Vol. 3 No. 4 (2024)

Pakistan Journal of Medical & Cardiological Review

https://pakjmcr.com/index.php/1/about

Online ISSN 3007-2387

Print ISSN 3007-2379

Male Involvement in Family Planning and Associated Factors among Women Attending PUMHS Tertiary Care Centre

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Keywords:
High-Risk Pregnancy; Maternal and Fetal Outcomes; Medical Record Completeness; Obstetric Documentation; Placenta Accreta Spectrum; Quality Improvement

Received on 01 Dec 2024

Accepted on 17 Dec 2024

Published on 25 Dec 2024

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Abstract

Background: Male involvement is a crucial but little-known factor of family-planning adoption in patriarchal cultures. Poor interaction between males tends to limit the reproductive freedom and the use of contraceptives by women. **Objective:** The aim to measure the degree of male interest and determine aspects influencing the involvement of men in the contraceptives decision-making process of married women at the Obstetrics and Gynaecology Department, Peoples University of Medical and Health Sciences (PUMHS), Nawabshah. **Methodology:** A cross-sectional study, which passed through six months, was carried out among 110 married women of reproductive age (18 40 years). Primary data were gathered using structured interviews based on sociodemographic characteristics,

knowledge, communication, and decision patterns. The descriptive frequencies and chi-square were used in the statistical analysis to investigate relationships between male participation and contraception decision-making. **Results:** The average age of the participants was 29.7 /5.8 years; 83 percent indicated that they had a husband in family-planning discussions. It was observed that in 47 percent joint decision was made, 39 percent was husband-led, and 14 percent was woman-led. Sharing of decisions was significantly associated with the involvement of males (2 = 11.9; p = 0.003). Eighty-five percent of the spouses were reported to communicate about contraception and had a strong association between male engagement and the use of contraceptives (p < 0.001). There was also a correlation between joint decision-making and higher female education. **Conclusion:** The involvement of males makes a significant contribution to the fair use of contraceptives. Incorporation of men in counseling, outreach and education programs is necessary to enhance reproductive autonomy and enhance the family-planning results.

INTRODUCTION

When it comes to reproductive health, family planning (FP) is a pillar and defines the survival of the maternal and child health. It frees couples to make free and responsible decisions on the number and spacing of their children hence enhancing maternal health and socioeconomic stability[1]. FP also helps in preventing unwanted pregnancies, unsafe abortions, and maternal deaths in the world at large[2]. However, the policy focus over the decades has not resulted in higher contraceptive prevalence or a decreased unmet need: the latest available population data shows that only 34 percent of married women use modern contraception and 17 percent of the unmet need, as found in the Pakistan Demographic and Health Survey of 2017-18 [3].

Traditionally, FP programs in Pakistan have primarily targeted women, whereas they fail to consider the decisive role of men in a patriarchal family setting 4. There is some evidence to indicate that the approval, discussion and support of the husband are some of the best predictors of using contraceptives [5,6]. In a situation where men are misinformed about contraception, whether they think contraception makes them infertile or is against their religious beliefs, women tend to be pressured to stop or refuse FP services [7]. Inadequate couple communication and gender power disparity are thus covert obstacles, even in cases where the level of awareness and access to services is sufficient[8].

Evidence on low- and middle-income countries demonstrates that the involvement of men in FP counseling leads to better birth control uptake, maintenance, and satisfaction[9]. Ethiopian, Nigeria, and Tanzanian studies have established that joint

decision-making is a major contributor to the rise in contemporary contraceptive use and a decrease in the unmet need [10-12]. On the other hand, male-only initiatives tend to meet with passive or underground resistance or opposition in other words [13]. Male-positive FP strategies are now promoted in the World Health Organization and UNFPA, which focus on collective responsibility and couple-based interventions[11]

The sociocultural setting in Pakistan necessitates male participation and makes it difficult. What is considered traditionally to be associated with masculinity is fertility and many societies consider FP to be the concern of a woman [14]. A 2024 study in Karachi, has pointed out that disapproval of husbands was the major driving force of non-use of contraceptives even in instances where women possessed knowledge of contraceptives [16]. In another study, in rural Punjab, it was noted that the educational status of men and their proper knowledge of FP had strong tie with those of their wives using contraceptives [17]. The presence of this evidence supports the claim that without equal enlightenment and participation of men, enhancing the level of knowledge among women will solely not result in an increase in the rates of FP utilization.

Although its role in shaping real contraceptive decision-making in the Pakistani health-care setting is increasingly being appreciated, there is a shortage of data on the effect of male participation in it. The majority of local studies have been descriptive in nature and have been quantitative in measuring awareness and not the behavioral outcomes. Consequently, this paper provides a secondary analysis of already gathered data within the Department of Obstetrics and gynecology, Peoples University of medical and health sciences (PUMHS), Nawabshah in order to establish the relationship between the presence of male involvement and decision-making and contraceptive use among women.

