

**SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES**

**UNIVERSITY OF GHANA**



**CONTRACEPTIVE USE AND ASSOCIATED FACTORS AMONG MEN IN AWUTU  
SENYA EAST MUNICIPALITY**

**BY**

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**DECLARATION**

I Dake-Kumah Innocent declare that except for other people's investigations/ work which have been duly acknowledged, this work is the result of my own original research, and that this dissertation, either in whole or in part has not been presented elsewhere for another degree

Dake-Kumah Innocent

Date

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Student

Prof. Francis Anto

Date

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Supervisor

## **DEDICATION**

This work is dedicated to my family especially to my father, Dr. Dake Gershon for his immeasurable support and to Prof. Anto Francis for his unlimited supervisory role to bring forth this work.

## **ACKNOWLEDGEMENT**

I give thanks to the almighty God first for seeing me through this course successfully.

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## ABSTRACT

### Background

Despite the benefits of contraceptives, its usage by men is minimal especially in low and middle income countries. Many epidemiological studies have reported contraceptive usage amongst women but there is paucity of data on contraceptive usage by men. Therefore, this study was aimed at determining the prevalence of contraceptive usage, the types of contraceptives frequently used and factors influencing contraceptive usage amongst men in Awutu Senya east municipality.

### Methods

This was a cross-sectional descriptive study involving men only from Kasoa-Ofaakor in the Awutu Senya East municipality. Data were collected on socio-demographic characteristics and contraceptive usage using a face to face semi-structured questionnaire. Descriptive statistics was done to determine the prevalence of contraceptive usage and the types of contraceptives used by men while multivariate analysis was performed to determine factors influencing contraceptive usage.

### Results

A total of 385 men with mean age of 35 years were included in this study. The prevalence of contraceptive usage amongst men was 51.7% (95% CI: 46.7-56.7). Older men (aged > 50 years) reported lower levels of contraceptive usage compared to the younger men (aged 18-28 years) [OR=0.32; (95% CI: 0.117-0.875); p=0.026]. The level of contraceptive usage significantly increased with increasing level of education. Muslims reported lower levels of contraceptive usage compared to Christians [OR=0.56; (95% CI: 0.32-0.97); p=0.037]. Male health workers [OR=5.17; (95% CI: 1.66-16.04); p=0.005] reported higher levels of contraceptive usage while

Zoom lion workers [OR=0.12; (95% CI: 0.04-0.28);  $p<0.001$ ] reported lower levels of contraceptive usage compared to teachers.

### **Conclusion**

Even though contraceptive usage remains crucial to family planning amongst couples and its practice prevents unintended pregnancies and abortion, its usage was low in the Awutu Senya East Municipality. However the benefits of contraceptive usage are enormous amongst families and communities. Therefore male-involvement in family planning initiatives and sensitization campaigns should increase the participation of men in reproductive health.

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## **ABBREVIATIONS**

DHS	DEMOGRAPHIC AND HEALTH SURVEY
FP	FAMILY PLANNING
GHS	GHANA HEALTH SERVICE
HIV/AIDS	HUMAN IMMUNODEFICIENCY VIRUS/ ACQUIRED IMMUNE DEFICIENCY SYNDROME
IUDS	INTRAUTERINE CONTRACEPTIVE DEVICE
MCH	MARTENAL AND CHILD HEALTH
MOH	MINISTRY OF HEALTH
STDS	SEXTUALLY TRANSMITTED DISEASES
UN	UNITED NATION
WHO	WORLD HEALTH ORGANISATION



## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background

Male contraceptives, also known as male birth control are methods of preventing pregnancy that primarily involve the male physiology. The most common kinds of male contraception include condoms, withdrawal and vasectomy (Kassa, Abajobir, & Gedefaw, 2014).

According to UN Population Division and from the Demographic and Health Series 2017, contraceptive methods that men use directly, or that require their co-operation to use, including condoms, withdrawal, rhythm and male sterilization, account for one-quarter of all contraceptive use worldwide. This represents 13% of married/in-union women. The prevalence of male methods vary widely by geography and by the four methods, as well as by quintile wealth groups.

In East Africa, contraceptive use among men is very low as compared to other developed countries. A study conducted shows that in May 2003, more than 50 in-depth interviews were conducted with community leaders, health care workers and couples in Matemwe. Despite free and easy access to contraceptives, only 2% of Matemwe women participated in the village's family planning programme. Several factors were found to influence contraceptive use, including strong Muslim beliefs, male dominance over females (especially in polygynous relationships), and limited exposure to modern ideas via education and travel. Participants indicated that in order to lower fertility in Matemwe, cultural barriers to family planning must be confronted. Successful implementation of a family planning program hinges on the ability of policymakers to

-integrate modern ideas about contraception with Matemwe's traditional religious and political culture (Joseph, Forste, & Flake, 2018).

In Ghana this is no exception as studies conducted indicates that men generally do not use contraceptive but few who use this methods too do not know how to use it very well. This has led to increased sexually transmitted diseases being spread easily among both men and women (Wilson, Ameme, & Ilesanmi, 2017)

## **1.2 PROBLEM STATEMENT**

The use of contraceptives among men worldwide compared to women is very low. Methods such as vasectomy, condom use and withdrawal which are male methods account for just about 7% of contraceptive use although usage varies considerably between countries (Glasier, 2010). Most men perceived that using contraceptive during sexual intercourse does not enhance sexual pleasure but makes their partners vulnerable to premarital relationships and by so doing it does not build trust in the relationship (Kabagenyi et al., 2014). According to Chao, Page & Anderson (2014), contraceptive usage is very low among men in Africa and most developing countries because of lack of awareness on how it should be used, the importance of its use pertaining to reproduction and also some have no education on how the usage will help better the health status of their partners.

Again, a research conducted with 100 couples shows that only 12 out of the 100 couples use the contraceptive effectively, which is 12% of 100 couples who partook in the study, its failure to achieve its targets is due to various factors such as exposure on how it should be used and failures of contraceptive due to inappropriate use. This indicates the existence of the problem which may lead to different health issues if not addressed appropriately (Chao et al., 2014).

