ROLE OF MEN IN FAMILY PLANNING IN THE AKATSI DISTRICT.

BY

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DECLARATION

I declare that all the work in this study has been made; and that it has not been submitted towards any other degree, nor is it being submitted concurrently in candidature for any other degree.

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<th>Abbreviation</th>
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<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
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<td>MCH</td>
<td>Material and child Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>ANC</td>
<td>Ante Natal Care</td>
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<td>GDHS</td>
<td>Ghana Demographic Health Survey</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>NPC</td>
<td>National Population Council</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>AJDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>MI</td>
<td>Macro International</td>
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<td>NPP</td>
<td>National Population Policy</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>AVSC</td>
<td>Access to Safe and Voluntary Contraception</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussions</td>
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<td>GOG</td>
<td>Government of Ghana</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<tr>
<td>DHS</td>
<td>Demographic &amp; Health Survey</td>
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<td>CHPS</td>
<td>Community - Based Health Planning Services</td>
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<tr>
<td>GSS &amp; MI</td>
<td>Ghana Statistical Services &amp; Macro International</td>
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EXECUTIVE SUMMARY

The rationale for this study is to provide a baseline information for male involvement in family planning programmes for the District Health Administration and NGO’s the opportunity to redirect or improve upon their programmes in the Akatsi district.

The study was cross-sectional study employing the use of both qualitative and quantitative methods to study the characteristics and the extent of the role of men in family planning in the district.

Data were collected using a simple structured questionnaire for a total of 252 respondents, besides 3 FGD’S and in-depth interviews. This was to sought out men’s knowledge of family planning, current use, couple communication and family planning decision-making in the district.

Data analysis showed that the level of knowledge about family planning in the Akatsi district was about 92.5% and the level of education, religion, age and residence were the most significant as far as knowledge level was concerned.

For specific methods of family planning the one most known was the male condom and the least known methods were IUD, Diaphragm and male sterilization.
Approval and use of family planning methods were influenced by education, residence, number of living children and age, but education and place of residence were the most significant factors.

There was big gap between knowledge of family planning. 92.5% compared to 49.2% of the men who were using contraceptives at the time of the study; with condoms, pill and injection being the methods commonly used. Norplant and herbs were the least; Norplant is not available in the Akatsi district. 62.1% of men who wanted to delay having children for two years were using contraceptive, the rest 37.9% were not using contraceptives, showing the level of unmet need in the district.

Some of the causes of unmet need for contraception were lack of knowledge, fear of side effects, socio-cultural, familial disapproval and fear of vasectomy.

This study had showed that partner communication has a positive impact on the use of contraceptives with 62.4% of men who had talked to their partners using contraceptives. The qualitative study however showed a negative attitude of both men and women towards partner communication. While men in the district will divorce their wives for want of more children, the women after reaching their desired family size will go in for the injectables without informing their husbands.

The in-depths interviews with health workers showed that men are not interested in family planning, but beat and force the women for sex. Some of the reasons given for the
low level of male involvement are as follows; fear of vasectomy, polygamy, unsuitable opening hours of family planning clinics, shyness, side effects and lack of information about family planning methods.

In view of the wide gap between knowledge and use of family planning among men in the district, lapses in spousal communication, misconception about family planning methods and lack of information, there is the need for male involvement programmes to increase the contraceptive prevalence rate in the district.
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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Male involvement in family planning means more than increasing the number of men using condoms and having vasectomies. Male involvement also includes the number of men who encourage and support their partners and their 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 organization activities aimed at men as a discrete group, with the objective of increasing the acceptability and prevalence of family planning practice in either sex.

In the past, family planning programmes have focused attention primarily on women, because of the need to free women from excessive child bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception most of the family planning services were offered within maternal and child health centres; most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role.

A recent publication of the UNFPA (1995) listed the following reasons for the growing importance of male involvement in initiatives for family planning:

...
- The advent of the AIDS epidemic has spurred on intense interest in condom promotion.
- Men are more in favour of general principles of family planning than has been assumed.
- Male support affects both the adoption and the correct use of female contraceptives.
- Male involvement programmes can be cost-effective if they are highly focused and offer male contraceptive methods directly or by referral.
- Men's role in the abuse of reproductive rights and sexual violence directed towards female partners and relatives should no longer be ignored.
- The consensus reached at the International Conference on Population Development (ICPD) has created the necessary momentum for action.

One major difference between the concern for increasing male participation in family planning as at the late 1980's and now is the conceptual shift in the objectives. Earlier, the main concern had been increasing contraceptive use and driving demographic goals. In contrast, the Cairo Declaration demands the participation of men in family planning and reproductive health, in terms of gender equality and fulfilling various reproductive responsibilities.

It is argued that men are partners in reproduction and sexuality, and therefore it is logical that they equally share satisfying sexual lives and the burden of preventing diseases and health complications (Green et al. 1995). This broadening of the concept of male involvement to "male responsibility requires changes in the strategies of educational
campaigns and motivational efforts, where men and women need to be educated and informed about gender equality and their reproductive rights and responsibilities, and not only about the adoption of contraception.

Involving men and obtaining their support and commitment to family planning is of crucial importance in the African region, given their elevated position in the African society. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF International Planned Parenthood Federation. 1984). The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision making for the family planning matters, but would also accelerate the understanding and practice of family planning in general.

Studies in Sudan, showed a substantial difference in attitude according to literacy, educational level and income towards family planning.

Despite these findings, however, other studies have shown that religious beliefs concerning family size show no association with the decision to practice family planning.

Ghana was the third country in Sub-Saharan Africa to formulate and adopt strategies to address the effects of rapid population growth. (This was contained in a document entitled "Population Planning for National Progress and Prosperity: Ghana Population Policy of March 1969). One of the major objectives of the policy was to reduce the population growth from 3.0 to 1.7 per cent by the year 2000. [NPC/GOG. 1994, p.25]. However, the Ghana Statistical Services and Macro international of 1993 estimates the
rate of growth to be still around 3.0 percent per annum (2.9 to 3.1 percent), but with a marked decline of the total fertility rate from 5.5 to 4.6 births per woman (GSS&MI 1998, p.27).

Several factors account for the slow progress towards attainment of the rational growth in fertility reduction, one of which is the low national family planning acceptor rate of 13 percent (GSS&MI 1998, p 43).

In a critical review of the Ghana population Policy, Batse and Kumekpor (1989, p. 62) cited the over concentration on women and lack of concerted, male participation, as one of the major set -backs of the family planning component of the policy.

The authors recognized the decision making role of men in family planning as they stated "the internationalization by social acceptance of the role of the male partner as the conventional head and supporter of the family/household and as the person who determines the number of children, makes the decision making role of the male partner in family planning acceptance and use, of considerable importance; (Batsa and Kumekpor. 1989, p.80).

1.2 STATEMENT OF THE PROBLEM.

Generally contraceptive knowledge in Ghana is very high with 93 percent of currently married women and 96% of currently married men knowing at least one modern method of family planning. However, the percentage of currently married Ghanaian women using a family planning method is 22%, and for modern method 13% (GSS&MI.1998). There
is therefore the need to address the wide gap between knowledge and practice of contraception.

It has been observed that even though FP awareness in Ghana is high, its acceptance and practice is low since Ghanaians are predominantly pronatalist. Traditionally, in most rural Ghanaian communities men take most decisions affecting the family including the fertility of their women.

In the Ghanaian context it is a sign of masculinity, wealth and prosperity and prestige for a man to have many wives and children. (Sabina Mensah, 1992, pp.60). These create the problem of high maternal morbidity and mortality, high infant morbidity and mortality, which need to be addressed.

The most popular method of contraception in the Akatsi district is the injectable for women, depo medroxy progesterone (Personal Communication with Health Providers). Norplant is not available in the Akatsi district but tubal ligation is done only in the private clinic St. Paul's Clinic, which performs about twenty in a year. IUD usage is low because the women have the perception it might enter into their stomach and the men think it might give their partners cancer. Male condom is the most common method for men in the district. Vasectomy, a long term family planning method is non-existent in the district and as confirmed by service providers most of the men in Akatsi District are afraid of vasectomy, and as such they do not come to the health centre for family planning counselling. For example, only about two percent of clients bring their husbands for counselling at the Akatsi Health Centre. Twenty percent of husbands agree that their
wives should practice family planning. (Personal communication with Akatsi health providers, 2001). Apart from the above, family planning clinics are geared towards women, and Antenatal clinics, Postnatal clinics and child welfare clinics and are not meant for men.

1.2 RATIONALE FOR THE STUDY

The outcome of this study will provide a base line information for male involvement in family planning programmes geared toward men for the DHMT and will give NGO'S the opportunity to redirect or improve upon their programmes, in the Akatsi district.
CHAPTER TWO

2.0 LITERATURE REVIEW AND STUDY OBJECTIVES

2.1 Literature Review

2.1.1 Demographic and Health - Related Factors

The revised national population policy of 1994, recognising the role of males as important partners in family planning and for that matter contraceptive use and decision making, attempts to address the matter thus: special emphasis on IEC programmes shall be provided to reach the male population in their homes, clubs and associations on the health, social and economic hazards of prolific child bearing and on the need for the male populations to assume greater responsibility for the upkeep of their wives and children. Family planning services specifically directed at the male client shall be vigorously pursued [ GOG/ NPP, 1994, p.32 ].

