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MALE CONTRACEPTIVE USE IN THE ASUOGYAMAN DISTRICT OF THE EASTERN REGION.

**AUTHOR:
DR. NII AKWEI ADDO.**



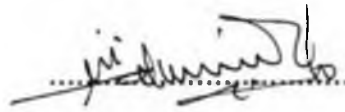
**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE AWARD OF THE MASTER OF PUBLIC (MPH.) DEGREE,
UNIVERSITY OF GHANA**

SEPTEMBER 1998

Declaration

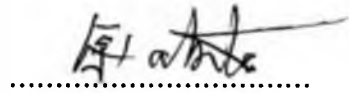
I, Dr. Nii Akwei Addo, do declare that this dissertation has been the result of my independent field research. Where material other than mine have been used, specific references have been made thereto. This work has neither been submitted towards the award of any degree, nor is it being submitted concurrently in candidature for any other degree.

CANDIDATE:

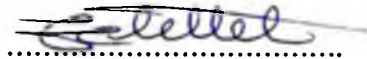


DR. NII AKWEI ADDO.

ACADEMIC SUPERVISORS:



PROF. JOHN S. NABILA



DR. (MRS.) EDITH TETTEH

Dedication

This work is dedicated to my dearest wife Zeinab, for standing by me through thick and thin for all these years. It is also dedicated to Fred and 'O' for being there when I needed them most. Thank you all and may the good Lord richly bless you.



EXECUTIVE SUMMARY

Until recently, fertility and family planning research in developing countries, as well as policy and programme formulation has generally relied on data collected from women. Increasingly however, attention is being paid to men. The literature on male contraceptive use in Ghana is limited. This study was conducted in response to a felt need by the District Health Administration of the Asuogyman District in the Eastern Region of Ghana.

The main objective of the study was to assess male contraceptive use as a basis for male involvement programme planning in the Asuogyaman District of the Eastern Region. Specifically data was collected on men's knowledge of family planning methods, reasons for practicing family planning, approval and ever use of family planning, current use, couple communication and family planning decision-making. Data was collected using a simple structured questionnaire from a total of 200 male respondents.

Data analysis showed that knowledge of family planning was high (91%), with 83.8% of men able to mention at least one method of family planning. The commonest methods known were the male condom (91.3%), the pill (83.8%) and the injection (60.5%) with least known methods being the diaphragm (21.1%), norplant (27.0%), female condom (34.0%) and male sterilization (34.1%). There were significant differences in knowledge by place of residence and level of education.

Over 90% of men in the Asuogyaman District approved of family planning.

However the high level of knowledge and approval of family planning was not reflected in the level of use. Whereas 91% of men knew about family planning only 52.2% had ever used contraceptives and 39.0% were using contraceptives at the time of the study. Level of education and knowledge of a family planning method significantly affected ever use and current use of contraceptives.

The level of unmet need for contraception among all men was 58.8% and 57.6% for married men. Eighty four percent of men indicated their intention to either continue or initiate contraception in future. There is thus a large potential for increasing contraceptive prevalence in the Asuogyaman District. The commonest reasons for not using family planning were desire for children, fear of side effects and religion.

The findings of the study do not however support the popular notion that men always want to play a dominant role in family planning decision making. Men in Asuogyaman indicated that family planning decision making should be mutual.

Attitudes of men toward family planning and reproductive decision-making might be changing and this calls for further in-depth research.

In view of the wide gap between knowledge and use of family planning among men in the district, there is the need for a male involvement programme to increase the contraceptive prevalence rate in the district.

ACKNOWLEDGEMENT

I give thanks and praises To God Almighty for a very fruitful year. To him be the glory.

I am most grateful to the Ministry of Health for sponsoring my study and granting me a study-leave with pay.

I have enjoyed total support, encouragement and direction from my Academic Supervisors, Professor John S. Nabila and Dr. (Mrs.) Edith Tetteh, and I am most grateful. It is my sincere hope that this relationship will continue after the study period.

The kindness and support of the District Director of Health Services, Asuogyaman District, Mrs. Grace Nkrumah-Mills and the entire District Health Management Team is highly appreciated.

I am equally grateful to the Volta River Authority Hospital Administration for logistic support during my field placement.

I also wish to express my sincere gratitude to all the respondents for agreeing to take part in the study.

Lastly, I thank all the academic staff of the School of Public Health and all others who had the uphill task of making me a better public health manager within the past twelve months.

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ABBREVIATIONS

1. AIDS	Acquired Immune Deficiency Syndrome
2. ATL	Akosombo Textiles Limited
3. AVSC	Access to Safe and Voluntary Contraception
4. CPR	Contraceptive Prevalence Rate
5. DHMT	District Health Management Team
6. DHS	Demographic and Health Survey
7. FP	Family planning
8. GDHS	Ghana Demographic and Health Survey.
9. GOG	Government of Ghana
10. GSS	Ghana Statistical Service
11. HIV	Human Immunodeficiency Virus
12. IEC	Information Education and Communication
13. IUD	Intrauterine contraceptive device
14. LI	Legislative instrument
15. MAP	Men as Partners
16. MCH	Maternal and Child Health
17. MI	Macro International
18. MOH	Ministry of Health
19. NPC	National Population Council
20. NPP	National Population Policy
21. PPAG	Planned Parenthood Association of Ghana
22. UNFPA	United Nations Fund for Population Activities
23. USAID	United States Agency for International Development
24. VRA	Volta River Authority

