

What does your partner want? Using a gender equality lens to assess partner support and involvement in Family Planning in Uganda

Bolanle Olapeju (✉ bolanle.olapeju@usuhs.edu)

Uniformed Services University of the Health Sciences

Anna Passaniti

Johns Hopkins Center for Communications Programs

Paul Odeke

USAID/Social and Behavior Change Activity

Zoé Mistrale Hendrickson

Johns Hopkins Center for Communications Programs

Judith Nalukwago

USAID/Social and Behavior Change Activity

Pallen Mugabe

USAID/Social and Behavior Change Activity

Leonard Bufumbo

USAID/Social and Behavior Change Activity

Musa Kimbowa

USAID/Social and Behavior Change Activity

Fiona Amado

USAID/Social and Behavior Change Activity

Emmanuel Kayongo

USAID/Social and Behavior Change Activity

Mabel Naibere

USAID/Social and Behavior Change Activity

Nanah Nanyonga

USAID/Social and Behavior Change Activity

Glory Mkandawire

USAID/Social and Behavior Change Activity

Richard Mugahi

Reproductive Health and Infant Division, Ministry of Health of Uganda.

Tabley Bakyaite

Department of Health Promotion, Education and Communication, Ministry of Health of Uganda

Richard Kabanda

Department of Health Promotion, Education and Communication, Ministry of Health of Uganda



Doug Storey

Johns Hopkins Center for Communications Programs

Keywords: decision-making, family planning, partner, support, Uganda

Posted Date: December 20th, 2022

DOI: <https://doi.org/10.21203/rs.3.rs-2382761/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Abstract

Background: While partner involvement in health-related decision-making is linked with positive health behaviors, a key gap in the literature exists on how this construct should be measured and the specific ways men and women in Uganda perceive partner support in the context of family planning. The USAID-funded Social and Behavior Change Activity (SBCA) in Uganda explored the differences in male versus female priorities in the decision-making considerations and preferred measures of partner support related to family planning in order to design contextually relevant solutions.

Methods: Cross-sectional study using a nationally representative telephone survey among 1177 men and women aged 18-49 years old in sexual partnerships. Key measures included current family planning use (Are you or your partner currently doing anything to prevent or delay becoming pregnant?); family planning decision-making considerations (In your experience, which of the following are the three most important considerations as you make family planning decisions?); and preferred partner support (What level of involvement would you like to see from your partner in your family planning decisions?). Multivariable logistic regressions explored factors associated with decision-making priorities and preferred partner support, adjusting for sociodemographic confounders.

Results: Two-thirds (66%) of men and women wanted a high level of involvement from their partner, which was associated with higher odds of using family planning (aOR: 2.46, 95% CI: 1.87 - 3.24). Specific ways partners could be involved included accompanying them to health services (39%), permitting them to get family planning services (26%), and jointly discussing family planning options (23%). Of note, more women wanted their partner to accompany them (45%) than men (33%) while more men (29%) wanted to jointly discuss options than women (15%).

Conclusions: Partner support needs to be operationalized differently for men and women; therefore, social and behavior change (SBC) interventions should employ a gender lens when implementing family planning programs. The project used these insights to implement a health campaign that leverages the views of key audiences; explicitly encourages partner dialogue across the various life stages; and empowers women with knowledge and skills to have honest conversations with their partners about when to have children and how many to have.

Plain English Summary

In Uganda, the uptake of family planning services may be influenced by the degree to which partners support or are involved in decisions and actions regarding family planning use. Partner support has been defined in other studies from the male perspective as either escorting his partner to the family planning clinic or providing approval or encouragement. Using a national telephone survey of adults aged 18-49 years, we explored differences in preferred levels of partner support for family planning among men and women. We found that most (two-thirds) male and female respondents wanted a high level of involvement from their partner, and this desire was associated with higher use of family planning. Respondents noted specific ways their partners could be involved: accompanying them to health services (39%), permitting them to get family planning services (26%), and jointly discussing family planning options (23%). Of note, more women wanted their partner to accompany them (45%) than men (33%), while more men (29%) wanted to jointly discuss options than women (15%). Our findings suggest that partner support is defined differently for men and women in Uganda. Behavior change programs should take this into account when implementing activities to improve family planning within communities. The study findings were also used to design and implement a health campaign in Uganda that explicitly encourages partner dialogue across the various life stages and empowers women with knowledge and skills to have honest conversations with their partners about when to have children and how many to have.

Introduction

Expanding access to family planning services so that individuals can choose when to have children strengthens global health and human rights in a myriad of ways, including lower maternal mortality rates, expanded educational opportunities, and empowerment of gender minorities(1, 2). Between 2010 and 2019, Uganda was among the top 10 countries with the largest increase in modern contraceptive use and the largest decline in total fertility in the world(3). Despite these recent gains, the unmet need for family planning in Uganda and elsewhere in sub-Saharan Africa remains high, with 28% of women in Uganda having an unmet need for family planning(4). In 2020, the Government of Uganda committed to reducing the country's unmet need for family planning and aimed to increase the modern contraceptive prevalence rate from 30.4–39.6% by 2025(5). To do this, efforts to address gender inequalities and foster partner involvement in family planning decisions and behaviors could be a promising approach. In this study, we refer to gender as the socially constructed social relationships between men and women in terms of their roles, behaviors, activities, attributes, and opportunities, and which are based on different levels of power(1). Gender is a hierarchical construct that produces inequalities, which in turn intersect with other social, economic, and health inequalities(6).