In spite of this laudable idea nothing or very little has been done in practical terms to address this issue of male involvement in family planning. Planned Parenthood Association of Ghana has established "Daddies Clubs" in workplaces for family planning information and limited service during leisure periods [Addo, 1996, pp. 14.15 ].

A world Bank report has indicated that 30% of the people of Ghana are below the poverty line ( Daily Graphic, April 25, 2000 ), and one of the causes of poverty has been cited as the inability of large family size, to adequately cloth, feed and educate their children. The vision 2020 of the Government of Ghana expects that Ghana will be among the
middle income countries by year 2020. However, this status can only be achieved if we are able to improve on our health status, among other things.

2.1.2 Social, Economic and Cultural Factors.

The literature on reproductive decision making in Sub-Saharan Africa strongly suggests that men play an important and often dominant role in couples adoption of modern contraception. [Dodoo, 1993 p. 95; Ezeh, 1993 p.163. Bankole, 1995, p. 325]. Cadwell and Cadwell [1987, p430], reported that the wife merely cooperated with the husband, the ancestors and even God in creating a child. They further stated that the African family structure placed reproductive decision making in the hands of the husband and the economic burden on the shoulders of the wife. Thus when family planning decisions were made they were likely to be surreptitious decisions by the wife alone or unilateral ones by the husband. [Beckman, 1983, p.415] identified the husband as the chief pro-fertility decision maker. Surveys indicate that at least one third of men believe that family planning decision making should be a joint decision [Green, 1990, pp.4.5]. This is particularly important for a patriarchal society whose children derive their legitimacy and inheritance from the father.

In Sudan, the role of men in making family decision has been recognised in the demographic literature. Studies conducted to assess the involvement of males in family planning issues and attitudes of urban Sudanese men towards family planning revealed that husbands are often involved in making family planning decisions and wives are influenced by their opinions. The data showed that husbands determined the use of family
planning, and that in general, attitudes of men are more favourable than previously believed by the service providers.

The study found that a large family size is desirable among low-income as well as high-income Sudanese men. The belief that Islamic teachings encourage large family size is widespread. Two-thirds of all men reported this belief for all circumstances except when the family is constrained financially or the mother's health would be endangered by repeated pregnancies. Substantial differences were found in these attitudes according to literacy, educational level and income. Despite these findings, however, other studies have shown that religious beliefs concerning family size show no association with decision to practice family planning.

In Ghana, a study has identified the following cultural factors as important in influencing contraceptive use: most men occupy leadership positions and dominate policy formulation - making decision both at the work place and in the home. Polygamy encourages men to have many children, and besides, the wives compete with their rivals for more children in order to please their husband. Children are believed to be gifts from God, and the more a couple has the better for the extended family and stronger the clan. (Odjambo, 1995, pp. 8-45).

Even in some communities, it is the in-laws who dictate the number of children a couple should have.
The pro-natalist culture in the rural communities, is apparently a response to their difficult socio-economic environment characterised by, labour intensive agricultural system coupled with unavailability of improved or mechanised technologies. Such a situation is further aggravated by the absence of social security scheme for rural self-employed persons, including farmers, fishermen, food processors, against sickness and old age. The low level of education coupled with lack of awareness or appreciation for the health hazards associated with frequent pregnancy, labour and delivery had resulted in high infant mortality.

The absence of spousal discussions on contraceptives can be a serious impediment for the adoption of family planning. Inter-spousal communication is thus an important step towards the eventual adoption and sustained use of contraceptive methods. The Ghana Demographic and Health Survey (1998) indicates that nearly one in two women have never discussed the practice of family planning with their husbands. Just over one in four women have discussed family planning once or twice, while similar percentages said they had talked with their spouse more often. A lack of discussion could be a reflection of lack of personal interest, or the presence of hostility or reticence in discussing such matters openly. Women aged 25-39 report more frequent inter-spousal communication on the practice of family planning than older women.

In another study (Knodal et al, 1979) comparison of the husband's and wife's responses concerning reproductive goals indicates only low to moderate agreement, suggesting a lack of meaningful communication between spouses, on the matter.
In a qualitative research to understand the dynamics of husband-wife communication and the reported discrepancy the men who reported no communication with their wives on reproductive goals or contraception or had discussed these issues only after having two or more children, were further asked about what discourages spouses from discussing their reproductive goals.

According to them, the main reasons why spouses do not take the initiative on early stage of married life to discuss their reproductive goals are shyness (34%), illiteracy (20%) never occurred to them (24%) and the perception that these discussions are useless and do not help in any way. Interestingly, a small proportion (7%) felt that women cannot give any advice on such matters, so why talk with them? This perhaps reflects the typical thinking of men that decisions on reproductive goals and contraception is a male domain and women do not have any role in such matters. [National Population Council. 1995.]

According to Omondi-Odhiambo (1997) even when a woman is favourably inclined to family planning, she may not take the initiative in using contraception without her husband's consent. Even the use of the most modern contraceptive methods, which are independent of coitus requires the husband's approval or financial support or both. He asserts further that in many less developed countries, men deny their wives access to contraception because they fear that it will encourage promiscuity. The study therefore suggests the need to obtain collaboration of men in family planning in order to ensure the success of programmes. This collaboration is important, as it is the man's opinion within the family, the village, the community and the nation as a whole that is critical.
2.1.3 Programme - Related Factors

2.1.3.1 Lack of Information

Although numerous studies have been conducted in Africa on the knowledge, attitudes and behaviour of women who use contraceptives, there is limited data on the characteristics of men and their impact on fertility control according to a pilot study done on male involvement in family planning in Pakistan, Zimbabwe and Columbia. It was found that lack of useful information and services rather than lack of interest have kept men from taking a more active role in family planning.

One important measure for the assessment of targets for Information, Education and Communication (IEC) and services is the proportion of unmet need for contraception. Unmet need refers to a discrepancy between expressed fertility goals and contraception practice. The most fundamental discrepancy is between an expressed preference to limit or space birth in the absence of contraceptive behaviour. Using data from the Demographic and Health Surveys of Ghana (1988 1998) and Kenya (1988 1993), married men were found to have high levels of unmet need of 24.3 percentage points and 23.5 percentage points, respectively.
2.1.3.2 Men's Knowledge of Specific Male Method of Family Planning

The best known methods are the male condom and periodic abstinence. Knowledge and use of the condom is on the rise due to the AIDS epidemic, and the prevention of Sexually Transmitted Diseases. Of all methods, African men know the least about vasectomy. The lack of availability of vasectomy in family planning programmes may in part explain the absence of knowledge about the method. (Lynam, P. et al 1993).

Research indicates that where vasectomy is accessible and promoted, men tend to know more about it and use it. Examples are Non-Scapel vasectomy in China, Turkey and Ghana (AVSC. 1995). Increasing acceptance of vasectomy will require overcoming misinformation and cultural barriers among African men, such as confusion of vasectomy with castration, and fear of its effects on male sexuality.

2.1.3.3 Programme - Related Factors:

The 1993 Annual Report of MOH (Ghana) observed numerous programme constraints that affect utilisation of contraceptives: Mentioned in the report are: inadequate equipment, occasional shortage of contraceptives, Low male involvement, insufficient facilities, unavailability of adequate number of well trained and motivated staff. lack of reliable means of transport. constraining the effective implementation of family planning out- reach services and lack of supervision of satellite clinic activities.

In 1997. Ghana participated in an AVSC International’s inter-regional workshop on men’s involvement in reproductive health, held in Mombassa, Kenya, from may 18-22. 1997. over 140 participants discussed practical ways to provide services to men and to support their constructive involvement in the health of their female partners. Some of the resolutions taken are as follows:
• Address male needs and services in family planning and reproductive health programme design and implementation.

• Provide information to men about various services available, types, site, time, etc.

• Use convenient and appealing design:
  - Separate clinics for males
  - Improved services at a exiting clinics
  - Work place services
  - Community-based services
  - Commercial and social marketing

• Increase contraceptive choice for men

• Train providers about male family planning and reproductive health needs.

• Use appropriate information Education and communication (IEC) interventions.

It was further decided that steps to initiate services are:

• Sensitize policy makers, programme managers, service providers and other key personnel on men as partners in reproductive health.

• Provide update of knowledge on STDS and male contraceptive options.

• Provide establishment of good quality no-scalpel vasectomy service facilities at all PHCS.

• Focus on IEC activity

• Promote family life education to adolescent addressing, sexuality, human reproduction and premarital counseling.
Between 1980 to 1997 the Planned Parenthood Association of Ghana (PPAG), embarked on the male involvement in sexual and reproductive health project.

The basic goal of the project was to change male attitudes for increase acceptance and practice of family planning and to sensitize men about gender issues.

The project was initiated by three branches of the associations of the PPAG, namely Ashanti, Northern and Western Branches. Male groups are identified at workplaces such as industrial establishments and institutions including the National vocational Training Institute (NVTI), taxi drivers unions and functional literacy groups. Some of the activities and target groups are of follows.

