Global Journal of Medical Science ISSN (Online): 2709-8699 ISSN (Print): 2789-6951

OPEN ACCESS

Article

Husbands' involvement in contraceptive use: assessing decision-making and support dynamics

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DOI: *10.61561/ssbgjms.v6i01.36*

Keywords

Contraception, Decision-making, Gender-Inequality, Heath Education

Article Information

Received Date: Jan 22, 2025
Revised Date: Feb 02, 2025
Accepted Date: Feb 09, 2025
Published Date: Feb 11, 2025

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Abstract

Introduction: *Contraceptive use is critical in family planning, health management, and socioeconomic development. However, gender dynamics, education, and economic factors often influence household decision-making and support systems. Understanding the role of husbands in contraceptive use, including their participation in decisions and financial support, is essential for designing more inclusive reproductive health policies. This study examines the involvement of husbands in contraceptive practices among couples.*

Methods: *This was a descriptive, cross-sectional study conducted from March 2000 to June 2000 at a purposively selected slum of Dhaka in Shaymoli, Adabar, and Agargaon and some sections of a government colony to evaluate husbands' involvement in contraceptive use, focusing on assessing decision-making and support dynamics. A total of 300 participants were selected using a purposive sampling technique. Data analysis was done on a computer using SPSS.*

Result: *The study revealed that most respondents were between 20 and 30 years old, while husbands were predominantly 35 and 44. A significant proportion of respondents (36%) were illiterate, compared to 25.3% of husbands. The majority (43.3%) had a monthly income between Tk 3,000-3,999. Contraceptive use was high (91.3%), with female methods (76.29%) being more common than male methods (23.71%). Women primarily made contraceptive decisions (81.3%), with limited husband involvement (18.7%). Husbands' education significantly influenced decision-making, whereas income levels showed no significant correlation. In most cases, husbands provided financial support for travel and contraceptives.*

Conclusion: *This study emphasizes the limited involvement of husbands in contraceptive decision-making, with most decisions made by women independently. Higher male education correlated with greater participation, while economic factors showed no significant effect. Enhancing male engagement and shared responsibility in family planning is essential to achieving more balanced reproductive health practices.*

Introduction

In all societies, the family is a basic social unit. The word family is a popular term used by social scientists and defined as a group of biologically related individuals living together and often eating from a shared kitchen. The father, mother and their children form a family called a nuclear or primary family[1]. Usually, a man from one family lives with a woman from another family after marriage. These terms may also be used with different connotations. For example, the family of origin or the family into which one is born, the family of procreation, or the family which one sets up after marriage. When a man marries, he expects many things from his conjugal partner. He expects his wife to share everything that belongs to him, and in return, she will bear and care for the children born to them. He also expects that she will serve all his needs and will be a source of joy. On the other hand, women also have many dreams and expectations. Every man and woman expects a happy Family. When a man and woman live together without any inhibition imposed, a sexual relationship is a natural consequence, and unless they are infertile, children are a natural outcome. The ultimate fulfilment of womanhood is achieved when a woman becomes a mother. If fertility is not controlled by the couple a woman will be pregnant one or two years apart continuously. But this is not always desirable. Different measures have been used since ancient times to prevent fertility. Some of these methods were very cruel, for example-destructive injury to the penis and the introduction of big pieces of rock salt into the vagina after delivery to cause cicatrices[2]. Before the development of modern methods of birth control, men had to be actively involved in limiting family size, as in the case of some cruel methods mentioned. Then came the knowledge of withdrawal or periodic abstinence and condoms. Withdrawal is a method that has been chronicled since early history, while condoms were first used more than 400 years ago. The use of contraceptives in our country is relatively very new. Though initiated by NGOs, much of the current prevailing practices

result from government efforts. Presently, three broad categories can be identified as in use:

1) Modern temporary methods (oral pills, IUD, injection & condom)
2) Modern permanent methods (tubectomy and vasectomy) and
3) Traditional methods (periodic abstinence, withdrawal, and other traditional fertility control procedures)[3].

