



# A determinant for family planning attitudes and practices of men: marriage features

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## Abstract

**Aim** This study was conducted to determine both the use of family planning methods among married men between the ages of 20 to 50 and some marriage characteristics affecting this use.

**Methods** This was a descriptive and correlational study conducted in May and June 2014. The study sample included 375 males. The study data were collected using a survey form as well as the Family Planning Attitude Scale, Marital Adjustment Scale, and Marital Problem Solving Scale. The determinants of the Family Planning Attitude Scale were found using hierarchical multiple regression analysis. The risk factors for not using family planning were evaluated by logistic regression analysis.

**Results** According to Model 2, to which family features were added, the male himself ( $\beta = -0.117$ ) and his spouse ( $\beta = -0.154$ ) either graduated from primary school or received no formal education. They lived in an extended family ( $\beta = -0.129$ ), and an increasing desire for more children ( $\beta = -0.184$ ) decreased the family planning attitude score. The risk factors for not using family planning were evaluated using logistic regression analysis. Accordingly, the risk for not consulting family planning services is increased by older age (OR: 1.037; CI: 1.010–1.064), desiring to have more than three children (OR: 1.279; CI: 1.01.038–1.575), and not having received information about family planning (OR: 1.871; CI: 1.145–3.057) ( $p < 0.05$ ).

**Conclusion** Marital adjustment is an important tool in making decisions about family planning. It is necessary to enable men to access to the correct information that will carry them to the relevant resources.

**Keywords** Attitudes · Determinant factor · Family planning · Man · Marriage features

Accepting family planning services as a part of reproductive health is one of the most important changes in the family planning area. In addition to this change in the philosophy

of family planning, there have been many alterations and developments in family planning methods and the offering of services. Despite these developments, the use of family planning services is not at the desired level, and certain issues still remain. The issues related to family planning may be summarized as follows: (1) the deficient (low) use of modern methods, (2) an unsatisfied demand for family planning services, and (3) family planning responsibility being completely left to women (Akın et al. 2009; Altay and Gönener 2009). It has been emphasized that “male” knowledge and attitudes related to the ideal family size, sexual orientation, ideal intervals between births, and use of family planning methods are the determinants of the number of children within the family. This shows that it is necessary to consider men’s needs in fertility health, which have been ignored so far (Akın et al. 2009). The need for increasing men’s participation in fertility health and focusing on men’s perceptions of family planning practices were

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discussed in the Fourth International Population and Development Convention. Despite this political goal, the current studies in this field prove that men still have insufficient information about family planning (Wambui et al. 2009), and they are more informed about traditional methods (Tilahun et al. 2013). The health professionals in family planning clinics also said that men rarely apply for services at family planning centers, either on their own or with their wives (Akindele and Adebimpe 2013). Also, women sometimes qualify family planning as their own responsibility (Bıradar and Bhovi 2013). Porche (2012) describes men as family planning centers' "lost customers."

It is important to note that men do not make use of family planning services because of religious, social, and cultural factors (Hoga et al. 2014). Despite these determinants, their use of these services can be increased by their higher formal education levels (Tilahun et al. 2013) and motivational interviews held either with men alone or with them and their spouses together (Shattuck et al. 2011). The characteristics of family planning clinics present another obstacle to the use of family planning by men. These clinics are mainly addressed to women (Porche 2012), which indicates the need for male-friendly clinics (Akindele and Adebimpe 2013). Men's needs in family planning vary by their age (Shattuck et al. 2011; Kisa et al. 2013). Hence, age-specific programs are needed in clinics, just like the ones offered to women (Shattuck et al. 2011). There are occasional differences of opinion between the providers and consumers of health services. Couples believe that the family planning methods they use have many side effects, while service providers and policy-makers claim that these side effects are tolerable compared with unplanned pregnancies (Hyttel et al. 2012). The difference in opinions may be a factor preventing men from consulting family planning services.