Role of Gender Equality and Partner Support in Family Planning

Recent studies have identified strong associations between such gender inequalities and family planning use(6, 7). The freedom to choose when to have children and how many children to have offers both women and men opportunities to achieve their fullest potential, a central premise of gender equality movements(8). Meeting family planning needs not only relies on the extent to which relevant family planning services are readily available, but also the extent to which available services are utilized within communities(9). Use of family planning services depends on men and women's abilities as sexual partners to negotiate contraceptive use as well as navigate power dynamics in partnerships and personal relationships in order to ensure shared responsibility in the uptake of family planning(10).

Public health studies and interventions, including those in sexual and reproductive health, often conceptualize men as the primary decision-makers within the household, while women are the primary enactors responsible for intrahousehold health(11, 12). Consequently, many health programs further exacerbate existing unequal power dynamics and have been gender-neutral—not explicitly taking gender-related differences in health needs and health-seeking behavior into account(11)—or even gender-exploitative—taking advantage of unbalanced gender norms, roles, and relations(13). There is a need for studies that explore desired partner involvement in family planning within communities with the intent of challenging the assumption that men are the primary decision-makers within the household, and that their involvement in family planning decision-making should or must uphold this norm.

Review of Relevant Literature

Improving partner responsibility and involvement in sexual and reproductive health care may positively impact mental health and well-being for individual women as well as couples(14). A study conducted in rural Uganda demonstrated that women who found it difficult to have conversations with their partner about reproductive health issues, including family planning, were significantly more likely to have symptoms of depression and anxiety compared to women who found these conversations easy(15). Other studies also conducted in Uganda found that the majority of women expressed a general discontent with partner involvement in reproductive health, with many women describing a lack of autonomy in decision-making about their health(16, 17). These studies cited financial dependency, gender disparities, lack of autonomy, poor communication between couples, and perceptions regarding social norms as major challenges to reproductive health service utilization(16, 17). More broadly, these couple-centric challenges to reproductive health care act as a barrier to achieving the ideals of gender equality by preventing both women and men from achieving their fullest potential, as individuals and as couples.

Research Gaps and Study Aims

One major gap in the current understanding is how to adequately define and operationalize partner support in family planning. In many contexts, family planning service providers have defined partner support as when a man escorts his female partner to a health facility(18–20). In addition, partner support is typically reported by women as their partner's approval(21) or encouragement(22) of contraceptive use, or involvement in contraceptive discussions and decision-making, with limited studies exploring partner support from the man's perspective(20, 23). Striking a balance between these different perspectives (provider, female, and male) would improve the current understanding of partner support and male engagement in family planning. This study aims to explore family planning decision-making and partner support using a gender equality lens. Specifically, we explore differences in male versus female priorities in decision-making considerations and preferred measures of partner support related to family planning.

Relevant underpinnings for this study include the social support theory(24), which refers to resources such as advice and information, emotional support, services, or appraisals that people have access to, based on their relationships and social ties(25). The exchange of such social support can take place daily within couples' lives and influence their decisions or actions, such as whether or not to use a contraceptive method(26). We also posit that in order to improve partner support in family planning, research and interventions alike must employ a gender-transformative approach that accounts for gender dynamics and differences(27, 28). Amidst the backdrop of hegemonic inequitable gender norms related to family planning in Uganda(8), our research investigates how couple dynamics in family planning can be better quantified and leveraged in the design of relevant family planning programs for Ugandan men, women, and couples.

Methods

Overview

This study was implemented by the United States Agency for International Development (USAID)-funded Social and Behavior Change Activity (SBCA) in Uganda, a 2020–2025 program managed by the Johns Hopkins University Center for Communication Programs that envisions a Uganda where individuals and communities are healthy, resilient, and supported by strong and adaptable systems and institutions to lead productive lives(29). The program provides social and behavior change (SBC)-related technical assistance to the Ministry of Health and other stakeholders to design and implement SBC initiatives that contribute towards a healthy nation. Specific outcomes include a reduction in maternal and child mortality, malaria prevalence, total fertility rate, new HIV infections, and tuberculosis prevalence, and improved nutrition outcomes. This study was part of formative research to identify individual and social cultural determinants affecting the uptake of key desired health behaviors and practices, including family planning. Results of this study and other formative research have since been used to inform the design and implementation of contextually relevant SBC interventions.

Study Design and Participants

Study data were drawn from a cross-sectional nationally representative telephone survey of adults aged 18–49 years in Uganda in December 2020. The telephone survey was conducted due to limitations in face-to-face data collection during the COVID-19 pandemic in the context of high telephone ownership (about 77%) in Uganda(30). Study inclusion criteria included the following: i) Resides in one of the four selected regions of Uganda: Central, Northern, Western, and Eastern; ii) Communicates effectively in the local language or English; iii) Provides informed consent; and iv) Has access to a mobile phone either personally or through someone in the household.

