

ORIGINAL ARTICLE**Effect of Male Partner's Support on Spousal Modern Contraception in a Low Resource Setting****Olayinka Balogun¹, Abiodun Adeniran¹, Adegboyega Fawole¹, Kikelomo Adesina¹, Abiodun Aboyeji¹, Peace Adeniran²****ABSTRACT**

Background: As efforts continue to increase contraceptive uptake, male partner support remains important in spousal modern contraceptive use.

METHODS: A prospective cross-sectional survey involving women on modern contraception was conducted at the family planning clinic of the University of Ilorin Teaching Hospital, Nigeria, between December 2013 and April 2014. All consenting participants completed a self-administered questionnaire designed for the study, and statistical analysis was done with SPSS version 20.0 using with chi square test and logistic regression; p value <0.05 was significant.

RESULTS: There were 305 participants: 208(68.2%) were multipara, the commonest current and previous contraceptives used were IUD and injectables while male partner was responsible for discontinuation in 30(23.3%) of previous users. Covert contraceptive use was 22(7.2%), male partner support was 209(68.5%) as payment for the contraceptives (203; 66.6%) or transportation to the clinic (198; 64.9%). Also, 55(18.0%) women failed to comply with contraception recently due to male partner hindrance (25;45.5%) or inability to pay for contraceptive (11;20%) or transportation to the clinic (8;14.5%). Male partners hindered contraception by reporting the woman to relatives/friends (8;32%) or denying her money for feeding allowance (6;24%); 277(90.8%) women want contraception to be couple decision while 261(85.6%) want contraception administered only if both partners consented. The significant predictors of male partner support were awareness about the contraceptive use ($p<0.001$,OR0.114; CI0.041-0.319), level of education ($p0.007$,OR1.488;CI1.114-1.9870) and social class ($p0.029$,OR0.690;CI0.495-0.963).

CONCLUSION: Male partner hindrances and costs of contraceptive or transportation to clinic are important in noncompliance. Male partner education, subsidized/free contraceptives and mobile/community services will improve compliance.

KEYWORDS: Female contraception; Male partner support; Spousal contraception

DOI: <http://dx.doi.org/10.4314/ejhs.v26i5.5>

INTRODUCTION

Rapid population growth is a critical issue worldwide especially in developing countries; many reproductive age women in sub-Saharan Africa do not use contraception for reasons including lack of male partner support (1,2). Men's support or opposition to women's contraception have a strong influence on contraception uptake especially in developing

countries (3,4). In Nigeria, contraception uptake was 15.1% with 9.8% for modern methods, fertility rate 5.5 per woman and no change in uptake between 20008 and 2013(5). Efforts on contraception activities had traditionally focused on females only contraceptive efforts or those without active male partner involvement have not resulted in the desired contraception change to

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produce national fertility decline (6). Marriages in Africa are characterized by males' determining family size and contraception without respect for the woman's opinion. Involving men in family planning should not be limited to increased use of male methods but increased support, approval and greater community influence in male-centered policy and programs on contraception (7).

Women who believe that their male partners support contraception are twice likely to use contraception effectively (8). Female partners of men with awareness of female contraception were three times likely to desire it and five times more likely to express the intent to use with partner's support (9).

MATERIAL AND METHODS

The study was a cross-sectional survey conducted at the family planning clinic of the University of Ilorin Teaching Hospital, Nigeria. It is a gynaecologist-supervised clinic which offers contraceptive services to females of all ages, parity and educational status. Clients (with or without referral) as well as couples had the opportunity for counseling on fertility regulation and uptake of appropriate methods. Available contraceptive methods include hormones (oral and parenteral), implants, intrauterine devices (IUDs), barrier methods and both male and female surgical contraception. Clients are seen for follow-up as necessary to counsel, reinforce continuation, monitor and treat side effects.

The study was conducted between December 2013 and April 2014. The inclusion criteria were women on contraception and in a relationship with a male partner. Women who were unwilling to participate in the study or not on contraception were excluded from the study. Male partner was defined as a male with whom the woman (participant) was having consensual stable relationship irrespective of whether there has been a legal marriage or not. Support includes tangible

acts that demonstrate involvement or other forms of responsibility of the male partner towards the procurement, use and ensuring availability of the woman for follow-up or other demands relating to the contraception.

The sample size was calculated using the previously described formula (10) and was based on the prevalence of modern family planning use among Nigerian women of 12% (4), a confidence level of 95%, a degree of accuracy of 0.05 and an estimated attrition rate of 10% giving a minimum sample size of 178. The sampling method was purposive in which all consenting consecutive eligible clients were recruited. The information collected included demographic parameters, male partner's awareness that woman was using contraceptive, his attitude towards it and the effect of this support on compliance with contraception. Confidentiality was maintained by using codes instead of names and keeping the data away from non-members of the research team.

