

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,**

**KUMASI, GHANA**

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**SCHOOL OF PUBLIC HEALTH**

**DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE  
HEALTH**



**FACTORS ASSOCIATED WITH MALE INVOLVEMENT IN FAMILY  
PLANNING IN THE ASUOGYAMAN DISTRICT, GHANA**

**BY**

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**JUNE, 2019**

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,  
KUMASI, GHANA**

**KNUST**

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**(BSc. PUBLIC HEALTH EDUCATION)**

**A THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION,  
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REPRODUCTIVE HEALTH.**

**JUNE, 2019**

## DECLARATION

I, **SOSU MICHAEL WONDER**, hereby declare that this thesis is my own work towards the award of Master of Public Health Degree in Population and Reproductive Health and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been given.

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Head of Department Signature Date

## DEDICATION

This work is dedicated to the Almighty God for the strength and wisdom granted me to be able to put together this dissertation work.

To my dear Son, SOSU EYRAM FERDINAND and wife GLORIA AKUAMOAH-BOATENG for their sincere love, advice and support towards my education

I also dedicate this piece of work to my parents Mr Joseph Sosu and Mad Juliana Agbeve, my brother and sisters, Sosu Richard, Caroline Mawufemo Sosu, Lena Sosu, Mawunyo Sosu and Selasi Sosu for their immerse support towards my education



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## **ABBREVIATIONS/ACRONYMS**

AIDS	Acquired Immuno Deficiency Syndrome
CHRPE	Committee on Human Research, and Publication Ethics
CI	Confidence Interval
COV	Coverage of Vaccines
DHMT	District Health Management Team
EPI	Expanded Programme on Immunization
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immune Virus
IE&C	Information Education and Communication
IUD	Intra-Uterine Device
KDHS	Kenya Demographic Health Service
LI	Legislative Instrument
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-Governmental Organization
OR	Odds Ratio
R3M	Reducing Maternal Morbidity and Mortality
SDGs	Sustainable Development Goals
STIs	Sexually Transmitted Infections
W H O	World Health Organization

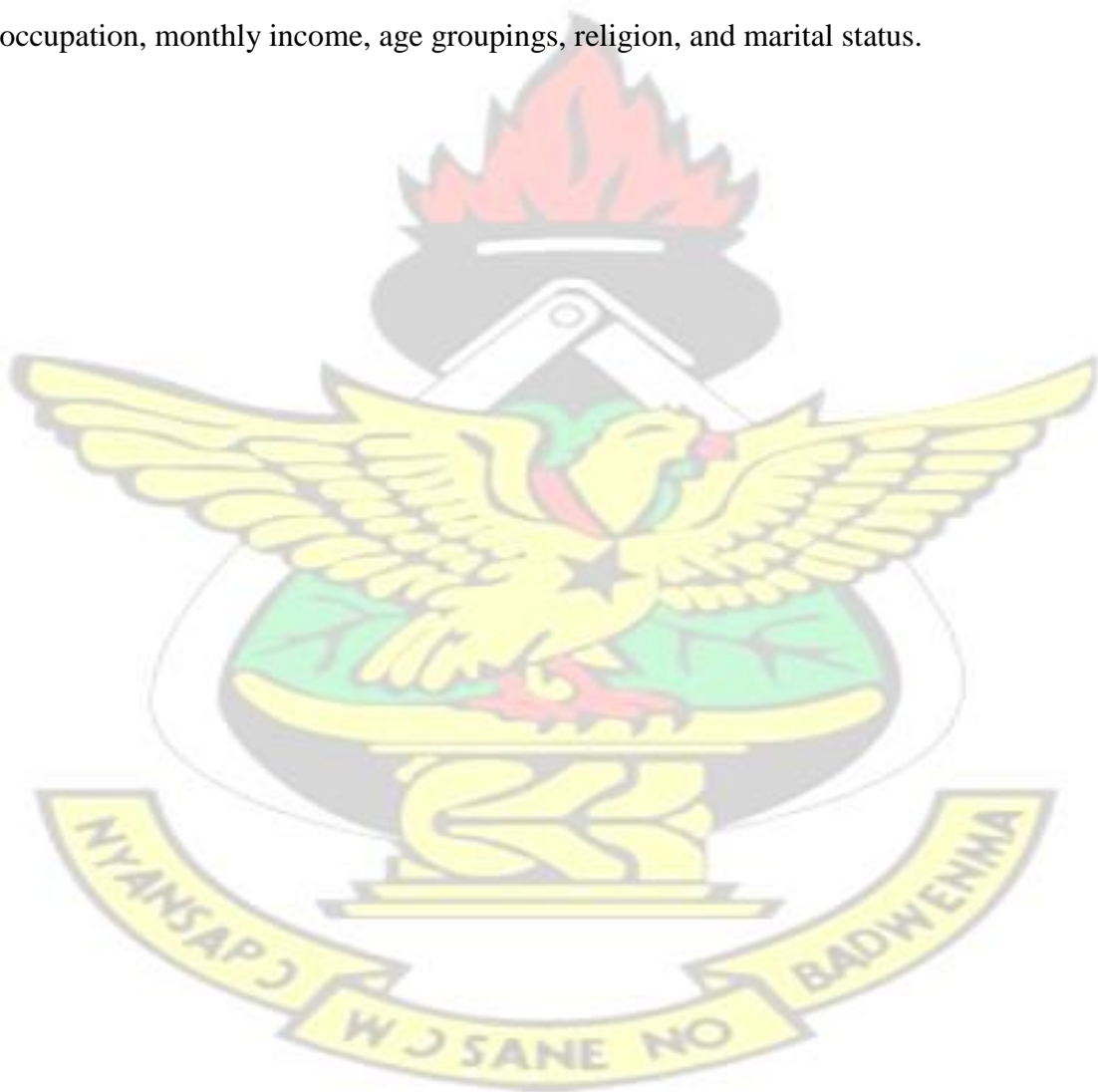
## ABSTRACT

Family planning (FP) is a way of controlling populations and it helps in reducing unintended pregnancies. Pregnancy is expected to occur by choice and not by chance and the goal of family planning is to assist couples and individuals of all ages to achieve this reproductive goal to improve their general reproductive health. The continuous use of contraceptive methods has not only resulted in the improvement of health-related outcomes, but also greatly reduced neonatal, infant and maternal mortality. However, family planning coverage remains low in Ghana at 24% as well as in the Asuogyaman district at 17% per the 2016 district annual report.

The study employed a quantitative method to determine factors influencing male involvement in FP in the Asuogyaman district. The study design was cross-sectional. A structured questionnaire was used to gather data from 308 respondents by simple random sampling. Data was checked for completeness and accuracy and analyzed using STATA version 12.1 at a significant level of 5%.

Contraceptives awareness (94.7%) and knowledge (71.3%) were high among male respondents. Though a majority (70.3%) perceived family planning as good for controlling family size and the prevention of unwanted pregnancies, up to 44% of male respondents' perceived contraceptive use makes a woman promiscuous and 62.3% said their religious and traditional beliefs were against its use. Condoms (52.5%) were the most used of the contraceptive methods. Upon multivariate logistic regression, factors associated with male involvement in pregnancy planning were ethnicity, educational level, occupation and monthly income. Factors associated with male involvement in planning desired family size included age groupings, ethnicity, occupation and religion. Factors associated with male involvement in family planning/contraceptives use were marital status, occupation, and religion.

In conclusion, contraceptive knowledge among men was found high, marginal number of men had negative attitude towards contraceptives of making a women promiscuous. An average number of men had involved in family planning with regard to pregnancy planning, desired family size and contraceptives/family planning use. However, contraceptives/family planning use was found above average among men of reproductive age. Significant factors associated with males' involvement in pregnancy planning, desired family size and FP method use were ethnicity, educational level, occupation, monthly income, age groupings, religion, and marital status.





## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background Information

Family planning (FP) is a way of controlling population size and it helps in reducing unintended pregnancies (Cates, 2010). Pregnancy is expected to occur by choice and not by chance and the goal of family planning is to assist couples and individuals of all ages to among others achieve this reproductive goal so as to improve their general reproductive health (Gaetano et al., 2007). Over the years, family planning was seen as female-centered program, where various interventions were directed towards the health of women with little attention paid to men (Yeshareg, Zelalem., 2014). Men were not considered in family planning, because it was perceived, that family planning and reproductive health are female responsibility (Raju, Leonard, 2000) even though there were few male commodities available.

In sub-Saharan Africa, it is broadly accepted that men,, are the decision makers regarding family formation despite women's impact in the everyday decision making of the home (Piotrow, 1992). According to (Dahal, 2005) there was a move towards counselling men to make an informed contraceptive choice and to take an increased role and responsibility for reproductive health and FP.

A number of studies have shown that providing men with information about reproductive health issues and involving them in counselling sessions can help make them more supportive of contraceptive use and more aware of the significance of shared decision making. For example, a survey conducted in Ethiopia revealed that involving husbands in FP education, in their own settings, significantly improved use of modern contraceptives, since most Ethiopian women will not initiate contraception without their husbands' knowledge (Terefe *et al.*, 1993). Health educators at this point are also

able to address some of the men's misconceptions about FP and its side effects as to the use of modern contraceptives, a common impediment to practising family planning (Terefe *et al.*, 1993).

Contraception is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low-resource settings (Prata *et al.*, 2008). Contraceptive use has greatly helped individuals and couples in the actualization of their basic right to freely decide on the number of children they want to have. The continuous use of contraceptive methods has not only resulted in the improvement of health-related outcome but greatly reduced infant, neonatal and maternal mortality. It has also led to improvements in schooling and economic outcomes, especially for girls and women (Char, 2011)

Lack of male involvement in decision-making on FP and reproductive health has made women to secretly access the services and are causing marital problems leading to divorce. A study conducted in northern Uganda found that women resort to the covert use of contraceptives (Orach *et al.*, 2015). Men from inception are seen as decision makers of family matters and are therefore seen as the first initiators of family planning. Whenever the men discover that their wives are utilizing family planning services, they urge the women to stop or remove the method and not letting community members know about it due to societal stigmatization (Orach *et al.*, 2015). The 2014 Ghana Demography Health Survey (GDHS) (Ghana Statistical Service [GSS], 2014) shows that the knowledge of males in family planning is as high as 99%, but this does not actually reflect in the use of FP by men. This situation can be attributed to the perception that, family planning is a means of preventing women from becoming pregnant and not giving birth to the preferred number of children that couples want to have (Terefe *et al.*, 1993). The people of Lulyia tribe in Kenya believe that the more

females you give birth to, the wealthier you become as females were seen as source of wealth in the form of bride price they will attract. Men, therefore, prevent their wives from accepting family planning. Others also believe that

Family Planning can lead to sexual promiscuity which in turn leads to stigmatization (Eliason et al., 2013).

Male involvement is not only limited to the uptake of male FP methods but also includes the number of men who encourage and support their partners and their peers to use FP (Green and Chens, 2003). It also involves the influencing of policy environment to be more conducive to the development of male-related programs. Therefore male involvement should be understood as all organizational activities whose main aim is to increase the prevalence of contraceptive for either gender (Butto and Mburu, 2015)

Studies suggested that well-oriented programs in family planning focusing on male involvement and participation, will encourage usage, more responsible sexual behaviour, increase contraceptive use, and improve communication between partners (Green and Chens, 2003). According to Gaetano *et al*, 2007 efforts to encourage a change in health staff attitude, along with improved organizational climate and periodic in-service training are requirements for improving male involvement in FP. This research, however, seeks to investigate other factors associated with male involvement in FP in the Asuogyaman district in the Eastern Region of Ghana.

## **1.2 Problem Statement**

Men have been observed to be knowledgeable of FP but their participation has been as low as 15% (GSS, 2006 and 2014). Some reasons that have been ascribed as contributing to prevent male involvement in family planning uptake include sociocultural factors, the attitude of health professionals towards male reproductive issues, religion, and cost of procedures, employment and education (Dahal, 2010). Also

fear of side effects is a major impediment to use of FP services. Failure to involve men in the family planning programs in a patriarchal society has serious consequences even if women are motivated to practice contraception because of opposition from the spouse. In Kenya, opposition from spouse accounted for 23% of the unmet family planning needs as stated in the Kenya Demographic and Health Survey (KDHS, 2010). In Ghana, various interventions have been made by the government and NonGovernmental Organization (NGOs) to increase FP coverage (Gaetano *et al*, 2007). Although success has been made, the unmet need for FP in the country is still high (Eliason, 2013). According to the 2014 (GSS), 30% of currently married women have an unmet need for FP services, with 17% having an unmet need for spacing and 13% having an unmet need for limiting.

In the Asuogyaman district, the circumstances are not different. Various interventions from government and NGOs are implemented in the district, but the uptake and prevalence of family planning are still low. The 2016 annual report of the district recorded a 17% acceptor rate, which is below the national acceptor rate of 24% (GSS, 2014). The district recorded three maternal deaths and (12%) unsafe abortions from teenagers, which could have been averted with the use of contraceptive. The continuous use of contraceptive methods in family planning has improved health related outcomes for women and children but the coverage in Ghana is still low and Asuogyaman District at 17% is even below the national coverage of 24% (GSS, 2014). Studies have shown that, male involvement can improve coverage hence this study to assess factors associated with male involvement in FP in the Asuogyaman

District.