- Daddies clubs at factories and plantations to mobilize men and their subsequent involvement in family planning programs
- Hotel managers and drinking bars-keepers are used as a point for introducing a wide range of contraceptive to their clients.
- Functional literacy groups: The Association organizes seminars for the facilitators of functional literacy groups coupled with film shows on family planning and STD/AIDS to their adult learners.
- Trainers at the NVTI / ITTU also benefit from the male involvement programme through lectures and video films shows on various health issues related to family planning.
• Drivers and Artisans union are formed in the various cities. A Recourse person like medical doctors come and talk to them on issues related to reproductive health such as STD/AIDS and family planning.

• The Family Life Education programme of the Association, which is organized among in- schools and out-of-school youth. The subject taught are:

• The reproductive cycle

• Healthy relationship among boys and girls

• Dangers of early sexuality, teenage pregnancy and abortion.

In order to target specific concern of males, PPAG in 1995 with the assistance from Engender Health (formally known as VSO international) started clinic based SRH services for men in Accra. The services included male sterilization (vasectomy) and the patronage was quite appreciable. The clinic services were subsequently extended to Cape Coast and Takoradi.

As at now PPAG has planned to:-

• Review and develop a standardized curriculum in male involvement in family planning and reproductive health activities.

• Turn Daddies clubs into couples clubs.

• The Association currently has merged the project with the empowerment of women project. In the ensuing years, the thrust will be to mainstream gender in to all programmes under taken under the project.
2.2 STUDY OBJECTIVES

2.2.1 GENERAL OBJECTIVES

To study the characteristics and the extent of the role of men in family planning in the Akatsi district.

2.2.2 SPECIFIC OBJECTIVES

1. To determine the role of men in family planning decision making in the study population.

2. To determine males knowledge, attitudes and practices of family planning in the Akatsi district

3. To determine the extent of spousal communication about family planning in the study population

4. To identify the factors that inhibit or enhance male involvement in family planning in Akatsi district.

2.3.3 ASSUMPTION

The assumption of this study is that men in the Akatsi district participate actively in family planning programmes at all levels and family planning programmes need not be geared towards them.
CHAPTER THREE

3.0 METHODS

3.1 Study Design

The study is a cross-sectional study, employing the use of both qualitative and quantitative methods to study the characteristics and the extent of the role of men in family planning in the Akatsi District.

3.2 Variables

*Dependent Variable:

**Male Involvement:** (Definition on page 16)

Independent Variables:

1. Knowledge of family planning methods
2. Age
3. Occupation
4. Sex
5. Marital Status
7. Place of residence.
8. Religion
9. Cultural beliefs/ Attitudes.
10. Approval of Family Planning
11. Partner Communication
12. Service Factors

- Clients satisfaction
- Accessibility / Availability
3.3 Definitions of some Main Concepts

(1) **Male involvement:** Is 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.

(2) **Partner Communication:** When a man and a woman are talking regularly with their partners about FP and agreeing that decisions on the use of F.P should be made together.

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

(4) **Approval of Family Planning:** A man is said to approve of family planning when he has positive attitude towards family planning and answers yes to a question such as Do you approve of family planning.
<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>CHARACTERISTICS</th>
<th>OPERATIONAL DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic</td>
<td>Age</td>
<td>Age at last birthday</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>Male or female</td>
</tr>
<tr>
<td>Socio - cultural</td>
<td>Education</td>
<td>Highest level attained</td>
</tr>
<tr>
<td></td>
<td>Marital Status</td>
<td>Single, married. Widowed, or divorced</td>
</tr>
<tr>
<td></td>
<td>Religion</td>
<td>Form of worship., such as Christians,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moslems &amp; Traditionalists.</td>
</tr>
<tr>
<td></td>
<td>Cultural</td>
<td>Any beliefs on taboos associated with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>male involvement</td>
</tr>
<tr>
<td></td>
<td>Residence</td>
<td>Urban or Rural</td>
</tr>
<tr>
<td>Economic</td>
<td>Occupation</td>
<td>Employment – Status, such as farmers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fishermen, Artisans, Salary worker.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unemployed.</td>
</tr>
<tr>
<td>Services Factors</td>
<td>Clients Satisfaction with care</td>
<td>Adequate care rendered</td>
</tr>
<tr>
<td></td>
<td>Accessibility and</td>
<td>Living within five kilometers from</td>
</tr>
<tr>
<td></td>
<td>Availability FP Clinics.</td>
<td>FP Facility.</td>
</tr>
</tbody>
</table>
3.4 Study Area

Akatsi District is located on the southern part of the Volta Region. The district is bounded on the south by Ketu District on the north by Ho District on the west by South Tongu and east by Ketu District. The district has a population of 87,793 according to provisional result from the 2000 population and housing census, with five sub-districts, namely Akatsi, Gefia, Ave-Dakpa, Averorpeme and Wute.

The people are spread out among at least 500 villages and hamlets, many of which have population of less than fifty people. The district occupies an area of approximately 906 square kilometers. The climate is characterised by two rainfall seasons. The major one last from April to July and the minor one from September to November. December to March is a dry period.

The economy of the district revolves mainly around subsistence agriculture with main staples being cassava and maize.

The people are predominately Ewes. The principal religions are Christianity and traditional religion. Many shrines and fetishes can be found in most communities. The district is mainly rural with infrastructure gradually developing. Electricity has been extended to the major communities. Most communities do not have source of potable water and streams and dams remain their major sources of water. The road network is poor and apart from the two trunk roads (Ho Akatsi and Accra Atiako) that are motorable throughout the year, there are a number of feeder roads, which are rendered unmotorable during the rainy season.
The educational institutions are both publicly and privately owned:

There are 18 health facilities: 5 ministry of Health. 8 Reproductive and child health family planning. 2 private maternity Homes, 2 private clinics. There is no Hospital. Many of the communities are far from health centres and people find it difficult to make the journey on foot. In addition, outreach services and supervision are hampered due to lack of transportation.

3.5 **Study Population**

The study population comprised all males 15 - 60 years in the Akatsi District. This gave a population base of 25,025 (Akatsi District - DHMT. 2001)

3.6 **Sample Size**

The estimation of sample size was computed with Epi info 6-computer software based on a study population of 25,025. Level of contraceptive acceptor rate for Volta Region. 30.80% (GSS &MI, 1998) and a worst acceptable results of 25.0%. (It is assumed that the acceptor rate for Akatsi District is similar to that of the Volta Region).

This yielded a sample size of 241 at 95.0% confidence level.

A total of 252 questionnaires were sent out as shown below.

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>95%</td>
<td>241</td>
</tr>
</tbody>
</table>
3.7 Sampling Procedure

1) In the quantitative study a systematic random sampling technique was used in the sub-districts - Akatsi sub-district and Ave-Dakpa sub-district (the rural locality). Each sub-district was divided into four zones. The minimum number of respondents per day was determined by proportionate sampling based on the sample size of 250, with each research person interviewing 10-12 respondents each day. There were 4 research assistants.

The various villages were selected at random, by a team of research persons led by the supervisor, starting from the center of each sub-district and randomly selecting a different village each day. From the villages, clusters were selected and from each cluster compounds were selected. And within the compounds households were selected. From the households respondents were interviewed, serially, till the required number of respondents were obtained.

2) In the qualitative study, focus group discussions for both men and women in the reproductive age group (15-60 years) were held. In all three such discussions were held, two for men (one in Akatsi and the other in Ave-Dakpa) and one focus group discussion for women in Akatsi Sub-district. The male FGDS consisted of 10 men each while the female FGDS was made of 8 participants.

Participants were selected by contact persons from the communities.

3.8 Plan for Data Collection

Two sub-districts were selected for the study, namely Akatsi sub-district and Ave-Dekpa sub-districts (which is the rural community).
Permission for the study was sought through the District Director of Health Services, from the following:

The District Chief Executive Akatsi, Traditional Authorities, Assemblymen and the Heads of the health facilities in the Sub - districts.

The DHMT helped to identify four research assistants for the quantitative study, and 2 for the focus group discussion.

A day was set at the DHMT conference Hall for the pre testing of the FGD's. The facilitator and note taker went through how to conduct a focus group discussion and especially the use of open-ended questions, probing, seeking clarification and paraphrasing responses of participants. The principal investigator reviewed the questions to eliminate any ambiguities.

Three days were used for pre testing of the quantitative study. The four -research assistants went through the questions, translating them into the Ewe Language, with the facilitator making corrections and giving clarification, when necessary. The 4 research assistants took turns to review the questionnaires until they were able to interpret them in the Ewe language.

The FGDS and quantitative study were held simultaneously.

Pre testing for the quantitative study was held in Gefia, a sub - district not far from Akatsi sub - district. (After the days work, the principal investigator and the team went through the questionnaires and made corrections and explained mistakes to the research assistants)
3.9 Data Collection

In all 3 FGDS were held, 2 for men between the ages 15 - 60 years and 1 for women, within the same age group.

The facilitator and a note taker conducted the focus group discussions in the Ewe language and recorded on audiotapes.

They were later translated and transcribed into English.

(2) In the quantitative study, data collection was done using simple structured questionnaires. These were administered by the four trained research assistants to eligible respondents, (in the two Sub-districts).

The principal investigator did daily checks of filled questionnaires, to ensure completeness and accuracy of data entry.

