

The roles of men in family planning – a study of married men at the UKM primary care clinic

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Abstract

Introduction: Traditionally, family planning initiatives were concentrated on women despite it being a family matter. As family dynamics evolved over the years, fathers' involvement in family planning has become crucial in enhancing the family well-being.

Objectives: This study aimed to identify the role played by men in family planning activities and the association of socio-economic characteristics with these roles.

Methodology: This was a cross-sectional study carried out in a university primary care clinic. All married male attendees to the clinic, aged 50 years and below, were approached to answer a set of self-administered questionnaires, asking for their involvement in family planning practices. The data were analysed using descriptive and inferential statistics.

Results: There were 167 participants in the study. A high proportion of men participated in the discussions regarding previous pregnancies (60.42%), future child planning (89.76%) and desired family size (89.76%). However, the discussions on the usage of family planning methods (FPMs; 39.16%) were significantly low. Socio-economic factors associated with higher likelihood of men discussing family planning activities were older age ($p < 0.0$), higher education level ($p = 0.010$), higher monthly income ($p < 0.001$) and longer duration of marriage ($p = 0.0049$).

Conclusions: The level of participation of men varied in the discussions of four family planning activities. The roles taken by men in family planning were associated with older age and higher socio-economic class. The majority of men needs to be encouraged to play a more active role in the discussion of FPMs.

Introduction

The issue of unwanted pregnancies in the rising global population is of concern. The World Bank hypothesised that the estimated global population would be surpassed due to this issue, showing the dire need of an intervention in the form of family planning and contraception.^{1,2} As the implementation of family planning will achieve a significant decrease in the projected population size, it needs to be actively practiced to reduce the adverse effects of overpopulation.¹

The benefits of family planning are bountiful. Not only will it reduce infant morbidity and mortality, it will also enhance child growth and development. Greater effects can be seen on the parents, where their pregnancy risks and intervals could be lowered and regulated. It also enables the achievement of a desired family size (DFS) and helps parents make informed choices. Social health problems such as HIV/AIDS and teenage pregnancies could be better controlled.³⁻⁷

Despite family planning being a family matter, its initiatives were usually concentrated on women^{8,9} because traditionally, fathers made little or no effort in child raising. Women were usually the ones who performed childcare duties.¹⁰ Many studies done on fertility and contraception also concentrated on women possibly due to the variety of female contraceptive methods as opposed to that of the males. In reproductive and health matters, men's effort in family planning remained invisible.¹¹

The notion that men are uninterested in taking an active role in family planning can be contested as researches done on this area are limited obsolete. The case is especially true for developing nations like Malaysia, where the most recent research on this topic dated back to decades ago. Also, as family dynamics have evolved over the years, fathers' involvement in family planning has become crucial in enhancing family well-being. Hence, this study aims to identify men's involvement in discussing family planning activities with their spouses and their association with socio-economic characteristics.

Methods

Study design

This was a cross-sectional survey describing the roles of men in family planning and determining its association with their socio-economic status. All the married male attendees at the clinic, aged 50 years and below, were approached to answer a set of self-administered questionnaires, asking about their involvement in family planning activities.

Study site

This survey was carried out from January to March 2014 at the Universiti Kebangsaan Malaysia (UKM) primary care clinic. The university primary care clinic served as a family practice clinic to a population within 10 km of its radius. Services offered in the clinic include general outpatient treatment, antenatal care, chronic disease follow-up and family planning services. Patients visiting the clinic amounted up to 200 daily, most of which were elderly patients. The UKM primary care clinic was chosen as the site of study due to its accessibility among service-users in Cheras, Kuala Lumpur. Cheras, a suburb of Kuala Lumpur, the capital city of Malaysia served as an ideal site due to its location situated between the urban city centre and the outskirts of Selangor state. Therefore, its population was an good representation of a typical middle-class Malaysian society.