The fact that the male role in family planning is as important as the female role (Altay and Gönener 2009) and the relationship between family planning and culture are highly important. Thus, the issues related to men in family planning should be re-determined in every culture. Certain family-related dynamics may also affect their attitudes toward family planning and using family planning methods. However, the literature shows that the effect of marital characteristics on family planning beliefs and behaviors have not been evaluated. This type of evaluation is important to determine how to promote the effective use of family planning services by men. These evaluations will provide insight into the situations in a number of different countries when they are conducted in Turkey, because Turkey displays both eastern and western characteristics. For this reason, this study aimed to determine the family planning attitudes and use of family planning methods of married men aged from 20 to 50 years as well as certain marital characteristics that affect these situations.

## Methods

### Design and sample

This is a descriptive and correlational study conducted in Kırşehir, Turkey, in May and June 2014. The researchers utilized the template charts of the World Health Organization to determine the sample size. In Turkey, the rate of not using family planning methods is 27%. Based on this rate, the sample size required to estimate the actual value of this rate within 0.06 points at 99% confidence level was a minimum of 346. In total, 375 men participated in the study, and they all lived in Kırşehir. There are nine primary health care centers in the province of Kırşehir. The study was conducted in three of these centers, and the centers were selected by draw. The researchers determined the number of males that could be included in the sample considering the number of married men within the area served by the primary health care centers. Respectively, 102, 112, and 156 men were included in the study.

### Instruments

The study data were collected using the survey form created by the researchers, Family Planning Attitude Scale, Marital Adjustment Scale, and Marital Problem-Solving Scale. The survey form included questions concerning the participant's age, education levels of the participants and their spouses, family type, age when getting married, use of family planning methods, and reasons for using these methods. The participants were also asked if they had received any information about family planning, how they made their decision related to family planning, and the number of children they wished to have.

*The Family Planning Attitude Scale:* (FPAS) was created in Turkish by Orsal and Kubilay (2007). It is a Likert-type scale with 34 items. Each statement is scored from 1 to 5. "I totally agree" counts as 1 point, "I agree" as 2 points, "neutral" as 3 points, "I disagree" as 4 points, and "I totally disagree" as 5 points. No items are scored inversely. The lowest possible score is 34, and the highest is 170. The scale has three sub-dimensions: the attitude of society toward family planning (15 items; lowest score: 15; highest score: 75), attitude toward family planning methods (11 items; lowest score: 11; highest score: 55), and attitude toward birth (8 items; lowest score: 8; highest score 40) (Orsal and Kubilay 2007). The Cronbach's alpha value of the scale was found to be 0.938 for this study.

*Marital Adjustment Scale:* This scale includes 15 questions. It was created by Locke and Wallace, and the validity and reliability studies of its Turkish version were

conducted by Tutarel-Kışlak (1999). The internal consistency of the scale was 84%, and the consistency of the split-half test was 64%. The correlation of the test-retest procedure was 54%. The item analysis, factor structure analysis, and criterion-dependent validity analysis found that the Marital Adjustment Scale was valid and reliable. The scale has been used reliably in more than 50 studies so far. The maximum score on the scale is 60. Higher scores indicate good adjustment. The Cronbach's alpha value of the scale was found to be 0.846 for this study.

*Marital Problem Solving Scale:* This scale was created by Baugh et al. (1982). The validity and reliability studies of the Turkish version of this scale were conducted by Hünler and Gençöz (2003). It aims to determine how married individuals solve and perceive the problems in their relationships and what skills they use in solving their marital problems. The scale includes nine items. The creators of the scale found the internal consistency coefficient of the scale to be 0.95. The scale has a one-factor structure. Its correlation with the Dyadic Adjustment Scale is 0.51. The Cronbach's alpha coefficient of the scale was 0.91, and the item-total correlation was between 0.63 and 0.73. The possible scores that can be obtained on the scale are between 9 and 45. Higher scores show that the individual perceives him- or herself to be successful in terms of solving marital problems. The Cronbach's alpha value of the scale was found to be 0.885 for this study.

## Procedure

Permission to conduct this study was obtained from the Non-Interventional Ethics Commission at Ahi Evran University. Institutional permission was also obtained from the institutions where the study was conducted, and informed consent was obtained from the research participants.

