ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG EASTERN REGION, GHANA

ASSESSING TAXI DRIVERS KNOWLEDGE AND ATTITUDE THAT INFLUENCE PARTNER USE OF MODERN FAMILY PLANNING METHODS IN WA MUNICIPALITY OF GHANA

BY

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DECLARATION AND CERTIFICATION

I, MARTIN KANGMENNAANG declare that this submission is my own work towards the MPH 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 made in the text.

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DEDICATION

This work is dedicated to the Almighty God whose abundant grace, mercy and love have seen me through the period of this program.

Secondly to my dear wife madam Fina Yirilabuo and lovely children Micaiah and Micah Kangmennaang. Thanks a million times for your love, encouragements and support. You are a wonderful wife, mother and friend. I love you with all my heart. God richly bless you.

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I wish to state that I am personally accountable for any shortcoming of this study.

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ABSTRACT

Background: The uptake of modern family planning (FP) methods remains a major challenge in sub-Saharan Africa. Current use of modern contraceptive methods in Ghana stand as 22%. This is in spite of considerable public education and investment in the provision of services. The Upper Wes Region of Ghana has some of the worst indicators of FP uptake in the country. It has been postulated that this may be due to the highly patriarchal social system. An improved understanding of male attitude towards family planning in the Region will help in the design of interventions targeted at improving male acceptability and overall increased FP uptake.

Methods: This is a cross-sectional study that employed a questionnaire administered to taxi drivers (an entirely male-dominated vocation) in four communities in Wa, the regional capital. The questionnaire enquired into socio-demographic background, knowledge of family planning methods and attitudes towards their use. Questionnaires were administered by trained fieldworkers at various taxi stations in the communities. Descriptive analysis compared findings in the present survey with the findings in a similar study in Wa in 2013 that used the same instrument and interviewed 250 respondents. Bivariate and multivariate analysis explored the association between the socio-demographic background of respondents, attitudes towards FP and respondents' willingness of to pay for FP services.

Results: Four hundred and ten male taxi drivers were interviewed. The median age was 34 (interquartile range 28-42) years. Only 12.1% of respondents had been schooling beyond high school. The majority (59.7%) were Muslims and of the Waali and Dagarti tribes (91.5%). About 62.1% of respondents approved of FP use (82.4% in the 2013 survey). More than half (61.2%) of respondents indicated a willingness to pay the cost of FP services to their partners. The independent predictors of this willingness were: Approval of FP (Odds Ratio OR= 6.77 95% Confidence

Interval-CI 3.73-12.28), past experience with couple counseling (OR= 4.20, 95% CI 1.35 - 13.09), believing that wife access to family planning will make her unfaithful (OR= 0.27, 95% CI 0.13 – 0.57), being Waali/Dagarti (OR= 0.81, 95% CI 0.02 – 0.32) and having more than one wife (OR= 0.18, 95% CI 0.06 – 0.51).

Conclusion: There has been reduction the number of men indicating FP approval since 2013. Male attitudes towards FP are rooted within levels of FP education, ethnicity and fear of spousal infidelity. A multidimensional approach is needed to overcome male apprehensions towards spousal adoption of FP in this community.

LIST OF ABBREVIATIONS

AIDS----------Acquired Immune-Deficiency Syndrome

ANC----------Antenatal Clinics

CHPS CMP----------Community Health Based Planning and Services Compound.

CHRAJ----------Commission on Human Right and Administration Justice

CI----------Confidence Interval.

DHS----------Demographic Health Survey

FM----------Frequency Modulation

FP----------Family Planning

GDHS----------Ghana Demographic Health Survey

GPRTU----------Ghana Private Road Transport Union

HIV----------Human Immune Virus

HOSP----------Hospital

HW----------Health Worker

ICPD----------International Conference on Population and Development

IPPF----------International Planned Parenthood Federation

IUD----------Intrauterine Device

MBCP----------Male Birth- Control Pill

MCH----------Maternal and Child Health

MDG----------Millennium Development Goals

OR----------Odds Ratio

SHEP----------School Health Program

SSA----------Sub- Sahara Africa

STI----------Sexually Transmitted Infections

TV----------Television

UWR----------Upper West Region

WHO----------World Health Organization

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

Family planning is a method used to control or space childbirth either naturally or artificially. It allows couples to attain their desired number of children and determine the spacing of pregnancies (WHO, 2015).

Family planning and its interventions are among the most cost-effective health interventions especially considering their close link with maternal and infant health and survival.

An important intervention towards achieving this target is the promotion of modern family planning (FP) among women in sub-Saharan Africa (SSA). Uptake of modern FP methods remains low in SSA and this is associated with a high incidence of unwanted pregnancies, unsafe abortions, unplanned deliveries and maternal mortalities.

One of the significant limitations of the policy has been the non-involvement of males in family planning either as users or supporters of their partners in the use of family planning methods. Almost all, if not all family planning methods or program were women-oriented with very few aimed at involving men both as users and supporters .The reasons for placing greater emphasis on women instead of men were that since women bear the risks and burden of pregnancy and childbearing, they should have the greatest stake and interest in protecting their own reproductive health (Olawepo and Okedare, 2006). It was against this background that most of the modern family planning methods developed since 1960, such as the Pill, Intra-Uterine Device (IUD), Injectable, Diaphragm/Foam/Jelly and Norplant were focused on women. The only methods for men are limited to Condoms and Vasectomy (Population Reports, 1998). It is also important to

state that the clinic-based service delivery designed for family planning has made it difficult to include men. Services have often been offered in maternal and child health (MCH) clinics (Olawepo, 2003). It is based on this that many men see these clinics and their staff as serving only women and children and thus not male-friendly and convenient. In view of this men feel uncomfortable seeking services in that setting.

The active involvement of men will undoubtedly increase their commitment and joint responsibility in all areas of sexual and reproductive health. The ignorance of males (husbands and partners of female clients) of family planning was a large constraint on the success of family planning efforts when women were the only targets.

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice of' either sex (Becker and Costenbender, 2001).

Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society (Ann Biddlecon and Bolaji.Fapohunda .,1998). Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF, 1984) The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms

of decision-making for family-planning matters, hut would also accelerate the understanding and practice of family planning in general.

Historically, the predominant methods of preventing births in most parts of the world were methods used by or requiring the cooperation of men. The oldest of these, coitus interrupts or withdrawal, was known to at least three ancient religious traditions (Cummings and Bremner, 1994) and historical demography reveals that it was the principal method responsible for the demographic transition in Europe in the last century (Wrigley, 1969). It is still used by estimated 35 million couples worldwide, and is the method most widely used in Turkey, a country with substantial access to modem methods. Nearly as many couples are thought to rely on periodic abstinence or the rhythm method (Herndon, 1992).

Globally, there are over one hundred and twenty million (120 million) couples who do not use contraceptives despite the fact that they want to space child bearing, and an additional three hundred million (300 million) are dissatisfied with most of the family planning methods available. Assessment of available research found that there is still a lack of representative data on male, especially, related to knowledge and attitude towards family planning, as well as data on service for males. Besides, there is no strategic presentation for males and family planning,

In the Ghanaian society, men are considered not only as leaders and family heads but decision makers in all aspects of life including contraceptive use. Thus, it is the man who decides the family size. He also decides whether the search for the male or female child should continue or not. It is the man who decides on his own wishes whether there should be intimacy between the couple and it is the responsibility of the woman to satisfy the sexual desire of her man at all costs and times without getting pregnant. It is against this background that all efforts are made to actively involve

men in family planning issues since the success of any family planning program depends to a greater extent on the involvement of both the wife and husband. Regrettably, this does not seem to be the situation in the Wa District where most men believe ignorantly that the practice of family planning should be the sole responsibility of the woman and not the man and hence their minimal or non-involvement in family planning practice.

CHAPTER TWO

2.0 LITERATURE REVIEW

The use of any method of FP (Family Planning) by women is often influenced by their husbands. Men have rarely been involved in either receiving or providing information on sexuality, reproductive health, or birth spacing. They have also been ignored or excluded in one way or the other from participating in many FP programs as FP is viewed as a woman's affair. Traditionally, men are the heads of households and decision makers in all issues in their respective households. Men decide on FP and the number of children as well as how to use what is produced by the family. Also, findings have shown that since men were the decision makers, they were expected to initiate discussions on FP and the number of the children the couple want to have. Men were perceived as the sole providers for their family needs. Women were not considered decision makers, but implementers of what had been decided by men, without questioning men's decisions. The high level of awareness about contraception but very low level of use has been established in studies in Nigeria

According to a survey conducted in the United States, it was realized that on average, males comprise only 6% of all family planning clinic clientele, who really use the service (Burt, Aron & Schack, 1994). At the US-Federally subsidized clinics, males made up only 2% of the total client population, meaning few men patronize the family planning service.

Evidence suggests husband's/partner's support for family planning influences a woman's modern contraceptive use. (Mubita-Ngoma & Kadantu, 2010; Stephenson & Tsui, 2002; Williamson, Parkes, Wight, Petticrew, & Hart, 2009)

Since the 1994 International Conference on Population and Development (ICPD), interest in men's involvement in reproductive health has increased. Evidence indicates that male involvement can lead to contraceptive uptake through the pathway of increased spousal communication. However, FP programs have traditionally focused on women as the primary beneficiaries and men have been considered as the silent partners of the services

Consequently, in recent years the importance of including men in reproductive health matters has received increasing recognition. A key recommendation of both the 1994 international Conference on Population and Development and the 1995 fourth World conference on women was that programs encouraged husbands and wives to share in the responsibilities pertaining to fertility and reproductive health. A first step towards increasing men's participation in the reproductive health is to understand their knowledge, attitude and practices regarding a range of issues.

Until recently, data about men's family planning, knowledge, attitude and practices were scarce. Most large-scale family planning surveys-the knowledge, attitudes and practices and the world fertility surveys, the contraceptive prevalence surveys and the first round of the Demographic and Health survey (DHS), included only women and focused on determinants of their contraceptive use (Drennan, 1998)

The lack of attention to men in surveys probably reflected their limit options for participating in contraceptive use (Ringheim, 1993).

A woman can, of course control her fertility without her husband's cooperation, yet when men and women are aware of and responsive to each other's health needs, they are more likely to obtain necessary services. Moreover, strengthening communication between partners about reproductive health promotion can lead to better health for the entire family (Drennan, 1998)

2.1 Availability and accessibility of family planning service to males.

Despite the fact that men play an important role in reproductive health, studies have shown that there are certain hindrances to male utilization of family planning service. Range of family planning methods available to men is limited, and this as a result inhibits men's capacity to participate in fertility regulation. (Green, et., al.,1995). The inadequacy of male method of contraceptives has caused considerable media attention surrounding a recent breakthrough, in the development of a male birth-control pill (MBCP). The fact of the issue is that, production of a new male method of contraceptive is still about 5-10 years away with some technical hurdles to overcome (Duorsky, 2008).

Men would use a hormonal male contraceptive, delivered by injection and/or implant; this would be less intrusive method, likely that men will show more interest in using family planning (Heinemann et. al., 2005). Other studies have revealed that there are a lot of choices to make on family planning methods for male, including the traditional methods, but because of certain beliefs coupled with inadequate knowledge of certain methods of contraception some men are against their use with reasons best known to them (Nzoka, 2000). Here, the reality is that family planning services available for men are few and, besides, the facilities providing family planning services are also not enough, even the few available are not male user-friendly.

According to a survey on approved contraceptive use, men's lack of access to the family planning service is a barrier to its use. Therefore, men cannot share their responsibility on reproductive health, including family planning if they cannot access the service. Most family planning clinics, according to a study mainly cater for women, so men are not comfortable visiting these clinics (Population Report, 1994). This contradicts the findings of a study done in Danfa, Ghana that showed that men can easily access family planning service (IPPF, 1984). The study shows that

men even prefer buying the condoms from existing mobile outreach clinics than buying it from drug stores. Similarly, a case study conducted in Khaochakan district in Thailand showed that majority of males knew where the family planning service was available, some know about health centers, others, hospitals whiles some primary health care units and drug stores. The real situation on the ground is that although men are aware of family planning service, access and utilization is low and poor.

According to a Bangladesh Health and Demographic survey which aimed at identifying the factors that influence male involvement and access in family planning, male participation is strongly influenced by demographic, socio-economic, cultural and psychological, communication and service factors (World Population Policies, 2003).

2.2 Utilization of family planning service by males

According to a survey conducted in the United States, it was found that on average; male comprise only 6% of all family planning clinic clientele (Burt, Aron and Schack, 1994). This compared to a research carried out in Danfa in Ghana, males prefer visiting mobile clinics for obtaining condoms rather than buying it in a store (IPPF, 1984). This indicates that males patronized the service brought to them at their door step rather than going to the health centers. Another survey revealed that even though there has been some success in trying to increase male utilization of family planning service, the reality remains that most males do not utilize the service and it is evident that while some positive strides have been taken, some negative influence act to inhibit male utilization of family planning service (Sonenstein and Pleck, 1995). GDHS (2014) results of a survey showed that married men and sexually active men who reported having ever used one or more male methods of contraception, which are male sterilization, male condom, periodic abstinence and withdrawal, the most popular male method, the condom has been used by few males, both married

and unmarried males. While male sterilization is practically non- existent in Ghana. What is known in literature is that most male methods are used by few males. Of the other two traditional methods, according to studies periodic abstinence is reported as used more than withdrawal by both married and unmarried men (GDHS, 2014).