Development of the questionnaires

A set of self-administered questionnaire was used in the study. The questionnaire was adapted from National Family Development Board.¹² The original questionnaire was designed for a survey to study the contraceptive methods used among Malaysian women. Therefore, modifications were made to the questionnaires so that it suited the present study objectives and could be administered to men. There were two sections to the questionnaire. The first section was on participants' demographic and socio-economic data. These included their marital span, marital status, highest education level, number of children and average monthly income. The second section was on the participants' roles in family planning decision, which was measured by their involvement in the discussion of four family planning activities: pregnancy planning (PP), future children planning (FCP), family planning method (FPM) and DFS. For both sections, the number of questions totalled up to 25, including some subquestions. For each family planning activity, participants responded on whether they had discussed the

activities and whether they made the decision jointly or unilaterally. A 'joint decision' was made when opinions of the wife and husband were considered equally, whereas a 'unilateral decision' was made when either the wife or husband had more influence on the decision made.

The content validation of the items in this questionnaire was by means of discussing with a family medicine specialist who had ample experience in working on men's health. The questionnaire was prepared in two languages: Malay and English. The original items were constructed in English and translated to Malay, then back to English. The forward- and backward-translated versions were validated by accredited translators from the university linguistic department. This was followed by face validation with a group of 10 men who fulfilled the inclusion criteria, but were not included in the actual study. Feedback was obtained and we noted no discrepancy between the wording of the questionnaire and interpretation by the participants. With the final versions of the questionnaires, a pilot study was carried out in the clinic to test for the feasibility of survey and time needed to answer the questionnaires. Participants took 15 to 20 minutes on average to complete the questionnaires.

Recruitment of participants

A sample size of 166 participants was needed in order to have 99% certainty that the proportion of decision would fall between 40 and 60, using the OpenEpi online sample size calculator (<http://www.openepi.com/SampleSize/SSPropor.htm>). The convenience sampling method was adopted with the inclusion criteria being married men below or equal the age of 50 (assumed to be in reproductive age), while men who were unfit to respond (e.g., emotionally and psychologically disturbed or mentally challenged) were excluded. Accompanying persons of patients to the clinic were also included. A total of 117 (70%) respondents were accompanying persons, 42 (25%) were patients at the clinic while 8 (5%) were staff at the clinic.

The questionnaire was distributed via direct solicitation, where the researcher approached the male attendees, explained the nature of study and obtained their consent to participate as respondents. Sampling was done during the day as the clinic only operated during these practice hours. Recruitment started from 8 am to 3 pm on weekdays as records in the clinic showed that patient consultations peaked during those hours. The time of sampling was also adjusted based on the availability of

researchers to be present to provide assistance to respondents. An information sheet that contained a statement assuring participant anonymity and confidentiality was also distributed before gaining written consent. All respondents were requested to complete the questionnaire on the spot, with the researcher available at the site in case any assistance was needed. Most of the respondents did not need help in answering the questionnaires. However, there were a few respondents who discussed with their wives while answering. The study was approved by the UKM Research Ethics Committee (FF-2014-171).

Data analysis

The data were analysed using SPSS (IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY). Descriptive and inferential statistics were applied. A *t*-test was used to determine the association between a continuous variable and

a categorical outcome, while cross-tabulation and Chi-square tests were used to determine the association between a categorical variable and categorical outcomes. Simultaneous multivariate logistic regression analysis was undertaken to identify the independent association between the husband discussing the four family planning activities and socio-demographic characteristics. We excluded religion in the regression models because ethnicity and religion were closely related, and collinearity was observed when they were included. The *p*-value was set at 0.05 for statistical significance.