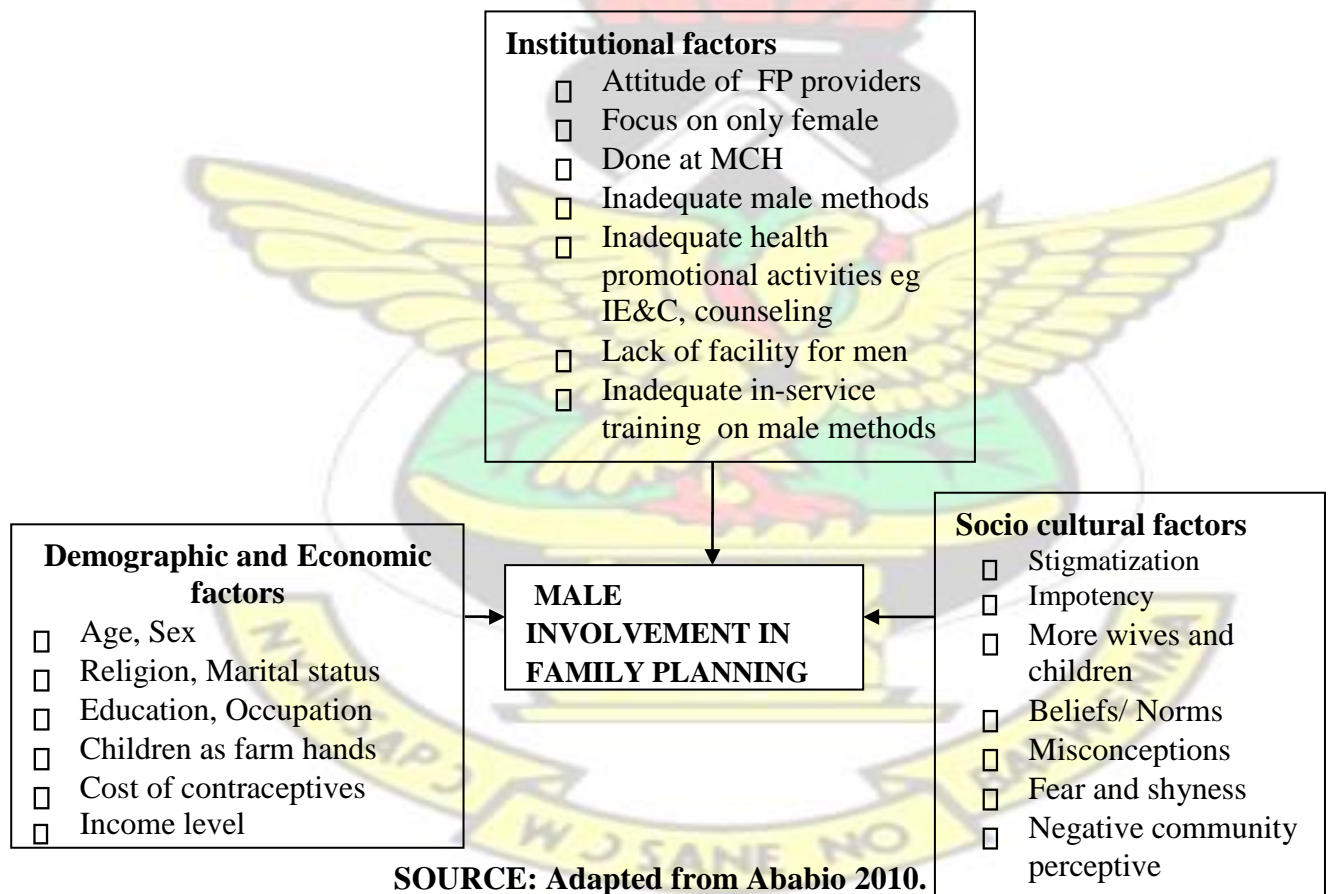
### **1.3 Study Rationale**

Family planning is often considered as a female-centered programme, with most attention paid to women and little to men (Aryeetey *et al.*, 2010). From my experience



on the field, men have been concerned about how most of the programs are directed towards women. It is on this ground that my research seeks to determine factors associated with male involvement in FP in the Asuogyaman district. Findings of the study will help the District Health Management Team (DHMT) to design appropriate interventions and specific measures that can potentially help in improving male involvement and uptake of FP by couples and individuals to enable the prevention of unintended pregnancy and mortalities. The findings of the study will also serve as a source of information to help improve male involvement in FP in the country.

Figure 1.1 Conceptual Framework



This conceptual framework identifies various factors associated with male involvement in FP services. These factors include socio-cultural factors such as the desire for more wives and bigger family size which is considered the signifier of a man's potency.



Additionally, stigmatization from community members influences on male involvement as well as a desire for male children. Shyness, fear and misconception are major socio-cultural determinants of male involvement in FP services. Economic factors also play a role in influencing male involvement in FP services. Men believe that the cost of procedures are very expensive and cannot afford the cost of surgery therefore will not enquire about what he cannot afford.

A third factor which also deters male involvement in FP services is institutional factors which include the attitude of FP services providers, lack of facilities to handle male issues on reproductive health and inadequate providers of men family planning services.

### **1.5 Research Question**

- What are the knowledge, attitude and perception of males about family planning in the Asuogyaman district?
- What is the level of males' involvement in family planning in the Asuogyaman district?
- What are the demographic, social, cultural, economic and other relevant factors that are associated with male involvement in the district?

### **1.6 General Objective**

To assess factors associated with male involvement in family planning in the Asuogyaman district in the Eastern Region of Ghana.

### **1.7 Specific Objective**

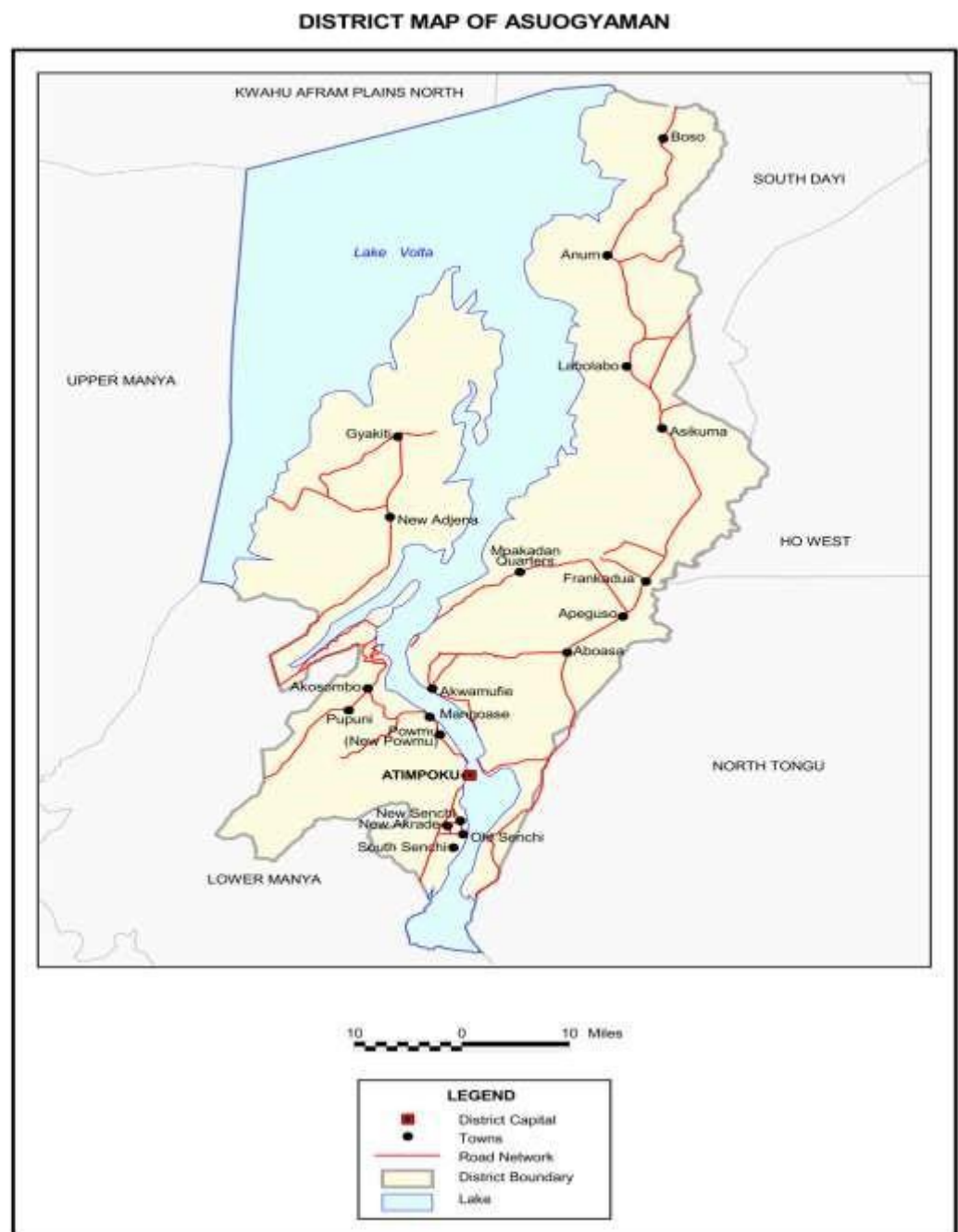
1. To explore the knowledge, attitude and perception of men about family planning in the district.
2. To determine the level of male involvement in family planning in the Asuogyaman district.

3. To determine the demographic, socio-economic, cultural and other relevant factors that are associated with male involvement in family planning in the district

### **1.8 Profile of Asuogyaman District**

The study is conducted in Asuogyaman District which is created under local government instrument LI 1431 of 1988 as a result of Ghana Government redemarcation exercise carried out to operationalize decentralization programme in the country from the defunct Kaoga District, which had Somanya as the capital. It lies between latitudes 6° 34' N and 6° 10' N and longitudes 0° 1' W and 0°14'E. and bordered in the north by the Afram Plains South District and to the south and west by the Upper and Lower Manya districts respectively. Asuogyaman is a traditional district situated between the Volta and Eastern Regions and share borders to the East with Kpando, North Dayi, Ho and the North Tongu Districts of the Volta Region.

Figure 2.1: District map of Asuogyaman



**SOURCE:** Ghana Statistical Service, 2014

### **1.9 Family Planning coverage in the Asuogyaman district**

Trends in FP coverage are used to assess and monitor the success of programmes over time.

The table below shows a contraceptive prevalence rate of the district in the years of 2015 and 2016.

The table shows that contraceptive use decreased from 20% in 2015 to 17% in 2016 despite the interventions from government and anon-governmental organization (NGO)[Reducing Maternal Mortality and Morbidity (R3M)] in the district.

**Table 1.1: 2015 – 2016 Family planning coverage in the Asuogyaman District**

SUB-DISTRICT	2015			2016		
	TARGET	ACC	COV (%)	TARGET	ACC	COV (%)
Anum/Boso,	4185	828	20	4341	416	10
Akosombo.	4147	540	11	4356	443	10
Gyakiti	2005	516	26	2177	409	19
Atimpoku	3149	524	17	3153	603	20
Akwamufie	6897	1251	18	7873	1001	13
Senchi	2195	957	44	2379	1328	55
Total	22578	4616	20	24279	4200	17

## 1.10 DEFINITION OF TERMS

**Male involvement:** a man who either supports his partner in contraceptive use or actually participates in FP by using a method (Butto and Mburu, 2015)

**Contraceptive prevalence rate:** the percentage of women who are currently using a method of contraption (GSS, 2014)

**Partner communication:** how often the two partners talk or discuss family planning (Kabagenyi *et al.*, 2014)

**Knowledge of method:** A partner is reported to know a method if he/she spontaneously mentions a method after prompting (GSS, 2014)



**Unmet needs:** Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour (GSS, 2014)

**Access:** the ability to get to a place or the opportunity to use something without any difficulty (Bertrand, 1995)

**Utilization:** the state of using or have used  $\geq 1$  modern FP technique [contraceptive pill, intrauterine device, injection, male/female condom, male/female sterilization (Ibnouf *et al.*, 2007)

## 1.11 ORGANIZATION OF REPORT

The study report was organized into six chapters. The first chapter one, included introduction to the study, the problem statement, study rationale, conceptual framework, research question, general objective, specific objective, profile of study area, family planning coverage of Asuogyaman district, definition of terms and how the report will be organized. Chapter two dealt with the reviewed of literature relevant to the study. Reviewed literature was organized in line with the study objective. Chapter three of the study considered the study type and design, data collection techniques and tools, study population, inclusion and exclusion criteria, study variables, sampling estimation, sampling technique, pre-testing, data handling and analysis, ethical consideration, study limitations, and assumption. Chapter four considered the presentation of results on tabular form and chapter five discussed these results in line with the the research objectives and literature.

The final chapter, six, looked at conclusion and recommendations from the study.



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## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

This section reviewed previous works based on the study topic and the related objectives of the study which sought to assess factors associated with male involvement in family planning in the Asuogyaman district in the Eastern Region of Ghana. The reviewed literature has been categorized into sections which include; the concept of family planning, benefits of family planning, demographic, socioeconomic, and cultural and other relevant factors associated with male involvement in family planning, knowledge of males on family planning, the attitude of males towards family planning, the perception of males on family planning, and level of male involvement in family planning.

#### **2.1 Concept of family planning**

Family planning (FP) in diverse literature has been defined in different ways, but more importantly it enables individuals or couples to attain their desired number of children by birth spacing and timing of their children through the use of modern contraceptives (implants, injectables, condoms) or traditional methods (periodic abstinence and withdrawal method) to the prevention of pregnancy (Shah, 2007). The synonym of FP is sometimes called birth control, which equally connotes the prevention of pregnancies and limiting the family size of couples on planning their families. The term contraceptive or contraception refers to devices or medications that are used by couples to reduce the likelihood of ovum fertilization by the sperm cells (spermatozoa) (Shah, 2007). Contraceptive methods could be either temporary or permanent. Temporary methods include periodic abstinence during the fertile period, coitus interruptus

(withdrawal), lactational amenorrhea which is the natural occurring periods of infertility during breastfeeding and postpartum amenorrhea.