A study was conducted in northern Nigeria on the linkages between socio-economic characteristics, attitudes and familial contraceptive use. The result disclosed that there is high knowledge of contraceptive but low rate of its utilization. Community and culture affect a person's attitude towards family planning, desired sex of children, preferences about family size, family pressure to have children and whether FP accords with customs and religious beliefs (Dixon-Meuller, 1999).

According to a study conducted on knowledge of and attitudes about family planning and its use by a convenience sample of men in Ghana. It indicated that increase in knowledge has significant effect on the respondents. The study again identified socio-cultural misconceptions resulting from lack of knowledge and education as the main deterrents for the use of different family planning methods including vasectomy (Rhoda Adwoba Akafuah and Marie-Antoinette Sossou 2008).

2.3 Knowledge and perception of males about family planning

In Ghana, knowledge of contraception is higher among males than females, however, usage is low (GDHS, 2014). Contraception in general is perceived to be a woman's business and women who use contraceptives are stigmatized and accused of promiscuity by society

2.4 Religious and cultural influence on modern family planning services

Considering religious affiliations, Catholics and Muslims have been regarded as Pronatalists in their ideology on contraception; they observe population increase as positive and objective

artificial fertility control mechanisms. However, as mentioned by (Palamuleni, 2014), the strength of one's religiosity or degree of one's adherence to the norms of a given religion may exert an influence on one's mode of life including reproductive behaviors; knowledge of family planning services is an essential pre-condition for practicing contraceptives.

Studies have documented that some of the obstacles faced by individuals or couples who want to delay or avoid a birth include lack of knowledge about methods and how to use or where to obtain family planning services (Robey et. al., 1996).

2.5 Roman Catholicism

Within Catholicism, the primary purpose of marriage and sexual intercourse is procreation (Schenker, 2000). Every act of intercourse must remain open to conception. Contraception destroys any potential to produce new life and violates the principal purpose of marriage (Schenker and Rabenwu, 1993). This contraception ban is against unnatural means of contraception, which include chemical and barrier methods (Schenker and Rabenwu, 1993). Abstinence and the rhythm method are the only officially approved methods of birth spacing (Schenker and Rabenwu, 1993). These forms of family planning may be used for medical, economic, and social indications (Schenker, 2000) Contraceptive intent and results when these methods are used are no longer considered sinful (Gudorf, 2003) All other forms of birth control are forbidden. (Schenker and Rabenwu, 1993). In Catholicism, new life is treated as a person from the moment of conception (LoPresti, 2005) All forms of abortion and emergency contraception are prohibited (LoPresti, 2005) except for measures normally taken to save a mother that result in the death of the fetus (Gudorf, 2003)

2.7 Protestantism

Literal interpretation of the Bible has resulted in disapproval of contraception among conservative Protestants, such as Evangelical and Fundamentalist Protestants; the use of contraception would violate God's command to "be fruitful and multiply."(LoPresti, 2005).

Protestants believe that marriages should be procreative; there are no prohibitions against using contraception within a marriage that already has children (LoPresti, 2005). Reproductive health decisions, such as the final size of the family, the appropriate conditions for contraception and the choice of contraception, are left to the discretion of the couple (LaHaye and LaHaye, 1998) Virtually all liberal Christian communities accept the use of contraception within marriage for the purpose of exercising responsible parenthood, enhancing marital love, and protecting women's health (LoPresti, 2005) Health care providers should begin contraception discussions with Protestant patients by determining which Protestantism denomination the couple are affiliated with and whether they adhere to conservative beliefs about contraception.

Protestantism considers abortion a sin; however, the permissibility of abortion and emergency contraception varies between denominations. Conservative Protestantism has condemned all abortion (LoPresti, 2005). The majority of mainstream conservative Protestant denominations permit terminations when the mother's life is threatened (LoPresti, 2005). In situations of unwanted pregnancies, the decision is left to the woman. Liberal Protestants favor a woman making her own decision to actualize her moral agency (LoPresti, 2005).

2.8 Islam

Central to the beliefs of Islam is that Allah—God—is the creator of the universe and humankind (Rashidi and Rajaran, .2001), (Hasna, 2003) Islam is a comprehensive system used to regulate

spiritual and political aspects of individual and communal life (Rashidi and Rajaran, 2001) By studying various religious sources, Islamic jurists classify human actions as obligatory, recommended, permitted, disapproved but not forbidden, or forbidden (Hasna, 2003). Distinct schools of Islamic jurisprudence have developed over time (Omran, 1992). These schools represent different traditions of interpretation and are not considered distinct denominations (Omran, 1992).

2.8.1 Islamic beliefs about family planning

The majority of Islamic jurists indicate that family planning is not forbidden (Omran,. 1992). Muslim opinion regarding the further classification of contraception ranges from permissible to disapproved (Omran, 1992). Some fundamentalist Muslims insist that any form of contraception violates God's intentions (Poston, 2005).

Historically, coitus interruptus has been permitted in the Quran (Poston, 2005). When contraception justification is provided, such as health, social, or economic indications, coitus interruptus becomes recommended (Omran, 1992). Through analogous reasoning, authorities permit modern methods of contraception as lawful, given that they are temporary, safe, and legal (Scenker and Rabenwu, 1993). Any device that does not induce abortion (Poston, 2005) and is reversible may be used (Omran, 1992). Irreversible sterilization methods are not permitted (Hasna, 2003). Contraception may be used only within marriage (Pennachio, 2005). Justifiable reasons for contraceptive usage include health risks, economics, preservation of the woman's appearance, and improving the quality of offspring (Maquire, 2001). Health risks need not be life-threatening (Omran, 1992). Continuous hormonal contraception, as it is reversible, is permissible as a form of contraception; however, it may not be acceptable to some women who value regular monthly menstruation. In contraception discussions with Muslims, health care providers should

first determine whether the couple holds conservative beliefs about contraception and whether they consider contraception to be permissible and encouraged or permissible yet disapproved.

The Islamic concept of *Hejab*—modesty—may affect gynecological care (Pennachio, 2005). Some societies interpret this concept as meaning health care practitioners of the same gender are required to carry out all medical examinations (Dhami and Sheikh, 2000). Such religious restrictions among traditional Muslims may prevent women having intimate examinations when a health care provider of the same sex is not readily available (Rashidi and Rajaran, 2001), thereby influencing medical care and contraceptive decision-making.

2.9 Covert family planning

The common definition of "covert use" is contraceptive use without the knowledge of the spouse. A study in Navrongo, Ghana (a rural setting), provided a unique opportunity to compare family planning service records on contraceptive use with survey interview data from the same women and their spouses (survey interviews were conducted by interviewers who were not aware of the contraceptive status of the respondent). Among 57 percent of the couples in which the wife was a known contraceptive user, the wife reported in the survey interview that she was using contraceptives and her husband reported that she was not (Phillips et al., 1997).

A study in Uganda found that over 15 percent of women who were using contraceptives said that they were doing so without their partners' knowledge (Blanc et al, 1996)

Problem Statement

Family planning and its interventions are among the most cost-effective health interventions especially considering their close link with maternal and infant health and survival.

An important intervention towards achieving this target is the promotion of modern family planning (FP) among women in sub-Saharan Africa (SSA). Uptake of modern FP methods remains low in SSA and this is associated with a high incidence of unwanted pregnancies, unsafe abortions, unplanned deliveries and maternal mortalities.

Men's participation is crucial to the success of family planning programs and women's empowerment and associated with better outcomes in reproductive health such as contraceptive acceptance, continuation and safer sexual behaviors.

Cultural or religious oppositions and gender-based barriers are some of the reasons for low utilization of family planning.

Limited knowledge, choice, access to methods and attitudes of men towards family planning, perceived fear of side-effects and poor quality of available services are barriers to male acceptance of modern family planning services in SSA.

Consequently, in recent years the importance of including men in reproductive health matters has received increasing recognition. A key recommendation of both the 1994 international Conference on Population and Development and the 1995 fourth World conference on women was that programs encouraged husbands and wives to share in the responsibilities pertaining to fertility and reproductive health, however, in most communities in Ghana such as Wa municipality still records low levels of male involvement in modern family planning usage.

Hence, this study seeks to assess male knowledge and attitude that influence partner use of modern family planning services in the Wa Municipality of Ghana.

Research Questions

1. What are some of the factors that prevent males from assessing or practicing modern family planning services?
2. What socio-cultural and religious barriers prevent males from practicing modern family planning?
3. Do men have adequate knowledge on the importance of modern family planning with regards to prevention of unwanted pregnancies, birth or child spacing and prevention of STIs?
4. What is the level of involvement of men in modern family planning procedures?

OBJECTIVES

General Objective

- To describe male knowledge and attitude that influence partner use of modern family planning methods in Wa Municipality

Specific Objectives

- To assess the level of awareness of the various modern family planning methods in Wa Municipality.
- To assess the level of use (including their spouses) of modern family planning methods in Wa Municipality.
- To assess attitude towards covert modern family planning use in Wa Municipality
- To assess attitudes favoring couple counselling at ANC (Postpartum clinics)

- To compare all the above with findings made in similar studies in 2013 with the same design and instrument.

- To identify male willingness to pay for modern family method.

CHAPTER THREE

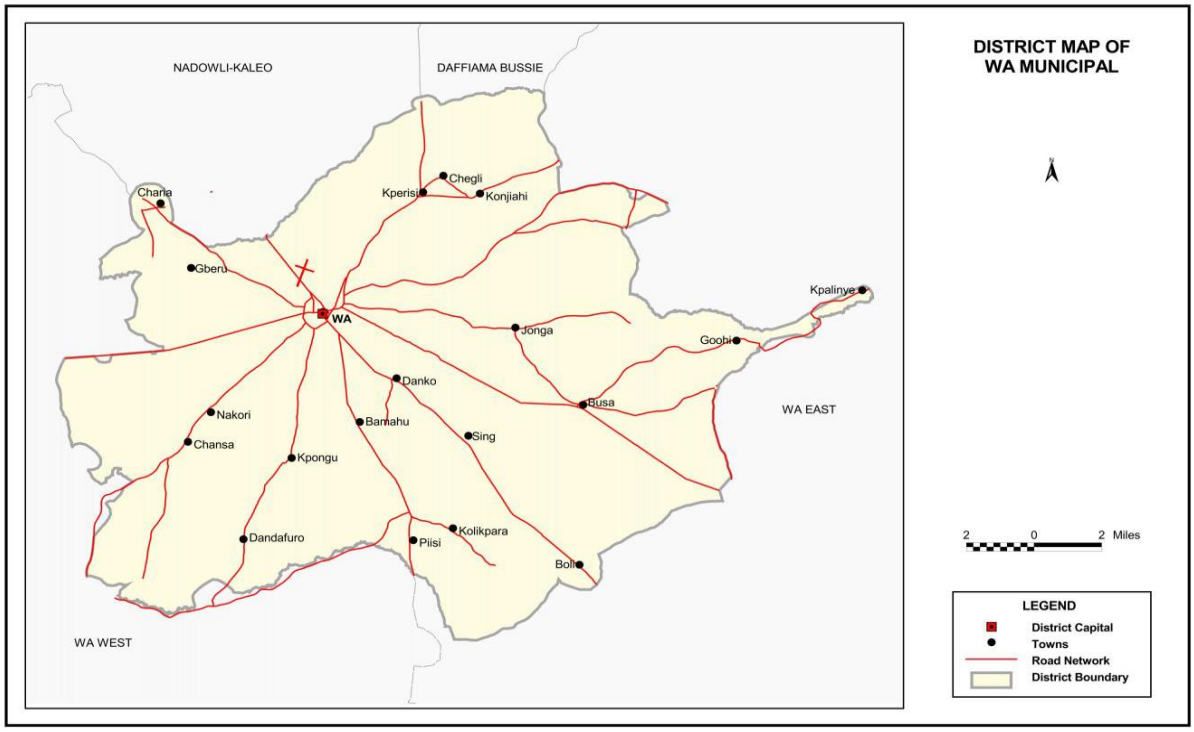
3.0 METHODOLOGY

3.1 Study Site

The Wa Municipality shares administrative boundaries with Nadowli District to the north, Wa East District to the east and to the west and the south Wa- West District. It lies within latitudes 1º40'N to 2º45'N and longitudes 9º32'W to 10º20'W.

Wa Municipality has its capital as Wa, which also serves as the Regional capital of Upper West Region. It has a land area of approximately 579.86 square kilometers, which is about 6.4% of the Region. The Assembly is empowered as the highest political and administrative body charged with the responsibility of facilitating the implementation of national policies.

Map of Wa municipality



3.2 Physical features, Geology and Soil characteristics of Wa Municipality

Wa Municipality lays in the Savannah high plains, which generally, is gently undulating with an average height between 160 m and 300m above sea level. The two main drainage systems in the capital include; Sing-Bakpong and its tributaries to the south and Billi and its tributaries to the north (Wa Municipal, 2014).

Underlying the Municipality are predominantly Pre-Cambrian, granite and metamorphic rocks.

There are two main types of soil; the laterite and the savannah ochrosols. The laterite soil occurs abundantly all over the Municipality and is excavated for roads and housing construction. The savannah ochrosols on the other hand are shallow but support the growth of a variety of crops including millet, sorghum, soya beans, groundnuts, rice and yams.

3.3 Vegetation

The vegetation is one of the guinea savannah grassland type, made up of short trees with little or no canopy and shrubs of varying heights and luxuriance, with grass ground cover in the wet season. Commonly occurring trees are shea, dawadawa, kapok and baobab. Cashew and mango are exotic species that grow well in the area.