## Statistical analyses

The research data are presented as numbers, percentages, and standard deviations. For normal distributions, Kolmogorov-Smirnov analysis and skewness-kurtosis values were used. The determinants of the Family Planning Attitude Scale were determined by hierarchical multiple regression analysis. For the analysis, the variables were turned into a dummy variable. The data were included in the analysis as follows:

1. age: continuous variable
2. education levels of the participants and their spouses: primary school or less = 1, secondary school and higher = 0
3. family type: extended family = 1; nuclear family = 0

4. number of the marriages: two or more = 1; one = 0
5. first marriage age: continuous variable
6. desired number of children: one or two children = 0; three or more = 1
7. Marital Problem-Solving Scale: continuous variable
8. Marital Adjustment Scale: continuous variable
9. family decision making for family planning = 0; unilateral decision making for family planning = 1
10. having obtained information about family planning = 0; not having done so = 1

The risk factors for not using family planning were evaluated using logistic regression analysis. Using family planning was encoded as 1 and not using family planning was encoded as 0. The independent variables were included in the analysis as follows:

1. age: continuous variable
2. education levels of the participants and their spouses: primary school or less = 1; secondary school and higher = 0
3. family type: extended family = 1; a nuclear family = 0
4. number of the marriages: two or more = 1; one = 0
5. first marriage age: continuous variable
6. desired number of children: one or two children = 0; three or more = 1
7. Marital Problem-Solving Scale: continuous variable
8. Marital Adjustment Scale: continuous variable
9. family decision making for family planning = 0; unilateral decision making for family planning = 1
10. Family Planning Attitude Scale: continuous variable

## Findings

The average age of the men participating in the study was  $40.5 \pm 9.3$  years, and 34.4% of them were either primary school graduates or had not received any formal education. Of their spouses, 62.7% were primary school graduates or had not received any formal education. Also, 32% of the participants were part of a nuclear family; 38.7% did not use any type of family planning method (their spouses also did not use any), while 13.9% said that their spouses used family planning methods; 29.9% of the participants used condoms. The rate of participants who had undergone a vasectomy was 6.7%. The desire to limit the number of children born into the family was the reason for using family planning methods in 65.3% of the participants. Of the men, 31.2% had not received any kind of education or information related to family planning. However, the rate of the men that consulted a health institution about this matter was close to this percentage (30.9%). Of the men, 68.5% made their family planning decisions together with

their wives. The men in the study obtained a mean score of  $49.8 \pm 11.7$  on the society dimension of the Family Planning Attitude Scale. They obtained  $35.8 \pm 8.5$  points on the family planning method dimension and  $26.4 \pm 6.2$  points on the attitude toward birth dimension. Their total mean score was  $112.1 \pm 22.6$ .

An analysis of the participants' marital characteristics indicated that 88.3% of them were married for the first time, and 68% had nuclear families. The average age of the participants when they married for the first time was  $22.8 \pm 3.4$  years. The average number of children they wished to have was  $3.0 \pm 1.2$ . Their mean score on solving marital problems was  $35.0 \pm 6.6$ , and  $42.9 \pm 8.3$  on marital adaptation.

The score determinants of the Family Planning Attitude Scale were evaluated using hierarchical multiple regression analysis. In Model 1, the study evaluated the extent to which the sociodemographic variables determined the scores and found that the participants ( $\beta = -0.185$ ) or their spouses ( $\beta = -0.195$ ) being primary school graduates, or having had no formal education, reduced the family planning attitude scores. Sociodemographic variables explained the family planning attitude scores at a 12% level. Model 2, which included the marital characteristics, showed that the family planning attitude score was reduced when men ( $\beta = -0.117$ ) and their spouses ( $\beta = -0.154$ ) were primary school graduates or had no formal education. The score was also reduced when there was a high rate of participants living in extended families ( $\beta = -0.129$ ) and when they were willing to have more children ( $\beta = -0.184$ ). However, an increase in the marital adjustment scale score ( $\beta = 0.171$ ) indicated a more positive attitude. These variables were determined at a 22% level. Model 3, which included family planning characteristics, receiving information about family planning, and making decisions together with the spouse, did not make any contribution to the model. On the other hand, the variables in Model 2 were the ones that made a remarkable contribution to Model 3 (Tables 1 and 2).

