ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG EASTERN REGION, GHANA

MALE ATTITUDE TOWARDS FAMILY PLANNING IN THE TEMA METROPOLIS

by

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Declaration

I hereby certify that except for reference to other people's work, which I have duly cited, this Project submitted to the Department of Community Health, Ensign College of Public Health, Kpong is the result of my own investigation, and has not been presented for any other degree elsewhere.

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Dedication

This work is dedicated to my lovely wife Mrs. Barbara Baddoo and daughter Dawn Naa Ashardey Djormo Baddoo for their kind support, prayers and understanding.

Acknowledgement

I thank God Almighty for seeing me through this program successfully. I am very grateful to my sister Mrs. Patience Gbadam for supporting me through the MPH program. I am also grateful to the Management and staff of Fresh Spring Chemist, Tema whose facility was used for the research, for their support and contributions. I am also grateful to my supervisor Dr. Stephen Manortey for his commitment and contribution towards the successful completion of this research. Finally am grateful to all who contributed in diverse ways to make this research a success.

Definition of Terms

Definitions of some Main Concepts

Male involvement: It's the use of male contraceptive, including men who encourage and support their partners and their peers to use family planning and who influence the policy environment to be more conducive to developing male related programmes.

Partner Communication: When a man or woman holds regularly discussion with their partners about family planning and agree that decisions on the use of family planning should be made together.

Knowledge of Family Planning Methods: A man is said to have knowledge of family planning methods if he mentions the method spontaneously or after description by an interviewer.

Approval of Family Planning: A man is said to approve of family planning when he has a positive attitude towards family planning and responds in the affirmative to a question regarding approval of family planning.

Total Fertility Rate (TFR): is defined as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the current age-specific fertility rates.

Contraceptive prevalence rate: Measures the proportion of women of reproductive age (WRA) who are using (or whose partner is using) a modern method of family planning at a particular point in time.

Abbreviations

AIDS : Acquire Immunodeficiency Syndrome

AOR : Adjusted Odds Ratio

CBD : Central Business District

CPR : Contraceptive Prevalence Rate

DHS : Demographic and Health Survey

FP : Family Planning

GDHS : Ghana Demographic and Health Survey

GIMPA : Ghana Institute of Management and Public Administration

HIV : Human Immunodeficiency Virus

ICPD : International Conference on Population and Development

IE&C : Information, Education and Communication

IUD : Intra Uterine Device

JSS : Junior Secondary School

KNUST : Kwame Nkrumah University of Science and Technology

LI : Legislative Instrument

MLE : Measurement, Learning & Evaluation

OR : Odds Ratio

PHC : Population and Housing Census

SDGs : Sustainable Development Goals

SHS : Senior High School

SSA : Sub-Saharan Africa

SSS : Senior Secondary School

STD : Sexually Transmitted Disease

TFR : Total Fertility Rate

UNDESA : United Nations Department of Economics and Social Affairs

WHO : World Health Organization

Abstract

One factor that might contribute to the lack of success of the African population control programmes may be that they tend to be directed towards women only, ignoring the role of men in contraceptive decisions. Male involvement in family planning methods can increase its uptake and continuation by improving spousal communication through pathways of increased knowledge or decreased male opposition. This study assessed the attitude of men towards Family Planning in the Tema Metropolitan Area in the Greater Accra Region of Ghana.

The study was cross-sectional and employed quantitative methods. The study population consisted of both married men and men with at least one child. The study involved 400 randomly selected respondents. Quantitative data was collected through interviewing with structured questionnaires. All data analysis was done using STATA statistical software.

Awareness of contraceptive methods was high among men in the Tema Metropolis, however, use was low. The media was the most cited source of information on family planning. An association of socio-demographic variables revealed that age and marital status were significantly associated with modern family planning use ($P< 0.05$). Respondents who were single have an increased odds of practicing family planning as compared to those who are engaged but not yet married (AOR =6.75;$p<0.05$) adjusting for all other covariates in the predictive model. Having a prior discussion regarding contraceptives with partners was found to be significantly associated with the practice of family planning ($p<0.05$).

Men can play an important role in family planning either by their active use of contraceptives or by supporting their partner's use of contraceptive methods. Therefore, males supporting their partners will also help in better acceptance, correct use and compliance to family planning methods.

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1.0 Introduction

The goal of family planning is to assist couples and individuals of reproductive age to achieve their reproductive goals and improve their general reproductive health (GDHS, 2014). Family planning remains one of the most cost effective public health measures available in developing countries (Prosser *et al*., 2005). Use of family planning is associated with lower rates of maternal and infant mortality and can influence economic growth in the long term. Expanding access to and improving the quality of family planning programs around the world is central to improving and maintaining the health of individuals and societies and helping them reach their full potential (Prosser *et al*., 2005).

Contraceptive usage being one of the needs of today's age, necessitates equal involvement of both men and women, but most studies conducted in developing countries regarding fertility control, had mainly concentrated on the women's responses and males were totally ignored in the past. Although, men played a major role in the decision and use of contraceptives, very few efforts had been made in the past to directly involve them in family planning programs (Decarlo *et al*., 1996). The major barriers to include men in family planning services were the limited funds for male services, predominantly female staff in family planning clinics, negative staff attitude and lack of staff training to better handle men involved in family planning (Forrest, 1987). However, it had been realized in recent years, the need to include men and draw conclusions based on direct responses. Female focused studies had therefore suggested husbands' opposition as a major obstacle in fertility control endeavours. Kamal and Fowler (1991) also reported male's attitude to be one of the obstacles in contraceptive use (Maan *et al*., 2003).

Most family planning programs targeted women and associated interventions often designed to address and mitigate barriers to the use of family planning services. According to (Cleland *et al*., 2010), attitudinal resistance remained a barrier to access contraceptives. Many studies and interventions had been done to increase the use of modern family planning methods among women but however the progress was still low.

A study by (Tawiah, 1997), asserted that the effectiveness and utilization of modern family planning methods among women was poor due to lack of approval from their partners or husbands. The roles and responsibilities of men in the use of modern family planning methods and fertility regulations had been ignored, understudied and underutilized, yet sociological factors such as culture and religion were in favour of men as decision-makers both at family and community levels (Wadembere, 2013).

Strengthening communication between partners about reproductive health and proactively involving men in health promotion could lead to better health for the entire family. In recent years the importance of including men in reproductive health matters had received increasing recognition.

1.1 Background

Fertility and population growth rates were much higher in sub-Saharan Africa than in any other region of the world (Clelan*det al*., 2010). There were concerns that uncontrolled population growth would hinder the attainment of development and health goals in Africa unless fertility declined through the adoption of effective modern contraceptive methods, as witnessed in other parts of the world (Cleland *et al.*, 2010).

One of the notable reasons why family planning in Asia had been relatively more successful than in sub-Saharan Africa was that, Asia had experienced significant economic change (Duze *et al*., 2007). In addition, vigorous population campaigns in the region had involved local community leaders and other influential people. The campaigns were aimed at creating the desire to limit family size and to provide contraceptives and family planning services as a means of controlling fertility (Duze *et al*., 2007).

Similar efforts had gained momentum in sub-Saharan Africa but with little results. Early marriage and low levels of contraceptive use continued to be normative. One factor that might contribute to the lack of success of the African population control programmes may be that they tend to be directed towards women only, ignoring the role of men in contraceptive decisions (Duze *et al*., 2007).

In Africa especially Nigeria, women were the primary target for family planning programmes but there was growing recognition that reproductive health was the joint responsibility of men and women (Kabagenyi *et al*., 2014). Men were key persons in the reproductive decision-making process and their decisions had profound influence on women's health (Berhane *et al*., 2011). Male involvement in family planning methods could increase its uptake and continuation by improving spousal communication through pathways of increased knowledge or decreased male opposition (Kabagenyi *et al*., 2014). Since in some cultures male significantly influences the choice of birth control methods, birth number, birth sequencing, and timing, along with an opinion regarding the birthing method (Porche, 2012).

However, male involvement was not only restricted to the uptake of male family planning methods but also included the number of men who encouraged and supported their partners and their peers to use family planning. It also involved the influencing of policy environment to be more conducive to development of male related programs. Therefore, male involvement

should be understood in all organizational activities whose main aim is to increase the prevalence of contraceptive for either gender (Green *et al*., 2003). However, traditional beliefs, religious barriers and lack of male involvement had weakened family planning interventions (WHO, 2012;Oluwatosin *et al*., 2015).

Gearing Family Planning programmes towards women as noted by Freedman *et al*, (1987) might have seemed pragmatic and cost effective at the time, but it failed to take into account that men frequently held the contraceptive decision-making power (Joesoef *et al*., 1988; WHO, 1982). Ignoring the role that men played in this area may have contributed to the halt in the rise of contraceptive prevalence in some parts of the world, and has certainly led to a growing dissatisfaction among women about the disproportionate burden they had to bear for contraception.

In its Plan of Action, the 1994 International Conference on Population and Development (ICPD) acknowledged that men had been by-passed by Family Planning programmes and needed to be reintegrated into sharing jointly the responsibility for contraception (Adelekan *et al*., 2014).

The 2014 Ghana Demographic Health Survey (GDHS) assessed male respondent's attitudes towards contraception by asking men age 15-59 whether they agreed or disagreed with two statements about family planning use: 1) contraception was a women's business and a man should not have to worry about it; and 2) women who used contraception may become promiscuous. The results on attitudes towards family planning showed that the majority of Ghanaian men age 15-59 thought that men should take some responsibility towards family planning, with 73 per cent of the men rejecting the statement that contraception was a woman's business and that man should not have to worry about it. However, 24 per cent of the men agreed with the statement, and 3 per cent said they "don't know". Regarding the

statement that women who used contraception may become promiscuous, 46 per cent of the men agreed with the statement and 49 per cent disagreed, and 5 per cent of men said that they "don't know"(GDHS, 2014).

1.2 Problem statement

One of the major ways to reduce the population growth and achieve the set target was through the encouragement of the use of modern family planning methods. Contraceptive prevalence in Ghana which was 27 per cent would increase to 57 percent if all currently married women who say they want to space or limit their children were to use a family planning method (Akafuah *et al*., 2008).

However it's been very difficult to achieve this target because there was a growing recognition in Ghana that men played a significant and influential role in reproductive decision-making and family planning practices. According to Piotrow & Rimon (1997), many family planning managers had seen men as obstacles to women's use of contraceptives due to power differentials, conflicting gender roles, and lack of economic resources and these factors had prevented many women from effectively negotiating use of contraceptives and safer-sex practices with their male partners. Qualitative research found the macho stereotype of men as the barrier that prevented men from learning more about family planning (Piotrow & Rimon, 1997;Akafuah *et al*., 2008).

1.3 Justification of the study

Evidence has shown that programs targeting men should develop messages focused on the economic and health benefits of limiting births (Shattuck *et al*., 2011). There had been a slight

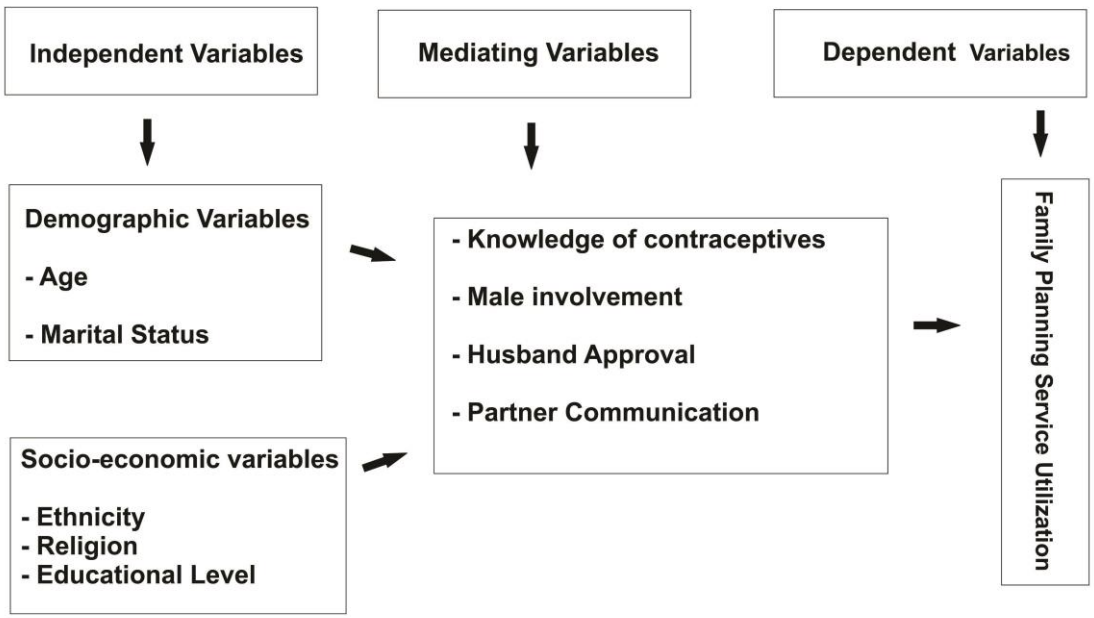
increase in the Total Fertility Rate (TFR) in Ghana over the past six years, from 4.0 to 4.2 children per woman. The contraceptive prevalence rate in Ghana was 27 percent and the unmet need for family planning was 29.9 percent which were quite low resulting in the increase in the population growth (GDHS, 2014).