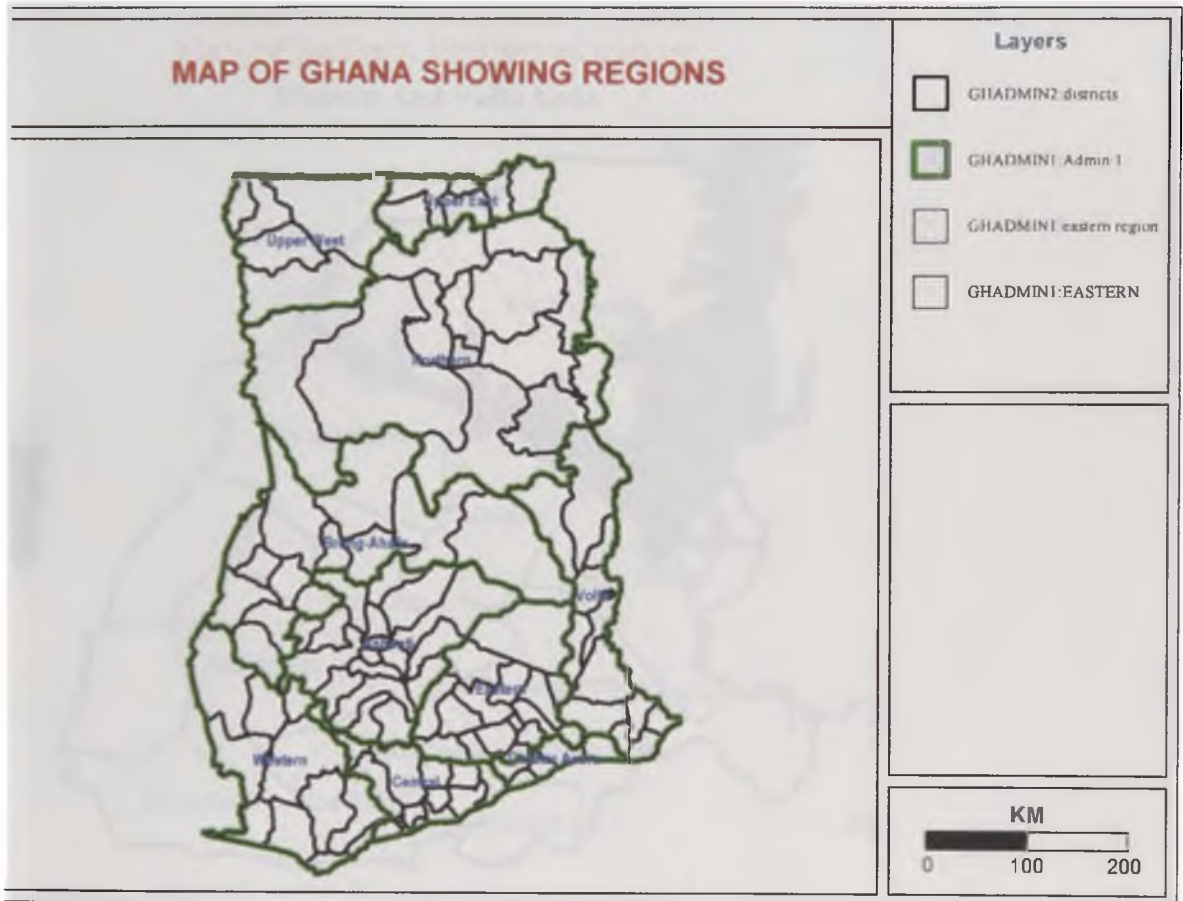
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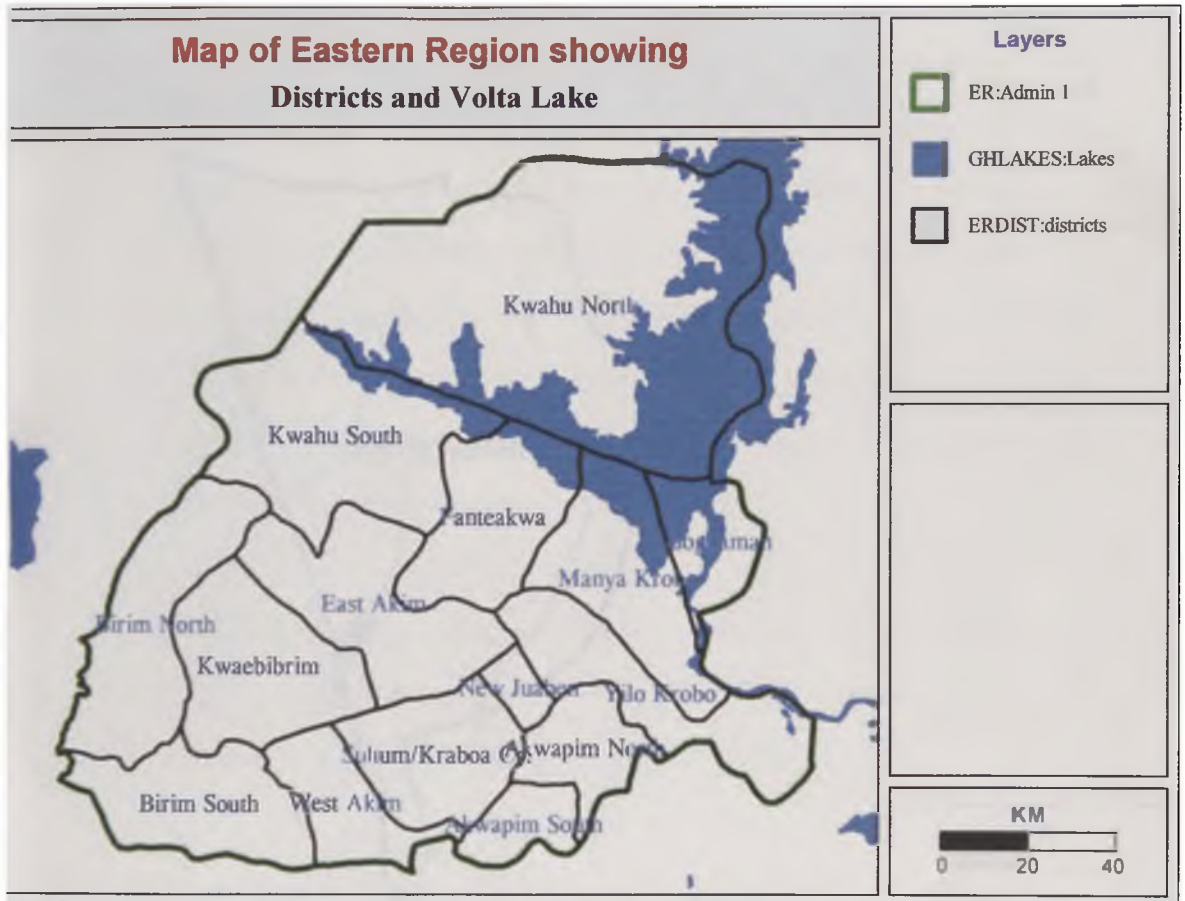
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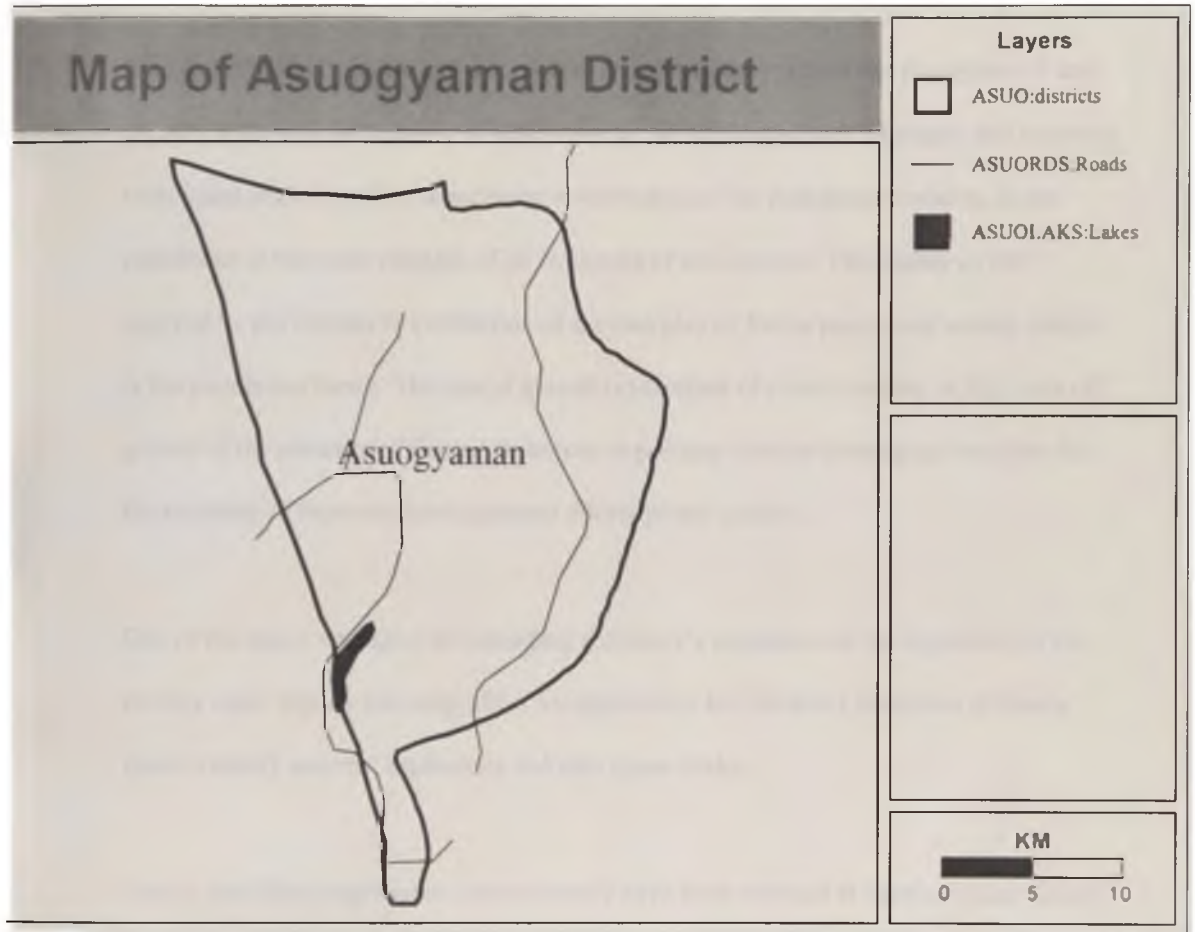
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CHAPTER ONE

1.0 INTRODUCTION: THE PROBLEM

1.1 BACKGROUND TO THE STUDY

Man is both an instrument and a consumer of production. As such the population of any country is the sole beneficiary of development. All developmental strategies and planning techniques must therefore of necessity revolve around the population variable, as the population is the most valuable of all resources of any country. The quality of life enjoyed by the citizens is a reflection of the interplay of forces paramount among which is the population factor. The rate of growth is therefore of prime concern. A high rate of growth in the presence of limited resources as pertains in most developing countries has the tendency to frustrate developmental efforts of any country.