The risk factors of not using family planning methods were evaluated using logistic regression analysis. Accordingly, the variables that increased the risk of not using family planning methods were stronger in age (odds ratio: 1.037, confidence interval: 1.010–1.064), desiring to have more than three children (odds ratio: 1.279, confidence interval: 1.01.038–1.575), and receiving no information about family planning (odds ratio: 1.871, confidence interval: 1.145–3.057) ( $p < 0.05$ ). The other variables were not considerable risk factors ( $p > 0.05$ ) (Tables 3 and 4).

## Discussion

This study evaluated the use of contraceptives among married men and their attitudes toward family planning in general. In addition, the study inquired whether certain marital

**Table 1** Some features related to family planning

Family planning methods	Number	%
Do not use any family planning method	145	38.7
Condoms	112	29.9
Vasectomy	25	6.7
Withdrawal	41	10.9
Their wives	52	13.9
Reason for using family planning methods		
Limiting the number of children	245	65.3
Healthy sex life	76	17.6
Good process that is shared with the couples	52	11.2
Status of receiving information about family planning		
Not getting information about family planning	117	31.2
From the health center	116	30.9
Doctor	45	12.0
Nurse	23	6.1
Television	13	3.5
Written press	26	6.9
Internet	35	9.3
How they make a decision about family planning		
Their wives	65	21.7
Themelves	53	14.1
Together with their wives	257	68.5
	Average	± SD
<i>Family planning attitude scale</i>	112.1	± 22.6
<i>Attitude of society toward family planning</i>	49.8	± 11.7
<i>Attitude toward family planning methods</i>	35.8	± 8.5
<i>Attitude toward birth</i>	26.4	± 6.2

characteristics had an effect on their attitudes and on their use of family planning methods. Of the males participating in the study, 38.7% said they currently did not use any family planning methods and that their spouses also did not use them. According to a national study, the rate of married women in Turkey not using any family planning methods was 26.5%

**Table 2** Some features related to marriage

Number of the marriages	Number	%
One marriage	331	88.3
Two or more	44	11.7
Family type		
Nuclear family	255	68.0
Extended family	120	32.0
	Average	± SD
<i>First marriage age</i>	22.8	3.4
<i>Desired number of children</i>	3.0	1.2
<i>Marital Problem Solving Scale</i>	35.0	6.6
<i>Marital Adjustment Scale</i>	42.9	8.3

**Table 3** Determinants of family planning attitudes (multiple linear regression-hierarchical model)

	$\beta$	<i>p</i> value	<i>t</i>
Model 1 Sociodemographic variable		26.213	0.000
Age (continuous)	-0.078	-1.526	0.128
Education (elementary school and below = 1)	-0.185	-3.441	0.001
Their wife’s education (elementary school and below = 1)	-0.195	-3.492	0.001
Model 2 Sociodemographic variable and marriage feature		8.921	0.000
Age (continuous)	-0.016	-0.310	0.757
Education (elementary school and below = 1)	-0.117	-2.220	0.027
Their wife’s education (elementary school and below = 1)	-0.154	-2.853	0.005
Family type (extended family = 1)	-0.129	-2.714	0.007
Number of marriages (two and above = 1)	0.014	0.274	0.784
First marriage age (continuous)	0.035	0.693	0.489
Desired number of children (continuous)	-0.184	-3.625	0.000
Marital Problem Solving Scale (continuous)	0.024	0.432	0.666
Marital Adjustment Scale (continuous)	0.171	3.074	0.002
Model sociodemographic variable, marriage and family planning feature		8.751	0.000
Age (continuous)	-0.006	-0.119	0.905
Education (elementary school and below = 1)	-0.110	-2.054	0.041
Their wife’s education (elementary school and below = 1)	-0.154	-2.832	0.005
Family type (extended family = 1)	-0.131	-2.724	0.007
Number of marriages (two and above = 1)	0.017	0.348	0.728
First marriage age (continuous)	0.038	0.757	0.449
Desired number of children (continuous)	-0.186	-3.642	0.000
Marital Problem Solving Scale (continuous)	0.026	0.454	0.650
Marital Adjustment Scale (continuous)	0.170	3.035	0.003
Decision making for family planning (for making it independently = 1)	-0.012	-0.253	0.800
Getting information on status about family planning (no = 1)	-0.058	-1.211	0.227
Model 1	<i>R</i> = 0.350	<i>R</i> <sup>2</sup> = 0.122	<i>F</i> = 17.180
Model 2	<i>R</i> = 0.474	<i>R</i> <sup>2</sup> = 0.225	<i>F</i> = 11.712
Model 3	<i>R</i> = 0.477	<i>R</i> <sup>2</sup> = 0.228	<i>F</i> = 9.702