Sampling and Sample Size

The sampling procedure included a probability proportional to size (PPS) sampling of enumeration areas (primary sampling units), stratified by region, and based on projected data from the most recent 2014 national census. Next, study enumerators visited the enumeration areas and worked with community leaders to acquire a list of representative phone numbers for all households in the area. Specifically, study team members visited each household, briefly introduced the study, and requested the contact number of the head of the household or responsible adult. The target number of telephone numbers was then randomly selected from the list of representative phone numbers within the enumeration area. After this, study data collectors systematically contacted, recruited, and interviewed sampled respondents. An adult man or woman was selected from each household. If a potential participant was not reachable, a replacement telephone number was then randomly selected from the list of representative phone numbers.

The telephone survey recruited a total of eight households from all 175 enumeration areas for an overall sample of 1400 based on the following parameters: an outcome prevalence of 0.50 (for maximum variability); power = 0.80; alpha = 0.05; delta = 0.075; and a design effect of 1.5. This study explores family planning outcomes and thus excludes ineligible participants who are not in sexual partnerships (n = 233) for an analytical sample size of 1177 adults.

Data Collection

The telephone survey was administered in December 2020. Trained data collectors called participants, explained the purpose and benefits of the study, conducted eligibility screening, and obtained informed consent before proceeding with the survey questions. The survey interview lasted about 20–30 minutes and included questions on sociodemographic characteristics and behavioral outcomes related to family planning, malaria, maternal and child health, HIV, and COVID-19.

Ethical considerations

The ethical review and approval of the study were conducted by the Institutional Review Boards (IRB) from the Johns Hopkins Bloomberg School of Public Health (IRB No. 00013837) and the Makerere University Institute of Public Health Higher Degrees, Research and Ethics Committee (No. 864). Before participating in the telephone survey, all respondents provided verbal consent.

Measures

Key variables included the following:

Current family planning use (yes versus no) was based on the survey question: Are you or your partner currently doing anything to prevent or delay becoming pregnant?

Family planning decision-making considerations were assessed using the survey question: In your experience, which of the following are the three most important considerations as you make family planning decisions? Response options included discussing with my partner; choosing the right method; knowing a place where I can get family planning services; getting money to pay for family planning services; my partner or I do not approve of family planning; and other responses.

Preferred partner support was explored using two constructs: preferred level of partner support and specific partner support activities. The *preferred level of partner support* was assessed using the survey question: What level of involvement would you like to see from your partner in your family planning decisions? Response options included no, some, or high involvement.

Specific partner support activities were explored with the survey question: What specific involvement would you like to see from your partner in your family planning decisions? Response options included giving permission to go to the

health center to get more information about family planning; accompanying me to the health center; discussing with me family planning options to consider; giving me permission to use family planning; paying for the family planning service.

Other variables included reasons for non-use of family planning (Why are you or your partner NOT doing anything to prevent or delay becoming pregnant?); sociodemographic characteristics by region (Central, Northern, Western, and Eastern); age in years (18–24, 25–39, and 40–49); location (urban versus rural); education (< primary, primary, \geq secondary); and parity (0, 1–4, \geq 5).

Analysis

Cross-tabulations and tests of associations explored male and female differences in sociodemographic characteristics and family planning outcomes, decision-making priorities, and preferred partner support. Multivariable logistic regressions explored factors associated with decision-making priorities and preferred partner support. Covariates included current use of family planning, age, sex, region, rural versus urban residence, education, and parity.

Results

Description of Study Population

The study population presented in Table 1 comprised 53% men and 47% women. On average, the population was aged 25 to 39 years old (61%), lived in rural areas (72%), had less than secondary education (42%), and had one to four children (63%). There were significant sex differences in age, education, and parity. Specifically, women were more likely to be 25 to 39 years old or have more children while men were more likely to be educated.

Table 1
Description of Study Population

| | Male (N = 625) | | Female (N = 552) | | Total (N = 1177) | | P- value |
|---------------------|----------------|--------------|------------------|--------------|------------------|--------------|----------|
| | No. | % | No. | % | No. | % | |
| Region | | | | | | | 0.746 |
| Central | 160 | 25.6 | 139 | 25.2 | 299 | 25.4 | |
| Eastern | 166 | 26.6 | 157 | 28.4 | 323 | 27.4 | |
| Northern | 132 | 21.1 | 104 | 18.8 | 236 | 20.1 | |
| Western | 167 | 26.7 | 152 | 27.5 | 319 | 27.1 | |
| Age (years) | | | | | | | 0.011 |
| 18–24 | 55 | 8.8 | 66 | 12 | 121 | 10.3 | |
| 25–39 | 371 | 59.4 | 350 | 63.4 | 721 | 61.3 | |
| 40–49 | 199 | 31.8 | 136 | 24.6 | 335 | 28.5 | |
| Location | | | | | | | 0.825 |
| Urban | 178 | 28.5 | 154 | 27.9 | 332 | 28.2 | |
| Rural | 447 | 71.5 | 398 | 72.1 | 845 | 71.8 | |
| Education | | | | | | | < 0.001 |
| Less than primary | 152 | 24.3 | 210 | 38.0 | 362 | 30.8 | |
| Primary | 266 | 42.6 | 223 | 40.4 | 489 | 41.5 | |
| Secondary or higher | 207 | 33.1 | 119 | 21.6 | 326 | 27.7 | |
| Parity | | | | | | | 0.036 |
| None | 28 | 4.5 | 22 | 4.0 | 50 | 4.2 | |
| One to four | 375 | 60.0 | 371 | 67.2 | 746 | 63.4 | |
| Five or more | 222 | 35.5 | 159 | 28.8 | 381 | 32.4 | |
| Total | 625 | 100.0 | 552 | 100.0 | 1177 | 100.0 | |