A new contraceptive method – Norplant, has been introduced in recent years. The family planning program was started in our country in the early 1960s, and IUD and vasectomy were the two methods of choice in these early years. Gradually, pills, then injectables, and minimap tubal ligation were introduced. Bangladesh's family planning program has an exceptional achievement to its credit. In the program's early years in Bangladesh, males as active users played an important role in fertility decline. Twenty thousand vasectomies were done in a month in the mid-eighties[4]. However, for past years, family planning has come to be considered a woman's concern, and lately, in the history of the development of modern contraception, family planning, and fertility control measures are becoming almost exclusively aimed toward women. The argument has been made that the biomedical community focused on designing female contraceptive methods for six reasons:

1) Female becomes pregnant;
2) Interference is possible in more points of the female reproductive system than in that of the male system;
3) Preventing ovulation and implantation of one egg per month appears easier than preventing the production of millions of sperm;
4) In the absence of complete sexual fidelity in a monogamous society protecting one woman will on average, prevent more pregnancies than protecting one man;
5) Within a couple, the women are believed to be more motivated than the man to control fertility;
6) Women have more significant contact with health facilities[5].

For a planned family, the adoption of an appropriate contraceptive method depends upon both the husband and wife. In our country, most husbands think that it is the responsibility of the wife to practice contraceptive methods to prevent conception. A woman is at risk and faces death and other complications when she is forced to resort to do abortion to terminate an unwanted pregnancy. Repeated pregnancies are a burden on a woman. So, preventing conception is more of a concern for wives than husbands. The use of proper contraceptives can prevent at least 25% of all maternal deaths[6]. However, even if a woman is eager to prevent conceptions, she often faces problems such as, she does not get approval from her husband to use contraceptives., the husband does not take an active part as a user, physically she may be unable to use all types of contraceptives, she may suffer from complications related to contraceptives, she does not get any support for management of complications resulting from the use of contraceptives. In all these situations, husbands play an essential role in decision-making regarding contraceptive use. The vital role of men in contraceptive use is as the supportive half of a contracepting couple. No standard definitions are advanced by research for the word "support." As generally understood, it includes a positive role in decision-making. Couples can either make a joint decision, or a man can allow his partner to make a decision that suits her. Support may also include being the conduit of information about methods for the partner or purchasing those marketed contraceptives. Involvement in overcoming problems, such as side effects or complications of method use, is also a supportive role for male partners. This may include emotional support for minor complications or financial or logistical support for a clinic visit for side effect management. A second role for men in using contraceptives is as acceptors themselves[7]. Male involvement in family planning refers primarily to two distinct yet interrelated indicators: one increase in the use of male methods and an increase in the support by males of female method use. and the second is an increase in the involvement of men in family planning decision making concerning method use[8].

Methods

This was a descriptive, cross-sectional study conducted from March 2000 to June 2000, at a purposively selected slum of Dhaka in Shaymoli, Adabar, and Agargaon and some sections of a government colony to evaluate husbands' involvement in contraceptive use, focusing on assessing decision-making and support dynamics. All currently married women of reproductive age willing to be interviewed served as the study population. A total of 300 participants were selected by purposive sampling technique. A structured questionnaire was used to collect all relevant data. After the data collection, all the data forms were checked for accuracy, consistency, and completeness. A final analysis was done by computer using SPSS. Tables & figures were prepared as per the objective of the study. Informed written consent was taken from the participants. Ethical clearance was taken from the National Institute of Preventive and Social Medicine (NIPSOM).