Results

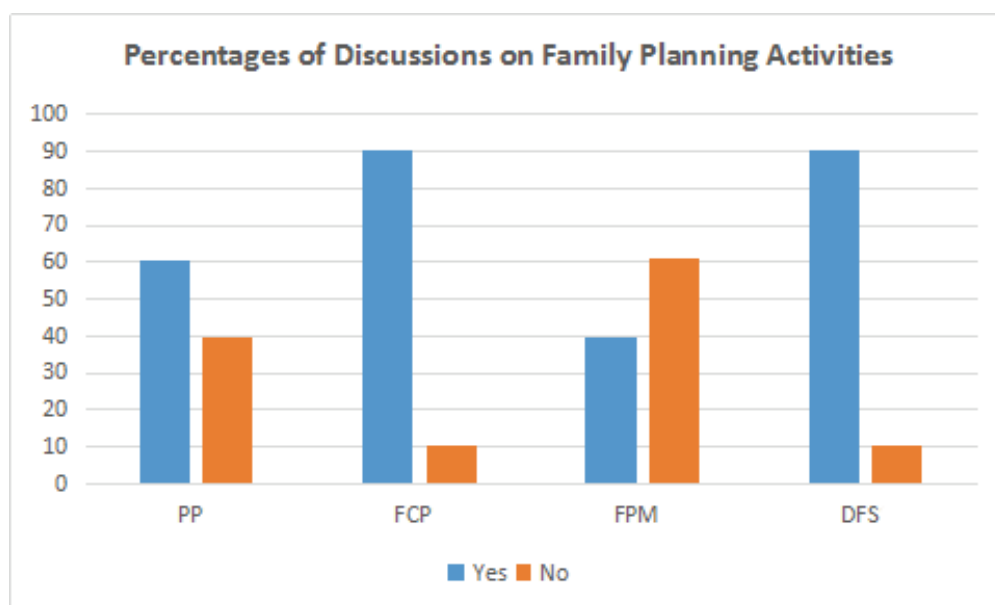
Out of the 200 men approached, 33 refused to participate, mainly due to disinterest and time constraint. This gave a total of 167 respondents in the sample and a response rate of 83.5%. **Table 1** shows the demographic profiles of the respondents.

Table 1. Demographic profiles of respondents, *n* = 167

	Mean (SD)	Frequency	Percentage (%)
Age (years)	38.3 (±7.8)	–	–
Ethnicity			
Malay		95	57.2
Chinese		44	26.5
Indian		22	13.3
Others		5	3.0
Religion			
Islam		95	57.2
Buddhism		27	16.3
Hinduism		18	10.8
Christianity		24	14.5
Others		2	1.2
Highest education level			
No formal education		1	0.6
Primary education		7	4.2
Secondary education		53	31.9
Tertiary education		105	63.3
Occupational status			
Employer		21	12.7
Employee		120	72.3
Self-employed		20	12.0
Family caretaker without pay		1	0.6
Retired		3	1.8
Unemployed		1	0.6

Table 1. Demographic profiles of respondents, $n = 167$

	Mean (SD)	Frequency	Percentage (%)
Monthly household income			
<RM 2000		15	9.0
RM 2001–3000		45	27.1
RM 3001–4000		40	24.1
RM 4001–5000		29	17.5
RM 5001–6000		18	10.8
RM 6001–7000		9	5.4
>RM 7000		10	6.0
Marital status			
Married		163	98.2
Widower		3	1.8
Total years of marriage			
0–10		81	48.8
11–20		45	27.1
21–30		39	23.5
31–40		1	0.6
Total number of children			
0		22	13.3
1		38	22.9
2		47	28.3
3		21	12.7
4		27	16.3
>4		11	6.6

**Figure 1.** Percentages of discussions in different family planning activities

Almost all respondents discussed FCP and DFS with their spouses (**Figure 1**). About two-thirds of the respondents discussed their PP

with their wives. Despite their participation in these family planning activities, it was found that men tended not to bring the issue of FPMs into discussions.

