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Factors Influencing Male involvement in Family Planning Method in Health Service Careat Jinja Regional Referral Hospital

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ABSTRACT

In Africa, Uganda in particular, the decision depends mainly on man. If we have to improve contraceptive prevalence rates, we need to look into obstacles to male participation in Family Planning. Available data in Uganda indicates that most males have a positive attitude towards family planning but obstacles to their participation have not been established fully. This study determined factors influencing men's participation in family planning in Jinja Regional Referral Hospital. The study was a cross-sectional descriptive study carried out among adult men seeking health care services in Jinja regional referral hospital. This study involved the use of structured questions to collect both quantitative and qualitative data from the respondents. Data was coded and entered into a database created using Microsoft Excel, then cleaned and edited. Data set was then imported into STATA 14.2 for analysis. Bivariate and Multivariate logistic regression was done to ascertain the relationship between dependent and independent variables. Descriptive statistics was presented inform of frequency tables, pie charts and graphs. Out of the 353 participants, majority (41.1%) were aged 30-39years, attained secondary education (48.4%) and were married (51.3%). 31 of the respondents were using contraceptives giving a prevalence of 8.8%. Only 7(2.0%) of the participants in the study would opt for permanent sterilization. At multivariate analysis, age, level of education, residence, number of children, income level, wanting more children and involvement in contraceptive choice were significantly associated with contraceptive use among males. Uptake of contraceptives among males is very low. Predictors of contraceptive use among males include; age, level of education, residence, number of children, income level, wanting more children and involvement in contraceptive choice.

Keywords: contraceptive prevalence, Family Planning, and sterilization

INTRODUCTION

Contraception, or family planning, allows women, men and couples to choose if and when to have children by way of voluntarily and intentionally delaying, spacing or limiting pregnancies [1]. Thus, contraception has been, and continues to be, a key focus of the global agenda for maternal health. Access to and use of contraception by women and men can improve the health, economic, and social domains of their lives [2]. Spacing or limiting pregnancies allows for improved health outcomes for a mother and her child, together with better financial and resource management resulting from smaller, healthier families, and reduced child care demands [3]. Delayed childbearing increases a woman's likelihood of higher educational attainment, and better employment prospects, a higher level of financial independence and empowerment, as well as reducing the risks and complications associated with early pregnancies [4]. Contraceptive use also prevents or reduces the likelihood of high-risk and unintended pregnancies, which can lead to unsafe abortions and adverse maternal health outcomes [5-10].

Uganda has one of the highest fertility and maternal mortality rates in the East African region, estimated at 5.4 births per woman in 2016 [11] and 343 maternal deaths per 100,000 live births in 2015 respectively. Taken together, these figures underscore the high maternal health burden faced by Ugandan women of reproductive age [2]. Uganda also consistently has one of the lowest contraceptive use prevalence rates

among East African countries [3].

METHODOLOGY

Study area

The study was conducted in Jinja Regional Referral Hospital, which located in eastern part of Uganda in Busoga sub region.

Study design

This was a descriptive and analytical cross-sectional study of adult men who sought treatmentfrom Jinja regional referral hospital.

Sample size determination

The sample size was calculated using Kish Leslie formula (1965)$n=Z^2P(1-P)/e^2$
where n= estimated minimum sample size required,
z= 1.96 for 95% confidence interval,
P=proportion of a characteristic in a sample. e= Theacceptable margin of error set at 5%.
Considering a 35.6% contraceptive use among men in Uganda [12],

$$n = \frac{(1.96)^2 x 0.356 x (1-0.356)}{(0.05)^2} = 353,$$

Therefore, a sample of 353 participants was used.

Sample procedure and sample determination

All men of reproductive age were interviewed as long as they were receiving treatment from thehospital and accepted to participate in the research

Inclusion criteria

All men above the age of 18 years who received services from Jinja Regional Referral Hospitaland consented to participate in the research were included in the study.

Exclusion criteria

Men below 18 years age
Adult men who were not around the study area at the time of the studyThose who were not willing to participate in the research

Data collection method

This study involves the use of structured questions to collect both quantitative and qualitativedata from the respondents using researcher-administered questionnaires. Both the researcher and the research assistants issued self-administered questionnaires with sections and subsections to collect data from the respondents.

Data collection procedure

Participants consented to participate in the study, and with the help of research assistants, the participants were guided to fill in the questionnaire completely.