Statistical analysis was done with SPSS version 20.0, the results were expressed in tables with percentages. The Pearson's chi square was used for comparison with calculation of odds ratio at 95% confidence interval, logistic regression and p value <0.05 was termed significant.

Ethical approval was obtained from the ethical review committee of the University of Ilorin Teaching Hospital (UITH) before the commencement of the study. The study was sponsored by the researchers, and there was no conflict of interest in the conduct of the study.

RESULTS

There were 305 participants in the study; the women were younger than their male partners (mean ages of 37.12 ± 7.38 vs. 43.35 ± 8.57). Also, 208 (68.2%) were multipara, 86 (28.2%) grandmultipara; last childbirth was less than 6 months in 14 (4.6%) and more than 48 months in 115 (37.7%) (Table 1).

Table 1: Socio-demographic variables of participants

Variable	Frequency (n=305)	Percentage
Age		
Mean age	37.12 ± 7.38	
Range	20-59	
Level of formal education		
None	30	9.8
Primary	58	19.0
Secondary	84	27.5
Tertiary	133	43.6
Religion		
Christianity	178	58.4
Islam	125	41.0
Others	1	0.3
Parity		
1	11	3.6
2-4	208	68.2
≥5	86	28.2
Last childbirth (months)		
< 6	14	4.6
6-12	60	19.7
13-24	44	14.4
25-36	38	12.5
37-48	34	11.1
>48	115	37.7
Type of family		
Monogamy	264	86.6
Polygamy	41	13.4
Male partner's age		
Mean age	43.35 ± 8.57	
Range	22-72	
Social class		
Low	41	13.4
High	264	86.6

In Table 2, the two commonest currently in-use contraceptive methods were IUD (137; 44.9%) and injectables (116; 38.0%). The commonest reason for contraception was child spacing (138; 45.2%) while 129(42.3%) have used contraception previously. The two commonest previously used methods were IUD (54; 34.9%) and injectables

(37; 28.7%). Previous methods were discontinued due to desire for pregnancy [37(28.7%)] and male partner hindrances [30(23.3%)]. In all, 50(16.4%) of participants were experiencing complications from current method and 14(28.0%) were contemplating discontinuation.

Table 2: Previous and current contraceptive use by participating women.

Variable	Frequency (N=305)	Percentage
Present contraceptive method		
Barrier	6	2.0
Oral pills	18	5.9
Implant	27	8.9
Injectable	116	38.0
IUD	137	44.9
Others	1	0.3
Reason for contraception		
Delay pregnancy	32	10.5
Child spacing	138	45.2
Completed family size	135	44.3
Previous contraceptive use		
Yes	129	42.3
No	176	57.7
Previous method used (n=129)		
Implant	6	4.6
Barrier	8	6.2
Oral pills	33	25.6
Injectable	37	28.7
IUD	45	34.9
Reason for discontinuation (n=129)		
Influence of friends	15	11.6
Male partner influence	30	23.3
Complication	35	27.1
Desired pregnancy	37	28.7
Others	12	9.3
Duration of present use (years)		
1-2	118	38.7
>2	187	61.3
Complications on present method		
Yes	50	16.4
No	255	83.6
Severity of complication (n=50)		
Not severe to disturb normal activity	25	50.0
Severe to disturb normal activity	6	12.0
Not severe to contemplate stopping	5	10.0
Severe, contemplating stopping	14	28.0

In Table 3, the male partners were unaware of the woman's contraceptive use in 22(7.2%) because the men disagreed about contraception (11; 50%) or desired more children (11; 50%). There was male partner support in 209(68.5%); it was in the form of payment for the contraception (203; 66.6%) or payment for transportation to clinic (198; 64.9%). Also, 55(18.0%) women had failed

to use contraception in the preceding three months, and the male partner was responsible in 25(45.5%); 11(20%) had no money to pay for contraception and 8(14.5%) had no money for transportation. The methods used by male partner to prevent woman's use of contraception included reporting her to relatives/friends (8; 32%) or denial of money for house-keep (6; 24%).

Table 3: Male partner awareness, support and attitude to contraception.