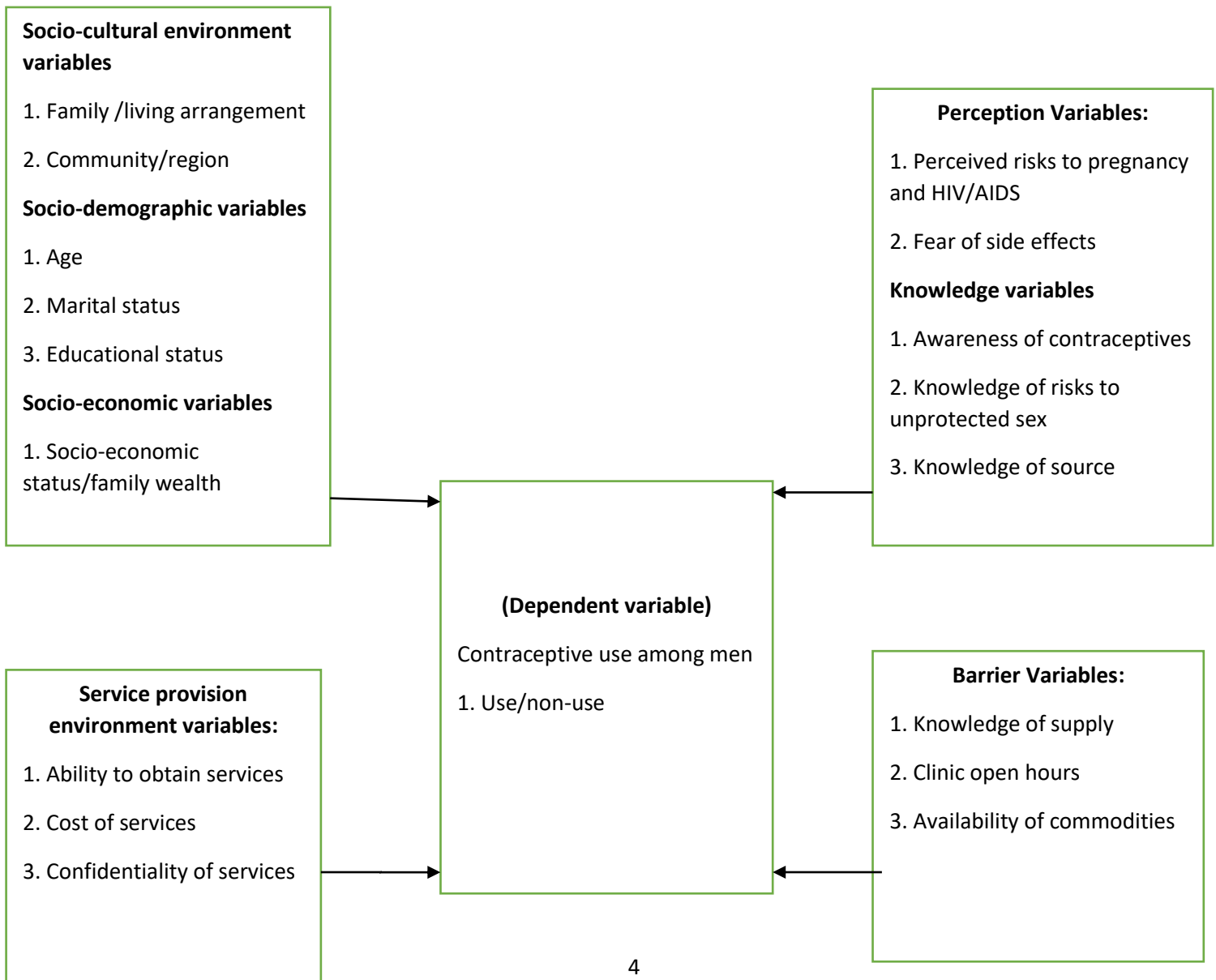


Recent developments in the world and in Ghana show clearly the effect of HIV/AIDS, and other sexually transmitted diseases (STDs) and also the need to check population explosion. It is now common knowledge that the use of contraceptives is very relevant and important against the background of low use of contraceptives among men world-wide as captured in the literature and the effect being caused by STDs and population increases in Ghana. It is very important and relevant to find out what the usage of contraception among men is in the study area in Ghana. Hence, the purpose of this current study is to assess the factors influencing the use of contraceptives among men in Kasoa-Ofaakor in the Awutu-Senya East Municipality.

### 1.3 Conceptual framework

The conceptual framework shows the relationship between the dependent variable (contraceptive use among men) and the independent variables. These variables have direct effect on contraceptive use or non-use among men.

**Figure 1:** Conceptual framework of factors associated with contraceptive usage



### **Conceptual Framework Description**

The use of contraceptives among men takes into consideration Socio-cultural environment variables such as (Family /living arrangement, Community/region, Source of sexuality information); Socio-demographic variables such as Age, Marital status and Socio-economic variables which include Socio-economic status/family wealth. These factors have direct influence on the intermediate factors because Family /living arrangement, Community/region, Source of sexuality information will determine whether an individual or couple will use or not use contraceptive because this group of people expose you to some information about contraceptive use , whiles age, marital status will also influence the use of contraceptives because at certain ages you will not be allowed to use contraceptives because of community mentality that you are not matured. Again, marital status also influences your usage because it exposes one to the type one likes. Taking into account factors such as Socio-economic status/family wealth, some men cannot afford certain types of contraceptives which is an intermediate factor for contraceptive usage. This leads to whether the men are aware of the contraceptives usage and have knowledge of risks to unprotected sex. These will directly influence whether they will use the contraceptive or not because some of the men lack the awareness or the dangers involve in unprotected sex. Service provision is a key factor that is Clinic opening hours, Waiting time, Ability to obtain services, Cost of services, Confidentiality of services, Contraceptive counseling. All these factors will influence the usage of contraceptives because accessibility of the contraceptive should make an individual use or not use the contraceptive and confidentiality of such information by a healthcare provider will also influence whether clients or men will come and asses the service. Perception Variables such as perceived risks to pregnancy and HIV/AIDS, Fear of side effects and Partner communication have effect

on its use. Some men think certain contraceptives when used give side effects. This makes them reluctant to its use, and some partners reject the use of contraceptive because it was not properly communicated to one partner. This directly influences the usage while barrier variables are also considered very important because certain things limit the men from assessing the contraceptive use. Other things may include Knowledge of supply, Clinic open hours, Availability of commodities, Distance to facility and Privacy. These are barriers because when commodities are not available we cannot not get asses before using the contraceptive and also the distance of the facility is far which will prevent others from going to assess the services. This also applies to confidentiality when men come to assess the service. Contraceptive assessors should not be made public so that his or her friends get to know. Some people will not come again when they are betrayed this way.

#### **1.4 Main Objective**

The main objective was to assess factors influencing the use of contraceptives among men in Awutu Senya East municipality.

##### **1.4.1 Specific Objectives**

The specific objectives are to:

1. Determine the most frequently used contraceptives by men in Kasoa-Ofaakor in the Awutu Senya East municipality.
2. Determine factors that influence contraceptive use among men in Kasoa-Ofaakor in the Awutu Senya East municipality

#### **1.4.2 Research questions**

The questions that guided the study are:

1. What are the most frequently used contraceptive by men in Kasoa-Ofaakor in the Awutu Senya East municipality?
2. What are the factors influencing contraceptive use among these respondents?

## CHAPTER TWO

### RELATED LITERATURE REVIEW

#### 2.1 Scope of the Review

This section reviews related literature on the subject. It touches on aspects such as the reasons for low contraceptive usage and its related consequences in the world, Africa and Ghana and the major factors responsible for them.

#### 2.2 Contraceptive usage in the world

Statistics show that reproductive-age married women who used modern or traditional contraceptive method rose from 55% to 63% between 1990 and 2010, according to a global analysis. Most of the increase was due to a 10–percentage-point rise in contraceptive prevalence in the developing world, although contraceptive use also increased in developed countries (Surveys, Cluster, Surveys, America, & Africa, 2013). In contrast, advances in male-directed methods have been confined to refinements in the type of condom and technique of vasectomy. It has been argued that research on new male-directed methods is unnecessary and that resources would be better directed toward making existing methods more widely available. Yet despite their limitations, up to 30% of couples worldwide use a male method of contraception this just indicates the low usage of contraceptives among men as compared to women (Van Assche & Vereecken, 1978).

According to CDC 2015, Contraceptive method effectiveness is critical for minimizing the risk for an unintended pregnancy, particularly among women for whom an unintended pregnancy would pose additional health risks. The effectiveness of contraceptive methods depends both on

the inherent effectiveness of the method itself and on how consistently and correctly it is used. Methods that depend on consistent and correct use have a wide range of effectiveness depending on whether it is IUDs and implants are considered long-acting, reversible contraception (LARC); these methods are highly effective because they do not depend on regular compliance from the user and this is made possible when men are involved in the process (Who, 2004). Modern contraceptive methods constitute most contraceptive use. Globally in 2015, 57 per cent of married or in-union women of reproductive age used a modern method of family planning, constituting 90 per cent of contraceptive users. When users of traditional methods are counted as having an unmet need for family planning, 18 per cent of married or in-union women worldwide are estimated to have had an unmet need for modern methods in 2015 also contraceptive use among married or in-union women cannot be sustained without the involvement of men ,this implies that, men indirectly use contraceptive as their partners are actively using it(United Nation, Department of Economic and Social Affairs, 2015).

Contraceptive usage worldwide have provided and helped to decrease over dependence on public facilities as well as reducing the dangers posed to women who give birth to certain number of children and are ineligible to give birth again. The use of contraceptive by these women will help restore their health status pertaining to reproduction (Mary, Hughes, Furstenberg, & Teitler, 1995).

### **2.3 Contraceptive usage in Africa**

Contraceptive usage in Africa is very low as compared to other developed countries. This low usage can be associated to many factors as contraceptive use increased globally, and levels of unmet need fell. Between 1990 and 2010, the proportion of reproductive-age married women

who had an unmet need for family planning (either modern or traditional) declined from 15% to 12%. This can mainly be linked to the fact that the men influence the usage of contraceptive of their respective partners due to different reasons (Surveys et al., 2013).

Studies also conducted in East Africa, Tanzania was to identify cultural barriers to modern contraceptive use in Matemwe village, Zanzibar. In May 2003, more than 50 in-depth interviews were conducted with community leaders, health care workers and couples in Matemwe. Despite free and easy access to contraceptives, only 2% of Matemwe women participated in the village's family planning programme. Several factors were found to influence contraceptive use, including strong Muslim beliefs, male dominance over females (especially in polygynous relationships), and limited exposure to modern ideas via education and travel (Joseph et al., 2018).