Data handling and analysis

Completed questionnaires were checked and protected safely in waterproof bags and kept away from non-members of the research. Data was then coded and entered into a database created using Microsoft Excel, then cleaned and edited. Data set was imported into STATA 14.2 (Statacorp, Lakeway Drive, USA Texas) for analysis.
Descriptive statistics involved generation of frequency distributions of demographic characteristics. Inferential statistics through a Pearson Chi-square test was used to measure the association of independent variables and contraceptive methods utilization at bivariate analysis, with significance considered at ≤0.2. A multivariable logistic regression was performed to identify factors that were significantly associated with the utilization level at bivariate level analysis ($p \leq 0.05$) to determine adjusted odds ratios (AOR). The odds ratios (OR) associated with these factors were reported as a measure of strength, together with the respective 95% confidence intervals.

Ethical considerations

Voluntary and informed consent

Voluntary recruitment was done with utmost respect to participant's autonomy and an informed consent was signed. Informed consent was obtained after fully explaining the details of the study to them in English and local languages. Participants were not coerced to enroll themselves if they did not want to. Participants were allowed to withdraw from the study at any time they wished without coercion or compromise their entitled work.

Risks and adverse events to participants

Maximum care was taken into consideration to minimize risks to study participants. Possible risks in this study included occupying the patient's time, hence possibly delaying them from receiving health care during data collection.

Privacy and confidentiality

Identification of participants was done by

means of numerical codes. Details of respondents werekept under lock and key for privacy and confidentiality purposes throughout the course of research. Respect of the respondents‟ rights and fair treatment was strictly adhered to thus minimizing harm and discomfort to them. There was no disclosure of participants‟ names to the public and all identities were removed from the results before publication.

Selection of participants

Consecutive sampling method was used to select participants to ensure continued selection forthe study while only adhering to the eligibility criteria strictly. No bias was made in terms of tribe, interest group, race or religion.

Approval procedure

Approval to carry out the study was sought from the Kampala International University Research Ethics Committee (KIU-REC). After approval by the REC, the study may be registered with the Uganda National Council for Science and Technology (UNCST). The clearance will be presented to the hospital administration of Jinja Regional Referral hospital prior to data collection to acquire permission to proceed with the study at the study site.

RESULTS

Out of the 353 participants, majority (41.1%) were aged 30-39years, attained secondary education (48.4%) and were married (51.3%). 62.0% were from rural,69.4% had no formal employment and majority (33.1%) were Catholics as shown in the table below.

Table 1: Socio-demographic characteristics of the Respondents

Variable	Frequency(N=353)	Percentage (%)
Age		
≤20	51	14.4
21-29	89	25.2
30-39	145	41.1
≥40	68	19.3
Level of education		
No formal education	37	10.5
Primary	94	26.7
Secondary	171	48.4
Tertiary	51	14.4
Marital status		
Married	181	51.3
Single	104	29.5
Divorced	16	4.5
Cohabiting	44	12.5
Widowed	08	2.3
Residence		
Urban	134	38.0
Rural	219	62.0
Occupation		
No formal employment	245	69.4
Business	67	19.0
Formally employed	41	11.6
Religion		
Catholic	117	33.1
Anglican	98	27.8
Pentecostal	49	13.9
Muslim	64	18.1
Others	25	7.1

Out of the 353 participants in this study, 31 were using contraceptives giving a prevalence of8.8% as shown in the figure below.