They also include the use of reproductive hormones such as oral pills and long-acting injections and implants, placement of a device in the uterus like copper-bearing and hormone-releasing intrauterine devices. Also, interposing a barrier method that prevents the penetration of the sperm into the upper female genital tract such as condoms, diaphragms, and spermicidal.

Permanent methods of contraception include; male and female sterilization which are vasectomy and tubal ligation.

The concept of FP emerged when the world population by 1900 was estimated to be about 1.7 billion, and in 1999 it was reported to have risen to 6 billion that is according to World Health Organization (WHO), which trigger the needs for people to plan their families. Presently, it is estimated that about 80% of the world population live in developing countries and is further pronounce to be risen to 90% by the year 2050 (Admasu, 2015).

Accompany with this population increase, and the limited resources, each day about 1,600 women and more than 10,000 children who are newly born die from preventable pregnancy and childbirth complications.

With this, nearly 99% of maternal deaths and 90% of neonatal deaths have been reported to occur in less developed countries such as sub-Sahara Africa and for that Ghana (Butto & Mburu, 2015).

In 2012 for example, WHO predicted 287,000 maternal deaths in 2010 to have occurred; off which sub-Saharan Africa constituted 56% of maternal deaths and 29% to have occurred in Southern Asia and these were found to be the greatest contribution to the burden of maternal deaths globally (Marius et al., 2014).

This burden could be reduced by regulating human fertility rate through the use of FP in spacing children and limiting births. In Ghana, fertility rate has shown a decline of the number of children per woman from 6.4 in 1988 to 4.2 in 2014 of the number of children per woman according to the Ghana Demographic and Health Survey (GDHS). The dropped in fertility rate over a decade has also resulted in a decrease in infant mortality to 41 deaths per 1,000 live births which is about 28% decline rate since 1998, and under-five mortality, however, saw a slight increase to 60 deaths per 1,000 live births to indicates 44% rate within the same period (GSS, 2014).

FP plays a key role in all these, however, contraception in Ghana is often seen as a woman business with less male involvement simply because contraception is believed to make a woman promiscuous, with about 73% of men not to have involved in FP in Ghana (GSS, 2014).

Women ill patronage in reproductive health/FP services is reported to be influenced by lack of male involvement thereby making their female partners suffer the consequences. The involvement of males in FP does not only help in the acceptance of FP or contraceptives but also ensure the effective use and continuation of the method (Marius et al., 2014).

Ensuring male involvement in FP could help in the achievement of the postmillennium development goals (MDGs) and the current sustainable development goals (SDGs) to the reduction of maternal deaths and impact of HIV prevalence (Kassa et al., 2014).

To increase the use of contraceptives and FP among women, call for male involvement, and this has greater health impact and the reduction of maternal mortality, and infant and child mortality, and also increased results in the schooling of girls and as well women economic empowerment (United Nations, 2017).



This study, therefore, sought to assess factors associated with male involvement in family planning in the Asuogyaman district in the Eastern Region of Ghana.

## **2.2 Benefits of family planning**

The benefits of FP are enormous to the socio-economic empowerment and health impacts of individuals, families, communities, societies and the nation as a whole.

Few of such benefits are outlined below;

### **2.2.1 Benefits of family planning to the family**

The following are among some of the benefits of family planning to the socioeconomic empowerment and health impacts of the family;

Through FP, the basic necessities such as food, water, housing, education and clothing of each family member are been achieved. It also helps families to spend less money and be accumulating savings over a period of time, and be able to make education for their children more affordable, and the children are better educated to the highest level and are able to take good care of their parents in the future (Marius et al., 2014).

It reduces substantially the illness of mother and child and therefore boosts family incomes that could have been used in paying for hospital bills and treatment of ailments. Again, once the mother is healthy she will be able to engage in productive economic activities to support the family, and the family will live in harmony and peace (Marius et al., 2014).

### **2.2.2 Benefits of family planning at the community level**

The use of FP in a community by women helps reduces health risks to women and guarantees them more control over their sexual and reproductive lives. With better health and greater control over their lives, women can take advantage of education,



employment and civic opportunities in their communities and the overall well being of the community been improved (Kassa et al., 2014).

Maternal, child morbidity and mortality in the community would be reduced, and issues of taking care of the sick will be avoided and peoples can engage in productive economic ventures. Also through family planning, women health, in general, will be improved, and prevent the spread of diseases in communities such as the sexually transmitted diseases like HIV/AIDS (Kassa et al., 2014).

Through the use of FP, issues of abortions from unwanted pregnancy, and also a precursor of maternal deaths will be prevented. Also, the resources of the family and community will well manage to enhance the social and economic lives of the people (Kassa et al., 2014).

### **2.2.3 Benefits of family planning at the national level**

Uptake of FP by women will contribute to the improvement of health service issues like diarrhoea and pneumonia management of children at less cost and lessen national budget on the procurement of logistics and provision of the facility. National health programme such as nutrition programme, expanded programme on immunization (EPI), and family planning programmes become efficient and contribute directly to the improvement of maternal and child health and healthy growth and development in children(United Nations, 2017).

Also, with smaller population size family and government will have to reduce burden in the provision of infrastructure and logistics, and other essential equipment which are important to the social and economic growth of the country and the general well being of the people in the country(Marius et al., 2014).

The education of the people will be improved and ensure a healthy nation, promote enhance productivity in the country and self-sufficiency to building sustainable

development in the country. Again, issues of unwanted pregnancies which lead to unsafe and induced abortions putting the burden on the national health system could be prevented through the use of family planning. With the uptake of family planning will contribute to the reduction of maternal and infant mortality in the country(Marius et al., 2014).

#### **2.2.4 Benefits of family planning at the global level**

At the global level, the uptake of FP by women and families will contribute greatly to the attainment of the sustainable development goals (SDGs) and targets on the reductions of maternal and infants mortality by the United Nations and target for HIV/AIDS prevalence and impacts around the globe(United Nations, 2017). The agenda 2020 on FP set up by the United Nations which focuses on the 69 poorest countries, and Every Woman, Every Child which seeks to outline broader strategies of accelerating the improvements of women, adolescents and children health by 2030 will equally be achieved(United Nations, 2017).

#### **2.3 Factors influencing male involvement in family planning**

Among factors that have been identified to have a greater impact on the utilization of reproductive health services by women is the participation of males in FP services. This has been highlighted by the 1995 International Conference on Population and Development indicating the responsibilities of men in women reproductive health and called for men active involvement in women contraceptives uptake and other reproductive health services according to Hemaideh *et al.*, 2016. Male involvement was reported to include the use of male FP methods and increase decision- making concerning women contraceptives uptake and desired family size (Hamaideh *et al.*,

2016). Male involvement in FP also indicates their acceptance and support of their partners' wants, preferences of FP methods, and sexual and reproductive health rights of their wives to ensuring fairness (Kassa *et al.*, 2014).

A number of these factors are interfering women uptake and the low coverage of FP services, and as well as the desire for more children to be underpinned by the low level of knowledge on contraceptives and unavailability of the preferred method to use. Others factors include fear of health effects, opposition by religious bodies and husband and low level of male involvement in family planning (Kassa *et al.*, 2014). In addition, others factors could be demographic, socioeconomic, cultural and among others which could have a significant influence on male involvement in family planning in the study area which is further discussed below;

### **2.3.1 Socio-demographics and economic factors**

Various socio-demographic and economic factors influenced male involvement in FP. In a study by Malkawi *et al.*, (2016) in Kenya found men's level of education and number children a man has to have a significant influence on male's involvement in FP. The study also found demographic factors like an age to affect male involvement whereby the elderly men were more likely to have involved in FP than the younger in age. Again, those who had more than two children were found to have a lower rate of current contraceptives use. In similar study indicates previous contraceptives use to have an association with men's attitudes towards FP whereby men were found to have indicated that having more children as a man shows masculinity and a man is more respected (Malkawi *et al.*, 2016).

However, a study conducted in Ghana found no significant association with men socio-demographic variables such as age, a number of wives, level of education and ever had children to significantly influenced male's involvement in FP. With the majority of men

in Ghana aged 15-59 years thinking that men should have a responsibility towards family planning and support women FP uptake (GSS, 2014). In Ethiopia by Marius *et al.*, (2014) study found a strong association between age, marital status and male's involvement in FP to have indicated older aged men and cohabitation to have influenced on FP uptake by men. Similarly, in Malawi, the study had shown age and marital status to significantly influenced male's support for their wives in FP uptake, and more men were found to have been in support of vasectomy as a method for FP (Marius *et al.*, 2014).

In a study conducted by Butto & Mburu, (2015) in Kenya found 48% of men not have involved in FP and 6% only was reported to have used family planning in Kenya, and have equally found respondents age, education, number of children, and type of marital relation to have significantly influenced on the male FP involvement.

However, other studies by the same author found men with no formal education to be less likely to have involved in family planning and support of their partners to uptake FP services (Butto & Mburu, 2015).

In Aduayi *et al.*, (2017) study also found respondents age group and the number of children to have a statistically significant association with the level of males' involvement in FP. The study also found men level of education to have a significant association with males' level of involvement in FP practices, and again indicate that men with no formal education made up of 89% and were less likely to have involved in FP.

In Butto & Mburu (2015) study found religion to have an association with men contraceptives use ( $p=0.003$ ), and as well as the type of marital relation to having equally influenced the level of male involvement FP. Again, the study found



monogamous marriage men to have 3.8 increased chance of involving in FP and to have offered support to their wives FP services uptake.

Another study by Soremekun (2018) found men engagement in FP to have a direct influence on their partners' uptake of reproductive health services in regard to FP choices, decision making on FP and contraceptives behaviour of men(Soremekun, 2018).

In addition, Aduayi *et al.*, (2017) also found age, religion, education and occupation to have significant influence on overall male involvement in family planning practices, and males perceptions towards FP services, and as well as Soremekun (2018) study equally found age, religion, and education to significantly influenced males overall FP practices and uptake of contraceptives.

In amulti-variable logistic regression analysis in Ghana found the age of respondents, occupation, marital status and religion to have a significant influence on men uptake of modern contraceptives and an increased level of knowledge on FP methods(Aryeetey *et al.*, 2010).

With related study also in Uganda found age, place of residence, occupation, and marital status to have significantly influenced on males non-use of contraceptives and as well as the fear of side effects which were making men not to allow their wives to use contraceptives(Orach *et al.*, 2015).

### **2.3.2 Socio-cultural factors**

Cultural beliefs and perceptions, as well as cultural standards of society, serve as barriers to males' involvement in FP practices. In Marius *et al.*, (2014) study found male respondents to have believed that men needed to be involved in FP services because they play dominant role in family decision-making in FP practices, and found



men as heads of the family to have exerted a lot of significant influence on women's decision-making on FP uptake.

The study equally found decision pattern at home to include jointly decisions, maledominated decision and females dominated decision-making by respondents in which males decision-making was found to have dominated females decision which was influenced by cultural norms of making the man the head of the family (Marius *et al.*, 2014).

In Nigeria, a similar study found men who followed their wives to FP clinic to have been perceived as been dominated by their wives or been controlled by their wives because men perceived FP to be the responsibility of women. By this, 65% of men in Nigeria were found to have disapproved men attending FP clinic with their wives (Marius *et al.*, 2014).

In Soremekun (2018), indicates many men to believe the use of FP to limiting births and spacing of children to have encouraged promiscuity among women and so disapproved the patronage of the services. Also, the study found males uptake of FP and involvement to be associated with socio-cultural norms and a determinant of gender relations in society, and so can promote male involvement in FP activities in Nigeria (Soremekun, 2018).

In Zimbabwe, a study found 42% of married women to have belief that, women use of FP is the responsibility of men to decide whether or not their wives would be allowed to use FP methods (Aduayi *et al.*, 2017), and in Ethiopia women who were found to be at risk of unplanned pregnancies because they have had unprotected sex have reported to have been opposed by their husbands (Aduayi *et al.*, 2017). In Ghana, women FP uptake was found to have been influenced by cultural norms and beliefs where women are met to obtained permission from their husbands before using any contraceptive

method, and cultural position of men being the head of the family influenced decision-making with regard to women reproductive health and FP (GSS, 2014).

## **2.4 Males knowledge of family planning**

The influence of male involvement in FP and support of their wives to the uptake FP services is dependent on their knowledge level of the various contraceptive methods and the use of it. With regard to a study conducted by Aduayi *et al.*, (2017) found almost all men (99.7%) to be aware of FP with condoms been the most commonly known method and the least known FP method was vasectomy.

Major sources of FP methods were found as 54.2% through radio, 12.7% school, and 11.4% from friends and relatives, and the most commonly used FP methods were condoms (49.5%), and 19.8% were emergency contraceptive pills. Again, current contraceptives use was found to 66.1%, with currently used contraceptive methods to involve condoms (49.5%), withdrawal/coitus interruptus (22.5%), contraceptive pills (19.8%), and the least used contraceptive methods to have similar proportions of 0.6% for implanon and vasectomy (Aduayi *et al.*, 2017).

In Tlahun *et al.*, (2013) in Ethiopia men condoms used was very low and a high level of contraceptives knowledge with about 96% to have known at least one form of a contraceptive method. In a related study by Duze & Mohammed (2006) found nearly two-thirds (63.6%) of males to have knowledge of contraceptive methods, and a similar proportion to have known of at least one method of contraception. However, the study found men place of residence, age and education to have significantly influenced on men contraceptives knowledge and use.