(3) In depth interviews were held with health workers providing family planning services at both health centers. Structured questionnaires were administered to the Head of Ave Dakpa health center and the Nurse in charge of the MCH/FP units. The same in depth interview was repeated at Akatsi health center, to the public health nurse in charge of the FP unit and one to the CHN's. Through these interviews, service provider and service related factors that affect male involvement in FP in Akatsi district were obtained.
3.10 **Data Analysis**

The Data collected were analysed using SPSS software. A coding manual was prepared based on the questionnaires and dummy tables were also prepared for the presentation of the findings. The data were summarised by using, descriptive statistics of simple frequencies, percentages, cross tabulations, means and $p$ values for any relationships between the independent and dependent variables.

Data collected from the Focus Group Discussions were recorded, translated, transcribed and analysed manually by the team. Analysis of the in-depth interviews were treated similarly.

3.11 **Ethical Consideration**

No equipment, like tape recorder was used without the consent and knowledge of respondents. Respondents were assured that maximum confidentiality would be kept throughout the study and after.

3.12 **Limitations**

(1) Problems of finance, logistics and transport constituted limitations to the study: such as DHMT computers got broken down due to electrical faults.

(2) Family planning and for that matter contraception is a subject matter which most people would not discuss openly. This could therefore affect the quality of responses.
CHAPTER FOUR

STUDY FINDINGS

4.1 Survey Findings

4.1.1 Socio-demographic Characteristics of Respondents

A total of 252 respondents were interviewed consisting mainly of the youth, adolescents and men, with ages ranging from 15 to 60 years. About thirty-one percent of respondents were between 40 - 60 years; the mean age was 38.04 years. 19.8% respondents were between the ages 26 - 30 years; 6.7% between 16 - 20 years; 14.3% between 21 - 25 years; 13.5% between 13 and 35 years and 14.3% between 36 and 40 years.

65.5% of the respondents were married; 25.4% were single and the rest were divorced 4.4%, separated 2.8% and widowed 2.0%.

The majority of respondents were Christians (72.6%); 25.8% traditionalists. 1.2% Moslems and others constitute 0.4%.

As shown in table 1 about (24.2%) of the respondents were not-having children. Those with 1, 2, 3, 4, 5, or more children were about (15.1%) (15.1%) (14.7%) (8.3%) and (22.6%) respectively.
Table 1: **Distribution of Respondents by number of living children they had.**

<table>
<thead>
<tr>
<th>No. of living children</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>61</td>
<td>24.2</td>
</tr>
<tr>
<td>1</td>
<td>38</td>
<td>15.1</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
<td>15.1</td>
</tr>
<tr>
<td>3</td>
<td>37</td>
<td>14.7</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>8.3</td>
</tr>
<tr>
<td>5</td>
<td>57</td>
<td>22.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>252</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

As shown in table 2, 9.9% of the respondents were unemployed: the rest had the following occupations: 40.9% farmers, 0.4% fishermen, 12.7% salary workers. 23.8% artisans, and others formed 12.3%.

**Table 2: Occupation of Respondents**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>25</td>
<td>9.9</td>
</tr>
<tr>
<td>Farmers</td>
<td>102</td>
<td>40.4</td>
</tr>
<tr>
<td>Fishermen</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Salary workers</td>
<td>32</td>
<td>12.7</td>
</tr>
<tr>
<td>Artisans</td>
<td>60</td>
<td>23.8</td>
</tr>
<tr>
<td>Others</td>
<td>32</td>
<td>12.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>252</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 3: *Educational Level of respondents:*

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Number of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>28</td>
<td>11.1</td>
</tr>
<tr>
<td>Primary</td>
<td>41</td>
<td>16.3</td>
</tr>
<tr>
<td>Middle/Jss</td>
<td>121</td>
<td>48.0</td>
</tr>
<tr>
<td>Tec./Com./Voc/Sec.</td>
<td>40</td>
<td>15.9</td>
</tr>
<tr>
<td>Poly/ Post Sec.</td>
<td>14</td>
<td>5.6</td>
</tr>
<tr>
<td>Higher</td>
<td>8</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>252</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in table 3, 11.1% of respondents have had no education 64.3% had had basic education, i.e. Primary, Middle/JSS; and the rest (24.7%) Technical, Secondary and Higher education.

4.1.2. **Knowledge of Family Planning**

When respondents were asked whether they had heard about family planning, 92.5% said Yes and only 7.5% had not, with the source of information being the radio (34.5%); a combination of radio and health workers (23.0%), while the church, Television, and wife as sources of information form 0.4% each.
A fewer urban men had heard of family planning (50.6%) than rural men (49.3%). Men with basic education who had heard of family planning form 64.8%; those with higher education form 26.2% and with no education form 9.0%

The difference is significant at 95% confidence level. (P = 0.01).

Men with 5 children and more had heard of family planning 24.03% than men with no children 22.3%. followed by men with 2 children, 1 child, 3 children and 4 children in that order.

When respondents were asked whether they know of any family planning method 73.0% answered yes while 27.0% has not.
Table 4: Selected background characteristically of men having knowledge of any family planning method

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of men having knowledge about any family planning method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 40</td>
<td>134</td>
<td>72.8</td>
</tr>
<tr>
<td>40+</td>
<td>50</td>
<td>27.2</td>
</tr>
<tr>
<td><strong>Educational level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>12</td>
<td>6.5</td>
</tr>
<tr>
<td>Elementary</td>
<td>151</td>
<td>62.0</td>
</tr>
<tr>
<td>Higher</td>
<td>21</td>
<td>31.5</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christians</td>
<td>145</td>
<td>78.8</td>
</tr>
<tr>
<td>Moslems</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Traditionalist</td>
<td>36</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>89</td>
<td>48.5</td>
</tr>
<tr>
<td>Urban</td>
<td>95</td>
<td>51.6</td>
</tr>
<tr>
<td><strong>No. of living children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>41</td>
<td>22.3</td>
</tr>
<tr>
<td>1. Child</td>
<td>30</td>
<td>16.3</td>
</tr>
<tr>
<td>2. Children</td>
<td>34</td>
<td>18.5</td>
</tr>
<tr>
<td>3. Children</td>
<td>28</td>
<td>15.2</td>
</tr>
<tr>
<td>4. Children</td>
<td>12</td>
<td>6.5</td>
</tr>
<tr>
<td>5. or more children</td>
<td>39</td>
<td>21.2</td>
</tr>
</tbody>
</table>

As shown in table 4: Younger men 134 (72.8%), men with some basic form of education, 151 (62.0%). Christian 145 (78.8%) and urban men 95 (51.6%) have a better knowledge of family planning method, than older men, men with no education. Moslems and traditional men and men in the rural community in Akatsi.

Men with no children knew more about family planning methods than men with 5 children or more; followed by 2 children, 1 child, 3 children and 4 children.

Respondents were asked to spontaneously mention all the family planning methods they had heard of. Then respondents were probed, for further knowledge of other methods not mentioned spontaneously.
Table 5 shows the distribution of respondents by knowledge of specific methods both unprompted and prompted.

**Table 5: Male knowledge of family planning methods.**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>KNOWLEDGE UNPROMPTED</th>
<th>KNOWLEDGE PROMPTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>43.1</td>
<td>18.6</td>
</tr>
<tr>
<td>Male Condom</td>
<td>59.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Female Condom</td>
<td>12.7</td>
<td>31.0</td>
</tr>
<tr>
<td>Injection</td>
<td>37.2</td>
<td>24.3</td>
</tr>
<tr>
<td>IUD</td>
<td>4.4</td>
<td>10.7</td>
</tr>
<tr>
<td>Vaginal tablets</td>
<td>11.9</td>
<td>28.2</td>
</tr>
<tr>
<td>Norplant</td>
<td>3.9</td>
<td>25.1</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>7.2</td>
<td>26.5</td>
</tr>
<tr>
<td>Male sterilisation</td>
<td>2.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>4.3</td>
<td>12.0</td>
</tr>
<tr>
<td>Rhythm/Abstinence</td>
<td>8.3</td>
<td>37.5</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>8.3</td>
<td>41.7</td>
</tr>
</tbody>
</table>

The method known by most respondents was the male condom. This was mentioned by 71.0% of men when unprompted and prompted responses were combined. The methods known the least were the IUD, Diaphragm, male sterilization, Norplant, Vaginal Tablets.
Female sterilisation and female condom. Rhythm/ Abstinence, withdrawal, injection and the Pill in that order.

The level of knowledge about family planning was confirmed during the Focus Group Discussion, in the following statements made by discussants:

- If you have too many children "Asiwó Mateju – atuwo o" literally meaning your hand cannot meet them. This will make them if not all became thieves others will involve themselves in disgraceful acts. Secondly if you space your children the woman will be healthy (m).

- Our birth rate is too high there is scarcity of food and also because presently school fees are high. So there is a need to give birth to the number you can care for (m)

The above were mainly based on economic hardships, health of family and education for children. But there was a negative response from Ave – Dakpa, as shown below

- It is good you have many children as some will go to school to become soldiers and teachers. If the children come to you, you will be happy. That is why in the past our grandfathers had many children. In this town people who have many

4.1.3 Approval of Family Planning

Ninety one percent of the respondents approved of family planning, while 9.0% of them disapproved of family planning.

68.7% of men below age 41 years approved of family planning, while 31.3% of men above 40 years disapproved of family planning this difference is significant at 95%
confidence level. \( P = 0.006 \). 65.7% of men with basic education approved of family planning, followed by 24.7% men with higher education and 9.6% with no education. 24.3% of men with no children approved of family planning followed by men with 5 or more children. 23.5% 1 child, 3 children, 2 children and 4 children respectively.