One of the major strategies for managing a country's population is the regulation of the fertility rates. Family planning offers an opportunity for the direct limitation of family sizes to satisfy national aspirations and also space births.

Family planning programmes internationally have been targeted at persons in sanctioned union and especially women. A major factor leading to this bias could be the preponderance of female centered family planning methods, most of which do not need the physical participation of the male. There are as at the present time only two modern family planning methods available for use by men. These are vasectomy, a permanent

method of contraception and the male condom, a short-term method that requires proper and consistent use at every act of penetrative intercourse for maximum effectiveness.

Reversal operations after vasectomy are not easy and the success rates poor. Reversible family planning for men has been under scrutiny for years. A number of bold attempts at introducing new male only methods including the male oral contraceptive pill have however not yielded any definitive outcomes. (Blobel et. al, 1992, p. 248, 250; Hendon, 1992, p.10, Diczfalusy, 1985, p. 7).

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 rate from 3.0 in 1969 to 1.7 per cent by the year 2000. (NPC/GOG, 1994, p.25). However, the Ghana Demographic and Health survey of 1993 estimates the rate of growth to be still around 3.0 percent per annum (2.9 to 3.1 per cent), with a modest decline of the total fertility rate from 6.4 to 5.5 (Ghana Statistical Service/Macro International Inc, 1994, p.25).

Several factors account for the slow progress towards attainment of the national goal in fertility reduction, one of which is the low national family planning acceptor rate of 10 per cent (NPC/GOG, 1994, p.7).

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 setbacks of the family planning component of the policy. They recognized the decision making role of men in family planning as illustrated in the following statement: “the internalization 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, one of considerable importance” (Batse and Kumekpor, 1989, p80).

1.2 STATEMENT OF THE PROBLEM

Historically, many family planning programmes have assumed that men do not approve of family planning or that they perceive family planning as something that does not concern them. Most programmes are therefore directed at women. However procreation involves the active participation of both male and female partners. This apparent neglect of males in family planning in general and contraception in particular has affected male support for and use of family planning.

Male support for and use of family planning is low in the Asuogyaman district.

The number of new acceptors using male condoms continue to fall from a high 1604 acceptors in 1994 to as low as 153 new acceptors in 1997.(Asuogyaman District Health Administration, 1994, 1995, 1996, 1997).

The most popular method of contraception in the district is the injectable contraceptive for women, depo-medroxy progesterone acetate. (Ministry of Health, 1996).

This method does not need the physical participation of the male partner. Women can use it without the partner's knowledge, and indeed this assertion is confirmed by service providers as central to the recent rise in the number of new acceptors.

The prevalence of long-term methods of contraception for females has been generally low especially Norplant implants and bilateral tubal ligation.

This is because male partners refuse consent or even threaten divorce if the woman insists on having the method. (Nkrumah-Mills, Personal Statement, February 3 1998).

Vasectomy, a long-term permanent contraceptive method for men has been available since 1993 in the district. However, the first and only case was recorded in May 1998.

This low male support for and usage of family planning methods has been identified by the district as one of the key factors contributing to the declining contraceptive acceptor rate in the district.

1.3 OBJECTIVES

1.3.1 Main objective

The main objective of the research was to assess male contraceptive use in the Asuogyaman District as a basis for informing 'male involvement in family planning' programme planning in the Asuogyaman District.

1.3.2 Specific objectives

The specific objectives of the study were:

- To determine the level of knowledge of family planning methods among men aged 15-59,
- To determine the proportion and characteristics of men aged 15-59 years approving of, and ever-using family planning,
- To determine the current level of contraceptive use and intentions for future use among men in the Asuogyaman district

- To determine the extent of unmet need for contraceptives among men in the Asuogyaman district,
- To determine male attitudes toward family planning, including
 - reasons for practicing and non practice of family planning among respondents,
 - the extent of couple communication about family planning in the past year among the study population,
 - the role of men in family planning decision-making in the Asuogyaman District,

1.4 LITERATURE REVIEW

Population policies intended to address fertility and growth rates in Africa in general, (Ghana inclusive) and family planning programmes in particular have been focussed more on women to the neglect of men. Ezech (1993, p.163) examined the influence of spouses over each other's contraceptive attitudes in Ghana and emphasized the need for

active involvement of men in programmes designed to address the fertility and reproductive health issues of developing countries. He showed that spousal influence, rather than being mutual or reciprocal, is an exclusive right exercised only by the husband. The wife's attitude toward contraception is strongly influenced by the husband's attitudes and background characteristics, especially education, but the husband's views are not similarly influenced by his wife. He attributed the limited impact of family planning programmes in developing countries to the continued neglect of men as equal targets of family planning programmes.

Most family planning programmes and messages are directed towards women. They have remained women-to-women programs, with many community-based programs and communications addressed primarily to the contraceptive needs of women. (Ezeh, 1993, p.170). In Ghana for instance, assessments of family planning activities are based on women's knowledge, attitudes and practices. All coverage indicators are based on the number of female acceptors. (MOH, 1996, p19).

In a study on attitudes of urban Sudanese men towards family planning, Khalifa (1988, p.241) reported that the decision to practice family planning was made by males in the main and husbands were responsible for providing contraceptives where family planning was practiced.

Dow et al (1986, p.107), in a study of characteristics of new contraceptive acceptors in Zimbabwe hypothesized male attitudes to be a major facilitating or inhibiting factor in female contraceptive use, and 80% of acceptors reported prior partners approval.

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, p.430) 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. The other two-thirds think the male should make the decision (Green, 1990, pp.4,5). This is particularly important for a patriarchal society whose children derive their legitimacy and inheritance from the father.

Couples' ability to communicate on family planning issues has been cited in major studies of the causes of unmet need for family planning in developing countries as another important factor which influences reproductive decision making, in addition to social factors such as husbands' approval of family planning, lack of knowledge of modern methods, and societal disapproval of contraception (Bongaarts and Bruce, 1995, p.57, Westoff and Bankole, 1995 ; Casterline et al., 1997, p.174). In some countries or among some social groups, the male partner had greater influence than his spouse (Lasee and Becker, 1997, p.15).

An evaluation of male contraceptive acceptance in rural Ghana by Lamprey et. al (1978, p.224) showed that although some women may use the IUD or the pill without their husband's knowledge, most will not. In this study, it was found that 9% of female acceptors studied who initiated contraceptive usage without their spouses knowledge stopped using the family planning method because the husband objected.

One important measure for the assessment of targets for Information, Education and communication, (IEC) and services is the proportion of unmet need for contraception. It refers to a discrepancy between expressed fertility goals and contraceptive practice. The most fundamental discrepancy is between an expressed preference to limit or space births in the absence of contraceptive behaviour.

Like most family planning issues, the concept of unmet need has been applied mainly to women.