Kassa *et al.*, (2014) of Uganda found 91.6% of men to have knowledge of modern contraceptive methods and 99.2% to have said they have ever heard of FP methods.

In Ghana, modern contraceptives knowledge (97%) of men was found to be universal, with 56% to have known more than one FP methods, and 65% of men to have ever used modern family planning method, and 82% of respondents thought contraceptives are effective to the control of births (Aryeetey *et al.*, 2010).

In Tanzania, men contraceptives awareness was reported to be equally universal, and about 99.7% to have known more than one FP method and 67% were found to have ever used family planning methods (Mosha *et al.*, 2017).

Among FP methods men have ever used were reported low such as injectables, oral contraceptives except for condom, which was reported high among married men. With FP knowledge, it was universally reported in Tanzania (100%) and 82.3% were found to have ever used modern contraceptives method (Mosha *et al.*, 2017).

In another study in Malawi found 50% condoms used among men and women, contraceptive pills was 36.3%, periodic abstinence/ rhythm was 33.4%, Injectables 23.4%, withdrawal method was 20.6%, Intra-Uterine Devices 13.5%, tubal ligation 12.3%, diaphragm was 12.2% and vasectomy as 10.6% (Akwenabuaye *et al.*, 2013). And in a similar study by Nzioka (2012) found an increased number of male to have knowledge and interest in FP, and this was reported among the young men and educated men.

In Ghana, according to the Ghana Demographic and Health Survey; contraceptives knowledge was reported universal among both men and women; with about 99% of men and women to have had knowledge of contraceptives' regardless of their marital relationship. Men aged 15-49 years about 99% have knowledge of modern methods and 81% knew of the traditional methods, and about 77% to have known withdrawal method, the male condom was 99%, emergency pills 87%, female condom 88% and Injectables 83% (GSS, 2014).

In a related study by Akafuah & Sossou (2008) in Ghana (Accra) found sociodemographic characteristics like education, religion, marital status, the influence of education from the media to significantly affects men contraceptives' knowledge and the involvement of it.

#### **2.4.1 Attitude and perceptions of males towards family planning**

The involvement of males in FP could be influenced by their attitude and perceptions towards the uptake of FP services. In Mosha *et al.*, (2017) found majority of men (96%) to have had positive attitude towards FP, with most of them to have had positive perceptions about FP as effective methods to the control of births, and some were found to have recommended FP to their friends and relatives as means of birth control in Tanzania.

In a related study by Kassa *et al.*, (2014) which assess men attitude towards FP and have found about 51.1% of men to have developed interest in knowing more about FP while 48.9% were found to have had no interest in FP, and however had believed in the natural birth control processes (Kassa *et al.*, 2014).

Again, Aduayi *et al.*, (2017) found 89.5% of men to have had a good perception about FP and 82.9% beliefs FP to be good while 33.9% and 18.6% to have agreed that condom use doesn't reduce sexual satisfaction and vasectomy as the desirable method of practice. Overall assessment of men positive perceptions was 89.5% and negative perceptions of men towards FP was found to about 10.5% (Aduayi, 2017).

In Nigeria, about 89% of men were found to have approved of their spouses using FP while 11% disapproved of their wives using FP methods, with about 65% of males to have disapproved their wives attending family planning clinics and 26% to have been in support (Marius *et al.*, 2014).



Again, in a qualitative study by Tilahun *et al.*, (2013) found more men to have a positive attitude towards FP, and as well as more men were found to have been in support of their wives in the uptake of family planning services.

Notwithstanding, about 3% of men were found to have had negative attitude towards FP in which a 45 years old man have said “What will I do in a family planning clinic, contraception is women’s business, I will just give my wife the necessary financial support she needs” Overall, males attitudes and perceptions towards FP was found to be high (91%) and 64% to have ever used contraceptives (Tilahun *et al.*, 2013).

In Duze & Mohammed (2006) study found 55% of men to have had an unfavourable attitude towards family planning and 35.7% were found to have had a favourable attitude towards the use of family planning by women. According to Aryeetey *et al.*, (2010) men perceptions about FP in Ghana was found to be associated with their use of modern family planning methods, and Mosha *et al.*, (2017) found 40% of men to have indicated that they will not discuss FP uptake with their wives.

Kabagenyi *et al.*, (2014) study found social norms and health system support factors to significantly affect men involvement in FP and participation in other reproductive health services, and to have found some of the men who said the use of vasectomy make men to lose their masculinity and do not support uptake of vasectomy (Kabagenyi *et al.*, 2014).

Orach *et al.*, (2015) study in Uganda found men who are the heads of families and be the sole decision-maker to significantly influence women FP use, for which most women were found to have been expected their men to initiate the decision on the discussion of FP at home, and when the men failed to do so the woman is likely not to have used contraceptives’. In Ghana, a study by Akafuah & Sossou (2008) found men attitude towards FP to have been influenced by their socio-demographic characteristics



such as education, religion, marital status and exposure to the media to affects their involvement and support of their wives to the uptake of family planning method.

## **2.5 Male involvement in family planning**

The level of males' involvement in FP in Ethiopia was found to be about 8.4%, and a similar proportion to have participated in the use of FP, and more males were found to have reported in support of the use of male condoms (Kassa *et al.*, 2014).

Among the reasons cited to have accounted for the low involvement of males' in family planning to include: men desire for more children, wife or partner refusal, fear of side effects, prohibition by religion, and lack of awareness on FP methods. In the same study by Kassa *et al.*, (2014) found men who support their wives in FP services uptake to be more likely to have involved in FP services. Again, men who were found to have encouraged their wives to used FP were more likely to have involved in FP services, and as well as support their wives, motivates them and share their responsibility in reproductive health services uptake and encourages men to develop a supportive attitude towards FP. Other factors such as lack of FP information, and inaccessibility of the FP methods to men have accounted for the low level of involvement in family planning services(Kassa *et al.*, 2014).

In Tanzania, a study by Mosha *et al.*, (2017) found a low level of males' involvement in FP to have been influenced by educational level, contraceptives information sources, occupation, level of household income, and distance from the health facility to have affected males' FP services.

In a related study by Akwenabuaye *et al.*, (2013) found spousal involvement in FP to have taken place after having two or more children, and contraceptives used to have been found to always initiate by the husbands. It, therefore, requires the needs to address barriers to males' involvement in FP to create the supportive environment for men to

be able to partake in FP services of women, as well as address men negative attitude towards FP (Kabagenyi *et al.*, 2014) in Uganda.

In Ghana, overall male involvement in FP and the support of women uptake of FP services to be about 8.2% (GSS, 2014).

# KNUST



## **CHAPTER THREE**

### **MATERIALS AND METHODS**

#### **3.1 Study Design**

The research combines descriptive and analytical observational study types. The study was a cross-sectional design. A quantitative method of data collection was used in the study.

#### **3.2 Data Collection Techniques and Tools**

The interview was the method/technique used for data collection. Structured and semi-structured questionnaires were designed for the collection of data. The questionnaire designed had both open-ended and closed questions and also probing to help the respondents with no trouble, share their views on the study. Views of respondents were sought from their own setting to make them comfortable to bring out their ideas and experiences and using the local language of the people in the area which is Twi and Ewe. The questionnaire covered the following areas, demography of the respondents, views on the level of knowledge and perception, accessibility and availability of the services to men and utilization of the services. There was a one-day training organized for three (3) research assistants to help them in data collection.

#### **3.3 Study Population**

The study was carried out on males between the ages of 15-49 years and it is because this age group is seen as the reproductive age group.

#### **3.4 Inclusion Criteria**

All males 15-49 years living in Asuogyaman district for a period of one year and before the start of the study.

### 3.5 Exclusion Criteria

1. Males who do not live in the area during the study period were excluded.
2. Males below the ages of 15 years and above 49 years were excluded from the study.
3. Persons who do not accept to be part of the study

### 3.6 Study Variables

The study variables described below

#### 3.6.1 Dependent Variable

The dependent variable is the level of male involvement which includes Pregnancy Planning (PP), Desired Family Size (DFS) and Family Planning Method (FPM)

#### 3.6.2 Independent Variable

The independent variables in the study include: demographic data such as

- Age,
- Religion,
- Marital status,
- Occupation, ➤ Education.
- Ethnicity,
- Monthly income earned and
- Number of years in marriage.

### 3.7 Sample Size Estimation

The sample size for the study will be calculated using Cochran (1977) formula,

$$n = \frac{z^2 pq}{d^2}$$

Where  $n$  = sample size for the study,  $z$  = the standard deviation which correspond to 95% confidence level (1.96),  $p$  = the proportion of FP users (0.24) [GSS, 2014]. ).

$q = 1-p = (1-0.24)$   $d$  = degree of accuracy desired. (0.05)

$$n = \frac{(1.96)^2 \times 0.24(1-0.24)}{(0.05)^2}$$

$$n = \frac{3.8416 \times 0.24 (0.76)}{0.0025}$$

$$n = \frac{(3.8416) (0.1824)}{(0.0025)}$$

$$n = \frac{0.7007}{0.0025}$$

$$n = 280$$

In order to make room for non-response, a ten percent (10%) of the sample size was added so as to enable the research work to be used to make a generalization of the prevalence of FP utilization by men in the district.

$$\frac{10 \times 280}{100} = 28$$

$$n = 308$$

Therefore the actual sample size that the researcher used for the study was 308 men in the Asuogyaman district.

### 3.8 Sampling Technique

A multi-stage sampling technique was used to select three sub-districts, a simple random sampling using the lottery approach to select three sub-districts to take part in the study. During the sampling, names of all six sub-district was written on a paper, cut into six pieces and folded into the same shape. These pieces of papers were placed in a container where a volunteer pick from the container and any sub-district that is picked,



was used as a research site for the study. 5 communities were randomly sampled for two sub-districts and 4 communities from 1 sub-district and then 22 men aged 15 to 49 years were systematically chosen from the households selected in these communities for the study. Participants were sampled by systematic random sampling in which a house is selected at random and the next house nearer to the door of the previously entered house was chosen in the same lane with the previously selected house to be entered and interview males who are within the defined age category of the study until the expected total number of the study is achieved.

### **3.9 Pre-testing**

The questionnaire was pre-tested in a community, which is not part of the study district but in a district close to the study site. This is to help the researcher to find out gaps in the questions and address them before they are administered to the selected population.

### **3.10 Data Handling**

Data received from participants were coded and handled with confidentiality by the principal investigator. All responses from the participants were conducted privately to ensure adequate privacy and confidentiality during the period of interview and filling of the questionnaires. Assistance was offered to participants who could not read or write in a language that the participants understand by the research assistant. Daily data compilation was done and after, particulars were locked in a safe place and the key was kept by the principal investigator.

### **3.11 Data Analysis**

Daily compilation of data was employed by the researcher so as to enable him to check for completeness and accuracy. Responses from participants were coded to enable easy analysis. The statistical software used was STATA version 12.1 for the analyses of the data. Data collected was summarized and discussed using frequency tables.

Univariate logistic analysis was carried out to identify the association between the dependent and independent variables. A p-value less than 0.05 were considered statistically significant. The variables that show statistical significance were incorporated into a multivariate logistic regression model for further analysis to generate odds ratio (OR) and 95% confident intervals (CI).

### **3.12 Ethical Consideration**

Ethical approval was sought from the Committee of Human Research and Publication Ethics (CHRPE), Kwame Nkrumah University of Science and Technology before the study is conducted. An introductory letter was also obtained from the School of Public Health, Kwame Nkrumah University of Science and Technology, to be sent to Asuogyaman district health directorate to seek for permission to enable the researcher to undertake the research in the district. Since this is a research that involves human participants from communities in the district, the leaders in the selected communities were visited to seek their consent to enable easy entry into the communities and to prevent any interference of the research by community members. Also signed or thumbprint consent was sought from respondents to allow them freely decide to participate in the research.

### **3.13 Study limitations**

The study did not seek information from men above 50 years of age. It is limited to men between the ages of 15 to 49 years.

### **3.14 ASSUMPTIONS**

Men with a low level of education are less likely to get involved in family planning

## **CHAPTER FOUR**

## **RESULTS**

## Introduction

This section presents the results of the study based on the set objectives of the study, which are categorized into sections.

### 4.1 Respondents socio-demographic characteristics

Table 4.1 on pages 47 and 48 depict the respondents' socio-demographic characteristics. Nearly quarters (23.7%) were within 25-29 years, and similar proportions were between 30-34 years and 35-39 years. About half (49.0%) of the respondents were Akan, a quarter (25.7%) were Ewe and 21.0% belong to the GaAdangbe tribe. More than half (52.7%) were married, singles were 20.3% and those cohabiting were 16.3%. Also, nearly a third (32.7%) had secondary/SHS education, 21.3% had elementary/JHS education and nearly the same proportion had a primary and vocational education. Again, more than a third of the respondents were traders, 28.3% were involved in farming, unemployed were 21.3% and civil servants were 5.3%. With regards to religion, about 23.7% were Catholic, 29.0% were charismatic/Pentecostal, Orthodox churches were 20.3% and Islam constitutes 19.0%. About 29.7% of respondents earned their monthly income above GHS900 and nearly the same proportions earned either below or above GHS500 for their monthly income. Nearly two-thirds (55.7%) of respondents had married for up to 4 years, 26.7% had married for 5-9 years and 13.7% were found to have married for up to 10-14 years.

