



## Research Article

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# Pattern of spousal support and communication among family planning clients in a tertiary care centre in north western Nigeria

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## Abstract

**Background:** Globally, there has been the recognition of the importance of male involvement in family planning and providers sees their support as an effective way of reducing barrier to accessing Family Planning services. **Aim:** Assess the pattern of spousal support and communication for family planning. **Methodology:** This was a mixed study design. A structured questionnaire was used to collect information from Family Planning client, attending Ahmadu Bello University Teaching Hospital's Reproductive Health clinic and Ahmadu Bello University Medical Centre. An in-dept. interview (with FP providers) and FGDs (with clients) were also conducted. **Result:** A total of 280 clients that were served with questionnaire across the two facilities within three months. Of the 280 respondents only 65% had tertiary level of education. Prior discussion of family planning with spouse was found in 82.5% of respondents and in 80.3% of the respondents said their spouses were aware of the chosen method. However, it was only in 39.5% of clients that, the chosen method was influenced by their spouses. Financial support by spouse was found in 69% of respondents. In 90% of respondents, there was the influence of the spouse on the intended duration of the chosen method. However, it was only in 33.5% of the respondents that the spouse influenced the discontinuation of previous method. **Conclusion:** Couple communication and spousal support were present in over two-third of family planning clients in Zaria, Northern Nigeria. Targeting men in behavioral change communication will improve the uptake of family planning services and improve the continuation of use of long-term contraceptives.

**Keywords:** Family Planning, Male support, spousal communication, clients, respondent.

## INTRODUCTION

Parents have a basic human right to determine freely and responsibly the number and spacing of their children [1]. In most cases parent believe that the number of children or the spacing is determine by chance. In a typical environment like ours the more the children one has, the more you are appreciated in the society. A man might not even know the number of children he has.

The shift in focus on men's reproductive health was influenced by the 1994 Cairo (ICPD) Action Plan to promote gender equality and equity, empower women, and improve family health in society. Changing and improving the way in which men are involved in reproductive health can only have a positive impact on women, men, and children health [2]. Spousal communication and male involvement in decision-making can also positively influence family-planning use and continuation [3,4]. However, few existing studies explore the dynamics of this communication and how they factored into family planning decision making [5].

Educating and counseling men about contraceptive choices is essential if they are to be supportive of women's reproductive health [6]. Men in the developing world (and particularly in sub-Saharan Africa) are often the primary decision-makers about family size and use of family planning [5, 6]. Couple discordance about fertility intention and contraceptive use can pose a major barrier to consistent contraceptive use that is difficult to measure [7, 8].

## MATERIALS AND METHODS

A mixed study design was used to assess spousal support in the use of family planning in two health facilities (tertiary and secondary) of Ahmad Bello University Zaria, Kaduna State, Nigeria -Ahmadu Bello University Teaching Hospital (ABUTH) and Ahmadu Bello University Medical Center from 1<sup>st</sup> of February to June 30<sup>th</sup> 2016. The two hospitals have high input of clients seeking reproductive health services. Married women with at least one child, attending the Family Planning clinic at the two study sites were recruited during the period of study. Both quantitative and qualitative (focus group discussion) methods were used for data collection. Using a structured questionnaire designed for the study, data was collected from clients at the point of exit (client exit interview). A written informed consent was obtained from all clients attending the reproductive health units, who satisfied the inclusion criteria and who agreed to participate

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in the study. They were duly counseled. The inclusion criteria were: reproductive age and being married. The data obtained included the patient demography, indications for seeking family planning services and motivation from spouse. Others were the outcome of the services-overall service satisfaction. Further data was obtained concurrently using qualitative tools. These include in-dept interview (IDI) and Focus Group Discussion (FGD). The IDIs involved two experienced providers from each of the two study sites and was centered on exploring their observations/assessment of the participation of men in FP services in their facilities. One FGD was conducted in each of the study sites among the exit clients (six in each group).

There were three major questions in the FGD guide that was used for the discussion and these questions focused on general knowledge, level of their spousal support and if possible, how can they improve the level of their spouse's involvement in issues regarding Family Planning and get his full support in future. The FGD was largely conducted in the local language (Hausa) and English. Data from the qualitative investigation were transcribed and analyzed manually. Ethical clearance for the study was obtained from the Ethical Committee of Ahmadu Bello University Teaching Hospital Zaria.