50.4% of rural men approved of family planning while urban men form 49.6%. This difference is significant at 95% confidence level, \( P = 0.011 \).

Majority of Christians 73.0% approved of family planning followed by traditionalist 25.2%. Moslem 1.3% and other 0.5%.

4.1.3.1 Ever use of family planing methods

59.1% of men in the Akatsi district had ever used family planning whiles 40.9% had not. Out of the total men who had ever used family planning method with their partners, 76.5% are below 40 years and 23.5% above 40 years.

61.7% of men with basic education had ever used family planning method with their partners. Those with higher education formed 32.8%, and without education 5.4%. This is significant at 95% confidence level \( P = 0.00 \).

Men with 5 children or more 21.5% had ever used family planning method with their partners; 21.5% of men with No children had ever used family planning method with their partners, with the rest being men with less than 5 children. 55.0% urban men had
ever used family planning method as against 45.0% of rural men. This difference is significant at 95% confidence level. \( p = 0.04 \) (Table 6).

**Table 6** Selected background characteristics of men approving of and ever using family planning.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Approval of family planning [ N = 230 ]</th>
<th>Ever used a family planning method [ N = 149 ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>68.7</td>
<td>76.5</td>
</tr>
<tr>
<td>40+</td>
<td>31.3</td>
<td>23.5</td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>9.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Elementary</td>
<td>65.7%</td>
<td>61.7</td>
</tr>
<tr>
<td>Higher</td>
<td>24.7</td>
<td>32.8</td>
</tr>
<tr>
<td>No of children living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 &gt;</td>
<td>24.3</td>
<td>21.5</td>
</tr>
<tr>
<td>Nil</td>
<td>23.5</td>
<td>21.5</td>
</tr>
<tr>
<td>&lt; 5</td>
<td>52.2</td>
<td>57.0</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>50.4</td>
<td>45.0</td>
</tr>
<tr>
<td>Urban</td>
<td>49.6</td>
<td>55.0</td>
</tr>
</tbody>
</table>
4.1.3.2 Reasons for using Contraceptives

Reasons given by respondents for ever using contraceptives were: to limit the number of children (41.8%); limit number of children with economic liability (11.6%); to limit and space children (10.3%), while space children and economic liability were each mentioned by 9.6% of respondents. Health of wife; to avoid unwanted pregnancies and STD’s by using condoms are the other reasons, given by respondents, for using contraceptives.

4.1.3.3 Current use of Family Planning.

50.8% of respondents were not using contraceptives at the time of the study while 49.2% were using contraceptives. Of those using contraceptives 46.8% were using condom; 12.1% the Pill, 12.1% injection, followed by Rhythm/Periodic method (8.9%), vaginal foam 1.6% Diaphragm 1.6%.

Abstinence 1.6%, withdrawal 1.6%, Norplant 0.8%, and others form the rest (Table 7)
Table 7: Current use of family planning methods in the Akatsi District.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>Frequency distribution of contraceptive methods used by partners</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>58</td>
<td>46.8</td>
</tr>
<tr>
<td>Pill</td>
<td>15</td>
<td>12.1</td>
</tr>
<tr>
<td>Injection</td>
<td>15</td>
<td>12.1</td>
</tr>
<tr>
<td>Rhythm/Period</td>
<td>11</td>
<td>8.9</td>
</tr>
<tr>
<td>Vaginal foam</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Abstinence</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Herbs</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Norplant</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>8.8</td>
</tr>
<tr>
<td>Total</td>
<td>124</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Current contraceptive use among men in the Akatsi District is as follows:

Single men 28.2%, married 66.1%. Divorced 1.6%, separated 2.4%. widowed 1.6%.

Christians form the majority of men currently using contraceptives (77.4%).

Traditionalists 2.1% and Moslems 1.6%
Men with basic education (primary and middle/ JSS) form 59.6% currently using contraceptives: men with higher education form 35.5%, with no education 4.8%. The difference is significant at 95% confidence level. (P =0.000).

Urban men currently using contraceptives form 53.2% as against Rural men 46.8%

Some of the statements that come out when respondents were asked how they were protecting themselves now are as follows:

- I don’t have any children. but I wish to have 4. I am using condom which is normally called “PASSPORT” (m)
- I have two (2) children with two (2) wives, the woman who’s child is younger is going for the injectable (Depo), the woman with the older child is not practicing any family planning method as she need to be pregnant this time (m)

When the women were asked of the current family planning method and whether their husbands are in favour, the following issues came out:

- I use the natural method by calculating the time I will ovulate. I know it my husband is in favour (w)
- I was using the injectable (Depo). My husband was not in favour and more so he was not aware that I am doing it. Now I have stopped and wanted to be pregnant

4.1.3.4 Unmet Need for Contraception

About 116(46.0%) of the men will like to have children after two years. However, only 72 (62.1%) of those who wanted to have children after two years, were using contraceptives. The rest (37.9%) were not using contraceptives. Thirty five percent of the
respondents said they don’t know when they intend to have their next children, while the rest gave reasons like my wife had divorced me; I had stopped having children and menopause. when asked the same question.

Men not using contraceptives give the following reasons: 16.4% no partner, 12.5% because my partner has stopped giving birth, 10.9% not interested, 6.5% against my religion. 6.3% will start after their last children, with other reasons being; woman is already sterilised. old and has stopped having children, because of side effects of contraceptives; partners not staying together. more children to take care of me in future.

During the FGD the following reasons were given for Non – use of contraceptives

- Lack of understanding especially those of our rural folk if people explain what is family planning to them, they have been saying that you want them to be sick e.g with the Depo that is why you want them to do it (m)
- The religion in which the person may be, do not allow him to use family planning method (m)
- In our culture family planning method are not right. If the woman with you delivered up to a certain number and she cannot bear it again then you go in for another woman (m)

Reduction in sexual feeling and expensive family planning devices were some additional reasons given, for non use of contraceptives.
4.1.3.5 Future use of Contraceptives

Majority of the respondents will like to use contraceptives in future (78.2%). The common methods they intend to use were; female sterilisation (7.7%), injection (37.2%), Pill (6.1%), Condom (22.4%), Norplant (1.5%), Rhythm (4.6%), Foaming tablet. (1.0%). Yet to seek for medical advice (3.1%). Abstinence (0.5%), Herbs (0.5%) and others.
4.1.4 Attitude towards Family Planning

Men’s attitude toward and ever use of family planning is presented in table 8.

Table 8: Men’s attitude towards and practice of family planning in Akatsi District.

<table>
<thead>
<tr>
<th>Item</th>
<th>Ever used family planning method [N = 149]</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a relationship who should have a major say in FP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>109</td>
<td>73.1</td>
</tr>
<tr>
<td>Woman</td>
<td>14</td>
<td>9.4</td>
</tr>
<tr>
<td>Both</td>
<td>23</td>
<td>15.4</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100.0</td>
</tr>
<tr>
<td>Who makes the decision to use FP in your relationship?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondent</td>
<td>99</td>
<td>66.5</td>
</tr>
<tr>
<td>Wife/Partner</td>
<td>10</td>
<td>6.5</td>
</tr>
<tr>
<td>Both</td>
<td>40</td>
<td>26.8</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100.0</td>
</tr>
<tr>
<td>Who should decide on the number of children a man/wife should have?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>102</td>
<td>68.5</td>
</tr>
<tr>
<td>Woman</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Both</td>
<td>45</td>
<td>30.2</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100.0</td>
</tr>
</tbody>
</table>
When men who had ever used family planning were asked who should have a major say in family planning, the majority (73.1%) mentioned the man.

As to who makes the decision to use family planning, the majority was for the man (66.5%). The majority (68.5%) answered that the man should decide on the number of children a man and wife should have. In all, decision by both partners was second favoured.

When attitudes were viewed against background factors such as Age. Education and residence, younger men, men with basic education and men in the rural community said the man should have a major say in family planning issues.

As to who should decide on the number of children a man and his wife should have: men with basic education, younger and living in the rural community were in favour of the woman. As to who makes the decision to use family planning in a relationship the decision was for the man or woman.

4.1.5 Initiation of Family Planning

Twenty three percent of men, would like a woman to initiate family planning after the third child. Among men who approved of family planning only 11.3% said family planning should be initiated before the first birth.

And a large proportion of respondents who approve of family planning would only use family planning methods after the woman has had at least one child.
Table 9: *Men's attitude toward initiation of contraception by parity.*

<table>
<thead>
<tr>
<th>When should a woman use family planning</th>
<th>Total sample [N = 252]</th>
<th>Respondents approving of family planning [N = 230]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before her first child</td>
<td>10.3</td>
<td>11.3</td>
</tr>
<tr>
<td>After first child</td>
<td>15.9</td>
<td>15.2</td>
</tr>
<tr>
<td>2(^{nd}) child</td>
<td>9.1</td>
<td>9.6</td>
</tr>
<tr>
<td>3(^{rd}) child</td>
<td>23.0</td>
<td>23.9</td>
</tr>
<tr>
<td>4(^{th}) child</td>
<td>21.0</td>
<td>22.2</td>
</tr>
<tr>
<td>5(^{th}) child</td>
<td>3.6</td>
<td>3.0</td>
</tr>
<tr>
<td>6(^{th}) child</td>
<td>6.3</td>
<td>6.5</td>
</tr>
<tr>
<td>shouldn't use FP.</td>
<td>6.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Don't know</td>
<td>2.8</td>
<td>2.2</td>
</tr>
<tr>
<td>It depends on the woman</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Others</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in table 9, about 1 in 9 (10.3%) of the total respondents said a woman should use family planning, for postponing onset of child bearing.

