ENSIGN COLLEGE OF PUBLIC HEALTH

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FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING

A CASE STUDY AT THE TEMA METROPOLIS, GHANA

BY:

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DECLARATION

I, Kenneth Missah, hereby declare that this research dissertation is my own conceptualized work under supervision. This project submitted to the Department of Community Health, Ensign College of Public Health, Kpong has not been presented in whole or in part to any other University for the award of any degree. All references cited in this dissertation have been duly acknowledged.

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DEDICATION

I dedicate this work to the Almighty God, my dad and mum, Mr. Thomas Missah and Mad. Eunice Darkwaa, my siblings, my supervisor Dr. Stephen Manortey for his relentless effort to ensure everything is done appropriately.

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ABSTRACT

Background

Usage of family planning services in developing countries have been found to avert unintended pregnancies, reduce maternal and child mortality. Men as the main decision-makers in most African families have an important role to play towards acceptance of family planning methods. However, it's usage still remains low. Hence, the objective of this study was to investigate the factors that influence male involvement in family planning.

Method

This was a descriptive cross-sectional study conducted in the Tema Metropolis of the Greater Accra Region of Ghana. Two hundred and twenty seven (227) males between the ages 19 and 58 years were recruited using stratified and simple random techniques and quantitative method research approach was then employed to assess perceived factors that contribute to male involvement in family planning. A well-structured questionnaire was used to source primary data from respondents, entered into excel 2016 and analyzed with Stata version 14. Univariate, bivariate and logistic regression analyses were performed to display the outputs.

Results

The study revealed that a little over two-thirds (68.72%) of the respondents disagreed in total family planning is an issue for only women. The majority (83.26%) of the respondents, reported their communities accept the act of men accompanying their wives or partners for family planning services, however, 36.12% of them reported that their family and friends see it strange for men to attend family planning with their wives/partners. Out of the 34.4% male respondents who reported

ever attending any such family planning clinic, 56.41% had attended just once. Marital status, employment status and knowledge about family planning of respondents were positively associated with male involvement in family planning ($P<0.05$). Major significant factors contributing to male involvement in family planning were old age (46-58), being unmarried and self-employment.

Conclusion

In this study, the level of male involvement was low, although most men were aware of family planning in the Tema Municipal, the uptake of the family service was low. Old age, being unmarried and self-employment were the factors that influence male involvement in family planning. Thus, there is the need for the office of the Metro Health Directorate to intensify health education on the benefits of family planning with male involvement The family planning programs should incorporate the responsibility and role of males in the uptake of family planning service.

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ABBREVIATIONS/ACRONYM

CPR	Contraceptive Prevalence Rate
CHPS	Community- based Health Planning and Services
CHO	Community Health Officers
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GSS	Ghana Statistical Survey
HIV	Human Immunodeficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Foundation
MOH	Ministry of Health
SSA	Sub-Saharan Africa
UN	United Nations
MoH	Ministry of Health
SRH	Sexual and Reproductive Health
WHO	World Health Organization

CHAPTER ONE

1.0 **INTRODUCTION**

1.1 **Background**

Until recently, fertility and family planning research in developing countries, as well as policy and program formulation, have generally relied on data collected from women. Increasingly, however, attention is being paid to the inclusion of men. Family planning is a way of controlling the population and helps in reducing unintended pregnancies (Cates, 2010). Direct and indirect benefits of family planning include the reduction in the spread of HIV to newborn babies (Reynolds *et al*., 2008); reduction of maternal mortality and morbidity (Cleland *et al*., 2012); reduction in neonatal, infant and child mortality (Rutstein, 2005); reduction recourse to often unsafe abortion (Sedgh *et al*., 2012) and improvement in education and employment opportunities for women who are able to delay initiation of childbearing (Singh *et al*., 2009).

The reasons for the new interest in men are not hard to find. First, information that has become available from surveys conducted over the past decade suggests that men and women do not necessarily have similar fertility attitudes and goals (Basset *et al*., 2000). Second, the scope of fertility and family planning research has expanded to include such broader reproductive health issues as sexually transmitted diseases, on which data from both men and women are needed (Reynolds *et al.*, 2008).

Although women bear children and most modern contraceptives are female-centered, childbearing has an impact on the lives of men too. This impact may be felt financially if men accept the responsibility of supporting their children and in a range of other ways, including the health and

well-being of their wives and children. Often, a man's social status is also affected when he becomes a father (Ijadunola *et al.*, 2010).

The male partner may play an impact role in decision-making regarding contraceptive use and the number of children they would like to have. In some countries or among some social groups, according to Lasee and Becker (1997), the male partner has greater influence than his spouse. In Ghana, the wife's attitude toward contraception is strongly influenced by her husband's attitude and background characteristics, especially education but the husband's views are similarly influenced by his wife (Ezeh, 1993).

Family planning in Ghana dates as far back as 1956 (Adanu *et al*., 2009). However, studies have shown that uptake of family planning in Ghana has not been encouraging. The 2011 Multiple Indicator Cluster Surveys (MICS), reported that the contraceptives prevalence rate among Ghanaian women was 34.7% and about of 26.4% of women had an unmet need for family planning (GSS, 2012). The facts indicate low use of contraceptives use among Ghanaian women. The prevalence of contraceptive use is lowest currently amongst married women in the youngest and oldest age groups (GDHS, 2014). Married women in urban areas are more likely to use contraceptive methods than married women in rural areas (GDHS, 2014). The contraceptive prevalence rate (CPR) among women was highest in the Volta Region and lowest in the Northern Region (GDHS, 2014).

The perception that men will necessarily have more influence on reproductive health decisions because they typically control the family's assets, and are accepted as the household head. The actual situation is likely to depend on other factors which vary over time and by location. For instance, among the Yoruba of Nigeria, the fertility desires of both marriage partners are important predictors of the couple's fertility. However, whereas the husband's desire is dominant in

predicting the couple's behavior when the number of living children is small, the wife's desire becomes more important as the number of children grows (Ijadunola *et al*., 2010). In Taiwan, when spouses disagree over whether to have another child, the wife tends to prevail (Dewi, 2009).

Efforts to promote family planning in developing countries have often been criticized for the exclusion of men. The consequence of the female-only approach has been that some men view family planning with suspicion, regarding it as being aimed at undermining their authority in the family. For instance, men in Nigeria typically believe that contraception makes it easy for their wives to engage in extra-marital sexual relations (Ijadunola *et al*., 2010). While men's attitudes toward family planning are generally positive, some studies show that men believe that they should be in control of when a couple should use contraceptives (Mbizvo *et al.*,1996).

The low involvement of male in family planning is believed to be as a result of several factors. These factors include male's perception on family planning, their socioeconomic and demographic profiles, policies in place, mass media campaigns, inter-personal communication from health workers, advice from family members, spousal communication and health systems in place(Arundhati,2011). According to Ijadunola *et al.,* (2010), there is an urgent need to increase male involvement in family planning in Ghana. Low levels of knowledge, social stigma, shyness, embarrassment, and job responsibilities contributes to the low involvement of males in family planning (Mullany, 2006; Agha, 2010).

Failure to involve men in family planning programs may result in serious implications. Even when women are educated and motivated to practice contraception, they may not do so because of opposition from their husbands. Individuals interviewed in urban Sudan believed that the male partner decides whether a couple will use contraceptives and which method would be chosen. (Khalifa,1988)

The importance of men in reproductive decision-making and its effect on contraceptive use as well as the behavior of couples has been increasingly recognized as a subject of interest in the global context (Basset *et al.*,1993; Karra *et al.*,1997). The ICPD-POA and the 1995 Beijing Conference on women and reproductive health reaffirmed the importance of responsible parenthood and the need to include men in family planning and reproductive health programs and actions (IPPF,2005/2006).

It is widely accepted that family planning services are essential to fertility decline. The proximate determinant of ongoing fertility decline in the developing world has been the widespread adoption of contraception. Previous studies have shown that the availability and accessibility of family planning services is an important determinant of contraceptive use (Tsui *et al*., 1992). In Vietnam, the case of obtaining contraceptives has been shown to be an important factor in the success of family planning programs hence the need for male involvement in family planning (UN,1997).

1.2 Problem Statement.

The Ministry of Health (MoH), with assistance from John Hopkins University in 1997 launched an educational campaign program in all the regions of Ghana focusing on male involvement in family planning. According to Arundhati (2010), male involvement in reproductive health and family planning is a very important factor in the success of any sexual and reproductive health (SRH) program. This is due to the fact that in developing nations like Ghana, societal norms and religious beliefs ensure men are often the primary decision-makers on the use of family planning by their partners and also decide family sizes (Adelekan *et al*., 2014). These in effect ensures lower contraceptive prevalence, increased unsafe abortions, failure of reproductive health programs and eventually high maternal mortality (Ijadunola *et al*., 2010). There are barriers that may impede

male involvement in family planning such as poverty, unemployment, religion, cultural and societal norms and education (Eni, 2005). Men may be deeply and psychologically involved in family planning but these barriers may not allow them to demonstrate their involvement. Inadequate male involvement in family planning has been identified as the major factor affecting family planning acceptance in Africa in general (Ndezenko *et al.*,2001). Despite a reported appreciable knowledge in family planning nationwide, male involvement is not encouraging and it is a barrier to even female acceptance and practice of family planning (GSS, 1998). The study, therefore, seeks to ascertain why male involvement, approval, and practice of family planning are low and how men can move to a high level of knowledge and awareness and provide a higher level of support for women and the practice of family planning.