In Ghana, as in the rest of sub-Saharan Africa, there was a substantial need to improve family planning uptake. Fresh Spring Chemist located in the central business area of the Tema metropolitan area was selected because Tema being an industrial hub of Ghana draws people from different parts of the country hence its population represent a fair sample of the Ghanaian population, in terms of representation of ethnic backgrounds, religions and level of education.

1.4 Conceptual Framework

Male attitude influence family planning service utilization as depicted in the conceptual framework below (Figure 1.1).

Figure 1.1: Male attitude that influence family planning utilization



Source: Adapted from Gizaw and Regassa (2011)

The conceptual framework shows an understanding of how male attitude affect family planning service utilization. The framework was adapted by the investigator from (Gizaw and Regassa, 2011) through the exhibition of knowledge on the issue in the study. Men generally are known to show little or no interest in family planning and use of its commodities. Recent studies suggested that well oriented programs focused on participation, encourage usage, more responsible sexual behaviour, increase contraceptive usage, and better communication between partners (Green *et al*., 1996).

1.5 Research Question

I. Do men know about family planning and its methods?

II. Do men support their partners in the use of modern family planning methods?

III. Do men generally discuss family planning with their partners?

1.6 Primary Objective

This study therefore seeks to assess the attitude of men towards family planning in relation to knowledge, involvement and practice of family planning.

1.7 Specific Objectives

- To assess the knowledge and use of modern family planning methods among men of reproductive age.
- To determine the level of male support in the use of contraceptives.
- To assess spousal communication regarding family planning.

1.8 Profile of the Study Area

The Tema Metropolis was created from the erstwhile Tema Municipality in 2007 with the promulgation of Legislative Instrument (LI) 1929. In 2012, the Kpone-Katamanso Sub-Metropolitan Council was carved out of the Tema Metropolis to establish the Kpone-Katamanso District. The Tema Metropolis had three Sub-Metropolitan Councils namely; Tema West, Tema East and Tema Central.

Tema Metropolis was a coastal district situated about 30 kilometres East of Accra, the capital city of Ghana. It shared boundaries in the northeast with the Dangme West District, southwest by Ledzokuku Krowor Municipal, north-west by Adentan Municipal and Ga East Municipal, north by the Akwapim South District and south by the Gulf of Guinea. The Ashiaman Municipal was an in-lock enclave within the Tema Metropolis. The Metropolis covered an area of about 87.8 km2.

The Greenwich Meridian (i.e. Longitude 0º) passed through the Metropolis, which meets the equator or latitude 0° in the Ghanaian waters of the Gulf of Guinea. The Metropolis proximity to the sea with its low lying terrain which projected into the sea makes it a natural endowment for a harbour. This evidently informed the decision of the construction of the Tema Harbour in 1957, making the Metropolis "the Eastern Gateway of Ghana".

The culture of the people of Tema was seen in their way of life. These include inherited ideas, beliefs, values and knowledge. Since culture was dynamic, some practices of the people had undergone changes over the years. The original settlers of Tema were the Ga-Dangmes. However, because it was a popular destination of migrants, several ethnic groups could be found here. The dominant ethnic groups were the Akan, Ga-Dangme and Ewe. Other fairly well represented groups were the Mole-Dagbani and the Guans. The diverse nature of the inhabitants fostered interethnic tolerance and social solidarity that had promoted peace and harmony in the district. This had also reduced ethnocentrism.

The traditional festivals celebrated by the people were Kpledzoo and Homowo. "Kpledzoo" celebrated between March and April whiles "Homowo", which literally means hooting at hunger was celebrated from August to September every year. The religious composition of the Metropolis population was diverse since the inhabitants were of varied background. Prominent amongst them were Christians, Islam and West Africa Traditional religion.

Tema had both public and private health facilities that were spread across the entire Metropolis and their classification by type of facility was based on their functions and the range of services they provided. The total number of health facilities in the public sector was 46 (54.2%), was higher than that of private health facilities 16 (38.9%).

The Metropolis had many public and private tertiary and pre-tertiary educational institutions with one full fledge private university, the Datalink University, and satellite campuses for four other universities, namely, Methodist University, Presbyterian University, Ghana Institute of Management and Public Administration (GIMPA) and Kwame Nkrumah University of Science and Technology (KNUST).

The Metropolitan Area served as the industrial hub of Ghana with over 500 industries that produce chemicals, clothing, consumer electronics, electrical equipment, furniture, machinery, refined petroleum products, steel and tools. The country's biggest port and harbour facilities were located in Tema.

Basically, there are four types of commercial transport systems in the Metropolis; these are bus, commercial vehicles "trotro", shared and hired taxi services. All transport activities both within and intercity, originates and terminates at the various vehicle terminals and station at Community One which is also the central business district (CBD) of the Metropolis.

Tema metropolis had a Total Fertility Rate of 2.3 (GSS, 2014). However there was not much information on the contraceptive prevalence rate and the unmet need for family planning in the metropolis.

1.9 Organization of the report

The study was organized into six chapters. Chapter One covered the introduction, background of the study, statement of the problem, justification, objectives, research questions, and

background of the study area. Chapter Two reviewed related literature by other scholars with respect to the specific objectives. Chapter Three provided the methodology by which the study was conducted. Chapter Four dealt with the findings of the study while Chapter Five discussed the findings. Chapter Six dealt with the conclusions and recommendations, after which the references followed.

Chapter 2

2.0 Literature Review

2.1 Introduction

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through the use of contraceptive methods and the treatment of infertility. A woman's ability to choose when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion reducing infant mortality (WHO, 2016).

Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

2.1.1 Contraceptive use

Contraceptive use had increased in many parts of the world, especially in Asia and Latin America, but continued to be low in sub-Saharan Africa (WHO, 2016). Globally, use of modern contraception had risen slightly, from 54% in 1990 to 57.4% in 2015(WHO, 2016). Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive

method had risen minimally or plateaued between 2008 and 2015(WHO, 2016). In Africa it went from 23.6% to 28.5%, in Asia it had risen slightly from 60.9% to 61.8%, and in Latin America and the Caribbean it had remained stable at 66.7% (WHO, 2016).

Use of contraceptives by men made up a relatively small subset of the above prevalence rates. The modern contraceptive methods for men were limited to male condoms and sterilization (vasectomy) (WHO, 2016).

2.1.2 Global unmet need for contraception

An estimated 225 million women in developing countries would like to delay or stop childbearing but were not using any method of contraception (WHO, 2016). Reasons for this included:

- limited choice of methods;
- limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people;
- fear or experience of side-effects;
- cultural or religious opposition;
- poor quality of available services;
- users and providers bias
- lack of spousal support.

The unmet need for contraception remained too high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 24.2% of women of reproductive age had an unmet need for modern contraception (WHO, 2016). In Asia, and Latin America and the Caribbean – regions with relatively high contraceptive prevalence –

the levels of unmet need were 10.2 % and 10.7%, respectively (Trends in Contraception Worldwide 2015, UNDESA) (WHO, 2016).

Other secondary benefits of family planning programs included prevention of sexually transmitted diseases(STDs) and HIV through promoting condom use besides preventing unwanted pregnancies among HIV-positive women hence averting mother-to-child transmission (Malalu, 2014).

More than half a million women, nearly all of them in the developing world, die each year in pregnancy or childbirth. This amounted to one every minute. Another million suffered serious, sometimes permanent pregnancy-related injuries. Much of this suffering and death could be prevented through effective family planning engendered by modern contraceptives. Contraceptive use protected women from the health risk of unwanted pregnancies and gives women control over their lives. The principal effort in population control is family planning, which aims at communicating to a society the desirability of limiting family size for economic, social and maternal health reasons (Mairiga *et al*., 2010).

At the 2012 London Summit on Family Planning, donors and national governments committed to providing access to modern contraceptives by 2020 to an additional 120 million women around the world who have unmet need for family planning, as well as to focusing on the human rights of women and girls and to launching a reinvigorated global platform for achieving universal access to family planning. Yet this renewed commitment also highlighted the challenges of achieving universal access to family planning, including in countries such as Rwanda that had seen impressive gains.

In spite of these gains, there remained high unmet need for contraception, as 19% of married women, and households continued to face barriers to accessing quality family planning

services, including physical access, cost, lack of accurate information, limited knowledge, side effects, and partner communication.

In order to increase uptake and promote retention in family planning programs, it was critical to understand local perspectives on birth, fertility, contraception, and family composition (Farmer *et al*., 2015).

In developing countries, research indicated that the number of women wanting to avoid pregnancy and therefore needing effective contraception, increased substantially, from 867 million (57%) to 1520 million in 2012 (Tilahun *et al*., 2014). However, the unmet need for modern contraceptives was still very high, particularly in sub-Saharan Africa, south Asia, and western Asia. Although it remains a real challenge to ensure consistent access to family planning services, evidence from Demographic and Health Survey (DHS) data shows that it was men's attitude towards contraception that was a more important barrier to overcome (Tilahun *et al*., 2014).

The low uptake of modern family planning methods in Sub-Saharan Africa including Ghana was associated with high incidence of unintended pregnancies, unsafe abortions, and maternal deaths. Evidence exists that if couples could space their pregnancies by at least two years apart through the use of family planning, up to 35% of maternal deaths and up to 13% of child mortalities could be averted, whilst 25% of under –five mortalities could be averted if birth intervals were at least three years (Eliason *et al*., 2014). The cost-effectiveness of family planning in poverty reduction and socio-economic development in the developing world could not be disputed.

Male involvement in reproductive health(RH) services utilization encompasses the way men accept and indicate support to their partners' needs, choices and rights including using contraception and their own reproductive and sexual behaviour to promote observance of

human rights and the need to enforce equity. Consequently, it was particularly relevant in male-dominant cultures where men already have an all-encompassing involvement in decisions pertaining to family and society (Kassa *et al*., 2014).

Research suggested that male involvement could increase uptake and continuation of family planning methods by improving spousal communication through pathways of increased knowledge or decreased male opposition(Hartmann *et al*., 2012). Yet, despite growing evidence on the benefits of engaging men in reproductive health decision-making, fertility rates and unmet need for family planning remained high in many sub-Saharan African countries. While there are many influential factors, low contraceptive prevalence has been attributed in part to men's opposition to or non-involvement in family planning (Kabagenyi *et al*., 2014).

Male engagement has historically been depicted as obstructive by impeding women's decision-making on use of family planning, or non-existent among male partners who were absent altogether due to lack of interest in matters related to reproductive health. However, at the same time, men dominate decision-making regarding family size and their partner's use of contraceptive methods in many traditionally patriarchal settings. Women point to their male partner's resistance to family planning as a significant barrier to uptake and continuation, resulting in decisions to use contraceptive methods covertly or not at all (Mosha *et al.*, 2013).

Fear of spousal retaliation due to disagreements about whether to use contraception had also been shown to be a significant barrier among women. This seemingly contradictory role among men of being both key decision makers regarding fertility desires and remaining detached from reproductive health issues had posed considerable challenges in African contexts to involve men to address the low contraceptive prevalence rates.

Studies conducted in African contexts have found that limited knowledge about family planning was a key determinant of men's negative perception of and lack of engagement in family planning as well as gender norms regarding men's roles (Kabagenyi *et al*., 2014).

Renewed interests in involving men stem not only from women's reproductive health needs, but also to address men's own sexual health concerns, as well as efforts to achieve the Sustainable Development Goals (SDGs) to ensure healthy life and promote wellbeing and also to promotes gender equity and empower all women.

Provision of appropriate contraceptive knowledge was essential to enhance male participation in reproductive health. It was now increasingly recognized that the actions required to achieve improvements in family planning should also encourage the active participation of men, hence exploring the role of husband's contraceptive practices was particularly important (Rekha *et al*., 2015).

