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CLINICAL ARTICLE

A community-based, mixed-methods study of the attitudes and behaviors of men regarding modern family planning in Nigeria

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ABSTRACT

Objectives: To investigate the knowledge, attitudes, and extent of involvement of men in family planning in Nigeria, and to evaluate spousal communication regarding family planning. *Methods:* A community-based, mixed-methods study enrolled participants in Gwagwalada, Abuja, Nigeria between January 11 and June 30, 2012. Quantitative surveys including semi-structured interviews were used to collect information from married men regarding their knowledge and attitudes to modern family planning. The qualitative components constituted focus group discussion sessions and in-depth interviews that included married men, married women, religious leaders, community leaders, and family-planning providers. *Results:* Quantitative surveys were completed by 152 men; 99 (65.1%) reported that they would accompany their wives to family-planning clinics in the future, 116 (76.3%) reported approving of the use of modern contraception by their wives, and 132 (86.8%) reported wanting to know more about family planning. Both quantitative and qualitative aspects of the study indicated that husbands were the major decision makers regarding family size, choice of contraceptive, and pregnancy timing. *Conclusion:* In terms of fertility goals and family planning, men were the primary decision makers; consequently, obtaining their support and commitment to family planning is of crucial importance in Nigeria.

1. Introduction

In African societies, the family remains a component of population regulation in which men occupy crucial roles. Despite concerted population control measures being enacted by stake holders in Nigeria, including the federal government, Nigeria's population continues to rise, with the current population of 182 million people being projected to reach 397 million by 2050 [1].

Although Nigeria has a national family planning policy, the dividends of this policy continue to be sub-optimal, as evidenced by the low contraceptive prevalence rate (10%), high total fertility rate (5.5 per 1000 women), high burden of unmet family planning needs, and other deleterious effects of unchecked population growth including high maternal and infant mortality [2].

Modern family planning methods available in Nigeria include condoms, injectable contraception, oral contraceptive pills, implants, intrauterine devices, female sterilization, and male sterilization. Unfortunately, the utilization of these methods remains poor. The male condom is the most commonly used modern contraceptive method while permanent methods are the least used [2].

Religious beliefs, costs of contraception, fear of side effects, myths, misconceptions, provider attitudes, lack of support from men, and poor spousal communications are documented barriers to increased uptake of family planning among couples in Nigeria and other parts of Sub-Saharan Africa [3–5].

It has been reported that interventions to promote the involvement of men in family planning have yielded some positive results in other low-income countries [6], but this concept is yet to be fully explored in Nigeria. Men are perceived as major barriers to the uptake of modern contraception in some communities [7,8], with lack of spousal communication regarding contraception being evident in studies conducted in South-West [9] and Northern Nigeria [10]. Open and frequent communication regarding family planning between husbands and wives has been found to improve reproductive health behavior and decision making [11]. A multilevel analysis of male involvement in reproductive health in Bangladesh recorded that, "couples who discuss family planning matters were likely to discuss and understand the potential advantages and disadvantages of different contraceptive methods and that the frequency of inter-spousal communication is sometimes regarded as an indicator of safe family planning practice with ability of couples to practice contraception appropriately and consistently" [12]. Consequently, existing assumptions that men in Nigeria are not interested in or supportive of family planning and contraception could be inaccurate.

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The aims of the present study were to examine knowledge and attitudes to contraception of men in Nigeria and the extent of their involvement in family planning choices, as well as to evaluate the level of spousal communication that occurs on issues relating family planning.

2. Materials and methods

The present cross-sectional mixed-method study enrolled participants from Gwagwalada in Nigeria's Federal capital territory between January 11 and June 30, 2012. The study design was approved by the research and ethics committee of the University of Abuja Teaching Hospital and the Health department of Gwagwalada Area council. In addition, traditional rulers in the rural communities included were approached by the research team to obtain their approval and support before beginning the study. All participants provided verbal consent for participation.

Gwagwalada, with an estimated population of 158 618 in 2006 [13], has experienced an influx of people from different parts of the country during the last decade, resulting in the area having a diverse population in terms of ethnicity, religion, and socioeconomic status. Gwagwalada comprises 10 wards: Gwagwalada central, Zuba, Quarters, Kutunku, Tunga-maje, Dobi, Paiko, Ibwa, Ikwa, and Gwarko; the first five wards are urban communities and the latter five wards are rural settlements.