1.3 Rationale of the Study

In sub-Saharan Africa, family planning and reproductive health care research and interventions place a disproportionate emphasis on women and largely ignore the role of men (Mbizo *et al*., 1996). As a result, male participation in family planning and reproductive health has been low (WHO, 1995).

Men in Africa, are heads of their households and are often key figures in domestic decision making, particularly about fertility behavior and preference and that authority is supported by tradition.(Obionu,1998). They are the main link between the family and the prevailing culture and are the major players in bringing development to the home. Fapohunda *et al.*, (1998), observed that Africa family structure shapes spousal perceptions of fertility and that men and women do not necessarily have the same views about family planning and reproduction because their interests are shaped by expectations which are determined by the social structure of their households and

community. The failure to include men in reproductive research could reduce coverage, bias findings, and undermine the applicability of findings for policy and programs.

Indeed, an understanding of men's perspective on family planning and reproductive health could provide more insights that are possible by studying women because men have more power than women in reproductive decision making including the number of children and whether or not use family planning. As such their views need more careful and systematic analysis especially since those views are important determinants of women reproductive attitude and behavior (Rutenberg *et al.*, 2002; Ezeh, 1993). Men dominate decisions and policies in the public domain. Therefore, an understanding of their reproductive perspectives could identify program interventions to promote the use of services by men both as family planning clients and partners to women clients and this, in turn, would influence family planning and reproductive health policies.

1.4 Conceptual framework of male involvement in family planning

A conceptual framework is a research tool intended to assist the researcher develop awareness and understanding of the situation under scrutiny and to communicate it effectively and efficiently. Hence the conceptual framework below shows the interplay of the various factors that will facilitate male involvement in family planning using the health belief model as the theoretical guide. Male awareness and understanding of family planning and the need to adopt a family planning method are the individual perceptions of males which are influenced by direct factors such as socio-economic and demographic characteristics and intermediate factors such as interpersonal communication by health workers, mass media campaign and policies on male involvement in family planning. All these result in cue to action as male individuals now adopt a

positive reproductive health action and behavior which will facilitate more male involvement in family planning.

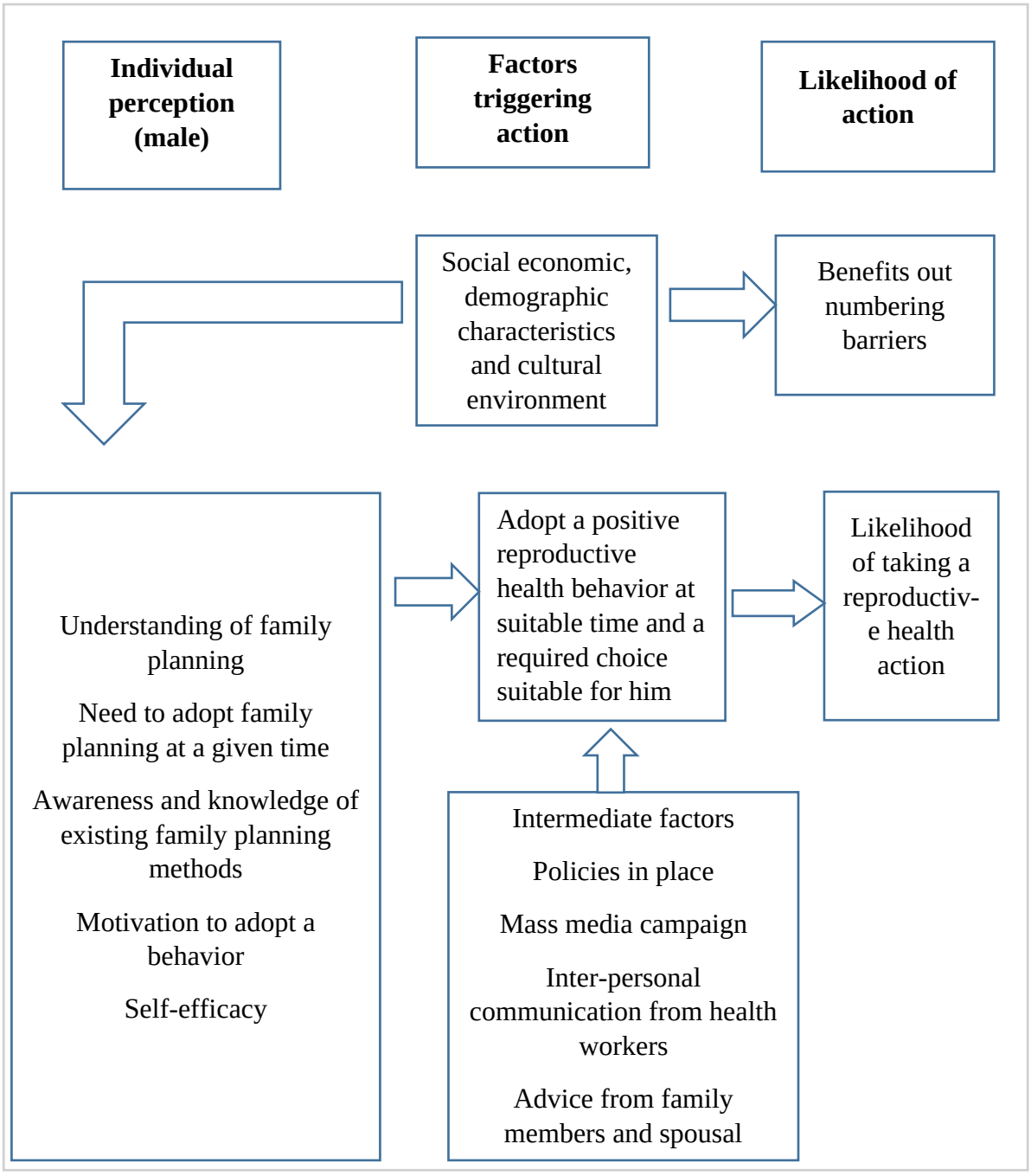

Fig 1:1 Conceptual framework of male involvement in family planning

Source: *Adapted from previous research (Brugin, 2004)*

1.5 Research Question

In order to arrive at any reasonable and meaningful conclusion, the following research questions were used.

1. What is the proportion of male involvement in family planning?
2. What is the level of knowledge and perception of men concerning family planning?
3. What are the barriers that affect male participation in family planning?

1.6 General Objectives

The general objective of the study is to explore the involvement of men in family planning within the Tema Metropolis in the Greater Accra Region of Ghana.

1.7 Specific Objectives

In pursuance of this, the study was guided by the following specific objectives:

a) To assess the knowledge and the perception of males concerning family planning.
b) To determine the proportion of males who are involved in family planning.
c) To identify the barriers to male participation in family planning.
d) To explore the association between selected socio-demographic characteristics and male involvement in family planning.

1.8: Profile of the Study Area

Tema Metropolis is one of the districts of the Greater Accra Region, located in the Southeastern part of Ghana. The new Tema Metropolis is a virtually fully-built –up area. It is a vibrant

commercial and industrial city – about the only well-planned city in the country. It has a large harbor – one of the world's biggest man-made harbors which is the main seaport entry to Ghana. The new Tema Metropolis is bounded in the North-East by Ashaiman Municipality, in the North-West by Adentan Municipality, on the West by Ledzokuku-Krowor Municipality, in the South by the Gulf of Guinea and in the East by the Kpone-Katamanso District. With a growth rate of 3.1 percent, the population of Tema Metropolis is estimated to be 330,792 (as projected from the 2010 census). The population of male adults 18 years and above is estimated to be about 100,000 from the 2017 population distribution in the Tema Metropolis [Tema Metro Health Directorate 2017].

1.9: Scope of the study

The study was conducted to find out male involvement in family planning within the Tema Metropolis. It was done by administering structured questionnaires to males residents 18 years and above to ascertain their involvement in family planning. This was done over a period of 3 months within the Tema Metropolis in the Greater Accra Region of Ghana.

1.10: Organization of study

The study was organized into chapters that follow the order as Introduction, Literature review, Methodology, Results, Discussion, Conclusions, and Recommendations.

CHAPTER TWO

2.0: LITERATURE REVIEW

2.1: Background

Family planning is a deliberate effort of couples to regulate the number of children and spacing at birth. It aims at improving family lives at the micro level and contributes to the sustainable socio-economic efforts at the macro level. This is done through fertility decline among other mechanisms. However, variables such as education, religion, socio-economic as well as socio-cultural factors often affect the effectiveness of family planning programmes. The World Health Organization (WHO) explained that despite great progress over the years, many women worldwide want to prevent pregnancy but they and their partners are not using contraceptives and some of the reasons for this unmet need are quality of service, unavailability of range of methods, fear of opposition from partners and worries of side effects and health concerns among others (WHO,2007). One factor that deserves attention is the involvement of males in family planning.

Male involvement in family planning means more than increasing the number of men using condoms and having vasectomies; it also includes the number of men who encourage and support their partners in contraception and encourage peers to use family planning and who influence the policy environment to be more conducive to developing male related programmes. In this context, male involvement should be understood in a much broader sense than male contraception and should refer to all organizational activities aimed at men as a discrete group, which has the effect of increasing the acceptability and prevalence of family planning practice of either sex (Obionu, 1998).

There have been several decades of neglect of male involvement in family planning dating back to the 1960s with the development of modern contraceptive methods for women. One of the reasons why family planning program focused on women instead of men was the assumption by many providers that women have the greatest stake and interest in protecting their reproductive rights. (Mbizvo *et al.*,1996). But the growing number of family planning research is facing challenges on the isolated focus on the women and focusing on the influence of their male partner on protecting women reproductive health. This is especially true in sub-Sahara African (SSA) where men influence decision making in many ways (Ezeh, 199;, Marrida *et al*., 2004).

