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MALE INVOLVEMENT IN FAMILY PLANNING IN THE BEKWAI MUNICIPALITY

BY

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DECLARATION

With the exception of the duly acknowledged references, I, Bernard Anim Akoto, hereby declare that this dissertation is the result of my own original work under the supervision of Dr. Adom Manu. This work has not been presented for any other degree in this university or elsewhere either in whole or in part. I am responsible for the views expressed and the factual accuracy of its contents.

……... Date: ..25th June, 2020…….

Bernard Anim Akoto
(Student)

30th June, 2020

…… Date: …….

Dr. Adom Manu
(Supervisor)

DEDICATION

I dedicate this work to my wife, Shirley, and children Jerome, Renee and Bahkita, and to Almighty God for his love and grace.

ACKNOWLEDGEMENTS

I thank God for his mercies, strength, knowledge and understanding given to me to pursue this studies. I am grateful to my supervisor, Dr. Adom Manu for his unflinching support, encouragement self-dedication and teachings which led to the completion of the research. Without his guidance this project wouldn't have been a success. Also to my mum and siblings, wife and children for their prayers, my childhood friend and colleague Mr. Kwasi Safo Boakye for their support through this project. I would also like to thank the entire staff of Department of Population, Family and Reproductive Health at the School of Public Health, University of Ghana, Legon. Special thanks to the entire staff of the Bekwai Municipal Health Directorate. I am also grateful to all who made this work a fruition.

ABSTRACT

Introduction: Family planning is a voluntary and informed decision by an individual or couple on the number of children to have and when to have them, by use of modern or natural FP methods. Most available studies have revealed low patronage by males. This study sought to explore male involvement in family planning in the Bekwai Municipality**.**

Methods: A descriptive cross-sectional study was conducted to explore male involvement in family planning in the Bekwai Municipality. A multi-stage sampling technique was used to select a total of 534 respondents using a structured questionnaire. The Statistical Package for Social Sciences (SPSS) version 20 was used for analysis of data. A composite variable was generated to assess male involvement in Family Planning (FP), knowledge level and level of perception on FP. Associations between variables were determined using chi square test and logistic regression.

Results: Perception about male involvement about FP was good (86.7%). Male involvement in FP was low as 35% of the respondents did not involve themselves in FP activities. Male involvement in Family Planning was influenced by; knowledge on FP importance of family planning [$\chi 2=6.06$, $p= 0.014$], distance to get FP services [$\chi 2= 5.22$, $p=0.022$] and means of access to FP services [$\chi 2= 15.67$, $p<0.000$].

Conclusion: Male involvement in family planning in the Bekwai Municipality was low even though participants had good perception of family planning. Knowledge on importance of family planning among men, distance to family planning clinics and means of access to FP services were the factors identified in this study to be influencing male involvement in family planning.

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LIST OF ABBREVIATIONS

KNBS .....Kenya National Bureau of Statistics

ICPD ..... International Conference on Population and Development

HIV .....Human Immunodeficiency Virus

AIDS..... Acquired Immunodeficiency Syndrome

GDHS .....Ghana Demographic and Health Survey

MCH .....Maternal and Child Health

STD..... Sexually Transmitted Diseases

IMNCS .....Improving Maternal, Neonatal and Child Survival

FP..... Family Planning

CHPS .....Community-Based Health Planning and Services

CHO..... Community Health Officer

MBCP .....Male Birth Control Pill

HBM .....Health Behavior Model

FGD .....Focus Group Discussion

SPSS .....Statistical Package for Social Science

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Family planning services play a very important role in reducing maternal and infant mortality. Expanding the availability of family planning services and increasing utilization in developing countries could avert up to 42% of maternal deaths (Shazia et al., 2010). Direct and indirect benefits of family planning such as reduction in the spread of HIV to new born babies (Reynolds, 2008); reduction of maternal mortality and morbidity (Cleland et al., 2012); reduction in neonatal, infant, and child mortality (Rutstein, 2005); reduction in unsafe abortion (Sedgh et al., 2012); and improvement in education and employment opportunities for women who are able to delay initiation of childbearing (Singh et al., 2009).