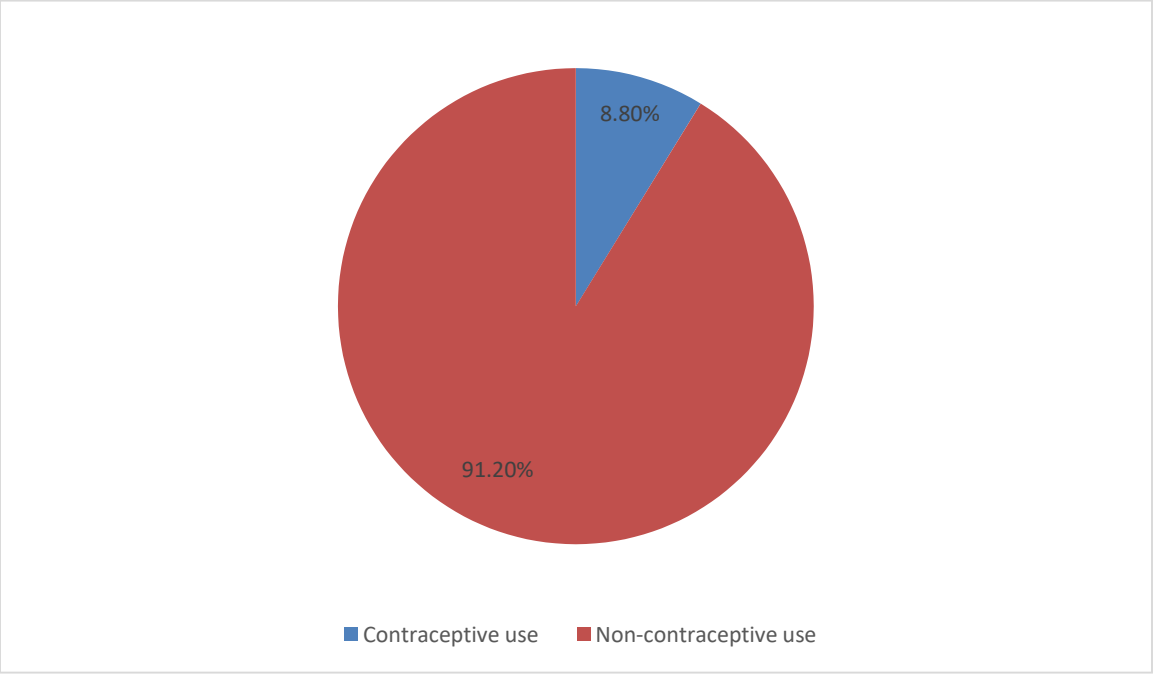

Figure 2: Contraceptive prevalence among males

Only 7(2.0%) of the participants in this study would opt for permanent sterilization as shown inthe figure below.

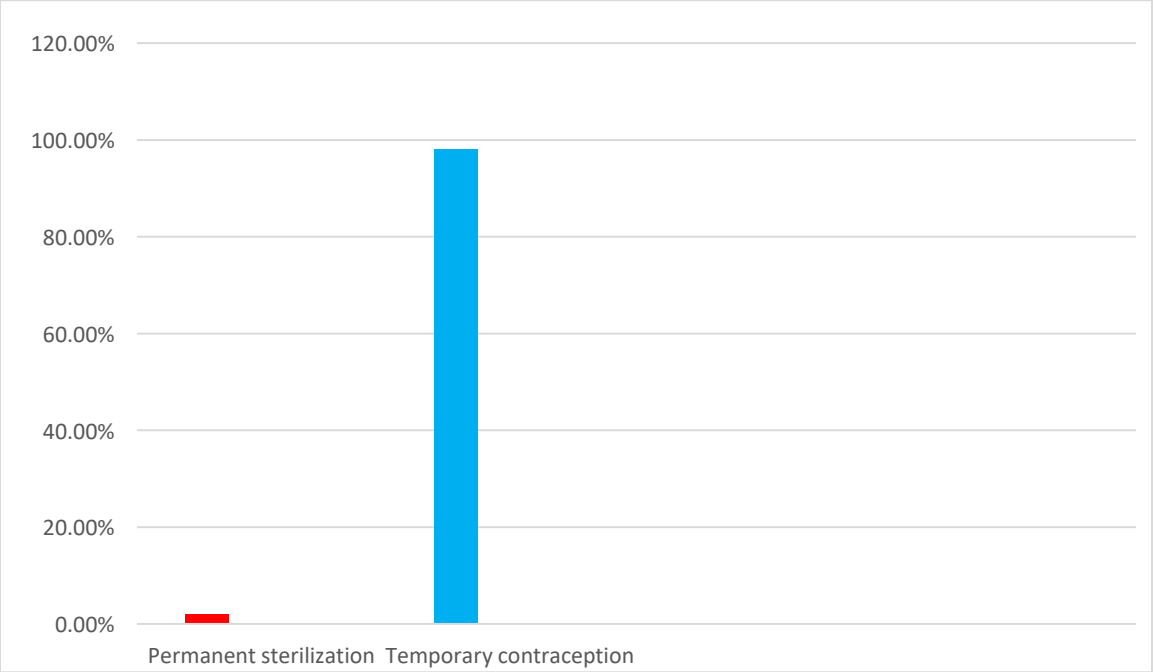

Figure 3: Proportion of males opting for permanent contraception

From table 2 below, age, level of education, residence, occupation, estimated distance to the health facility, partner's level of education, income level, number of children, man's desired number of children, duration of marriage, involvement in contraceptive choice and wanting children were significant at Bivariate analysis and were therefore considered for multivariate analysis.