2.2 Spousal communication

Previous studies conducted in Ghana and Nigeria suggested that spousal communication predicted contraceptive use, and available evidence shows that women whose partners disapprove of modern contraceptive practice were unlikely to use them (Ezeanolue *et al*., 2015). In Ethiopia, barriers to women's unmet need for contraception include their husbands' opposition, religion, poor knowledge, and lack of communication between spouses. Many family planning programs in these settings were designed with no consideration for the role of men in influencing their female partner's contraceptive decision making (Ezeanolue *et al*., 2015).

Promoting spousal discussion of family planning had frequently been advocated as a viable policy tool for narrowing the gender gap in partners' fertility intentions in developing countries (Owuor *et al.,* 2004). Discussion between spouses was expected to increase contraceptive use, because a sizable minority of women cited their husband's disapproval of contraception as the reason for non-use, despite having never discussed family planning with their husband (Bongaarts *et al*., 1995).

Researchers had argued that women who reported infrequent discussion may, in fact, wrongly perceive that their partner disapproves of family planning, and may therefore feel inhibited from using a method. This line of reasoning was supported by empirical research conducted in a wide range of contexts, which shows that spouses who had discussed the topic are 2–10 times as likely as those who had not to practice contraception (Owuor *et al*., 2004).

Another empirical study conducted by Manortey *et al.* reported a statistically significant evidence of association between contraceptive usage among reproductive aged women and they having had prior open discussion with their sexual partners (Manortey *et al*., 2017).

2.3 Myths and Misconceptions

Another important barrier to contraceptive use was the myths and misconceptions about modern methods, such as exaggerated or erroneous reports about side effects, misconceptions about short- or long-term health problems and negative stereotypes about persons who practice family planning. Myths and misconceptions about methods could spread through informal communication via social networks and might lead to continued negative perceptions. Data from the Measurement, Learning & Evaluation (MLE) project from Kenya, Nigeria and Senegal demonstrated high levels of misinformation about family planning in

urban areas. In MLE baseline surveys conducted between 2010 and 2011, at least half of the men interviewed in six cities in each of the countries where the project was carried out believed that contraceptive users would have health problems (Gueye *et al.,* 2016).

Inadequate and incorrect knowledge of modern contraceptives had been associated with low method uptake and use; however, even in settings where knowledge of family planning is high, myths and misconceptions were associated with low demand for and use of contraceptives (Gueye *et al.,* 2016).

Studies conducted in African contexts had found that limited knowledge about family planning was a key determinant of men's negative perception of and lack of engagement in family planning as well as gender norms regarding men's roles. Some studies suggested also that spousal communication was low even in cases where men approve of family planning (Kabagenyi *et al*., 2014).

Despite these initial findings, less was known regarding the full range of men's perception towards male and female contraceptive use.

To address this gap, this study examined views regarding men's involvement, as evidenced by partner communication, approval, support, or utilization of family planning methods and its implications for future research and intervention design.

Understanding the role of men in their spouses' contraceptive decision-making could contribute to efforts aimed at increasing uptake of contraception in Ghana and other African countries.

Chapter 3

3.0 Methodology

3.1 Study Area

Fresh Spring Chemist is both wholesale and retail pharmacy located within Community One which happens to be the central business district (CBD) of the Tema Metropolis. Community one is home to the Central market in the metropolis where inhabitants from the various "*Communities*" in the metropolis come to conduct daily businesses, as well as obtain their health needs. Fresh Spring Chemist is a one stop pharmacy that attracts a lot of clientele within the Tema Metropolis. Men who entered the pharmacy to transact business were targeted for the study.

3.2 Study Method and Design

A cross-sectional study design was employed for the study. The study was conducted between January and February 2017 and it adopted the quantitative approach which provided the option to examine the relationship between variables.

3.3 Data Collection Technique and Tools

A well-structured questionnaire comprising open and close ended questions was administered to participants to obtain information using a local language that they very well understood. However, for those who could read, the questionnaire was given to them to provide their views.

3.4 Study Population

The study population included both married and unmarried men with at least one child. Also, for one to be included, he must be an adult resident of the metropolis and must have made a continuous stay for at least a year. Any male that fell outside this category was excluded from the study. In Ghana, men by their role as heads of households, were known to significantly contribute in the decision making process on the usage of contraceptives. Hence the study seeks to assess the attitude of men towards family planning.

3.5 Study Variables

The study examined some background characteristics of respondents such as age, level of educational, occupation and religion. Other variables which were studied include level of knowledge of the various modern contraceptive methods among men, attitude of men towards contraceptive use as well as male support towards family planning.

3.6 Sampling Techniques and Sample Size

The study selected 400 men based on the inclusion criteria using convenience sampling. The size of the sample was calculated using the sample size formulae as follows;

$$n = \frac{Z^2 p(1-p)}{e^2}$$

Where,

n = Sample size,

z = Critical value at 95% CI,

p = Contraceptive prevalence within the study area

e = Error margin (alpha level).

Using a contraceptive prevalence rate for the study area as 50% and an estimated margin of error of 5%, an expected sample size of 384 was derived. This was rounded off to 400 participants making room for non-response, missing or damaged questionnaires.

3.7 Pre-testing

The research tools for the study were pre-tested in Hem Pharmacy which was also located in Tema Community One. This allowed the researcher to make appropriate corrections prior to the total investment in the study. The pre-test moment also served as a learning period for the data collectors, as it offered the opportunity to learn some ethical considerations in dealing with men in respect to family planning as a subject of discussion.

3.8 Data Analysis

Data collected were checked for completeness. Data was then compiled and cleaned using Microsoft Excel version 2010. The cleaned data was then imported into STATA Statistical software package (Stata Corp. 2007.Stata Statistical Software Release 14: Stata Corp LP, College Station, TX USA) for analysis. Processed data from both univariate and multivariate analyses were presented in tables mostly in the form of frequencies and percentages and predictive models respectively. Prior choosing the independent variables for the predictive regression model, bivariate analyses were conducted on some selected categorical variables to test for their level of association with the dependent variable.

3.9 Ethical Consideration

Ethical approval was obtained from the Ethical Review Committee of the Ensign College of Public Health. Also, administrative approval was obtained from the leadership of Fresh Spring Chemist. Finally, an informed consent was sought from potential respondents prior to enrolling them in for interviews, in that, any information obtained from them would be securely protected and made available only to individuals authorized to use it. Participants were assured of total confidentiality from persons related to the study and the research team.

3.10 Limitations of the Study

The sample size used was so small that the findings of this study could not be generalized to all male residents in the Tema Metropolis, an area known to be the industrial city of Ghana. Secondly, this was purely a quantitative study which in no way could have elicited all detailed information which otherwise would be gathered from a qualitative research. Also, some information gathered from the respondents including their ages could not be verified with any documentation given the circumstance of recruitment. The only option left for the research was to use personal discretion to justify and accept such responses.

3.11 Assumption

The study upheld the assumption that;

1) the study population was representative of the total population and
2) the information given by the respondents were true.

Chapter 4

4.0 Results

In this cross sectional study, a well-structured questionnaire which included closed and open ends was administered to about 400 study participants. The study population included men who are married as well as unmarried men with at least one child and any male that fell outside this category was excluded from the study.

Table 4.1: Demographic characteristics of the respondents.

VARIABLE	FREQUENCY	PERCENTAGE (%)
Age Group		
18 – 24 yrs.	5	1
25 – 31 yrs.	66	17
32 – 38 yrs.	145	36
39 – 45 yrs.	103	26
46 – 53 yrs.	46	11
54 – 60 yrs.	27	7
61 - 68yrs	8	2
Educational Level		
None	4	1
Primary	15	3
Middle School /JSS	60	15
SSS/SHS /Vocational	114	29
Tertiary/Polytechnic	202	51
Other	5	1
Ethnic Group		
Akan	167	42
Ewe	91	23
Ga	80	20
Others	62	15
Religion		
Christianity	338	85
Islamic	41	10
Traditional	16	4
Other	5	1
Occupation		
Private Sector Worker	146	37

Self-Employed	146	37
Public Sector Worker	91	22
Unemployed	17	4
Marital Status		
Single	62	16
Married	254	64
Engaged, yet to be married	33	8
Divorced/Separated/Widowed	26	7
Co-habitation(living together)	25	6
Number of children		
1	125	31
2	120	30
3	71	18
4	48	12
>4	36	9
Age	Mean = (39yrs)	SD=(8.89)

Table 4.1 above, showed that, majority (145) representing about 36% of the total respondents were between the ages of 32-38 years. It was followed by respondents who fell within the ages of 39-45 years with a frequency 103, representing about 26%. The table also showed that respondents below 24 years represented only 1% of the responses.

It could also be observed that 320 of the respondents had at least senior high education representing about 81% at the time of the study, while primary and middle school represented about 18% of the responses and nearly 1% had no formal education.

Furthermore, table 4.1 showed the largest ethnic group of the respondents during the study to be the Akans with a frequency of 166 representing about 42%, while 23% of respondents were Ewes representing 90 responses. 20% representation was those from the Ga ethnic group whereas the other ethnic groups had about 15% representation.

338 of the total respondents were Christians, representing about 85% of the responses. Muslims and Traditionalist represented about 10% and 4% respectively; this was also shown in the table.

From table 4.1, it was deduced that 37% of the study participants were private sector workers as well as the same for self-employed participants. Meanwhile 22% were public sector workers and about 4% were unemployed.

Most respondents interviewed had at most 4 children representing about 91% with only 9% having more than 4 children. It was derived that about 64% of the respondents were married and 16% were single. 8% of responses came from respondents who were engaged but yet to get married and 6% of respondents lived together while 7% were divorced, separated or widowed.

4.1 Perception of Men towards Modern Contraceptive Method

This section sought to understand the attitude of respondents' perception about promoting family planning and if they approved of it to stop pregnancy.

Table 4.2: *Distribution of the promotion and approval of the use of family planning.*

Promotion of Family Planning		
Response	**Frequency**	**Percentage**
It is good and has to be promoted	284	71
It is not good and has to stop	89	20
I am indifferent about it	37	9
Approval of Family Planning		
Yes	274	69
No	86	21
Not Sure	39	10

When asked the question "*What they think about the promotion of family planning?"* 71% of the respondents reported family planning was good and had to be promoted while about 20%

said it was not good and had to stop. About 9% of respondents however, were indifferent about it. Also, from the above Table 4.2, it was realized that about 69% of those interviewed indicated approval of their partners of the use of family planning to stop pregnancy. About 21% of respondents said they don't approve due to religious beliefs, side effects and other reasons while 10% were indifferent about it.

4.2 Knowledge and use of various Contraceptive Methods

This section sought to determine the awareness and usage of some contraceptive methods, which were known and practiced by the male respondents (or their spouse), that is males who are married or single men who had at least one child.

Table 4.3: Distribution of respondents on contraceptive knowledge and it usage among men

	Knowledge		**Usage**	
Contraceptive Methods	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Male Condom	375	96%	278	71%
Withdrawal	360	92%	247	63%
Rhythm (Calendar)Method	347	89%	230	59%
Female Condom	340	87%	34	9%
Emergency	326	83%	174	44%
Pill	325	83%	82	21%
Injectable	324	83%	50	13%
Implants	283	72%	36	9%
IUD	231	59%	18	5%
Foam or Jelly	209	53%	45	12%
Diaphragm	191	49%	10	3%

From table 4.3, it was observed that majority of the respondents that is, 96% and 92% said they were aware of Male Condom and withdrawal respectively but 71% and 63% of them had actually used it; furthermore 49% of the respondents were aware of Diaphragm but only 3% had their spouse used it, which showed that even though close to 50% of the respondents were aware of it only a few used that method. Depicted in figure 4.2, an overwhelming proportion of the respondents had knowledge and used a male condom, withdrawal and rhythm in that order indicating the top three contraceptive method and the least methods practiced include the Diaphragm, Foam/jelly and the IUD.