Pierre Ngom (1997, p.196), in an article in 'Studies in Family Planning' introduced the concept of men's unmet need for family planning. As alluded to earlier, this had been mainly applied to women only. Using data from the Demographic and Health Surveys of Ghana (1988, 1993) and Kenya (1989,1993), married men were found to have high levels of unmet need, 24.3 percentage points and 23.5 percentage points respectively.

Attitude, behaviour and knowledge influence contraceptive use. These high levels of unmet need may therefore be due to attitudinal and or behavioural issues given the fact that a high level of knowledge (91% of all men and 94% of currently married men) of

modern contraceptives existed among men.(GSS/MI, 1994, p.35). However research has shown that attitudes are easier to change, than behaviours. There is therefore the need for getting specific information and services to men with the view to inducing positive attitudes and behaviours with respect to family planning. This will in the long run increase male involvement in family planning, comprising essentially of support for and use of family planning methods.

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 population to assume greater responsibility for the upkeep of their wives and children. Family planning services specifically directed at the male clients shall be vigorously pursued” (GOG/NPP, 1994, p32).

In spite of this laudable idea nothing or very little have 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 services during leisure periods. (Addo, 1996, pp.14,15). Access to Voluntary and Safe Contraception, AVSC International, is an Agency of USAID popularizing long term and permanent contraceptive methods for both men and women. AVSC International is introducing a ‘Men as Partners’ (MAP) programme in the country to address some key male issues in family planning. Gradually the importance of men in family planning is gaining ground in the country.

The Ghana Demographic and Health Surveys like most DHS, report a national picture and at best regional trends. District specific data are usually not published. The current level of knowledge of modern contraceptives in the Eastern Region of Ghana is 95 percentage points while current level of use by married men is 14.4 percentage points. (GSS/MI, 1994, p.42). There is no district specific data in the Asuogyaman district on contraceptive use in general and male use of contraceptives in particular.

Whereas a global situation as presented in the DHS is essential for national policy planning, it is equally important to generate district specific data to form the basis for local level specific programme implementation planning.

1.5 HYPOTHESIS

The key assumption of the study was that male contraceptive use was positively related to knowledge of and attitude towards family planning.

1.6 JUSTIFICATION FOR THE STUDY.

Use of male only methods of contraception is low in the district. New acceptor rate for condoms had decreased from over one thousand in 1994 to 153 in 1997.

Access to Voluntary and Safe Contraception, AVSC International, in 1993 established a clinic for long term and permanent methods of contraception in the VRA hospital, which serves as the district hospital. The total number of mini laparotomies for bilateral tubal ligation and norplant insertions remains low (See table 1 below). This has in the main been blamed on poor spousal consent.

The clinic recorded its first vasectomy operation in May this year.

Table 1. Number of new family planning acceptors, Asuogyaman District, 1994-97.

YEAR	METHOD MIX								
	TEMPORARY METHODS							PERMANENT METHODS	
	PILL	MINI PILL	CONDOM	FOAM TAB.	DEPO.	NORPL ANT	IUD	FEMALE	MALE
1994	928	40	1604	258	753		25	20	
1995	772		1223	328	1559	0	23	14	
1996	452		514	234	974	23	33	38	
1997	149	113	153	96	823	4	28	59	

(SOURCE: BASED ON MCH/FP RECORDS, ASUOGYAMAN DISTRICT).

The district had identified as one of its priorities for the ensuing year, 'Male involvement in family planning'. For effective implementation of any male involvement programme in family planning, there is the need to understand the role of men in inhibiting or promoting family planning and the factors that affect male involvement in family planning programmes.

This study was undertaken with the view to providing base line information for 'male involvement' in family planning programme planning and implementation in the Asuogyaman District.

1.7 DEFINITION OF KEY CONCEPTS/TERMS

MALE INVOLVEMENT:

EZEH (1993, p 170) described male involvement as follows;

“A man who either supports his wife or partner in contraceptive use or actively participates in family planning by using a method of contraception is involved in family planning” This definition is adopted in this dissertation.

CONTRACEPTIVE USE:

Contraceptive use in this paper refers to either member of a couple using a method. Thus a man reporting use implies either he is actively using a method or his partner is.

KNOWLEDGE OF FAMILY PLANNING

A man is reported as having knowledge of family planning if he answers ‘YES’ to the specific question- Have you ever heard of family planning?

KNOWLEDGE OF A METHOD

A man is reported as knowing a method if he mentions the method spontaneously (unprompted), or after hearing it described by the interviewer (prompted).



CHAPTER TWO

2.0 STUDY AREA AND RESEARCH METHODOLOGY

2.1 ASUOGYAMAN DISTRICT

Asuogyaman district in the Eastern Region of Ghana is one of the newly created districts.

It was created by power of Legislative instrument L.I 1431 of 1988 out of the former Kaoga district. Asuogyaman literally means “the river bank state” This is because the major towns in the district line the Volta River, which also houses the Akosombo hydroelectric dam. The creation of the dam has left in its wake mass displacement and relocation of communities. This has led to socioeconomic problems, notably unemployment, occupation changes, lack of portable water and electricity and income generating activities.

The main job opportunities are with the Volta River Authority (VRA), Akosombo Textiles limited (ATL), the Volta River Estates and the public service. These are mainly restricted to the Akosombo Township.

Aside formal employment, most of the people engage in inland fishing in the river Volta or subsistent farming.

The literacy rate in the district is low. There are 28 Junior Secondary Schools and 7 Senior Secondary Schools.

The projected district population for 1997, based on the 1984 census is 81,261 with a projected male (15 –59) years population of 21,775 and a projected ‘women of fertile

age' population of 16,252. The total land area is 1,507 square kilometres and the population is divided into 139 communities.

A review of the contraceptive acceptor rate in the district over an eight-year period, 1990-1997 shows a mean coverage of 18.25 per cent. Although modest achievements have been made in coverage from a low of 9% in 1990, this has been mainly in the area of female oriented services. (Asuogyaman District Health Administration, 1997). The number of new acceptors using male condoms continue to fall from a high 1604 acceptors in 1994 to as low as 153 new acceptors in 1997.(Asuogyaman DHMT, 1994, 1997). Also, apart from the injectable contraceptive for women, depo-medroxy progesterone acetate, the prevalence of long-term methods has been generally low especially Norplant and bilateral tubal ligation. This is because male partners refuse consent or even threaten divorce if the woman insists on having the method. Thus male support for and usage of family planning methods has been low in the district.

2.2 RESEARCH METHODOLOGY

2.2.1 The study

This was a crossectional descriptive study undertaken to provide base line information on Male Contraceptive Use in the Asuogyaman District relevant to addressing low male involvement in family planning in the district.

Specifically, data collected included knowledge of family planning methods, reasons for practicing family planning, approving and ever using family planning, couple communication and family planning decision-making.

2.2.2 VARIABLES

The study variables were age, occupation, place of residence, marital status, level of education, knowledge of family planning methods, attitude toward family planning, partner communication and contraceptive use.

2.2.3 Study population

The study population comprised all males, 15-59 years, resident in the Asuogyaman District. This gave a population base of 21,775. (Asuogyaman DHMT, 1997). Only 'de facto' males were included in the research.

2.2.4 Sample size

The estimation of sample size was computed with Epi Info 6 computer software based on a study population of 21,775, level of contraceptive use among men in the Eastern Region of Ghana, 15.0%, (GSS/MI, 1994, p.42) and a worst acceptable result of 10%. This yielded a sample size of 194 at 95.0% confidence level. A total of 200 questionnaires were sent out.

2.2.5 Sampling methodology

2.2.5.1 Sampling

A multistage random sampling methodology was employed in the selection of respondents

Stage 1.

The district was divided into four zones based on ethnicity, culture and geography of the district. This coincided with the current health sub-district demarcation.

Stage 2

A list of all communities in each subdistrict was made and purposively divided into two: rural and urban.

Study communities were selected from the rural/urban stratification in a ratio of two rural communities to one urban community by simple balloting per subdistrict. This was to ensure representation of both rural and urban communities in the study sample. A representative sample of 12 communities were selected. (See annex one).