Inclusion criteria:

- Married women of reproductive age
- Women willing to participate in the study

Exclusion criteria:

- Women who had been married within 6 months
- Women who had recently delivered a baby
- Women who had recently had a spontaneous abortion
- Women who had a hysterectomy

- Known infecund women
- Women whose husbands were abroad

Results

Table 1: Distribution of Respondents by Age and Husbands' Age (n=300)

Age	Respondents	Percentage
Respondents Age		
Mean age	25.6	
< 20	26	8.7
20 – 24	92	30.7
25 – 30	105	35.0
31 – 34	54	18.0
35 – 39	23	7.7
Husbands' Age		
Mean age (Husbands)	33.8	
< 25	13	4.3
25 – 34	126	42.0
35 – 44	135	45.0
> 44	26	8.7

Those respondents (65.7%) were between 20-30 years of age, A slightly smaller portion (7.7%) were 35 years and above. Around one-quarter of the sample, i.e. 25.7% were in the 30-39 years age group. A large portion (45%) of the respondents' husbands were between 35-44 years. Only a tiny percentage (4.3%) were below 25 years and 8.7% were above 44 years. Compared to the respondents, where there were 39.4% below 25 years, there were only 4.3% husbands below 25 years indicating that there was considerable age difference between husband and wife (Table 1).

Table 2: Distribution of couples by educational level (n=300)

Level of Education	Respondents		Respondent's Husband	
	n	%	n	%
Illiterate	108	36	76	25.3
Never went to school but can read and write	53	17.7	61	20.3
Primary	67	22.3	59	19.7
Secondary	39	12.9	48	19.0
Higher Secondary	12	4.0	18	6.0
Graduate	9	3.0	19	6.3
Masters	12	4.0	19	6.3

Of the 300 respondents, 36% were illiterate, and 17.7% stated that they had never gone to a formal school but could read & write. The second largest group of respondents had educational levels of class I to V years i.e. primary level. Slightly more than 10% of respondents had an educational level of higher secondary or above. Among the husbands, a smaller proportion (25.9%) was in the illiterate group. Among those who were literate, except for the first two groups (i.e., no schooling but can read and write and primary level education), there was a higher proportion of husbands in all successively higher educational groups (Table 2).

Table 3: Distribution of respondents by monthly family income (n=300)

Family income (BDT)	Number	Percentage
< 3000	58	19.3
3000 - 3999	130	43.3
4000 - 4999	37	12.3
5000 - 5999	26	7.7
6000 - 6999	16	5.3
7000 >	36	12.0

The proportion of respondents (43.3%) reported a monthly income between Tk 3,000 and Tk 3,999, followed by 19.3% with an income of less than Tk 3,000. A smaller percentage (12.3%) had a monthly income between Tk 4,000 and Tk 4,999, while 7.7% reported incomes from Tk 5,000 to Tk 5,999. Only 5.3% of respondents had an income between Tk 6,000 and 6,999, and 12.0% earned Tk 7,000 or more (Table 3).

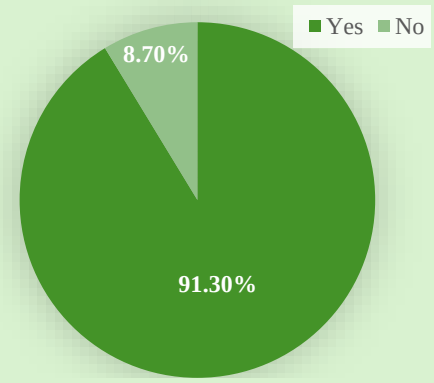

Figure 1: Distribution of respondents by current contraceptive use (n=300)

Out of 300 couples 91.3% (274) couples were currently using contraceptives and a small percentage of 8.7% (26) stated to be non-users.

Table 4: Distribution of contraceptive uses by type of contraceptive use (n=300)

Type of Contraceptive	Number	Percentage
Female method users		
Pill	103	37.59
IUCD (CT)	2	0.74
Injection	99	36.13
Norplant	0	0
Ligation	5	1.83
Male Method Users		
Condom	30	10.95
Periodic Abstinence	33	12.04
Withdrawal	1	0.36
Vasectomy	1	0.36

Concerning the type of contraceptive used, most respondents (76.29%) were female method users and 23.71% were male method users. It was found that about 37.6% of respondents were taking oral pills and 36.13% were taking injections. Among the male method users, 10.9% were Condom users and 12.04% followed periodic abstinence from sex (Table 4).