Figure 4.1: Knowledge and use of various contraceptive methods among respondents

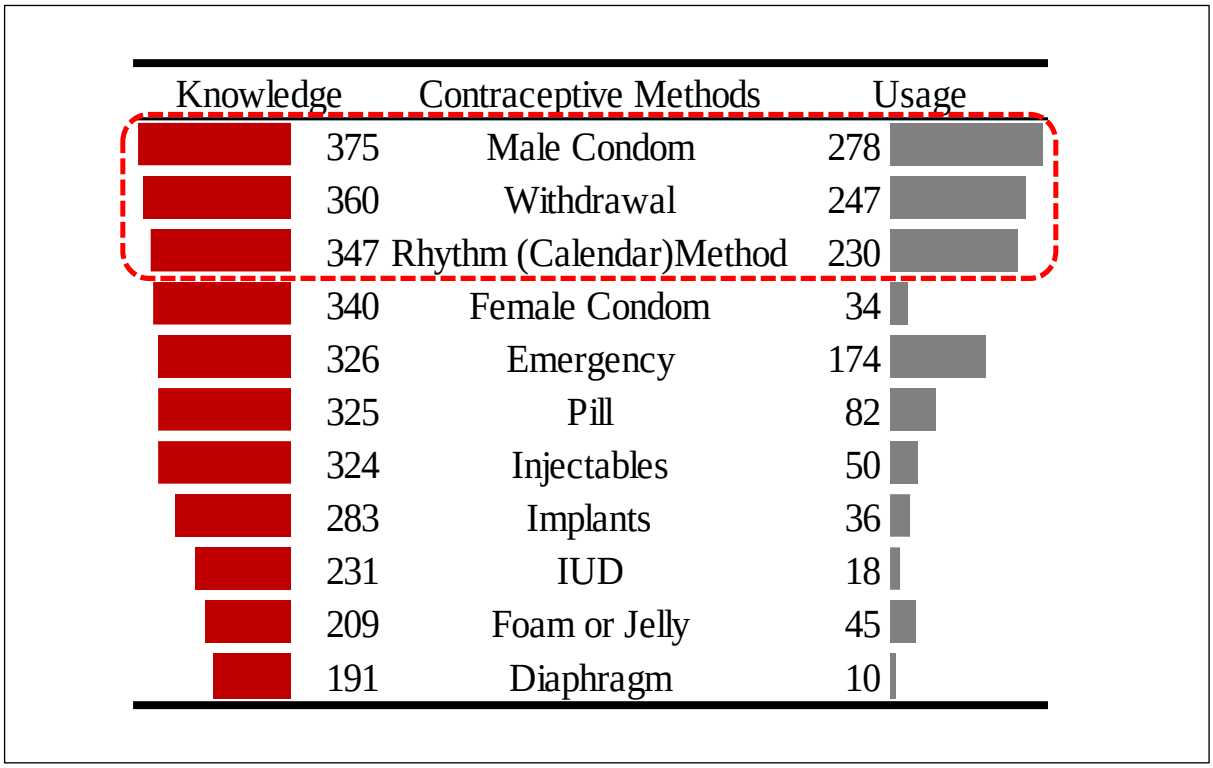


Table 4.4: Respondents knowledge of contraceptive method against marital status.

	Married		Engaged		Co – Habitation		Divorced		Single	
Methods	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Diaphragm	133	68	11	6	6	3	14	7	30	15
Foam / Jelly	143	67	15	7	8	4	15	7	31	15
Implant	191	66	18	6	15	5	20	7	45	16
IUD	155	66	19	8	9	4	19	8	33	14
Pill	213	64	27	8	18	5	24	7	50	15
Injectables	212	64	25	8	17	5	23	7	53	16
Male Condoms	242	63	33	9	20	5	25	7	62	16
Female Condoms	220	63	31	9	16	5	23	7	57	16
Rhythms	224	63	31	9	21	6	26	7	52	15
Emergency	210	63	29	9	17	5	22	7	54	16
Withdrawal	232	63	31	8	22	6	25	7	57	16

Table 4.4, showed a cross tabulation of knowledge/awareness of contraceptive methods as against their marital status. The respondents who had knowledge about the contraceptive method, Diaphragm constituted 68% of married men, 15% of single men and 6% of those engaged; that is out of those who were aware of the diaphragm method. From table 4.4, we could also observe that, a high proportion of married men had the most extensive knowledge of contraceptive method with condoms, withdrawal and rhythms having 242, 232 and 224 representation out of close to 400 respondents interviewed. This could be attributed to counselling sessions they might have received during their marital life and other factors as well which is related to either before marriage or after marriage.

Furthermore, respondent who were single but had at least a child had some knowledge of contraceptive methods; 62 respondents were aware of condom while 57 respondents each had knowledge of withdrawals and female condoms. Also male respondents who were engaged, living together and were either divorced, separated or widowed were aware of such methods with 31 of the respondent who were engaged being aware of rhythm and female condoms, 20 respondents representing co habitation had knowledge of male condoms while a proportion of respondents who were divorced/separated/widowed were mostly aware of rhythm, condoms and withdrawals contraceptive methods.

Table 4.5 Distribution of Contraceptive usage by marital status

	Married		Engaged		Co – Habitation		Divorced		Single	
Methods	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Diaphragm	7	64	1	9	1	9	0	0	2	18
Foam / Jelly	25	54	3	7	3	7	8	17	7	15
Implant	20	56	5	14	5	14	2	6	4	11
IUD	11	61	2	11	2	11	3	17	0	0
Pill	58	67	7	8	6	7	7	8	8	9
Injectables	29	56	9	17	5	10	6	12	3	6
Male Condoms	175	61	23	8	15	5	22	8	49	17
Female Condoms	21	62	4	12	3	9	2	6	4	12
Rhythms	151	64	21	9	14	6	22	9	27	12
Emergency	150	59	24	9	14	6	20	8	46	18
Withdrawal	103	58	18	10	12	7	10	6	36	20

Table 4.5 showed a cross tabulation of knowledge/awareness of contraceptive methods as against their marital status. A low response that showed that respondents had used contraceptive method that is Diaphragm constituted 64% of married men, 18% single men with at least one child and as low as 9% engaged; that is out of those who were aware of the diaphragm method. From table 4.5, we could also observe that, a high proportion of married men mostly use condoms as contraceptive method, rhythms and emergency having 175, 151 and 150 representation out of close to 400 respondents interviewed. This could be attributed to counselling sessions they might have received during their marital life and other factors as well which is related to either before marriage or after marriage.

Among respondents who were single but had at least a child, it was detected that 49 of them mostly used condom while 46 and 36 of them had used emergency and withdrawals respectively. Also male respondents who were engaged, living together and were either divorced, separated or widowed reportedly used contraceptive methods, with 24 of them who were engaged using the emergency contraceptive, 14 using male condoms while a proportion of respondents who were divorced/separated/widowed mostly use rhythm and condoms contraceptive methods, this is also shown in Appendix A.

4.3 Support towards family planning

This section sought to answer questions on the level of male support in the use of contraceptives, factors that influence the choice of contraceptives method and source of information dissemination obtained on family planning. This section was to also determine if men discussed family planning with their partners. It was observed that only 34% of the respondents received counselling from a health worker as seen in the Table 4.6 below.

Table 4.6: Distribution of family planning by counselling, usage and need

	Responses	**Frequency**	**Percentage**
Counselling from a health worker	Yes	137	34%
	No	262	66%
Usage	Yes	101	25%
	No	299	75%
Need	Yes	140	36%
	No	252	64%

On the question of usage of a method by the partners, it was realized that a very significant proportion representing 75% of the respondents said they and their partners were not using any family planning method while 25% did. A further probe revealed that about two-thirds (64%) of the respondents interviewed felt that they did not need to use any family planning method while 36% thought otherwise as shown in table 4.6.

Table 4.7:Distribution of perceived reasons which will mostly influence respondent's choice of contraceptive method.

Factor that Influence FP Choices	Frequency N=400	Percentage
Safety	196	50%
Cost	185	47%
Availability	162	41%
Reliability	153	39%
Ease of Use	107	27%
Health Worker Advise	99	25%

Effects on Sexual Pleasure	81	21%
Reversibility	71	18%
Partner's Decision	61	16%
Privacy	49	13%
Opinion from Friends	12	3%
Other	2	1%

When respondent were asked, what will mostly influence their choice of contraceptive method, safety, cost and availability of the contraceptive was among the top three factors that was highly ranked with a representation of 50%, 47% and 41% respectively. However, opinions from friends didn't seem to have any impact to the respondents' choice. Thereby scoring as low as 3% of the responses but when it came to the case of use and advise from the health worker 25% each thought that would be one of the reasons they would be mostly influenced. This was depicted in Figure 4.2.

Figure 4.2: Top 3 reason that will influence respondent FP method Choice

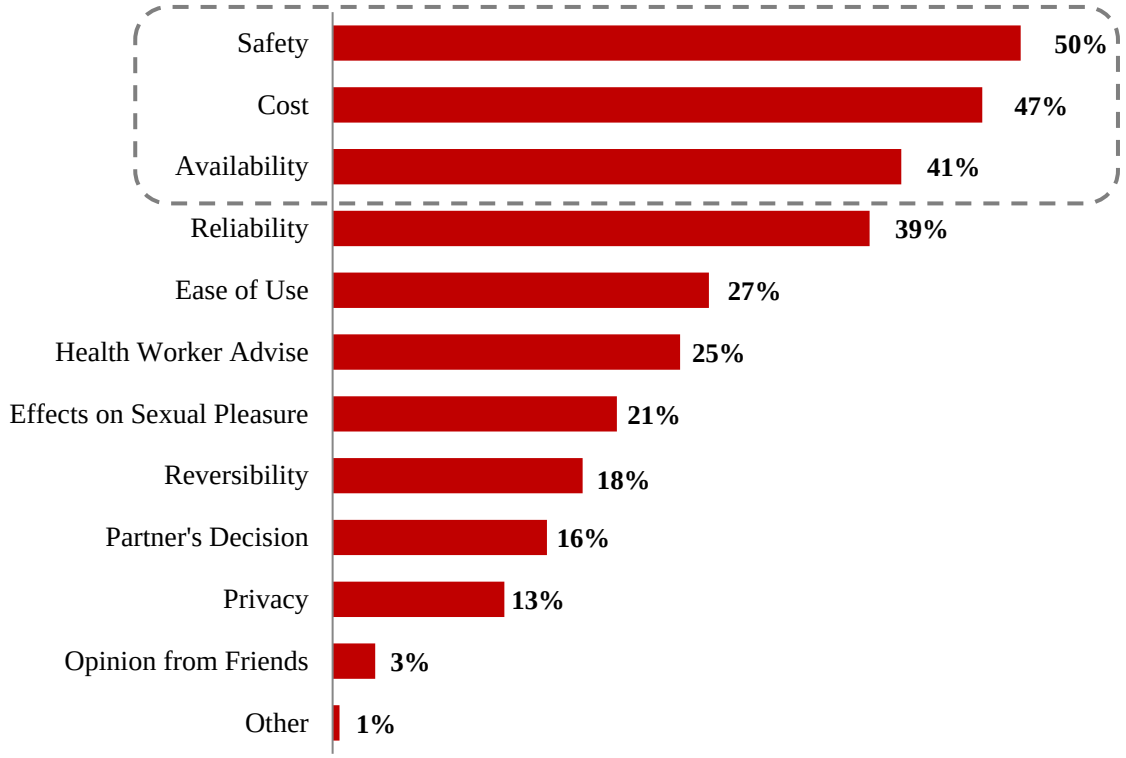


Table 4.8: Source of information on Family Planning

Communication Channel	**Frequency**	**Percentage**
TV	132	33%
Radio	116	30%
Health Worker	63	16%
Internet	37	9%
Posters	4	1%
Other	13	3%
Never Heard	30	8%

Majority of the respondents obtained family planning information on television and radio constituting 33% and 30% respectively. Posters contributed the least communication channels representing 1% while 8% have never heard of information on family planning.

Table 4.9: Distribution of respondents on source of obtaining contraceptive service

Service Provider	**Frequency**	**Percentage**
Pharmacy	170	43.4
Hospital	109	27.8
TV	37	9.4
Health Control	11	2.8
Health worker friend	8	2
Chip**s** Compound	6	1.5
Other	37	9.4
Never	14	3.6

On the issue of assessing providers of contraceptives, a question was asked on where they got contraceptives service from, about 70% said they got the service from the pharmacy and hospitals, while less than 10% obtained services from health control, health worker friend and chip compounds. 3.6% said they had never received services on contraceptives.

Table 4.10: *Distribution of respondents' discussion pattern of family planning with partner*

Duration	**Frequency**	**Percentage**
Never Discussed before	161	41%
Less than 1yr ago	104	27%
Between 1-3yrs	31	8%
More than 3yrs	36	9%
Can**'**t Remember	60	15%

Again, on the issue of discussion of family planning, a question was asked on *"When was the last time you have discussed family planning with your partner?"* Of the total responses as shown in Table 4.10, 41% said they had never discussed family planning with their partner, 27% said it was less than a year ago, 25% can't seem to remember at all and 9% said its being more than a year. Nevertheless, only 8% which constituted the least response said they had discussed family planning with the other partner.

Table 4.11: *Distribution of FP Counselling sessions attended with their spouse.*

Responses	**Frequency**	**Percentage**
Yes	75	19%
No	325	81%

To determine the level of male involvement in family planning, a question was asked to find out if the study participants and their partner had attended family planning counselling sessions together; 81% respondents said they had never attended sessions with their spouses on counselling while 19% said they had attended sessions with their partners.