3.4 Climate

Wa Municipality has two marked seasons, namely, the wet and dry seasons. The South- Western Monsoon winds from the Atlantic Ocean bring rains between April and October, while the North Eastern Trade winds from the Sahara Desert bring the long dry season between November and March. The mean annual rainfall varies between 840mm and 1400mm.

Most of the rainfall occurs between June and September and it is not unusual to have very high rainfall figures concentrated in a few rainy days. One feature of the rainfall pattern is that it tends to occur in heavy downpours thus, that encourages run-off rather than soil moisture retention. Erratic rainfall regime is clearly shown in the water balance, which is a reflection of the poor soil moisture condition in the area. It has been calculated that there are four humid months, in terms of soil moisture conditions and the period is only adequate for the cultivation of crops such as millet, guinea corn, yam, groundnuts and beans. The rainfall pattern is irregular and unreliable. Sometimes, it results as long period of no rain during the farming season which affects harvest.

3.5 Study Design

The study design is a descriptive cross-sectional one. A quantitative method of data collection was used to achieve this purpose of describing male knowledge and attitude that influence partners use of modern family planning methods in Wa municipality.

3.6 Study Population

The study population for this study was Male Taxi Drivers (Married) residing in Wa municipality.

3.7 Inclusion Criteria

The study participants were:

1. Married Taxi Drivers who falls within the study age group (18-69 years)
2. Married Taxi Drivers within the age specified and stays in the community for at least one year.
3. Taxi Drivers with at least one child who falls within the age group.

3.8 Sample Size Calculation

Computation of the sample size came out with 377 males by using family planning prevalence rate of 50% confidence interval of z=1.96, margin of error=5%. The Calculated sample size yielded 377 respondents (410 Adjusted). Four hundred and ten (410) subjects was used for the study.

Table 3.8.1: Sample Size Calculation

Margin of Error	5%
Confident level	95%

Population size	10,000
Prevalence of family planning	50%
Addition	9%
Total Sample size	410

3.9 Sampling Method

A purposive sampling method was used to select four commercial towns (Wa Central, Bamahu, Kambali and Kpaguri) in Wa municipality for the study.

A purposive sampling method was again used to select 103 respondents (Taxi Drivers) in the Wa Central and Bamahu communities and 102 respondents from Kambali and Kpaguri respectively. In all, a total of four hundred and ten (410) males' taxi drivers of ages between 18-69 years were selected and interviewed.

Research assistants were stationed at these four commercial towns to seek the consent and administered the questionnaire to consented Taxi Drivers.

3.10 Data Collection Method

The method of data collection employed was interview through administration of questionnaire to achieve this purpose. The questionnaire was both open-ended and closed ended and also exploratory in nature to help respondents easily share their views. The questionnaire was

administered in a confined place to ensure privacy. The questionnaire was also translated into the local language (Waali and Dagaari) for easy understanding of the respondents.

Again as part of the preparation for data collection two days were set aside to train four (4) research assistants in data collection skills to help with the administration of the questionnaire.

3.11 Data Management and Analysis

Data entry (double entry) and cleaning was done using Excel and statistical analyses done with STATA 14. Discussion on analysis was done on both specific and general objectives. Comparative descriptive analysis was performed with test of proportions used to compare the responses from different backgrounds. Univariate, bivariate and multivariate analyses were performed to access how male knowledge and attitude influence partner use of modern family planning methods in Wa municipality of Ghana. A test of association was considered significant with a p-value of < 0.05.

3.12 Pre-Test

The questionnaire was pre-tested in Tamale municipal on 20 taxi drivers. The purpose of the pre-test was to remove ambiguities and unnecessary items in the questionnaire and also to incorporate omissions that might have been omitted from the questionnaire. Pre-testing also gives a fair idea of the responses to be obtained from the field.

3.13 Challenges of the Study

1. Low level of participation by male. ---Effort was made to assure participants that no identifier (s) such as names and pictures will not be included in the study.
2. Some respondents were not willing to give all the information required by the researchers because of the fear of being penalized. ---Efforts was made to reduce this problem by assuring them of their confidentiality of all information provided.

3. Low response from Catholic and Muslim respondents due to their religious doctrine – Participants were assured that information given out is purposely for the research and not for any other purpose.

3.14 Ethical Consideration

Ethical approval was obtained from the Ethics Review Board of Ensign College of Public Health.

Municipal approval was also obtained from the chairmen of Ghana Private Road Transport Union (GPRTU) of the various study areas within Wa Municipality and individual informed consent sought from each participant before the questionnaire was administered to them.

The participants consent was sought to involve them in the study. Informed consent that is the permission to involve them in the study was also sought from all the respondents before interviewing them. The purpose and the objectives of the study, and any potential risk or benefits inherent in the study was explained to the respondents. The respondents were given opportunity to ask questions about the study at any stage, and to withdraw from the study at any time they feel insecure. Privacy and confidentiality was ensured by dealing with the respondents on individual basis.

3.15 Expected outcome of the Study

The findings of this study would be useful for the following policy regulation and implementation:

1. Family planning education programs
2. Maternal and child health
3. Health promotion activities.

4. Health education in schools (SHEP)

3.16 Dissemination of Findings

The findings of this study would be disseminated to stakeholders such as Ghana Health Service, Ghana Education Service and CHRAJ for implementation of Policies and health education in improving family planning services and to avert the low level of male involvement in modern family planning in Wa-UWR.

Stakeholders: A stakeholders meeting shall be held in the Wa municipality to disseminate the findings of the study. A research brief shall also be prepared and shared with stakeholders at both regional and national levels.

Local FM Radio: Air time shall also be secured over the local FM station (Radio Upper West and Radio Progress) to organize a program to discuss the findings of the study. The program shall allow for listener participation through phone-in, whatsapp and text message.

CHARPTER FOUR

4 RESULTS

Background Characteristics

A structured questionnaire was administered to 410 respondents.

The mean age of the respondents was 34 ± 10.6 years with a minimum of 20years and a maximum of 69yers with a standard deviation of 10.59.

4.1: Demographic Characteristics

Table 4. 1: Demographic Characteristics of Respondents

VARIABLES	FREQUENCY (%)
Age Groups	
20-29	130 (31.7)
30-39	148 (36.1)
40-49	81 (19.7)
50-59	34(8.2)
60-69	17(4.1)
Educational Level	
None	71 (17.3)
Primary	73(17.8)
Middle/JHS	136(33.2)
SSS/SHS/Vocational	80 (19.5)
Tertiary/Polytechnic	49(12)
Others	1(0.24)
Ethnicity	
Waali/Dagaati	375(91.5)
Fanti	7 (1.7)
Akan	1(0.24)
Others	27(6.6)

4.2 Marital Status

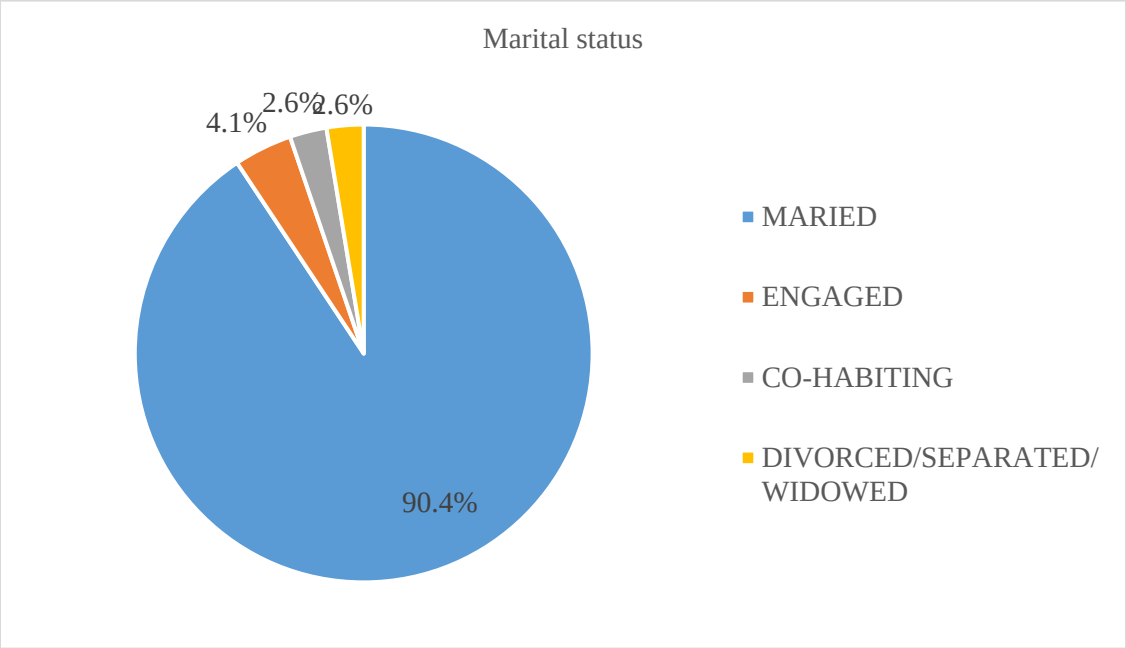


Figure 4.2: Marital status of respondents

Source: Field Work 2017

With reference to Figure 4.2, shows that married couples formed the majority of the respondents, out of the 410 respondents 371 respondents were married giving a percentage of 90.49%, followed by engaged respondents of 17 with a percentage of 4.15%. This indicates that the respondents who were interviewed majority were married couples.

4.3: Religious beliefs of respondent

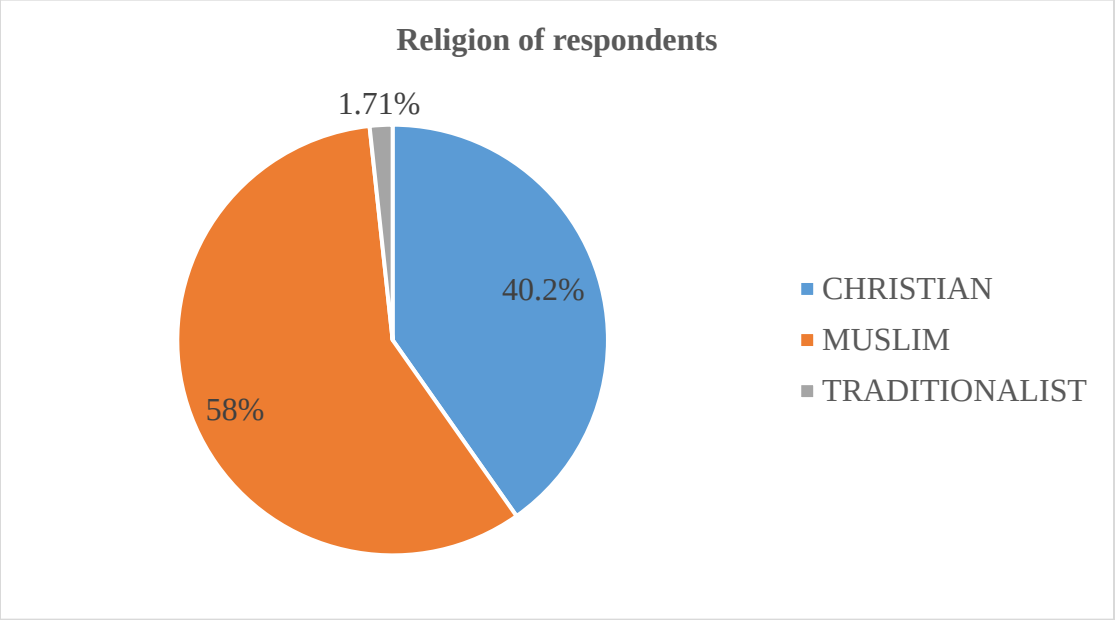


Figure 4.3 Respondents Religion

With reference to Figure 4.3 shows the religious levels of the respondents, it was evident that Islam was the religion of the majority (58%) of the respondents followed by Christianity (40%). The least religion was Traditional religion representing 2% of the respondents.

4.4 Number of children of respondents

Table 4.4 Number of children of respondents

Number of Children	Frequency (%)
1	110 (26.8)
2	80 (19.5)

3	65 (15.9)
4	44 (10.8)
5	29 (7.1)
6	21 (5.1)
7	14 (3.4)
8	6 (1.5)
9	2 (0.5)
10	4 (0.9)
11	1 (0.2)
12	1 (0.2)

* : Respondents who are married but without children were not considered here

Source: Fieldwork 2017

The number of children of respondents as tabulated on Table 4.4 shows that majority of the respondents have at least a child during the period of the interview only about 8% of the respondents at the time of interview were not having a child.

4.5 Number of wife/ wives of respondent

Table 4.5 Number of wives of respondents

Number of wives	**Frequency (%)**
1	357 (87.07)
2	32 (7.80)
3	10 (2.44)

* : Respondents who are either divorced/separated or widowed are not represented here

Source: Fieldwork Feb, 2017

Table 4.5 shows the number of wife/wives of respondents, it was evident that respondents with one wife formed the majority of the people interviewed with a corresponding

percentage of 87%, followed by respondents with two wives with a percentage of 7.8%, however, 2.7% of the respondents were either divorced, separated or widowed.

4.6 Attitude of men towards modern contraceptive use

Table 4.6.1: Men knowledge about the promotion of modern family planning.

Promotion of FP	**Frequency (%)**
Good	284(69.27)
Bad	79(19.27)
Indifferent	47(11.46)

Source: Fieldwork Feb, 2017

Table 4.6.1 shows men knowledge about the promotion of modern family planning in Wa-UWR. The table indicates that out of the 410 respondents, 284 representing 69% said that the modern family planning is good and has to be promoted while 79 respondents representing 19% indicated that the modern family planning contraceptive is not good and has to stop, meanwhile 47 respondents with a percentage of 11.5% were indifferent about the promotion of modern family planning in the municipality.