(Hacettepe University Institute of Population Studies 2014). Zeyneloğlu et al. (2013) conducted a study in the southeast area of Turkey and found that the rate of the men who did not use any family planning methods was 60.4%. The nationwide and regional studies conducted in Turkey, as well as this study, have found varying percentage rates of the lack of family planning method utilization (Hacettepe University Institute of Population Studies 2014; Zeyneloğlu et al. 2013). This difference is the result of social change, cultural beliefs, gender norms in society, and the wish to have a child (Adams et al. 2013; Zeyneloğlu et al. 2013). In the region where this study was conducted, the rate of non-utilization of family planning methods was a little higher than in other studies, and this was probably due to couples’ wishes to have children. The most common method used by men who sought family planning services was condoms. A study in an Eastern Anatolian town determined that the most commonly used of all modern methods for males was the condom (Bostancı 2011). A

nationwide study in Turkey determined that the condom was the second most common method used among married women (Hacettepe University Institute of Population Studies 2014). Another study concluded that the family planning methods for women were more varied, and they were also continuously changing. The methods addressed to men were very limited, and this resulted in low rates of use among them (Darroch 2008). In this study, the rate of condom use is a little higher than in the other studies; this demonstrates that men are willing to take more responsibility when they are provided with more varied family planning methods.

Reasons for not using family planning methods indicated by the participants showed that they did not associate family planning with a healthy sex life or regard it as a process shared with the partner. The traditional perspective stipulates that the main reason to use family planning methods is to limit the number of children; this seems to be a serious obstacle in men’s use of these methods. Moreover, the participants did not have any



**Table 4** Risk factors for not using family planning

Variables	<i>B</i>	Odds ratio	(95% CI)	<i>p</i> values
Age (continuous)	0.036	1.037	(1.010–1.064)	<b>0.007</b>
Education (elementary school and below = 1)	0.031	1.032	(0.604–1.761)	0.909
Their wife's education (elementary school and below = 1)	0.178	1.195	(0.694–2.056)	0.521
Family type (extended family = 1)	−0.030	0.971	(0.590–1.596)	0.907
Number of marriages (two and above = 1)	0.321	1.378	(0.667–2.849)	0.386
First marriage age (continuous)	0.012	1.012	(0.945–1.084)	0.736
Desired number of children (continuous)	0.246	1.279	(1.038–1.575)	<b>0.021</b>
Marital Problem Solving Scale (continuous)	−0.002	0.998	(0.958–1.039)	0.927
Marital Adjustment Scale (continuous)	−0.015	0.985	(0.954–1.017)	0.345
Decision making for family planning (for making it independently = 1)	0.033	1.034	(0.623–1.715)	0.898
Getting information on status about family planning (no = 1)	0.627	1.871	(1.145–3.057)	<b>0.012</b>
<i>Family Planning Attitude Scale</i>				
<i>Attitude of society toward family planning</i> (continuous)	−0.012	0.988	(0.962–1.015)	0.388
<i>Attitude toward family planning methods</i> (continuous)	0.006	1.006	(0.969–1.044)	0.770
<i>Attitude toward birth</i> (continuous)	0.042	1.043	(0.995–1.093)	0.082