Table 4.12: *Distribution of male support for family planning*

Response	Frequency	Percentages
Yes	269	67.3
No	131	32.7

Tables 4.12 showed the level of support by the spouse on family planning method and from the table about 67% of the respondents agreed to support their partners use a family planning method but 33% did not. Graphical representation of respondents who are aware and use the various contraceptive methods are shown in Appendix A.

Table 4.13: *Bivariate analysis of some demographic data on currently practising Family Planning (FP)*

Variable Currently practising FP	Yes (%)	No (%)	p-value
Age Group			**0.030***
18-24	**1(1.0)**	**4(1.3)**	
25-31	**11(10.9)**	**55(18.4)**	
32-38	**43(42.6)**	**102(34.1)**	
39-45	**32(31.7)**	**71(23.8)**	
46-53	**12(11.9)**	**34(11.4)**	
54-60	**2(2.0)**	**25(8.4)**	
61-68	**0(0.0)**	**8(2.7)**	
Educational level			**0.162**
None	**0(0.0)**	**3(1.0)**	
Primary	**1(1.0)**	**13(4.4)**	
JHS	**18(18.0)**	**41(13.9)**	
SHS	**23(23.0)**	**91(30.7)**	
Tertiary	**56(56.0)**	**146(49.3)**	
Other	**2(2.0)**	**2(0.7)**	
Marital Status			**0.001***
Single	**4(4.0)**	**58(19.5)**	
Married	**73(72.3)**	**181(60.8)**	
Engaged	**7(6.9)**	**26(8.7)**	
Co-habit	**9(8.9)**	**15(5.0)**	
Divorce	**8(7.9)**	**18(6.0)**	
Religion			**0.099**
Christianity	**79(79.8)**	**259(86.6)**	
Islamic	**13(13.1)**	**28(9.4)**	
Traditional	**7(7.1)**	**8(2.7)**	
Other	**0(0.0)**	**4(1.3)**	
Approval of FP			**0.001***
Yes	**91(90.1)**	**183(61.4)**	
No	**8(7.9)**	**78(26.2)**	
Not sure	**2(2.0)**	**37(12.4)**	
Partner discussion			**0.001***
<1yr	**48(47.5)**	**59(19.73)**	
Between 1-3yrs	**16(15.8)**	**15(5.0)**	
>3yrs	**14(13.9)**	**24(8.0)**	
Can't remember	**12(11.9)**	**50(16.7)**	
Never discussed	**11(10.9)**	**151(50.5)**	

Note:* "indicate the measured association is statistically significant at p value < 0.05"

Table 4.13 showed a bivariate analysis between some demographic data and the use of contraceptives in family planning. It was realized that there was a significant difference between Education and the use of contraceptive. Most of the respondents who were currently practicing FP had received Tertiary/Polytechnic Education representing 56% of the total responses; but majority of those who said otherwise also had at least SSS/SHS/Vocational education representing up to 80% of the total responses.

On the marital status section from the same table, 181 respondents who were married were currently not practicing family planning constituting about 61%. Also, there was a statistically significant association between marital status and the practice of family planning since the p value (0.001) was less than 0.05.

Furthermore, responses that fell within 32-38 age groups were mostly the ones who were currently practicing family planning constituting about 43% of respondents while majority of the same age group said no representing 34%. However there was a statistical significant association between the Age Groups and the use of contraceptive since the p value was 0.030 which was less than 0.05.

Furthermore, table 4.13 showed that there was a statistically significant association between Approval of Family Planning and the use of a family planning method as well as those who discuss family planning with their partners since the p value of 0.001 and 0.001 respectively were less than 0.05. Those who approved of family planning were no different from those who used contraceptives.

Table4.14: *Multiple logistic regression of factors influencing the practice of Family Planning.*

Variables	Categories	p-value	OR (95% CI)	p-value	AOR (95% CI)
Age group	18-24		1.00		
	25-31	0.848	1.25(0.13,12.28)	0.476	3.00(0.15,61.47)
	32-38	0.645	0.59(0.06,5.46)	0.461	3.04(0.16,58.32)
	39-45	0.605	0.55(0.06,5.16)	0.475	2.95(0.15,57.61)
	46-53	0.768	0.71(0.07,6.98)	0.396	3.66(0.18,73.20)
	54-60	0.394	3.12(0.23,43.02)	0.122	13.76(0.50,380.82)
	61-68		1.00		
Marital Status	Engaged		1.00		
	Single	0.042*	3.90(1.05,14.51)	0.011*	6.75(1.54,29.65)
	Married	0.367	0.67(0.28,1.61)	0.584	1.35(0.46,3.99)
	Cohabit	0.181	0.45(0.14,1.45)	0.430	0.55(0.13,2.40)
	Divorced	0.405	0.61(0.19,1.97)	0.595	0.68(0.16,2.82)
Educational level	None		1.00		
	Primary	0.075	13(0.77,219.11)	0.437	3.60(0.14,91.06)
	Middle/JHS/JSS	0.428	2.28(0.30,17.46)	0.942	1.09(0.09,12.81)
	SSS/SHS/Voc	0.180	3.96(0.53,29.61)	0.406	2.80(0.25,31.57)
	Tertiary/Poly	0.344	2.61(0.36,18.96)	0.570	1.99(0.18,21.68)
	Other		1.00		
Approval of Family Planning	Yes		1.00		
	No	0.001*	4.85(2.25,10.47)	0.022*	2.83(1.16,6.88)
	Not Sure	0.003*	9.20(2.17,39.02)	0.031*	5.38(1.16,24.89)
Partner Discussion	<1yr		1.00		
	1-3yrs	0.507	0.76(0.34,1.70)	0.228	0.57(0.23,1.42)
	>3yrs	0.392	1.39(0.65,2.99)	0.963	1.02(0.42,2.50)
	Can't remember	0.001*	3.39(1.62,7.08)	0.042*	2.40(1.03,5.57)
	Never discussed	0.001*	11.17(5.43,22.97)	0.001*	9.16(3.86,21.74)

Note:* "indicates statistical significant at p value < 0.05**"**

Dependent Variable: Currently Practicing FP

Chapter 5

5.0 Discussions

5.1 Involvement, Approval and Practice of Family Planning

The acceptance of contraception among men requires knowledge about appropriate contraceptive methods, more communication between partners, fostering awareness, and mutual sharing of concerns for partners' contraceptive practices (Green *et al*., 1995).

The primary objective sought to assess the attitude of men in the Tema Metropolitan Area towards family planning. From the research findings, it was observed that males who visited the facility were not active participants in attending family planning counselling sessions with their spouse as an overwhelming 81% of respondents interviewed said they had never attended family planning sessions. Also when it came to discussions on family planning, about 56% which was more than half of the respondents had never discussed or can't remember discussing planning family with their partners while 27% discussed it less than a year ago.

Even though 69% approved of the use of family planning to stop pregnancy, about 21% wanted more children, others had religious beliefs and some thought it was not reliable to practice family planning. Furthermore, 75% of the respondents interviewed weren't use any family planning method.

5.2 Male Perception towards Family Planning

About 71% of the respondents thought family planning was a good thing and had to be promoted whiles 20% said they did not agree. Majority of those respondents agreed on the use of family planning to stop pregnancy representing 69%.

A decision on family planning affected his manhood, his sex life, his family and religion. Religions and traditionally held beliefs were of utmost concern to the people of Tema and Ghana as a whole. Some respondents did also realized the importance and need for family planning in contemporary times but nevertheless, to them, they disapproved of family planning to stop pregnancy representing 21% due to religious beliefs and perceived side effects.

A high proportion of the respondents were married men with most of them aware of the various contraceptive methods. In a similar study by Kassa *et al* in Debremarkos town, Northwest Ethiopia, married men had knowledge on family planning services. This might be due to interventions by the health sector and increased exposure to health education and media advocacy. However most of them were comfortable with either the use of the male condom, withdrawal or rhythmic (calendar) method. In this regard just a few of the respondents had their spouse use a contraceptive method before.

5.3 Support towards Family Planning

Most respondents interviewed had never received family planning counselling from a healthy worker indicating 66% response likewise 81% said they had never attended family planning counselling sessions together with their spouses while 75% had never used any family planning methods. Institutional and social norms which defined reproductive health as a "woman's issue" and the limited choice of available male contraceptives might be some of reasons that hinder constructive participation (Kabagenyi *et al*., 2014). The low uptake of modern family planning methods in Sub-Saharan Africa (SSA) including Ghana was associated with high incidence of unintended pregnancies, unsafe abortions, and maternal deaths (Eliason *et al*., 2014). This situation may likely occur in the Tema metropolis

since 75% of the respondents were currently not using any FP method either by themselves or their spouse. The cost-effectiveness of family planning in poverty reduction and socio-economic development in the developing world could not be disputed (Population Reference Bureau, 2009).

Although the Government of Ghana had created an appreciable level of awareness about family planning services through its educational campaign programmes, only 25% of respondents were currently using the service.

Also in order to influence male participation in family planning in the Tema, safety, cost and availability of contraceptive methods might be considered, since most respondents interviewed would consider these factors to inspire their influence in the choice of family planning methods; as this was interpreted in table 4.9 where 50%, 47% and 41% considered safety, cost and availability of contraceptive methods respectively as their main factors.

Moreover, the second research question which sought to investigate male support in the usage of family planning method saw about 67% of the respondents agreeing to support their partners in using a family planning method. This findings was lower than a study done by Berhane *et al* in Ethiopia where 80.9% of men approved the use of contraceptives by their wives as well as a study carried out in the Philippines where 72% of husbands strongly approved of contraception (Biddlecom *et al*., 1997). This might be attributed to the fact that most of the respondents do not desire that either they or their spouse use any form of contraceptive method as a result side effects, religious beliefs as well as the myths and misconceptions about it while others want to have more children.

Also about 67% of the respondents were willing to support their partner in using a family planning method. This might be due to the fact that most of the respondents had a tertiary level of education hence might be privy to the importance of family planning but however

unwilling to use it because of the myths and misconceptions surrounding it among other reasons.

Comparing if the level of education of the respondents had an influence on the usage of family planning methods; It was found out that even though most of the respondents do not use family planning methods, 56% of the respondents who did had at least secondary school education.

However, an association of socio-demographic variables revealed that age and marital status were significantly associated with the practice of family planning ($P< 0.05$), similar to findings by Kumar *et al* in India and Aryeetey *et al* in Ghana. Also an association between approval and use of family planning was found to be statistically significant ($p<0.05$).

5.4 Partner communication regarding Family Planning

The last objective of this study was to assess spousal communication regarding family planning in the Tema Metropolis. To evaluate this objective better the following questions were considered. These include; where do they often get contraceptive services from, the last time they discussed family planning with their partner and if they have attended family planning counselling sessions with their partner.

To begin with, a large proportion of the respondents interviewed obtained information through the electronic media. Television and radio constituting a total of 63% were the source of communications channels where information was obtained by the respondents'. In a study in india, 70% of the subjects stated that their most common source of information about contraception was from friends (72%) followed by radio and television (70%) (Rekha *et al*., 2015). This was similar to the study findings and implies that health care providers and modern means of communication and media had established greater awareness in the public.

Communications research had shown that mass media interventions work by stimulating discussion within social networks (including but not limited to discussion between spouses), which then led to subsequent contraceptive uptake (Rogers *et al*., 1999).

However most of the study participants in Tema representing about 43% obtain family planning services from pharmacies whiles just about 28% of the respondents obtain the services from the hospital. However 4% had never obtained any services. This might be due to the unavailability of adequate family planning service centres in the metropolis. Those available might not be service (male) friendly as a result of health worker attitude which compel most of the respondents or their partners to seek for the service in the pharmacy where they felt most comfortable.

From the results, it was observed that most of the respondents had never really discussed family planning with their partners before. This might also go to buttress the observation made that most of the respondents had never attended family planning sessions with their partners. Hence the third research question which sought to investigate if men discuss family planning with their partner had been interpreted in the sense that 56% of the male respondents interviewed had neither discussed with their partner nor can't remember at all with the rest having done that probably over a year ago.

Having a prior discussion regarding contraceptives with partners was found to be significantly associated with the practice of family planning as well as statistically significant in predicting usage. Those who had ever discussed the use of contraceptives with their partners irrespective of the length of time were more likely to use contraceptives (AOR = 2.4; $p<0.05$). This is because both partners were likely to understand the family dynamics and would together embrace the use contraceptives to evenly space child birth as well as control child birth.