Family Planning Use and Reasons for Non-use

Table 2 presents rates of family planning use and reasons for non-use. Overall, about a quarter (26%) of the study population (similar proportions among men and women) reported currently using family planning (defined as doing anything to prevent or delay becoming pregnant). Most common reasons noted by non-users of family planning included the fear of side effects (38%), disapproval from partner, family, or friends (23%), not knowing the appropriate method to use (11%), and cultural or religious concerns (9%), as well as the cost/inaccessibility of family planning services. None of these reasons differed significantly by sex.

Table 2
Family Planning Use and Reasons for Non-use

| | Male (N = 625) | | Female (N = 552) | | Total (N = 1177) | | P-value |
|--|-------------------|------|------------------|------|---------------------|------|---------|
| Currently using family planning | No. | % | No. | % | No. | % | |
| Yes | 463 | 74.1 | 405 | 73.4 | 868 | 73.7 | 0.782 |
| No | 162 | 25.9 | 147 | 26.6 | 309 | 26.3 | |
| Reasons for not using family planning among non-users | Male (N = 162) | | Female (N = 147) | | Total (N = 309) | | P-value |
| <i>Fear of side effects</i> | 61 | 37.7 | 56 | 38.1 | 117 | 37.9 | 0.936 |
| <i>Partner, family, or friends disapprove</i> | 31 | 19.1 | 40 | 27.2 | 71 | 23 | 0.092 |
| <i>Not knowing appropriate method to use</i> | 15 | 9.3 | 18 | 12.2 | 33 | 10.7 | 0.396 |
| <i>Forbidden by culture or religion</i> | 15 | 9.3 | 13 | 8.8 | 28 | 9.1 | 0.899 |
| <i>Family planning services are expensive/inaccessible</i> | 11 | 6.8 | 9 | 6.1 | 20 | 6.5 | 0.812 |

Family Planning Decision-making Considerations and Preferred Partner Support

The contexts of decision-making and support among family planning users are presented in Table 3. Most (85% each) men and women in Uganda aged 18 to 49 years equally considered discussing with their partners to be the biggest consideration for deciding to use family planning. Other important considerations equally noted by both men and women included choosing a family planning method (74%), knowing where to get a method (53%), and getting money to pay for family planning services (24%). Interestingly, significantly more men (28%) compared to women (20%) viewed getting the money to get family planning services as an important consideration.

Equal proportions of men and women in Uganda (66%) preferred a high level of involvement from their partners. Specific ways that respondents noted their partners could be involved included accompanying them to health services (39%), permitting them to get family planning services (26%), and jointly discussing family planning options (23%). Notable gender differences included more women (45%) wanting their partner to accompany them than men (33%) and more men (29%) wanting to jointly discuss family planning options than women (15%).

Table 3
Family Planning Decision-making and Preferred Partner Support

| | Male | | Female | | Total | | P- value |
|---|------|------|--------|------|-------|------|----------|
| | No. | % | No. | % | No. | % | |
| Decision-making considerations | | | | | | | |
| Discussing with partner | 525 | 84 | 479 | 86.8 | 1,004 | 85.3 | 0.180 |
| Choosing the right method | 459 | 73.4 | 415 | 75.2 | 874 | 74.3 | 0.495 |
| Knowing where to get method | 322 | 51.5 | 305 | 55.3 | 627 | 53.3 | 0.200 |
| Getting money to pay for services | 172 | 27.5 | 110 | 19.9 | 282 | 24 | 0.002 |
| Personal or partner approval | 45 | 7.2 | 45 | 8.2 | 90 | 7.6 | 0.540 |
| Preferred partner support | | | | | | | |
| High involvement overall | 405 | 64.8 | 367 | 66.5 | 772 | 65.6 | 0.544 |
| Accompany to health center | 209 | 33.4 | 247 | 44.7 | 456 | 38.7 | < 0.001 |
| Joint discussion | 183 | 29.3 | 85 | 15.4 | 268 | 22.8 | < 0.001 |
| Permit to go to health center or use method | 151 | 24.2 | 158 | 28.6 | 309 | 26.3 | 0.082 |
| Pay for method | 37 | 5.9 | 31 | 5.6 | 68 | 5.8 | 0.823 |