Table 4.6.2: Approval of the use of modern contraceptive to stop unwanted pregnancy

Approval of FP	**Frequency (%)**
Yes	267(65.12)
No	98(23.90)
Not Sure	45(10.98)

Source: Fieldwork Feb, 2017

With reference to Table 4.6.2, which shows the approval of the use of modern family planning to stop or prevent unwanted pregnancies. 267 respondents corresponding to a percentage of 65% agreed for the use of modern family planning to prevent unwanted pregnancy. 98 respondents representing 24% did not agree for the use of modern family planning to prevent unwanted pregnancy and about 11% were indifferent about the use of modern contraceptives to prevent unwanted pregnancies in Wa municipality.

4.7 Knowledge and use of various contraceptives methods

Table 4.7: Knowledge of family planning contraceptives.

DEVICE	**YES (%)**
Pills	289 (70.50)
IUD	54 (13.17)
Injectable	316 (77.10)
Implant	214 (52.20)
Male condom	375 (91.50)
Female condom	281 (68.54)
Diaphragm	42 (10.24)
Foam/jelly	88 (21.50)
Rhythm	297 (72.44)
Emergency	123 (30.00)

Source: Fieldwork Feb, 2017

Table 4.7, Depict male knowledge of modern family planning contraceptives in Wa municipality. The knowledge of modern family planning contraceptive methods/device was assessed on the respondents. Male condom recorded the highest number of 375 respondents representing 91.50%, followed by Injectable representing 77%, next on the list is Rhythm

(Calendar) method with a percentage of 72.44%. Pills recorded 289 respondents representing 70.50%, making it the fourth on the list and last but not the least is Diaphragm with a percentage of 10.24%.

4.8 Use of modern family planning contraceptives

Table 4.8 Use of family planning contraceptives

DEVICE	YES (%)
Pills	52(12.68)
IUD	3(0.73)
Injectable	59(14.39)
Implant	14(3.41)
Male condom	276(67.32)
Female condom	0
Diaphragm	0
Foam/jelly	3(0.73)
Emergency	0
Rhythm	196(47.8)

Source: Fieldwork Feb, 2017

With reference to Table 4.8, which shows the use of modern family planning contraceptives by commercial drivers in Wa municipality. It again came to light that male condom recorded the highest (67.32%) usage with respect to the various modern contraceptives. This was followed by the Injectable method which also recorded 14.39% .Next on the list is Pills with corresponding percentage of 12.68%. With regards to female condom, Diaphragm and emergency contraceptives no respondent or partner use it in the past one year.

4.9 Male attitude towards partner use of modern family planning

With respect to respondents receiving family planning counseling in the past one year, only 26% had received counseling and the majority 73% had not received any form of family planning counseling within a whole year.

4.10: Male and partners currently using FP

With regards to male and partner currently using family planning services, the study revealed that majority(68%) of respondents and their partners were not using any method of family planning services in Wa municipality.

4.11 Reasons for the choice of modern family planning by respondents in Wa municipality

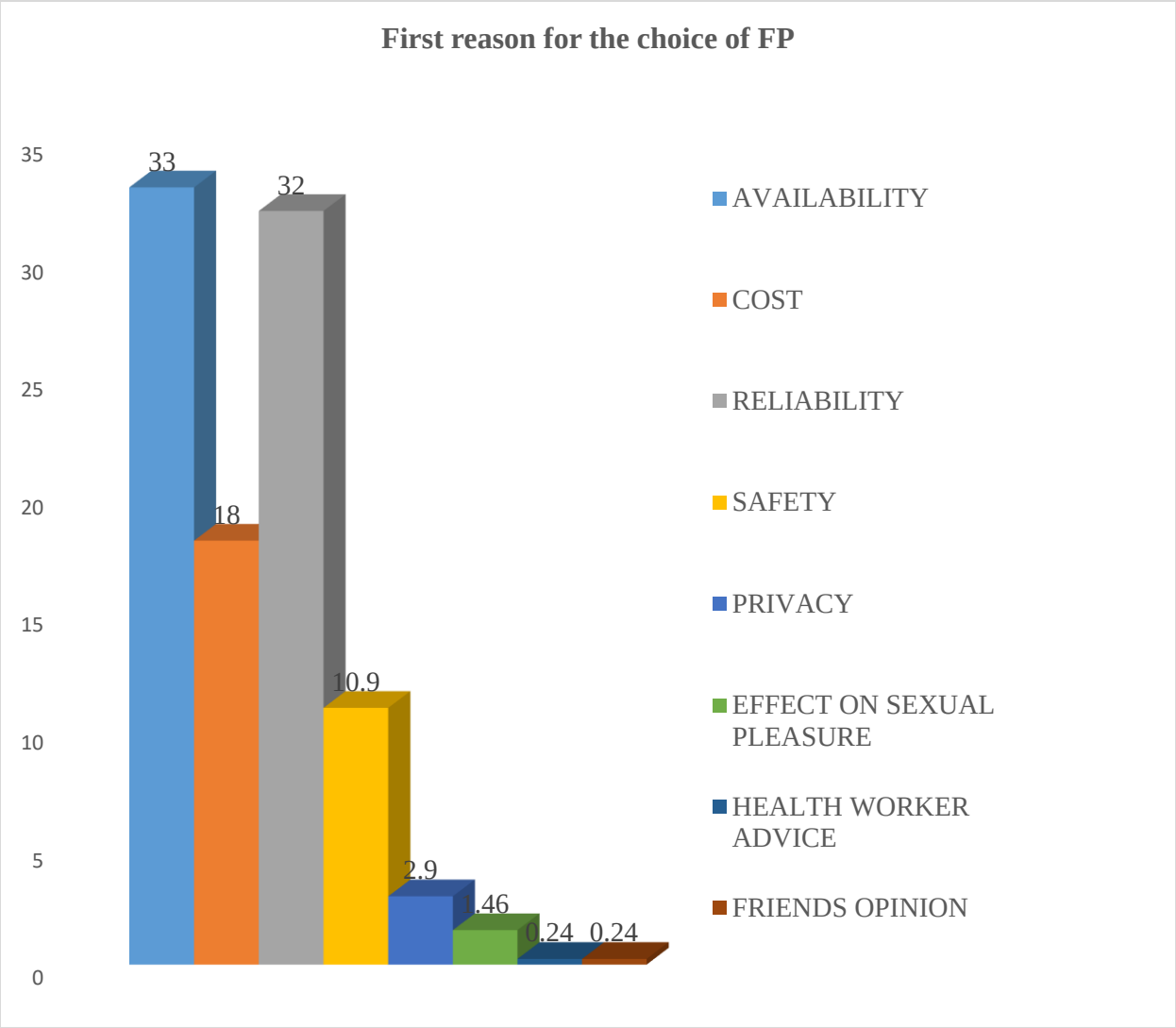


Figure 4.11.1: First reason for the choice of modern family planning method by respondents.

The above figure 4.11.1, depicts the first reason why respondents use family planning services in Wa municipality. It became obvious that the very first reason for family planning usage in Wa municipality was availability, next to it is reliability, cost and safety respectively. The last but not the least reason was health workers advice and friends opinion.

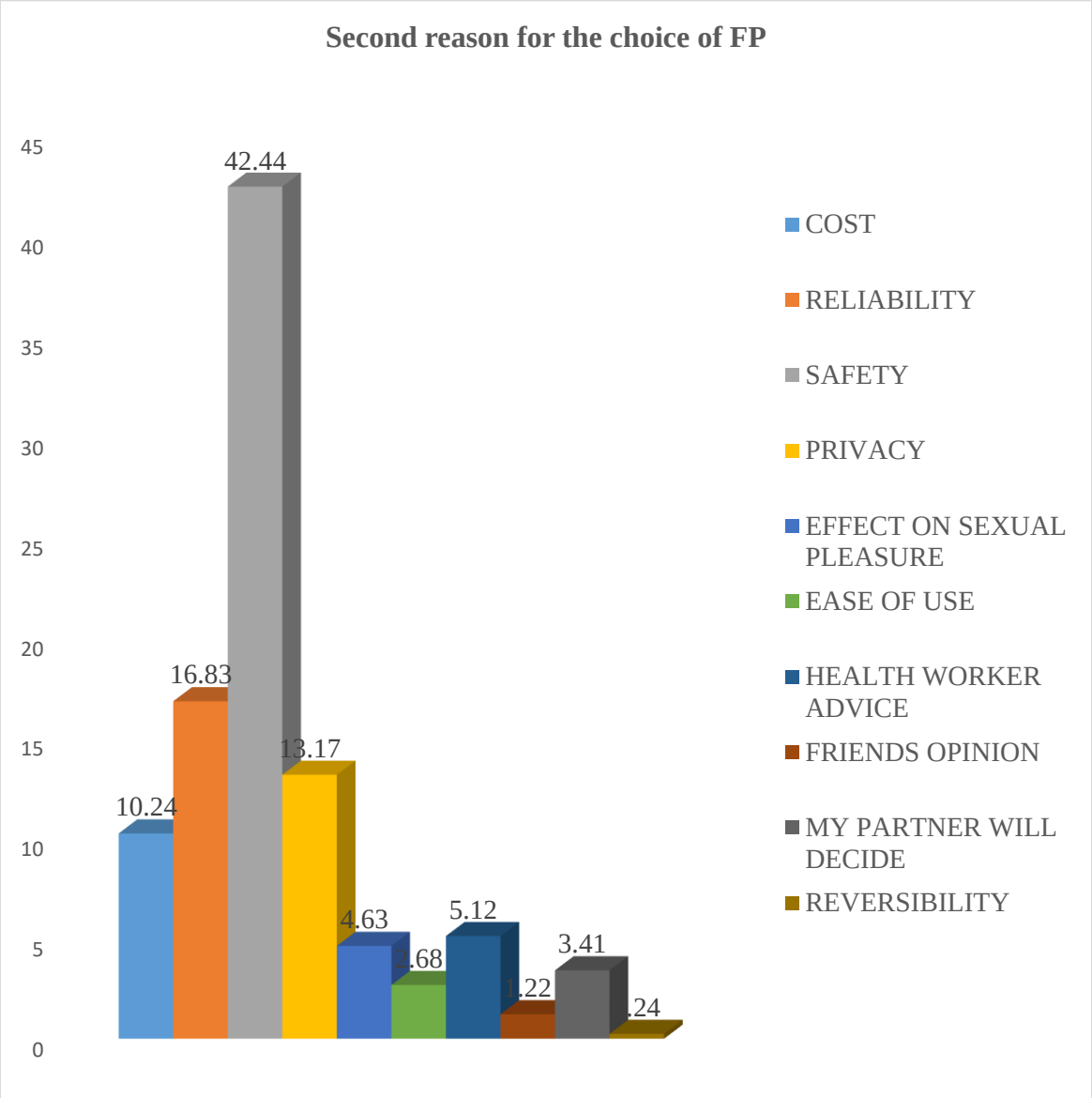


Figure 4.11.2: Second reason for the choice of modern family planning methods by respondents.

Source: Fieldwork 2017

With reference to figure 4.11.2, it shows the second reasons for the choice of family planning services in Wa municipality, safety recorded the highest reason followed by reliability and privacy, then health workers' advice respectively.

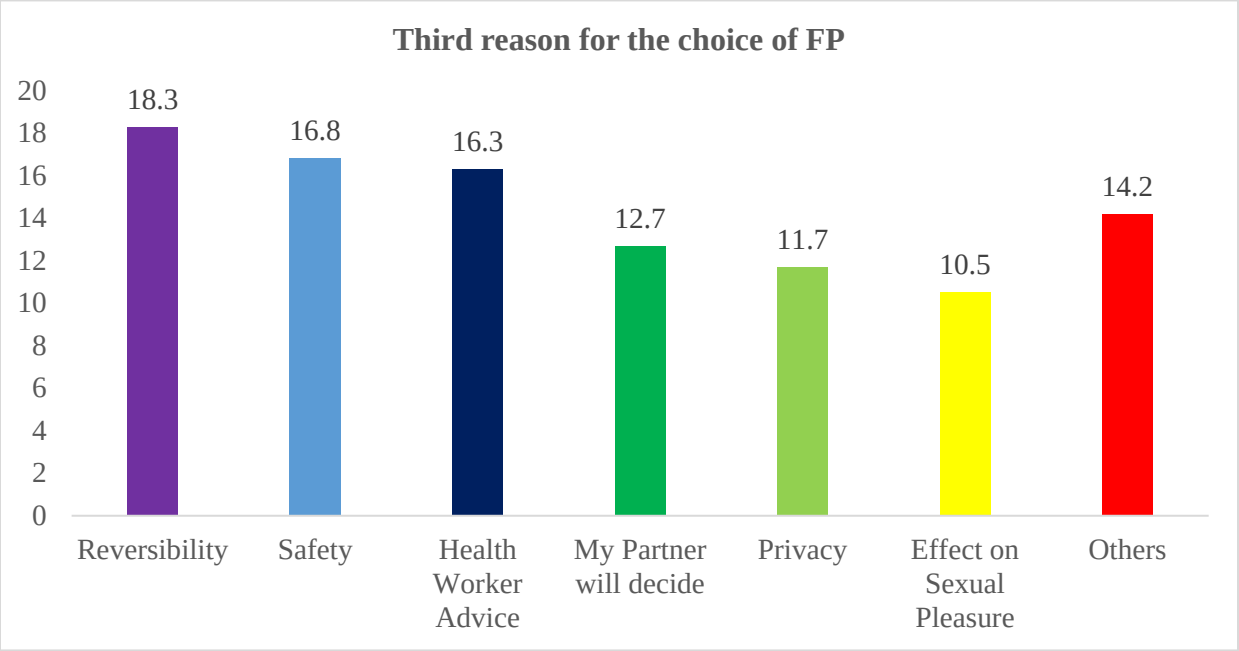


Figure 4.11.3: Third reason for the choice of modern family planning method by respondents

Source: Field Work 2017.