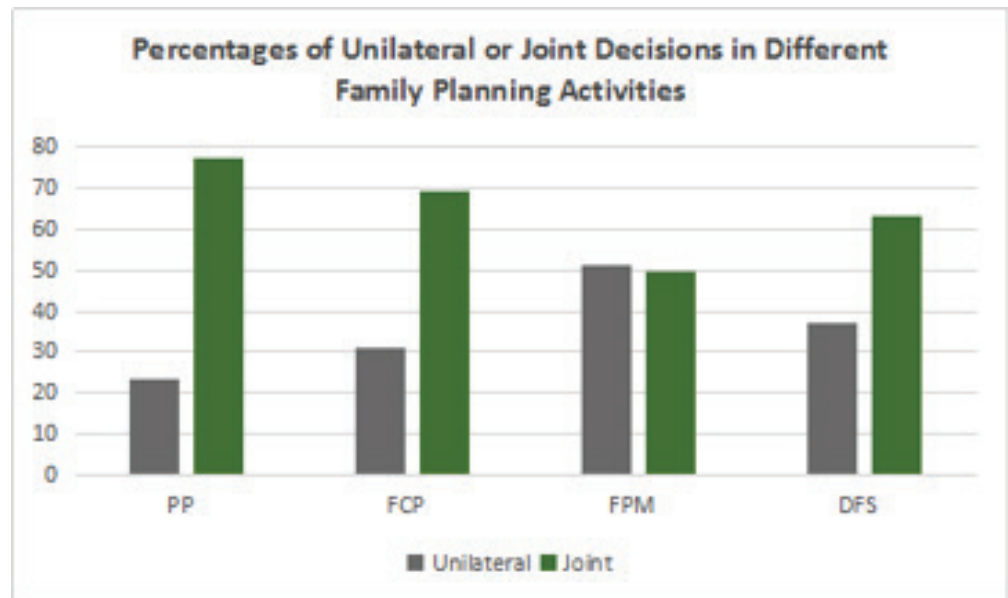


Figure 2. Percentages of discussions in different family planning activities

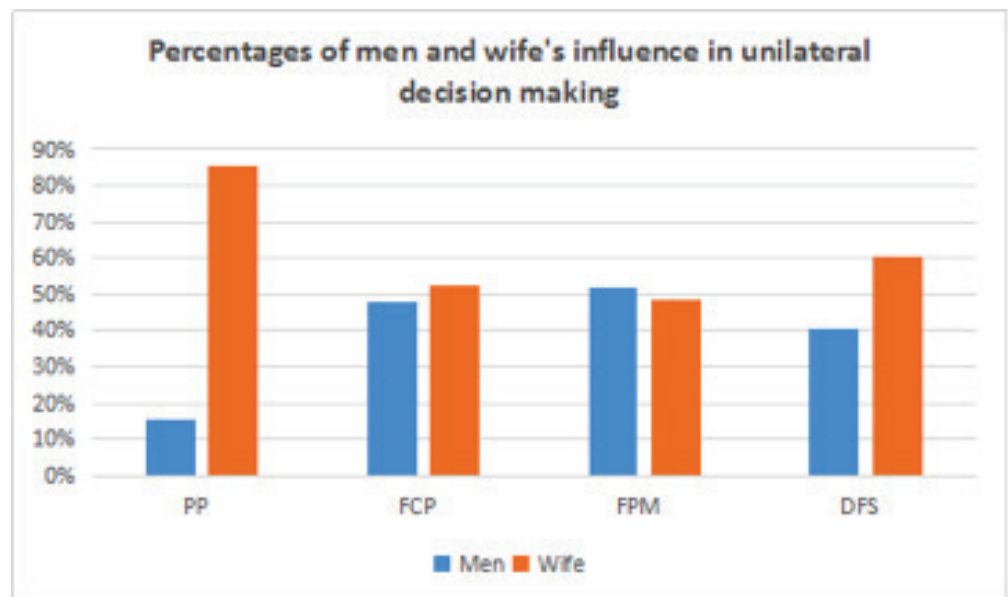


Figure 3. Percentages of men and wife's influence in unilateral decision making

Among the men who stated that they discussed family planning activities with their spouses, their involvement in the discussions were also assessed (**Figure 2**). Most decisions on PP, FCP and DFS were done jointly (shared decision by husbands and wives equally). However, among those who discussed FPM, slightly more than half of the decisions were made unilaterally, which means that the process of decision-making was more influenced by either the husbands or the wives.

Of the unilateral decisions made in different family planning activities, the wife's influence was significantly higher in the aspects of PP and DFS (**Figure 3**). In FCP and FPM discussions, cases of husband-influenced and wife-influenced decisions were distributed rather evenly (**Figure 3**).