Globally, 38% of pregnancies are either unwanted or unplanned. In Africa, unwanted pregnancies poses a major and continuing social, health, and development challenge. It accounts for more than a quarter of the 40 million pregnancies that occur annually in the region, which could be due to contraceptive failure, non-use of contraceptive in general and to a lesser extent due to rape. Considering the consequences, it is important to prevent unintended pregnancy by providing access to contraceptives including emergency contraception, safe abortion services and empowering women to determine their reproductive choices (Fotso *et al*., 2011), thus the need to involve men in family planning to ensure effective family planning in homes, communities and nations at large.

2.2: Family planning in Ghana

According to the 2014 Ghana Demographic and Health Survey (GDHS), only 27% of married women use family planning with 22% using modern methods and 5% using traditional methods. Thirty percent (30%) have an unmet need of family planning (GDHS, 2014). This high unmet need for family planning supports the need to involve the male partner.

According to a study done on factors influencing the uptake of family planning in the Talensi district in Ghana, it was revealed that 89% of respondents were aware of family planning services and 18% of respondents had used family planning services in the past. Parity and educational level of respondents were positively associated with usage of family planning services. Major motivating factors to the usage of family planning service were to space children, and to prevent pregnancy and sexually transmitted infections. Major reasons for not accessing family planning services were opposition from husbands (90%) and misconceptions about family planning and therefore the need for male involvement in family planning. (Apanga *et al.*, 2015).

Adongo *et al*.,(2006) tried to examine men's concerns about reproductive health services in a rural Sahelian setting of Northern Ghana whiles focusing on the Zurugelu and found out that community mobilization and male outreach was not sufficient for introducing behavioural change. Uptake of contraceptive services was greater and more sustained among the Zurugelu when combined with Community-Based Health Planning and Services (CHPS) and Community Health Officers (CHO) services than when Zurugelu lacked supporting CHO. Introducing CHPS and the services of CHO, to focus on men in the Zurugelu community, sustained and significant improved reproductive change among the Kassena-Nankana of northern Ghana (Adongo *et al*., 2007). In the same study, they investigated elements of the social system of the Kassena-Nankana that influence reproductive beliefs and behaviour and found out that women opting to practice contraception must do so at the considerable risk of social ostracism or familial conflict. Few women view personal decisions about contraceptives as theirs to make. Although children are highly valued for a variety of economic, social, and cultural reasons, mortality risks remain extremely high. (Adongo *et al.*, 2007)

2.3: Knowledge and perception concerning family planning among males

In a study to investigate men's knowledge, attitude and practice of family planning in Enugu Nigeria, it was revealed that males with some level of knowledge about family planning and modern contraceptive methods showed considerable opposition to their use on religious grounds (Obionu, 1998). In contrast, a survey done in Khartoum Sudan showed a strong positive attitude towards family planning services by men, with few actually using a method. Similarly, a study in Danfa in Ghana came out that more than two-thirds of rural men approved and accessed family planning services, and that men knew at least one modern method and they also prefer visiting mobile clinics for obtaining condoms rather than buying them in a chemical shop (IPPF, 2005/2006). This situation is common in most of the health centres due to the unconducive environment and the fact that the health facilities are not male user-friendly.

Another survey explored the knowledge, attitudes, and practice of family planning among men in the Ngara district of Tanzania. It was revealed that the male contraceptive prevalence was low and knowledge of male method was also limited. Various studies have shown that there is no direct relationship between knowledge and utilization of family planning service by men. Besides, men perceived that male methods such as vasectomy are associated with castration while condoms reduce sexual sensation on the part of men and this can easily result in the spread of sexually transmitted infection including AIDS (Ndenzako *et al.*, 2001).

A study conducted in the rural areas of Pakistan on knowledge and attitude among married men showed that knowledge and use of any contraceptive method were particularly low. Reasons for not using family planning and modern contraception included incomplete family size, negative perceptions, in-laws' disapproval, religious concerns, side-effects, and lack of access to quality services (Ghulam Mustafa *et al.*, 2015).

According to a study conducted in Bangladesh, a focus group discussion was employed to assess male knowledge and attitude towards family planning, the way they use what they know, and others. It was noted that men have knowledge and positive attitude towards family planning methods but are reticent to use it. The reason for which could be attributed to various factors (Dhaka, Bangladesh Population Council, 1996). Another survey conducted in Mpigi district in Uganda, it revealed that, men had limited knowledge about family planning, that family planning service did not adequately meet the needs of men and that, spousal communication about family planning issues is generally poor (Kaida *et al*., 2005).

Again, another study in the service area of the Jawaharlal Institute Urban Health Centre showed that most men were aware of most of the family planning methods such as the permanent method of sterilization, condoms, abstinence, and the other contraceptive devices and that even some men prefer particular methods to others (Kumahikupam, 2003). This shows that knowledge and preference play a role in male involvement in family planning, but not the utilization of the methods.

2.4: Availability and Accessibility of Family Planning Service to Men

Studies have shown that there are certain hindrances to male utilization of family planning service though male play an important role in reproductive health According to a demographic health survey conducted in Ilorin, Nigeria, family planning clinics are oriented to women, therefore, men often feel uncomfortable and unwelcome in these clinics (Olawepo *et al*., 2006). According to a survey on approved contraceptive use, men's lack of access to the family planning service is a barrier to its use. Therefore, men cannot share their responsibility on reproductive health, including family planning if they cannot access the service. Most family planning clinics, according to a

study mainly cater for women, so men are not comfortable visiting these clinics (Population Report, 1994).

Similarly, a case study conducted in Khao Cehakan District in Thailand showed that majority of males knew where the family planning service was available, some know about health centres, others, hospitals whiles some primary health care units, and drug stores. Majority of the male clients had to travel for the service at less cost (Eni, 2005). The real situation on the ground is that although men are aware of family planning service, access and utilization is low and poor.

A research conducted in Tanzania on condom access and usage, the study indicated that the use of condom is very low, primarily due to limited demand, and accessing the method in particular (Bongaarts, 2006). A survey was again conducted on cultivating men's interest in family planning in the rural EI Salvador. The study identified access to family planning as critical to sustainable development, by reducing the high risk of unwanted pregnancies that cause maternal and child deaths, besides reducing sexually transmitted infections, including AIDS (Lundgren *et al*., 2005).

2.5: Proportion of males involved in family planning.

A survey revealed that even though there has been some success in trying to increase male utilization of family planning service, the reality remains that most males do not utilize the service and it is evident that while some positive strides have been taken, some negative influence act to inhibit male utilization of family planning service (Sonenstein *et al.*, 1995). A household survey was conducted in an urban and rural area in Kwazulu-Natal, South Africa showed that knowledge about male family planning such as condom was very high, but few men reported consistent or occasional use (Cleland, 2006).

A study carried out in Bangladesh revealed that low use of male methods is likely to remain static in most of the developing countries. Even though there is a high level of contraceptive prevalence in some developing countries but the contraceptive use rate of male methods is very low. Despite the pioneering role played by age-old male methods in the evolution of family planning, the present contribution of male methods (traditional & modern) to the total contraceptive prevalence rate is still low (Hossain, 2003). Here, consultation with men (either alone or as part of a couple) covering a wider variety of topics on reproductive health issues, using skilled and competent service providers, preferably males will help close the gap between male and female access to family planning service in general.

The GDHS 2003, showed that married men and sexually active men who reported having ever used one or more male methods of contraception, which are male sterilization, male condom, periodic abstinence and withdrawal, the most popular male method, the condom has been used by few males, both married and unmarried males. Male sterilization, however, is practically non-existent in Ghana. What is known in literature is that most male methods are used by few males. Of the other two traditional methods, according to studies periodic abstinence is reported as used more than withdrawal by both married and unmarried men (GSS *et al*., 2004).

A survey conducted in the United States found out that on average; male comprise only 6% of all family planning clinic clientele, this compared to a research carried out in Danfa in Ghana revealed that males prefer visiting mobile clinics for obtaining condoms rather than buying it in a store (IPPF, 2005/2006). This indicates that males patronized the service brought to them at their door step rather than going to the health centres.

Also in a study on male involvement in family planning decision in sub-Saharan Africa, it showed that, generally, more male respondents disagreed than agreed that men should make decisions

about selected family planning issues in the family. Decision-making dynamics around method choice followed a slightly different pattern (Marius *et al*., 2014). This further add up the need to involve men in family planning

Another study on the role of men in fertility and family planning in Tigray region in Ethiopia showed that most of the family planning programs, moreover, have less attention towards the understanding of men's role in the effective and consistent utilization of contraceptive methods (Young *et al*.,2002). Family planning providers, in general, both government and private fail to address men's concern and fears, which are different from that of women. It was also observed that men generally, desire larger families than do their wives. This is because of the social and economic gain they derive from having a large number of children.

2.6: Factors and barriers that influence the patronage of family planning methods

There are many barriers to the use of modern contraception which include lack of awareness, lack of access, cultural factors, religion, and opposition to use by partners or family members and fear of health risks and side effects of the contraceptives.

According to Mullany (2006), the most prominent barriers to male involvement in family planning included low levels of knowledge, shyness/embarrassment, social stigma, and job responsibilities. It was also found that lack of knowledge about maternal health among Nepalese husbands impedes positive involvement in maternal health care. Agha *et al*., (2010), also reports that there is a higher probability of the couples adopting a modern contraceptive method when their mother-in-law was not living with them.