## RESULTS

Two hundred and eighty married women of reproductive age were interviewed. The socio-demographics of the respondents is depicted in Table 1. The mean age of the respondents was  $27.8 \pm 0.14$ . More than thirty five percent 35% (96) of the respondents have between 2 to 4 living children while 21% (59) had more than seven living children. Although the study was carried out in a Muslim dominated area 35% of respondent were Christians. Those who had tertiary level of education were 65% (128).

**Table 1:** Socio-demographic characteristics of Respondent.

Variable	frequency (No)	%	
<b>Age</b>	16-20	31	9.0
	21-25	73	30.0
	26-30	82	33.5
	31-35	52	19.5
	36-40	20	3.5
	>40	22	4.5
<b>No of living children</b>	1	42	15.0
	2-4 alive	98	35.0
	5 -7	81	28.0
	7and above alive	59	21.0
<b>Religion</b>	Muslim	180	64.5
	Christian	100	35.5
<b>Tribe</b>	Hausa.	116.	41.5
	Yoruba	50	17.8
	Ibo	41	14.6
	Others	54	19.2
	No response	19	6.7
<b>Level of education</b>	Tertiary	128	65.0
	Secondary	50	18.0
	Primary	25	9.0
	Informal	16	6.0
	No response	5	2.0.

Distribution of respondents by Level of spousal support/involvement for FP is shown in Table 2.

**Table 2:** Distribution of respondents by Level of spousal support/involvement for FP.

Variable	frequency (No)	%
Spousal initiation of discussion	48	17.0
Couple Prior discussion about FP	232	82.5
Approval for using FPC	198	70.7
Spousal awareness about coming for this service	220	78.6
Reminder/encouragement to go for this service	75	26.7
Financial assistance	193	69.0
Spousal awareness about chosen methods	230	80.3
Influence on chosen method	109	39.5
Spousal influence on intended duration	254	90.0
Influence discontinuity of previous method	94	33.5

Spousal awareness about chosen methods and spousal influence on intended duration occurred in more than 60% of the respondents. However only 17% of the respondents' spouse initiated the discussion. Among the method mix for FP, implant was most accepted with 52.8% (148) while Intra Uterine Device IUD was the least with only 10.4% (29)-Table 3.

**Table 3:** Choice of contraceptives methods among respondents

Variable	frequency (No)	%
Pills	38	13.6
Injectable	56	20.0
Implant	148	52.8
IUD	29	10.4
Male condom	94	33.5

### *In-dept. interview IDI*

Four out of the seven providers at the teaching hospital have been working as a family planning provider for more than 10years while only one provider has worked for more than 10 years at the Medical Center. When asked, if they had been seeing clients coming to clinic with their spouses:

One the provider at the teaching hospital answered as follows" *yes however this happened about 6-8years back but presently is very rear except if we (providers) requested for his presence at the clinic especially when the client is not educated enough to understand the counselling and occasionally we have had to send for a spouse because the wife does not understand English; if I can remember she was from Togo*"

*'Most of the spouses that follow their wives to the clinic, were young couples, who had 2 or 3 kids'.*

When asked what might be the reason for men not attending the clinic with their spouse – the provider that has worked for more than 10 years said *"it was no more mandatory for the clients to come for Family planning counseling with their spouses or have the consent of their spouses as it was obtained over a decade ago. She further said" Clients are at ease now for coming alone even sometimes without the knowledge of their spouses".*

A provider at the Medical center mentioned *"I have seen two couples without kids that came for counseling. One of them just got marriage and wanted to travel with his wife abroad for a one-year course and they don't want pregnancy now"*.

### **Findings of Focus Group Discussion**

#### **1. Spousal awareness and acceptability**

Although spousal awareness and acceptability of family planning and contraceptives was discussed to be high among the clients but some lack accurate detail information on contraceptive methods and their importance.

One client at the Medical Center said that *"men do know a lot about family planning but they will never allow their wives to know that they know"*. One other client at Teaching hospital said *"before I married my husband as his third wife, he told me that he told his other wives not to have more children since they already have nine and told them to go to the clinic for family planning and they can use any method but not IUD"*.

Another client said *"I tried discussing about family planning with my husband but he always refused to discuss it with me"*. She feels the man sees her to be a young lady and she should not be involved in such issues just after two kids.