Age was found to be a dominant factor in deciding if family planning should be initiated before the first childbirth, with men over forty years being more in favour. The
relationship between age of respondents and attitude towards when family planning should be initiated, is significant at 95% confidence level. (p = 0.045).

4.1.6 Partner Communication

As many as 178 of the respondents (70.6%) had ever talked to their partners about family planning, while 74 (29.4%) had never talked to their partners about family planning. Of those who had talked to their partners about family planning, 61.2% did so about 6 months ago, while 37.6% did the same one year and above, ago.

Reasons for never talking to partners about family planning are as follow:

- No partners (25.7%).
- Do not know how to use family planning methods (12.2%).
- No knowledge or awareness of family planning (10.8%).
- I want my wife to be pregnant (9.5%).
- Against my religion and can’t advice anybody (8.1%).
- Had stopped giving birth (8.1%).
- Rhythm/natural method (4.1%).
- Side affects (2.7%).
- Will do family planning after last child (2.7%).
- Contraceptives can fail (1.4%).
- Unfaithfulness of women these days (1.4%).
- Presently important and financial problems (1.4%).
- Not obtained the desired number of children (4.1%).
Table 10: Partner communication about family planning by selected background characteristics

<table>
<thead>
<tr>
<th>Status of Approval of family planning</th>
<th>Characteristics</th>
<th>Ever talked to partner about family planning</th>
<th>Don’t talk to partner about family planning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td>Age</td>
<td>125</td>
<td>79.1</td>
<td>33</td>
</tr>
<tr>
<td>&lt; 40</td>
<td>49</td>
<td>68.1</td>
<td>23</td>
</tr>
<tr>
<td>40+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>11</td>
<td>50.0</td>
<td>11</td>
</tr>
<tr>
<td>Nil</td>
<td>143</td>
<td>76.0</td>
<td>45</td>
</tr>
<tr>
<td>Elementary</td>
<td>20</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td>Rural</td>
<td>88</td>
<td>75.8</td>
</tr>
<tr>
<td>Urban</td>
<td>86</td>
<td>75.4</td>
<td>28</td>
</tr>
<tr>
<td>Religion</td>
<td>Christians</td>
<td>135</td>
<td>80.4</td>
</tr>
<tr>
<td>Moslems</td>
<td>3</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Traditionalist</td>
<td>36</td>
<td>62.0</td>
<td>22</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Do not Approve of Family planning</td>
<td>Age</td>
<td>&lt;40</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>40+</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Education</td>
<td>Nil</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td>Elementary</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>Higher</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>Residence</td>
<td>Rural</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>*Christians</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td></td>
<td>*Traditionalist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As shown from table 10: most of the men in Akatsi district who do communicate with their partners approved of family planning (3 to about 143 respondents), while only a minimal number of men who communicated with their partners did not approve of family planning (1 to 3 respondents). Younger men, men with at least some basic education and Christians who approved of family planning have a better partner communication.

It is also significant to note that three respondents from the rural community and three Christians who communicated with their partners do not approve of family planning. Therefore partner communication has a positive impact of family planning.

Some issues that came out when discussants were asked about family planning methods and whether spousal consent is necessary were as follows: -

- The men decide but the women should be involved if not you will fail (m)
- The man had to decide because some women feel shy to approach the man (m)

It appeared most of the men were in favour of spousal consent but one man from Ave-Dakpa had a negative attitude: -

- From the man; the woman has no authority over him when the man says we have to bring forth, the woman has no say, hers is just to obligate. If she refuses then she has to leave for him to find another woman (m).
The FGD for women showed that most women were in disagreement with spousal consent in family planning. Some of the statements are as shown below:

- We don’t discuss family planning in the house, the pregnancy will not come. You will no more have your menses if you use family planning (w).
- We don’t discuss anything on family planning because looking at things he will not agree on the issue. So I hide and go for the injection (w)

4.1.7 Perception of the Role of Men in Family Planning

Table 11: Perception of the role of men in family planning

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>WHO SHOULD TAKE ACTIVE ROLE IN FAMILY PLANNING</th>
<th>MEN</th>
<th>WOMEN</th>
<th>BOTH</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>118</td>
<td>68.2</td>
<td>13</td>
<td>7.5</td>
<td>42</td>
</tr>
<tr>
<td>40+</td>
<td>45</td>
<td>56.9</td>
<td>4</td>
<td>5.1</td>
<td>28</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>14</td>
<td>50</td>
<td>4</td>
<td>14.5</td>
<td>9</td>
</tr>
<tr>
<td>Elementary</td>
<td>137</td>
<td>67.8</td>
<td>11</td>
<td>5.4</td>
<td>53</td>
</tr>
<tr>
<td>Higher</td>
<td>12</td>
<td>54.5</td>
<td>2</td>
<td>7.1</td>
<td>8</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>79</td>
<td>61.2</td>
<td>10</td>
<td>7.7</td>
<td>39</td>
</tr>
<tr>
<td>Urban</td>
<td>84</td>
<td>68.3</td>
<td>7</td>
<td>5.6</td>
<td>31</td>
</tr>
</tbody>
</table>

As shown in table 11: Greater number of men in Akatsi think men should take an active role in family planning (12 to 137 respondents) while a reasonable proportion of men think both men and women should take active role in family planning (8 to 53 respondents). Men who think it should be the women are minimal. (2 to 13 respondents).

Again younger men, men with some basic education and urban men dominated in the perception that men should take active role in family planning.
4.1.8 **Reasons for Men Taking Part in Family Planning**

Almost all the respondents agreed that it is important for men to take part in family planning, the reasons given being as follows:

- Because the man takes every financial responsibility in the house (45.2%).
- Because men take decision and face every problem (13.1%).
- Limit and space the number of children (11.9%).
- Protection from STD’s and HIV/AIDS (3.2%).
- Men have higher sex drive than women (2.8%).
- For a healthy life (1.6%).
- Avoid unwanted pregnancy (2.8%).
- Because men can’t trust women (0.4%).
- Others (15.2%).

4.1.9. **Use of the Health Centre or Hospital for Family Planning.**

*Some of the feelings about the above were:*

- I don’t feel shy because the long life that you want to live may be short lived – for prevention of HIV/AIDS (m).
- Financial difficulties because may be the devices are expensive (m).

During the refreshment time the participants from Akatsi – sub – district said they only knew Akatsi health centre, is for treatment and even for family planning methods they only knew of injectables. They don’t know that condoms are sold at the Akatsi health centre.

- They say if you are practicing family planning then you became a man (Ne za Jitsu) meaning you will not menstruate again (only men don’t menstruate) so I am afraid (w).
- I have the interest to practice it but what people are saying is scaring. They say it can spoil or damage your cervix (w).

In the female FGD, fear of the side – effects of family planning methods was expressed:
4.1.10 **Findings From the Health Facilities**

Table 12: *Family Planning acceptors in the Akatsi District by methods and by year 1999 and 2000.*

<table>
<thead>
<tr>
<th>METHODS</th>
<th>1999</th>
<th>2000</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEW/</td>
<td>% OF</td>
<td>NEW/</td>
<td>% OF</td>
</tr>
<tr>
<td></td>
<td>CONTINUING</td>
<td>ACCEPTORS</td>
<td>CONTINUING</td>
<td>ACCEPTORS</td>
</tr>
<tr>
<td>ORAL PILL</td>
<td>601</td>
<td>3.04</td>
<td>854</td>
<td>4.86</td>
</tr>
<tr>
<td>CONDOM</td>
<td>839</td>
<td>4.25</td>
<td>1017</td>
<td>5.79</td>
</tr>
<tr>
<td>FOAMING TABLETS</td>
<td>187</td>
<td>0.94</td>
<td>422</td>
<td>2.40</td>
</tr>
<tr>
<td>IUCD</td>
<td>35</td>
<td>0.18</td>
<td>29</td>
<td>0.16</td>
</tr>
<tr>
<td>INJECTABLE</td>
<td>2430</td>
<td>12.32</td>
<td>3504</td>
<td>19.95</td>
</tr>
<tr>
<td>STERILIZATION</td>
<td>NIL</td>
<td>NIL</td>
<td>4</td>
<td>0.02</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4092</td>
<td>20.73</td>
<td>5830</td>
<td>33.2</td>
</tr>
<tr>
<td>WIFA</td>
<td>19727</td>
<td></td>
<td>17559</td>
<td></td>
</tr>
</tbody>
</table>

As shown in table 12; the highest acceptable contraceptive is the injectable – depo for women and for men is the condom. According to the health worker condoms are available at the Akatsi health centre and even some men send their wives to buy for them.