Variable	Frequency	Percentage
Partner aware of contraceptive use (n=305)		
Yes	283	92.8
No	22	7.2
Reason for lack of awareness (n=22)		
Want more children	11	50.0
Discussed before, husband disagreed	11	50.0
Husband support for contraception use (n=305)		
Yes	209	68.5
No	96	31.5
Husband ever paid for contraception		
Yes	203	66.6
No	102	33.4
If not, why? (n=102)		
Not aware am on contraception	22	21.6
Does not have money	9	8.8
Does not support that I'm using it	59	57.8
Others	12	11.8
Male partner ever paid for transportation		
Yes	198	64.9
No	107	34.1
If husband paid for transport, how often (n=198)		
All the time	113	57.1
Very rarely	12	6.1
Whenever he likes	25	12.6
Often	48	24.2
Failed to use your contraception in last 3months		
Yes	55	18.0
No	250	82.0
Reason for non-use (n=55)		
Stock-out at the clinic	3	5.5
I forgot	8	14.5
No money for transportation to the clinic	8	14.5
No money to pay for contraception	11	20.0
My partner prevented me from using it	25	45.5
Mode of prevention used by male partner (n=25)		
Physical beating	1	4.0
Requested for more children	1	4.0
Was not caring to me	1	4.0
Hid my clinic appointment card	4	16.0
Told me to stop contraceptive	4	16.0
Denied me money for house-keeping	6	24.0
Reported me to relatives/ friends	8	32.0

From Table 4, 207(67.8%) women rate male partner's knowledge of contraception as satisfactory while 277(90.8%) want couple to jointly decide contraception choices. Only 44(14.4%) women want before administration.

The significant predictors of male partner support for contraception were the contraception for child spacing or having completed family size and male partner's payment for the contraception (Table 5).

Table 4: Opinion of participants on contraception.

Variable	Frequency (N=305)	Percentage
Level of male partner's knowledge of contraception		
Very low	50	16.4
Low	48	15.7
Average	73	23.9
Above average	44	14.4
Very high	90	29.5
Who should take decision about contraception?		
Male partner alone	7	2.3
Woman alone	21	6.9
Couple	277	90.8
When should contraception be offered?		
Only if both partners agree	261	85.6
Woman alone agrees	44	14.4
Will education improve male participation in contraception?		
Yes	249	81.6
No	56	18.4
What education should be given to men		
Contraception doesn't mean extramarital affairs	4	1.3
Side effects of contraceptives	33	10.8
Male contraception	38	12.5
Danger of too many children	43	14.1
Family planning methods an safety	46	15.1
Benefits of family planning	141	46.2

From Table 6, on logistic regression, the significant predictors of male partner support were male partner awareness of the woman's use of contraception ($p < 0.001$, OR 0.114, CI 0.041-0.319), level of the man's education ($p = 0.007$, OR 1.488; CI 1.114-1.987), and social class ($p = 0.029$, OR 0.690; CI 0.495-0.963). The man's age, religion and number of wives was not significant.

DISCUSSION

In this study, the majority of contraceptive users were multipara using contraception mainly for child spacing and those who have completed family size. The commonest previous and current contraceptives were IUD and injectables. The male partner was responsible for previous discontinuation in 23.3% while current covert

contraception rate was 7.2%. The male partner supported contraception in 68.5% mainly by paying for the contraceptive or transportation to the clinic. The reasons for recent inability to comply with contraception included male partner hindrances and inability to pay for the contraceptive or transportation to the clinic. Methods used by male partner included reporting the woman to her relatives and friends as well as denying her money for feeding allowance. Most women opined that couples should agree on contraception and 14.4% want it administered on woman's desire only. Predictors of male partner support were male partner awareness about contraceptive use, his level of education and his social class.

Table 5: Effect of male partner support on female contraception.

Variable	Male partner support		χ^2	p value
	Yes	No		
Couple social class				
Low	37 (17.7)	4 (4.2)	26.561	0.002*
High	172 (82.3)	92 (95.8)	24.242	0.007*
Type of family				
Monogamy	182 (87.1)	82 (85.4)	37.879	<0.001*
Polygamy	27 (12.9)	14 (14.6)	4.122	0.042*
Reason for contraception				
Delay pregnancy	18 (8.6)	14 (14.6)	0.500	0.479
Child spacing	91 (43.5)	47 (49.0)	14.029	<0.001*
Completed family size	100 (47.8)	35 (36.5)	31.296	<0.001*
Complication on present FP				
Yes	33 (15.8)	17 (17.7)	5.120	0.023*
No	176 (84.2)	79 (82.3)	36.898	<0.001*
Failed to take FP on occasions				
Yes	34 (16.3)	10 (10.4)	13.091	<0.001*
No	175 (83.7)	86 (89.6)	30.349	0.001*
Partner prevented you from taking FP				
Yes	14 (6.7)	11 (11.5)	0.360	0.548
No	195 (93.3)	85 (88.5)	43.214	<0.001*
Partner paid for contraception				
Yes	186 (89.0)	71 (74.0)	51.459	<0.001*
No	23 (11.0)	25 (26.0)	0.083	0.773
Wife rating of partner knowledge				
Very low	27 (12.9)	23 (24.0)	0.320	0.571
Low	28 (13.4)	20 (20.8)	1.333	0.248
Average	53 (25.4)	20 (20.8)	14.918	<0.001*
Above average	27 (12.9)	17 (17.7)	2.273	0.131
High	74 (35.4)	16 (16.7)	37.378	<0.001*