It was found that in only around 14 percent of cases, the idea was initiated by the husband himself. In around 17 percent of cases, the wife had to begin using the male method. In a vast majority of cases, the male method resulted from the joint decision of both husband and wife. Thus, it was found that although in 23 percent of cases, the husband was willing to use a method, in only 14 percent of cases, he finally started using it (Table 5).

Table 5: Distribution by the spouse who took the initiative (n=300)

The spouse who took the initiative	Number	Percentage
Husband himself	9	13.9
Wife	11	16.9
Both	45	69.2

It was found that among women who had accepted a method, only in less than 20% of cases husbands had any involvement in decision-making about contraceptive use. In most cases, the women alone decided to use a method.

Table 6: Decision maker regarding the use of contraceptives (n=300)

Decision maker	Number	Percentage
Respondents herself	170	81.3
Husband	39	18.7

Out of 209 respondents, 76 did not have to pay travel costs. As either, they had had a permanent contraceptive method long ago (ligation) or had clinics very near to their homes. However, in 47.4 percent of cases, husbands were paying the cost of travel. In 12 cases, the cost of contraceptives was not also in question as these respondents had had a permanent or long-term method such as ligation or copper T. In around 79 percent of cases, husbands either paid the cost of contraceptives or procured them for their wives (Table 7).

Among illiterate husbands, 89.6% of respondents made the decision themselves, while only 10.4% of the decisions were made by the husbands. For husbands who never attended school but could read and write, 92.2% of the respondents made their own decisions, with 7.8% influenced by their husbands. In the primary education group, 72.3% of respondents decided independently; husbands made 27.7% of decisions.

Table 7: Monetary support for paying the cost of travel to the clinic or paying the cost of contraceptive method (n=300)

	Number	Percentage
The person bearing travel costs to get contraceptive		
Herself	34	16.27
Husband	99	47.37
No travel cost	76*	36.36
The person bearing the cost of the contraceptive		
No Cost	12#	5.74
Herself	34	16.27
Husband Brings	64	30.62
Husband Pays	99	47.37

** These women have contraceptives delivered at home or have clinics very near to their homes.*

 # Includes women who have CT, ligation, and pills delivered at home.

Among those with secondary education and above, 69.8% of respondents made their own decisions, with 30.2% of decisions by their husbands. Overall, 81.33% of women made decisions independently across all education levels, while 18.66% involved their husbands (Table 8).

Table 8: Relationship between husbands' education and decision-making regarding respondent's use of contraceptives (n=300)

Husband's Education	Decision-making regarding respondents' use of contraception				Total
	Respondent herself		Respondents husband		
	N	%	N	%	N
Illiterate	52	89.6	6	10.4	58
Never went to school, but can read and write	47	92.2	4	7.8	51
Primary	37	72.3	13	27.7	47
Secondary and above	37	69.8	16	30.2	53

$X^2 = 13.723$, d.f = 3, P < .05,

Among illiterate husbands, 89.6% of respondents made the decision themselves, while only 10.4% of the decisions were made by the husbands. For husbands who never attended school but could read and write, 92.2% of the respondents made their own decisions, with 7.8% influenced by their husbands. In the primary education group, 72.3% of respondents decided independently, whereas husbands made 27.7% of decisions. Among those with secondary education and above, 69.8% of respondents made their own decisions, with 30.2% of decisions made by their husbands. Overall, across all education levels, 81.33% of women made decisions independently, while 18.66% involved their husbands (Table 9).