One of the participants submitted as follows *"In this area, family planning is still not accepted because they don't know the importance and as a woman, we are not expected to be discussion family planning issues let alone about knowing what he knows about family planning, but I can do it he will not know especially the injection."*

#### **2. Spousal support in any way or form**

Majority of the respondents agreed that men will support their wives financially as long as they initiated the discussion, but if the woman starts the discussing the support may not be robust.

A client said *"my husband wouldn't have allow me to come here today but I told him that since am taking our son for immunization and I will like to go for family planning counseling, he gave me money, however he is not against family planning and will support me, he supported me today because of our son"*.

Another respondent in the teaching hospital said *"my husband use to bring me to the clinic and fully supported me but after our third child he told me to go by myself and I have my money I can pay; I only need his approval"*.

#### **3. Improving spousal support**

Majority of the participants were of the opinioned that as long as Family planning is a taboo in the community and religion is against, it will be very difficult to improve on the acceptance rate. One of the respondents stated *"Even those who are supporting their wives are doing so without the knowledge of their family especially their mothers if the mothers should know, they will label the bad wife"*.

One respondent categorically stated that *"i don't need his support and the commodities are not expensive, I can afford it"*. This particular respondent was a civil servant and in a polygamous marriage. But they blamed the health care providers for not doing much in sensitizing the men and telling them about the benefits of family planning.

One of the participants stated *"We cannot decide on our own and is difficult to talk to them, you people should find a way to talk to them. We come here most of the time without their support because if you wait for their support they will delay and before you know it, one is pregnancy again"* This particular client, was a postgraduate student.

One participant concluded by saying- *"if he supports me now, there is no guarantee that he will continue to support me"*. She added *"you know men can easy change or be influenced by others"*.

### **DISCUSSION**

In this study, implants are the most common acceptable method of contraception. This finding is in agreement with recent data by National Demography and Health Survey 2018 (NDHS) of Nigeria but not consistent with the study of Abdul and co-workers [9, 11]. Even though the documentation of Sule *et al* was from one of our study sites, their study preceded the availability of implants while that of Abdul and colleagues included primary care Centres [11].

The overall rate of male initiation for family planning was 17% in this study. This is similar to the study done by Marius and co-workers [13] and Bustamante and colleagues [14]. They found out that less than a quarter of men individually initiated discussions on such issues as when to use contraceptives [10, 13, 14].

The majority (82.8%) of the respondents had prior discussion about the issues of family planning with their husband. This is however higher than the report of Kolawole and co-workers and Ogunjuyigbe *et al* in Southern Yoruba land in Nigeria where 78 % of their respondents reported that decision were generally taken jointly with wife [15, 16].

Hartmann *et al* in their study, they supported the idea that communication is an integral component of successful interventions to increase male involvement in family planning [17].

Despite communication, approval is also very important, which 70.7% of the respondents got before seeking family planning services. In Northern Ghana Women feared that their husband's disapproval of family planning could lead to withholding of affection or sex or even preference for another wife [18]. However, Khalifa in his study noticed that decision not to practice family planning is found to be male-dominated, and husbands are responsible for providing contraceptives when family planning is practiced [19]. In Ethiopia, above 90% of male respondents have supported and approved using and choosing family planning methods [4].

Spousal support both financially, encouragement and reminder were below 50%, which indicate that they (the men) are not fully aware of or not concerned about the associated effort needed to get a family planning service for their wives. Some men worry that their wives might be unfaithful if they used contraception or that it might create conflict among multiple wives, which is consistency with the findings of Bawah *et al* [18]. The low level of the male involvement in the choice and duration of her chosen method of contraceptive in this study also indicate lack of commitment in the process.

The revelations from IDI were that changes have occurred in the way spouses support their wives by accompany them to the clinic. This might be due to the fact that women have more information than men regarding Family planning and this has empowered them.

In Nepal, male involvement in reproductive health is linked with societal and health system dynamics. Although, some factors hinder men's involvement in reproductive health in community level, the feeling of responsibility, education and positive attitude motivates men's involvement in reproductive health activities [20].

Focus group discussion was quiet reveling; carrying pregnancy through to labour, postpartum period and subsequently seeking for child spacing/ family planning are essentially a female gender issue and should be viewed as such. If a male is to be involved in family planning their role should be clearly spelt out for them. Focus should be on empowering women by educating them and being financially independence

It can be concluded that in our setting, that despite the high level of communication between spouses on FP, male partner support is low. Men involvement and support in FP are certainly priority areas for interventions if the narrative on the low uptake of FP in Northern Nigeria is to be changed.

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