Factors Associated with Family Planning Decision-making Considerations

Table 4 presents characteristics of people with different family planning decision-making considerations. Adults who viewed partner discussions as an important consideration were more likely to be from the Northern (adjusted odds ratio (aOR): 5.25; 95% confidence interval (CI): 2.76–9.98) and Western (aOR: 2.52; 95% CI: 1.52–4.18) regions. Those who valued such considerations were also five times more likely to be family planning users (aOR: 5.11, 95% CI: 3.58–7.30). Those who viewed choosing a family planning method as an important consideration were more likely to have higher levels of education (aOR: 1.56; 95% CI: 1.07–2.28) and had three times greater odds of using family planning (aOR: 3.38; 95% CI: 2.54–4.51). Those who noted knowing where to get a method as an important consideration had greater odds of having higher levels of education (aOR: 1.40; 95% CI: 1.01–1.93) as well as having one to four children (aOR: 2.66; 95% CI: 1.40–5.09) or more than five children (aOR: 2.40; 95% CI: 1.22–4.71). They also had about twice the odds of using family planning (aOR: 1.98; 95% CI: 1.51–2.59). While those who viewed having enough money to pay for services as an important consideration were less likely to be female (aOR: 0.65; 95% CI: 0.49–0.86) but more likely to have five or more children (aOR: 2.53; 95% CI: 1.01–6.36), this consideration was only marginally associated with family planning use (aOR: 1.36; 95% CI: 0.98–1.80). Finally, those who viewed partner approval as an important consideration for family planning were less likely to be in the Northern (aOR: 0.30; 95% CI: 0.13–0.72) or Western (aOR: 0.40; 95% CI: 0.19–0.84) regions. They were also less likely to have a primary (aOR: 0.57; 95% CI: 0.33–0.96) or secondary (aOR: 0.51; 95% CI: 0.27–0.95) education. Viewing partner approval as an important consideration for family planning was significantly associated with reduced odds of family planning use (aOR: 0.30; 95% CI: 0.19–0.47).

Table 4
Factors Associated with Family Planning Decision-making Considerations

| Characteristics ^a | Discussion with partner | | Choosing the right method | | Knowing where to get method | | Getting money to pay for services | | Personal or partner approval | |
|---------------------------------|-------------------------|-----------|---------------------------|-----------|-----------------------------|-----------|-----------------------------------|-----------|------------------------------|-----------|
| | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Female | 1.37 | 0.96–1.95 | 1.16 | 0.88–1.54 | 1.2 | 0.94–1.53 | 0.65** | 0.49–0.86 | 1.04 | 0.66–1.64 |
| Eastern | 1.07 | 0.68–1.68 | 1.04 | 0.70–1.55 | 1.31 | 0.93–1.85 | 1.14 | 0.76–1.70 | 1.57 | 0.87–2.83 |
| Northern | 5.25*** | 2.76–9.98 | 1.02 | 0.67–1.55 | 1.06 | 0.74–1.53 | 0.93 | 0.60–1.44 | 0.30** | 0.13–0.72 |
| Western | 2.52*** | 1.52–4.18 | 1.48 | 0.98–2.21 | 1.18 | 0.84–1.66 | 1.33 | 0.90–1.96 | 0.40* | 0.19–0.84 |
| 25–39 years | 0.74 | 0.40–1.39 | 1.38 | 0.87–2.18 | 0.7 | 0.46–1.07 | 1.12 | 0.69–1.82 | 1.08 | 0.51–2.28 |
| 40–49 years | 0.75 | 0.38–1.47 | 1.17 | 0.71–1.94 | 0.76 | 0.48–1.21 | 0.71 | 0.41–1.23 | 0.87 | 0.38–1.98 |
| Rural residence | 1.03 | 0.69–1.55 | 1.19 | 0.86–1.63 | 0.75* | 0.57–0.99 | 0.96 | 0.69–1.32 | 1.05 | 0.60–1.82 |
| Primary | 1.28 | 0.84–1.95 | 1.38 | 1.00–1.92 | 1.09 | 0.82–1.45 | 1.27 | 0.91–1.78 | 0.57* | 0.33–0.96 |
| Secondary or higher | 1.27 | 0.79–2.04 | 1.56* | 1.07–2.28 | 1.40* | 1.01–1.93 | 1.11 | 0.76–1.63 | 0.51* | 0.27–0.95 |
| One to four | 1.37 | 0.65–2.91 | 1.2 | 0.62–2.32 | 2.66** | 1.40–5.09 | 2.22 | 0.91–5.42 | 0.65 | 0.26–1.64 |
| Five or more | 1.34 | 0.60–3.00 | 1.12 | 0.56–2.24 | 2.40* | 1.22–4.71 | 2.53* | 1.01–6.36 | 0.82 | 0.31–2.18 |
| Currently using family planning | 5.11*** | 3.58–7.30 | 3.38*** | 2.54–4.51 | 1.98*** | 1.51–2.59 | 1.36 | 0.98–1.89 | 0.30*** | 0.19–0.47 |

^a Reference categories include (respectively) male sex, Central region, 18–24 years of age, urban residence, less than primary education, nulliparity, and not currently using family planning

*p ≤ 0.05; **p ≤ 0.01; *** ≤ 0.001

Factors Associated with Preferred Partner Support in Family Planning

Table 5 presents characteristics of people with preferred levels and specific measures of partner support. Adults who wanted a high level of involvement from their partners were less likely to be from the Eastern (aOR: 0.53; 95% CI: 0.37–0.76) region but were 2.5 times more likely to be family planning users (aOR: 2.46, 95% CI: 1.87–3.24). Those who wanted their partner to accompany them to the health center were more likely to be female (aOR: 1.64; 95% CI: 1.28–2.09) and from the Western Region (aOR: 1.87; 95% CI: 1.33–2.64), but this was not associated with increased odds of family planning use. Adults who preferred joint decision-making with their partners were less likely to be female (aOR: 0.46; 95% CI: 0.34–0.61), while adults who preferred having their partner's permission to go to the health center or use a method were more likely to be in the Eastern (aOR: 1.52; 95% CI: 1.04–2.24) or Northern (aOR: 1.83; 1.23–2.74) regions

and more likely to be family planning users (aOR: 1.45; 95% CI: 1.06–1.99). Finally, adults who preferred for their partner to pay for the family planning method were slightly less likely to be in the Eastern (aOR: 0.16; 95% CI: 0.07–0.39) or Northern (aOR: 0.10; 0.03–0.34) regions.

