriers to MI in FP mentioned were lack of knowledge on FP and poverty, while the facilitators proffered include increasing awareness on FP, religious leaders and traditional rulers championing the issue, and making FP free. There is a need by the Sokoto State Government and the various non-governmental organisations to increase the information on FP and the need for males to be involved through public enlightenment programmes using various media outlets. Also, the traditional and religious leaders should be made the champions of FP in their various communities.

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