**Table 4.1: Socio-demographic characteristics**

Indicator	Frequency (N=300)	Percentage (%)
Age groups		

15 – 19	27	9.0
20 – 24	32	10.7
25 – 29	71	23.7
30 – 34	52	17.3
35 – 39	56	18.6
40 – 44	26	8.2
45 – 49	36	12.0
<b>Ethnicity</b>		
Ewe	77	25.7
Akan	147	49.0
Ga- Adangbe	63	21.0
Other	13	4.3
<b>Marital status</b>		
Single	61	20.3
Cohabiting	49	16.3
Married	158	52.7
Divorced/separated	18	6.0
Widow	14	4.7
<b>Educational background</b>		
None	36	12.0
Primary	25	8.3
Elementary/JHS	64	21.3
Secondary/SHS	98	32.7
Vocational	28	9.3
Tertiary	49	16.3
<b>Occupation</b>		
Unemployed	64	21.3
Farmer	85	28.3
Trading	105	35.0



Civil servant	46	5.3
<b>Religion</b>		
Catholic	71	23.7
Charismatic/Pentecostal	87	29.0
Orthodox churches	61	20.3
Islam	57	19.0
Traditionalist	24	8.0
Other (specify).....		
<b>Monthly income</b>		
<500	32	10.7
501-600	37	12.3
601-700	34	11.3
701-800	52	17.3
801-900	56	18.7
>900	89	29.7
<b>Years of marriage</b>		
0-4	167	55.7
5-9	80	26.7
10-14	39	13.7
15-19	14	4.7

**Source: Author's fieldwork data, 2018**

#### **4.2 Knowledge of male involvement in family planning**

From table 4.2 on pages 49 and 50, the majority (94.7%) were found to have ever heard of family planning. About 83.3% of respondents said family planning means the use of contraceptives and nearly three-quarters (71.3%) said for child spacing, prevention of unintended pregnancy were 53.0%, and similar proportions said family planning makes women promiscuous and for the prevention of sexually transmitted infections (STIs). Nearly the same proportions heard of family planning on radio and television, health



workers were 73.7%, friends/relatives 65.3% and commercial/social clubs were 12.3%. More than three-quarters (85.3%) of men knew family planning could be accessed at the health centres, hospitals 61%, maternity homes constitute 65.3% and chemical shops were 79.7%. With regards to what contraceptives are; about 81.3% knew contraceptives as barrier methods, a hormonal birth control was 29.7%, natural methods were 43% and as drugs were 66.3%. Almost, all men were found to have known condoms (99%), emergency pills (81.7%) withdrawal method (81%), Injectables (63%), Implants (67%) and the least known methods were found to include; IUD, spermicides, diaphragm and male/female sterilizations. With regards to family planning/contraceptives side effect; more than three-quarters (83.7%) said it causes vaginal bleeding in women, weight gain 77.3%, fatigue 56.7% and mood swings were 78%.

**Table 4.2: Knowledge of male involvement in family planning**

Indicator	Yes		No	
	Freq (N=300)	Percent (%)	Freq (N=300)	Percent (%)
<b>Heard of family planning</b>	284	94.67	16	5.3
<b>Meaning of family planning</b>				
Child spacing	214	71.33	86	28.7
Prevention of STI	111	37.00	189	63.0
Promiscuity	101	33.67	199	66.3
Use of contraceptives	250	83.33	50	16.7
Prevention of unintended pregnancy	159	53.00	141	47.0
Stop bearing children	168	56.00	132	44.0
Other			300	100.0
<b>Source of information on family planning</b>				
Television	245	81.67	55	18.3
Radio	247	82.33	53	17.6
Friends/Relatives	196	65.33	104	34.6
Newspapers/posters/brochures	44	14.67	256	85.3
Health workers	221	73.67	79	26.3

Commercial/social clubs	37	12.33	263	87.6
Others	0	0	300	100.0
<b>Where one accesses family planning in the community</b>				
Hospital	183	61.00	117	39.0
Health centre	256	85.33	44	14.7
Private clinic	148	49.33	152	50.7
Maternity home	196	65.33	104	34.7
Chemist Shop	239	79.67	61	20.3
Others	0	0	0	0
Know any method to delay/avoid unintended pregnancy	300	100	0	0
Know what contraceptives are?	291	97.00	9	3.0
<b>Understanding of contraceptives</b>				
Barrier methods	244	81.33	56	18.7
Hormone birth control	89	29.67	211	70.3
Intrauterine devices	109	36.33	191	63.7
Natural methods	129	43.00	171	57.0
Drugs	199	66.33	101	33.7
Pregnancy prevention	253	84.33	47	15.7
Sterilization	162	54.00	138	46.0
<b>Contraceptive methods known</b>				
Pill	245	81.67	55	18.3
IUD	52	17.33	248	82.7
Condom	297	99.00	3	1.0
Spermicides	33	11.00	267	89.0
Injectables	189	63.00	111	37.0
Implants	201	67.00	99	33.0
Diaphragm	24	8.00	276	92.0
Periodic abstinence	160	53.3	140	46.6
Withdrawal	243	81.00	57	19.0
Traditional methods	184	61.33	116	38.6
Female sterilization	137	45.6	163	54.3
Male sterilization	126	42.00	174	58.0
Paracetamol	29	9.67	271	90.3
Other	0	0	300	100.0
<b>Known side effects associated with family planning methods</b>				
Weight gain	232	77.33	68	22.6
Low libido	121	40.33	179	59.6
Sweating	72	24.00	228	76.0
Fatigue	170	56.67	130	43.3
Vaginal bleeding	251	83.67	49	16.3
Mood swings	234	78.00	66	22.0

Over eating	69	23.00	231	77.0
Sleeping all the time	88	29.33	212	70.6
Other, .....	0	0	300	100.0

**Source: Author's fieldwork data, 2018**

**4.3 Males attitude towards family planning**

Table 4.3 on page 53 shows the attitude of males toward family planning. More than half (57.3%) of males believe that family planning issues need to be decided by men alone, and 20% believe that it should be decided by women only and two-thirds (66%) of males think both men and women should decide on family planning uptake. More than a third (38%) of men strongly agreed that too many children have a negative effect on the family economy and 26% had disagreed. Again, 32% of males agreed that too many children have a negative effect on the health of the woman, with nearly the same proportion to have disagreed. Again, about 44% of men have a negative attitude toward the family planning of making a woman promiscuous, more than half (54.3%) said the use of family planning is against their religious beliefs and as 62.3% said family planning is against their traditional beliefs.

**Table 4.3: Attitude towards family planning among male**

Indicator	Variables	Freq. (N=300)	Percentage (%)
<b>Believe that only men need to decide on FP</b>	Yes	172	57.3
	No	128	42.6
<b>Believe that only women need to decide on FP</b>	Yes	60	20.0
	No	240	80.0
<b>Believe that both women and men need to decide on FP</b>	Yes	198	66.0
	No	102	34.0
<b>Agree that too many children have a negative effect on families economy</b>	Strongly agree	114	38.0
	Agree	97	32.3
	Disagree	78	26.0
	Strongly disagree	11	3.6
<b>Agree that having too many children has a negative effect on the health of mother and children</b>	Strongly agree	96	32.0
	Agree	114	38.0
	Disagree	90	30.0
	Strongly disagree	0	0.0

<b>Believe that using a contraceptive is the responsibility of:</b>	Husband only	167	55.6
	Wife only	40	13.3
	Both	93	31.0
<b>Believe that women involved in the family planning are promiscuous</b>	Yes	32	44.0
	No	168	56.0
<b>See family planning as against religious beliefs</b>	Yes	163	54.3
	No	137	45.6
<b>See family planning as against traditional beliefs</b>	Yes	187	62.3
	No	113	37.6

**Source: Author's fieldwork data, 2018 4.4 Perceptions of men about family planning**

Table 4.4 indicates males' perceptions about family planning. Nearly three-quarter (70.3%) of men perceived that it is acceptable for a man to accompany the wife/partner to family planning clinic, and similar angle about 72.7% perceived it not to be acceptable for a man to accompany his wife/partner to family planning clinic. About 22% of men said their wives/partners feel acceptable to accompany them to the family planning clinic, and 78% of women feel it is not acceptable for their husbands to accompany them to family planning clinic. More than half (52.7%) of family/friends react strangely toward a man who accompanied the wife to family planning clinic and 72% of men are been stigmatized or ridicule for accompanying their wives/partners to family planning clinic. Also, about 22.3% of men reported been described as irresponsible when accompanying wife to family planning clinic and 30% is been described as controlled by the wife. More than a third (41%) of men have ever accompanied their wives/partners to family planning clinic, and 46.3% of men found health staff relationship with them been friendly and 30% had indifferent behaviour from health personnel.

**Table 4.4: Perception of males about family planning**

Indicator	Variables	Freq. (N)	Percentage (%)
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<b>Acceptable for a man to accompany his wife/ partner for Family Planning?</b>	Yes	211	70.3
	No	89	29.6
<b>Acceptable for men to accompany their partners to the family planning clinic?</b>	Yes	82	27.3
	No	218	72.6
<b>Females see it acceptable for men to accompany their partners to the family planning clinic</b>	Yes	66	22.0
	No	234	78.0
<b>Family /friends reaction towards a man who attends family planning with his wife/partner</b>	Strangely	158	52.6
	Praise him	70	23.3
	Indifferent	72	24.0
<b>Are men who are involved in family planning activities stigmatized in this community?</b>	Yes	216	72.0
	No	84	28.0
<b>Describe a man who is seen to be involved in family planning?</b>	Responsible	98	32.6
	Irresponsible	67	22.3
	Controlled by wife	90	30.0
	Stigmatized	45	15.0
<b>Ever attended a family planning clinic with your partner/wife</b>	Yes	123	41.0
	No	177	59.0
<b>Relationship of care providers towards you, partner/wife</b>	Very friendly	45	15.0
	Friendly	139	46.3
	Indifferent	90	30.0
	Unfriendly	13	4.3
	Rude	13	4.3

**Source: Author's fieldwork data 2018 Level of male involvement in family planning**

Table 4.5 on page 54, depicts the level of male involvement in family planning. A quarter (25.3%) of men had up to three (3) children and less than a tenth had above four (4) children. More than a third (43.3%) of men preferred male children and 8.7% of men preferred female children. About, 35.3% of men had planned their current pregnancy, and about 48.3% said the only husband should have a greater influence on the decision making of pregnancy, the only wife was 12.7% and 39.0% said both should have a greater influence on the decision making of pregnancy. Again, about 36.3% of men preferred less than four (4) children and 16.5% of men said they preferred to give

birth more than four (4). More than three-quarters (85.7%) had ever planned or discussed family planning with their wives/partners, with 60.3% said only husbands should have a greater influence on the desired family size, 4.7% said on wives and 35% said both should have a greater influence on the desired family size.

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**Table 4.5: Level of male involvement in family planning**

Indicator	Variables	Freq. (N=300)	Percentage (%)
<b>No of children (biological)</b>	0	76	25.3
	1	62	20.6
	2	24	8.0
	3	76	25.3
	4	28	9.3
	5	29	9.6
	6+	5	1.6
<b>Preferred sex of children</b>	Male	130	43.3
	Female	26	8.6
	Any	144	48.0
<b>Number of sons</b>	0	157	52.3
	1	76	25.3
	2	31	10.3

	3	34	11.3
	5	2	0.6
<b>Number of daughters</b>	0	93	31.0
	1	88	29.3
	2	72	24.0
	3	41	13.6
	4	4	1.3
	5	2	0.7
<b>Are these pregnancies planned?</b>	Yes	106	35.3
	No	194	64.6
<b>The greater influence on the decision making of pregnancy</b>	Husband	145	48.3
	Wife	38	12.6
	Both	117	39.0
<b>What is your desired family size (number of children)</b>	1	1	0.3
	2	8	2.6
	3	82	27.3
	4	109	36.3
	5	38	12.6
	6	49	16.3
	7	5	1.6
	8	8	2.6
<b>Ever planned or discussed this with your wife/partner</b>	Yes	257	85.6
	No	43	14.3
<b>Greater influence on the desired family size</b>	Husband	181	60.3
	Wife	14	4.6
	Both	105	35.0

Source: Author's fieldwork data, 2018

### Family planning method use

Table 4.6: Family planning method use

Indicator	Yes		No	
	Freq. (N)	Percentage (%)	Freq. (N)	Percentage (%)
<b>Ever used any family planning Method</b>	208	69.33	92	30.7
<b>Are you or your wife/partner currently using any family planning method</b>	141	47.00	159	53.0
<b>If YES, what are the methods</b>				
Pill	53	37.59	88	62.4
IUD	0	0	141	100.0
Condom	74	52.48	67	47.5

Spermicides			141	100.0
Injectables	9	6.38	132	93.6
Implants	40	28.37	101	71.6
Diaphragm	0	0	141	100.0
Periodic abstinence	0	0	141	100.0
Withdrawal	15	10.64	126	89.3
Traditional methods	15	10.46	126	89.4
Female sterilization	0	0	141	100.0
Male sterilization	0	0	141	100.0
Other method (specify	0	0	141	100.0
<b>IF NO, Why are you not using any method</b>				
Failure of method	15	9.43	144	90.6
Desire to conceive	140	88.05	19	11.9
Side effects	37	23.27	122	76.7
Medical officers advice	1	0.63	158	99.3
Uncomfortable	62	38.99	97	61.0
Prohibition by wife	31	19.50	128	80.5
Irrelevant	43	27.04	116	72.9
Lack of education on family planning methods	69	43.40	90	56.6
Reduces sexual desire	39	24.53	120	75.5
Others.....			156	100.0
<b>Ever planned/discussed using family planning methods with your wife/partner?</b>	257	85.7	43	14.3
<b>The greater influence on the use of family planning method</b>				
Husband	151	50.3		
Wife	69	23.0		
Both	80	26.7		

**Source: Author's fieldwork data, 2018**

Table 4.6 on page 55, summarizes men's views on family planning methods use.