Table 5
Factors Associated with Preferred Levels and Specific Activities of Partner Support

| Characteristics ^a | Overall Level of Support | | Specific Activities of Support | | | | | | | | |
|--|--------------------------|-----------|--------------------------------|----------------------------|---------|------------------|--------|---|---------|----------------|--------|
| | High involvement overall | aOR | 95% CI | Accompany to health center | | Joint discussion | | Permit to go to health center or use method | | Pay for method | |
| | | | | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Female | 1.16 | 0.90–1.49 | 1.64*** | 1.28–2.09 | 0.46*** | 0.34–0.61 | 1.26 | 0.96–1.65 | 0.88 | 0.53–1.47 | |
| Eastern | 0.53*** | 0.37–0.76 | 0.95 | 0.66–1.36 | 0.98 | 0.65–1.46 | 1.52* | 1.04–2.24 | 0.16*** | 0.07–0.39 | |
| Northern | 1.11 | 0.75–1.66 | 1.26 | 0.87–1.84 | 0.91 | 0.60–1.40 | 1.83** | 1.23–2.74 | 0.10*** | 0.03–0.34 | |
| Western | 0.86 | 0.60–1.24 | 1.87*** | 1.33–2.64 | 0.80 | 0.53–1.19 | 0.81 | 0.54–1.21 | 0.65 | 0.36–1.17 | |
| 25–39 years | 0.82 | 0.53–1.27 | 1.21 | 0.79–1.86 | 0.90 | 0.55–1.48 | 0.89 | 0.57–1.38 | 0.65 | 0.28–1.51 | |
| 40–49 years | 1.03 | 0.63–1.67 | 1.29 | 0.80–2.06 | 1.05 | 0.61–1.81 | 0.75 | 0.46–1.24 | 0.48 | 0.19–1.23 | |
| Rural residence | 1.14 | 0.85–1.53 | 1.22 | 0.92–1.63 | 1.00 | 0.72–1.39 | 0.86 | 0.63–1.17 | 0.85 | 0.49–1.48 | |
| Primary | 0.93 | 0.69–1.25 | 1.05 | 0.79–1.41 | 0.85 | 0.60–1.21 | 1.08 | 0.78–1.48 | 1.27 | 0.68–2.36 | |
| Secondary or higher | 1.41 | 0.99–1.99 | 0.98 | 0.71–1.36 | 1.39 | 0.96–2.01 | 0.9 | 0.62–1.30 | 0.62 | 0.28–1.36 | |
| One to four | 1.11 | 0.59–2.09 | 1.15 | 0.61–2.19 | 1.49 | 0.68–3.25 | 0.72 | 0.37–1.39 | 1.26 | 0.35–4.53 | |
| Five or more | 1.12 | 0.58–2.17 | 1.02 | 0.52–1.99 | 1.56 | 0.69–3.51 | 0.83 | 0.41–1.65 | 1.45 | 0.38–5.55 | |
| Currently using family planning | 2.46*** | 1.87–3.24 | 1.22 | 0.93–1.62 | 1.13 | 0.82–1.56 | 1.45* | 1.06–1.99 | 0.81 | 0.45–1.44 | |

^a Reference categories include male sex, Central region, 18–24 years of age, urban residence, less than primary education, nulliparity, and not currently using family planning

*p ≤ 0.05; **p ≤ 0.01; ***p ≤ 0.001

Discussion

Summary of findings

This novel study sought to quantify decision-making and preferred partner support for family planning in Uganda using a gender equality lens. Results showed that the major decision-making considerations significantly associated with current use of family planning included the following: partner discussion, choosing a family planning method, knowing where to obtain a method, and having enough money for family planning services. While both men and women desired a high level of overall involvement from their partners and this was associated with family planning use, sex differences were observed in decision-making considerations and specific partner support activities. These differences suggest that partner support should be operationalized differently for men and women and that SBC interventions would do well to employ a gender lens when implementing family planning programs.

Implications for SBC programming

SBC interventions can positively change gender norms and household power dynamics to improve well-being across multiple areas, including family planning and reproductive health. Our study corroborates existing literature on the importance of partner support for contraceptive use(14–20, 23). We show that while men and women mostly want their partners to support them in similar ways, they define this support differently. Specifically, men view financial provision while women view being escorted to get family planning services as important aspects of partner support. The findings suggest the need for interventions that push the narrative of partner support for family planning in Uganda using approaches that are sensitive to existing gender-based power imbalances among couples while seeking to encourage equitable partner communication.