Table 2. Associations between demographic profiles and discussing PP

Variables	Not discussed PP* (N = 57) Mean (SD)	Discussed PP* (N = 87) Mean (SD)	Test	p-Value
Mean age (years)	38.4 (±7.7)	40.9 (±6.4)	t-test = -1.98	0.050
Mean monthly income (RM)	3382.8 (±1169.6)	4864.6 (±1664.2)	t-test = -6.27	<0.001
Years of marriage (years)	13.95 (±9.5)	15.40 (±7.5)	t-test = -1.023	0.004
Ethnicity	n (%)	n (%)	$\chi^2 = 1.916$	0.384
Malay, N = 79	28 (35.4)	51 (64.6)	(df = 2)	-
Chinese, N = 42	16 (38.1)	26 (61.19)	-	-
Indian, N = 19	10 (52.6)	9 (47.4)	-	-
Religion	-	-	$\chi^2 = 5.313$	0.150
Islam, N = 78	28 (35.9)	50 (64.1)	(df = 3)	-
Buddhism, N = 27	13 (48.1)	14 (51.9)	-	-
Hinduism, N = 16	9 (56.3)	7 (43.7)	-	-
Christianity, N = 21	5 (23.8)	16 (76.2)	-	-
Highest educational level	-	-	$\chi^2 = 9.534$	0.002
No tertiary, N = 56	31 (55.4)	25 (44.6)	(df = 1)	-
Tertiary, N = 88	26 (29.5)	62 (70.5)	-	-

Table 3. Associations between demographic profiles and discussing FCP

Variables	Not discussed FCP* (N = 17) Mean (SD)	Discussed FCP (N = 149) Mean (SD)	Test	p-Value
Mean age (years)	37.12 (±7.8)	28.46 (±7.8)	t-test = -0.668	0.505
Mean monthly income (RM)	3915.9 (±1780.8)	4079.2 (±1648.5)	t-test = -1.591	0.115
Years of marriage (years)	11.24 (±7.6)	13.41 (±9.0)	t-test = -0.959	0.073
Ethnicity	n (%)	n (%)	$\chi^2 = 4.283$	0.117
Malay, N = 95	14 (14.7)	81 (85.3)	(df = 2)	-
Chinese, N = 44	2 (4.5)	42 (95.5)	-	-
Indian, N = 22	1 (4.5)	21 (95.5)	-	-
Religion	-	-	$\chi^2 = 4.906$	0.179
Islam, N = 94	14 (14.9)	81 (85.1)	(df = 3)	-
Buddhism, N = 28	1 (3.6)	27 (96.4)	-	-
Hinduism, N = 18	1 (5.6)	17 (94.4)	-	-
Christianity, N = 24	1 (4.2)	23 (95.8)	-	-
Highest educational level	-	-	$\chi^2 = 0.868$	0.352
No tertiary, N = 61	8 (13.1)	56 (86.9)	(df = 1)	-
Tertiary, N = 105	9 (8.6)	96 (91.4)	-	-

Table 4. Associations between demographic profiles and discussing FPMs

Variables	Not discussed FPM* (N = 101) Mean (SD)	Discussed FPM (N = 65) Mean (SD)	Test	p-Value
Mean age (year)	36.6 (±7.9)	41.05 (±6.8)	t-test = -3.878	<0.001
Mean monthly income (RM)	3382.8	4864.6	t-test = -6.27	<0.001
Years of marriage (years)	(±1355.3) 11.35 (±8.9)	15.40 (±7.5) 16.05 (±8.1)	t-test = -1.023	0.004
Ethnicity	n (%)	n (%)	$\chi^2 = 2.658$ (df = 2)	0.265
Malay, N = 95	61 (64.2)	34 (35.8)	-	-
Chinese, N = 44	22 (50.0)	22 (50.0)	-	-
Indian, N = 22	14 (63.6)	8 (36.4)	-	-
Religion	-	-	$\chi^2 = 4.319$ (df = 3)	0.229
Islam, N = 94	61 (64.9)	33 (35.1)	-	-
Buddhism, N = 28	17 (60.7)	11 (39.3)	-	-
Hinduism, N = 18	11 (61.1)	7 (38.9)	-	-
Christianity, N = 24	10 (41.7)	14 (58.3)	-	-
Highest educational level	-	-	$\chi^2 = 6.764$ (df = 1)	0.009
No tertiary, N = 61	45 (73.8)	16 (26.2)	-	-
Tertiary, N = 105	56 (53.3)	49 (46.7)	-	-