According to Thepa *et al*., (2010), intra-spousal communication was found to be positively associated with husbands' presence at a health facility delivery, also the fear of social stigma and feelings of shame for supporting their wife, elaborating on the traditional cultural norms that attach a negative value to husbands who play a supportive role during their wife's maternity period affects male involvement in family planning.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study method and Design

A descriptive cross-sectional study design was used to gather the needed data on male involvement in family planning in the Tema Metropolis. A quantitative method research approach was employed to access the perceived factors that contribute to male involvement in family planning.

3.2 Data collection Techniques and Tools

The main source of data was primary data. A structured questionnaire was used to source information from respondents. The questionnaire design included both close-ended and open-ended questions and captured the knowledge and perception of men about family planning and identified various barriers that affect male involvement in family planning.

3.3 Study population

Tema Metropolis is one of the districts of the Greater Accra Region, located in the Southeastern part of Ghana. A total of three new districts have been demarcated from the former Tema Municipality. Initially, two new districts, Adentan, and Ashaiman Municipalities were carved out and the rest of the district was upgraded to a Metropolitan status. These changes were gazetted on 28th February, 2008. Towards the end of 2011, another new district, Kpone-Katamanso was re-demarcated from the metropolis leaving the current district described in this profile.

The new Tema Metropolis is a virtually fully-built up area. It is a vibrant commercial and industrial city – about the only well-planned city in the country. It has a large harbor; one of the world's biggest man-made harbors which is the main seaport entry to Ghana. These and other resources, however, have attendant health and health-related implications for the population. For instance, diseases such as HIV/AIDS, Tuberculosis occupational accidents and other health disorders are more prevalent than elsewhere in the country. The new Tema Metropolis is bounded in the North-East by Ashaiman Municipality, in the North-West by Adentan Municipality, on the West by Ledzokuku-Krowor Municipality, in the South by the Gulf of Guinea and in the East by the Kpone-Katamanso District. The total square kilometers of the land area of the re-defined Tema Metropolis is yet to be documented as the Legislative Instrument that established the new metropolis does not indicate exact boundaries. Generally, the metropolis stretches between latitude $5^0$37'N in the southern coastline and latitude $5^0$41'N at its northern most limits. The Kwame Nkrumah or Accra- Tema Motorway delimits its northern boundary. The eastern and western boundaries fall within longitudes 0.0'and 0.5'W respectively. The Greenwich Meridian (Longitude zero) passes through the Metropolis and situated only about 50m from the Equator. Tema Metropolis is considered as being the city in the center of the world.

On the Tema coastline can be found a large harbour, which stretches nearly 2km long; and a Military Naval Base. These, along with it's numerous large as well as small industrial establishments make Tema very important for the economy and security of Ghana. With a growth rate of 3.1 percent, the population of Tema Metropolis is estimated to be 330,792(as projected from the 2010 National Population and Housing Census). The population of male adults 18 years and above was estimated to be about 100,000 from the 2017 population distribution in the Tema Metropolis [Tema Metro Health Directorate 2017].

The target population for the study were male adults age 18 years and above living in the Tema Metropolis who have met the prerequisites for inclusion into the study.

3.4 Study Variables

The variables for the study are as follow

3.4.1 Dependent variables:

The dependent variable in the study is composite variables comprising questions covering respondent interest and practical involvement in family planning such as “ever discussed family planning with wife, ever attended family planning clinic, ability to make time off busy schedule to attend family planning’’.

3.4.2 Independent variables:

The independent variable included: socio-economic indicators, demographic profile, cultural environment of men, male perception of family planning, awareness and knowledge of existing family planning methods, spousal communication, health systems and policies set in place.

3.5. Sampling

3.5.1 Sample size

The sample size was calculated using Cochran’s formula (1997) to estimate the sampled population that were interviewed

$$n = \frac{Z^2 \times pq}{e^2}$$

Where,

n = sample size (Cochran, 1977)

Z = the z-score that corresponds with 95% confidence interval which is 1.96

p = prevalence rate of men involved in family planning

q = Proportion of men who are not involved in family planning

e = Margin of error set at 5% (0.05)

Therefore,

$$n = \frac{(\ 1.96\ )^2 \times (0.18 \times 0.82)}{(\ 0.05\ )^2} \cong 227$$

Using p=18% as the prevalence of male contraceptive use in Ngara Tanzania (Fabien *et al*, 2001)

3.5.2 Sampling method

For the purpose of this study only men living in rural communities in the Tema Metropolis were interviewed. This is because patronage of family planning is high in urban areas compared to rural areas (GSS,2012). Stratified sampling technique was used as communities in each sub-Metro such as Tema East, Tema West and Tema Central were selected. The total number of houses within each community was divided by the sample size to get a sample interval. The list of house numbers was obtained from the Tema Metropolitan Assembly. A house was randomly selected within the interval and that served as the starting point. The interval was then selected randomly as subsequent houses. Within the selected houses, one male in each household was interviewed. Simple random

sampling was used to select respondents if there was more than one male adult in each household. In cases where there were no respondents, the next house was used and the count continued.

3.6 Pretesting

The questionnaire was pretested in the Nungua Municipal which is a district with similar socio-demographic characteristics as the Tema Metropolis. This helped to identify issues that were not clear in the questionnaire. It also enabled the research team to know the estimated time it would take to administer a questionnaire. After the pre-test, the questionnaire was modified as appropriate before it was finalized for the actual fieldwork.

3.7 Data handling

The data were collected on well-developed questionnaires. Data collected from the participants were double entered into Microsoft Excel 2016 and cleaned to ensure consistency and eliminate errors. All non-respondents were treated as missing. The cleaned data were then imported into STATA Statistical software package (*StataCorp.2007. Stata Statistical Software. Release 14.* StataCorp LP, College Station, TX, USA) for analysis.

3.8 Data Analysis

STATA Statistical software version 14. was used to analyze the data. Frequencies were run for key variables and the results were presented in table and charts. Bivariate analyses using Chi-square were performed to test the relationship between male involvement in family planning and socio-demographic characteristics. Multiple logistic regression was used to examine the

predictors of male involvement in family planning. The Logistic model was constructed with variables that were significant in the bivariate result. Odds ratios (OR) and their 95% confidence intervals were used to assess the strength of association. In all statistical analyses, a p-value of 0.05 was used to determine statistical significance.

3.9 Ethical consideration

Ethical approval for the study was obtained from the Ethical Review Committee of Ensign College of Public Health and administrative permission was sought from the Tema Metro office of Ghana Health Service (GHS). Permission was also obtained from the Assemblymen, the chiefs and opinion leaders of the various communities where the study was conducted before the commencement of the study. Signed individual informed consents were obtained from each participant before they proceeded to answer the questionnaire. Study participants were informed of their right to opt out of the study at any time they feel uncomfortable with the posed questions or feel physically and mentally harmed in the course of the data collection. Confidentiality of collected information was ensured.

3.10 Limitation of Study

The sample size was not large enough to give a true reflection of the population under study. Time and resources were limitations in my study as well.

3.11 Assumptions

It was assumed that respondents had good understanding of family planning, understood all the questions in the questionnaire and responded accurately to what was asked of them.

CHAPTER FOUR

4.0 RESULTS

4.1 Demographic characteristics of respondents

Table 4.1, represents a tabular distribution on information about demographic characteristics of respondents. The majority (52.86%) of the respondents were in the 33-45years age group, followed by 37.44% who were within 19-32years age group then 9.69% belonged to 46-58years age group. Also, the majority (86.7%) of the respondents had Secondary and higher education whiles only 3.52% of the respondents had attained primary education. About two-thirds (63.88%) of the respondents were married and the rest were not. A little over half (53.74%) of the respondents were employed, 6.6% were unemployed and 40% were self-employed.

Table 4.1 Demographic Characteristics of Respondents

Factors	Frequency	Percentage(%)
Age group		
19-32	85	37.44
33-45	120	52.86
46-58	22	9.69
Education		
Tertiary	136	59.91
SHS	61	26.87
JHS	22	9.69
Primary	8	3.52
Marital Status		
Married	145	63.88
Not married	82	36.12
Employment Status		
Unemployed	15	6.61
Employed	122	53.74
Self-employed	90	39.65

Source: *Field data, 2019*

In terms of the study participants, professed religious beliefs and practices as shown in Figure 4.1 Orthodox participants formed about a quarter of the sample (25.3%), Charismatic formed less than half (43.17%) and Catholic formed twenty percent (20.26%) of respondents.