More than two-thirds (69.3) has ever used family planning and about 47% of men or their wives/partners were currently using any method of family planning. Among the methods currently in use, more than half (52.5%) were using condoms, emergency pill 37.6%, implants 28.4%, traditional methods 10.5% and injectables 6.4%. The majority



(88.1%) of men were not using any form of FP method or their wives because they desire to conceive, fear of side effect 23.3%, lack of education on family planning methods 43.4%, feel uncomfortable 38.9% and reduce the desire for sex 24.5%.

#### **4.7 Associations between socio-demographic characteristics and pregnancy planning**

Table 4.7 on page 58, presents the logistic regression model on respondents' sociodemographic characteristics and pregnancy planning among male respondents of the Asuogyaman district of Eastern region, Ghana. Respondents who were older of between 45-49 years were more likely to have planned their pregnancy than those who are younger than 20 years, and was however found not to be statistically significant (OR=2.52; 95% CI 0.72-8.83;  $p=0.14$ ). Again, males respondents who belong to the Akan tribe were having 3.4 folds increased chance of planning their pregnancy (OR=3.36; 95% CI 1.81-6.24;  $p<0.001$ ) than those of the Ga-Adangbe ethnic group. Also, males respondents who were married (OR=8.17; 95% CI 2.42-27.59;  $p=0.01$ ) had an increased chance of planning for pregnancy than those who were widowed, and as well as those who had divorced/separated (OR=4.99; 95% CI 1.09-22.82;  $p=0.04$ ) were significantly more likely to have planned for their pregnancy. Again, men who were found to have had tertiary education, and as well as those who had vocational/SHS education was significantly more likely to have planned for pregnancy by an increased chance of 7.2-times and 3.4-times respectively.

Occupation significantly influences men planning of pregnancy by an increased chance of 2.2-folds among men who are traders and an increased chance of 3.8-folds among men who were found to be civil servants. Again, been a Muslim was however found to

have a significantly increased chance of 3-folds of planning for pregnancy than men who were found to be either Charismatic or Pentecostal believers. In addition, men who were found to have earned above GHS900.00 were significantly more likely to plan for pregnancy than those who were earning below GHS500.00 (OR=3.22; 95% CI 1.08-10.18; p=0.03). Men who had married for more years were more likely to have planned for their subsequent pregnancy than those who had married for not more than four years (OR=8.71; 95% CI 1.11-68.15; p=0.04).

**Table 4.7: Association between socio-demographic characteristics and pregnancy planning**

Respondent Characteristics	N (%)	Unadjusted OR(95%CI)	Pvalue	Adjusted OR(95%CI)	Pvalue
<b>Age groups</b>					
15-24	59(19.7)	1.00	-	1.00	-
25-39	123(41.0)	0.93(0.49-1.76)	0.83	2.52(0.72-8.83)	0.14
40-49	118(39.3)	1.65(0.85-3.20)	0.14	1.08(0.26-4.48)	0.91
<b>Ethnicity</b>					
Ewe	48(62.3)	1.00	-	1.00	-

Akan	109(74.2)	3.36(1.81-6.24)	<0.001	2.49(1.17-5.32)	0.02
Ga-Adangbe	29(46.0)	0.63(0.24-1.62)	0.33	1.16(0.52-3.09)	0.61
Other	8(61.5)	1.87(0.55-6.36)	0.31	1.11(0.26-4.71)	0.88
<b>Marital status</b>					
Single	35(57.4)	1.00		1.00	
Cohabiting	22(44.0)	2.03(0.56-7.39)	0.28	1.23(0.20-7.41)	0.82
Married	121(76.6)	8.17(2.42-27.59)	0.01	4.14(0.78-21.93)	0.09
Divorced/separated	12(66.7)	4.99(1.09-22.82)	0.04	2.07(0.32-13.62)	0.45
Widow	4(28.6)	1.47(0.28-7.45)	0.64	1.39(0.24-8.22)	0.71
<b>Educational background</b>					
No education	36(12.0)	1.00	-	1.00	-
Basic (Primary/JHS)	89(29.7)	1.26(0.57-2.75)	0.56	3.03(0.72-12.74)	0.13
SHS/Voc	126(42.0)	1.61(0.76-3.42)	0.21	3.39(1.00-11.48)	0.04
Tertiary	49(16.3)	5.37(1.76-16.37)	0.01	7.17(1.59-32.24)	0.01
<b>Occupation</b>					
Unemployed	39(60.9)	1.00		1.00	
Farmer	44(51.8)	0.27(0.85-0.84)	0.02	2.95(1.02- 8.51)	0.04
Trading	74(70.5)	2.22(1.22-4.04)	0.01	3.01(1.23-7.41)	0.02
Civil servant	37(80.4)	3.83(1.64-8.90)	0.02	1.60(0.48-5.27)	0.44
<b>Religion</b>					
Catholic	45(63.4)	1.99		-	-
Charismatic/Pentecostal	48(55.2)	1.87(0.67-5.20)	0.23	-	-
Orthodox churches	39(63.9)	1.44(0.74-2.82)	0.29	-	-
Islam	45(78.9)	3.05(1.42-6.54)	0.04	-	-
Traditionalist	17(70.8)	1.97(0.74-5.23)	0.17	-	-
<b>Monthly income in Ghana cedis</b>					
<500	32(10.7)	1.00		1.00	
501-900	179(59.7)	1.14(0.53-2.47)	0.73	5.05(1.24-20.57)	0.02
>900	89(29.7)	1.66(0.71-3.87)	0.24	3.32(1.08-10.18)	0.03
<b>Years of marriage</b>					
0-10	100(59.9)	1.00	-	1.00	-
11-20	56(70.0)	1.56(0.88-2.76)	0.12	1.52(0.54-4.27)	0.34
21-30	25(64.1)	1.19(0.58-2.46)	0.63	1.61(0.35-7.46)	0.54
31-40	13(92.9)	8.71(1.11-68.15)	0.04	3.06(0.29-31.91)	0.42

Source: Author's fieldwork data, 2018

#### 4.8 Associations between socio-demographic characteristics and desired family size

Table 4.8 of page 60, indicates the logistic regression model of males' sociodemographic characteristic and their desired family size. Age of male respondents

was significantly associated with desired family size, males aged above 40years were 2.01 times to have desired for a less family size than those who are still younger of about 20years (OR=2.01; 95% CI 1.02-3.63; p=0.03). Ethnic group of males significantly influence males desired for family size, whereby the Ewe and Akan were more likely to desired for a family size of four (4) than those of the Ga-Adangbe tribe. Married men were significantly more likely to desired for family size, with an increased chance of 3.7-times (OR=3.68; 95%CI 1.21-11.23; p=0.02). Educational level of men was significantly not associated with the desired family size males, however, males who were traders were more likely to desired for family size with twice increased chance of desiring for a family size of four (4) (OR=1.84; 95% CI 1.02-3.34; p=0.04).



**Table4.8: Association between socio-demographic characteristics and desired family size**

Respondent Characteristics	N (%)	Unadjusted OR(95% CI)	Pvalue	Adjusted OR(95% CI)	Pvalue
<b>Age groups</b>					
15-24	59(19.7)	1.00	-	1.00	-



25-39	123(41.0)	0.94(0.46-1.87)	0.85	0.64(0.35-1.02)	0.75
40-49	118(39.3)	0.51(0.25-1.01)	0.04	2.01(1.02- 3.63)	0.03
<b>Ethnicity</b>					
Ewe	56(72.7)	1.00			
Akan	102(69.4)	2.34(1.27-4.28)	0.01	2.17(1.02-4.63)	0.04
Ga-Adangbe	31(49.2)	0.36(0.18-0.73)	0.01	2.46(1.02-5.92)	0.04
Other	10(76.9)	3.44(0.86-13.69)	0.08	4.01(0.78-20.56)	0.09
<b>Marital status</b>					
Single	40(65.6)	1.00			
Cohabiting	30(61.2)	2.11(0.63-7.02)	0.23	0.94(0.17-5.03)	0.94
Married	116(73.4)	3.68(1.21-11.23)	0.02	2.34(0.47-11.56)	0.29
Divorced/separated	7(38.9)	0.84(0.20-3.51)	0.82	0.35(0.04-2.56)	0.30
widow	6(42.9)	0.39(0.12-1.28)	0.12	1.01(0.19-5.30)	0.98
<b>Educational background</b>					
No education	36(12.0)	1.00		1.00	
Basic (Primary/JHS)	89(29.7)	3.21(1.38-7.43)	0.04	0.47(0.12-1.82)	0.28
SHS/Voc	126(42.0)	2.01(0.94-4.29)	0.06	0.58(0.17-2.03)	0.40
Tertiary	49(16.3)	2.79 (1.09-7.12)	0.02	0.44(0.10-1.91)	0.27
<b>Occupation</b>					
Unemployed	50(78.1)	1.00	-	1.00	-
Farmer	46(54.1)	0.33(0.15-0.68)	0.03	4.77(1.61-14.16)	0.01
Trading	72(68.6)	1.84(1.02-3.34)	0.04	2.69(1.07- 6.75)	0.03
Civil servant	31(67.4)	1.75(0.82-3.71)	0.14	1.77(0.59-5.26)	0.30
<b>Religion</b>					
Catholic	56(78.9)	1.00	-	1.00	-
Charismatic/Pentecostal	50(57.5)	0.36(0.17-0.73)	0.01	1.70(0.97-3.89)	0.02
Orthodox churches	40(65.6)	1.41(0.72-2.77)	0.32	1.39(0.62-3.10)	0.42
Islam	41(71.9)	1.89(0.93-3.88)	0.08	1.75(0.72-4.29)	0.22
Traditionalist	12 (50.0)	0.74(0.30-1.83)	0.52	0.95(0.32-2.88)	0.93
<b>Monthly income in Ghana cedis</b>					
<500	32(10.7)	1.00		-	-
501-900	179(59.7)	0.70(0.31-1.62)	0.40	-	-
>900	89(29.7)	0.85(0.34-2.08)	0.73	-	-
<b>Years of marriage</b>					

0-10	111(66.5)	1.00		-	-
11-20	58(72.5)	1.33(0.73-2.39)	0.34	-	-
21-30	19(48.7)	0.48(0.24-0.97)	0.04	-	-
31-40	11(78.6)	1.84(0.49-6.89)	0.36	-	-

Source: Author's fieldwork data, 2018

#### 4.8 Association between socio-demographic characteristics and family planning method uptake

Age of respondents and the uptake of the family planning method were found not to be significantly associated from the logistic regression analysis, and as well as other variables such as ethnicity, marital status and educational level, even though there was an increased chance of uptake of family planning methods with respondents sociodemographic characteristics. Unemployed respondents were more likely to uptake family planning method with an increased chance of 4-folds (OR=3.75; 95% CI 1.19-11.76; p=0.02). However, respondents who were found as orthodox churches were having a decreasing chance of up taking family planning methods (OR=0.32; 95% CI 0.12-0.86; p=0.02) than those who belong to the Charismatic/Pentecostal churches, and monthly income earned and years of marriage was equally not statistically significant with the uptake of family planning methods.

**Table 4.9: Association between socio-demographic characteristics and FP method**

<b>Respondent Characteristics</b>	<b>N (%)</b>	<b>Unadjusted OR(95%CI)</b>	<b>Pvalue</b>	<b>Adjusted OR(95%CI)</b>	<b>Pvalue</b>
<b>Age groups</b>					
15-24	59(19.7)	1.00		1.00	-
25-39	123(41.0)	1.36(0.57-3.23)	0.47	0.52(0.04-6.73)	0.62
40-49	118(39.3)	1.21(0.52-2.85)	0.66	0.69(0.08-6.34)	0.75
<b>Ethnicity</b>					
Ewe	68(88.3)	1.00	-	1.00	-
Akan	126(85.7)	1.26(0.57-2.82)	0.56	0.71(0.19-2.55)	0.60
Ga-Adangbe	52(82.5)	0.52(0.26-1.01)	0.05	2.21(0.61-8.00)	0.32
Other	11(84.6)	1.16(0.23- 6.00)	0.86	0.54(0.06-5.24)	0.59
<b>Marital status</b>					
Single	49(80.3)	1.00	-	1.00	
Cohabiting	44(89.8)	1.46(0.25- 8.52)	0.67	2.41(0.17-35.05)	0.52
Married	136(86.1)	1.03(0.22-4.91)	0.97	3.03(0.84-20.30)	0.07
Divorced/separated	16(88.9)	1.33(0.16-10.86)	0.78	22.78(1.11-46.64)	0.04
widow	12(85.7)	0.29(0.08-1.05)	0.06	1.93(0.13-8.97)	0.63
<b>Educational background</b>					
No education	36(12.0)	1.00	-	1.00	-
Basic (Primary/JHS)	89(29.7)	1.28(0.44-3.75)	0.65	7.49(0.87-64.56)	0.07
SHS/Voc	126(42.0)	1.20(0.43-3.30)	0.72	2.98(0.45-19.87)	0.25
Tertiary	49(16.3)	1.20(0.36-3.96)	0.76	0.76(0.049-11.89)	0.85
<b>Occupation</b>					
Unemployed	60(93.8)	1.00	-	1.00	-
Farmer	68(80.0)	0.68(0.35-1.32)	0.26	1.28(0.44-3.76)	0.65
Trading	80(85.7)	1.50(0.69-3.21)	0.29	2.28(0.94-5.47)	0.06
Civil servant	39(84.8)	1.39(0.53-3.65)	0.50	1.28(0.44-3.76)	0.65
<b>Religion</b>					
Catholic	61(85.9)	1.00	-	1.00	-