World fertility survey showed that utilization of family planning methods varied widely from 11% in Africa to 69% in Asia (Darroch, 2013). Most Family planning programmes and projects historically offered these services exclusively to women since they were viewed as the main target group with very little attention to the involvement of men. However, (Dvorsky, 2008) observes that only a few programmes attempted to encourage male involvement in family planning decision making and in use of methods such as vasectomy, condom. As such there is a general consensus that male involvement in family planning does not only help in the acceptance of contraceptives, but, more importantly it is efficient and of perpetual use (Dvorsky, 2008). Therefore, irrespective of the woman intentions to use contraceptives her desire may be rendered incapable if her husband does not approve its use.

The focus on addressing gender inequalities to optimize health outcomes resounds in the field of family planning. However, global family planning initiatives, including Family Planning 2020, continue to concentrate primarily on women, with less attention to men (Hardee, Croce-Galis, & Gay, 2016).

Although some family planning programs include men as an integral part of their intervention strategy, men are more commonly involved as gatekeepers or decision makers for women's health or as "add-ons" in activities that focus on providing information and services to women (Geleta, Birhanu, Kaufman, & Temesgen, 2015; Raj, et al., 2016). Ijadunola et al. (2010), argues that there is an urgent need to increase male involvement in family planning decision making to improve family planning uptake. Ghana Demographic Health Survey revealed low involvement of males in family planning in Ghana (GDHS, 2005). Some reasons contributing to low male involvement in Family Planning includes Low levels of knowledge, social stigma, shyness, embarrassment and job responsibilities contributes to low involvement of males in family planning (Agha, 2010). There has been limited knowledge of how to fully incorporate men in reproductive health programmes despite their participation in family planning decision making being thought as having some economic benefits (Hawkes, 2000).

Many countries in sub-Saharan Africa have persistent high rates of unmet need for family planning and relatively low proportions of contraceptive use (Aryeetey, et al., 2010). Factors affecting service provision include tenuous commodity security and suboptimal service factors (Cleland, Ndugwa, and Zulu, 2011). At the individual woman level also, numerous obstacles work against the utilization of family planning service (Paul et al, 2014). Studies

have shown that barriers to family planning services include risk perception, insufficient knowledge needed to make informed choices, opposition from male partners, and health service limitations (Paul et al 2014).

Gender experts agree that men should be encouraged to be supportive partners of women's reproductive health while also meeting their own reproductive health needs, and engaged as agents of change in families and communities (Greene, 2006). Constructive male engagement in family planning entails a thoughtful, gender sensitive approach that places gender equality and women's empowerment on equal footing with other desired outcomes (Gilles, 2015). Constructively engaging men, including adolescent boys, to be users of Reproductive Health services themselves, shifting gender norms, and improving communication and joint decision making in couples can be challenging and require long- term efforts as a result of low socio-economic factors (Oluwasanmi, Pengpid, & Peltzer, 2011). This study sought to assess the male involvement in family planning in the Bekwai Municipality.

1.2 Problem Statement

All over the world, family planning services remain unmet (Lasie, and Backer, 2012). Even though many women desire to control the number of childbirth and conception in their lifetime, they have no access to effective family planning (Cleland, et al, 2014). Despite modernization, and an increase in the Family planning methods, male involvement in the use of contraceptives is still low with condom use being as low as 15.2% Kenya National Bureau of Statistics (KNBS, 2010). There has been increasing attention by the World Health Organization (WHO) to improve constructive male involvement in the reproductive health. A

study conducted by Wiafe (2015) in Sunyani found that reproductive health professionals are failing to target male involvement in reproductive health decision making and the use of health resources. The benefits of family planning are not being fully achieved since most men are not getting involved in Africa with Ghana not being an exception (Ijadunola et al., 2010). The cause of low involvement of males in family planning is believed to be caused by several factors. These factors include male's perception on family planning, their socioeconomic and demographic profiles, policies in place, mass media campaigns, inter personal communication from health workers, advice from family members, spousal communication and health systems in place (Arundhati, 2011).

The family planning coverage in the Bekwai Municipality is not encouraging. Between 2014 and 2017, there has been marginal increase in coverage from 25% to 30.3% respectively. According to the Bekwai Municipal Health Directorate's Annual Performance Review (2017), there has been an increase in family planning Acceptor Rate amongst females from 29.5% to 31%, which is above the national target of 28%. However, the male acceptor rate and involvement in family planning services is as low as 11%. Male involvement in reproductive health and family planning is a very important factor in the success of any sexual and reproductive health (SRH) programme. This is due to the fact that in developing nations such as Ghana, societal norms and religious beliefs ensures men are often the primary decision makers on the use of family planning by their partners and they also decide family sizes (Adelekan, Omoregie and Edoni, 2014). Studies by Adongo et al., (2013) show, that although knowledge of at least one method of family planning is high (98%) among men, their involvement is low.