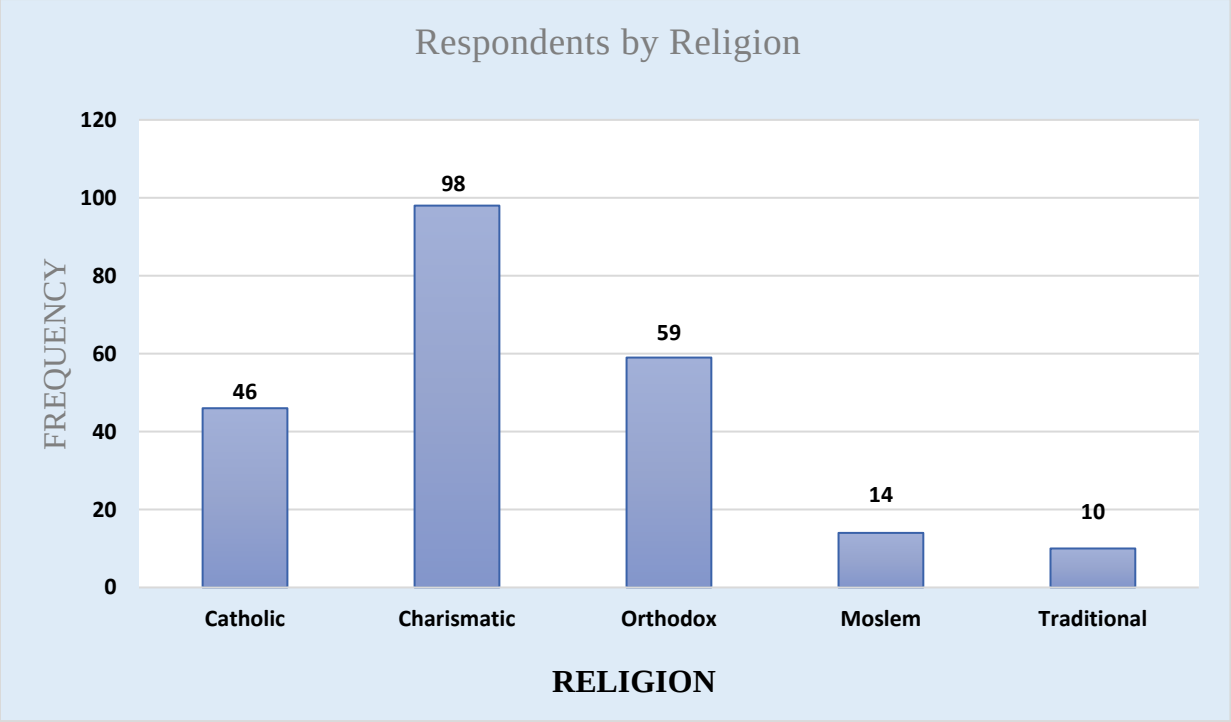

Fig 4.1: Distribution of respondents by religious beliefs and practices.

4.2 Respondents Knowledge and Perception of male involvement in Family Planning

Table 4.2 below presents information on the respondent's knowledge and perception of male involvement in family planning. Majority (83.26%) of the participants, said their communities accept the act of men accompanying their wives or partners for family planning services, though 36.12% of them reported that their family and friends see it strange for men to attend family planning with their wives/partners. A little over two-thirds (68.72%) of the respondents disagreed in total when asked if family planning is an issue for only women. More than half (52%) of the

respondents said men who are involved in family planning, are not stigmatized, but 34% of them indicated that their communities consider men involved in family planning as abnormal. Concerning the barriers to male involvement in family planning, less than half (40.53%) of the respondents said the cost in normal. Half of the respondents (51.4%) indicated that it takes them less than 30mins to get to a family planning clinic. The time spent at a clinic was considered normal by most of the respondents since the majority (44.4%) said they spend less than an hour. More than three-quarters (78.5%) of the participants said the family planning staffs were friendly and beyond and health talks given at family planning clinic were very helpful as 94% of respondents ascertain to that, though 2% said its complete waste of time.

Table 4.2: Respondent's perception on family planning

Factors	Frequency	Percentages (%)
Comm. Acceptability		
Yes	189	83.26
No	38	16.74
FP issue for women		
Strongly disagree	100	44.05
Disagree	56	24.67
Neutral	29	12.78
Agree	13	5.73
Strongly Agree	29	12.78
Family and Friends reaction		
Strangely	82	36.12
Praise Him	46	20.26
Indifferent	99	43.61
Comm. Stigmatization		
Yes	109	48.02
No	118	51.98
Pressure from relatives to have more children		
Yes	81	35.68
No	146	64.32
Description given to men who patronize FP		
Helpful	58	25.55
Responsible	50	22.03

Normal	39	17.18
Abnormal	77	33.92
Poor	3	1.32
Cost of accessing Family planning services		
Expensive	55	24.23
Normal	92	40.53
Cheap	48	21.15
No idea	32	14.1
Length of time at Family planning services		
Less than 1 hour	102	44.93
1-2 hours	79	34.8
2-3 hours	34	14.98
3-5 hours	9	3.96
More than 5 hours	3	1.32
Perception of the time spent for FP services		
Short	53	23.35
Normal	103	45.37
Too Long	71	31.28
The Attitude of Family Planning Staff		
Very friendly	79	34.8
Friendly	100	44.05
Indifferent	23	10.13
Unfriendly	21	9.25
Rude	4	1.76
Perception of health talks at FP services		
Very helpful	107	47.14
Helpful	107	47.14
Unhelpful	8	3.52
Complete waste of time	5	2.2
How long it takes to get to FP clinic		
less than 30mins	117	51.54
30mins to 1 hour	78	34.36
1 - 2 hours	31	13.66
More than 2 hours	1	0.44

Source: *Field data, 2019*

Regarding respondents' knowledge on family planning as displayed in Figure 4.2, more than half (59.47%) reported they knew sufficiently and also a lot about family planning, whiles only 3.96% admitted not knowing anything about family planning

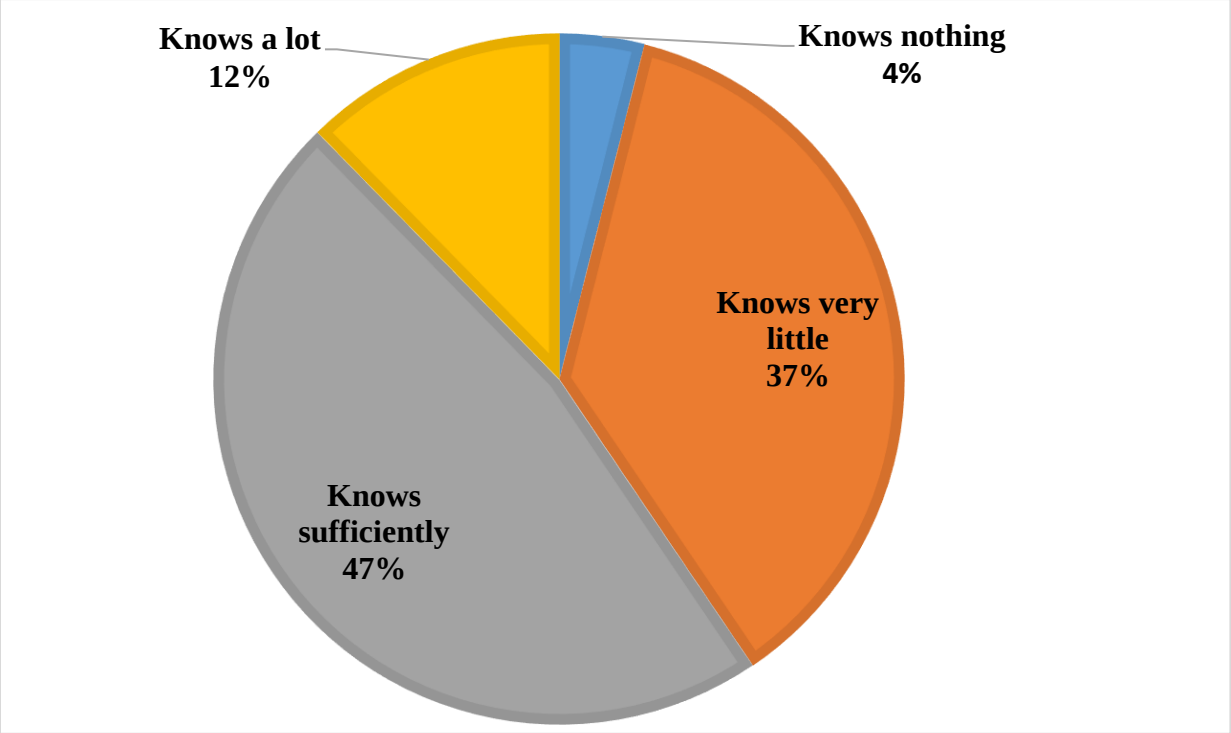

Fig 4.2: Respondents knowledge about family planning

Source: *Field data, 2019*

4.3 Enabling factors for male involvement in family planning

Table 4.3 below shows other enabling factors that encourage male involvement in family planning. About 60.8% of respondents had discussed family planning issues with their wives or partners and most respondents (78.26%) felt normal during family planning discussion though 11.60% and 10.14% of respondents felt shy and embarrassed respectively during the discussion. Most respondents (81.94%) had seen and read about family planning from many sources most predominantly the electronic media. The proximity of family planning center to most respondents

(66%) was close though there were no special arrangements for men as mentioned by 62% of respondents.

Table 4.3: Factors that encourage male involvement in family planning

Factors	Frequency	Percentage(%)
Discussed FP with partner/wife		
Yes	138	60.79
No	89	39.21
Respondent's feeling during FP discussion with partner/wife		
Normal	108	78.26
Shy	16	11.60
Embarrassed	14	10.14
Respondent saw/read about FP from source		
Yes	186	81.94
No	41	18.06
Respondent sources of FP information		
Internet	37	19.89
Media	136	73.12
Organization /Work	13	6.99
Proximity of FP facility to respondent resident		
Very close	59	25.99
Close	104	45.81
Far	58	25.55
Very Far	6	2.64
FP special arrangement for men		
Yes	87	38.33
No	140	61.67

Source: *Field data, 2019*

4.4 Male participation in family planning.

Concerning male participation in family planning, the results revealed that most (65.6%) of the respondents had never attended any family planning clinic. Among the 34.4% who reported ever attending any such family planning clinic, 56.41% have attended just once. Most of the

respondents (76.65%) indicated family planning is important and are ready to recommend to friends to also attend.