Stage 3

The minimum number of respondents per sub-district was determined by proportionate sampling based on sub-district populations and a total sample size of 200. The total number of respondents per sub-district was as follows; Atimpoku/Senchi-33, Akwamufie-40, Anum/Boso-58 and Adjena/Gyakiti-69. The total number of respondents per community was approximately a third of the estimated total respondents for that sub-district.

2.2.5.2 Identification of respondents

Within each community, a team of research persons led by a supervisor located the center of town and standing there, or as close as physically possible, spun a sharpened pencil. All men aged 15 to 59 years in households that fell in line with the tip of the pencil were recruited and interviewed serially till the required number of respondents was obtained. Where at the end of the line the requisite number of respondents had not been attained, eligible respondents in the set of households in the opposite direction were interviewed.

The same process was repeated at the next selected site community till the requisite number of respondents was obtained.

2.2.6 Data collection methods and analysis

2.2.6.1 Data collection methods

The data collected related to knowledge of family planning and family planning methods, attitude towards family planning and use of family planning. Data were derived from primary source. This involved field data collection using a simple structured questionnaire. Trained research assistants administered questionnaires to eligible respondents and they filled in responses as given by respondents.

The lead investigator did daily checks of filled questionnaire to ensure completeness and accuracy data entry.

2.2.6.1 Data analysis

The data collected was analysed by EPI INFO 6 computer software. A coding manual was prepared based on the questionnaire. Dummy tables were also prepared for presentation of the findings. The data set was entered into the field created in EPI INFO 6, and cleaned by the author. The analysis programme was used to produce frequencies, cross tabulations, means and p values.

2.2.7 Limitations

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.

The principal language spoken is Twi. However the study questionnaire was in English. Data collection staff therefore had to translate responses into English. Although a standard register of locally acceptable words and translations was agreed upon, during training of data collection staff, misunderstanding on the part of the interviewer or the respondent and the issue of translating responses could affect the outcome of the survey.

2.2.8 Ethical considerations

Confidentiality and anonymity of respondents was assured. Names of respondents were not entered on the questionnaires. Participation in the study was voluntary and consent was sought from respondents before all interviews were conducted.

CHAPTER THREE

3.0 FINDINGS

The key findings of the survey are presented in this section as follows;

Background characteristics of respondents, knowledge of family planning, approval and ever use of family planning, current use of family planning, Attitude toward family planning, and partner communication.

Of the 200 questionnaire sent, all were returned. However 13 questionnaires were rejected because they were incompletely filled. A total of 187 completely filled questionnaires formed the data set for analysis.

3.1 BACKGROUND CHARACTERISTICS

The mean age of the respondents was 33.8 years with the highest number of respondents belonging to age 28 years (6.4%). About 41 percent were less than thirty years old, 28 percent between 30-39 years, 21 percent between 40-49 years, and 10 percent 50 years and above.

A little over half (57.0%) of the respondents were married while 37 percent were single.

The rest, 5.3% comprised of the following categories: divorced 3.7%, separated 1.1% and widowed 0.5%.

The majority of respondents were Christians (88.8%). There were eight (8) traditionalists and 13 Moslems (7.0%).

Thirty three per cent of the respondents did not have any children at the time of the study.

Table 2 shows the total number of living children by the frequency of respondents.



Table 2. Number of living children by frequency of Respondent, Asuogyaman District.

No. of living children	Frequency	Percentage of total
Nil	62	33.2
One	26	13.9
Two	25	13.4
Three	26	13.9
Four	22	11.8
Five or more	26	13.9
Total	187	100

About twenty percent of the respondents were unemployed. The rest of the men had the following occupations; salaried workers formed 29.4%, small-scale artisans 13.9%, and fishermen 1.1% of the total of 187 men studied. About a third of the respondents were farmers, this being the commonest occupation.

Table 3 below shows the level of education of the respondents. Overall, the majority of the respondents had had basic education and below (67.9 %), with the rest attaining at least secondary/commercial level or higher.

About two thirds of the respondents live in rural areas (64.7%) and the rest live in urban areas.

Table 3. Educational level of respondents.

Educational level	Number of respondents	Percentage of total
Nil	17	9.1
Primary school	14	7.5
Middle/JSS	96	51.3
Secondary/SSS	30	16.0
Post Secondary	22	11.8
Higher	8	4.3
Total	187	100

3.2 KNOWLEDGE AND APPROVAL OF FAMILY PLANNING

Knowledge of family planning was assessed by three different ways. Respondents were firstly asked if they had ever heard of family planning and their sources of information. A respondent was categorised as knowledgeable of family planning if he had ever heard of family planning. Interviewers then asked respondents to spontaneously mention all the family planning methods they had ever heard of. These were designated as unprompted responses. Interviewers then probed for further knowledge going on to describe other methods not mentioned spontaneously by the respondent and asking if they had heard of them. These were designated as prompted knowledge.

TABLE 4. Male knowledge of family planning methods, Asuogyaman District.

Method	Percentage of respondents [N=185]		
	Knowledge unprompted	Knowledge prompted	Total
Pill	55.1	28.6	83.8
Male condom	73.5	17.8	91.3
Female condom	11.4	23.2	34.0
Injection	31.9	28.6	60.5
IUD	16.2	26.5	42.7
Vaginal tablets	24.3	21.1	45.4
Norplant	5.4	21.6	27.0
Female sterilisation	17.3	30.3	47.6
Male sterilisation	9.7	24.3	34.1
Diaphragm	7.0	14.1	21.1
Rhythm/Abstinence	14.6	21.6	36.2
Withdrawal	17.3	24.3	41.6

Generally knowledge of family planning among respondents was high. Almost Ninety eight (97.9%) per cent of the respondents had heard of family planning with the commonest source of information being the radio (68.3%) followed by health workers (59.1%). Newspapers were the least popular source of information of family planning. Knowledge of specific methods was however lower than general knowledge of family planning, with 89.3% of respondents mentioning at least one method.

Table 4 shows the distribution of respondents by knowledge of specific methods both unprompted and prompted. The commonest method known was the male condom. This was mentioned by 91.3% of men when unprompted and prompted responses were

combined. The least known methods were the diaphragm, the norplant, the female condom, and male sterilization in that order.

Urban men knew more about family planning methods (97.0%) than rural men (85.1%), and this difference is significant at 95% ($p=0.01$).

Knowledge of family planning methods increased with level of education. Men with post basic education or higher were more knowledgeable (98.3%) than men with elementary or no education at all (85.0%) and this difference is significant. ($p=0.006$). Christians were more knowledgeable 92.2% than non-Christians, 69.2% and 62.5% for Moslems and traditionalists respectively.

Men with 5 or more children knew more knowledgeable about family planning methods (90.0%) than men with less than five children (82.4%).

Ninety percent of the respondents approved of family planning. Place of residence had no significant impact on approval of family planning, however the more educated men were more likely to approve of family planning when compared with the uneducated men or those men who had only basic education.

Forty six percent of Moslems disapproved of family planning as against 7.2% Christians. All the traditionalists in the survey sample approved of family planning. Overall 9.6% of men disapproved of family planning.

3.3 USE OF FAMILY PLANNING METHODS

3.3.1 Ever use of family planning methods.

Fifty two percent of the men in Asuogyaman district had ever used a family planning method. Out of the total number of men who had ever used a family planning method, persons with five or more children (12) form 46.2% with the rest being men with less than five children at the time of the study. Men with basic education (elementary education) or no formal education were less likely to use family planning methods than those with secondary or higher education, $p=0.001$. (See table 5).

Table 5. Selected background characteristics of men approving of and ever using family planning, Asuogyaman District.