Charismatic/Pentecostal	80(91.9)	0.71(0.37-1.35)	0.29	0.58(0.19-1.79)	0.34
Orthodox churches	48(78.7)	0.32(0.12-0.86)	0.02	0.47 (0.15-1.45)	0.19
Islam	49(85.9)	0.54(0.18-1.57)	0.25	0.27(0.08-0.91)	0.04
Traditionalist	19(79.2)	0.33(0.09-1.16)	0.08	0.28(0.072-1.14)	0.08
<b>Monthly income in Ghana cedis</b>					
<500	32(10.7)	1.00		1.00	
501-900	179(59.7)	0.68 (0.22-2.09)	0.50	1.63(0.43-6.18)	0.47
>900	89(29.7)	1.45(0.40-5.21)	0.57	2.36(0.78-7.07)	0.12
<b>Years of marriage</b>					
0-10	137(82.0)	1.00		-	-
11-20	71(88.8)	1.73(0.78-3.83)	0.18	-	-
21-30	35(89.7)	1.92(0.63-5.79)	0.25	-	-
31-40	14(100.0)	1		-	-

**Source: Author's fieldwork data, 2018**

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.0 Introduction**

This chapter presents the discussion of the results from the study findings. The discussions are based on the objectives of the study, which sought to assess factors associated with male involvement in family planning in the Asuogyaman district in the Eastern Region of Ghana. From the study, contraceptive awareness among males was found to be high, of about 94.7% and 71.3% knew contraceptives are used for prevention of unintended pregnancy, child spacing and the prevention of sexually transmitted infections (STIs). Male attitude towards family planning/contraceptives indicates 44% and were of the view that, family planning makes a woman promiscuous, and 62.3% said their religious and traditional beliefs are against the use of family planning/contraceptives. The majority (70.3%) of men perceived family planning to be good and acceptable for planning family size and prevention of unwanted pregnancies.



Again, male involvement in family planning from the study was found to be as high as 85.6%. This percentage has reported having ever planned with their wives on the next pregnancy and the number of children they desire. About 35.3% of respondents reported to have planned their current pregnancy, about 69.3% were found to have ever used family planning methods, and 47% reported their wives were currently using family planning/contraceptives. The most used contraceptive method was condoms and constituted 52.5%.

From the current study, factors associated with male involvement in pregnancy planning were educational level, occupation and year of marriage. Among factors associated with male involvement in planning desired family size were age groups of males, ethnicity, occupation, marital status, educational level and year of marriage. Lastly, factors that were found associating with male involvement in family planning/contraceptives use were marital status ethnicity, occupation, and religion of respondents.

#### **5.1.0 Knowledge, attitude and perceptions of men about family planning**

Increased knowledge of males on contraceptives, with a positive attitude and good perceptions towards family planning/contraceptives, are key players to holistic male involvement in reproductive health services like family planning and contraceptives use. The discussion on these are classified and discussed as follows:

##### **5.1.1 Males knowledge on contraceptives and family planning**

Males' knowledge of contraceptives and family planning methods influence their involvement in family planning and contraceptives and could trigger the use of family planning and contraceptives among women in reproductive age. In the study, however, males' knowledge of contraceptives was found to be very high, and most men were found to know the use of contraceptives. Contraceptives knowledge of men was

measured on their understanding of contraceptives and use, and most men were found to have cited contraceptives are meant for spacing of children, prevention of unintended pregnancy and sexually transmitted infections (STIs). The increase in contraceptives awareness and knowledge among men in this current study could be attributed to the public health education carried out by the Ghana Health Service personnel such as the community health officers in communities and through the mass media like TV, radio, and public gatherings (GHS, 2017). This education mostly includes family planning and contraceptives use, and the widely circulated public education on the use of condoms to the prevention of sexually transmitted infections

(STIs) such as HIV/AIDS. These findings, however, were not quite different from the findings of Aduayi *et al.*, (2017) in which contraceptives awareness was equally reported high and was attributed to similar findings as reasons for the increased in contraceptives knowledge and awareness.

Again, the current study shows most men heard about contraceptives through media like radio, television and from health workers. Also, most men were found to have accessed contraceptives at the health facilities such as hospitals/maternity homes and some have reported to have bought contraceptives from chemical shops.

Among reported contraceptives/family planning methods that respondents had ever heard about were: condoms, emergency pills, withdrawal method, Injectables, Implants and the least known methods were: IUD, spermicides, diaphragm and male/female sterilizations.

All these could be attributed to the reproductive health education disseminated by reproductive health personnel through either the mass media or at the community level as cited in GSS (2014).

These, however, was equally found reported by Aduayi *et al.*, (2017); Tilahun *et al.*, (2013) in Ethiopia, Duze& Mohammed (2006); and Kassa *et al.*, (2014) of Uganda; all reporting increased contraceptive awareness and knowledge of men.

In Ghana, a study by Aryeetey *et al.*,(2010) found modern contraceptives awareness and knowledge among men to be universal, and similar to Mosha *et al.*, (2017) study of Tanzania which were not different from this current study, and these studies equally cited increased public health education carried out by community health officers as the contributing factors to the increased in contraceptives knowledge among men.

In addition, men were found to have increased knowledge on family planning/contraceptives side effect. In this current study, cited contraceptive side effects include vaginal bleeding, weight gain, fatigue and mood swings among women after taking these methods. Contraceptives side effects were equally cited in studies conducted by Akwenabuaye *et al.*, (2013); Nzioka (2012); GSS (2014); and Akafuah & Sossou (2008). These call for more research into contraceptive side effects as this is likely to be a factor which could prevent men of not allowing their women to use contraceptives as this in the current study was reported as a factor that could be promoting a negative attitude of men towards contraceptives and family planning.

### **5.1.2 Men's attitude and perceptions towards family planning**

In the study, little above half of the men were found to have a positive attitude towards family planning as a similar proportion of men think family planning uptake should be decided by men alone, and about two-thirds of men think the decision on contraceptives use should be decided by both couples. This actually gives a marginal indication of a change in males' supremacy in which men are mostly perceived as the sole decision-makers in households because from the study an increased number of men said a decision on contraceptives should be decided upon by both couples. This equally could

be attributed to public education on the female involvement in decision and women empowerment campaign champion by women advocacy groups and other governmental and non-governmental institutions, and this might have influenced men's decision to involve their wives on decision-making concerning family planning. These findings, however, could be related to Mosha *et al.*, (2017); Kassa *et al.*, (2014); and Aduayi *et al.*, (2017) which also reported positive attitude and perceptions of men towards family planning as effective methods to the control of births, and said they had recommended FP to their friends and relatives as a means of birth control. However, Aduayi *et al.*, (2017) found men to have a negative attitude towards vasectomy because it is perceived to reduce the sexual satisfaction of men and however preferred to use condoms, this was similar to this current study as a lot of men reported now to vasectomy. This might be due to the perceived perceptions that vasectomy make a man impotent could have contributed to a lot of men not using vasectomy.

Again, more than a third of men were found to have had negative attitudes toward family planning because, it is perceived of making women promiscuous, and more than half of men said the use of family planning is against their religious and traditional beliefs as per this current study. Similar findings, however, were reported in Nigeria by Marius *et al.*, (2014) of men to have disapproved of their wives using family planning, and as well as Kabagenyi *et al.*, (2014) study reported similarly as reasons for males non-involvement in family planning.

## **5.2 Male involvement in family planning**

Male involvement in family planning could be influenced by their level of awareness, knowledge, perceptions and attitude towards family planning methods and contraception. However, contraceptive knowledge and awareness of men in the study



were not translated into the level of involvement in family planning at various stages. In the current study, two-thirds of men were involved in planning their current pregnancy, and more than two-thirds had planned their family size with their partners/wives and on the family planning methods to use. Again, two-thirds of men had planned with their wives on their desired number of children of 1-4, and 33.7% had planned on their desired family size of more than 5. The involvement of men in family planning could again be due to the education on birth control and the need to reduce family size, and the availability and accessibility of contraceptives and family planning methods. Despite, there were some men who did not involve in family planning which could be attributed to lack of contraceptives information and inadequate education on the various family planning methods.

In a related study by Kassa *et al.*, (2014); Mosha *et al.*, (2017); Akwenabuaye *et al.*, (2013); and GSS (2014) equally cited male involvement in family planning, and other factors contributing to lack of male involvement in family planning to include; lack of FP information, and inaccessibility of the FP methods by men to have accounted for the low level males' involvement in family planning services. In addition, from the current study more than two-thirds of men reported to have ever used family planning and about 47% of men reported their wives/partners are currently using various forms of contraceptives/family planning methods. Among reported contraceptives methods that are currently been used were found to include condoms, injectables, emergency pill, implants, traditional methods like periodic abstinence and withdrawal method. Similar methods were equally reported by Akwenabuaye *et al.*, (2013); Kabagenyi *et al.*, (2014); and GSS (2014).

### **5.3 Factors associated with male involvement in family planning**

Male involvement in FP and contraception could help women uptake of

contraceptives and a key to global fertility regulation and control among women of reproductive age. However, these roles of family planning and contraceptives have been reported in previous studies and in this current study to have influenced the various stages of FP and the involvement of males' to improve on women uptake of contraceptives.

From the current study factors influencing male involvement in FP was measured in terms of pregnancy planning, desired family size and family planning/contraceptives use. In study older men were found to have desired a lesser family size of 1-4 than those who are still younger of less than 30years. And so the age of men was found to be a strong predictive factor in determining the family size of a couple. In a related study by Malkawi *et al.*, (2016) in Kenya found age to affect male FP involvement whereby the elderly men were more likely to have involvement in FP than the younger in age.

Again, ethnic group of males was found as a strong predictor of male involvement in pregnancy planning and desired family size whereby men of the Akan origin were more likely to have involved in family planning which might be attributed to cultural norms and beliefs, as well as geographical variation with regard to occupational activities where children are used as a form of labour could have influenced their decision to give birth to more children. In addition, the occupation of men was found to have an influence on the desired family size whereby men who were unemployed and those involved in trading were more likely to have had a larger family size as compared to those who are farmers. Similarly, factor equally influences their use of contraceptives/family planning methods as the unemployed and traders were more likely to have used a contraceptive/family planning method as compared those who are farmers.

To add to this, marital status, religion, educational level and monthly income level were found to have a significant influence on pregnancy planning, desired family size and uptake of contraceptives/family planning among men of reproductive age. Men with at least secondary education were more likely to plan their family than those who had no formal education. In related studies by GSS (2014); Marius *et al.*, (2014); Butto & Mburu, (2015); Aduayi *et al.*, (2017); and Soremekun (2018) found age, religion, education and occupation to have a significant influence on overall male involvement in family planning practices. In a multivariate analysis by Aryeetey *et al.*, (2010) study in Ghana equally found occupation, marital status and religion to have a significant influence on men uptake of modern contraceptives and as well as increased knowledge level of men on FP methods. However, cultural barriers to male involvement in family planning in this current study was less reported but was again reported in studies conducted by Marius *et al.*, (2014); Aduayi *et al.*, (2017); and GSS (2014) reported cultural norms and beliefs where women have to obtain permission from their husbands before using any contraceptive method, as well as cultural position of men being the head of the family to influenced decision-making regards to women reproductive health and FP.

## **CHAPTER SIX**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **6.0 Introduction**

This section summarizes the findings of the study to draw conclusions and recommendations from the results. The conclusions of the study findings help to make evidence-informed recommendations to stakeholders and policymakers to shape reforms and enhance males' involvement in sexual and reproductive health services such as family planning and contraceptives use.

#### **6.1 Conclusions**

The outcome of the study concluded that, males in Asuogyaman had a high knowledge of contraceptives as a means to prevent unintended pregnancy and child spacing but does not actually reflect in the involvement family planning with the factors mitigating FP practice is the negative attitude that, contraceptives makes women promiscuous and the fact that it is against their religion and tradition. In the study, significant factors that are associated with male involvement in pregnancy planning were; educational level, occupation and year of marriage. Factors that are associated with male involvement in planning desired family size were found to include; age groups, ethnicity, occupation, marital status, educational level and year of marriage, and among significant factors that are associated with male involvement in family planning/contraceptives use were; marital status, occupation, ethnicity and religion of the man.

#### **6.2.0 Recommendations**

The following recommendations are made based on the findings of the study.

1. The Ministry of Health (MOH) should collaborate with the Ghana Health

Service to create a male-friendly environment at the various health facilities

especially at the reproductive health unit and as well as educate health



personnel to develop a positive attitude towards men during family planning clinic sections.

2. The Ghana Health Service should intensify public education on contraceptives/family planning and as well as other reproductive health services in the district.
3. Non-governmental organizations working in the area of FP in the district should support in educating men on the importance derived from the patronage of the services to the family and community at large.
4. Form father-to-father support groups where men can share experiences of FP and encourage good practices or methods.
5. Contraceptive for male use rather than condom and vasectomy should be developed to increase choice for male method.

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## APPENDIX

### Appendix 1: Work plan

The study which seeks to determine that factors associated with access to and utilization of family planning services by males in the Asuogyaman district will span for a period of ten months starting from January to October 2017.