The above figure 4.11.3, shows the third reasons for the choice of modern family planning services in Wa municipality, it was evident that reversibility recorded the highest third reason for the choice of family planning services in Wa municipality followed by safety, health worker's advice, my partner will decide, privacy, effect on sexual pleasure and ease of use as the main reasons for the choice of modern family planning in Wa municipality.

4.12 Modern family planning service delivery points in Wa municipality

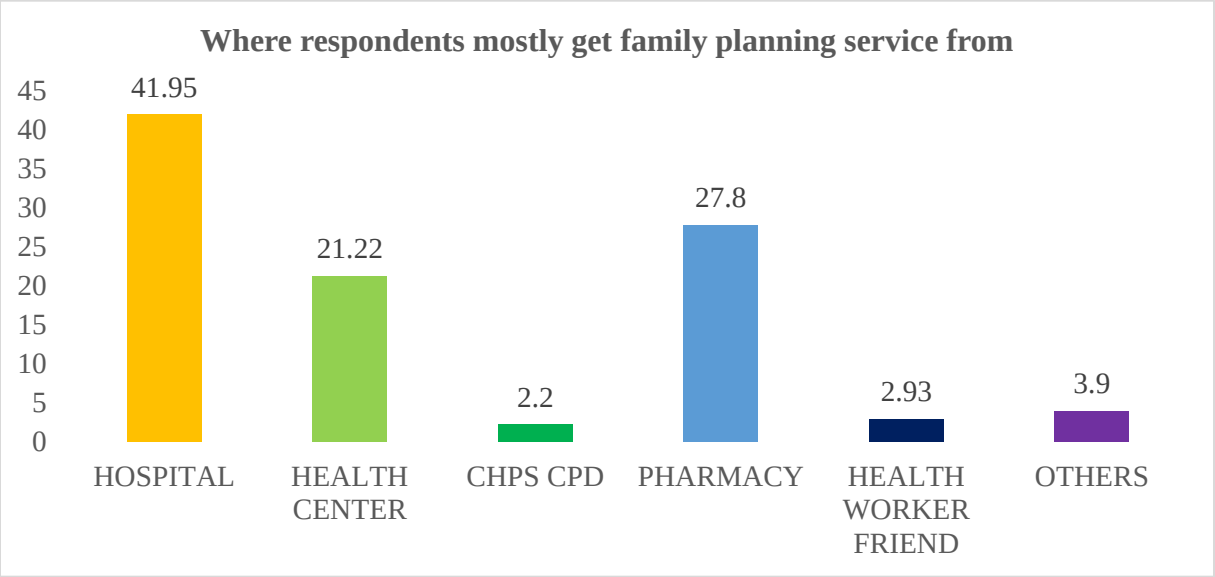


Figure 4.12: Where respondents and partner mostly get the family planning contraceptives service from.

Source: Fieldwork 2017.

On modern family planning service delivery points, figure 4.12 , shows that most of the respondents had their family planning services provided for them in the hospital (42%) followed by pharmacy (28%) and then health facility (21%),

4.13 Male attitude towards partner use of modern family planning in Wa municipality

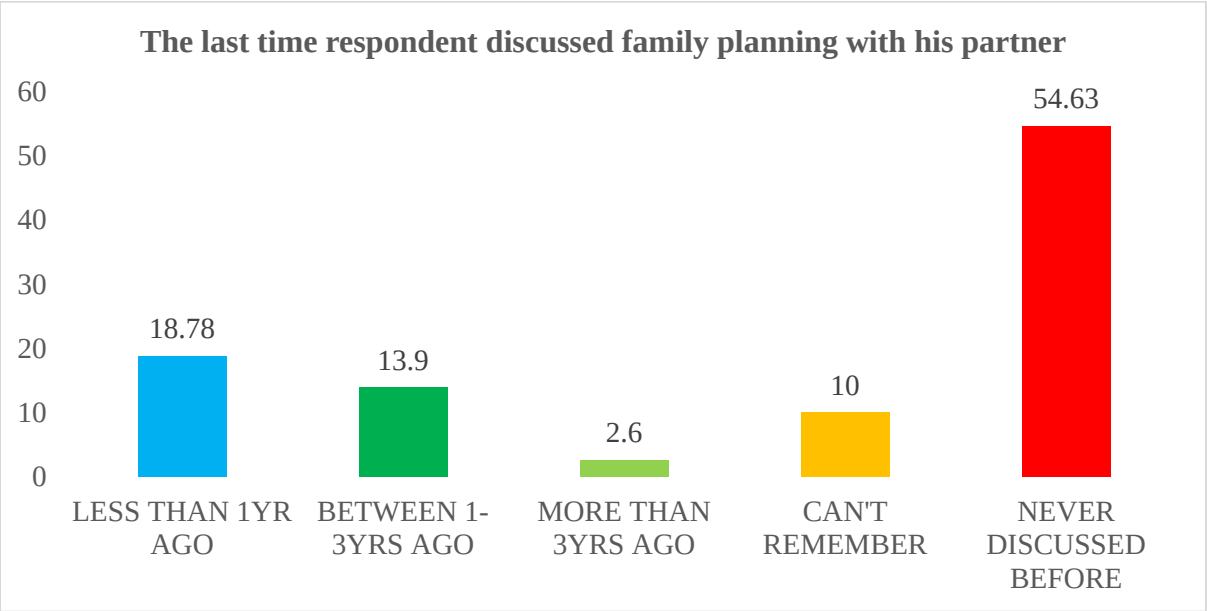


Figure 4.13.: Couples Discussion of Modern Family Planning Methods at Home.

Source: Fieldwork 2017.

It is evident from figure 4.13, shows that majority of the respondents (55%) never discussed modern family planning services at home with their spouses, about 19% discussed it less than one year ago and about 14% also discussed it between one and three years interval whilst about 10% could not remember the exact year they discussed family planning methods with their spouses,

4.14. Couples attending family planning counselling sessions together

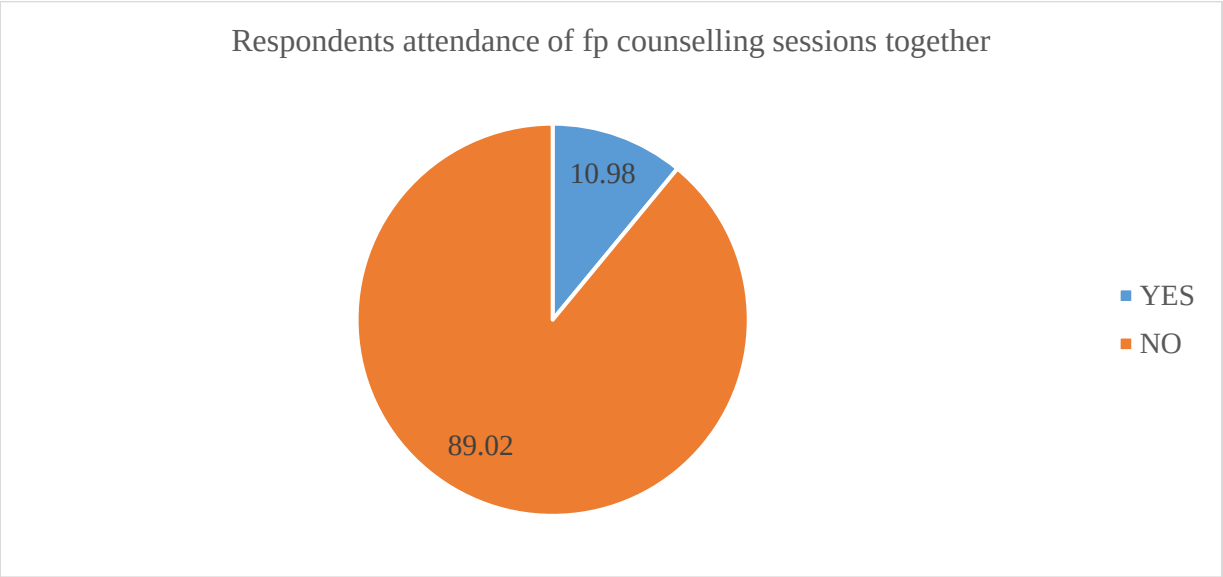


Figure 4.14: Have respondents and partners ever attended family planning counseling sessions together.

Source: Field Work 2017.

The above Figure 4.14, shows that only about 11% of the respondents ever attended family planning counselling sessions with their partners and the rest about 89% had never attended any family planning counselling sessions with their partners.

4.15: Respondents accompanying partners to antenatal clinic in Wa municipality

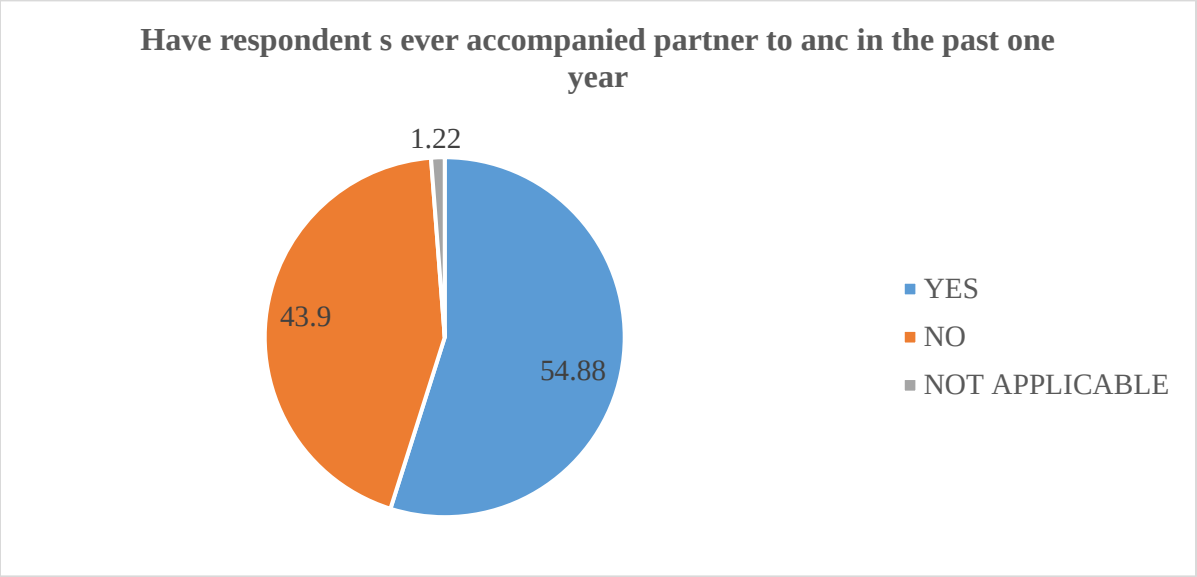


Figure 4.15: respondents ever accompanied his partner to the antenatal clinic in the past one year

Source: Field Work 2017.

With reference to Figure 4.15, which depicts whether respondents ever accompanied partner to ANC in the past, it was evident that about 55% and 59% accompanied their partners to ANC services in 2017 and 2013 respectively, however, about 44% and 37% in 2017 and 2013 said no to accompanying their partners to ANC services and about 1% and 4% said that it was not applicable to accompany their partners to ANC.

4.16: Respondent's willingness to pay for the cost of family planning services provided to their partners.

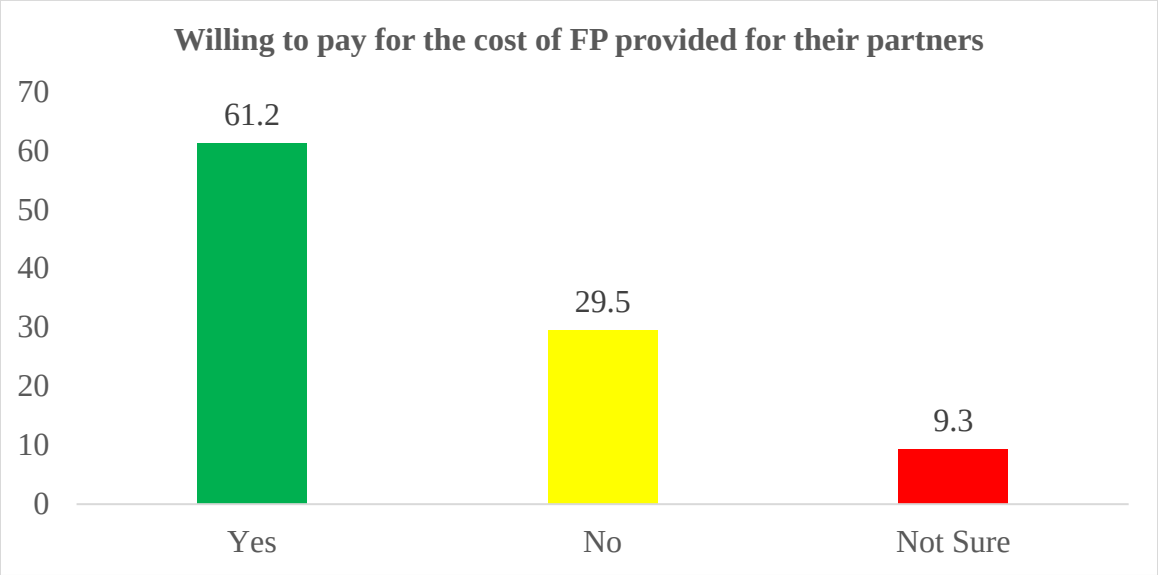


Figure 4.16: Respondents willingness to pay for the cost of family planning for their partners.