Research conducted in Uganda about perceptions, and concerns among men in the use of contraceptives highlights the fact that prior research on contraceptive uptake has indicated that male partners strongly influence women's decisions around contraceptive use, there is limited in-depth qualitative research on knowledge and concerns regarding modern contraceptive methods among Ugandan men (Thummalachetty et al., 2017).

## **2.4 Contraceptive use in Ghana**

Contraceptive use in Ghana is not different from other developing countries in Africa. The usage of contraceptives among men generally in Ghana is generally low due to different factors. Some of the factors may include socio-demographic factors and accessibility to the contraceptives. Accessibility is a major barrier to the usage of contraceptive in Ghana. Studies conducted shows that, in most low- and middle-income countries contraceptive use remains low even after delivery which pertains to women, when there is a window of opportunity to improve uptake.



Recent estimates from 21 developing countries including Ghana indicate that only 31% of women within the first 2 years of delivery use a FP method. About 77% of postpartum women within this period in Ghana have an unmet need for contraception. Factors that are likely to influence contraceptive use after delivery include, personal, relationship, reproductive and health system factors such as exposure to contraceptive messages during maternal and child health (MCH) care this studies pertains to women because family planning cannot be attributed to men without considering the major beneficiaries which are the women (Wuni, Turpin, & Dassah, 2018).

A study conducted in Ashanti Region of Ghana stresses on some of the major factors attributing to the low patronage or use of contraceptives by both men and women. These factors are mainly attributed to choosing a type of contraceptive method. In order to choose a method, one needs to have good knowledge of all the other available methods in terms of characteristics and the one that offers the optimal combination of the characteristics wanted. Pre –requisite knowledge of types and use of contraceptive can help to inform the individual on the availability and access to this contraceptive, also study shows that the coverage of contraceptive is very low in Ashanti region of Ghana accounting for 17.5% (Agyei-baffour, Boahemaa, & Addy, 2015). Also Fear of side effects, especially those perceived to impair fertility, remain the leading cause of non-use of modern contraception in Ghana based on the Demographic and Health Survey (DHS) and other sources. Fear of side effects increased in importance as a reason for non-use from 18% in 1998 to 26% in 2003 and in 2008, 16% of non-users said they do not intend to use it in the future because they are opposed to using family planning (up from 5.8% in 2003) (Hindin, Mcgough, & Adanu, 2014).

In Ghana, a study conducted in the Volta Region shows that knowledge of contraceptive method and knowledge of access to services were significantly associated with the uptake of contraceptive method. This is also attributed to non-availability. Without the access to the contraceptive one cannot use it (Wilson et al., 2017).

## **2.5 Factors influencing contraceptive usage and types**

The factors known to be influencing contraceptive usage are service provision, socio-demographic (age, educational status and marital status), knowledge variables such as awareness of contraceptives, Knowledge of risks to unprotected sex and availability of commodities. Also the various types of contraceptive include (the pill, the male and female condom, the diaphragm, the cervical cap, the intrauterine device (IUD), contraceptive implant, contraceptive sponge, sterilization, natural method (withdrawal) and emergency contraception). Out of all these types of contraceptive methods, only three is being used by men, this include; male condom, sterilization (vasectomy) and natural method (withdrawal); this highlights the limited methods available to men and this impacts on its usage.

According to findings from studies in Ghana (Ivy, Osei, Frances, & Harding, 2014), respondents exhibited high levels of awareness of the various contraceptives available. The most commonly cited methods were the male condom, the calendar method and the injectable. Others included the pill, the IUD, the implant and spermicides; a few women talked about local preparations (mostly herbal) used for pregnancy prevention. Female sterilization, male sterilization and emergency contraception were mentioned infrequently. Also a studies conducted in Ghana specifically Kumasi shows some relationship as previously noted, qualitative studies have shown that some men do not want their partners to use female-controlled methods because of a lack of

trust in their partners this as a result leads to these men unlikely to accept this methods, because of the fear that their partners will be unfaithful (Ivy et al., 2014).

## CHAPTER THREE

### METHODS

#### 3.1 Study Design

This was a cross-sectional descriptive study involving men aged 18 years and above from Kasoa-Ofaakor in the Awutu Senya East municipality. Participants were mainly teachers, artisans, health workers and sanitary workers who were identified through their departmental offices in the municipality. Data were collected on their socio-demographic characteristics and contraceptive usage using a face to face semi-structured questionnaire.

#### 3.2 Study Area

The study was carried out in Kasoa-Ofaakor located in the Awutu Senya East Municipality. It is the fastest growing city in Ghana today and is located 36 kilometers west of Accra the capital city of Ghana. Kasoa is on the Accra-Cape Coast road. Over the last 40 years, the population of Kasoa-Ofaakor grew very fast from 863 in 1970 to 69,384 in 2010 indicating an increase of more than 79 times (2010 Housing and Population Census). The phenomenal population growth of Kasoa-Ofaakor resulted from spill-over effect from the cities of Accra and Tema, both of which are industrial cities in Ghana.

In Kasoa-Ofaakor, there are more than ten public and private primary schools, a number of Junior High Schools and some second cycle institutions. We also have two driving schools. This growing city can boast of banks, hospital and clinics, car sales points, police station, hotels, some restaurants, lorry stations, stores and heavy vehicular movement, among others. Food-crop farming, petty trading, construction and formal sector employment are among the key economic

activities in the municipality. The agricultural produce includes maize, cassava, yams, plantain, banana, citrus, mangoes and avocado pear. We have Christians, Muslims and Traditional worshippers in Kasoa-Ofaakor.

### **3.3 Study Population**

The study population was made up of both married and unmarried men aged 18 years and above who reside in Kasoa-Ofaakor. The population was made up of Fantes, Ewutus and a traditional home to Gomoa and Awutu tribes. Now, Gas, Akan's, Ewes, Walas, Basares among others form part of the population. The target population was made up of all males in Kasoa-Ofaakor. Males who reside outside Kasoa-Ofaakor were not included in the study.

### **3.4 Study Variables**

Dependent variable is Contraceptive usage.

Independent variables were: age, marital status, level of education, occupation, religious affiliation and accessibility to contraceptive, proximity to facility and social environment of participants. Provide a table of variables

### **3.5 Sample size and sampling technique**

#### *Sample size determination*

The sample size was calculated based on this formula: provide reference for the formula

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

Where Z is the normal deviate=1.96; p= proportion of the target population estimated to have the desired characteristics (50%). q= 1 – P, e = error margin = .05

$$\frac{(1.96)^2 \times 0.5(1-0.5)}{(0.05)^2} = \frac{3.8418 \times 0.25 \times 0.96045}{0.0025} = 384.18 = 384$$

10 percent non-response;  $0.1 \times 384 = 38.4 + 384 = 423$  men.

Therefore the minimum number of men selected was 385.

Assumption: it was assumed that the rate of utilization of contraceptive in Awutu Senya East was 50% and this applies to Kasoa-Ofaakor. (Demographic Health Survey, 2014).

### 3.5.1 Sampling Technique

Firstly, the target populations were subdivided based on their profession as follows; male teachers, male artisan workers, male health workers and male sanitary workers (Zoom Lion workers). The lists of workers were collected from their employer. The participants were recruited through systematic sampling base on the sampling frame of each type of profession and the sample size was shared proportionately per the study population using the formula:

$$\frac{\text{Study population}}{\text{Total population of groups}} \times \text{Estimated sample size}$$

**Table 1: Distribution of sample among the professional groups**

S/N	Groups	Total Population	Sample Selected
1	All Male Teachers	150	80
2	All Male Health Workers	68	35
3	All Male Zoom Lion Workers	103	54
4	All Male Artisan Workers	409	216
Totals		730	385

The first participant was selected using a random number generated for each group to pick a participant within the first sampling interval of the systematic selection. For instance, for all male teachers, the sample size selected was 80 participants, to avoid bias in sampling the first participant was selected using a random number generator to pick the first participant, subsequent participants were picked based on the formula below:

Sample of  $n$  units from  $N$  units, every  $k$ th item is picked from the sampling frame starting with the  $i$ th unit ( $i < k$ ) where  $k$ , is the sampling  $interval = N/n$ , which is  $150/80 = 2$ . The starting point was randomly selected from a list of participants using a random number generator. The selected starting point was 5, the 7th person on the list was then chosen followed by the 9th, and so on. If additional participants are required at the end of the list, the count loops to the beginning of the list to make up the required sample size. This applied to subsequent groups.