Table 4.4: Level of male participation in family planning

Factors	Frequency	Percentage(%)
Ever attended FP clinic		
Yes	78	34.36
No	149	65.64
Number of times attended FP		
Once	44	56.41
Twice	20	25.64
Thrice	5	6.41
Four or more	9	11.54
Importance of FP to Respondents		
Not important	26	11.45
Important	84	37
Very important	77	33.92
Extremely important	40	17.62
Recommend FP to friend/relative		
Yes	174	76.65
No	53	23.35
Any challenges accessing FP services		
Yes	25	32.05
No	53	67.95
Main challenges to FP		
Lack of male FP providers	26	11.45
Stigmatization	23	14.54
Masculinity power	26	11.45
Wives with negative comm. Perception	11	4.85
Unsupportive	3	1.32
Peer pressure	8	3.52
Fewer contraceptive methods	22	9.69
lack of knowledge about FP	35	15.42
Shyness	29	12.78
Cultural beliefs	34	14.98
Know of Side effects of FP for men		
Yes	61	26.87
No	166	73.13

Figure 4.3 shows a distribution of respondents own perceived challenges in accessing family services. The common perceived challenge of family planning indicated by the respondents was the few methods and side effects. Most (15.4%) of the respondent said the most common problems of family planning faced by men who engage in family planning is lack of knowledge, followed by cultural beliefs (14.98%), stigma (14.54%), the least mentioned problem was unsupportive wife (1.32%) even though 73.1% of the respondents said family planning does not have side effect.

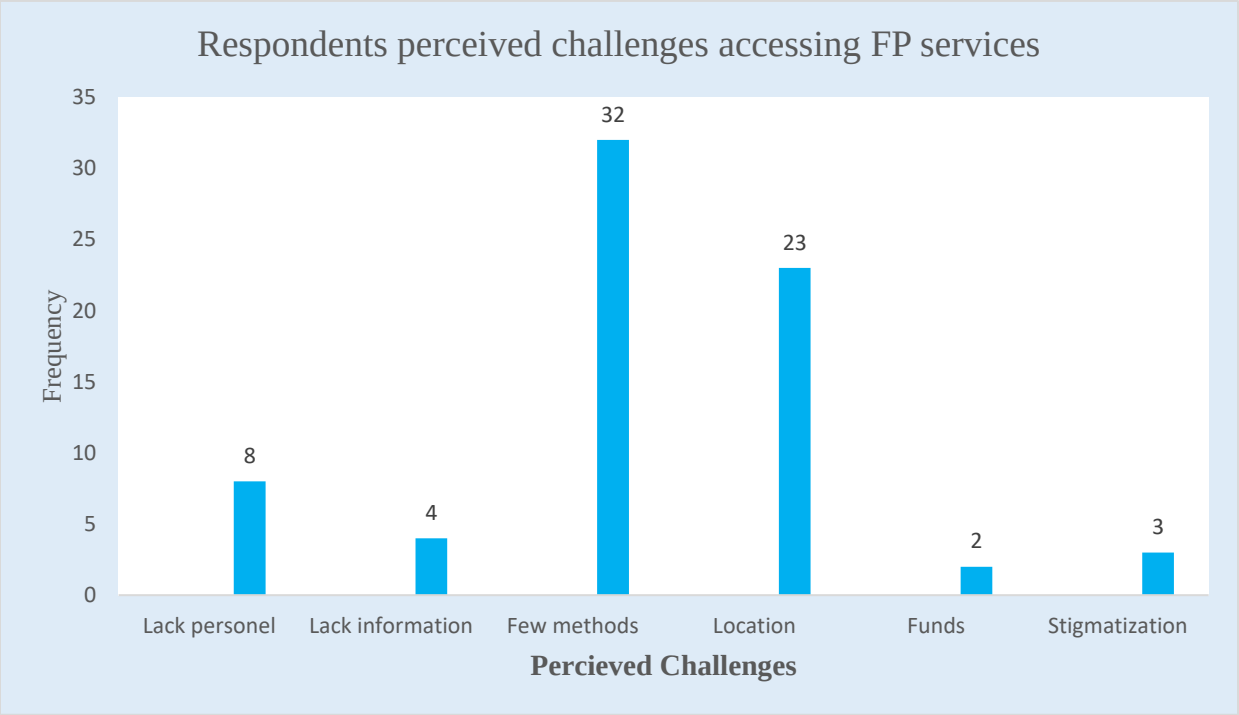

Fig.4.3 Respondents perceived challenges accessing family planning services.

Source: *Field data, 2019*

Regarding the side effects as shown in Figure.4.4, majority (61.7%) of the respondents indicated impotence as the common side effect, followed by high blood pressure (20%) and a small proportion of them (1.7%) indicated scrotal pain as a known side effect.

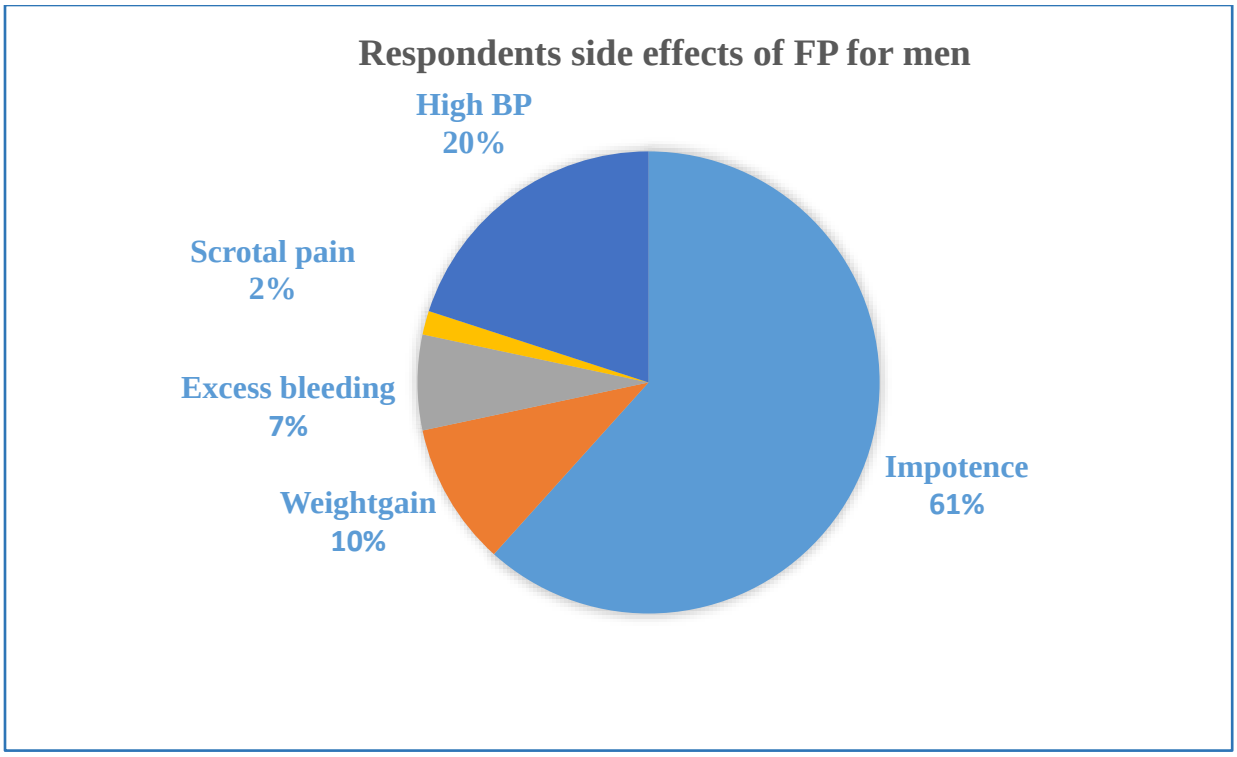

Fig 4.4 Respondents side effects of family planning for men.

Source: *Field data, 2019*

Respondents were asked why most males do not go for family planning.Approximately twenty eight percent (27.75%) of them attributed it to shyness and stigma, 27.31% thought it is for women, 19.38% of them indicated masculine power, and 12.33% of them indicated lack of education on family planning, only a small percentage (5.29%) of respondent said they had no time, though 7.93% of them said it was due to cultural reasons.

4.5 Bivariate associations between selected demographic characteristics and male involvement in family planning.

Table 4.5 represents bivariate analysis on factors associated with male involvement in family planning in Tema Metropolis. There was no association between age groups and male involvement, though males within the age group (33-45), 55.13% were involved in family planning

than males within the age groups (19-32) which was 41.03% (p=0.087).On the Educational level of respondents, males who had secondary school education and above were involved in family planning as compared to their counterparts who had basic education (5.13%) and primary education (1.28%) though there was no significant association (p=0.198), However men who were married (76.92%) were significantly involved in family planning as compared to those who were not married (23.08%), (p=0.004). Employment status was also associated with male involvement, in that men who are employed (67.95%) were significantly involved in family planning compared with men who were unemployed (7.69%), (p=0.002). Males who knew sufficiently about family planning (58.97%) were significantly involved in family planning as compared to those who knew a little (20.51%) and knew nothing (1.28%) (p= 0.001).