Characteristic	Percent	
	Approval of family planning. [N=169]	Ever used a family planning method. [N=97]
Age		
<40	88.5	48.1
40+	94.7	61.4
Educational level		
Elementary	89.8	43.7*
Higher	91.7	70.0
No. of children living		
<5		
5+	89.4	53.1
	96.2	46.2
Residence		
Rural	90.1	52.9
Urban	90.9	50.8

* Significant at 95% level, $p<0.05$. Approval and ever use were categorised as yes or no.



The probability that a man had ever used a family planning method was positively related to the knowledge of family planning, $p=0.001$.

Sixty six percent of men who had ever-used family planning methods lived in rural areas as against 34 percent in urban areas.

3.3.2 Reasons for using contraceptives

The main reasons why men used family planning in the Asuogyaman district were on account of financial problems, 43.9%; to space and limit births 34.7%; to limit number of children, 28.6%; and to protect the health of their partner, 19.4 percent.

3.3.3 Current use of family planning

About forty percent (40.6%) of men in the study area indicated that they were using contraceptives at the time of the study; the commonest method being the male condom (36.8%) followed by the pill (28.9%). Of those using family planning methods, 3.9% were using traditional methods (Table 6) whiles the rest used modern methods. Thus the current level of use of modern contraceptives is 39.0 percent.

Table 6. Family planning methods commonly used by men in the Asuogyaman district.

Method	No. of men currently using method	Percent
Male condom	28	36.8
Pill	22	28.9
Injection	17	22.4
Vaginal tablet	6	7.9
Withdrawal	1	1.3
Natural family planning	2	2.6
Total	76	100

The level of current contraceptive use was higher among men with post basic education (53.3%) than men with basic or no education at all and this difference is significant at the 95% level, $p=0.01$.

A minimum of basic education (middle school level education) results in a four-fold increase (40.8%) in the level of current use of family planning methods when compared with men without any formal education (9.1%) at all. When disaggregated by residence, 43.0% of those currently using family planning methods were living in rural areas as against 36.4% in urban areas.

Married men constituted 59.2% of those currently using family planning methods while single men constituted 38.2%, with divorced men making up the rest of 2.6 percent.

However when married men were considered as a set more than half (57.9%) were not using contraceptives. Christians were more likely to use family planning methods (42.8%) than traditionalists (25.0%) and Moslems (23.1%).

3.3.4 Unmet need for contraception

Almost ninety one percent (170) of the respondents would want to have children after two years. However only 70 (41.2%) of those who wanted children after two years were using contraceptives. The rest (58.8%) were not using any family planning methods. When disaggregated by marital status, 57.6% of the married men were not using any contraception.

Men not using contraceptives currently gave the following reasons for non use; desire for more children, 27.0%; lack of partner, 22.0%; wife pregnant, 10.0%; religion and fear of

side effects, 7.0% each. Ten percent of the respondents indicated they had no reason for not using contraceptives whiles lack of knowledge, cost and other health reasons were the reasons given by the rest of the respondents.

3.3.5 Future use of contraceptives

The majority of respondents expressed their intent to either continue using contraceptives or initiate contraceptive use in the future. Of the total number of respondents, 156 (84.3%) indicated their intention to use contraceptives in the future. This comprised 46.8% current users and 53.2% new users. The common methods men intend to use in future include Injection, (29.5%), male condom (28.8%) and the pill (18.6%). Five per cent each would like to use norplant and bilateral tubal ligation. Only two men (1.3%) intent to use male sterilisation as their choice of family planning method in future. Three of the current users however do not intent to continue use in the future.

3.4 ATTITUDE TOWARD FAMILY PLANNING

Men's attitude toward and ever use of family planning in the Asuogyaman district is summarised in table 7 below. Among respondents who had ever used family planning, the majority indicated that both men and women should have a major say in deciding to

Table 7. Men's attitude toward and practice of family planning, Asuogyaman District.

Item	Percent	
	Total respondents [N=186]	Ever used a family planning method. [N=97]
In a relationship, who should have a major say in family planning?		
Man	39.2	38.1
Woman	11.8	9.3
Both	45.2	52.6
I don't know	0.5	
They should never use it.	3.2	
Total	100.0	100.0
Who made the decision to use family planning in your relationship?		
Respondent	32.4	26.9
Wife/Partner	16.9	17.2
Both	50.0	55.9
Other	0.7	
Total	100.0	100.0
Who should decide on the number of children a man and his wife should have?		
Man	51.1	46.4
Woman	7.0	7.2
Both	41.9	46.4
Total	100.0	100.0

use family planning, 52.6%; and that the decision to use family planning in their relationship was made by both (55.9%) of them.

Table 8. Selected background characteristics of male respondents by attitude toward family planning, Asuogyaman District.

Attitude toward family planning	BACKGROUND CHARACTERISTICS					
	Percent					
	Age		Educational level		Residence	
	<40yrs	40yrs+	Elementary	Higher	Rural	Urban
In a relationship, who should have a major say in family planning?						
Man	74.0	26.0	67.1	32.9	67.1	32.9
Woman	72.8	27.3	72.7	27.3	45.5	54.5
Both	63.5	36.5	65.9	34.1	68.2	31.8
Who made the decision to use family planning in your relationship?						
Respondent	77.3	22.3	72.7	27.3	65.9	34.1
Wife/Partner	43.5	56.5	82.6	17.4	73.9	26.1
Both	65.2	34.8	58.0	42.0	58.0	42.0
Who should decide on the number of children a man and his wife should have?						
Man	77.9	22.1	69.5	30.5	66.3	33.7
Woman	69.2	30.8	92.3	7.7	76.9	23.1
Both	59.5	40.5	62.0	38.0	60.8	39.2

The same pattern emanates when all the responses from the respondents are rationalised. Men's responses as to who should make the decision on the number of children that a man and his wife should have did not show a clear polarization. Whereas 51% indicated that the man should decide on the number of children a couple should have, almost 42% laid the responsibility on the two partners. When the responses are viewed against selected background characteristics, (Table 8) men with higher education, men forty years or more and rural men indicated family planning decision making must be the responsibility of both partners. Younger men and less educated men indicated that men should have the major say in family planning.

3.5 INITIATION OF FAMILY PLANNING

When asked to indicate when a woman should initiate family planning, (40%) of respondents indicated that women should use family planning after the first child. Among men who approve of family planning, only 14.2% said family planning should be initiated before the first birth. And indeed the 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, Asuogyaman District.

When should a woman use family planning?	Percent	
	Total sample [N=187]	Respondents approving of family planning. [N=169]
Before her first child	12.8	14.2
After:		
1 st child	40.6	42.0
2 nd child	12.8	13.0
3 rd child	10.2	11.2
4 th child	10.2	10.1
5 th + child	8.0	9.5
Should not use it	5.3	
Total	100.0	100.0

Less than one in five (12.8%) of the total respondents said a woman should use family planning for postponing onset of child bearing. Age was a dominant factor in deciding if family planning should be initiated before the first childbirth with men less than forty years being more favourable

3.6 PARTNER COMMUNICATION

The majority of the respondents, (117) out of the total of 187 had ever discussed family planning with their partners. Respondents' reaction to partner communication was categorised into two; ever talked to partner about family planning and never discussed family planning with partner. Those who had ever discussed family planning were further stratified into two groups as follows; last discussion within three months and last discussion longer than three months. These two data sets were then reviewed against selected background characteristics.

Table 10. Partner communication about family planning by selected background characteristics, Asuogyaman District.

Characteristics of respondents	Ever talked to partner about family planning.	
	Total [N=117]	Within past three months [N=63]
Age		
<40	57.7	52.0
40+	75.0*	57.1
Educational level		
Elementary	59.8	52.0
Higher	69.5	57.1
No. of children alive		
<5	60.0*	66.7
5+	80.8	51.0
Residence		
Rural	65.3	46.2*
Urban	58.5	69.2

- Significant at 95% level, $p < 0.05$.