But there were no condoms at Ave – Dakpa at the time of the study:

- We don’t have condoms in the Akatsi district we are short of condoms. Not available at our centres as at now (Ave – Dakpa Health centre).
Additional deductions made from the in-depth interviews with the health workers are as follows:

- Our messages are targeted for men. We meet them at the ANC, post-Natal clinic and church meetings, funeral and drumming gatherings but they don’t want to hear about vasectomy.
- The opening times are not suitable. Some of the men come to us in the house. Some health workers are kind to the men but some are harsh to them.
- The men in the district are not interested. The men want to have many children – polygamy and they need farm helps. They beat and force the women for sex.
CHAPTER FIVE

5.1 DISCUSSION OF FINDINGS

5.1.1 Family Planning Knowledge.

From this study, at least 92.5% of respondents had heard of family planning in the Akatsi district. Their commonest source of information was the radio (34.5%) and a combination of health workers and the radio (23%).

Urban men and men with basic education had more knowledge about family planning than those in rural community and those with no education. At least 73.0% of respondents knew about a family planning method. Again urban men in Akatsi township had more knowledge about family planning methods (51.6%) as against men from Ave-Dakpa, the rural community (48.5%). This difference is significant at 95% confidence level ($p = 0.00$). Also, men with basic education (62.0%) knew of family planning methods better than those with no education (6.5%). This difference is significant at 95% confidence level ($p = 0.00$)

Younger men had better knowledge (72.8%) than older men (27.2%).

It is worth mentioning that the level of knowledge for Christians (78.8%) is higher than that of respondents of other religions e.g. Traditionalists and Moslems.

Moreover men with no children know about family planning more than men with 5 children or more. This may be due to the fact that men in Akatsi who had attained their
desired family size and might be older than those without children show little interest in family planning; educational level may also be a contributing factor.

Similar findings have been elicited in studies by AHADZIE and KORKOR (1997). In Ahadzie and Korkor’s study, level of knowledge was found to be higher among men in the Greater Accra Region (the most Urbanized region), than in all other regions. However, this urban feature does not explain the relatively high proportion of men in the upper east Region who have knowledge of family planning.

Studies in Egypt, Morocco, Kenya, Zimbabwe and Ghana had shown that the best known family planning methods are the condom and periodic abstinence. Knowledge and use of condom is on the rise, due to the AIDS epidemic.

5.1.2 Approval, Ever Use of Family Planning

Men's approval and ever use of family planning were viewed against the following characteristics: Age, Educational level, Residence and number of living children. Younger men, men with basic education and men in the urban area were more likely to approval family planning method than other men. Which clearly depicts that men who have attained their desired family size, older and without education show little interest in family planning in the Akatsi District.

Studies in Mali (1997) and Kenya (1997), based on DHS findings had also shown education to be the strongest predictor of men’s attitude towards family planning. Better-educated men are more likely to approve of family planning, as are men in monogamous
marriage. In most countries, men who live in urban areas are more likely to approve of family planning than their counterparts in rural areas.

5.1.3 Reasons for using contraceptives, current use, concept of unmet need and future use of contraceptives

Majority of men in the Akatsi district will use contraceptives to limit the number of children they have. Spacing and economic liability were also some of the factors. Health of wife and the use of condoms to prevent unwanted pregnancies and STD’s were also mentioned.

Of the 92.5% respondents who had heard of family planning, 50.8% of them are not using contraceptives at the time of this study. Only 49.2% were using contraceptives, the most preferred to use being the condom, pill and injection. Norplant was the least preferred method, followed by Herbs.

In this study, married men, men with basic education and Christians were in the majority of current users of contraceptives. The relationship between educational level and current use of contraceptives, is significant at 95% confidence level (P = 0.000).

Similar findings were recorded by studies in Tanzania, 1994 and Morocco, 1992, where the percentage of educated men practicing family planning was 52.0% as against 7% men without education. In Morocco, 60% of educated men were practicing family planning as against 31.0% with no education. Forty six percent of respondents, in the Akatsi district will like to have children after 2 years. However, only 62.1% of those who wanted to
have children after two years were using contraceptives. The rest (37.9%) were not using contraceptives, thus indicating level of Unmet need.

Ngom (1997, p.192) using DHS data from Ghana and Kenya, estimated unmet need to be 24.3% for married men in Ghana and 23.5% for married men in Kenya. When corrected for men whose wives were pregnant, menopausal, or infecund, the unmet need for contraceptives was 53.3%, which is relatively higher than found by Ngom. There is, therefore, the need for innovative and male friendly approaches to convert this potential non-users into users.

The commonest reason why men in the Akatsi district were not using contraceptives are; no partner, don’t know how to use any method, not interested, religion, will start after last child, side effects. Bangaarts and Bruce (1995, p. 72.73), in a study of causes of unmet need for contraceptives and the social context of services, concluded that the principal reasons for non use of contraceptives were lack of knowledge, fear of side effects, social and familial disapproval. Men in Nigeria would not use family planning because they believe that contraception makes it easier for their wives to engage in extramarital sexual relationships. (Bankole, 1994, p 10).

5.1.4 Attitude toward family planning

In this study, most men who had ever used family planning methods believe that the man should dominate in family planning issues (Table 6).
However, when their attitudes were viewed against the background of age, education and residence: younger men, men with basic education and men in the rural community said men should have a major say in family planning issues. As to who should decide on the number of children a man and his wife should have, men with basic education, younger and men living in the rural community were in favour of the woman making such a decision. As to who makes the decision to use family planning in a relationship, the decision was for either the man or the woman.

Studies in other African countries like Nigeria and Kenya had shown that the perception that men will necessarily have more influence in reproductive decision making because they control the family assets and are accepted as heads of the household may be an exaggeration.

Bankole (1995, p.320) observed that among the Yoruba of Nigeria, the fertility desire of both partners were important predictors of the couple's fertility.

Gage – Brandon and her colleagues (1994, p.6) also reported that women in Kenya had greater control over reproductive decision – making than their Ghanaian counterparts.

Generally, as to when a woman should initiate family planning, most of the respondents in Akatsi district will initiate family planning after the third child (23%). Only 11.3% will want their women to initiate family planning, before the first birth.
Younger men were more in favour of initiating family planning, before the first childbirth.

5.1.5. **Partner Communication**

Most of the respondents (70.6%) in this study had ever talked to their partners about family planning. While 29.4% had never talked to their partners about family planning, 61.2% had talked about family planning 6 months prior to the study.

The reasons given for not talking to partners about family planning were similar to those given for Non-use of family planning methods. When partner communication is viewed against status of approval of family planning, age, educational level, religion and residence: younger men, men with basic education and Christians who approved of family planning had better communication with their partners. (Table 10).

Many analysts consider communication between husbands and wives as one of the most important factors associated with family planning practice. A study in Ghana carried out by John Hopkins University showed that communication between spouses was the most significant pathway to family planning adoption following on IEC campaign.

Similar results were also obtained in Egypt and Niger (DHS comparative studies No 18)
5.1.6 Perceptions of the Role of Men in Family Planning and Use of Health Centres for Family Planning

The reasons men gave for taking part in family planning were similar to their reasons for using family planning methods e.g. economic hardship; to limit and space birth; men have higher sex drive, and for protection from STD’s and HIV/AIDS, among others.

From the FGDS, the main reason why men in the Akatsi district will not attend family planning clinics are, perceived cost of family planning devices, side effects, shyness and lack of information about family planning methods. For the women their main problem was the side effects.

5.1.7 Findings from the Health Facilities

In-depth interviews with the health workers show that men, in the district, are not interested in family planning, because they want to have many wives and children – (to help them on their farms). They also do not encourage their women to come for family planning.

Apart from the above, the opening times are not suitable for the men. Some health workers are kind to the men whilst others are harsh.

Family planning programmes are targetted at men in the district at ANC, post-Natal clinics, church meetings, funerals and drumming gatherings. But men do not want to hear about vasectomy. Data from the Akatsi Health centre shows that the most acceptable contraceptive is the injectable (“dep0”) for women and the condom for men. On the other hand, there is no equity in the distribution of these contraceptives, in the district.
CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The level of knowledge about family planning in the Akatsi district was about 92.5%, and level of education and residence were found to be the most significant variables as far as knowledge level is concerned. Religion was also a significant factor since 78.8% of Christians had higher knowledge than Traditionalists and Moslems. It is important to mention that men with no children knew more about family planning than men with 5 children or more.

For specific methods of family planning, the one known by most respondents, was the male condom and the least known methods were IUD, Diaphragm and male sterilization.

Approval and ever use of family planning methods was influenced by education, residence and number of living children and age, but education and place of residence were the most significant factors.

Majority of the men in the Akatsi district will use contraceptives to limit and space birth and because of economic reasons and for the prevention of STD's including HIV/AIDS.

There was a big gap between knowledge of family planning 92.5%, compared to 49.2% of men using contraceptives at the time of the study: with condoms, pill and injection.
being the most commonly used methods. Norplant and herbs were the least. Norplant is not available in the Akatsi district.

62.1% of men who wanted to delay having children for two years were using contraceptives, the rest 37.9% were not using contraceptives - showing the Level of unmet need in the district. In this study, the causes of unmet need for contraception were lack of knowledge, fear of side effects and socio-cultural and familial disapproval.

The majority of the men in Akatsi district will like to use contraceptive in future but prefer their women to go in for the injectables than they using condoms. It is important to note here that no respondent made mention of vasectomy.

As to who should decide on whether or not family planning should be practiced. it was either the man or the woman, with men in the rural community more in favour of male dominance in family planning issues.