Another study conducted by Manortey *et al* in Worawora, Ghana also reported a statistically significant evidence of association between contraceptive usage among reproductive aged women and they having had prior open discussion with their sexual partners (Manortey *et al*., 2017).

A study conducted in Ghana in Navrongo (Bawah, 2002) suggested that spousal communication predicted contraceptive use, and available evidence showed that women whose partners disapproved of modern contraceptive practice were unlikely to use them (Odimegwu, 1999).

Chapter 6

6.0 Conclusions and Recommendations

6.1 Conclusions

In this study, our research findings on male attitude towards family planning in the Tema Metropolitan Area had proven that the level of male participation in family planning in the study area was low and most of the respondents did not attend family planning counselling sessions. This could be associated with low male involvement in family planning.

However, an association of socio-demographic variables revealed that age and marital status were significantly associated with the use of modern FP methods.

Also form the research findings, it was realized that 75% of the respondents were not using any family planning methods even though 71% thought family planning was a good thing and had to be promoted. Meanwhile, a few of the respondents did not agree to the fact of using family planning to stop pregnancy because of religions and traditionally held beliefs as well as side effects of the contraceptives which was an utmost concern to the men in Tema municipality.

Furthermore, 75% of respondents interviewed revealed they did not use any family planning method hence a lower male support in the usage of family planning method. However 67% of the respondents were willing to support their partners to practice family planning.

Moreover to add more interesting aspect to this study, we established a relationship between knowledge and usage of contraceptive method and we conclude that almost all the respondents interviewed (96%) were aware of male condom but about 71% have used It. In

addition, when it came to withdrawals and rhythm 92% and 89% respectively of respondents were aware of these contraceptive method but 63% and 59% respectively had used. Hence, it could be deduced that the awareness was on the high level than it usage, that is more people were aware of the contraceptive methods but less people use it.

A large proportion of the respondents interviewed obtained information through the electronic media constituting a total of 63% of respondents obtaining information on these communication channels (TV and radio).

Finally it was observed that most of the men in the Tema Metropolitan Area did not discuss family planning with their partners contributing to the low participation in issues relating to family planning. However it was observed that having a prior discussion regarding contraceptives with partners was found to be significantly associated with the practice of family planning.

Studies had suggested that men can play an important role in family planning either by their active use of contraceptives or by supporting their partner's use of contraceptive methods. Therefore, males supporting their partners would also help in better acceptance, correct use and compliance to family planning methods. Family planning had a direct impact on the health of women, foetus, infant and children which in turn influenced the health status of families, communities and ultimately the society. The study area has high literacy rate among the male population (94.8%) due to its urbanized nature. Though the level of awareness, attitude and practice of our study subjects towards family planning might not be encouraging enough, a continuous effort needs to be put in to sustain and improve the existent scenario, in addition to advocating policy changes.

6.2 Recommendations

The following recommendations may further enhance the level of male involvement in family planning programs based on the findings of the study.

- ✓ Advocay programs organized by international organizations may include elements and initiatives that promote and encourage male participation instead of it being focused solely on women.
- ✓ Governmental and nongovernmental organizations, donors and stakeholders should ensure accessibility and sustained advocacy for the use of family planning services that are cost effective, safe and available.
- ✓ Male involvement programmes may be incorporated into the primary health care outreach activities of the district to save potential clients the problem of travelling to far off places for family planning services as well as reach those who are unable to access the service centres.
- ✓ The Ghana Health Service may encourage male participation in family planning by placing family planning clinics in male friendly locations as well as putting in initiatives that encourage participation and increase knowledge.
- ✓ The Ghana Health Service need to properly equip the various family planning clinics with the requisite resources and skilled personnel to manage the side effects and other complains that maybe associated with the use of the family planning services as this will encourage participation and increase knowledge.
- ✓ Policy makers and stakeholders may use the mass media especially the electronic media such as radio and television as a medium for creating awareness and advocating for male involvement in family planning.

- ✓ The Ministry of Health may liaise with Telecommunication companies to send IE&C materials as a means of intermittent reminders to mobile phones to sensitize, increase knowledge and encourage the population to embrace family Planning.

References

Akafuah, R. A. and Sossou, M.-A. (2008) 'Attitudes toward and Use of Knowledge about Family Planning among Ghanaian Men', *International Journal of Men's Health*, 7(2), pp. 109–120. doi: 10.3149/jmh.0702.109.

Bawah, A. A. (2002) 'Spousal Communication and Family Planning Behavior in Navrongo: A Longitudinal Assessment', *Studies in Family Planning*, 33(2), pp. 185–194. doi: 10.1111/j.1728-4465.2002.00185.x.

Berhane, A., Biadgilign, S., Amberbir, A., Morankar, S., Berhane, A. and Deribe, K. (2011) 'Men's knowledge and spousal communication about modern family planning methods in Ethiopia.', *African journal of reproductive health*, 15(4), pp. 24–32. doi: 10.4314/ajrh.v15i4.

Biddlecom, A. E., Casterline, J. B. and Perez, A. E. (1997) 'Spouses' Views of Contraception in the Philippines', *International Family Planning Perspectives*, 23(3), p. 108. doi: 10.2307/2950766.

Bongaarts, J. and Bruce, J. (1995) 'The Causes of Unmet Need for Contraception and the Social Content of Services', *Studies in Family Planning*, 26(2), p. 57. doi: 10.2307/2137932.

Cleland, J. G., Ndugwa, P. and Zulu, E. M. (2011) 'Family planning in sub-Saharan Africa : progress or stagnation ?', (November 2010), pp. 137–143. doi: 10.2471/BLT.10.077925.

Duze, M. C. and Mohammed, I. Z. (2007) 'Male knowledge, attitude, and family planning practices in Northern Nigeria', *African Journal of Reproductive Health*, 10(3), pp. 53–65. Available at: https://www.jstor.org/stable/30032471?seq=1#page_scan_tab_contents.

Eliason, S., Awoonor-Williams, J. K., Eliason, C., Novignon, J., Nonvignon, J. and Aikins, M. (2014) 'Determinants of modern family planning use among women of reproductive age

in the Nkwanta district of Ghana: a case-control study.', *Reproductive health*, 11(1), p. 65. doi: 10.1186/1742-4755-11-65.

Ezeanolue, E. E., Iwelunmor, J., Asaolu, I., Obiefune, M. C., Ezeanolue, C. O., Osuji, A., Ogidi, A. G., Hunt, A. T., Patel, D., Yang, W. and Ehiri, J. E. (2015) 'Impact of male partner ' s awareness and support for contraceptives on female intent to use contraceptives in southeast Nigeria', *BMC Public Health*. BMC Public Health, pp. 1–6. doi: 10.1186/s12889-015-2216-1.

Farmer, D. B., Berman, L., Ryan, G., Habumugisha, L., Basinga, P., Nutt, C., Kamali, F., Ngizwenayo, E., Fleur, S. and Niyigena, P. (2015) 'Motivations and Constraints to Family Planning : A Qualitative Study in Rwanda ' s Southern Kayonza District', 3(2), pp. 242–254.

GDHS (2014) 'Ghana Demographic and Health Survey'.

Gizaw, A. and Regassa, N. (2011) 'Family planning service utilization in Mojo town , Ethiopia : A population based study', 4(June), pp. 355–363.

Green, C., Chohen, S. and Belhadj-El Ghouayel, H. (1995) 'Male involvement in reproductive health, including family planning and sexual health', *Technical Report 28, UNFPA.* Available at: http://snap3.uas.mx/RECURSO1/unfpa/data/indexcds/c_074.pdf.

GSS (2014) 'Ghana Statistical Service (GSS), 2010 Population & Housing Census: District Analytical Report: Tema Metropolitan', p. 88. doi: 10.1186/s12913-014-0625-y.

Gueye, A., Speizer, I. S., Corroon, M. and Okigbo, C. C. (2016) 'Belief in Family Planning Myths at the Individual And Community Levels and Modern Contraceptive Use in Urban Africa', *HHS Public Access*, 41(4), pp. 191–199. doi: 10.1363/4119115.Belief.

Hartmann M1, Gilles K, Shattuck D, Kerner B, G. G. (2012) 'Changes in couples'

communication as a result of a male-involvement family planning intervention', *J Health Commun.* Available at: https://www.ncbi.nlm.nih.gov/pubmed/22545820.

John G Cleland, R. P. N. & E. M. Z. (2010) *Family planning in sub-Saharan Africa: progress or stagnation?* Available at: http://www.who.int/bulletin/volumes/89/2/10-077925/en/.

Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J. and Atuyambe, L. (2014) 'Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda.', *Reproductive health*. Reproductive Health, 11(1), p. 21. doi: 10.1186/1742-4755-11-21.

Kassa, M., Abajobir, A. A. and Gedefaw, M. (2014) 'Level of male involvement and associated factors in family planning services utilization among married men in Debremarkos town, Northwest Ethiopia.', *BMC international health and human rights*, 14, p. 33. doi: 10.1186/s12914-014-0033-8.

Maan, A. A., Mun, K. K. and Irf, M. (2003) 'Life and Social Sciences Contraceptive use Behavior and Male ' s Attitude Towards Women ' s Involvement in Family Planning', 1, pp. 102–105.

Mairiga, A. G., Kullima, A. A., Bako, B. and Kolo, M. A. (2010) 'Sociocultural factors influencing decision-making related to fertility among the Kanuri tribe of north-eastern Nigeria', *African Journal of Primary Health Care and Family Medicine*, 2(1), pp. 2–5. doi: 10.4102/phcfm.v2i1.94.

Malalu, P. K. (2014) 'Determinants of Use of Modern Family Planning Methods: A Case of Baringo North District, Kenya', *Science Journal of Public Health*, 2(5), p. 424. doi: 10.11648/j.sjph.20140205.18.

Manortey, S., Lotsu, P. and Tetteh, J. (2017) 'Factors Affecting Contraceptive Use among

Reproductive Aged Women: A Case Study in Worawora Township, Ghana', *Journal of Scientific Research and Reports*, 13(1), pp. 1–9. doi: 10.9734/JSRR/2017/29755.

Mosha, I., Ruben, R. and Kakoko, D. (2013) 'Family planning decisions , perceptions and gender dynamics among couples in Mwanza , Tanzania : a qualitative study', *BMC Public Health*. BMC Public Health, 13(1), p. 1. doi: 10.1186/1471-2458-13-523.

Odimegwu, C. O. (1999) 'Family Planning Attitudes and Use in Nigeria: A Factor Analysis', *International Family Planning Perspectives*, 25(2), p. 86. doi: 10.2307/2991946.

Oluwatosin, A. and Kolawole, O. (2015) 'Awareness , Knowledge , and Attitudes of Married Male towards Family Planning Uptake by Wives : Implications for Behavioural Counselling', 5(20), pp. 114–119.

Owuor, T. O. and Derose, L. F. (2004) 'Does Discussion of Family Planning Improve Knowledge Of Partner ' s Attitude Toward Contraceptives ?', 30(2), pp. 87–93.

Population Reference Bureau (2009) 'World PoPulation Data Sheet', *Population (English Edition)*, pp. 1–19. doi: 10.2307/1972177.

Porche, D. J. (2012) 'Men: The Missing Client in Family Planning', *American Journal of Men's Health*, 6(6), pp. 441–441. doi: 10.1177/1557988312459340.

Prosser, M., Smith, S., Johnston, B. and Stover, J. (2005) *Strengthening Family Planning Policies and Programs in Developing Countries : an Advocacy Toolkit*.

Rekha, T., Unnikrishnan, B., Mithra, P. P. and Kumar, N. (2015) 'Married Men ' s Involvement in Family Planning – A Study from Coastal', 9(4), pp. 7–10. doi: 10.7860/JCDR/2015/12101.5837.

Rogers EM1, Vaughan PW, Swalehe RM, Rao N, Svenkerud P, S. S. (1999) 'Effects of an

entertainment-education radio soap opera on family planning behavior in Tanzania.' Available at: https://www.ncbi.nlm.nih.gov/pubmed/10546311.

Shattuck, D., Kerner, B., Gilles, K., Hartmann, M., Ng, T. and Guest, G. (2011) 'Encouraging Contraceptive Uptake by Motivating Men to Communicate About Family Planning : The Malawi Male Motivator Project', 101(6), pp. 1089–1095. doi: 10.2105/AJPH.2010.300091.

Tawiah, E. O. (1997) 'Factors affecting contraceptive use in Ghana.', *Journal of biosocial science*, 29(2), pp. 141–149. doi: 10.1017/S0021932097001417.

Tilahun, T., Coene, G., Temmerman, M. and Degomme, O. (2014) 'Spousal discordance on fertility preference and its effect on contraceptive practice among married couples in Jimma zone, Ethiopia.', *Reproductive health*. Reproductive Health, 11(1), p. 27. doi: 10.1186/1742-4755-11-27.