### **3.6 Data Collection Tool and Procedures**

A semi-structured questionnaire was used to collect the data. The questionnaire was in three sections. Section one (demographic Characteristics), this section contains information on the participants age, marital status, level of education, occupation and religious affiliation, section two (detailed information on marital status) tries to enquire more into the number of children the individual have and also tries to enquire about the life children, if any, also the last section which captures information on the contraceptive usage status, whether the individual ever used a contraceptive before, type of contraceptive reasons for non-use and whether the individual knows any health facility or any other place this contraceptive can be assessed whether for free or not.

Each interview lasted for 15 -20 minutes and participants who could not read and write were given special explanation into questions in their local dialect by research assistants collecting data in the locality. The data were collected during break time for male teachers where they filled the questionnaire themselves, while for artisans, during their free times or during their break time. In the case of the zoom lion workers, they were engaged after early morning work and when they were preparing to depart to their various homes, this time was deemed suitable because these workers had appropriate time to answer questions pertaining to the study through interviews. For the health workers the questionnaire was given to them to complete during their free times.



### 3.7 Variables

Table 2: Sample variables

<b>Contraceptive-usage Variables</b>	<b>Description</b>	<b>Scale of measure</b>
Contraceptive usage	Participant ever used contraceptive and never used.	Categorical Value: Yes/No
Age of participants contact	Participants who were 18years and above.	Continuous variable
Educational status	Referred to the educational status mentioned by the participant during the interview.	Categorical Values: No Formal education, Primary, Secondary, Tertiary
Marital status	Referred to the marital status reported by the participant during the interview.	Categorical Values: Single, Married, cohabitation, Divorced/separation/widow
Religion	Referred to the religious background of the participants during the interview.	Categorical Values: Christian -Non-Christian
Community of origin	Refers to participants home town	Categorical Values: - Urban, semi-urban, rural.

Occupational status	Referred to the type of profession.	Categorical value: Health workers, teachers, artisans and zoom lion workers.
Future usage	This refers to respondents who will use contraceptive in the future or will not use contraceptive in the future again	Categorical value: Yes/No
Outcome of non-usage	This refers to respondents who know the outcome of not using contraceptives and those respondents who do not know.	Categorical value: Yes/No
Accessibility	Refers to respondents who know where to buy who get a contraceptive, whether pharmacy or hospital and respondents who do not know where they can get contraceptive.	Categorical value: Yes/No

Awareness	Refers to respondents who have ever heard advertisement and education about the importance of contraceptive usage and respondents who have not been educated or heard about advertisement of contraceptive.	Categorical value: Yes/No
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### 3.8 Data analysis

Data were entered using EpiData version 3.0 software. Stata version 15.0. Software was used for data analysis and cleaning. Measures of central tendencies (mean or median) and frequencies were determined. Univariate analysis was performed to determine the proportion of participants that had used contraceptive. Bivariate analysis was employed using Chi-square or Fisher exact test for categorical variables. Logistic regression was also used to investigate factors independently associated with contraceptive usage. Firstly, the association between outcome (contraceptive usage) and independent variables (demographics, accessibility, future-usage, outcome of non-usage, type of occupation and awareness factors) was examined. Then each dependent variable with a P-value less than 0.05 was included in the logistic regression analysis. All statistics were discussed at the 95% confidence interval (CI), and the level of significance was set at 0.05.

### **3.9 Quality control**

Five data Collection Assistants were trained on how to effectively administer questionnaire, conduct interviews and also handle ethical issues, the data collectors were chosen from the Kasoa-Ofaakor community who could speak the local dialect. The questionnaire was pre-tested in Winneba, a community in the Efutu Municipality. The questionnaire was reviewed after the pretesting based on problems identified during the exercise.

### **3.10 Ethical Consideration**

Ethical approval for the study was obtained from the Ethical Review Committee of the Ghana Health Service (GHS), through the School of Public Health University of Ghana. Ethical review number: GHS-ERC 032/02/19

#### **3.10.1 Privacy/Confidentiality**

All information gathered in relation to the participant's participation was kept confidential and was not revealed to anyone. Identities were not revealed in reports or publications that will result from the study while the data, both in hard copy and digital format, collected was kept for the purpose of analyses only.

### **3.11 Voluntary withdrawal**

The decision of each participant in this study to participate was entirely voluntary. He/she was allowed to ask as many questions as possible until a better understanding is achieved. A participant was also allowed to withdraw participation at any time as he/she wished without the need for any explanation.

### **3.12 Potential Risks/Benefits of the Study**

There is no foreseen potential risk in participating in the study except that it may took part of the precious time of participants and the need of participants who provided some personal information such age, marital status and contraceptive usage. The benefit of the study is that it identified factors influencing usage of contraceptive.

### **3.13 Consenting**

For every participant, he or she was taken through the consenting process that is, what the study was about and what we seek to achieve, the benefits of the study to the community and nation as well as the potential risk involved. He/she was made aware that it is entirely voluntary and thus can decide to stop at any time in the process. To prove consent, every participant was made to either sign or thumb print the consent form before the questionnaire was administered.

### **3.14 Data storage and usage**

It was explained to every participant that all the information obtained was stored in files and put under lock and key. At the end of the study any personal identifying information was destroyed beyond identification by anybody else.

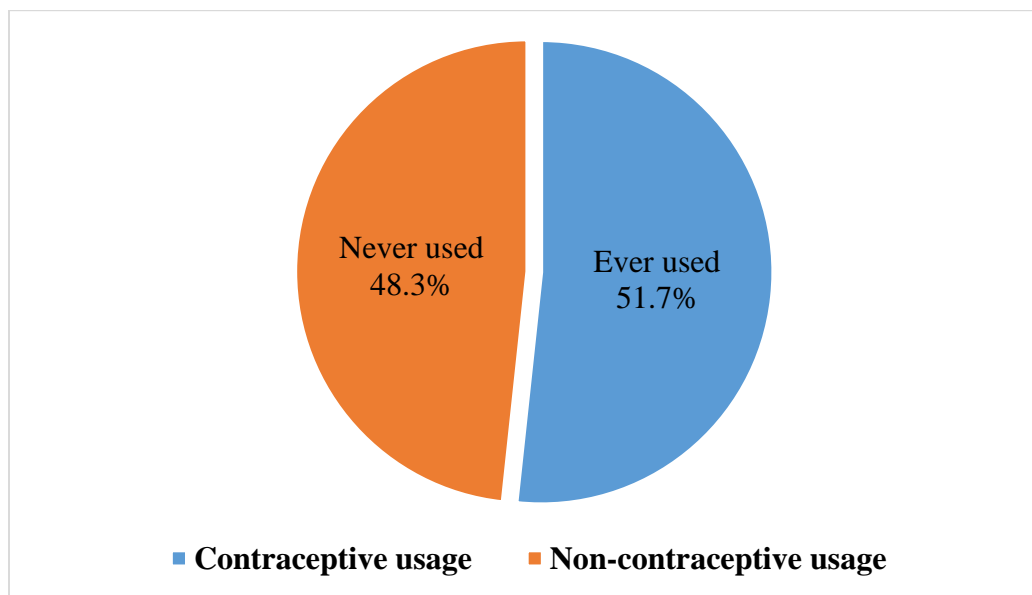
## CHAPTER FOUR

### RESULTS

#### 4.1 Socio-demographic Characteristics of Respondents

A total of 385 men aged 18 – 71 years (mean: 35.2 years), participated in this study. One hundred and fifty-four (40.0%) were aged 18-28 years with 16 (4.6%) being 61 years and over. Of the 385 respondents, 51.4% (198) were married, 38.7% (149) had attained basic level education, 74.8% (288) were Christians and 49.9% (192) were resident in semi-urban communities (Table 3).