Table 9: Relationship between monthly family income and decision-making regarding respondents' use of contraceptives (n=300)

Family Income (BDT)	Decision-making regarding respondents' use of contraception				Total
	Respondent herself		Respondents husband		
	N	%	N	%	N
<2999	35	76.1	1	23.9	46
3000 – 3999	89	83.2	18	16.8	107
4000 – 4999	18	78.3	5	21.7	23
5000 and above	28	84.8	5	15.2	33

$X^2 = 1.486$, d.f = 3, P < .05

Discussion

The ICPD Program of Action states explicitly that "Special research should be undertaken on factors inhibiting male participation to encourage male involvement and responsibility in family planning"[5]. Keeping this point in mind, this study was carried out as an attempt to assess the degree of husband's involvement in contraceptive use in a selected group of women in Dhaka city and to find out whether the husband's involvement in contraceptive use is related to husband's education and monthly family income. The degree of involvement for this study was judged by considering different indicators. One indicator was the use of the contraceptive method by the husband himself. In this sample of 300, over ninety percent of couples were currently using contraceptive methods, and most of them were female method users. The ratio of male and female method users was around 1:3. According to BHDS 1996-97, male method users are 2.9 times lower than female method users[9]. In the present study, as in the BDHS 1996-97, periodic abstinence from sex and condoms were the more popular male methods. It was observed that only around one-fourth of the husbands had a reasonable degree of involvement because these husbands were using a method themselves. However, upon further finer analysis, it was found that even in this group, only a small fraction of husbands started using the method on their initiative, and in a still smaller proportion of males, the idea was initiated by the husband himself. As expected, in this study, the husband's education and monthly family income influenced the husband's active involvement. When involvement was studied in decision-making regarding respondents' use of contraceptives, it was found that in less than twenty percent of cases, husbands were involved in decision-making. This finding corresponds with the findings of Benkola et al. in 18 developing countries where wives rather than their husbands initiated contraceptive use and differs from the study by Barnet in 10 developing countries where husbands usually were involved in decisions about contraceptives[10]. When involvement was studied considering the husband's educational level, it was found that the husband's involvement in terms of decision-making was higher when the education level was secondary and above, compared to a lower level of education. This study could not find any relation between monthly family income and husband's involvement in decision-making. As a monetary supporter, husband's involvement was good. In most cases, the husband paid the travel costs to get contraceptives and paid the cost of contraceptives or procured them for their wives. Looking at involvement from these angles, husbands were found to show a moderate degree of involvement in contraceptive use. However, monetary support is not a very strong point for measuring involvement. In the current study, most respondents were housewives, so they had no other way to get money except from their husbands. Studying the relationship between two factors that were taken as a hypothesis, it was found that in most cases, monthly family income was not an influencing factor, but the husband's education had some degree of influence on contraceptive use. It may be helpful to mention that during the interview, it was found that many women were very eager to talk about their husbands regarding the attitude of their husbands about family planning and contraception. Many were very disappointed about their husbands' indifferent and often adverse attitude. They felt that to build a happy family, responsibility should be jointly shared.

Limitations of The Study

The study was conducted in three areas of Dhaka city with a small sample size. So, the results may not represent the whole community.

Conclusion

This study highlights the limited involvement of husbands in contraceptive use and decision-making despite their crucial role in family planning. The findings reveal that while most respondents independently made decisions about contraception, male engagement remained low, particularly in adopting male contraceptive methods. Educational level significantly influenced decision-making autonomy, with higher male education correlating with increased involvement. However, economic factors showed no significant impact on decision-making patterns. The study underscores the need for strategies that promote shared responsibility in reproductive health and enhance male participation.

Recommendation

Further studies on a larger scale in representative samples, covering all social and cultural strata, will be carried out to determine the degree of male involvement in contraceptive use by couples in our country. Studies exclusively including men may be carried out to understand their viewpoints and

facts that inhibit them from contraceptive use. As lack and incorrect knowledge of contraceptives create baseless fear in the minds of men, well-designed studies on knowledge of men about methods of contraception available in the country should be carried out. Based on the findings of these studies, motivational and educational programs for men should be developed to enhance their involvement.

Funding: No funding sources

Conflict of interest: None declared

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To cite: Fatema Shabnam. Husbands' involvement in contraceptive use: assessing decision-making and support dynamics. SSB Global Journal of Medical Science [Internet]. 2025 Feb. 11 [cited 2025 Feb. 11];6(01):3-8. Available from: https://ssbjournals.org/index.php/ssbgjms/article/view/36