access to resources or to information about family planning and accessed the media or the internet. The most important reason for this lack of access was presumably the fact that neither men's traditional perspectives nor the health system itself regarded men as users of family planning services. Researchers should not ignore the fact that men are the dominant decision-makers related to the number of children in the family as well as the intervals between births even though they have little input in family planning matters (Mosha et al. 2013). For this reason, it is reasonable to aim to include men in family planning practices. However, health facilities have failed to keep up with this development. In this study, a very small portion of male participants (30.9%) had received education and information on family planning from a health center. This datum points to the need for the expansion of family planning services provided by health centers, particularly the services addressed to males. Informing men about family planning will make a positive contribution even though they would not use it themselves. For instance, a relevant study found that the men who were informed about at least one family planning method (50.3%) talked more frequently to their spouses about family planning than those who did not know about any methods (20.7%) (Katende et al. 2011). Another study determined that 83.6% of men not only decided which family planning method to use together with their wives, but they also believed that men should take responsibility in family planning (77.5%) (Altay and Gönener 2009). In this study, the rate of participants that made family planning decisions with their spouses was 68%, demonstrating the importance of informing both men and women about family planning.

The scores that the participant males obtained on the subdimensions of the Family Planning Attitude Scale and on

the entire scale prove that the sample had a moderate attitude. These attitude scores are important since they show that social perspective still matters to individuals. The study conducted with Turkish women also found similar attitude scores for men and women (Ejder-Apay et al. 2010). Even though men and women face the same cultural judgments, it is commonly known that women have a more positive attitude toward the use of family planning (Jabeen et al. 2011). This attitude may still be affected by inaccurate beliefs about family planning methods. Adams et al. (2013) found that some males believed using contraceptive methods before having a child would lead to infertility. That study also found that men felt ineffective regarding their participation in family planning services when their wives used family planning methods without informing them (Adams et al. 2013). Despite that finding, it is commonly known that men make the final decision about the size of the family (50%), and family size is affected when couples wish to have sons (Kahansim et al. 2013).

According to this study, the family planning attitude score was reduced when men and their wives had low education levels, lived in extended families, and wished to have more children. This score increased in direct proportion with the marital adjustment score. In addition, the risk of not using family planning methods was increased when men got older, when they wished to have more children, and when they did not receive any information about family planning. The collective evaluation of these two results indicates that education and the number of children couples wish to have are the two most important factors in family planning. The collective decision of both spouses on the use of family planning methods is an important element regarding the determination of the family size. Married men with higher education levels

consulted with their wives more often in deciding the size of the family. Despite this finding, there are still problems to overcome in family planning. Currently, women regard the ideal number of children as two; they, however, have more children than they wish to have. In Uganda, many people (65%) have the perception that their society dictates having five or more children. In this study, the average number of children that married men wished to have was  $3 \pm 1.2$ . In Uganda, the majority of men (> 69%) believed that having a large family would decrease their quality of life. A considerable portion of them (30%), however, believed that they would lose their social respectability if they had a small family (Katende et al. 2011). A study conducted in California with low-income couples found that the couples used contraceptive methods for 5.4 years on average to postpone having children for economic reasons, even though they desired to have one or two children. When men and women were compared, it appeared that men were the ones who were unwilling (70%) to have more children (Foster et al. 2008). A majority of the men participating in this study (65.3%) said that they used family planning methods to limit the number of children they would have. The ability of the family to function at a high level decreased as the number of family members increased. The ability of parents to control behavior within the family and to communicate well were disrupted as well (Alacahan 2010). Limiting the number of children within the family is effective in reducing mother and infant deaths since it both promotes a healthy performance of family functions and prevents too many births as well as small intervals between them (Akın et al. 2009). If spouses act together in a responsible manner in having children, this can help prevent abortions and keep the family at a size that is satisfactory to both parents. Unplanned pregnancies occurred mainly when the withdrawal method was used; it was also the most common reason for abortions (Bostancı 2011). The withdrawal method, which is the oldest known family planning method, is so common because of men's desire to be active in family planning choices (Bostancı 2011; Türk and Terzioğlu 2012). However, men do not always select an effective family planning method. Hotun-Şahin et al. (2008) determined that most married men relied on contraceptives used by females and had a negative attitude toward vasectomy and using condoms. Single men, on the other hand, had a negative attitude toward the use of hormonal pills that may be produced for their use in the future.