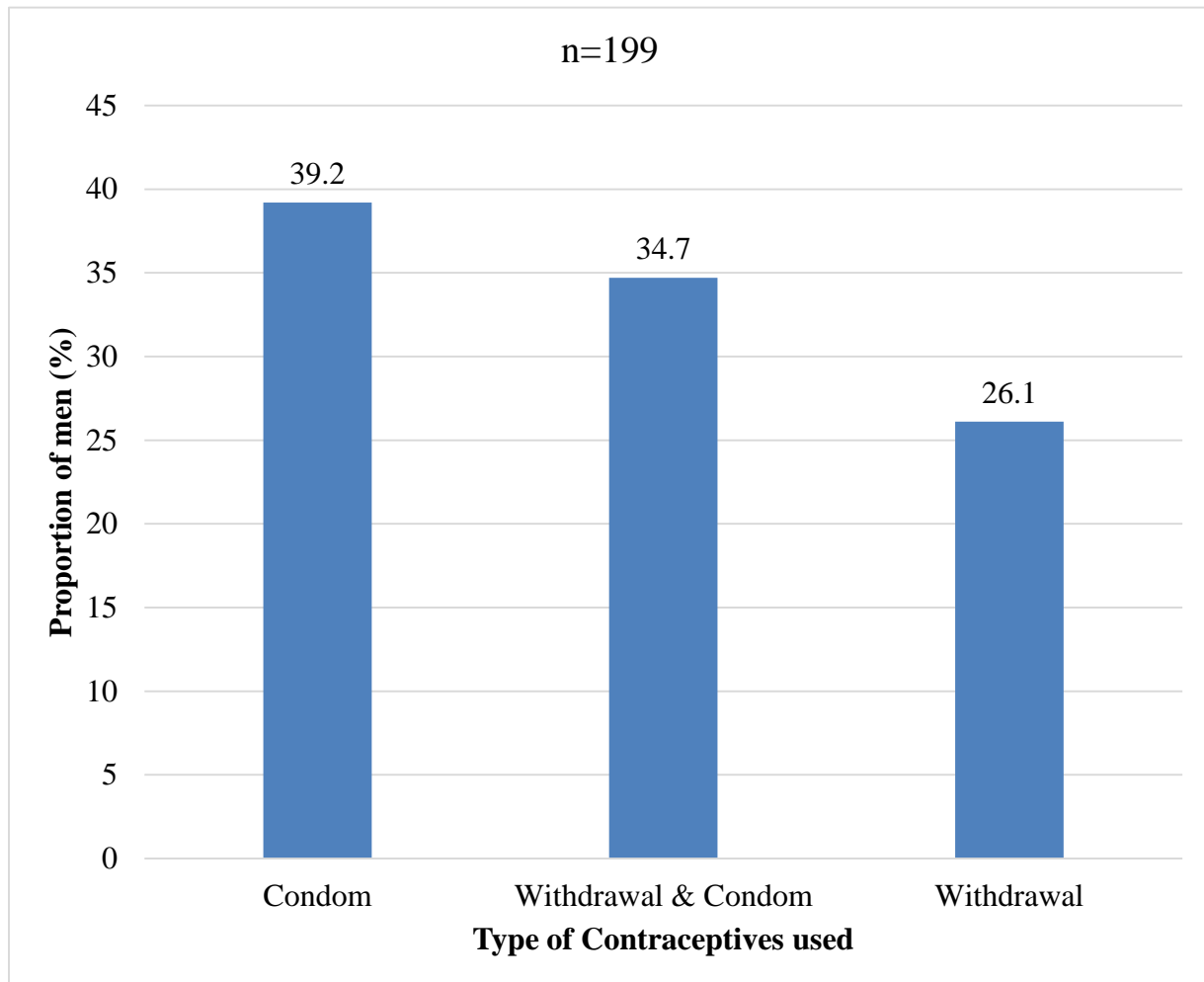
#### 4.2 Contraceptive usage



**Fig. 2: Prevalence of contraceptive use** Of the 385 respondents, 51.7% (199) reported ever using one form of contraceptive or the other (95% CI: 46.7-56.7) (Fig. 2).

**Table 3: Socio-demographic characteristics of study participants**

<b>Variables</b>	<b>N=385(%)</b>
<b>Age in Years</b>	
18-28	154(40.0)
29-39	103(26.8)
40-50	69(17.9)
51-61	43(11.2)
>61	16(4.6)
<b>Marital Status</b>	
Single	179(46.5)
Married	198(51.4)
Divorced	8(2.1)
<b>Level of Education</b>	
No Formal	59(15.3)
Basic	149(38.7)
Secondary	109(28.3)
Tertiary	68(17.7)
<b>Religious Affiliation</b>	
Christian	288(74.8)
Muslim	94(24.4)
Traditionalist	3(0.8)
<b>Community of origin</b>	
Village	66(17.1)
Town	192(49.9)
City	127(33.0)



**Fig. 3: Types of contraceptives methods frequently employed by the respondents**

Amongst those who reported ever using a contraceptive method, 39.2% (78) indicated that they use only condoms, 26.1% (52) reported practicing the withdrawal method only whilst 34.7% (69) reported employing both the withdrawal and condom.



#### **4.3 Socio demographic Characteristics of participants by contraceptive usage.**

Significant associations were observed between contraceptive usage and age groups, marital status, level of education, religious affiliation and community of origin ( $p < 0.05$ ). Participants aged 18-39 years reported significantly higher proportions of contraceptive usage compared to older age groups ( $p < 0.001$ ). Single men reported higher proportion of contraceptive usage compared to those who were married or divorced and this difference was statistically significant ( $p < 0.001$ ). In this study, the proportion of contraceptive usage increased with the level of education and this was statistically significant ( $p < 0.001$ ). Christians reported higher proportions of usage compared to non-Christians and this difference was statistically significant ( $p < 0.001$ ). City dwellers also reported higher proportions of contraceptive usage compared to those who reside in towns (semi-urban) and villages (rural) and this difference was statistically significant ( $p < 0.001$ ) (Table 4).

#### **4.4 Crude Odds ratios of Contraceptive usage and socio demographic factors.**

Table 3 below shows univariate logistic regression model to show the association between socio-demographic characteristics and contraceptive usage. Significant associations were observed between contraceptive usage and age groups, marital status, level of education, religious affiliation and community of origin ( $p < 0.05$ ) (Table 5).

**Table 4: Socio demographic Characteristics of participants by contraceptive usage.**

Variables	N=385(%)	Contraceptive-usage		X <sup>2</sup> value	P value
		Ever-used (%)	Never-used (%)		
<b>Age in Years</b>				52.8	<0.001
18-28	154(40)	99(64.3)	55(35.7)		
29-39	103(26.75)	65(63.1)	38(36.9)		
40-50	69(17.92)	25(36.2)	44(63.8)		
51-61	43(11.17)	10(23.3)	33(76.8)		
>61	16(4.16)	0(0.00)	16(100.0)		
<b>Marital Status</b>				22.0	<0.001
Single	179(46.49)	114(63.7)	65(36.3)		
Married	198(51.43)	84(42.4)	114(57.6)		
Divorced	8(2.08)	1(12.5)	7(87.5)		
<b>Level of Education</b>				69.7	<0.001
No Formal	59(15.32)	7(11.9)	52(88.1)		
Basic	149(38.70)	66(44.3)	83(55.7)		
Secondary	109(28.31)	73(67.0)	36(44.3)		
Tertiary	68(17.66)	53(77.94)	15(22.1)		
<b>Religious Affiliation</b>				16.2	<0.001
Christian	288(74.81)	166(57.6)	122(42.4)		
Muslim	94(24.42)	32(34.0)	62(66.0)		
Traditionalist	3(0.78)	1(33.3)	2(66.7)		
<b>Community of origin</b>				8.5	0.015
Village	66(17.14)	25(37.9)	41(62.1)		
Town	192(49.87)	98(51.0)	94(49.0)		
City	127(32.99)	76(59.8)	51(40.2)		

**Table 5: Crude Odds ratios of Contraceptive usage and socio demographic factors.**

<b>Variables</b>	<b>Crude(OR)</b>	<b>(95% CI)</b>	<b>p-value</b>
<b>Age in Years</b>			
18-28	ref		
29-39	0.95	(0.57 1.59)	0.847
40-50	0.32	(0.17 0.57)	<0.001
51-61	0.17	(0.07 0.37)	<0.001
>61			
<b>Marital Status</b>			
Single	ref		
Married	0.42	(0.28 0.63)	<0.001
Divorced	0.08	(0.009 0.68)	0.020
<b>Level of Education</b>			
No Formal	ref		
Basic	5.9	(2.5 13.8)	<0.001
Secondary	15.0	(6.22 36.5)	<0.001
Tertiary	26.2	(9.89 69.0)	<0.001
<b>Religious Affiliation</b>			
Christian	ref		
Muslim	0.38	(0.23 0.61)	<0.001
Traditionalist	0.36	(0.032 4.09)	4.09
<b>Community of origin</b>			
Village	1.0		
Town	1.70	(0.96 3.03)	0.066
City	2.40	(1.32 4.5)	0.004

#### **4.5 Adjusted Odds ratios of Contraceptive usage and socio demographic factors.**

After adjusting for possible confounders, only age groups, level of education and religious affiliations remained independently associated with contraceptive usage (Table 6).