This research will determine how male support, discussion or opposition predicts contraceptive use, therefore, it will provide evidence in designing culturally sensitive couple based interventions on FP. In an environment where reproductive decisions are dictated by common patriarchal structures, empowering the male is possibly the best avenue to achieving a just and sustainable reproductive health output.

METHODOLOGY

Study Design and Setting

The study was a descriptive cross-sectional one that was carried out at the Department of Obstetrics and Gynecology, Peoples University of Medical and Health Sciences for Women (PUMHS), Shaheed Benazirabad, Sindh, Pakistan. The research employed a secondary analysis of data which was initially collected in the period May 16, 2024 to November 15, 2024 in a study that investigated the attitude of males to family planning.

The current paper focuses on another research question of trying to establish the role of male involvement on the decision making and actual use of birth control methods by women. They were collected among 110 women visiting the antenatal outpatient and emergency of the tertiary-care hospital, which caters to a population of both urban and rural communities with low and middle-income households in central Sindh.

Inclusion Criteria

- Married women aged 15–40 years
- lived with their husbands and could explain what involvement of spouses in family-planning decisions.
- Able to give informed consent.

Exclusion Criteria

- Women that have cognitive problems or communication problems.
- Those individuals who are not willing to partake.

Participants were also recruited regardless of whether they were pregnant or not.

Data Collection Instrument

A structured and pre-tested questionnaire was used to collect data by conducting the questionnaire face-to-face using a trained female postgraduate trainee who spoke the local language (Sindhi or Urdu).

The instrument was composed of 4 sections:

1. Sociodemographic: age, education, place of residence (urban/rural), work, and socioeconomic status.
2. Reproductive history: number of living children, parity.
3. Family planning knowledge and practice: modern and traditional birth control methods awareness and use.
4. Male involvement measures: husband discussion on FP, permission or support on use of contraceptives, joint decision-making and attendance on FP counseling sessions.

Variable Definitions

- Male involvement was assessed using a composite measure of 3 items, namely spousal discussion, approval and joint decision-making. A score of 2 and above meant high involvement and below 2 meant low involvement.
- Contraceptive decision-making was either woman-led, joint or husband-led.
- Current contraceptive use Currently contraceptive use was the self-reported use of any FP method by the woman at the time of data collection.

Data Analysis

The SPSS version 26 was used to analyze data. They were used to summarize the socialiodemographic characteristics, the male involvement levels and the birth control

methods of the participants using descriptive statistics in the form of frequencies, percentages and means and standard deviation. The Chi-square test was used to test male involvement and contraceptive decision-making or use. Bivariate analysis variables with a p-value of less than 0.20 were inserted into a binary logistic regression model to establish independent predictors of contraceptive decision-making and use. The adjusted odds ratios (AORs) with 95% confidence intervals were used to show the level of strength of association, and a p-value of below 0.05 was set as a statistically significant value.

Ethical Considerations

The ethics of the original study were approved by the Institutional Review Board of PUMHS (No: PUMSHW/SBA/PVC/ER/2024/48). The data used in this secondary analysis was in anonymized form that was only used in academics. To ensure the required confidentiality all identifying information was removed before analysis. No personal contact with the participants was done at this stage.

RESULTS

Participant Characteristics

This study included 110 reproductive aged married women. The average age of the respondents was 29.7 5.8 years with a range of ages of 18 to 40 years. The modal age group was 2630 years (38% of the respondents) followed by the 3135 years (30%). In terms of education, 21 percent of women remained illiterate, 16 percent attended primary school, 14 percent attended middle school, 23 percent attended matriculation, 17 percent attended intermediate school and 9 percent attended graduates. Almost all the respondents were already married and residing with their husbands. The household demographic was represented in the majority of respondents (approximately 90 percent) who were not at work with their employers.

In general, 83 percent of husbands were said to be taking part in family-planning discussions and decisions. Of these, 61 per cent were reported to be proactively helpful, i. e., they promote the use of contraception, take their wives to counselling or talk about appropriate practices. Only 17 per cent of participants also claimed little or no involvement of the husband in family-planning issues The average male-involvement score established based on the participation in discussion, permission, and shared decision-making was 2.4 ± 0.8 (on a scale of 0 to 3 scale), suggesting a high involvement of the husband.

On the issue of contraceptive decision-making 47 percent of women were found to have joint decisions, 39 percent of decisions were husband-led, and 14 percent of decisions were independent. The mean age of women who made joint decisions was

30.2 5.5 years, which was a little higher than the age of women married to husbands (28.9 5.9 years), but this was not significantly different (p = 0.21).