Source: Field Work 2017.

Figure 4.16, shows the percentages of respondents who were willing to pay for the cost of family services provided for their partners, majority (61%) were willing to pay for the cost of FP services provided for their partners while about 29% refused to pay for the cost of FP services provided. Meanwhile about 9% were indifferent about whether to pay or not.

4.17: How worried will respondent be if you found out that your partner was using family planning method without your knowledge?

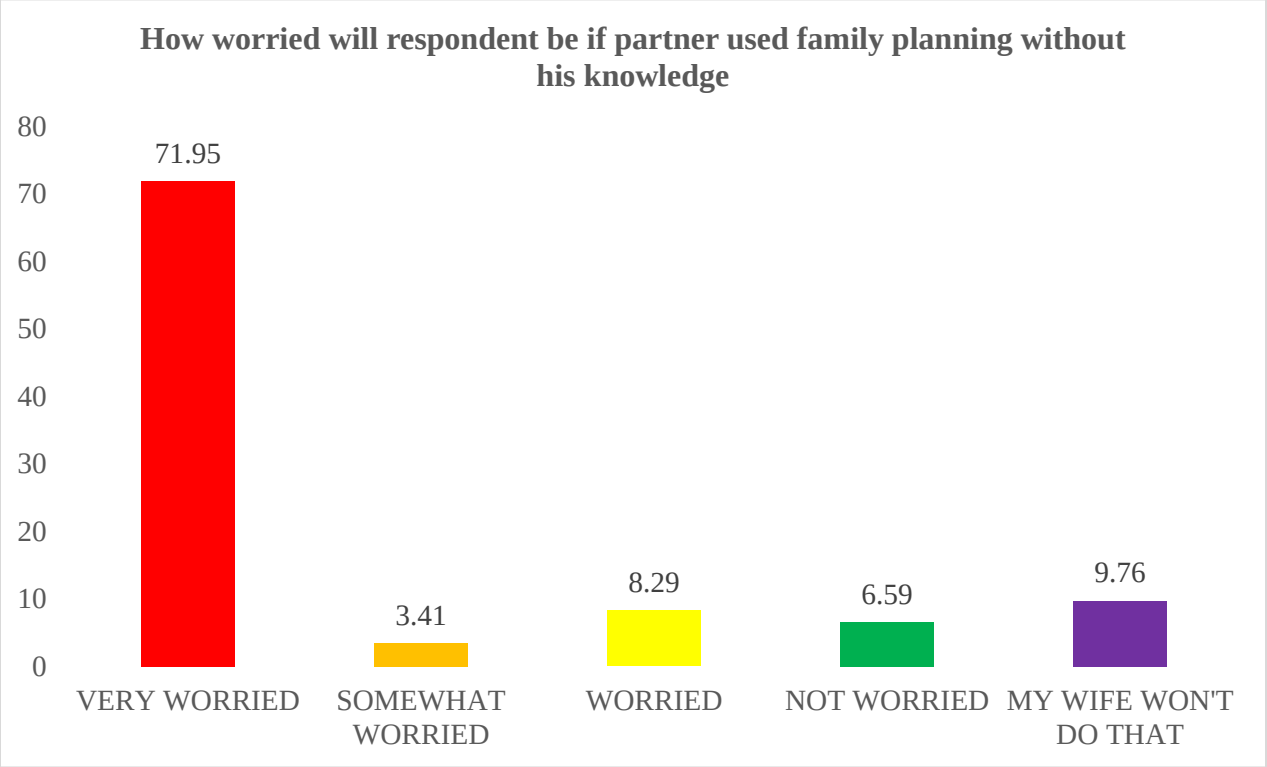


Figure 4.17: whether respondents will worried if partners used family planning without their knowledge.

Source: Field Work 2017

With reference to figure 4.17, majority (72%) of the respondents said they would be very worried if partners used family planning without their knowledge. With regards to those who said they would not be worried only about 7% said they will not be worried if their partners used family planning services without their knowledge.

4.18: Testing for association between background characteristics and some selected variables

Table 4.18.1: Testing for association between number of children and approval of family planning

Number of Children	Approval of family planning by respondents	
	Yes (%)	Not Sure (%)
1	74 (27.7)	13 (28.8)
2	52 (19.5)	3 (6.6)
3	53 (19.8)	2 (4.4)
4	32 (11.9)	1 (2.2)
5	17 (6.3)	5 (11)
6	9 (3.3)	10 (22.2)
7	6 (2.2)	4 (8.8)
8	1 (0.3)	3 (6.6)
9	0 (0.00)	2 (4.4)
10	2 (0.74)	1 (2.2)
11	0 0.00	1 (2.2)

*: Pearson's Chi Square test, P< 0.0001. Respondents without children were omitted.

Source: Field Work 2017

Tables 4.18 above shows significant association between the number of children per respondents and the approval of the use of family planning to stop unwanted pregnancies(P<0.05). Respondents who approved the use of family planning to stop unwanted pregnancies had between 1 to 6 children while those who disapproved the use of family planning had fewer children.

Table 4.19: Testing for association between current usage of family planning and where respondents get the services from.

Current usage of FP	**Where respondents get FP services**					
	Hospital	Health Centre	CHPS Compound	Pharmacy	Health worker	Other
Yes	60 34.8%	21 24.1%	1 11.1%	48 42.1%	2 16.6%	0 0.00%
No	112 65.1%	66 75.8%	8 88.8%	66 57.9%	10 83.3%	16 100%

*: Pearson's Chi Square test, P=0.002

Source: Field Work 2017

Table 4.19, was to found out whether there was any association between partner who were currently using family planning method and where partners or respondents get the service from. The result on table 4.19, shows a significant association (P<0.05) between partners who were currently using family planning and where the services were obtained from.

Table 4.20: Testing for association between approval of usage of family planning and the last time respondents discussed family planning with partners.

APPROVAL OF FP	THE LAST TIME RESPONDENTS DISCUSSED FP WITH PARTNERS AT HOME				
	< 1yr	1-3yrs	>3yrs	Cannot remember	Never discussed before
Good	70 90.9%	46 80.70%	7 63.6%	31 75.6%	113 50.44%
Bad	4 5.19%	8 14%	4 36.3%	8 19.5%	74 33%
Indifferent	3 3.89%	3 5.2%	0 0.00%	2 4.87%	37 16.5%

*: Pearson's Chi Square test, P< 0.0001

Source: Field Work 2017

It was again prudent to test for the association between respondent's approval of the use of family planning to stop unwanted pregnancies and the last time couples/partners discussed family planning at home. As evident from Table 20, it was found out that there is a significant (P<0.05) association between respondent's approval of the use of FP to stop unwanted pregnancies and the last time partners discussed FP at home.

Table 4.21: Testing for association between respondent's current usage of family planning method and the spouse needs to use family planning methods/devices.

Current usage of FP by respondent or partner	Partner or spousal need to use FP	
	Yes (%)	No (%)
Yes	105 (60.6)	27 (11.39)
No	68 (39.4)	210 (88.61)

*: Pearson's Chi Square test, P< 0.0001

Source: Field Work 2017

4.22: Demographic characteristics and willingness to pay for FP as a proxy indicator of male attitude

Table 4.22: Demographic characteristics and willingness to pay for FP as a proxy indicator of male attitude

Variables	Categories	Willingness to pay		Bivariate analysis		Multivariate analysis
		Yes	OR(95 % CI)	P-VALUE	OR(95% CI)	P-VALUE
Age	Above 34yrs	110(56.1%)	0.66(0.44-0.99)	0.04	0.64(0.35-1.14)	0.94
	34yrs and below	141(65.9%)				
Highest educational level	Tertiary/Polytechnic	41(82%)	5.25(2.08-13.2)	<0.01	1.86)0.65-5.60)	0.23
	SSS/SHS/Vocational	46(57.5%)	1.56(0.81-2.98)	0.18	0.67(0.29-1.58)	0.45
	Middle/JHS	87(64%)	2.04(1.13-3.70)	0.02	1.31(0.61-2.82)	0.47
	Primary	44(60.3%)	1.74(0.89-3.41)	0.10	0.91(0.38-2.16)	0.88
	None	33(46.5%)	1.00			

Ethnicity	Waali/Dagaari	220(58.7%)	0.18(0.06-0.54)	<0.01	0.83(0.02-0.33)	<0.01
	Others	31(88.6%)	1			
Religion	Muslim	138(56.3%)	0.59(0.39-0.90)	<0.01	1.31(0.74-2.35	0.34
	Christian	113(68.5%)	1.00			
Number of children	>4	33(42.3%	0.38(0.23-0.64)	<0.01	1.00(0.44-2.30)	0.63
	< OR = 4	218(34.3%)				
Age of last child	>3YRS	61(50%)	0.52(0.33-0.80)	<0.01	1.47(0.57-3.82)	0.43
	< OR = 3YRS	190(66%)				

*: OR=Odds Ratio, CI= confident Interval at 95%, < = Less than, P value= Probability value

Source: Field Work 2017

From the above Table 4.22, it shows demographic characteristics. The Table indicate that male who belongs to the Waali/Daagari ethnic group were 0.83 times less likely to pay for the services of modern family planning (OR O.83 (0.02-0.33 CI, PV<0.01)

4.23 Attitude towards modern family planning and the willingness to pay for modern family planning services

Table 4.23; Willingness to pay for FP as a proxy indicator of male attitude.

Variables	Categories	Willingness to pay		Bivariate analysis		Multivariate analysis
		Yes	OR(95% CI)	P-VALUE	OR(95% CI)	P-VALUE
Approve use of FP methods	Yes	208(77.9%)	8.20(4.87-13.80)	<0.01	6.77(3.73-12.28)	<0.01
	No	43(30.1%)				
Attended FP counselling together	Yes	40(88.9%)	5.84(2.21-15.5)	<0.01	4.20(1.35-13.09)	0.013
	No	211(57.8%)				
Worried about FP making wife unfaithful	Yes	166(55.3%)	0.23(0.12-0.44)	<0.01	0.27(0.13-0.57)	<0.01
	No	70(84.3%)				
Consider divorce wife over covert use of FP	Yes	26(48.7%)	0.53(0.32-0.89)	<0.01	0.66(0.32-1.33)	0.25
	No	215(64%)				
Number of wives	>1	11(26.2%)	0.18(0.09-0.39)	<0.01	0.18(0.06-0.51)	<0.01
	<1	235(65.8%)				

*:OR= Odds Ratio, CI= Confident Interval, <= Less than, >= Greater than, P value= Probability Value.

Table 4.2 revealed that among the independent predictors of male attitude and willingness to pay for modern FP, the following predictors were statistically significant (Approval of the use of modern FP: OR 6.77, 3.73-12.28 CI, PV<0.01)(Attended FP counselling together, OR4.20, 1.35-13.09CI, PV=0.013) (Worried about FP making wife unfaithful, OR 0.27, 0.13-0.57CI, PV<0.01) With regards to the number of wives, it was respondents who had more than one wife who were statistically significant with OR 0.18, 0.06-0.51CI and PV<0.01

4.24: Comparison of 2017 and 2013 attendance of FP counseling and usage of FP methods by respondents

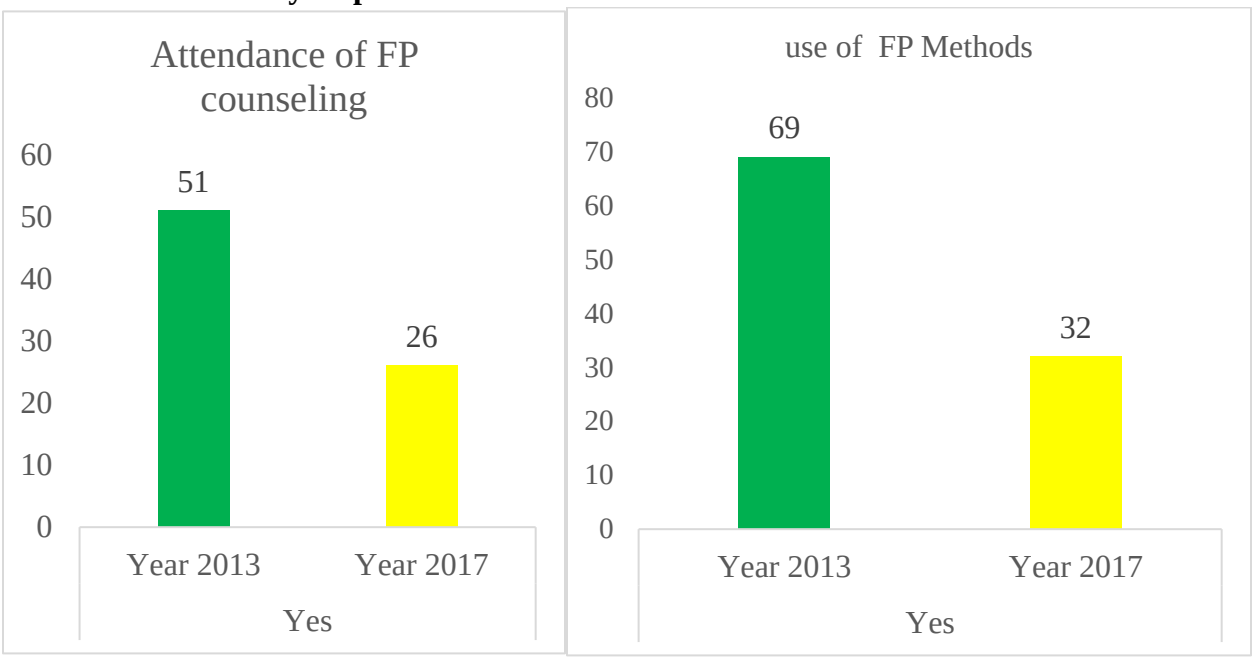


Figure 4.24.1 : Compares attendance of FP counseling and use of FP methods in 2013 and 2017.