Table 5. Associations between demographic profiles and discussing DFS

Variables	Not discussed DFS* (N = 17) Mean (SD)	Discussed DFS (N = 149) Mean (SD)	Test	p-Value
Mean age (years)	33.2 (±6.7)	38.91 (±7.73)	t-test = -2.929	0.004
Mean monthly income (RM)	3333.5	4145.6	t-test = -2.940	0.006
Years of marriage (years)	(±983.7) 6.9 (±6.3)	(±1700.2) 13.9 (±8.8)	t-test = -4.148	0.000
Ethnicity	n (%)	n (%)	$\chi^2 = 3.014$ (df = 2)	0.222
Malay, N = 95	12 (12.6)	83 (87.4)	-	-
Chinese, N = 44	2 (4.5)	42 (95.5)	-	-
Indian, N = 22	1 (4.5)	21 (95.5)	-	-
Religion	-	-	$\chi^2 = 4.319$ (df = 3)	0.229
Islam, N = 94	12 (12.8)	82 (87.2)	-	-
Buddhism, N = 28	2 (7.1)	26 (92.9)	-	-
Hinduism, N = 18	1 (5.6)	17 (94.4)	-	-
Christianity, N = 24	1 (4.2)	23 (95.8)	-	-
Highest educational level	-	-	$\chi^2 = 6.764$ (df = 1)	0.009
No tertiary, N = 61	6 (9.8)	55 (90.2)	-	-
Tertiary, N = 105	11 (10.5)	94 (89.5)	-	-

Bivariate statistics was applied to determine the presence of any association between men's socio-economic characteristics and the decision-making in different family planning activities. Different aspects of family planning activities were associated differently with different socio-economic characteristics (Table 2–5). Men who discussed PP and FPM were

associated with older age, higher income, longer duration of marriage and higher education level (Table 2 and 4); while those who discussed DFS were only associated with older age, higher income and longer duration of marriage (Table 5). There was no association found between men who discussed FCP with any of the socio-economic characteristics studied. (Table 3).

However, from multivariate analyses, independent associations between men who discussed family planning activities and socio-demographic characteristics were demonstrated only in PP and FPM discussion (**Table 6**). Older men and higher monthly household income were independently associated with higher odds of discussing PP. After controlling for age, shorter duration of marriage was independently associated with higher odds of discussing PP. This reversed association was noted in bivariate analysis. With regards to FPM discussion, the only independent association was found with having tertiary education after controlling for age, monthly household income and duration of marriage. (**Table 6**).

Table 6. Multivariate logistic regression for independent association between men's role in the discussion of four family planning activities and their socio-demographic characteristics

Family planning activities	Nagelkerke R Square	Independent variables (Demographic factors)				
			Adjusted OR	95% Confidence Interval		
				Lower	Upper	p- value
Discussing PP	.358	Age (years)	1.170	1.000	1.370	0.050
		Monthly household Income (RM)	1.001	1.000	1.001	0.000
		Years of marriage				
		Ethnicity Malay*	.882	.779	.999	0.049
		Chinese	.583	.235	1.449	0.246
		Indian	.422	.125	1.418	0.163
		Tertiary Education Yes	2.230	.857	5.803	0.100
Discussing FCP	.093	Age (years)	.957	.797	1.150	0.641
		Monthly household Income (RM)	1.000	.999	1.000	0.455
		Years of marriage				
		Ethnicity Malay*	1.094	.929	1.288	0.283
		Chinese	3.475	.736	16.414	0.116
		Indian	3.232	.393	26.553	0.275
		Tertiary Education Yes	2.097	.623	7.059	0.232
Discussing FPM	.255	Age (years)	1.082	.944	1.239	0.257
		Monthly household Income (RM)	1.000	1.000	1.001	0.064
		Years of marriage				
		Ethnicity Malay*	1.002	.897	1.119	0.978
		Chinese	1.452	.650	3.240	0.363
		Indian	.998	.346	2.882	0.997
		Tertiary Education Yes	3.240	1.330	7.889	0.010
Discussing DFS	.150	Age (years)	.989	.815	1.200	0.911
		Monthly household Income (RM)	1.000	.999	1.001	0.959
		Years of marriage				
		Ethnicity Malay*	1.120	.921	1.362	0.255
		Chinese	2.459	.500	12.094	0.268
		Indian	2.798	.329	23.820	0.346
		Tertiary Education Yes	1.553	.403	5.992	0.523

Discussion

It was believed that Malaysian men had lower awareness towards family planning compared to their female counterparts. A 1970 study by the National Family Development Board⁹ demonstrated that the majority of men discussed with their wives on family planning activities such as PP, FCP and DFS. However, with regards to FPM, less than half of them held discussions with their wives. The same trend could be seen in this study, where decisions on PP, FCP and DFS were made jointly, but decisions on FPM were made unilaterally. Factors associated with men participating in family planning discussions were older age, higher income, higher educational level and shorter duration of marriage.