Women who had secondary (matric or higher) education had higher chances of reporting joint decision-making (55 0) compared to women who had primary education or less (33 0). On the same note, the percentage of joint decision-making rose with the husband score on involvement. The respondents had universal (100%) knowledge on at least one modern contraceptive method. Oral pills (78 percent), injections (74 percent), and condoms (65 percent) were the most familiar, then intrauterine devices (47 percent). Approximately 85 percent of women had discussed family planning with their husbands in the previous year as well as the frequency of the discussion was highly correlated with the male participation (X^2 = 14.7; p < 0.001). Among couples who talked about family planning, 71 percent were using some type of contraception, and 32 percent who had no discussion on the matter had some type of contraception. There was a strong correlation between male participation and contraceptive decision making pattern (X^2 =11.9; p = 0.003).

In couples that had a very active husband, 58 percent of couples jointly decided, 29 percent were husband-led and 13 percent of the couples were woman-led. By contrast, in situations where men played a minor role, decisions of husbands prevailed (68 %). This trend is an indication that the more males are involved, the more decisions among couples are more balanced.

Table 2. Relation between Male Involvement and Contraceptive Decision-Making.

In the table, the distribution of decision-making patterns with the degree of male involvement is given. Chi-square test points out that it is significantly associated (p<0.01).

Male Involvement Level	Joint Decision	Husband-led Decision	Woman-led Decision	χ^2 (df, p-value)
High (n=91)	53 (58%)	26 (29%)	12 (13%)	
Low (n=19)	4 (21%)	13 (68%)	2 (11%)	11.9 (2, 0.003)

χ^2 test, df=2, p=0.003; statistically significant.

Table 3. Family Planning Knowledge and Communication Patterns

This table summarizes contraceptive knowledge, discussion with husbands, and their association with male involvement.

Variable	Frequency (%)	Association with male involvement (χ^2, p-value)
Discussed FP with husband	94 (85%)	14.7, p<0.001

$\chi^2=14.7$, $p<0.001$, showing strong association between discussion and male involvement

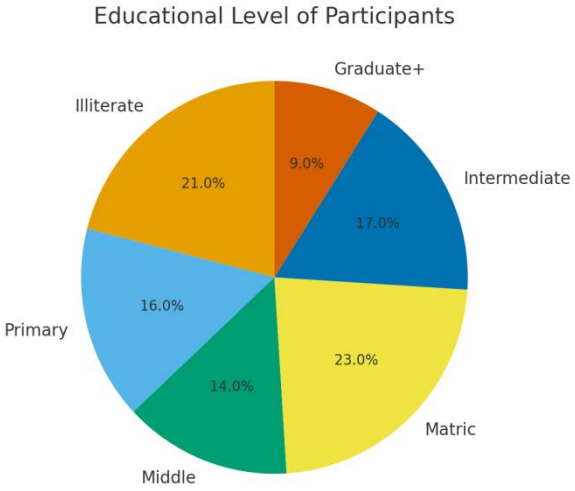

Figure 1. Educational level of participants. Most respondents had secondary-level education (Matric and Intermediate combined: 40%).

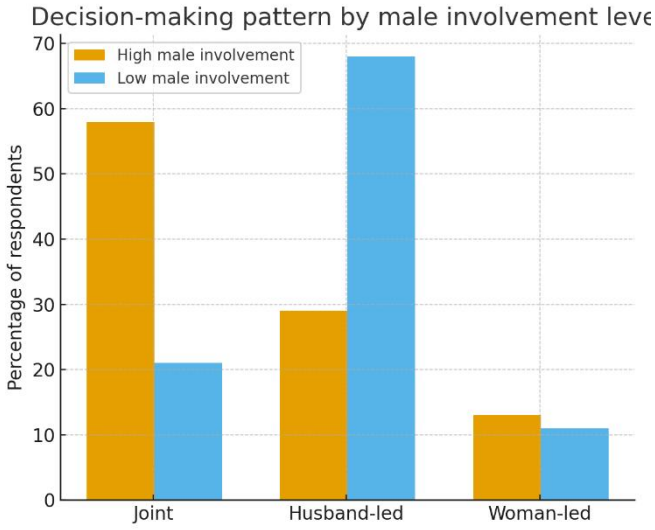

Figure 2. Contraceptive decision-making pattern by male involvement level. Joint decision-making predominates among couples with high male involvement (58%).

CONCLUSION

The results indicate that the male participation is still a decisive factor in the start of contraceptive behavior and shared decision-making among couples in this context. More educated women and those who reported spousal communication had a significantly increased probability of involvement in joint decisions on contraceptives.