It was evident that in the year where more people attended FP counseling, more respondents used the FP services. This shows that FP counseling is a predictor of usage of FP contraceptives in the community.

4.24.2: Comparison of Approval and Promotion of FP in 2017 and 2013

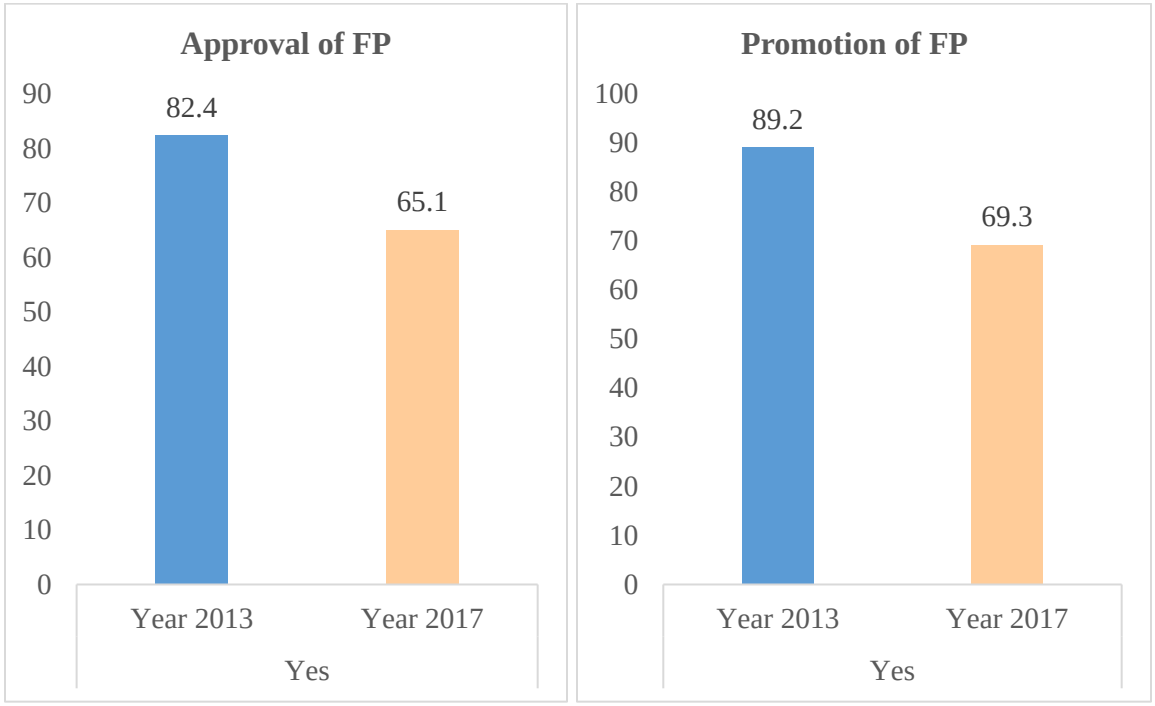


Figure 4.24.2: Comparing Approval of FP and Promotion of FP in 2017 against 2013

The comparison revealed that majority of respondents in 2013 approved the use of family planning to prevent unwanted pregnancies likewise its promotion as against a small proportion in 2017. This indicates that the promotion of FP education was high in 2013 than in 2017.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

In recent years, there has been a tremendous advancement in the development of safer and more efficient and effective contraceptives coupled with provision of available, accessible and affordable family planning services in every corner of the country.

Globally in 2015, 57% of married or in-union women of reproductive age used a modern method of family planning constituting 90% of contraceptives users(Trend in contraceptive use worldwide 2015), yet large gaps remains in the proportion of total demand for family planning satisfied with modern methods in countries where overall contraceptive use is low.

5.1 Background Characteristics

With regards to age group, the study found that males in the 30-39 age groups were in the majority (36%). Collectively majority (87.5%) of the respondents fell between the ages of 20-49yrs, and accidentally this age group forms the most sexually active age group in the population. The mean age of the respondents is 34yrs with a minimum of 20yrs and a maximum of 69yrs with a standard deviation of 10.59.

With educational background, it was revealed that, those who had received some level of education are in the majority (82.6%) compared to those without any form of education. Moreover, the higher one moves along the educational ladder, the more knowledge about family planning the person has. However, it was found that education is not a predictor of the knowledge of modern family planning in Wa community.

Concerning the ethnicity of the respondents, it was realized that 91.4% of the respondents were from the Waali/Dagaari ethnic group.

5.2 Knowledge and attitude of men towards modern contraceptives use

5.2.1 Knowledge and Perception

It was found from the study that generally, across the age groups, more (54%) people have an idea about family planning than those who do not have any idea.

The idea about family planning among men was to determine, how family planning is perceived among them. Apart from just having an idea, majority of the respondents seemed to have some level of knowledge about what family planning is. This confirmed a study done by GDHS, (2014) which disclosed that knowledge about family planning is high among males, and that, majority of men know at least one method of contraception. A similar study done in Nigeria also revealed that knowledge of family planning is high among male than females (Alfred et, al., 2016).

5.2.2 Counseling of men in family planning

The study showed that majority (73%) of men interviewed had never had a counselling before. This confirmed a study done in New York, on male involvement in reproductive health, which showed that, the range of family planning methods available, to men is sometimes limited and as a result, prevents men from fully participating in fertility regulation (Green et, al, 1995)

Another study done in Tanzania on the impact of demand factors, quality of care and access to facility on contraceptive used found a positive relationship between quality which include counselling of family planning services and use of contraceptives (Arends-Kuenning and Kessy. 2007).

5.2.3: Respondents who were using FP at the time of the interview

Concerning current use of family planning, it was revealed that only 32% of the respondents interviewed were using any family planning method. This study confirms the findings of GDHS (2014) that knowledge of family planning is high but low in usage. A similar studies done in Wa municipality on predictors of postpartum family planning uptake: understanding providers and potential family planning in the Wa municipality also found that only 46% were using FP (Tirah Haruna, 2012). In Nigeria a study on the role of men in family planning found out that only 32.3% of males were using any of the family planning methods (Alfred et, al., 2016).

5.2.4 Information on modern family planning in Wa municipality

With regard to where respondents get most information on modern family planning, it came to light that majority of the respondents get their information on family planning through the Radio (55.4%) and Health worker (20.5%), the rest were insignificant. This findings support a similar studies on attitude towards and use of knowledge about family planning among Ghanaian men, it revealed that the most source of family planning information were through the mass media (Radio and TV) (Ossou and Marie-Antioinette, 2008).

5.2.5 Men involved in antenatal services (ANC) and FP discussion

The study determined to find out whether men were involved in antenatal and maternity service of their spouses. More than half of the respondents (55. %) had ever accompanied their spouses to ANC service. These findings were in contrast to the findings of a study on male partner

involvement in maternity care in Ablekuma South District (Doe and Roseline Dansowaa, 2013). They found out that 83% of males were involved in ANC

However, the study affirms a similar work done in Russia on the presence of a companion during labour, which found that about 68% declined having their husbands present in ANC services (Bakta and Lee. 2010). A similar study done in Uganda on male partner antenatal attendance and HIV testing in eastern Uganda shows that only 5% of men accompanied their spouses to ANC (Byamugisha et al, 2011).

Concerning men who have ever discussed family planning with their spouses, the study shows that more than half of the respondent (54.63%) have never discussed family planning with their spouses. This findings confirms the work on discussion of family planning improve knowledge of partner's attitude towards contraceptive, found out that couples do not discuss family planning issues in Sub-Sahara Africa (Derose et. al.,2014).

With regards to the willingness to accompany partners to FP counselling sessions, it was revealed from the study that majority about (58%) expressed their willingness to accompany their partners to FP counselling sessions. These findings were in contrast to a study on male partner involvement in maternity care in Ablekuma South District, Ghana. They found out that majority (83%) of males were involved in ANC (Ossou and Roseline Dansowaa, 2013).

These findings support a similar study done in UK on whose welfare in the labour room? He found out that men participations in maternal health was gradually increasing (Draper, 1997).

5.2.6 Male attitude towards partner use of family planning

The study again sought to find out male attitude towards partner use of family planning in Wa municipality. The attitude of men were categorized into the following: the willingness to pay for the cost of FP service provided to their partners and covert use of FP by their spouses.

Generally, the study revealed that male attitude is a major factor that affect modern family planning acceptance in Wa municipality. With regards to willingness to pay for FP services for spouse, the study revealed that 61% of the respondents were in the affirmative.

Concerning covert use of family planning by partners, it was revealed that Out of the 410 respondents majority (72%) indicated that they would be very worried if their partners or spouses were involved in that. The findings in this study confirms a similar work in Uganda, they found out that disagreement between husbands and wives carries high social cost including violence, divorce or husbands bringing in another wife (Blanc, et, al., 1996).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

This is one of the few studies that looked on male knowledge and attitudes that influence partner use of modern family planning in Wa municipality.

Knowledge about family planning was high but utilization of the services was low. Male attitudes towards modern family planning in the study area were rooted in the levels of family planning education and fear of spousal infidelity. Men with higher level of education appears to have little interest in issues related to family planning. Educational level was significant predictor of knowledge about family planning. Males have high knowledge of family planning than their female counterparts. Majority of the respondents expressed worried over covert use of family planning by spouses.

6.2 RECOMMENDATIONS

1. A multidimensional approach is needed to overcome male apprehensions towards spousal adoption of FP in this community.
2. The Education and Promotion unit of Wa municipal Health Administration should collaborate with GPRTU to educate drivers on FP issues.
3. To improve maternal Health and reduce maternal mortality in Wa municipality, one of the key strategies the ministry of Health and Ghana Health Service can use, is the increased male involvement in maternity care.

4. Health facilities should restructure their maternal health clinics to make them more male friendly. The policy of not allowing male partners into the labour and FP service room must be reviewed.
5. Further research on male knowledge and attitudes that influence partner use of family planning should be conducted extensively and should involve a larger sample size so as to be possible to generalize the findings to all drivers in Wa municipality.

REFERENCES

Adongo, Philip B, James F. Phillips, Beverly Kajihara, Cornelius Debpuur and Fred N. Binka .(1997) . Cultural factors constraining the introduction of family planning among the Kassena-Nankana of Northern Ghana Social Science and Medicine 45(12); 1,789-1,804.

Akafuah A R, and Sossou M. (2008). Attitude Toward and Use of Knowledge about Family Planning among Ghanaian Men.

Ann E. Biddlecon and Bolaji M. Fapohunda. (1998). Convert conceptive use: Prevalence, motivation and consequences; volume (108).

Arends-Kuenning, M. and F. L. Kessy. (2007). The impact of Demand factors, Quality of Care and Access to facilities on contraceptives use in Tanzania Journal of Biosocial Science 39(1): 1-26.

Bakhta, Y. and Lee, R.H. (2010). A survey of Russian women regarding the presence of a companion during labor. International journal of Gynecology and Obstetrics, 109(3), 201-203.

Becker, S. and Costenbender, E. (2001). Husbands and wives reports of contraceptives use studies in family planning, 32(2), 111-129.

Blanc, Ann K, Brent Wolf, Anastasia J. Gage, Alex Chika Ezeh, Stella Neema and J. Ssekamatte-Ssebuliba. (1996). Negotiating reproductive outcomes in Uganda" Calverton MD. Macro International and Kampala, Uganda; institute of Statistics and Applied Economics, Makerere University.

Burt, Martha R., Laudan Y. Aron, and Lori R. Schack.(1994). Family Planning Clinics: Current Status and Recent Changes in Services, Clients, Staffing, and Income Sources. A report prepared for the Kaiser Family Foundation. Washington, DC: The Urban Institute.

Byamugisha, R. A. Astron, A. Ndeezi, G. Karamagi C, Tylleskar, T and Tumwine, J. (2011). Male partner antenatal attendance and HIV testing in Eastern Uganda: a randomized facility-based intervention trial: Journal of the international AIDS society. 14(1), 43.

Cummings D, Bremner W. (1994). Prospects for new hormonal male contraceptives. Clinical andrology, 23:893-922.

D. Alfred Adewuyi, Ph, D, Peter Ogunjuyigbe Ph. (2016). The Role of men in family planning: An Examination of men knowledge and attitude to contraceptive use among the Yorubas.

Derose L. F, Dodoo, N. EEzeh A.C. and Owuor, T. (2004). Does Discussion of Family planning improve knowledge of partner's Attitude Towards Contraceptive. International Family Planning Perspective 30:2

Dhami S, Sheikh A. (2000). The Muslim family: predicament and promise. West J Med 2000 Nov; 173(5):352–6.

Dixon-Meuller. (1999). Gender inequalities and reproductive health: Changing priorities in an era of social transformation and globalization. Belgium, International union for the Scientific Study of Population (Policy and Research).

Doe, Roseline Dansowaa. (2013). School of Public Health College osf Health Science Male Partner Involvement In Maternity Care In Ablekuma South District, Accra.