Specific SBC approaches based on findings

USAID SBCA used these insights to inform the newly designed national multimedia umbrella family health campaign named “Happiness.” The campaign was developed using human-centered design processes leveraging the views of community members, leaders, and health providers in the program design and implementation. The campaign also infuses behavioral science and economic approaches, such as narrative storytelling and nudges like special invitations or personalized messages to male partners, respectively. Campaign messages explicitly encourage partner dialogue and communication across the various life stages: during courtship, pregnancy, childbirth, and rearing. In addition, the campaign aims to empower women with knowledge and skills to have honest conversations with their partners about when to have children and how many to have. By engaging community gatekeepers and influencers, the campaign is also addressing negative gender norms and positioning family planning as not just a woman’s responsibility, as well as highlighting the fact that women have a right to use family planning regardless of partner approval. The freedom to choose when to have children and how many children to have offers both women and men opportunities to achieve their fullest potential, a central premise of gender equality.

Policy and Research Implications

The study findings suggest that appropriate policies that operationalize partner support are needed for increased family planning uptake. At the community level, further efforts are needed to explore how by-laws can go beyond enforcing male attendance for antenatal visits to also accommodate joint decision-making related to family planning. This may include communication strategies during provider interactions with individual and couple clients. Given study findings highlighting respondents’ concerns about where to get a family method as well as the cost of services, policies should explore how family planning services can remain accessible to all community members regardless of gender, location or financial status. Additional research should uncover specific subgroup differences in partner support for family planning, such as how perceived partner support differs among younger versus older couples, type of sexual relationship (married versus unmarried), family planning needs (spacing versus limiting) as well as other cultural or psychosocial drivers of the heterogeneity in perceived partner support in Uganda.

Strengths and Limitations

Noteworthy strengths of this novel research include the use of nationally representative quantitative data employing a person-centered gender equality approach to understand how study populations define what partner support means to men and women in Uganda. However, we acknowledge some limitations that future researchers should aim to address. These include the use of cross-sectional data, which does not permit the inference of causality, as well as the use of telephone interviews, which may be prone to social desirability bias and the inability to observe non-verbal cues.

Conclusion

This innovative study explored the specific ways men and women in Uganda perceive partner support and involvement in the context of family planning. Study findings suggest the need to operationalize partner support differently for men and women when implementing family planning programs. Study findings can inform the design of necessary individual- and couple-level interventions to reduce unmet need for family planning in Uganda.

Abbreviations

| | |
|-------|--|
| aOR | Adjusted Odds Ratio |
| CI | Confidence Interval |
| IRB | Institutional Review Board |
| PPS | Probability Proportional to Size (PPS) |
| SBC | Social and Behavior Change |
| SBCA | Social and Behavior Change Activity |
| USAID | United States Agency for International Development |

Declarations

Ethical Approval and Consent to Participate

The study received ethical approval from the Johns Hopkins Bloomberg School of Public Health (IRB No. 00013837) and the Makerere University Institute of Public Health Higher Degrees, Research and Ethics Committee (No. 864). All respondents provided written informed consent prior to participating in the survey. All methods were performed in accordance with the relevant guidelines and regulations in accordance with the Declaration of Helsinki.

Consent for Publication

Not applicable

Availability of Data and Materials

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

Funding

This work is made possible by the support of the American people through the United States Agency for International Development under the USAID Uganda/Johns Hopkins University Cooperative Agreement #2061720CA00005. The funders had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Authors' Contributions

BO conceptualized the study and analyzed the data. BO, AP, ZH, and PO drafted the manuscript. JN, PM, LB, MK, FA, EK, MN, NN, GM, RM, TB, RK and DS assisted with interpretation of the results and critically edited and reviewed this manuscript. All authors read and approved the final manuscript.

Acknowledgements

The authors wish to thank USAID Uganda and Sheila Nyakwezi for their financial support and technical oversight of the USAID/Social and Behavior Change Activity (SBCA). The authors also want to acknowledge all project staff who contributed to the study design, implementation, and reporting, including Arzum Ciloglu, Jen Orkis, and Leanne Wolff. Final acknowledgements go to Hatchile Consult Ltd for supporting the data collection exercise and all study participants.

References

1. Manandhar M, Hawkes S, Buse K, Nosrati E, Magar V. Gender, health and the 2030 agenda for sustainable development. *Bull World Health Organ.* 2018;96(9):644–53.
2. Bongaarts J. Can family planning programs reduce high desired family size in sub-Saharan Africa? *Int Perspect Sex reproductive health.* 2011;37(4):209–16.
3. United Nations Department of Economic and Social Affairs PD. *World Fertility and Family Planning 2020: Highlights.* New York; 2020.
4. Uganda Bureau of Statistics and ICF. *Uganda Demographic and Health Survey 2016.* Kampala, Uganda and Rockville. Maryland: Uganda Bureau of Statistics and ICF; 2018.
5. Family Planning. 2030. Uganda| Family Planning 2030 2021 [Available from: <https://fp2030.org/uganda>].
6. Magar V, Heidari S, Zamora G, Coates A, Simelela PN, Swaminathan S. Gender mainstreaming within WHO: not without equity and human rights. *Lancet (London England).* 2019;393(10182):1678–9.
7. Slaymaker E, Scott RH, Palmer MJ, Palla L, Marston M, Gonsalves L, et al. Trends in sexual activity and demand for and use of modern contraceptive methods in 74 countries: a retrospective analysis of nationally representative surveys. *The Lancet Global Health.* 2020;8(4):e567-e79.
8. Uganda Bureau of Statistics and Ministry of Gender LaSD. *Gender Issues in Uganda: An analysis of gender based violence, asset ownership and employment.* Kampala, Uganda; 2019.