Table 4.5 Bivariate analysis of male involvement in FP and selected demographic characteristics

Factors	**Male involvement in Family planning**		**p-value**
	Yes	No	
Age group			
19-32	32(41.03)	53(35.57)	0.087
33-45	43(55.13)	77(51.68)	
46-58	3(3.85)	19(12.75)	
Education			
Tertiary	50(64.10)	86(57.72)	0.198
SHS	23(29.49)	38(25.50)	
JHS	4(5.13)	18(12.08)	
Primary	1(1.28)	7(4.69)	
Marital Status			
Married	60(76.92)	85(57.05)	0.004
Not Married	18(23.08)	64(42.95)	
Employment Status			
Employed	53(67.95)	69(46.31)	0.002
Unemployed	6(7.69)	9(6.04)	
Self Employed	19(24.36)	71(47.65)	
Knowledge about FP			
Knows nothing	1(1.28)	8(5.37)	0.001
Knows very little	16(20.51)	67(44.97)	
Knows sufficiently	46(58.97)	61(40.94)	

Knows a lot	15(19.23)	13(8.72)

Source: *Field data, 2019*

4.6 Multivariate Logistic regression analysis of factors associated with male involvement in family planning.

Table 4.6 presents the multivariate logistic regression analysis of factors associated with socio-demographic characteristics and male involvement in family planning. Males within age-group (33-45) were 0.2 times less likely to be involved in family planning than those within the age-group (19-32). (AOR=0.83, 95%CI: 0.43-1.59). Also, males within the age (46-58) were 0.8 times less likely to be involved in family planning compared the young age group (19-32), (AOR=0.17, 95%CI: 0.04-0.70). In relation to education, males who are with SHS level of education are 3.8 times more likely to be involved in family planning compared to those with tertiary education who are 1.9 times more likely. Males who were not married were 0.6 times less likely to be involved in Family planning than men who are married. (AOR=0.39, 95% CI 0.20-0.78). Those who are self-employed were significantly involved in family planning, though 0.7 times less like to be involved compared to those unemployed (AOR=0.26, 95% CI: 0.07 - 0.97).

Males who are employed were also 0.1 times less likely to be involved compared to those unemployed. In relation to respondent's religious beliefs, Catholics were 0.1 times less likely to be involved in family planning compared to the traditionalist (AOR=0.89, 95%CI: 0.15 - 5.40) as well as the Moslem who were 0.2 times less likely unlike the Orthodox or Charismatic respondents who were 2 times more likely to be involved in family planning. Respondents who knew a lot and sufficiently were 9 times and 5 times more likely respectively to be involved in family planning (AOR=8.79, CI: 0.81 - 95.89) (AOR= 4.93, CI: 0.51 - 47.25). In summary, after adjustment, only three factors stood out significant. These included men who were within age groups (46-58), men who

were not married and those who were self-employed. The model was good with a p-value of 0.75 from the goodness of fit of the model.

Table 4.6 Multivariate logistic regression analysis of factors associated with male involvement in family planning.

FACTORS	p-value	UNADJUSTED OR (95%CI)	p-value	ADJUSTED OR (95%CI)
Age- groups				
19-32	Reference	1		1
33-45	0.791	0.92 (0.52 - 1.65)	0.571	0.83 (0.43 - 1.59)
46-58	0.042	0.26 (0.07 - 0.95)	0.014	0.17 (0.04 - 0.70)
Educational Level				
Primary	Reference	1		1
JHS	0.714	1.56 (0.15 - 16.46)	0.602	2.02 (0.14 - 28.58)
SHS	0.190	4.24 (0.49 - 36.67)	0.281	3.79 (0.34 - 42.88)
Tertiary	0.195	4.07 (0.49 - 34.04)	0.620	1.85 (0.16 - 21.00)
Marital Status				
Married	Reference	1		1
Not married	0.004	0.40 (0.21- 0.74)	0.008	0.39 (0.20 - 0.78)
Employment Status				
Unemployed	Reference	1		1
Employed	0.800	1.15 (0.39 - 3.44)	0.803	0.86 (0.25 - 2.91)
Self Employed	0.120	0.40 (0.13 - 1.27)	0.045	0.26 (0.07 - 0.97)
Religion				
Traditional	Reference	1		1
Catholic	0.978	1.02 (0.23 - 4.53)	0.899	0.89 (0.15 - 5.40)
Charismatic	0.719	1.29 (0.32 - 5.33)	0.613	1.57 (0.27- 9.02)
Orthodox	0.658	1.39 (0.32 - 5.93)	0.536	1.75 (0.30 - 10.30)
Moslem	0.939	0.93 (0.16 - 5.54)	0.836	0.80 (0.10 - 6.45)
Knowledge about FP				
Knows nothing	Reference	1		1
Knows very little	0.555	1.91 (0.22 - 16.39)	0.604	1.83 (0.19 - 17.99)
Knows sufficiently	0.096	6.03 (0.73 - 49.95)	0.167	4.93 (0.51 - 47.25)
Knows a lot	0.048	9.23 (1.02 - 83.94)	0.075	8.79 (0.81 - 95.89)

Source: *Field data, 2019*

CHAPTER FIVE

5.0 DISCUSSION

5.1 Demography of Respondents

The study found most (52.86%) of the respondents to be middle-aged adults between 33 and 45years with the entire respondents between age 19-58 which had similar findings to a study in Lome, Togo (Tekou *et al*., 2018). Also, most of the respondents (86.7%) had Secondary school or higher level of education which contradicts study findings in Kibaha district in Tanzania where the highest level of formal education attained by most respondents (65.5%) was primary education (Msovela *et al*., 2016). Majority of the respondents were married as well as a little over half of them were employed. In addition, Charismatic participants were the majority followed by Orthodox participants then the Catholics.

5.2 Knowledge and Perception of males concerning Family planning.

From the analyzed data it was observed that majority of respondents in the studied area (83.26%) accept the act of male spouses accompanying their partners for family planning services. This finding, however, was contrary to the findings from a study in the Kassena-Nankana District in the Northern part of Ghana where women opting to practice family planning must do so at considerable risk of social ostracism or familial conflict (Adongo *et al*., 1997) and not even thinking of male partners accompanying them to family planning clinic. The results of the study revealed that most men strongly disagreed that family planning is an issue for women which was contrary to findings in Malawi, where family planning is seen as a women's domain and because of this, male involvement in Family Planning remains lower than wanted (Dral A.A *et al*., 2018).

On assessing the knowledge level of the study participants on family planning, it was revealed that more than half of the men had sufficient knowledge about family planning. The finding in this study was similar to other related studies, such as a survey conducted by GDHS (2003), where 99% of all men know at least one method of contraception. On the contrary, a study conducted in Mpigi District in Uganda revealed that men have limited knowledge about family planning and that family planning service does not adequately meet the needs of men (Kaida *et al*., 2005).

The study showed that sixty percent (60.8%) of respondents had discussed family planning with wives or partners which was similar to a study conducted by Thapa *et al*., 2010 which showed intra-spousal communication to be positively associated with husbands' presence at a health facility delivery thereby increasing male involvement in family planning.

A question to tease out respondents' perception of the cost of family planning services and the time spent at family planning services showed they found each of them to be in the expected ranges. Majority indicated time to arrive at family planning centres was less than 30 minutes which was similar to study done by Eni in 2005, where the majority of the clients had to travel for the services at less cost.

Majority of respondents said family planning staffs in the facilities they visit were friendly and health talks given at family planning clinic area were very helpful even though 62% of respondents say there is no special arrangement for men at family planning services as also said by Tekou *et al*., 2018 that women have greater motivation than men to use family planning services, and they usually interact more with health care services in general than men.

Most respondents (81.94%) get their information about family planning from the media which was similar to research done in rural Uganda where 73% of men reported obtaining information via radio (Dougherty *et al*., 2018).

5.3 Barriers to male participation in Family planning.

Concerning barriers to male participation in family planning the results reveal that most of the respondents (65.6%) had never attended family planning which is similar to a finding from a study conducted in Chorkor, an inner city in Ghana, where only (6.6%) have ever accompanied their wives/partners to the Family Planning clinic (Atuahene *et al*., 2017).

This study also revealed that among those who had ever attended a family planning clinic, the majority (54.61%) had attended once, which has similar findings to that in communities in Afar, Ethiopia where Husbands' involvement in family planning was about 42.2% (Chekole *et al*.,2019). However, most of the respondents indicated family planning is important and are ready to recommend to friends. Fifteen percent (15.4%) of the respondent said the most common problem of family planning faced by men who engage in family planning is lack of knowledge which was similar to study by Mullany (2006) which found that lack of knowledge about maternal health among Nepalese husbands impedes positive involvement in maternal health care. This was followed by cultural beliefs (14.98%) then stigma (14.54%) as also said by Thapa *et al*., 2010 suggest that fear of social stigma and feelings of shame for supporting their wife, elaborating on the traditional cultural norms that attach a negative value to husbands who play a supportive role during their wife's maternity period affects male involvement in family planning. Regarding the side effects, the majority (61.7%) of the respondents indicated impotence as the common side effects followed by high blood pressure (20%) and a small proportion of them (1.7%) indicated

scrotal pain as a known side effect. Most men boast of their sexual performance and if family planning method will render them unable to perform well then it will deter them from involving in family planning as also stated in another study by Kassa *et al*.,(2014) that perceived fear of side effects were the part of factors causing low patronage of family planning by men.

Regarding respondents' perceptions, on the reasons why men generally do not attend family planning clinic, about 28 % said it was due to shyness and 27 % mentioned it being more women-oriented. This result is similar to a demographic health survey conducted in Ilorin-Nigeria, where family planning clinics were oriented towards women, therefore, men felt uncomfortable and shy in these clinics (Olawepo *et al.*, 2006).