Roles of men in family planning

Decision making and responsibility towards family planning often start with successful inter-spousal communication.¹³ As seen in the results, a significantly higher proportion of men engaged in the discussions with their spouses. Furthermore, their success was reflected by the mutual decisions made. We also noted that men with higher socio-economic status discussed family planning more than men with lower socio-economic status. This was likely to be because of the urban setting of the study site where men often had higher socio-economic status compared to those in rural settings. This concurred with the high proportion of participants with tertiary education. The high proportion of men discussing family planning matters may also indicate an improvement in men's involvement compared to statistics published in 1970.⁹ This could be due to an elevated level of awareness towards family planning activities and an improvement in the socio-economic status of Malaysians.

We postulated that awareness and exposure to family planning matters and societal influence were important reasons for men's involvement in family planning matters. From the literature, men were willing to participate in reproductive health programmes but lacked the knowledge, information and access to do so.¹⁴ Our findings noted a higher proportion of men were involved in the discussion of FCP than PP. This could be because men only start to be involved in family planning discussions after they have had children. Without much discussions done on previous pregnancies, they would want to discuss about future pregnancies. With the current societal exposure on the role of men in family planning and their experience with their wife's past pregnancies, men are more prepared to discuss FCP.

On the other hand, other researchers proposed that the low level of men's participation in the discussions might probably be attributed to traditional notions about gender roles, where families have been shaped to make decisions led by men. As the lead of the house, men would have the final say in all matters other than family planning.¹⁵ Ashford⁵ further confirmed that the opposition by family members on men's involvement in family planning decisions also led to the absence of their participation. Therefore, creating an environment that facilitates men's involvement in family planning in health care settings or in the society may encourage men's involvement. On the other hand, a balance of influence between men and women in family planning is important, because men's unilateral opposition to family planning will prevent women from regulating their fertility rights.¹⁶ Nevertheless, the specific reasons behind the current higher level of men's involvement in family planning matters need to be further explored.

Regarding FPMs, the lack of its discussion might be due to the perception that operationalising family planning is the sole role of women. Since women are the ones visiting clinics for regular check-up, service providers will tend to feel that it is easier and more convenient to motivate a woman for family planning rather than a man.¹⁴ Men would be unlikely to seek family planning services in a women-specific medical centre. Furthermore, Samuel¹⁶ reported that some men view that if any FPM is used, it was seen as a sign of unfaithfulness and lack of commitment to the marriage. However, despite the low discussion rate, men tended to exert more influence in unilateral decision-making, which might imply that the interest of men in the discussions might be more than usually assumed.¹⁷ This emphasised the need of creating health care settings that facilitate men's involvement in family planning.

Socio-economic effects on family planning

Demographically, men were regarded as economically responsible, but uninvolved in fertility and family management issues.¹⁵ This was reflected by the abundance of published studies on family planning matters focusing only on women as their primary subjects in Malaysia. As a culturally diverse nation, the Malaysian society has been shaped in a way that different people hold different beliefs and practice their own respective traditions. Men were also believed to hold greater authority in the home and community in Malaysia.¹⁸ These cultural differences might account for the social recognition of masculinity and femininity, and

have a profound impact in influencing the sexual roles of men and women, especially in their health practices.¹⁴

Greene and Biddlecom¹⁵ reported that men tended to make decisions in a problem-oriented manner. This is evident in this study because a low PP discussion is associated with low men's monthly income. It can then be inferred that men tended to discuss family planning according to their economical ability. The less capable a couple is financially, the less likely a pregnancy would be planned, because a solution to encounter financial lacking is to abstain from continuous reproduction. Various studies also lent support to the fact that a higher educational level (an important determinant of income) increased the approval and acceptability of men towards family planning.^{9,19,20} These findings suggested that men's involvement in family planning could be an engagement beyond providing financial support for the family. Men would participate in family planning as long as they are well aware of it regardless of their financial status. However, the basic need of financial support is often fulfilled in men with higher educational level and income.