The effect on family planning use of both men and women by education level has been proved in other studies, consistent with this study (Zeyneloğlu et al. 2013; Bostancı 2011). For instance, a relevant study found that the use of modern family planning methods by men that had middle school or higher degrees was almost twice as high as among those men with no formal education (Katende et al. 2011). In most developing countries, men are the decision-makers in reproductive matters as well as the use of contraceptives and the number of

children they and their wives had (Odeyemi and Ibude 2011). There are also studies with opposite findings showing that men are deficient in both participating in family planning decisions and seeking family planning services (Ijadunola et al. 2010). Although some men have a lack of knowledge concerning family planning, they want to be informed, particularly about methods used by men (Akindele and Adebimpe 2013). Society-based education programs designed for males are effective in increasing men's awareness and knowledge in family planning (Odeyemi and Ibude 2011). The 2013 data from Turkey Population Health Research demonstrated that the fertility rate in women decreased as their education levels increased. The total fertility rate was 2.26, while this rate was 3.76 among those women that did not have any formal education or did not graduate from primary school. The rate was 1.66 for those women who had at least a high school education (Hacettepe University Institute of Population Studies 2014).

Marital adjustment is described as spouses' having a good relationship, solving their problems together, making joint decisions in family matters, and being happy with their marital life (Erbek et al. 2005). Marital adjustment is inevitably effective in making good family planning decisions. Marital adjustment also has a positive effect on the family planning score, as shown by this study (Table 3). A high level of marital adjustment has a positive effect on issues related to fertility health, resulting in fewer complaints. Çoban et al. (2008) found that marital adjustment and positive attitudes toward menopause helped women have fewer complaints in the climacteric period. Similarly, the couples with fertility-related health problems had high scores regarding marital adjustment ( $46.29 \pm 6.98$ ), and marital adjustment was affected by the environmental pressure related to having children (Taşçı et al. 2008). According to research results, couples that had strong marital adjustment usually had more children (Bayraktaroğlu and Çakıcı 2013). Also, the skills to solve marital problems were the most effective factor influencing marital satisfaction (Hünler and Gençöz 2003). It is commonly believed that a satisfactory adjustment and the ability to solve marital problems can be gained through positive communication between spouses. Could this positive communication be effective in helping couples make decisions regarding family planning? There are many studies showing that positive communication between spouses may lead to an increase in joint decision-making regarding family planning methods and the use of contraceptives (Hartmann et al. 2012; Mosha et al. 2013). Hence, marital adjustment is an important tool regarding effective family planning.

Lack of information is also an obstacle regarding the use of family planning methods. Unless health facilities offer male-specific family planning information and services, men's knowledge and family planning practices may be affected by culture and beliefs. Relevant studies found that there are many individuals who believe that it is a sin to use family planning

methods. Furthermore, some couples prefer ineffective family planning methods because of the influence of their culture and beliefs (Odeyemi and Ibude 2011; Zeyneloğlu et al. 2013). Being informed about family planning methods also increases sharing between spouses. The men who were informed about at least one family planning method (50.3%) talked more frequently to their spouses about family planning than those who did not know about any methods (20.7%) ( $p = 0.0496$ ) (Katende et al. 2011). For this reason, there is a need for more resources to enable men to access accurate information.

## Conclusion

This study found that men make rare use of family planning services, do not receive sufficient information about this issue, and have a moderate attitude toward family planning. Men's attitudes toward family planning are affected negatively by age, education level, a lack of information about family planning, living in an extended family, and wishing to have a high number of children. Marital adjustment improves attitudes toward family planning. The researchers believe that improving marital adjustment and problem-solving skills and teaching couples positive communication methods will have a positive effect on family planning attitudes.

## Compliance with ethical standards

**Conflict of interest** The authors have no conflict of interest. All authors certify that there is no financial relationship with the commercial identities mentioned in the manuscript that might lead to a conflict of interest.

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