Respondents aged 51-61 years had a 68% lower level of contraceptive usage compared to those aged 18-28 years and this difference was statistically significant [OR=0.32; (95% CI: 0.117-0.875); p=0.026].

Men who had attained basic level education were 5 times more likely to use contraceptives compared to those with no formal education [OR=5.05; (95% CI: 2.10-12.18); p<0.001]. Those who had secondary level education were 7.7 times more likely to use contraceptives compared to those with no formal education [OR=7.73; (95% CI: 3.03-19.72); p<0.001]. Men who had attained tertiary education were 16 times more likely to use contraceptives compared to those with no formal education [OR=16.00; (95% CI: 5.80-44.02); p<0.001].

Muslims had a 44% lower level of contraceptive usage compared to Christians and this difference was statistically significant [OR=0.56; (95% CI: 0.32-0.97); p=0.037] (Table 6).

**Table 6: Adjusted Odds ratios of Contraceptive usage and socio demographic factors.**

<b>Variables</b>	<b>Adjusted (OR)</b>	<b>(95% CI)</b>	<b>p-value</b>
<b>Age in Years</b>			
18-28	ref		
29-39	1.37	(0.672 2.771)	0.389
40-50	0.56	(0.234 1.325)	0.186
51-61	0.32	(0.117 0.875)	0.026
>61			
<b>Marital Status</b>			
Single	ref		
Married	1.38	(0.744 2.568)	0.304
Divorced	0.86	(0.083 0.911)	0.902
<b>Level of Education</b>			
No Formal	ref		
Basic	5.05	(2.097 12.18)	<0.001
Secondary	7.73	(3.032 19.72)	<0.001
Tertiary	16.0	(5.798 44.02)	<0.001
<b>Religious Affiliation</b>			
Christian	ref		
Muslim	0.56	(0.322 0.965)	0.037
Traditionalist	1.13	(0.077 16.62)	0.927
<b>Community of origin</b>			
Village	ref		
Town	1.24	(0.646 2.388)	0.514
City	1.80	(0.882 3.538)	0.108

#### **4.6 Perception and Knowledge variables influencing Contraceptive Usage among Respondents**

On chi square analysis, significant associations were observed between previous contraceptive usage and future usage, outcome of non-contraceptive usage, accessibility and awareness ( $p < 0.05$ ) (Table 7).

#### **4.7 Knowledge and perception variables influencing contraceptive usage among men using multiple logistic regression.**

After adjusting for possible confounders, only future contraceptive usage remained independently associated with contraceptive usage. Men who declared never to use contraceptives in the future had 84% reduced risk of contraceptive usage compared to those who accepted to use contraceptives in the future [OR=0.16; (95% CI: 0.09-0.26);  $p < 0.001$ ] (Table 8).

**Table 7: Perception and Knowledge variables influencing Contraceptive Usage among Men**

Variables	Total	Contraceptive Usage		X <sup>2</sup>	P value
	N=385(%)	Ever (%)	Never (%)		
<b>Future usage</b>				74.5	<0.001
I will use	148(38.4)	118(79.7)	30(20.3)		
I will not use	237(61.6)	81(34.2)	156(65.8)		
<b>Outcome non usage</b>				13.5	<0.001
I know	345(89.6)	190(55.1)	155(44.9)		
I do not know	40(10.4)	9(22.5)	31(77.5)		
<b>Accessibility</b>					
I know	370(96.1)	196(53.0)	174(47.0)	6.3	<0.001
I do not know	15(3.90)	3(20.0)	12(80.0)		
<b>Awareness</b>				16.9	<0.001
I am aware	203(52.7)	125(61.6)	8(38.4)		
I am not aware	182(47.3)	72(40.7)	108(59.3)		

**Table 8: Using adjusted odds ratios with logistic regression of perceived and knowledge variables influencing contraceptive usage**

<b>Variables</b>	<b>Adjusted</b>		
<b>Perception &amp; knowledge</b>	<b>(OR)</b>	<b>95%CI</b>	<b>p-value</b>
<b>Future usage</b>			
I will use	ref		
I will not use	0.16	(.095 .259)	<0.001
<b>Outcome non usage</b>			
I know	ref		
I do not know	0.46	(.193 1.09)	0.079
<b>Accessibility</b>			
I Know	ref		
I do not know	0.34	(.086 1.38)	0.132
<b>Awareness</b>			
I am aware	ref		
I am not aware	0.64	(.401 1.02)	0.064



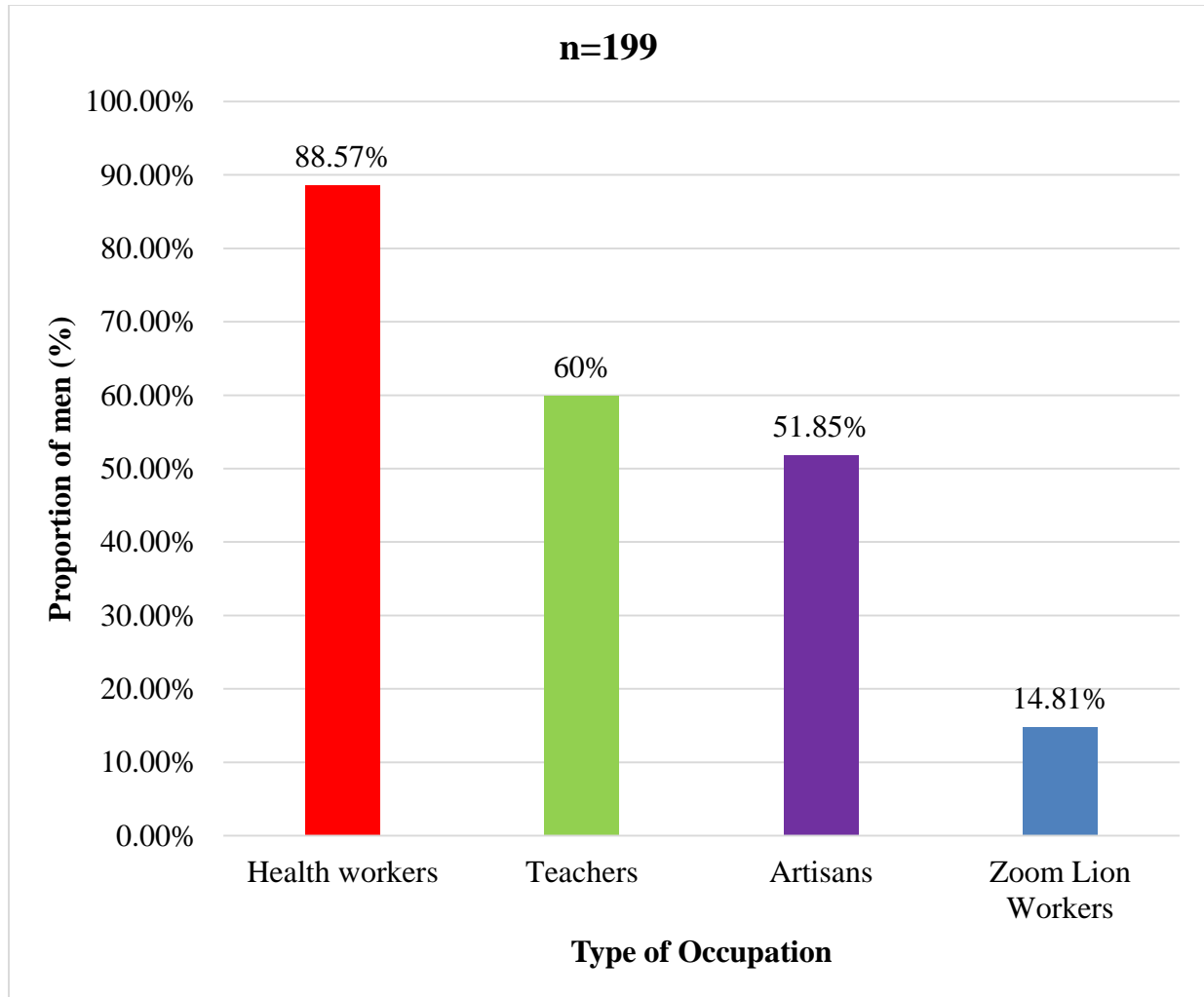


Figure 4: Contraceptive usage distributed according to types of occupation

Contraceptive usage was highest among health workers followed by teachers, then artisans before zoom lion workers.