Another trend displayed by this study was that men of older age tended to play a more active role in family planning discussions. Bivariate analysis results showed that age and longer years of marriage were related to men discussing PP. It could be a worrying trend in Malaysia that men only realise their role in the family in the later years of life, because younger men should also realise the benefits of family planning. After adjusting for all four socio-demographic factors, older age was independently associated with the discussion, but shorter duration of marriage (instead of longer) was also independently associated with the discussion. The reversal of the direction of association between men discussing family planning and duration of marriage was an interesting finding. Longer duration of marriage showed in the bivariate analysis finding was likely due to the confounding effect of age because longer duration of marriage is logically associated with older participants. After adjusting for age, the reversal of direction of association is comprehensible because discussing family planning should occur in those with shorter duration of marriage, as younger couples are more reproductive than older couples. Another plausible explanation is that, participants with longer duration of marriage could be from an older generation where engagement in family planning discussions might not be the norm. Thus, it could indicate that younger generations are discussing family planning more than the older generation.

FPM discussion was independently associated with tertiary education level instead of older age, higher income and longer years of marriage, which were noted in the bivariate analysis. Thus, the three latter socio-demographic factors are likely confounders. Discussing FPM may necessitate technical understanding of the methods used. Thus, having tertiary education may put men in a better position to discuss the methods for family planning. However, to truly understand the reasons for our observation requires another study that looks at both men and their wives in this matter.

Although DFS discussion was associated with some demographic factors, the subsequent multivariate analysis did not demonstrate a similar association because the number of men who did not discuss about DFS was small, $n = 17$. Thus, the sample size was not powered to study this dependent variable.

Significance of study and recommendations for future improvements

The findings of this study shed light on the current roles of men in family planning discussions. It is marked how far men have achieved in various family planning activities and serves as a benchmark to identify the areas needed for further improvements. This study contributed as a reminder that it is the responsibility of a couple to practice shared family planning decision-making, and men's participation should also be emphasised as equally as that of women.

While this study focused on men's opinion on the family planning roles of men in the UKM Primary Care Clinic, it should not be seen as being representative of all Malaysian men. We acknowledge that family planning issues should involve the couple as a whole. A more detailed and complete picture on men's role in family planning could be gained by interviewing men and their spouses simultaneously, as we have observed in this study where some participants discussed the questionnaire with their spouses. However, this would involve greater resources. Nevertheless, understanding the issues from the men's perspective alone helped to add another perspective to the issue.

Another limitation of this study was the adoption of the convenience sampling method, meaning that results should be considered indicative, and not definitive. A mean age of 38.3 years indicated that men involved in this study were less likely to be new, inexperienced parents. This was because the clinic in the study served a large proportion of patients with chronic illness, which meant that

participants tended to be older. Nevertheless, younger participants were found to have less discussion in various aspects of family planning compared to older participants. Thus, younger men could be targeted as they would also be in the active reproductive age group. Replications in other populations or conditions should be done to further define the generalisability of the study findings. Alternatively, a randomised sample should be used to increase the validity of results. It was also observed that some respondents discussed the questionnaire with their wives, which might have led to biases in the data. Another source of bias would be the timing of sampling, as social theories of masculinity suggested that men avoided women's clinics and they were less likely to attend clinics during office hours.

Conclusion

Overall, this study showed that men achieved significant participation in family planning activities such as PP, FCP and DFS but less in FPM discussions. However, FPM discussions were done slightly more unilaterally rather than jointly, with men exerting more influence on the decisions made.

Data analysis showed associations between men's age, monthly income, education level

and years of marriage with their roles in family planning. Older men, men who obtained a high level of education (tertiary level at least), men who have above average monthly income and men with shorter duration of marriage participated more in family planning. As an approach to improve men's roles in active family planning, men should obtain more information on available FPMs to enable discussion of family planning, and support their wives' and own use of family planning.

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How this paper makes a difference to general practice?

- This study showed that paternal involvement in family planning activities was greater with men of older age. Hence, younger men should be the focus of intervention for family planning activities.
- This study showed that men's involvement in FPMs discussion were low. Services in family planning clinics should be more inviting to men in order to improve this situation.

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