Wadembere, I. (2013) 'Attitude and willingness of men towards the use of modern family planning methods in Budondo Sub-County, Jinja, Uganda', (August). Available at: http://www.academia.edu/4239220/Attitude_and_willingness_of_men_towards_the_use_of_modern_family_planning_methods_in_Budondo_Sub-County_Jinja_Uganda.

WHO (2016) *Family planning/Contraception*. Available at: http://who.int/mediacentre/factsheets/fs351/en/.

Appendices

Appendix A

Figure 4.3: Distribution on respondents who are aware and use of diaphragm contraceptive method

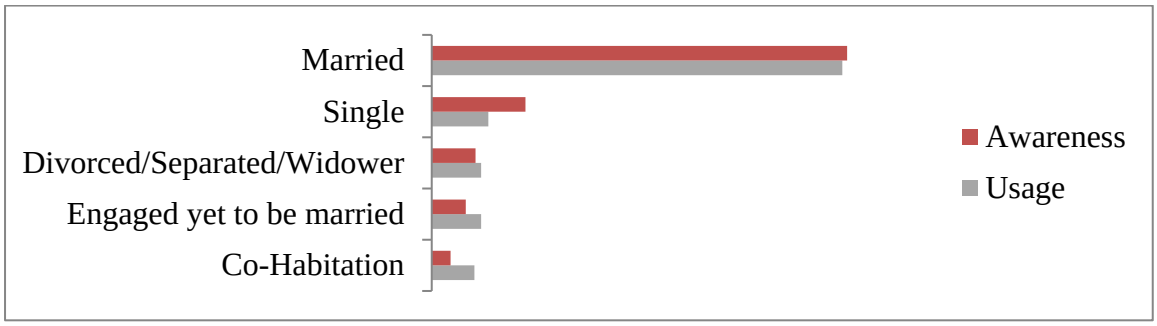


Figure 4.4: Distribution on respondents who are aware and use of foam/jelly contraceptive method

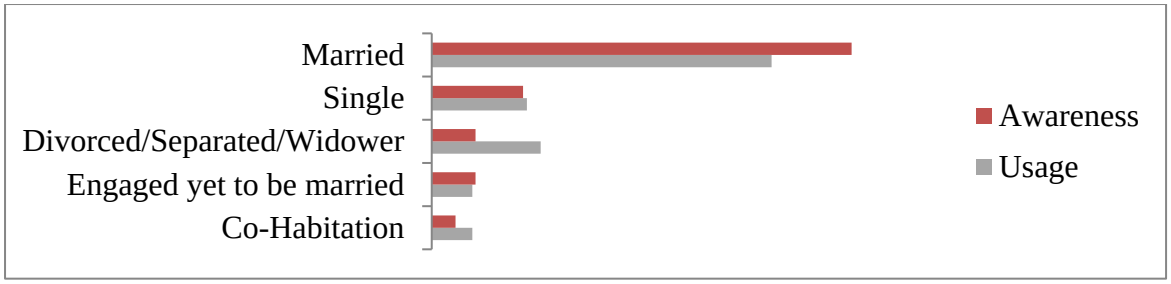


Figure 4.5: Distribution on respondents who are aware and use of Implants contraceptive method

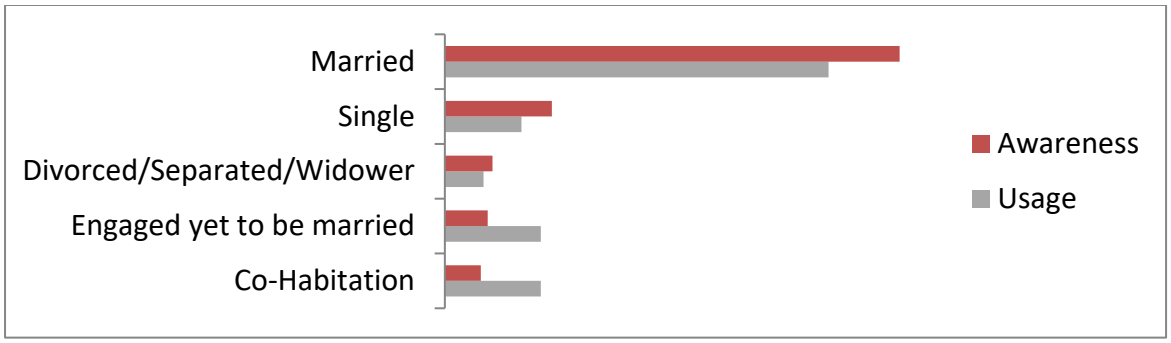


Figure 4.6: Distribution on respondents who are aware and use of IUD contraceptive method

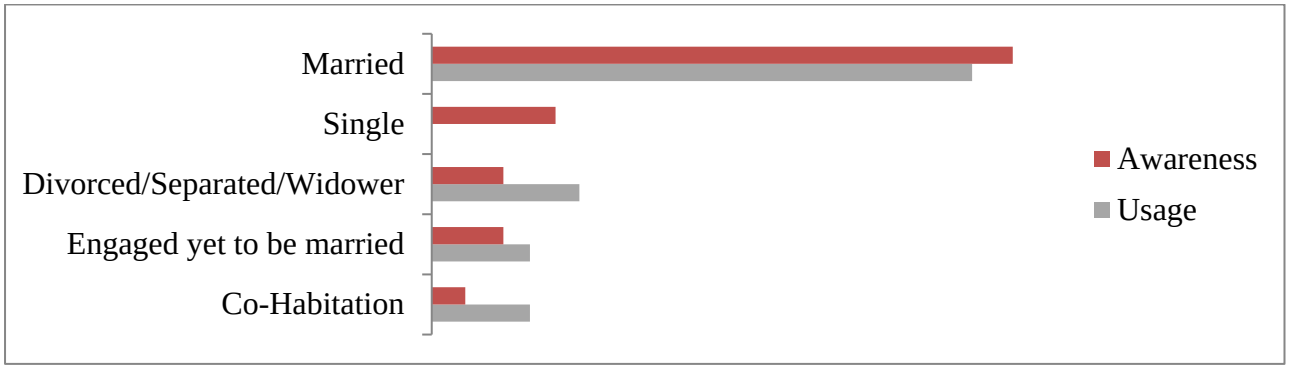


Figure 4.7: Distribution on respondents who are aware and use of Pills contraceptive method

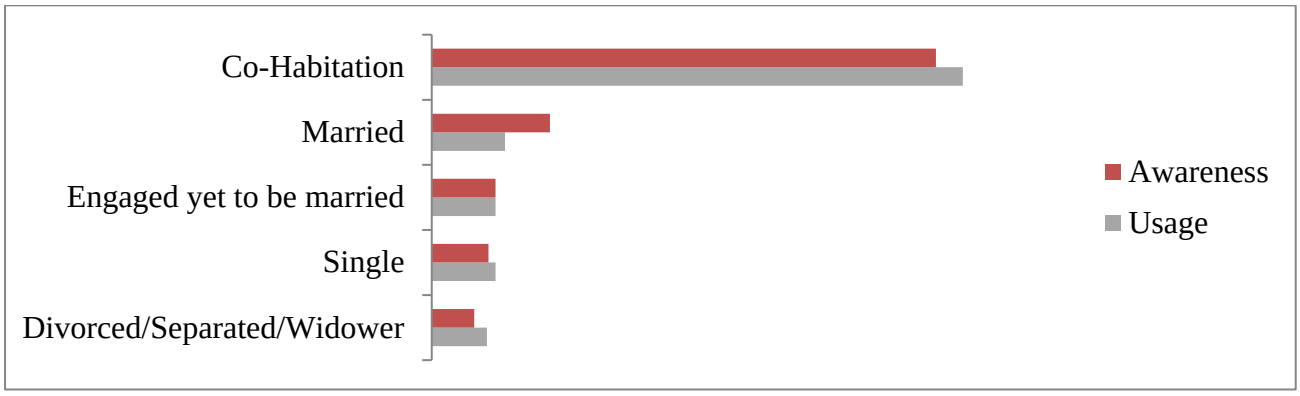


Figure 4.8: Distribution on respondents who are aware and use of Injectable contraceptive method

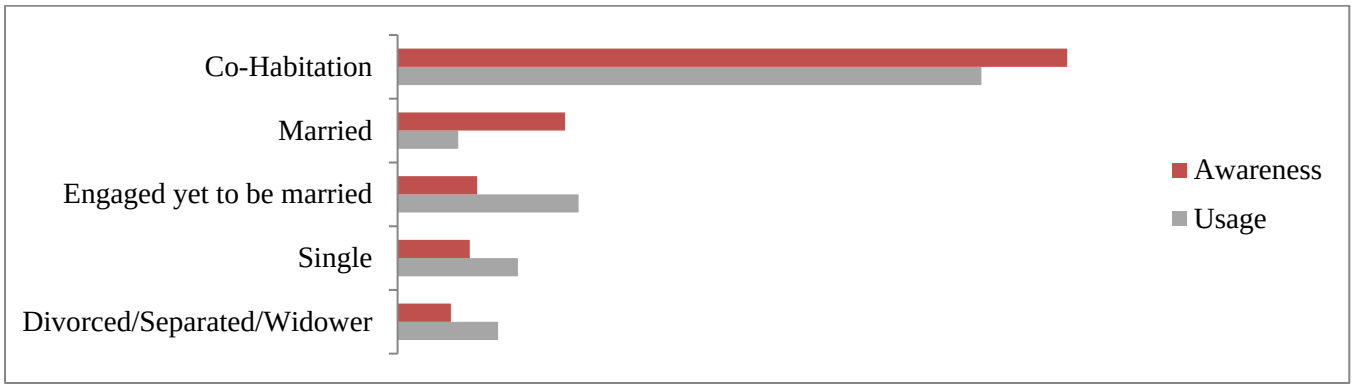


Figure 4.9: Distribution on respondents who are aware and use of Condoms contraceptive method

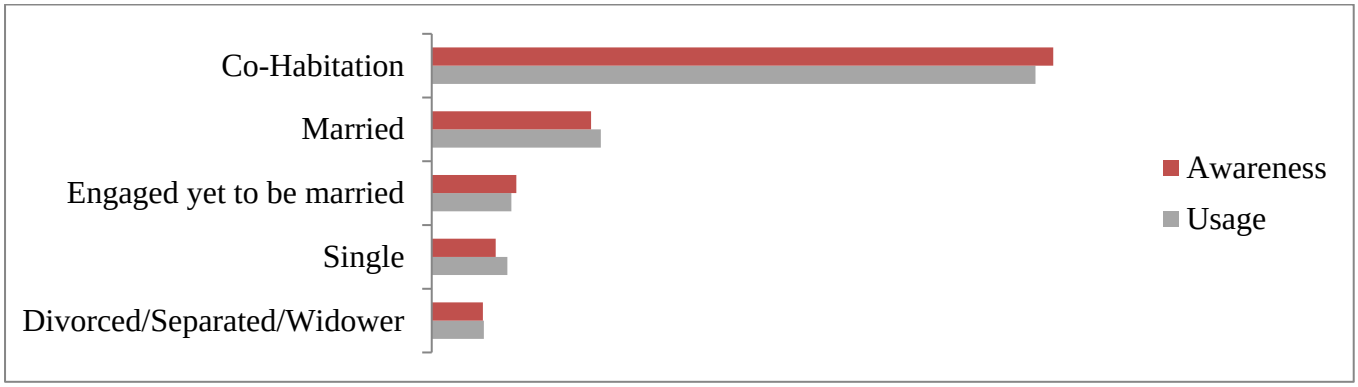


Figure 4.10: Distribution on respondents who are aware and use of Female condom contraceptive method