Table 2: Bivariate logistic regression of the factors influencing contraceptive use among males

Variable	N=353	Male contraception n(%)	cOR(95% CI)	P-Value
Age				
≤20	51	-	Reference	
21-29	89	05(5.6)	0.57(0.14-0.81)	0.440
30-39	145	11(7.6)	0.91(0.08-1.56)	0.320
≥40	68	15(22.1)	1.23(0.92-4.10)	0.140
Level of education				
No formal education	37	01(2.7)	Reference	
Primary	94	04(4.3)	1.13(0.72-5.06)	0.710
Secondary	171	12(7.0)	1.45(1.15-3.44)	0.052
Tertiary	51	14(27.5)	2.30(1.00-6.71)	0.003
Marital status				
Married	181	09(5.0)	3.67(2.33-10.36)	1.001
Single	104	08(7.7)	3.50(1.89-8.14)	0.250
Divorced	16	04(25.0)	2.61(0.84-4.51)	0.414
Cohabiting	44	08(18.2)	0.98(0.55-2.34)	0.235
Widowed	08	02(25.0)	Reference	
Residence				
Urban	134	22(16.4)	2.19(1.14-6.70)	0.190
Rural	219	09(4.1)	Reference	
Occupation				
No formal employment	245	15(6.1)	Reference	
Business	67	04(6.0)	4.63(2.36-11.38)	0.034
Formally employed	41	12(29.3)	5.51(1.79-8.84)	0.001
Religion				
Catholic	117	08(6.8)	Reference	
Anglican	98	10(10.2)	0.17(0.09-3.02)	0.516
Pentecostal	49	06(12.2)	0.65(0.25-3.19)	0.386
Muslim	64	04(6.3)	1.12(0.57-4.00)	0.712
Others	25	03(12.0)	3.10(2.60-7.84)	0.291
Estimated distance to the health facility(km)				
≤1	23	06(26.1)	10.02(8.22-17.12)	0.027
2-3	121	13(10.7)	5.22(3.90-13.23)	0.300
4-5	113	08(7.1)	3.49(2.47-6.07)	0.450
≥6	96	04(4.2)	Reference	
Estimated cost to the health facility				
1,000/=	25	04(16.0)	3.18(1.26-6.00)	0.531
2,000-5,000/=	219	14(6.4)	2.84(1.46-7.20)	0.428

≥5,000/=	109	13(11.9)	Reference	
Partner's level of education				
No formal education	36	-	Reference	
Primary	104	07(6.7)	0.86(0.07-1.50)	0.122
Secondary	176	16(9.1)	1.24(1.03-4.89)	0.013
Tertiary	37	08(21.6)	2.90(1.00-9.80)	0.005
Partner's occupation				
No formal employment	250	17(6.8)	Reference	
Business	61	06(9.8)	1.15(0.76-3.19)	0.752
Formally employed	42	08(19.0)	5.00(1.10-12.00)	0.618
Income level				
<100,000/=	75	01(1.3)	Reference	
100,000-500,000/=	154	11(7.1)	4.32(2.03-10.90)	0.100
500,000-1,000,000/=	110	14(12.7)	5.76(3.45-8.11)	0.007
≥1,000,000/=	14	05(35.7)	11.17(7.24-20.38)	1.204
Number of children				
≤2	109	07(6.4)	Reference	
3-4	169	14(8.3)	0.75(0.06-2.13)	0.058
≥5	75	10(13.3)	0.92(0.54-3.51)	0.017
Man's desired number of children				
≤2	71	11(15.5)	3.35(1.20-7.85)	0.140
3-4	187	14(7.5)	1.28(0.88-3.45)	0.613
≥5	95	06(6.3)	Reference	
Man's age at first marriage				
≤20years	47	08(17.0)	1.34(0.24-4.16)	1.000
21-29years	244	20(8.2)	0.77(0.05-2.97)	0.219
≥30years	62	03(4.8)	Reference	
Duration of marriage				
<5years	58	04(6.9)	Reference	
6-10years	221	16(7.2)	1.13(0.92-5.66)	0.002
≥11years	74	11(14.9)	1.36(1.14-4.40)	0.057
Do you want more children?				
Yes	201	12(6.0)	Reference	
No	152	19(12.5)	0.78(0.22-2.13)	0.142
Involvement in contraceptive choice				
Only 1 partner	213	13(6.1)	Reference	
Both partners	140	18(12.9)	1.80(1.04-5.23)	0.004
Partner's attitude towards contraception				
Good	261	26(10.0)	2.31(1.15-4.57)	0.204
Bad	92	05(5.4)	Reference	
Relationship of				

facility staff to you				
Good	309	30(9.7)	0.87(0.31-2.07)	0.910
Bad	44	01(2.3)	Reference	

P-value <0.2 was considered significant, CI-Confidence Interval

At multivariate analysis, age, level of education, residence, number of children, income level, wanting more children and involvement in contraceptive choice were significantly associated with contraceptive use among males as shown in the table below.