Draper J. (2000). Fathers in Making: Men, Bodies and Babies unpublished PhD Dissertation (Social Policy). Hull University of Hull: 2000

Drennam M. (1998). Reproductive health; new perspectives on men's participation: Population Report, series J. no. 46.

Dvorsky, George. (2008). Sentient Developments Institute for Ethics and Emerging Technologies.

Ghana demographic and health survey, 2014.

Green, Cynthia P., Sylvie I. Cohen, and Hedia Belhadj-El Ghouayel. (1995). Male Involvement in Reproductive Health, Including Family Planning and Sexual Health. Technical Report 28, United Nations Population Fund. New York: United Nations Population Fund.

Gudorf C. E. (2003). Contraception and abortion in Roman Catholicism. In: Maguire DC, ed. Sacred rights: the case for contraception and abortion in world religions New York: Oxford University Press;2003:55–78.

Hasna F. (2003). Islam, social traditions and family planning. ANS Adv Nurs Sci 2003;37 (2): pp 181–97.

Heinemann. (2005). Male Participation in family; A Review of Programmed. Approaches in the Africa Region. Paper presented at workshop on male participation, Banjul the Gambia,

Herndon N. (1992). Making Vasectomy Attractive, Network, 13, number 1. Family Health International, Research Triangle Park, North Carolina.

International Conference on Population and Development. (1996): Program of Action adopted at the International Conference on Population, Cairo 5-13 September 1994, New York, United Nations Population Fund.

International Planned Parenthood Federation. (1984). Male Involvcmnt in Family Planning**.** *73*- 76, 79-80.

LaHaye T, LaHaye B.(1998). Sane family planning In: The act of marriage: the beauty of sexual love. Grand Rapids, MI: Zondervan; 1998: 256–74.

LoPresti A. F. (2005). Christianity In: Manning C, Zuckerman P, eds. Sex and Religion. Toronto: Thomson Wadsworth; 2005:117–41.

Maguire D. C. (2001). Sacred choices: the right to contraception and abortion in ten world religions. Minneapolis: Fortress Press; 2001.

Mubita-Ngoma, C., & Kadantu, M. C. (2010). Knowledge and use of modern family planning methods by rural women in Zambia. Curationis, 33(1), 17-22.

National Population Report. (1994**).** National Population Policy (Revised Edition), Accra.

Nzioka, Charles. (2000). Research on men and the implications on the policy and program development in reproductive health, Sub Saharan Africa Region.80.

Omran A. R. (1992). Family planning in the legacy of Islam. New York: Routledge.

Ossou and Marie-Antioinette S .(2008). Attitude towards and use of knowledge about family planning among Ghanaian men.

Phillips, James F., Kubaje Adazu, Martin Adjuik, and Alex Nazzar.(1997). Denial of contraceptive use among known contraceptive adopters in a rural area of northern Ghana. Paper presented at the annual meeting of the Population Association of America, Washington, DC, 27–29 March.1997

Pennachio D. L. (2005). Caring for your Muslim patients. Stereotypes and misunderstandings affect the care of patients from the Middle East and other parts of the Islamic world. Med Econ 2005 May 6; 82 (9):46–50

Poston L**. (**2005)**.** Islam. In: Manning C, Zuckerman P, eds. Sex and religion. Toronto: Thomson Wadsworth; 2005:181–97.

Pleck and Sonenstein , (1995). The male role in family planning; what do we know? Commissioned paper for the committee on Unintended Pregnancy, Institute of Medicine. Washington, D.C. The urban Institute.

Palamuleni M. E**. (**2014). Demographic and Economic factors Affecting contraceptive use in Malawi; Journal of Human Ecology, 46(3); 331-341, 2014

Population Information Program: John Hopkins Centre for Communication Program, Baltimore, USA. (1998). New Perspectives on Men's Participation, Population Reports, 1998 Vol 26 (2),

Population Council. (1998). Getting Men Involved in Family Planning: Experience from an Innovative Program, Final Report, Dhaka.

Rashidi A. Rajaram S. (2001). Culture care conflicts among Asian-Islamic immigrant women in US hospitals. Holist Nurs Pract 2001 October; 16 (1):55–64.

Ringheim K. (1993). Factors that determine prevalence of use of contraceptive methods for men, studies in family planning, 1993, 24(2); 87-99.

Robey B, Ross J. & Bushan I. (1996). Meeting unmet need; New Strategies: Population Reports, 43:1-35, 1996.

Schenker J. G. (2000). Women's reproductive health: Monotheistic religious perspectives Intenational Journal Gynaecol Obstetric 2000; 70: 77–86.

Schenker JG, Rabenou V. (1993). Family planning: cultural and religious perspectives. Hum Reprod 1993;8 (6):969–76.

Stephenson, R., & Tsui, A. O. (2002). Contextual influences on reproductive health service use in Uttar Pradesh, India. [Article]. Studies in Family Planning, 33(4), 309-320.

Tirah Haruna. (2012). Kwame Nkrumah University of Science and Technology. College of Health Sciences. Predictors of Pospartum Family Planning Uptake: Understanding Providers and Potential Family Planning User Behavoir In The Wa Municipality of The Upper West Region, GHANA.

Wa Municipal Annual Report. (2014)

Williamson, L., Parkes, A., Wight, D., Petticrew, M., & Hart, G. (2009). Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research. Reproductive Health, 6 (1), 3.

WHO 2015 (2015b). World Contraceptive Use 2015 (POP/DB/CP/Rev2015). Available from www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2015.shtml. Accessed 28 May 2015.

Wrigley E. (1969). Population and history, London: Weidenfeld and Nicholson.

APPENDIXES

8.1 QUESTIONNAIRE ON MALE KNOWLEDGE AND ATTITUDE THAT INFLUENCE PARTNER USE OF MODERN FAMILY PLANNING SERVICES.

QUESTIONNAIRE

TOPIC: MALE ATTITUDE TOWARDS FAMILY PLANNING

INSTRUCTIONS: Tick or circle your choice(s) from the options given. Also supply the answer where options are not provided to choose from.

(REMINDER ABOUT ELIGIBILITY: MALE MARRIED OR WITH AT LEAST ONE CHILD)

SECTION A: DEMOGRAPHIC OR BACKGROUND INFORMATION

1	Age		I__I__I	AGE
2	Highest completed educational level	*1. None 2.Primary 3.Middle/JSS 4.SSS/SHS/Vocational 5. Tertiar/Poly, 6. Other:_____*	____	EDU
3	Ethnic group	*1. Waali/Dagaari, 2Fanti 3 Akan 4. Other(_____)*	____	ETHI
4	Religion	*1. Christian, 2.Muslim, 3.Traditionalist, 4.Other (_____)*	____	RELI
5	Occupation	*1. Taxi-driver 2. Trader 3.Student 4.Other(_____)*	____	OCU
6	Number of children		I__I__I	CHIL
7	How old is your last child?		I__I__I	CHIT
8	Marital status	***1**-Married* ***2**-Engaged, yet to be married* ***3**-Co-habitation (living together)* ***4**-Divorced/Separated/Widowed* *5-Single* ***6**-Other:_____ _____)*	____	MAS

SECTION B: ATTITUDE OF MEN TOWARDS MODERN CONTRACEPTIVE USE

1	What do you think about the promotion of FP?	**1**) It is good and has to be promoted **2**) It is not good and has to stop **3**) I am indifferent about it	I__I	PFP
2	Do you approve of the use of FP to stop pregnancy	*1-Yes 2 – No 3-Not sure*	____	AFP

SECTION D: KNOWLEDGE AND USE OF VARIOUS CONTRACEPTIVE METHODS

		AWARENESS	HAVE YOU OR YOUR PARTNER IN THE PAST USED THIS METHOD?	
1	**PILL** (Women can take a pill every day to avoid becoming pregnant)	1. Yes 2.No I____I	1. Yes 2.No I____I	PILL1 PILL2
2	**IUD** Women can have a loop or coil placed inside them by a doctor or nurse	1. Yes 2.No I____I	1. Yes 2.No I____I	IUD1 IUD2
3	**INJECTABLES** Women can have an injection by a health provider that stops them from becoming pregnant for one or more months	1. Yes 2.No I____I	1. Yes 2.No I____I	INJ1 INJ2
4	**IMPLANTS** Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	1. Yes 2.No I____I	1. Yes 2.No I____I	IMP1 IMP2
5	**CONDOM** Men can put a rubber sheath on their penis before sexual intercourse.	1. Yes 2.No I____I	1. Yes 2.No I____I	CON1 CON2
6	**FEMALE CONDOM** Women can place a sheath in their vagina before sexual intercourse.	1. Yes 2.No I____I	1. Yes 2.No I____I	CON1 CON2
7	**DIAPHRAGM** Women can place a thin flexible disk in their vagina before sexual intercourse	1. Yes 2.No I____I	1. Yes 2.No I____I	DIA1 DIA2
8	**FOAM OR JELLY** Women can place a suppository, jelly, cream in their vagina before sexual intercourse.	1. Yes 2.No I____I	1. Yes 2.No I____I	FOM1 FOM2
9	**RHYTHM (CALENDAR) METHOD** Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	1. Yes 2.No I____I	1. Yes 2.No I____I	RHY1 RHY2
10	**WITHDRAWAL** Men can be careful and pull out before climax.	1. Yes 2.No I____I	1. Yes 2.No I____I	WITH1 WITH2
11	**EMERGENCY CONTRACEPTION** As an emergency measure after unprotected sexual intercourse, women can take special pills at any time within five days to prevent pregnancy	1. Yes 2.No I____I	1. Yes 2.No I____I	EME1 EME2

SECTION E: ATTITUDES TOWARDS FAMILY PLANNING

1	Have you ever received FP counseling from a health worker?	*1. Yes 2.No*	I____I	REC
2	Is you or your partner currently using any family planning method?	*1. Yes 2.No*	I____I	USG
3	Do you currently feel that you and your spouse need to use a FP method?	*1. Yes 2.No*	I____I	NED
4	If you were to choose a FP method with your partner which three of these reasons will most influence you choice of method?	**1**).Availability *I____I* **2**). Cost *I____I* **3**). Reliability *I____I* **4**). Safety *I____I* **5**).Privacy *I____I* 6.) Effect on sexual pleasure *I____I* **7**). Ease of use *I____I* **8)** Health worker advice *I____I* **9**).Friend's opinion *I____I* **10**). My partner will decide for herself *I____I* **11)***. Reversibility I____I* **12**). Other *I____I*		INF1 INF2 INF3
5	Where do you MOSTLY get information on family planning?	*1. Radio,* *2. TV* *3. Internet* *4. Posters* *5. Health workers* *6. Church,* *7. Other _____)*	I____I	INFO
6	Where do you (and your partner) MOSTLY get the contraceptive services from?	***1****. Hospital,* ***2****. Health Ctr* ***3****. CHPS Cpd* ***4****. Pharmacy* ***5****. Health worker friend, 6. Other_____)*	I____I	WHE

7	When was the last time you discussed FP with your partner	*1. Less than 1yr ago,* *2. Between 1-3 yrs ago* *3. More than 3 yrs ago* *4 – Can't remember* *5 – Never discussed before*	I____I	LAST
8	Have you and your partner attended FP counseling sessions together?	*1. Yes,* *2. No*	I____I	ATT
9	If your partner asked you to accompany her to a FP counseling session, how willing will you be to accompany her?	*1. Willing,* *2. Not sure* *3. Not willing*	I____I	ACCO
10	If you were invited by a health worker, to accompany your partner to a FP counseling session, how willing will you be to go?	*1. Willing,* *2. Not sure* *3. Not willing*	I____I	CHIL
11	Have you ever accompanied your partner to antenatal clinic in the past?	*1. Yes,* *2. No* *3-Not applicable*	I____I	EVER
12	If you partner got pregnant (or is pregnant now) would you be willing to accompany her to antenatal clinic?	*1. Yes,* *2. No* *3-Not applicable*	I____I	ANC
12b	**If NO, please explain why:**			
13	Will you be willing to pay for the cost of FP provided to your partner	*1. Yes,* *2. No* *3-Not sure*	I____I	PAY
14	How worried will you be that if your partner used FP, she will sleep with other men?	*1. Very worried,* *2. Somewhat worried* *3. Worried* *4. Not worried* *5. "My wife won't do that"*	I____I	SLE
15	How worried will you be if you found out that your partner was using a FP method and you were not aware of it?	*1. Very worried,* *2. Somewhat worried* *3. Worried* *4. Not worried* *5. "My wife won't do that"*	I____I	WOR
16	Would you consider divorce if you found out that your partner was using a FP method and you were not aware of it?	*1. Yes,* *2. No* *3-Possibly*	I____I	DIVO

17	How many wives do you have		I____I	WIVS

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Dear Sir/Madam,

LETTER OF INTRODUCTION

We write to respectfully introduce to you Mr. Martin Kangmennaang (Student Identification number 157100058), a second year student of the Master of Public Health (MPH) degree program of the College.

As part of his graduation requirements, Mr. Martin Kangmennaang is writing a thesis on: **Male knowledge and attitude that influence partner use of modern family planning in Upper West Region.**

He has indicated that the research methodology he will use for the study is structured questionnaires to drivers from some selected lorry stations.

The student seeks to conduct a confidential and anonymous study and also seeks the consent of the individuals involved.

We would be grateful if you kindly accede him any assistance he may require in this regard.

Thank you.

Respectively yours,

Dr. Christopher N. Tetteh
Dean/ Head of Institution

Cc: The Station Master
Bamahu Lorry Station

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