Quantitative surveys using semi-structured interviews were utilized to collect information from married men regarding their knowledge of contraception and attitudes to modern family planning.

The sample size for the quantitative element of the study was determined using the formula:

$$n = \frac{Z^2 pq}{d^2}$$

where, n represents the minimum sample size, Z was 1.96, p was the national contraceptive prevalence rate of 10% [12], q was 1 – p, and d was 0.05, the level of precision. This resulted in a necessary sample size of 138, which was increased to 152 to account for an attrition rate of approximately 10%.

A multistage sampling technique was used to recruit married men aged at least 18 years for quantitative surveys. The wards included were selected using a balloting method. The names of each of the five urban wards were written on separate slips of paper of equal size; these slips were then mixed thoroughly in a small non-transparent container by a research assistant. Following this, two slips of paper were consecutively selected by a researcher (G.A.). The same process was repeated for the rural wards. Following this, convenience sampling was used to select residences from each of the four selected wards because no official sampling frame was available for the area.

The pre-tested questionnaire included sections detailing sociodemographic variables, knowledge about contraceptives, attitudes towards the use of contraceptives, contraceptive methods used, men's involvement in decision making, and spousal communication relating to family planning. The questionnaire was administered by an interviewer in a private place in English, "Pidgin" English, or the Hausa language, depending on the language spoken by each participant.

The responses to the quantitative survey were considered when designing the qualitative section of the study. A focus group discussion guide and in-depth interview questions were designed to obtain information from a diverse range of participants including married men, married women, religious leaders, community leaders, and family planning providers.

In rural communities, focus group discussants were purposively recruited by the heads of the male and female village meetings; in urban settings, male participants were mobilized by the chairperson of a residential group and female participants were identified by the chairperson of a local women's group. All participants were married and at least 18 years of age.

Focus group participants were divided into groups based on gender and age (two age groups: 18–35 years and 36–55 years). Focus group discussions were recorded and each discussion lasted 45–90 minutes. During focus group discussions, interviewers (G.A. and N.K. interviewed male participants; G.A. and a midwife interviewed female participants) were accompanied by field assistants who observed and took notes. The topics included in the focus group discussions included the ideal number of children for a couple, the primary decision makers and initiators of discussions regarding family planning, men's support for family planning, and perceptions within the community regarding family planning.

In-depth interview participants were purposively identified by the research team, with any participants in the focus group discussions considered ineligible for the in-depth interviews. Two participants from each of the following groups were interviewed: religious leaders, community heads/opinion leaders, male participants from rural areas, female participants from rural areas, male participants from urban areas, female participants from urban areas, family-planning providers from rural areas, and family-planning providers from urban areas. Interviews were conducted in private to ensure confidentiality and included the following discussion topics: the level of support for using family planning among men, community perceptions regarding family planning, and the availability and utilization of family planning services in the community.

Quantitative findings were analyzed using SPSS version 16 (SPSS Inc, Chicago, IL, USA). Correlations were assessed using the χ^2 test and $P < 0.05$ was considered statistically significant.

Qualitative data were analyzed manually and independently by two teams; the first comprised a researcher (G.A.) and an assistant (N.K.), and the second was an independent sociologist (W.T.) experienced in qualitative data analysis. The recorded focus group discussions were transcribed and compared; participant responses were coded and themes were generated. Subsequently, the findings of the two teams were compared and notable statements by participants were reported.

3. Results

The quantitative survey was completed by 152 married men aged 20–59 years, with approximately two-thirds of the participants aged 30–49 years (Table 1); 130 (85.5%) participants had completed at least primary level education and statistically significant correlations

Table 1
Sociodemographic characteristics (n = 152).

Variable	No. (%)
Age, y	
20–29	45 (29.6)
30–39	49 (32.2)
40–49	51 (33.6)
50–59	7 (4.6)
Education completed	
None	22 (14.5)
Primary	34 (22.4)
Secondary	52 (34.2)
Tertiary	44 (28.9)
Type of marriage	
Monogamous	22 (14.5)
Polygamous	34 (22.4)
Occupation	
Farming	47 (30.9)
Business/trading	39 (25.7)
Private-sector employment	32 (21.0)
Public-sector employment	31 (20.4)
Other	3 (2.0)
Religion	
Islam	64 (42.1)
Protestant	36 (23.7)
Orthodox	11 (7.2)
Catholic	35 (23.0)
Traditional	6 (3.9)