When viewed against background characteristics, there were significant differences in partner communication by age group, and number of children living. Place of residence became a significant variable when communication between partners within a time frame of three months before the study period was considered.

CHAPTER FOUR

4.0 DISCUSSION OF FINDINGS

The role of men in family planning in general and contraceptive use in particular has of recent times become important within the broad national aspirations of raising contraceptive prevalence, and reducing total fertility rates especially in sub-Saharan Africa.

In Ghana, the demographic and health surveys provide useful national data for programme planning and policy formulation regarding fertility control and family planning. However data sets are presented as national and regional aggregates only. For effective implementation at local level there is the need for base line data at district level. This research examined contraceptive use among a representative sample of men in the Asuogyaman District in the Eastern Region of Ghana.

Male knowledge of family planning was generally high with 91% of men having heard of family planning. Eighty nine percent of the men were able to mention at least one method with the male condom being the commonest (83.8%). These compared favourably with the national average of 91% of all men irrespective of marital status (GSS/MI, 1994, p.34) with 85% knowing about the condom.

The increasing prevalence of HIV/AIDS in Ghana has led to a vigorous condom promotion campaign, which may account for the condom being the commonest method known. And in deed in the Asuogyaman district there was a massive condom promotion in the early 1990, (See table one) which saw a rapid increase in the acceptor rate of condoms.

In a study of male knowledge, attitudes and practice of family planning in Zimbabwe using data from the 1988 Zimbabwean Male Fertility Survey, Mbizvo and Adamchak reported a level of knowledge of family planning higher than findings of this study. The level of male knowledge of family planning was 98 percent with 93.5 percent mentioning the pill as the most popular modern method then. (Mbizvo and Adamchak, 1991, p.37)

The diaphragm, norplant, female condom and male sterilization were the least known methods. One would understand why knowledge of the diaphragm is low given the fact that it is not in the mainstream of the Ministry of Health contraceptive commodity supply. It is mainly popularised and dispensed by the Planned Parenthood Association of Ghana (PPAG). The PPAG however does not operate in the Asuogyaman district. The female condom is also relatively new on the Ghanaian market. However Access to Voluntary and Safe Contraception - AVSC International - a partner in family planning service provision in Ghana in 1993 established a clinic in the district to popularise and provide long term and permanent contraception services. Five years later, only 27 percent of the men had heard of norplant and 34 percent of male sterilization. Perhaps this could be the result of providers targeting women for both service provision and IEC.

The level of knowledge of family planning methods was higher among men in urban areas than men in rural areas and this difference is significant, $p=0.01$. Knowledge also increased with age and men forty years or more were more knowledgeable than men less than forty years. However although this difference in knowledge by is significant, age might be a confounder since the older men are more likely to have been exposed to mass

media campaigns than younger men. Knowledge increased significantly with education, ($p=0.006$)

Approval of family planning was high among the study population with 90.4% of men approving of family planning, comparable to the level of knowledge.

However this higher level of knowledge and approval was not matched by a concomitant increase in the proportion of men who had ever used contraceptives.

Of the total men surveyed only 52.2% had ever used a family planning method while of those who were able to mention a method, 43.4% had never used a method.

The current level of use of family planning methods was even lower; at least 16 percentage points lower than men who knew of a method and had ever used family planning. The level of current use of contraceptives also referred to as the contraceptive prevalence rate (CPR) is an important demographic parameter that is strongly related to fertility levels. Ezeh, Seroussi and Raggars (1996) reported that apart from Ghana where about a third of married men were using contraceptives, the level of current use among married men in the West African sub region was generally low, ranging from as low as 0.4 percent in Mali to 19.9 percent in Ghana.

The Ghana Demographic and Health Survey of 1993 reported a contraceptive prevalence rate of 14.4 percent among married men in the Eastern Region of Ghana and a total fertility rate of 5.1 percent which although is below the national average of 5.5 is still high. (GSS/MI, 1994, p.42). The Ghana National Population Policy of 1994 aims at reducing the total fertility rate from the present 5.5 to 3.0 by the year 2020 and increase contraceptive prevalence rate by 50 percent by the same date. This calls for a more

concerted effort at narrowing the gap between knowledge and use of contraceptives and especially male involvement in family planning.

One common reason often given for the low contraceptive use among men is the narrow range of options available to men. However the GDHS of 1993 shows that the level of use of modern methods among women was equally low (10.1%), even though the range of options available to them is greater than that for men. It therefore seems that contraceptive use may be influenced by other factors worth studying. (GSS/MI, 1994, p.40)

The commonest reasons for not using contraceptives from the study were desire for children, fear of side effects and religion, aside the fact that one fifth of the respondents did not have partners. Bongaarts and Bruce (1995, p.72, 73) in a study of causes of unmet need for contraception and the social content of services, concluded that the principal reasons for non-use of contraceptives were lack of knowledge, fear of side effects and 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). One way to address such issues is through evolving innovative health education messages that address men's concerns and misconceptions with regard to family planning.

The common methods used by men in the Asuogyaman district include the male condom, the pill, and the injectable contraceptive. Aside the injectable contraceptive, all the others

are short-term methods. The thrust of the national effort however is towards increasing the use of the long term and permanent methods since they are more reliable. (MOH, 1996, p.8). Given that men's knowledge of the long term and permanent methods is also low in the district the need for a male involvement program is even more crucial so as to increase awareness and use of these more reliable methods.

People's intention to use contraceptives in future furnishes essential information on possible changes in family planning behaviour in the near future. Although expression of intent may not of necessity be translated into use, it provides a crude measure of future demand for services. This guides programme planning and implementation with the view to assuring access to services and supplies. The majority of men (84.3% of 156 men) in the Asuogyaman district indicated their intention to use family planning in future although methods with higher failure rates were the common methods selected. One possible reason for the choice of these methods could be the low knowledge of respondents with respect to long term family planning methods. (See table 2).

The study has shown that the level of use increased with increased knowledge of family planning methods, ($p=0.006$). One can therefore surmise that once men's knowledge of long term methods is increased, their use of these methods will also increase. There is thus a large potential for increasing the contraceptive prevalence rate among men in the district from the current level of forty percent.

The concept of unmet need in family planning is traditionally defined as the number of women in union who do not desire a child within two years but are not using any family planning method. This excludes infecund women, women currently pregnant and amenorrheic women who intended a pregnancy or were using contraception. (Seltzer and Solter 1997, p.11). Unmet need thus measures a potential demand for contraception, aside current users, waiting to be converted into use. Beside contraceptive commodity supply estimation, the unmet need is better applied to focussed health education to increase new acceptor rate.

Although it has undergone a lot of refinement, this concept had been applied to women in union only. However from Ghana, Ngom (1997, p.192) reported an application of unmet need to men. Using DHS data from Ghana and Kenya he estimated unmet need to be 24.3% for married men in Ghana and 23.5% for married men in Kenya. In this study the level of unmet need among married men was 57.6 percent. When corrected for men whose wives were pregnant, menopausal, or infecund, the unmet need for contraceptives was 53.3 percentage points. There is therefore the need for innovative and male friendly approaches to convert this potential into use.

Attitude toward family planning forms an important bridge between knowledge of family planning and use. In the presence of positive attitude and high level of knowledge, the transition from non-use to use of family planning methods becomes less difficult and more favourable.

Male partners in the developing world especially sub-Saharan Africa play an important and dominant role in family planning decision making. As observed by Ezech (1993), the

wife's attitude toward contraception is strongly influenced by her husband's attitudes, although the husband's views are not similarly influenced. Isiugo-Abanihe (1994, p. 149) described Nigerian men as the dominant decision-makers within the family and that their reproductive preferences influenced their wives reproductive outcomes. Other studies (Mbizvo and Adamchak 1991, p.38; Mustafa and Mumford, 1984, p.444) show that men in Africa believe they should be in control of whether and when a couple uses contraceptives.

The perception that men will necessarily have more influence in reproductive decision making because they control the family assets and are accepted as head 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.