9. Casey SE, McNab SE, Tanton C, Odong J, Testa AC, Lee-Jones L. Availability of long-acting and permanent family-planning methods leads to increase in use in conflict-affected northern Uganda: evidence from cross-sectional baseline and endline cluster surveys. *Glob Public Health*. 2013;8(3):284–97.
10. Ghanotakis E, Hoke T, Wilcher R, Field S, Mercer S, Bobrow EA, et al. Evaluation of a male engagement intervention to transform gender norms and improve family planning and HIV service uptake in Kabale, Uganda. *Glob Public Health*. 2017;12(10):1297–314.
11. Beia T, Kielmann K, Diaconu K. Changing men or changing health systems? A scoping review of interventions, services and programmes targeting men's health in sub-Saharan Africa. *Int J Equity Health*. 2021;20(1):1–16.
12. Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do)... gender analysis in health systems research. *Health Policy Plann*. 2016;31(8):1069–78.
13. Jackson R, Kilsby D, Hailemariam A. Gender exploitative and gender transformative aspects of employing Health Extension Workers under Ethiopia's Health Extension Program. *Tropical Med Int Health*. 2019;24(3):304–19.
14. Hay K, McDougal L, Percival V, Henry S, Klugman J, Wurie H, et al. Disrupting gender norms in health systems: making the case for change. *Lancet*. 2019;393(10190):2535–49.
15. Jurinsky J, Perkins J, Kakuhikire B, Nyakato V, Christakis N, Bangsberg D et al, editors. Frequency of Easy Spousal Communication and Depressive Symptom Severity Among Men and Women in Rural Uganda. APHA's 2019 Annual Meeting and Expo (Nov 2-Nov 6); 2019: APHA.
16. Steele V, Patterson K, Berrang-Ford L, King N, Kulkarni M, Namanya D, et al. Factors influencing antenatal care attendance for Bakiga and Indigenous Batwa women in Kanungu District, Southwestern Uganda. *Rural and Remote Health*. 2021;21(3).
17. Roed MB, Engebretsen IMS, Mangeni R, Namata I. Women's experiences of maternal and newborn health care services and support systems in Buikwe District, Uganda: A qualitative study. *PLoS ONE*. 2021;16(12):e0261414.
18. Peneza AK, Maluka SO. 'Unless you come with your partner you will be sent back home': strategies used to promote male involvement in antenatal care in Southern Tanzania. *Global health action*. 2018;11(1):1449724.
19. Boniphace M, Matovelo D, Laisser R, Swai H, Yohani V, Tinka S, et al. Men perspectives on attending antenatal care visits with their pregnant partners in Misungwi district, rural Tanzania: a qualitative study. *BMC Pregnancy Childbirth*. 2021;21(1):93.
20. Kriel Y, Milford C, Cordero J, Suleman F, Beksinska M, Steyn P, et al. Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reprod Health*. 2019;16(1):89.
21. Akamike IC, Okedo-Alex IN, Eze II, Ezeanosike OB, Uneke CJ. Why does uptake of family planning services remain sub-optimal among Nigerian women? A systematic review of challenges and implications for policy. *Contracept Reproductive Med*. 2020;5(1):30.
22. Prata N, Bell S, Fraser A, Carvalho A, Neves I. Partner support for family planning and modern contraceptive use in Luanda. *Angola Afr J reproductive health*. 2017;21(1):35–48.
23. Shattuck D, Kerner B, Gilles K, Hartmann M, Ng'ombe T, Guest G. Encouraging contraceptive uptake by motivating men to communicate about family planning: the Malawi Male Motivator project. *Am J Public Health*. 2011;101(6):1089–95.
24. Lakey B, Cohen S. Social support theory and measurement. 2000.
25. Lin N, Ensel WM, Simeone RS, Kuo W. Social support, stressful life events, and illness: A model and an empirical test. *Journal of health and Social Behavior*. 1979:108–19.
26. Barnes MK, Duck S. Everyday communicative contexts for social support. 1994.

27. Cutrona CE, Suhr JA. Controllability of stressful events and satisfaction with spouse support behaviors. *Communication Res.* 1992;19(2):154–74.
28. Ozbay F, Johnson DC, Dimoulas E, Morgan C III, Charney D, Southwick S. Social support and resilience to stress: from neurobiology to clinical practice. *Psychiatry (Edgmont)*. 2007;4(5):35.
29. Odom KJ, Ottosson A, Draru J, Komujuni H, Nkolo EKK, Faramand TH. Improving Viral Load Suppression Among Men and Children Active in Care Through Community-Designed and Led Solutions: Protocol for Retrospective Closed Cohort Study in Eastern Uganda. *JMIR Res Protocols*. 2022;11(4):e32784.
30. Uganda National Malaria Control Division (NMCD). UBoSU, ICF. Uganda Malaria Indicator Survey 2018-19 Kampala, Uganda, and Rockville. Maryland: NMCD, UBOS, and ICF; 2020.