5.4 Factors that influenced male involvement in family planning.

The factors identified to be associated with male involvement in family planning clinics in this study include the reported marital status, employment status and knowledge about family planning. Male who were married were more likely to be involved in family planning than those not married which was contrary to a study in the Talensi district in Ghana where marital status was not associated with male involvement in family planning (Adongo *et al*., 2015). Also, males who were employed have a much higher likelihood to be involved in family planning clinics compared to their counterparts that reported being unemployed at the time of participating in the study. Men who knew sufficiently and a lot about family planning were more likely to be involved in family planning compared to those who knew nothing which was similar to the study by Adongo *et al*., 2015 which stated that educational level was positively associated with usage of family planning services. These factors were so because married and employed men tend to be more responsible and want to plan their family sizes. The same is true of those who knew much about family

planning. Those who knew much about family planning are aware of the various methods and their benefits.

In the unadjusted multivariate analyses, age groups, marital status and those who knew a lot about family planning stood out significant to influence male involvement in family planning. The predictive factors were age group (46-58) years, unmarried men and those who knew a lot about family planning which was similar to the results from the GDHS (2008) where men who knew a lot will use a form of contraception and were involved in family planning compared to illiterate men.

After adjusting for other predictor variables in the model, only three factors such as age group (46-58), unmarried men and those who were self-employed significantly influenced male involvement in family planning. It could be deduced that men aged (46-58) years are probably finished childbearing, getting to their retirement and would want to get involved in family planning to avoid unwanted pregnancies. This will prevent the high dependency burden of childbearing and also help them plan for their retirement. This was contrary to a study in Catalonia by Saurina *et al*.,(2012) where older age was not a factor influencing male involvement in family planning but in another study done in Malaysia, Kuala Lumpur city in a primary care clinic men age 45 years and beyond was associated with involvement in family planning (Ling *et al*.,2017). Unmarried men will use a form of male contraception as well as influence their partners to get involved in family planning because they are not married and would prevent unwanted pregnancy which would help in the uptake of family planning, unlike the married men who will not bother if their wives get pregnant or not and will not use any form of male contraception this has contributed to the high unmet need of family planning among married women of about 30% according to the GDHS 2014. Men who were self-employed significantly influence male involvement in family planning which was

contrary to a study in Debremarkos town in Ethiopia by Kassa *et al*.,(2014) where males who were unemployed and discussed family planning with their spouses influenced their involvement in family planning.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

Family planning is not an issue that concerns just women in their reproductive ages but the whole family unit given they are married and to some extent the larger community. Communities are gradually accepting the act of men accompanying their wives or partners for family planning services though few family and friends see it strange for men to do so. Concerning the constraints to male involvement in family planning which this sought to explore, it has been established that cost and time spent at the family planning clinic were normal and staffs at the family planning unit were friendly.

It was further established from the gathered data that most men have never attended any family planning clinic. However, among those who do, most of them have attended it once, even though the majority of respondents said family planning is important and would recommend it to friends and relatives. The main challenges preventing men from involving themselves and also accompanying their spouses to the family planning clinics include; lack of knowledge on the available services provided at a facility, cultural beliefs, and societal ridicule and stigmatization for patronizing family planning. Other perceived challenges identified from the study were fewer methods of services to choose from and side effects associated with family planning. There was a significant association between factors such as marital status, employment status and knowledge about family planning in relation to male involvement in family planning but after adjusting for

other covariates the oldest age group, unmarried men and being self-employed were the only factors that influence male involvement in family planning.

6.2 Recommendations

The following recommendations were made based on the findings

To the Health Personnel

- Health workers in the community should educate community members especially men on the need for them to be involved in the decision process when selecting a family planning method during durbars, festivals and social gatherings in the communities with chiefs, elders and opinion leaders present.

- The District Health Directorate must coordinate with the Assemblymen, chiefs and opinion leaders in each community to form cooperate groups with men in the community which would also serve as platforms to educate the men about family planning, its various methods and disabuse their minds of perceived side effects and cultural beliefs.

- The Medical Directors of health facilities in the study area should ensure family planning units be located far from the OPD with assigned male health workers attending to the male clients or have them run separate family planning clinics so that males will feel comfortable to patronize the services.

To Stakeholders and Innovators

- The study recommends that a conscious effort should be made by stakeholders to introduce more family planning options into the study region for the males to choose from.

- Governmental and non-governmental organizations, donors and relevant stakeholders should ensure availability, accessibility and sustained advocacy for use of family planning services involving men especially.

To Future Researchers

- Future students' research work should explore the use of a qualitative approach to help unearth in details the factors hovering around the lackadaisical attitude of male involvement in this all-important part of life.

- The sampling unit should be larger enough in future research work to capture more areas in the Tema Metropolis so it can be more representative.

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APPENDICES

QUESTIONNAIRE

Informed Consent

Dear Respondent,

I am Kenneth Missah a post-graduate student pursuing a Master in Public Health degree at Ensign College of Public Health Kpong. I am undertaking a research on the topic *"Male involvement in family planning in the Tema Metropolis of Ghana"*, and I/we request you to kindly participate in this survey which is voluntary and involves no risk to you. The information given is confidential and will be useful in improving family planning prevalence among men. The questionnaire/interview will take about 15-20 minutes to fill.

Do you agree to participate?

☐ Yes ☐ No

Date……/……/2018 Signature…….

RIGHT
Thumb print

QUESTIONNAIRE

SECTION A: DEMOGRAPHIC DATA/ PREDISPOSING FACTORS

A1. Age (at last birthday): ……..……..

A2. Educational level: 1) Primary 2) JSS/JHS 3) Secondary 4)Tertiary

A3. Marital status: 1) Married 2) Not married

A3a. If married, how many wives: 1, 2, 3, 3 or more

A4. Number of children: ……

A5. Employment status: 1) Employed 2) Unemployed 3) Self Employed

A6. Religion: 1) Catholic 2) Charismatic/Pentecostal 3) Orthodox churches 4) Moslem 5)Traditionalist

SECTION B: ENABLING FACTORS

B7. If you were to go to the FP clinic at the health facility, how long does it take you to get there?

1) Less than 30minutes 2) 30minutes - 1 hour 3) 1-2 hours 4) More than 2 hours

B8. In this community, is it acceptable for a man to accompany his wife/ partner for Family planning?

1)Yes 2) No

B9. Family planning is an issue that should concern only women

1) Strongly disagree 2) Disagree 3) Neutral 4) Agree 5) Strongly Agree

B10. How much do you know about family planning?

1) Knows nothing 2) Knows very little 3) Knows sufficiently 4) Knows a lot

B11. How do family and friends react when you attend family planning with your wife or partner.

1) Strangely 2) Praise him 3) Indifferent

B 12. Are men who are involved in family planning activities stigmatized in this community?

1) Yes 2) No

B13. Have you ever been influenced by your parents/ in-laws/ relations to have more children?

1) Yes 2)No

B13a. If yes give reasons. 1) Children are of one particular sex 2) Being an only child

3) Not having many children in the extended family 4)Other (specify)……..

B14. How would members of this community describe a man who is seen to be involved in family planning?.....

B15.How would you describe the cost of accessing family planning services?

1) Expensive 2) Normal 3) Cheap 4) No idea

B16. Do you get time off from work to attend family planning clinic?

1) Yes 2) No

B17. How long do u keep at the family planning unit?

1) Less than 1 hour 2) 1-2hours 3) 2-3hours

4) 3-5 hours 5) More than 5hours

B17a.How do you feel about time spent at the family planning? 1) Short 2) Normal 3)Too long

B18. How will you describe the attitude of family planning staff? 1) Very friendly 2) Friendly

3) Indifferent 4) Unfriendly 5) Rude

B19.How will you describe the health talks given at the family planning? 1) Very helpful

2) Helpful 3) Unhelpful 4) Complete waste of time

SECTION C: REINFORCING FACTORS

C20. Has any of the following people ever discussed family planning with you?

C20a. Your wife/partner: 1) Yes 2) No

C20b. Family member 1) Yes 2) No

C20c. Your friend: 1) Yes 2) No

C21. If yes to any above, how did you feel when they talked to you about family planning?

1) Normal 2) Shy 3) Embarrassed

C22. Have you seen/read about family planning from any source? 1) Yes 2) No

C22a. If yes, please specify the source

…….

C23. Do you know of any man who attends family planning with the wife/partner? 1)Yes 2) No

C24.How close is the family planning facility to you? 1)Very close 2) Close 3) Far 4) Very far

C25. Does the family planning clinic in this community have special arrangements for providing services to men? 1)Yes 2) No

SECTION D: MALE PARTICIPATION AT FAMILY PLANNING

D26. Have you ever attended a family planning clinic? 1) Yes 2) No

D27 How many times have you attended a family planning clinic. 1) Never 2) Once 3) Twice 4) Thrice 5) Four or more times

D28. What new information have you learned from family planning

……..

D29. How important is family planning to you? 1) Extremely important 2) Very Important 3) important 4) Not important

D30.Would you recommend family planning to a friend/relative? 1)Yes 2) No

D31.Are there any challenges accessing family planning services? 1)Yes 2) No

D31 a. If yes, please state the challenges

…….....

D32. In your opinion, what are the main challenges preventing men from involving themselves in family planning? (Tick all that apply)

1) Lack of male FP service providers. 2) Stigmatization 3) Masculinity power 4) Wives with negative community perception 5) unsupportive 6) Peer pressure 7) Fewer contraceptive choices for men. 8) Lack of knowledge about FP. 9) Shyness 10) Cultural beliefs

D33.How can we improve on the family planning services? Please list……

…….

……

D34. Do you know of any side effect of family planning for men? 1)Yes 2) No

D35 a. If yes, please specify/name them……

SECTION E: To recommend strategies of improving the existing situation

E36. In your opinion, why is it that male generally do not attend family planning?

…….....

THANKS FOR YOUR PARTICIPATION