Most of the men in the district will like to start family planning after the third child, but younger men were in favour of starting family planning before the first child.

This study shows that partner communication has a positive impact on the use of contraceptives. with 62.4% of men who had talked to their partners using contraceptives. Younger men, men with basic education and Christians had better inter - spousal communication.
The qualitative study however showed a negative attitude of both men and women towards partner communication. While men in the Akatsi district will divorce their wives for want of more children, the women after reaching their desired family size will go in for the injectables without informing their husbands.

From the focus group discussions, the main reasons why men in the district will not attend family planning clinics are:-

Cost of family planning devices, side effects, shyness and lack of information about family planning methods.

Health workers deductions about male involvement in the Akatsi district, are:

- They target men at ANC, post – Natal clinics, churches, funerals and drumming gatherings, but they are afraid of vasectomy.

- The opening hours of family planning clinics are not convenient to men.

- Male involvement is low in the Akatsi district because the men do not encourage their women to come for family planning. The women sneak to have the depo (injectables) so they would not like their men to accompany them.

- The men in the district are not interested. The men want to have many wives and children. Information from the health centre shows that there is no equity in the distribution of contraceptives in the district.
6.2 Recommendations

Based on the findings of the survey, the FGD and the in-depth interviews with health personnel, as well as the existing literature, the following recommendations are made:

1. There should be promotion of male involvement themes and especially the use of male contraceptives on the local Radio, Radio Volta, in the Local language to explain the use of various methods, so as to correct the various misconceptions about side-effects.

2. Male involvement programmes should be in-corporated 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.

3. Family planning Information. Education and Communication activities must target men so as to facilitate the conversion of the large pool of potential acceptors into users of contraceptives. The programmes should use teaching aids like posters, illustrations and video-films in the local language.

4. Collaboration of the DHMT with chemical sellers, male TBA’s, Hotel and bar keepers and other agencies to spread the message of male involvement in the district and social marketing of male contraception on the whole.

5. Encouraging women to accompany their partners for counselling and services, and sensitization on gender dynamics should be intensified at such sessions.

6. Promoting joint decision making can lead to sustained use. IEC messages must aim at promoting joint decision-making for family planning, in the district.
School health programmes must help to explain male involvement initiatives to the youth and contraception and counselling services must be made available to the youth.

The DHMT should ensure equity and availability of male contraceptives at the health centres, and hold sessions to explain misconception of the side effects of male contraception.

To discourage polygamy and large family size by the introduction of community based health financing and agricultural technical assistance in the communities.

Christianity to be promoted to enhance knowledge of family planning in the District

The DHMT through the CHN’S should help modify social norms that govern male behaviour in sexual relationships and parenthood in the district.

The District Assembly should collaborate with NGO’s to help with family planning activities in the Akatsi District.

CHPS should be introduced into the primary health care in the Akatsi district.

The DHMT should try to merge male involvement programmes with empowerment of women’s projects.
REFERENCES

1. AHADIZIE L. E. K. and KORKOR A. S. 1997 "contraceptive knowledge and use, agreement between spouses on use of contraceptive among Ghanaian men."


12. Green. CP 1990 "male involvement in Family planning Lessons Learnt and Implications for AIDS prevention" Global programs in AIDS/WHO; PP .5


APPENDIX 1

QUESTIONNAIRE FOR MALE USE OF FAMILY PLANNING IN THE AKATSI DISTRICT

Data Collection Tools:

QUESTIONNAIRE FOR QUANTITATIVE ANALYSIS – AKATSI DISTRICT

Interview’s identity number [ ] (please enter your I.D. number here).

SUBDISTRICT [ ] (please enter subdistrict codes as follows)

Akatsi District 01

Any other sub – district 02

Background characteristics

1. Age of respondent [ ] (Enter age in years as at birth day)
(For questions 2 – 7 mark most appropriate with an ) X

2. Marital Status

Single [ ]
Married [ ]
Divorced [ ]
Separated [ ]
Widowed [ ]

3. Religion

Christian [ ]
Moslem [ ]
Traditionalist [ ]
Other [ ] (please specify) .............

4. Number of living children (please tick most appropriate answer)

Nil [ ]
1 child [ ]
2 children [ ]
3 children [ ]
4 children [ ]
5 or more children [ ]

5. Level of education

Primary [ ]
Middle/JSS [ ]
Tech/Com/Voc./Sec. [ ]

68
6. Occupation

Unemployed [ ]
Farmer [ ]
Fisherman [ ]
Salary Worker [ ]
Other [ ] (please specify)

7. Usual place of Residence

Rural [ ]
Urban [ ]

B. Knowledge

8. Have you heard of family planning? Yes [ ] No [ ]

If yes, source of information.
If No, go to question (9)
(More than one response allowed)

Radio [ ]
Health care worker [ ]
Newspaper [ ]
Friend [ ]
Other [ ] (please specify)

9. Do you know of any FP methods? Yes [ ] No [ ]
If No, go to question 11
10. What family planning methods do you know of

<table>
<thead>
<tr>
<th>Unprompted response</th>
<th>Prompted response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>[ ]</td>
</tr>
<tr>
<td>Male condom</td>
<td>[ ]</td>
</tr>
<tr>
<td>Female condom</td>
<td>[ ]</td>
</tr>
<tr>
<td>Injection</td>
<td>[ ]</td>
</tr>
<tr>
<td>IUD</td>
<td>[ ]</td>
</tr>
<tr>
<td>Vaginal foam</td>
<td>[ ]</td>
</tr>
<tr>
<td>Norplant</td>
<td>[ ]</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>[ ]</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>[ ]</td>
</tr>
<tr>
<td>Rhythm/periodic</td>
<td>[ ]</td>
</tr>
<tr>
<td>Abstinence</td>
<td>[ ]</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

11. Do you approve of family planning?  
   Yes [ ]  No [ ]

   Please give reasons for your answer
   ...........................................................................
   ...........................................................................

C. Use of Family Planning

12. Have you or your partner(s) ever used family planning methods?
   
   Yes [ ]  No [ ]
If Yes, why did you or your partner use the FP methods?

If No, go to question 13.

REASONS FOR USE

Limit number of children [ ]
Space children [ ]
Limit and space children [ ]
Health of wife [ ]
Economic liability [ ]
Other (please specify) [ ] ..................

13 When do you plan to have your next child?

Less than two years [ ]
Two years or more [ ]

14. Are you or your partners using a contraceptive now? Yes [ ] No[ ]

If [ Yes ] what method are using ........................................

If [ No ] what is the reason for non-use? ................................

.................................................................

15. Would you like to use a family planning method in future?

Yes [ ] No [ ]

If Yes what method would you like to use .........................

If No, go to question 16.

D. Attitude toward Family Planning

16. In a relationship who should have a major say in deciding to use family planning. (Not applicable to Non – user)
17. Who makes the decision to use family planning in your relationship?

Respondent [ ]
Wife/partner [ ]
Both [ ]
Other (please specify who) ....................

18. Who should decide in the number of children a man and his wife should have?

Man [ ]
Woman [ ]
Both [ ]
Other (please specify who) ....................

19. When should a woman use FP?

Before her 1st child [ ]
After 1st child [ ]
2nd child [ ]
3rd child [ ]
4th child [ ]
5th child [ ]
6th child [ ]
Partner Communication

20 Have you ever talked to your partner(s) about family planning?

   Yes [ ]  No [ ]

   If (Yes), when was the last time you talked to your partner about family planning? ..........................................................

   ..........................................................................................

   If (No), why? ..........................................................................

   ..........................................................................................

21 How often have you talked about family planning with your partner(s)

   Rarely [ ]

   Regular [ ]

   Very often [ ]

   Never [ ]

(F) PERCEPTION OF THE ROLE OF MEN IN FAMILY PLANNING

22. Is it important that men take part in FP? (Why?) ..................

   ..........................................................................................

23. Who should take an active role in FP?

   (a) Men [ ]

   (b) Women [ ]

   (c) Both [ ]
APPENDIX 2

AKATSI DISTRICT COMMUNITY SURVEY
GUIDE FOR ROLE PLAY AND FIELD PRACTICE FGD/IDI

To Men

1. Can you please tell me what you know about family planning?
2. What is your desired family size. Do you really care whether they are boys or girls? Some wants boys, others girls. which is your choice and why?
3. How do you protect yourself from having children now?
4. Why do people refuse to use FP or contraception’s even after achieving the desired family size?
5. Who decides why FP methods should be used? And whether spousal concern is necessary.

To women:

1. What is your desired family size? What role do you play in arriving at this decision?
2. Are you obliged to reach this family size? Yes/ No
3. What efforts do you make to protect yourself? Is your husband in favour? If he is not, how do you overcome that obstacle?
4. Do you usually discuss FP in the home, who initiates the discussion? And What is the outcome of such discussions?
Health Workers:

1. Are your messages of FP targeted for men? If so, how do you go about it?
2. What forums do you use to target them (at work, churches, meetings)?
3. Whether men discuss their concerns and fear with them?
4. What category of men do you deal with (young or old or married, students)?
5. What are general impressions, perceptions about the role of men in FP?
6. Is the FP service delivery user friendly to men (opening hours, services, open during child welfare clinics or post – natal clinics)?

6. Do you have male methods of contraceptions? Are they often available at the health centers?

THANK YOU.