χ^2 : Chi square, *: statistically significant i.e (p value <0.05)

Table 6: Logistic regression showing predictors of partner support for contraceptive use

Variable	B	p value	OR	95% CI	
				Lower	Upper
Age	-0.028	0.057	0.972	0.944	1.001
Religion	0.534	0.306	1.705	1.036	1.808
Number of wives	0.176	0.526	1.193	0.692	2.052
Type of family	-0.141	0.692	0.869	0.433	1.743
Male awareness	-2.172	<0.001*	0.114	0.041	0.319
Level of education	0.397	0.007*	1.488	1.114	1.987
Social class	-0.370	0.029*	0.690	0.495	0.963

B: Coefficient of Logistic regression; OR: Odds ratio; CI: Confidence Interval; *: statistically significant p value (i.e. < 0.05)

The least number of contraceptive users in this study were less than six months postpartum. This may be related to the common prolonged lactation from exclusive breastfeeding in low resource countries with its attendant contraceptive benefit for the first six months post-partum (11). The desire for contraceptive decision to be made by the couple was similar to a report from Turkey where 66.7% men want contraception decision to be a joint one (12). This may be a reflection of the influence of the patriarchal culture where women are required to have the male partner accent in almost every decision. The high perceived partner support was a positive influence on the contraception uptake among participants (13). Generally, there are differences in desire for contraception among partners while a woman's real or perceived partner's opposition may discourage use even when she wants to stop childbearing (14). Sometimes, despite awareness and possible support for contraception, some men expect the woman to initiate the discussion or request for contraception (15). Although spousal communication regarding family planning has been associated with higher male partner approval of family planning (16), this may not be absolute as half of covert users in the study had partner disapproval during previous couple discussion on contraception. In countries with high fertility and unmet needs for contraception of which Nigeria is one, men are often reported as unsupportive of contraception because of regarding it as women's domain, extramarital relations, desire for large family and perceived side effects (6,17). This was reflected as half of covert contraception was because the male partners wanted more children.

Low contraceptive prevalence has been attributed to men's resistance (18) and unwillingness (19) with fear of spousal retaliation to disagreements on its use (20) thereby preventing uptake and continuation resulting in covert or non-use (21). Husband opposition to family planning is often a deterrent to the wife's use, and women whose partners disapprove are unlikely to use them (22). However, sufficiently motivated women use methods without partner's knowledge leading to covert use.

The covert contraception rate was similar with report from Zambia with a 6% to 20% rate among current users mainly from difficult spousal communication or husband disapproval (20).

Covert use signifies women's confidence in reproductive decision-making as they bear direct consequences of its non-use and dangers of too frequent births (13). Reports are indicating an increased use of contraceptive methods among women that can be used discreetly without the partner's knowledge (23). This largely protects the woman from assault and other methods used by men in preventing contraceptive use.

The male partner support was similar to reported couple agreement contraception rate of 29% to 92% from sub-Saharan Africa (24). The male partner support also encouraged longer duration of contraception as well as longer birth interval in this study similar to a study which reported that lack of male partner support is a factor in birth interval less than two years (25). Among female adolescent family planning clinic attendees in the US, partner awareness was 77.1%, 92.2% had the male partner's support and influence on decision for contraceptive use was male partner in 21.8% with highest likelihood of continuation related to mother and partner support (26). In patriarchal societies, there is male dominance and family headship, and decision-making is considered as a male role. This was reflected with most women's submission that contraception decision should be made by couples and administration should be done only if both partner agrees. In a review of attitudes of males in sub-Saharan Africa, 29% women opined that men should decide when to adopt contraception while 9% wanted men to decide the method (27). Another report from Sudan showed that the decision not to use contraception is taken by men, and in couples on contraception, the man provides the method (28).

When men support contraception, women's compliance is often hampered by other factors like costs of contraceptives and transportation. Many men cannot afford the partner's often high travel costs to clinics nor accompany the partner (29) while competition with meeting basic family needs often shift in favour of these basic needs making less fund available for contraception (30). The role of the male partner in discontinuation of previous and current contraception use brings to the fore reasons for discontinuation apart from pregnancy related issues. A report from Uganda showed that 43% of the women discontinued

contraception for reasons other than pregnancy including male partner's resistance (25).

In conclusion, although male partner support is central to compliance for women on modern contraceptives, adequate attention must be given to other factors like costs of contraception and transportation to the clinic. Therefore, subsidized/free contraceptives should be a priority in low resource settings while mobile/community contraceptive services will be of great assistance. Furthermore, community sensitization and education will encourage positive peer influence making relatives and friends to offer support to women on contraceptives.

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