**4.8 Type of Occupation and influence on contraceptive usage among men using adjusted odds ratios.**

On multivariate analysis, type of occupation was independently associated with contraceptive usage. Male health workers reported higher proportion of contraceptive usage (88.57%) compared to the other types of occupations. Health workers were 5 times more likely to use contraceptives compared to teachers [OR=5.17; (95% CI: 1.66-16.04); p=0.005]. Zoom lion workers had 88% reduced level of contraceptive usage compared to teachers [OR=0.12; (95% CI: 0.04-0.28); p<0.001] (Table 9).

**Table 9: Adjusted odds ratios: using multivariate analysis logistic regression model and its appropriate p-values for respondent’s occupation**

Occupation(males)	N=385(%)	(Contraceptive Usage)		Adjusted (OR)	p-value	95%CI
		(Ever %)	(Never %)			
<b>Teacher</b>	80(20.78)	48(60)	32(40)	ref		
<b>Health worker</b>	35(9.09)	31(88.57)	4(11.43)	5.17	0.005	(1.6-16)
<b>Zoomlionworker</b>	54(14.03)	8 (14.81)	46(85.19)	0.12	<0.001	(.04-.27)
<b>Artisan worker</b>	216(56.10)	112 (51.85)	104(48.15)	0.72	0.212	(.42-1.2)

**OR=odds ratio, CI =confidence interval, ref=reference group**

## CHAPTER FIVE

### DISCUSSION

This study was aimed at estimating the prevalence of contraceptive usage and its associated factors amongst men in the Awutu Senya East Municipality. The main findings in our study were as follows: the prevalence of contraceptive usage amongst men was 51.7% (95% CI: 46.7-56.7). Older men (aged > 50 years) reported lower levels of contraceptive usage compared to those younger (aged 18-28 years). The level of contraceptive usage significantly increased with increasing level of education. Muslims reported lower levels of contraceptive usage compared to Christians. Men who declared that they have never used contraceptives were less likely to use contraceptives in the future. Male health workers and Zoom lion workers were more likely to report higher levels of contraceptive usage compared to teachers.

Details of the results with respect to our objectives are discussed below as follows:

#### **5.1 Prevalence of contraceptive usage**

The prevalence of contraceptive usage of 51.7% found among men in the Awutu Senya East Municipality is much higher than that reported in a study conducted amongst sexually active men aged 15–54 years in Kenya which reported that 38.6%, 36.4% and 25.0% of the respondents were currently using none/traditional, partner method and male method of contraception (Ochako, Temmerman, Mbondo, & Askew, 2017). Differences in the socio-demographics, cultural and study designs could account for this variation in contraceptive usage. Lack of available family planning services amongst men in our settings could also explain the current level of contraceptive usage in this study.

Even though men are important given their role in sex and reproduction, research in Ghana has focused on contraceptive usage and family planning amongst women, with the aim to help reduce the burden of unintended pregnancies and abortions (Amalba, Mogre, Appiah, & Mumuni, 2014; Apanga & Adam, 2015; Eliason et al., 2014).

In Ghana increasing trends in contraceptive usage amongst women were observed from 5 consecutive Ghana DHS between 1988 and 2008 (Nonvignon & Novignon, 2014). In 2014, of 21.53% of women in Ghana were on modern contraceptives users (Nyarko, 2015). Out of Ghana, several studies have highlighted the influence of men on reproductive decisions such as number of children and contraceptive use and men's influence may not necessarily reflect the reproductive decisions of their wives (Biddlecom & Fapohunda, 2006; Ochako et al., 2015). Findings from this study have to a greater extent shown the importance of the role men may play as co-decision-makers relating to fertility and fertility control. Previously, family planning programs and related research have focused attention on women and this study shows that male involvement in family planning activities remains crucial.

## **5.2 Most Frequently used contraceptives by Respondents**

In this study, condoms were the most frequently used contraceptive method. These findings were consistent with findings in the Volta Region of Ghana which found that 94.78% of men used condoms in the year 2014 (Wilson et al., 2017). Increased accessibility, cost and effectiveness of condoms in the prevention of unintended pregnancies and sexually transmitted diseases could explain why condom use was the most preferred contraceptive methods amongst men in this study.

### **5.3 Socio demographic factors associated with contraceptive usage**

In this study, older men (aged > 50 years) reported lower levels of contraceptive usage compared to those younger (aged 18-28 years). This may be because they are less sexually active and are less likely to have multiple partners unlike younger men. A study conducted in Kenya showed that only 8.6 percent of all adolescents had ever used a contraceptive method (Kinaro, Kimani, Ikamari, & Ayiamba, 2015). This rate of contraceptive use amongst adolescents is lower compared to the prevalence of contraceptive usage due to differences in the age of the study participants. Adolescents unlike adults cannot afford the various methods of contraception and the age in which sexual activity begins varies across communities, ethnicities, cultures, regions and countries.

In this current study, the level of contraceptive usage significantly increased with increasing level of education. This finding was consistent with those conducted in Sunyani Municipality in the Brong Ahafo Region of Ghana (Wuni et al., 2018). Educated men tend to have a better understanding and knowledge of the benefits of contraceptives compared to uneducated men.

In this study Muslims reported lower levels of contraceptive usage compared to Christians. This finding is not consistent with those conducted in the Tafo Suame industrial area in Kumasi, Ghana which clearly showed that religion does not have any influence on contraceptive usage (Agyei-Baffour, Boahemaa, & Addy, 2015). The Islamic religion strongly prohibits contraceptive usage and encourage more procreation compared to Christianity. .

### **5.4 Perception and knowledge variables influencing Contraceptive usage**

Men who declared that they have never used contraceptives were less likely to have the intension of using contraceptives in the future in this study. These findings were inconsistent with findings

in Tafo Suame industrial area Kumasi, Ghana which showed no significant association between previous and current contraceptive usage (Agyei-Baffour et al., 2015). In this study, respondents who had never used contraceptive in the past had 80% reduced chance of using contraceptive in the future. This explain why future contraceptive usage is associated with previous usage, as previous contraceptive users continue to use contraception and family planning in order to prevent STDs and unwanted pregnancies.

### **5.5 Type of occupation and influence on contraceptive usage**

Teachers, Zoom lion, health workers and artisan workers were the various occupations, using multivariate analysis, type of occupation was independently associated with contraceptive usage. Male health workers and Zoom lion workers were more likely to report higher proportions of contraceptive usage compared to teachers and artisans. The association between contraceptive usage and types of occupation may be due to their educational level. It is worth noting that the level of contraceptive usage increased with increasing level of education in this study. The levels of contraceptive usage amongst health workers and teachers was high compared to artisans and zoom lion workers due to the differences in the educational background.

In Ghana, residence and education were key determinants of contraceptive use amongst women from 5 consecutive Ghana DHS between 1988 and 2008 (Avisah et al., 2018; Nonvignon & Novignon, 2014). Furthermore, female adolescent contraceptive use was significantly determined by age of adolescent, education, work status, knowledge of ovulatory cycle, visit of health facility and marital status (Nyarko, 2015). The multiple cox proportional hazards model analysis identified place of residence and the educational level of a woman as strong predictors of modern contraceptives use in Ghana.

In Kenya, a number of socio-demographic and socioeconomic factors were associated with contraceptive use (both partner and male methods) among sexually active men on bivariate analysis (Ochako et al., 2017). These factors include: men aged >25 years, number of children, education and wealth status, marital status, marriage type, gender norms, place of residence, region of residence, religion, discussion with a health worker, listenership to radio, reading a newspaper and watching television (Ochako et al., 2017).

Discussion of family planning with a health worker, region, education, wealth index: richer, richest surviving children and fertility preference were most significantly associated with modern contraceptive use among men (Kabagenyi, Ndugga, Wandera, & Kwagala, 2014).

Factors influencing contraceptive usage are similar even though gender differences may exist based on sociocultural factors. In our settings, more invasive male contraceptive methods such as vasectomy/sterilization are not being practiced as the men turn to favor the use of less invasive contraceptive methods like condoms.

## **5.6 Limitation**

The study was subject to some limitations. Firstly we failed to capture, other factors influencing contraceptive usage such as number of children, desire for future children, service provision and other important variables. Secondly, the results cannot be generalized to whole population of Ghana. Thirdly, recall and interview bias may have influence the response provided by the participants due to inability to vividly remember and provide sensitive information on their sexual or reproductive health.