The general level of awareness was high but still, to translate this into a fair decision-making process, the active participation of husbands is crucial.

DISCUSSION

The current research examined the level and the factors that influence male involvement on the family-planning decision amongst married women in a tertiary care hospital in Sindh. The percentage of husbands (83%) who were reported as involved in family-planning discussion was also high and male participation was very much associated with joint decision-making on contraceptives (X^2 = 11.9, p = 0.003). Spousal communication was also good (85%), and it positively related to contraceptive knowledge and uptake (p < 0.001). These results reveal the importance of men in reproductive-health decisions in patriarchal families.

The average age of the participants (29.7 5.8 years old) is similar to the other Pakistani and South-Asian cohorts in which the average contraceptive decision-making period falls between the late twenties to early thirties[18-20]. The young females (25 years and below) in this study had lower chances of reporting contraceptive use, which is in line with PDHS 2017-18 statistics that indicated low usage rates in young marriage because of early child bearing pressure[21].

Education was very strong, women who had attained at least secondary education (matric or higher) were more autonomous and more jointly determined (55%) compared to the women who had only primary or no education (33%). This trend has been replicated many times over in Pakistan[22], Ethiopia[23], and Iran[24], where literacy increases the bargaining ability and the ability to talk about fertility preferences.

The general male participation (83%) in this hospital sample was larger than the ones in community surveys in Punjab and Karachi (56% to 70%)[25,26]. This could be because of the urban semi-urban catchment of PUMHS, exposure to FP campaigns and health-facility exposure. The close correlation between the strong male involvement and joint decision-making is in line with the evidence provided in Nigeria[27], Ethiopia[28] and Bangladesh[29], where fatherly support significantly enhanced the adoption of contraceptives.

On the other hand, gender asymmetry was strengthened by the lack of husband involvement: 68% of women having low-involvement partners indicated that decisions were made by the husbands. Other male-dominated trends have also been reported in West Africa[30], which indicates culture-based requirements that men still have reproductive control.

The use of contraceptives was not only an awareness, but also universal (100%), but translation of knowledge into consistent use is not yet complete. It is also reported in

national surveys and qualitative research in South Asia[31,32] this knowledge-practice gap. In the present data, FP was discussed by 85 percent of the couples and discussion highly predicted joint decision-making and method use ($p < 0.001$). Hardee et al. have stressed that the continued use of contraception is caused not by information volume but by the quality of dialogue[33]. Likewise, Karachi-based study found that spousal communication increased the probability of contraceptive uptake by two folds34. Contraceptive prevalence was moderate in spite of high awareness and positive attitudes towards males. The reasons might be drugs side-effects anxieties, myths about infertility, religious reluctance, and they are already identified in PDHS 2017-18 and Khyber Pakhtunkhwa[21,35] by Khan et al. Moreover, although the presence of a male involvement was often mentioned, there was qualitative evidence that in most instances it is permission as opposed to partnership, meaning that the definition of involvement in the culture is different36.

Public-health implications: These results emphasize the need to have family-planning programs to incorporate men as active collaborators rather than supporting members. Engagement could be enhanced by means of couple-centered counseling, overcoming working hours (by having male health workers) and flexible clinic hours to serve working men[37]. The policy should encourage community-based education with religious and community leaders to dispel myths and make contraception a family-welfare responsibility[38].

Primary and operative measures: Behavior-change communication (BCC) on the social and economic advantages of planned families are necessary. This can be achieved by incorporating male-inclusive modules in the antenatal, postnatal, and immunization visits and make FP discussions around joint normal. Peer-educator models and FP sessions in the workplace have also been found to be effective in other, similar socio-cultural settings[40].

FUTURE RESEARCH

The longitudinal or mixed-methods designs must be used in future studies where the way the attitudes of men change with time and the ways couple dynamics affect the long-term use of contraceptives should be evaluated. Husbands should be included in interviews to give a fair opinion of decision processes. Generalizability will be improved by a broader community-based sampling, especially a rural and low-literacy population, which will inform context-specific interventions[41].

LIMITATIONS

Causal inference is not extensive as the study is a cross-sectional one. Self-reported answers are vulnerable to social-desirability bias, particularly in relation to reproductive

issues that are sensitive. The diversity in the community may not be reflected by the hospital-based setting. Nevertheless, the research contributes useful area data to associate male involvement in reproductive autonomy of women.

CONCLUSION

Male participation was now found to be a critical predictor of joint contraceptive choice. Key enabling factors were education, open communication between the spouses and the supportive attitudes of men. The gap between high awareness and moderate contraceptive use could be filled by strengthening the couple-based counseling and male-based outreach. The concept of involving men as partners and not gatekeepers is still vital in ensuring that equitable reproductive health is realized in Pakistan.

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