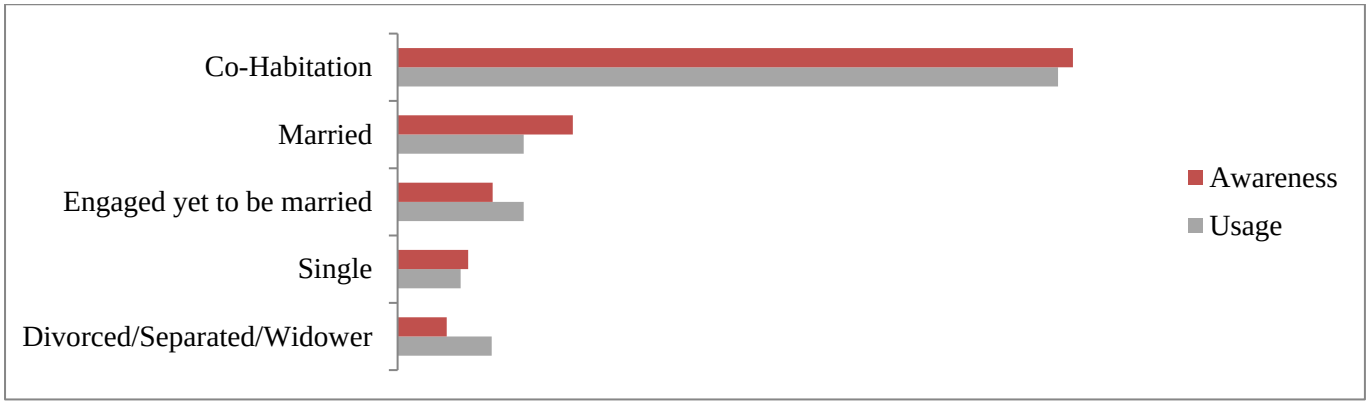


Figure 4.11: Distribution on respondents who are aware and use of Rhythm contraceptive method

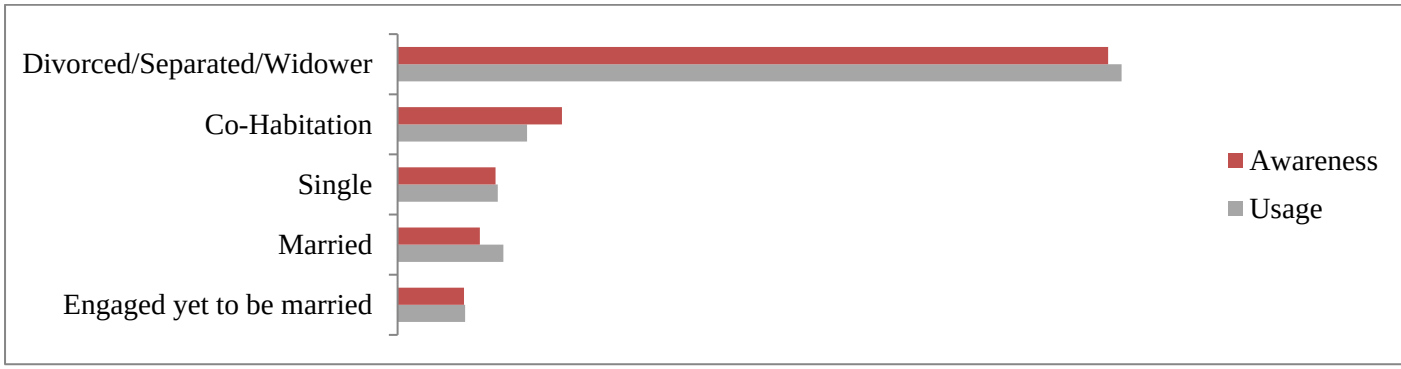


Figure 4.12: Distribution on respondents who are aware and use of Emergency contraceptive method

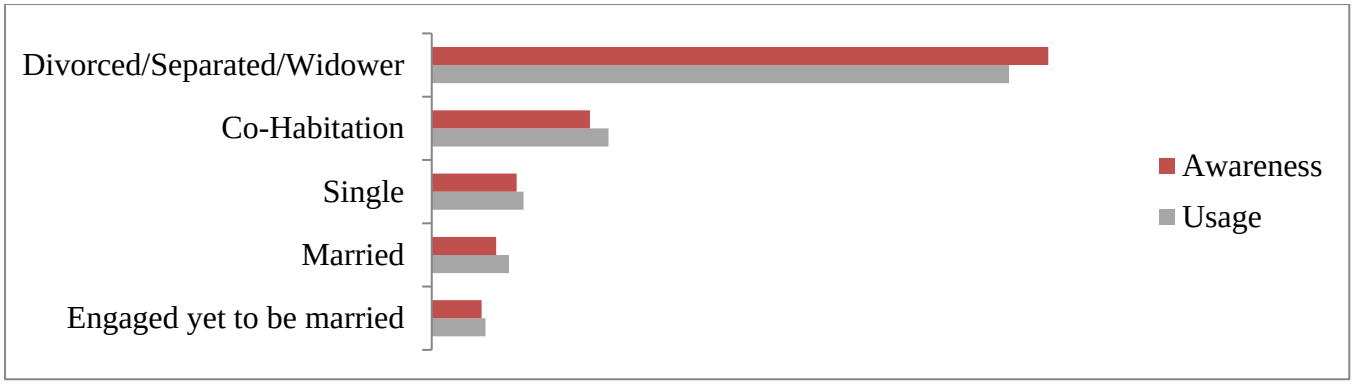
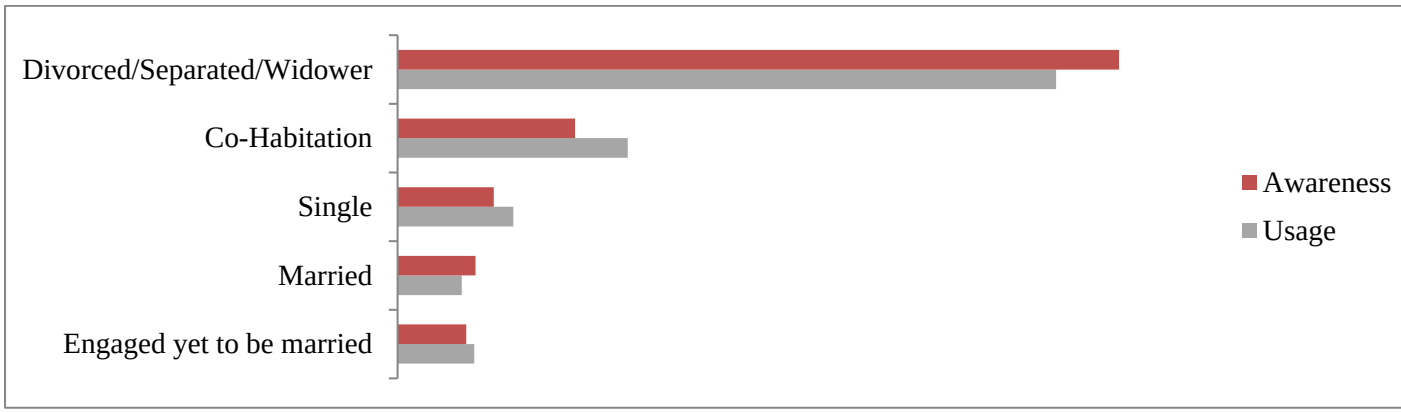


Figure 4.13: Distribution on respondents who are aware and use of Emergency contraceptive method



Appendix B

QUESTIONAIRE

NO:…….

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. Akan, 2. Sisala 3.Dagarti 4.Wala 5.Ga 6.Ewe 7.hausa 8. Other(_____)*	___	ETHI
4	**Religion**	*1. Christian, 2.Muslim, 3.Traditionalist, 4.Other (_____)*	___	RELI
5	**Occupation**	*1.Public servant 2. Private 3. Self Employed 4. Unemployed*	___	OCU
6	**Number of children**		I I I	CHIL
7	**How old is your last child?**		I I I y	CHIT
8	**Marital status**	***1**-Married **3**-Engaged, yet to be married **4**-Co-habitation (living together) **5**-Divorced/Separated/Widowed 6-Single **7**-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
3	**If No, Why?**			NAFP

SECTION C: KNOWLEDGE AND USE OF VARIOUS CONTRACEPTIVE METHODS

	CONTRACEPTIVE METHODS	AWARENESS	HAVE YOU OR YOUR PARTNER IN THE PAST USED	
1	**PILL** (Women can take a pill every day to avoid becoming pregnant)	*1. Yes 2.No* / /	*1. Yes 2.No* / /	PIL1 PIL2
2	**IUD** Women can have a loop or coil placed inside them by a doctor or nurse	*1. Yes 2.No* / /	*1. Yes 2.No* / /	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* / /	*1. Yes 2.No* / /	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	*1. Yes 2.No* / /	*1. Yes 2.No* / /	IMP1 IMP2
5	**CONDOM** Men can put a rubber sheath on their penis before sexual intercourse.	*1. Yes 2.No* / /	*1. Yes 2.No* / /	CON1 CON2
6	**FEMALE CONDOM** Women can place a sheath in their vagina before sexual intercourse	*1. Yes 2.No* / /	*1. Yes 2.No* / /	CON1 CON2
7	**DIAPHRAGM** Women can place a thin flexible disk in their vagina before sexual intercourse	*1. Yes 2.No* / /	*1. Yes 2.No* / /	DIA1 DIA2
8	**FOAM OR JELLY** Women can place a suppository, jelly, cream in their vagina before sexual intercourse	*1. Yes 2.No* / /	*1. Yes 2.No* / /	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	*1. Yes 2.No* / /	*1. Yes 2.No* / /	RHY1 RHY2
10	**WITHDRAWAL** Men can be careful and pull out before climax.	*1. Yes 2.No* / /	*1. Yes 2.No* / /	WIH1 WIH2
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* / /	*1. Yes 2.No* / /	EME1 EME2

SECTION D: SUPPORT TOWARDS FAMILY PLANNING

1	Have you ever received FP counseling from a health worker?	*1. Yes 2.No*	/ /	REC
2	Is you or your partner currently using any family planning method?	*1. Yes 2.No*	/ /	USG
3	Do you currently feel that you and your spouse need to use a FP method?	*1. Yes 2.No*		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 /____/ **2**). Cost /____/ **3**). Reliability /____/ **4**). Safety /____/ **5**).Privacy /____/ 6.) Effect on sexual pleasure /____/ **7**). Ease of use /____/ **8)** Health worker advice / /		INF1 INF2 INF3

		9).Friend's opinion /____/ **10**). My partner will decide for herself /____/ **11)**. *Reversibility* /____/ **12**). Other /____/		
5	Where do you often 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) get the contraceptive services from?	*1. Hospital, 2. TV 3. Health Ctr 4. CHPS Cpd 5. Pharmacy 6. Health worker friend, 7. 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 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
	If No: please reason:_____			
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*	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*	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	Will you support your partner in using a family planning method?	1.Yes, 2. No		SPU

18	If No, Why?	1, Religious beliefs 2, cost 3, Fear of side effects 4, wants to have more children 5, other (Please Specify)		NSPU

Appendix C

ETHICAL CLEARANCE

ENSIGN COLLEGE OF PUBLIC HEALTH - KPONG

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P. O. Box AK 136
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21st November, 2016.

INSTITUTIONAL REVIEW BOARD SECRETARIAT

Theophilus Baddoo,
Ensign College of Public Health.

Dear Mr. Baddoo,

OUTCOME OF IRB REVIEW OF YOUR THESIS PROPOSAL

At a meeting of the INSTITUTIONAL REVIEW BOARD (IRB) of Ensign College of Public Health held on 16th and 17th November 2016, your proposal entitled "**Male Attitude Towards Family Planning A Study Carried Out In Fresh Spring Chemist Ltd, Community One in the Tema Metropolitan Area** "was considered.

You have been granted approval to proceed with your project.

We wish you all the best.

Sincerely,

Dr (Mrs) Acquaah-Arhin
(Chairperson)

Cc. Dean of Ensign College.
Cc: Ag. Academic Registrar, Ensign College.

Appendix D

ENSIGN COLLEGE OF PUBLIC HEALTH

MALE ATTITUDE TOWARDS FAMILY PLANNING

A STUDY CARRIED OUT IN FRESH SPRING CHEMIST LTD, COMMUNITY ONE IN THE TEMA METROPOLITAN AREA

CONSENT FORM FOR DATA COLLECTION

Dear respondent,

My name is Theophilus Baddoo, a graduate student of Ensign College of Public Health, undertaking a thesis for the award of a Master of Public Health (MPH) degree.

The primary objective of this study is to ascertain why male involvement, approval and practice of family planning are low and how men can be encouraged to support and participate in the practice of family planning.

I will be asking you a few questions which will take a few minutes. Any information that you give during this study will be kept strictly confidential and only known to the research team. The complete report will be a combination of all information gathered from several other respondents and hence any finding made will not be attributed to you personally.

You are assured that no unfair treatment will be meted out to you because of your participation. If at any point during the study you feel you no longer want to participate, you have every right to pull out and any information about you will not be included in the study.

Your participation in this research will go a long way to contribute to knowledge and also help stakeholders to come up with programs that encourage positive attitudes in men towards family planning in order to help achieve set targets regarding maternal and child health as well as improving the general reproductive health of the population and the quality of family life.

Do I have your consent to apply the data collection tool to you now?

YES [ ] NO [ ]

Signature: _____ Date: _____