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATION

#### 6.1 Major Findings

One in two men were contraceptive users in this study. Younger men, educated men and Christian men had higher levels of contraceptive usage. Men who had never used contraceptives were less likely to use contraceptives in the future. Health workers and teachers reported higher levels of contraceptive usage compared to zoom lion workers.

#### 6.2 Conclusion

Even though contraceptive usage remains crucial to family planning amongst couples and its practice prevents unintended pregnancies and abortion, its usage was low in the Awutu Senya East municipality. However the benefits of contraceptive usage is enormous amongst families and communities. Therefore male-involvement in family planning initiatives should increase the participation of men in reproductive health.

#### 6.3 Recommendations

Based on our findings, the following recommendations are made:

1. Education on contraceptive usage should target those without formal education.
2. Sensitization campaigns on the benefits of contraceptive usage should target the adolescents and young adults because they are more sexually active and at risk of having unintended pregnancies.
3. Male-involvement in family planning initiatives should increase the participation of men in reproductive health.



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## **APPENDIX I: INFORMED CONSENT**

Project Title: **CONTRACEPTIVE USE AND ASSOCIATED FACTORS AMONG MEN IN AWUTU SENYA EAST MUNICIPALITY**

Introduction:

I am DAKE-KUMAH INNOCENT, a final year MPH student of University Ghana, Legon (School of Public Health).

I am conducting a study on **CONTRACEPTIVE USE AND ASSOCIATED FACTORS AMONG MEN IN AWUTU SENYA EAST MUNICIPALITY**. I am going to give you information on the study and invite you to participate in this research.

Purpose of the study

The research seeks to assess the factors influencing the use of contraceptives among men in Kasoa-Ofaakor. Findings from the study will be used as evidence for the reasons behind non – usage of contraceptives among men in the Awutu Senya East Municipality .It will inform the funding agencies, stakeholders and DHMT on strategies to adopt to improve the contraceptive usage by men in this Municipality by educating them on some of the risk factors that associated with non- usage of contraceptive. The findings will also serve as a basis for future research.

Role of participant

If you decide to take part in the study, participant was required to answer a set of structured questions concerning the study and the services provided to you. It will take at least 15 minutes of your time and will be administered to you by an interviewer.

#### Advantages/Risk of the study

Participating in this study is an opportunity for you to contribute to finding on some of the causes of non- usage of contraceptive among men in this Municipality

This in effect has led to implementation of strategies that improved its usage, apart from the time you spent during the interview, the study caused no risk or harm.

#### Confidentiality

All the information collected about you during the study was treated confidentially. Your name or that of your child was not used for the final data analysis.

#### Compensation

You have been duly acknowledged in the final thesis for your participation, cooperation and contribution.

#### Mode of participation

Participation is voluntarily and participants withdrew at any stage without any penalty.

#### Questions

Participants were at liberty to ask any question about the study as well as seek clarifications on any issue during administration of the questionnaire.

#### Signature of participant

I.....upon reading and understanding or

Obtaining verbal explanation on the study, I willingly decided to consent for my child to participate in the study.

Signature/Thumbprint.....

For further information/clarification or any issues of concern should contact:

Principal Investigator, Dake- Kumah Innocent (0546240381), dakekumah@gmail.com

Supervisor, Dr. Anto Francis (0244577063), fanto@ug.edu.gh

Administrator of GHS-ERC, (Hannah Frimpong, 0507041223)

Name of interviewer.....

Signature.....

Date...../...../.....



**APPENDIX II: Study Questionnaire**

**SCHOOL OF PUBLIC HEALTH**

**UNIVERSITY OF GHANA**



**DEPARTMENT OF EPIDEMIOLOGY AND BIostatISTICS**

**QUESTIONNAIRE**

**This research instrument is designed to collect data from men in Kasoa -Ofaakor)**

**INTERVIEWER:**

*Your participation in the study as said earlier is completely voluntary.*

*We would also like to assure you that all information collected in the course of the study will remain confidential.*

*Thanks a lot for your participation. In case you have any questions, please let us know.*

*Please also ask when you have a problem understanding the meaning of any of the question*

I am post graduate student of the School of Public Health, University of Ghana and conducting research on the topic: **CONTRACEPTIVE USE AND ASSOCIATED FACTORS AMONG MEN IN AWUTU SENYA EAST MUNICIPALITY** this information that will be given shall-

be treated with confidentiality and for academic purposes. **Confidentiality of the answers given is assured.** Thank you very much for your participation.

PARTICIPANT ID: .....

DATE: .....

**SECTION A: Socio-Demographic Data**

Participants ID		Response	Code
Question Number	Questions		
1	Age 18 years and above		age
2	Marital status  1. Single  2. Married  3. Divorced/Separated  4. Widowed  5. Co-habiting		maristat
3	What is your educational level?  1. No formal education  2. Primary  3. Secondary		education

	4. Tertiary		
4	<p>What is your religion?</p> <p>1. Christian</p> <p>2. Muslim</p> <p>3. Traditionalist</p> <p>4. Others, specified.....</p>		religion
5	How many children do you have?		children
6	<p>Main occupation?</p> <p>1 Male Teacher [ ]</p> <p>2 Male Health Worker [ ]</p> <p>3 Male Zoom Lion Worker [ ]</p> <p>4 Male Artisan Worker [ ]</p>		occupation

**SECTION B: Respondent marital status information**

Participants ID		Response	Code
Question Number	Questions		
7	Are you currently living with a woman or cohabiting  1 Yes [ ]  2 No [ ]  3 Others specify.....		current
8.	Is your partner or wife living with you now?  1 Yes [ ]  2 No [ ]  3 Others .....		partner
9	How many children are you having?  How many.....?		manych

10	<p>Are all of those children Alive?</p> <p>1 Yes [ ]</p> <p>2 No [ ]</p> <p>3 Not applicable.....</p>		
11	<p>How long would you like to wait in the future or now before giving birth to another child?</p> <p>1 how many years specify.....</p>		birthncd
12	<p>Which type of community arrangement do you live in?</p> <p>1 Village [ ]</p> <p>2 Town [ ]</p> <p>3 City [ ]</p> <p>4 Others .....?</p>		comarrage
13	<p>Have you ever used a contraceptive before? If no, move to Q17.</p> <p>1 Yes [ ]</p>		Cbefore

	2 No [ ]		
14	How old were you, when you first use it?  Specify.....		firstuse
15	Which type of contraceptive have you ever used?  1 Condoms [ ]  2 Vasectomy [ ]  3 Withdrawal [ ]  4 Others specify.....?		Tcontra
16	Where did you obtain your recent method of contraceptive?  1 Government health center [ ]  2 Private medical center [ ]  3. Other source.....		rmethod

**SECTION C: Section C: Contraception (Perception variables and knowledge variables)**

Question number	Question	Yes(1)	No (2)
17	Are you using any method currently to delay your partner from getting pregnant?		
18	Do you have a place you can get information on contraceptive types and availability?  if no move to Q20.		
19	Did the provider tell you or educate you on whether the method is permanent or temporary?		
20	Do you think you will use contraceptive in the future? If no, move to Q22.		
21	If no? Why don't you think you will use contraceptive in the future?  1. Religious reasons [ ]  2. Sexual sensitivity reduced (condom use) [ ]  3. Not Sweet [ ]  4. Others specify.....		

22	In the last 12months have paid any fees to buy or access contraceptive? If No, move to Q27.		
23	How much did you pay?  Specify amount.....		
24	Were you told by the provider what to do if you experience side effects		
25	Would you return to this provider?		
26	If No, why?  Specify reasons.....		
		Yes(1)	No(2)
27	Do you know the outcome of not using contraceptives? If No move to Q29.		
28	If yes, what are the outcomes or effects of not using?		



	<p>1 Sexual transmitted diseases [ ]</p> <p>2 Unwanted pregnancy [ ]</p> <p>3.Othersspecify</p> <p>.....</p>		
29	Do you know where to get contraceptive or aware on where to get it? If No, move to Q31.		
30	<p>Where do you know?</p> <p>1 Government hospitals [ ]</p> <p>2 Pharmacy shop [ ]</p> <p>3 Private hospital[ ]</p> <p>4 Others specify.....</p>		
31	Heard about family planning on the radio?		
32	Seen anything about family planning on the television?		
33	Read about family planning in a newspaper or magazine?		