While men's attitudes toward family planning have also been reported as generally positive by Greene (1992, p.9) and Green (1994, pp 3,4), Bankole and Singh (1998, p.22) found that although there was no systematic difference, husband's preferences had a greater influence than wife's preferences on contraceptive use in sub-Saharan Africa.

This study examined family planning decision making among men. Respondents were asked who should have a major say in family planning decision making, who actually made the decision to use family planning among current users and who should decide on

the number of children a couple should have. The findings of this study do not support the general notion that men always want to play a dominant role in family planning decision making. Men in Asuogyaman indicated that family planning decision making must be mutual. And in deed the decision to use family planning was mutual in the majority of cases. Among respondents who had ever used contraceptives, equal proportions (46.4%) indicated that both partners and men should decide on the number of children a couple must have.

Family planning is generally aimed at postponing births, spacing births, limiting births and ending births. The part of family planning that promotes postponement has not been popularised in Ghana, to the extent that nulliparous women and women outside the reproductive age are denied services. In a study of family planning service delivery points by the Ghana Statistical Services as part of a Situational Analysis in 1996, it is reported that service providers refused provision of family planning services to women with fewer than two children. In fact for long-term and permanent methods a client had to have had three or more children to qualify for service. (GSS, 1997, p72). This attitude undermines the client's wish to postpone births in particular and the whole family planning concept which seeks to offer an individual or couple free and informed choice of family planning services.

This survey sought the views of men on when a woman should use family planning with respect to parity. Less than one in five of respondents who ordinarily approve of family planning would use family planning methods to postpone births. Forty three percent of men in Asuogyaman would only use contraceptives after second or higher order births.

The study has shown that over eighty percent of men would not use family planning before the first birth.

The GDHS of 1993 in a review of the distribution of all women by number of living children at the time of first use of contraceptives according to current age, also showed that use before first birth was low, from about 4 percentage points for the age group 45-49 years to 20 percentage points for the age group 15-19 years.(GSS/MI, 1994, p.44).

Discussion of family planning by partners is generally seen as an acceptance of family planning. It is thus associated with greater contraceptive use.

Partner communication was generally high among current users of family planning.

Ninety percent of current users had ever discussed family planning with their partner, with 54.3% of current users indicating that their last discussion had taken place within a period of three months before the study.

CHAPTER FIVE

5.1 CONCLUSION AND RECOMMENDATIONS

5.1.1 Conclusion

Family planning programmes have until recently targeted women mainly because men have been traditionally seen as major barriers to family planning. However in recent times many family planning programmes have recognised the need to involve men, the forgotten 50 percent, in family planning. The 1994 Cairo International Conference on Population and Development endorsed this critically significant yet largely neglected role of male involvement by entreating all Governments to promote and encourage the equal participation of men and women in family planning. (UN, 1994, p.). This has led to a new interest in men and family planning. This study was conducted to determine men's contraceptive use in the Asuogyaman District in the Eastern Region of Ghana as a basis for male involvement programme planning. Knowledge of family planning is high among men in the Asuogyaman District, although this is mainly on short term and temporary methods.

In spite of the high level of knowledge of contraceptive methods and approval of family planning, the level of contraceptive use among men is low.

There is a large proportion of men who do not intend to have children in the immediate future but are not using contraceptives. Fortunately most men intend to use family planning in future. There is thus a large potential for increasing the current level of contraceptive use among men in the district.

Contraceptives are used mainly to space and limit births. The use of contraceptives to postpone births is not popular among men in the Asuogyaman District. Whether this behaviour is a result of lack of knowledge or an expression of the desire for children would require a future study into the factors that influence the initiation of family planning.

This study has shown that men in Asuogyaman have a positive attitude towards family planning. Contrary to the general notion, men indicated that Reproductive health decision making must be the joint responsibility of both partners. In practice both partners in the study area decided on the need to use family planning methods.

On the whole educational level, place of residence and number of living children strongly influenced knowledge, attitude and use of contraceptives.

5.1.2 Recommendations

In view of the low contraceptive use among men, the need to implement a programme to increase male involvement is justified.

Male involvement programmes must be implemented as part of the whole family planning programme and not as a separate entity.

Programme planners must provide information on long term and permanent methods of contraception to all individuals and couples, especially men.

For an effective male involvement programme there is the need to specify the components of the program and the desired outcome.

Male involvement programme indicators, for example counseling and referrals must be included on service delivery outputs/returns. This will facilitate a continuous evaluation of the programmes.

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.

Promoting joint decision making can lead to sustained use. IEC messages must aim at sustaining the positive male attitude towards family planning in the district.

Men are not a monolithic audience: there is thus the need to segment interventions and messages and to target these to specific subgroups of men.

Service delivery staff must encourage couple visitation, making the effort to relate to couples as a unit while maintaining the options of independent actions by clients. Implicit in this is right of individuals to information and service.

In addition to programme implementation, the results of this study must be used as the basis for assessing the impact of any male involvement programme that may be implemented.

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ANNEX

Data collection tools

QUESTIONNAIRE

MALE USE OF FAMILY PLANNING IN THE ASUOGYAMAN DISTRICT.

INSTRUCTIONS TO RESEARCH ASSISTANTS:

GREET AND SEEK PERMISSION OF RESPONDENT TO ADMINISTER QUESTIONNAIRE.
PLEASE USE LEAD PENCILS IN FILLING IN RESPONSES. AS MUCH AS POSSIBLE FILL IN ALL THE QUESTIONS. WHERE OPEN-ENDED QUESTIONS ARE USED PLEASE REPORT EXACT ANSWERS. DO NOT ATTEMPT PARAPHRASING ANSWERS BY RESPONDENTS.

INTERVIEWER'S IDENTITY NUMBER. [] (Please enter your personal I.D. number here).

SUBDISTRICT [] Please enter sub-district codes as follows:

Atimpoku/Senchi	01
Akwamufie/Apeguso	02
Anum/Boso	03
Gyakiti/Adjena/Akosombo	04

A:

Background characteristics.

1. Age of respondent. [] (Enter age in years as at last birthday)

(For questions 2-7, mark most appropriate response 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 []
 Poly/PostSec []
 Higher []
 Nil []

6. Occupation.

Unemployed []
 Farmer []
 Fisherman []
 Salary worker []
 Other [] (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 family planning methods?

Yes []

No []

If No, go to question 11.

If Yes,

10. What family planning methods do you know of?

	Unprompted response	Prompted response
Pill	[]	[]
Male condom	[]	[]
Female condom	[]	[]
Injection	[]	[]
IUD	[]	[]
Vaginal foam	[]	[]
Norplant	[]	[]
Female sterilization	[]	[]
Male sterilization	[]	[]
Diaphragm	[]	[]
Rhythm/Periodic Abstinence	[]	[]
Withdrawal	[]	[]

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 a family planning method?

Yes []

No []

If Yes, why did you or your partner use the family planning method?

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 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 you 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 of Family Planning.

16. In a relationship, who should have a major say in deciding to use family planning?

Man	[]
Woman	[]
Both	[]
Don't know	[]
They should not use family planning	[]

17. Who made the decision to use family planning in your relationship?

(Not applicable to Non-user).

Respondent	[]
Wife/Partner	[]
Both	[]

Other (Please specify who)

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

Man	[]
Woman	[]
Both	[]

Other. (Please specify who.)

19. When should a woman use Family Planning?

Before her first child	[]
After -		
1 st child	[]
2 nd child	[]
3 rd child	[]
4 th child	[]
5 th child	[]
6 th child	[]
Should not use family planning.	[]

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 []

THANK YOU.

List of communities.

- 1) Urban communities**
Akosombo
Atimpoku
Akwamufie
Boso
- 2) Rural communities**
Anum
Asikuma
Frankadua
Apeguso
Powmu
South senchi
Old Apaaso
Gyakiti