**Table 4.1 Gantt chart**

PROJECT EXECUTION PLAN (GANTT CHART)										
ACTIVITY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Reconnaissance visit										
Project planning										
Questionnaire development										
Ethical clearance										
Pre-testing of questionnaire										
Training of Research Assistants										
Data collection and entry										
Data analysis										
Report writing										
Dissemination										
Submission of report to Graduate school										



## Appendix 2: Budget

This budget has been prepared based on specific activity lines. The total cost of the study will be six thousand, two hundred and five Ghana cedis(GHS 6,205) as detailed in table 5.1.

**Table 5.1 Project execution budget**

ACTIVITY	ITEMS REQUIRED	UNIT COST IN GHS	FREQUENCY	TOTAL COST IN GHS
Reconnaissance visit	T & T	200	1	200
Project planning	Lap –Top	1700	1	1700
	Internet data	400		400
	Printing and photocopies	30		30
Questionnaire design	printing and photocopies	100		100
Ethical clearance		100		100
Pilot study	printing and photocopies	30		30
	T & T	100		100
Training of research assistants	A4 sheet	25	1 ream	25
	printing and photocopies	50		50
	Pens	2	10	20
	Flip chart	20	1	20
	Markers	50	1	50
	Note pads	10	4	40
	Venue	200	1	200
	Snacks and lunch	20	4	80
	T & T	20	3	60
Data collection	Allowance	300	3	900
Data management and analysis	Statistician	500	1	500

Report writing	Printing and photocopies	50		40
Dissemination	Venue	200		200
	Snacks and lunch	20	50	1000
Submission of report to Graduate School	Printing and photocopies	60	4	240
	CD copy	5	4	20
Researcher's Allowance		1000	1	1000
<b>TOTAL</b>				<b>6,205</b>

### APPENDIX 3: CONSENT FORM

Title of Project: Male involvement in family planning in the Asuogyaman district in the Eastern

#### Statement of person obtaining informed consent:

I have fully explained this research to \_\_\_\_\_ and have given sufficient information about the study, including that on procedures, risks and benefits, to enable the prospective participant make an informed decision to or not to participate.

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

#### Statement

#### of person giving consent:

I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction. I understand that my participation is voluntary (not compulsory).

I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it.

I understand that I may freely stop being part of this study at any time without having to explain myself.

I have received a copy of this information leaflet and consent form to keep for myself.

NAME: \_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE/THUMB PRINT:

\_\_\_\_\_

**Statement of person witnessing consent (Process for Non-Literate Participants):**

I \_\_\_\_\_ (Name of Witness) certify that information given to

\_\_\_\_\_ (Name of Participant), in the local language, is a true reflection of what I have read from the study Participant Information Leaflet, attached.

WITNESS' SIGNATURE (maintain if participant is non-literate):

\_\_\_\_\_

MOTHER'S SIGNATURE (maintain if participant is under 18 years):

\_\_\_\_\_

MOTHER'S NAME:

\_\_\_\_\_

FATHER'S SIGNATURE (maintain if participant is under 18 years):

\_\_\_\_\_

FATHER'S NAME:

\_\_\_\_\_

**Appendix 4: Information sheet for respondent**

This is an invitation to you to participate in a research study aimed to assess factors associated with male involvement in family planning in the Asuogyaman district in the Eastern Region of Ghana.

Before you decide to take part in this study, it is important for you to understand why the research is being done and what it will involve. Please take some time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you would want more information.

Take time to decide whether or not you wish to take part.

**Who is conducting the study?**

Sosu Michael Wonder is conducting this study under the supervision of Dr. Yeetey Enuameh of Kwame Nkrumah University of Science and Technology, School of Public Health and Department of Population, Family and Reproductive Health, Kumasi.

**What is the purpose of the study?**

This study is concerned with obtaining information on Male involvement in family planning in the Asuogyaman district. It aims to provide relevant information to management and relevant policy makers on which specific areas requiring intervention in order to improve family planning coverage in the district. The field work for this study will be in July 2017.

**Why have I been asked to take part?**

You have been chosen as a participant in the district to present your views on male involvement in family planning g services in the district.

**What would be involved?**

A semi-structured questionnaire will be administered to you at your own setting which is more comfortable. The questions will ask about participant views on male involvement in family planning and health worker's views on male involvement in family planning may not last more than 30 minutes.

**What happens next?**

If you are interested in taking part in this study then a consent form will be given to you to sign to affirm your willingness to take part in the study.

**Do I have to take part?**



It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You are still free to decide withdraw at any time and without giving reason.

**What are the benefits of taking part?**

There may be no direct benefits for completing the questionnaire. However, you will be providing useful and important information, which will contribute to the improvement in male involvement in family planning in the district.

**Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the study will be kept strictly confidential. No names will be recorded and so it will not be linked to you in any way in the report of this study. However, your participation in this study is entirely voluntary.

**What will happen to the results of the research study?**

The results of this study will be presented to the Department of Population, Family and Reproductive Health in the School of Public Health, Kwame Nkrumah University of Science and Technology and also published in academic journals. If you wish, you can obtain a copy of the published results by contacting Sosu Michael Wonder. You will of course not be identified in the final report or publication.

**Who is organizing and funding the research?**

The research is being undertaken by Sosu Michael Wonder, a student of Kwame Nkrumah University of Science and Technology under the supervision from an academic lecturer. The student is funding this research.

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## **Appendix 5: Respondent Questionnaire**

### **STUDY TITLE: MALE INVOLEMENT IN FAMILY PLANNING IN THE ASUOGYAMAN DISTRICT**

My name is Sosu Michael Wonder, an MPH student at the Department of community health, School of medical Sciences Kwame Nkrumah University of Science and Technology. I am conducting a study on factors associated with male involvement in family planning in the Asuogyaman district. The other people involved in the study are three research assistants, and a supervisor. I would expect you to cooperate and help to make the study a success. Please kindly, answer the questions below. All information provided would be strictly confidential and restricted to the research purpose only. Thank you.

### **DEMOGRAPHIC, SOCIO-ECONOMIC AND CULTURAL CHARACTERISTICS**

1. How old are you?                      Ans.....
  
2. Ethnicity  
Ewe [ ]      Akan [ ]      GaAdangbe [ ]      Other

(Specify).....

3. Marital status

Single [ ] Cohabiting [ ] Married [ ] Divorced/separated [ ] widow [ ]

4. Educational background

None [ ] Primary [ ] Elementary/JHS [ ] Secondary/SHS [ ]  
Vocational [ ]  
Tertiary [ ]

5. Occupation

Unemployed [ ] Farmer [ ] Trading [ ] Civil servant [ ]

6. Religion

Catholic [ ] Charismatic/Pentecostal [ ] Orthodox churches [ ] Moslem [ ]  
Traditionalist [ ] other please specify.....

7. Monthly household income in Ghana cedis

<500 [ ] 501-600 [ ] 601-700 [ ] 701-800 [ ] 801-900 [ ] >900 [ ]

8. How many years have you been married? Answer.....

NO	QUESTION	RESPONSE
<b>KNOWLEDGE OF MALE INVOLVEMENT IN FAMILY PLANNING</b>		
9,	Have you heard of family planning?	1) Yes 0) No
10,	What does family planning mean to you?	1) Child spacing [Yes/No] 2) Prevention of STI [Yes/No] 3) Promiscuity [Yes/No] 4) Use of contraceptives [Yes/No] 5) Prevention of unintended pregnancy [Yes/No] 6) Stop bearing of children [Yes/No] 7. others

11,	What is/are your source[s] of information on family planning?	1) Television [Yes/No] 2) Radio [Yes/No] 3) Friends/Relatives [Yes/No] 4) News papers/Posters/Brochures [Yes/No] 5) Health workers [Yes/No] 6) Commercial/ Social club [Yes/No] 7. others
12	Where can you access family planning services in the community?	1) Hospital [Yes/No] 2) Health centre [Yes/No] 3) Private clinic [Yes/No] 4) Maternity home [Yes/No] 5) Chemist Shop [Yes/No] 6. Others.....
13	Do you know any method to delay/avoid unintended pregnancy	1) Yes 0) No
14	Do you know what contraceptives are?	[Yes/No]
15	What is your understanding of contraceptives?	1) Barrier methods [Yes/No] 2) Hormone birth control, [Yes/No] 3) Intrauterine devices [Yes/No] 4) Natural methods [Yes/No]
		5) Drugs [Yes/No] 6) Prevent pregnancy [Yes/No] 7) sterilization [Yes/No] 8) Others.....
16	What types of contraceptive methods do you know?  (Circle all that apply)	1) Pill [Yes/No] 2) IUD [Yes/No] 3) Condom [Yes/No] 4) Spermicides [Yes/No] 5) Injectables [Yes/No] 6) Implants [Yes/No] 7) Diaphragm [Yes/No] 8) Periodic abstinence [Yes/No] 9) Withdrawal [Yes/No] 10) Traditional methods [Yes/No] 11) Female sterilization [Yes/No]



		12) Male sterilization [Yes/No] 13) Paracetamol [Yes/No] 14) Other method (specify) .....
17,	Indicate the side effects associated with family planning methods  (Circle all that apply)	1) Weight gain [Yes/No] 2) Low libido [Yes/No] 3) Sweating [Yes/No] 4) Fatigue [Yes/No] 5) Vaginal bleeding [Yes/No] 6) Mood swings [Yes/No] 7) over eating [Yes/No] 8) sleeping all the time [Yes/No] 9) Other, specify.....
<b>ATTITUDE TOWARDS FAMILY PLANNING AMONG MALE</b>		
18,	Believe that only men need to decide on FP	1) Yes 0) No
19	Believe that only women need to decide on FP	1) Yes 0) No
20	Believe that both women and men need to decide on FP	1) Yes 0) No
21	Agree that too many children has a negative effect on families economy	1) Strongly agree 2) Agree 3) Disagree 4) Strongly disagree
22	Agree that having too many children has a negative effect on the health of mother and children	1) Strongly agree 2) Agree 3) Disagree 4) Strongly disagree
23	Believe that using contraceptive is the responsibility of	1) Husband only 2) Wife only 3) Both

24	Believe that women involved in family planning are promiscuous	1) Yes 0) No
25	See family planning as against religious beliefs	1) Yes 0) No
26	See family planning as against traditional beliefs	1) Yes 0) No
<b>PERCEPTION OF MALES ABOUT FAMILY PLANNING</b>		
27,	In this community, is it acceptable for a man to accompany his wife/ partner for Family Planning?	1) Yes 0) No
28	Do males see it acceptable for men to accompany their partners to the family planning clinic?	1) Yes 0) No
29	Do females see it acceptable for men to accompany their partners to the family planning clinic?	1) Yes 0) No
30,	How do your family/friends react towards a man who attends family planning with his wife/partner?	1) Strangely 2) Praise him 3) Indifferent
31,	Are men who are involved in family planning activities stigmatized in this community?	1) Yes 0) No
32	How would members of this community describe a man who is seen to be involved in family planning?	1) Responsible 2) Irresponsible 3) Controlled by wife 4) Stigmatized
33	Have you ever attended a family planning clinic with your partner/wife?	1) Yes 0) No
34,	How will you describe the way care providers at the family planning clinic related to you and your partner/wife on your visit?	1) Very friendly 2) Friendly 3) Indifferent 4) Unfriendly 5) Rude

## LEVEL OF MALE INVOLVEMENT IN FAMILY PLANNING

### Matters regarding pregnancy

35. How many children are you having currently (biological)? Ans.....

36. Preferred sex of children                      Male [ ]      Female [ ]      Any [ ]

37. How many i) Sons do you currently have? Ans.....

ii) Daughters do you currently have?    Ans.....

38. Are these pregnancies planned?              1) Yes                      0) No

**IF "YES"**

39. Who has greater influence on the decision making of pregnancy?

Husband [ ]                      Wife [ ]                      Both [ ]

#### **Desired Family Size**

40. What is your desired family size (number of children)?

Ans.....

41. Have you ever planned / discussed this with your wife?

1) Yes                                      0) No

**IF "YES"**

42. Who has greater influence on the decision making?

Husband [ ]                      Wife [ ]                      Both [ ]

#### **Matters regarding Family planning method**

43. Have you or your wife/partner ever used any family planning method, including traditional methods? 1) Yes                      0) No

44. Are you or is your wife/partner currently using any family planning method, including traditional methods? 1) Yes                      0) No

CURRENT FAMILY PLANNING METHOD	
IF YES	IF NO

<p>45, what are the methods</p> <p>1) Pill [Yes/No]</p> <p>2) IUD [Yes/No]</p> <p>3) Condom [Yes/No]</p> <p>4) Spermicides [Yes/No]</p> <p>5)Injectables [Yes/No]</p> <p>6) Implants [Yes/No]</p> <p>7) Diaphragm [Yes/No]</p> <p>8) Periodic abstinence [Yes/No]</p> <p>9) Withdrawal [Yes/No]</p> <p>10) Traditional methods [Yes/No]</p> <p>11) Female sterilization [Yes/No]</p> <p>12) Male sterilization [Yes/No]</p> <p>13)Other method (specify) .....</p> <p>GO TO Q. 47</p>	<p>46. Why are you not using any method?</p> <p>1) failure of method [Yes/No]</p> <p>2) desire to conceive [Yes/No]</p> <p>3) side effects [Yes/No]</p> <p>4) medical officer advice [Yes/No]</p> <p>5) uncomfortable[Yes/No]</p> <p>6) prohibition by wife [Yes/No]</p> <p>7) don't know/not sure [Yes/No]</p> <p>8) Lack of education on family planning [Yes/No]</p> <p>9) Reduces sexual desire[Yes/No]</p> <p>10) others (7) (please specify)</p>
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47. Who has greater influence on the decision making?

Husband [ ]

Wife [ ]

Both [ ]

THANK YOU