Table 3: Multivariate analysis of the factors influencing contraceptive use among males

Variable	N=353	Male contraception n(%)	aOR(95% CI)	P-Value
Age				
≤20	51	-	Reference	
21-29	89	05(5.6)	0.37(0.12-0.61)	0.020
30-39	145	11(7.6)	0.62(0.06-1.07)	0.007
≥40	68	15(22.1)	1.04(0.73-3.20)	0.014
Level of education				
No formal education	37	01(2.7)	Reference	
Primary	94	04(4.3)	0.25(0.53-4.16)	0.084
Secondary	171	12(7.0)	1.04(0.75-2.55)	0.006
Tertiary	51	14(27.5)	1.10(0.50-5.61)	0.039
Residence				
Urban	134	22(16.4)	1.28(1.08-4.80)	0.019
Rural	219	09(4.1)	Reference	
Occupation				
No formal employment	245	15(6.1)	Reference	
Business	67	04(6.0)	3.53(1.45-9.26)	0.065
Formally employed	41	12(29.3)	4.62(1.09-7.73)	0.058
Estimated distance to the health facility(km)				
≤1	23	06(26.1)	8.03(5.11-14.00)	0.194
2-3	121	13(10.7)	3.34(2.10-11.43)	0.081
4-5	113	08(7.1)	1.38(1.07-5.16)	0.066
≥6	96	04(4.2)	Reference	
Partner's level of education				
No formal education	36	-	Reference	
Primary	104	07(6.7)	0.71(0.05-1.32)	0.184

Secondary	176	16(9.1)	1.02(0.08-3.84)	0.097
Tertiary	37	08(21.6)	1.97(0.82-7.94)	0.052
Income level				
<100,000/=	75	01(1.3)	Reference	
100,000-500,000/=	154	11(7.1)	2.22(1.52-8.20)	0.023
500,000-1,000,000/=	110	14(12.7)	3.16(2.16-7.05)	0.003
≥1,000,000/=	14	05(35.7)	9.12(5.00-16.18)	0.050
Number of children				
≤2	109	07(6.4)	Reference	
3-4	169	14(8.3)	0.53(0.03-1.24)	0.018
≥5	75	10(13.3)	0.71(0.21-2.70)	0.015
Man's desired number of children				
≤2	71	11(15.5)	2.44(1.30-6.97)	0.246
3-4	187	14(7.5)	0.84(0.60-2.65)	0.074
≥5	95	06(6.3)	Reference	
Duration of marriage				
<5years	58	04(6.9)	Reference	
6-10years	221	16(7.2)	0.93(0.61-4.92)	0.082
≥11years	74	11(14.9)	1.18(1.03-3.67)	0.061
Do you want more children?				
Yes	201	12(6.0)	Reference	
No	152	19(12.5)	0.54(0.13-1.96)	0.001
Involvement in contraceptive choice				
Only 1 partner	213	13(6.1)	Reference	
Both partners	140	18(12.9)	1.21(0.61-3.45)	0.028

DISCUSSION

Only 7(2.0%) of the participants in this study would opt for permanent sterilization. This is comparable global rates of male sterilization of 2.4%. This may be because users prefer to use contraceptive methods from community health facilities, which do not offer alternative methods [13-15]. Additionally, this may be due to fear of uncertainties like loss of children and the need to reproduce. Urban dwellers easily access family planning services compared to rural dwellers. In the present study, males with higher number of children had higher odds of contraceptive use compared to those with few children. However, this is inconsistent with a study which reported a higher prevalence among men with less than two children. With rising cost of living in the country, men opt to reduce spending in any way of which one of them is to slow down reproduction.

This study further indicated that males who did not desire more children had higher chance of using contraceptive than those who desired [16].

CONCLUSION

Uptake of contraceptives among males is very low. Predictors of contraceptive use among males include; age, level of education, residence, number of children, income level, wanting more children and involvement in contraceptive choice.

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