Currently, very little is known about the enablers and barriers of male involvement in the municipality. This study consequently sought to identify the factors that influence or inhibits male involvement in family planning at the Bekwai Municipality in the Ashanti Region.

1.3 Objectives of the Study

1.3.1 General Objective

To explore male involvement in family planning in the Bekwai Municipality

1.3.2 The specific objectives of the research are:

1. To assess the knowledge of males concerning family planning in the Bekwai Municipality.
2. To determine the perception about male involvement in Family Planning in the Bekwai municipality
3. To determine the proportion of males who are involved in family planning in the Bekwai Municipality.
4. To identify factors associated male involvement in family planning in the Bekwai municipality.

1.4 Research Questions

To achieve the study objectives, the following research questions were examined:

1. What is the level of knowledge of males concerning family planning in the Bekwai municipality?
2. What is the perception of male involvement in family planning in the Bekwai Municipality?
3. What proportions of males are involved in family planning in the Bekwai Municipality?
4. What factors are associated male involvement in family planning in the Bekwai municipality?

1.5 Justification of the Study

Male's participation at all levels in family planning programmes is regarded as a vital tool for achieving Ghana's health outcome. This study focused on filling the knowledge gap on the factors that constrain male involvement in family planning in Bekwai Municipality. The study is important because the findings could be used by the government as a basis for formulating policies that relate to family planning and reproductive health. Knowing the determinants of male involvement in family planning will deepen our understating of family planning utilization patterns in the district. This will help family planning programing and interventions, and consequently improve family planning utilization in the district. Finally, the findings of the study will serve as baseline information for future studies on male involvement in family planning.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter is devoted to an overview of the literature related to the study, which allows readers to gain an understanding of the many facets of the concept of family planning and male involvement in FP in contemporary literature.

Family planning is a way of controlling population and helps in reducing unintended pregnancies (Cates, 2010). The International Conference on Population and Development ICPD held in Cairo in 1994; emphasized the importance of male involvement in reproductive health.

In the public health sector, reproductive health services have long been offered mostly through the existing outlets of maternal and child health (MCH) centers and obstetrics and gynecology clinics. Unfortunately, these centres are usually attended by women and mothers only. This partly explains why population, development and health agencies have largely ignored men's influence on women's reproductive health actions and decisions and have also ignored the reproductive health needs of men (Senate Economic Planning Office, 2013).

2.2 The Family Planning Concept

Family planning helps save women and children's lives and preserves their health by preventing unintended and untimely pregnancies, reducing women's exposure to the health risk of child birth and abortion. Couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to information,

education and means to do so. The World Health Organization (WHO, 2007) explained that despite great progress over the years, many women worldwide want to prevent pregnancy but they and their partners are not using contraceptives and some of the reasons for this unmet need are quality of service, unavailability of range of methods, fear of opposition from partners and worries of side effects and health concerns among others.

Worldwide, 38% of pregnancies are either unwanted or unplanned. In Africa, unwanted pregnancy poses a major and continuing social, health, and development challenge. It accounts for more than a quarter of the 40 million pregnancies that occur annually in the region, which could be due to contraceptive failure, non-use and to a lesser extent due to rape. Considering the consequences, it's important to prevent unintended pregnancy by providing access to contraceptives including emergency contraception, safe abortion services and empowering women to determine their reproductive choices (Fotso, Cleland, Blessing, & Michael, 2011).

2.3 Male Involvement in Family Planning Initiatives

Following the Cairo initiative that took place about two decades ago, there have been various efforts and attention put in place to increase male involvement in family planning services. However, there is no accepted understanding of a broad meaning of active male involvement in family planning that exists. According to Toure (2011), male involvement is defined as all activities targeted at increasing the number of men who use contraceptives (Toure, 2011). However, his definition is criticized by Greene (2000) who defines male involvement as all organizational activities targeted at men with the objective of increasing the number of men that encourage and inspire their wives to use family planning services. Greene (2000) adds

that it is influencing the policy environment to make it conducive for male-related programmes and not just increasing the number of men who use contraceptives.

Cairo Action Plan defines male involvement in all activities that promote men's active participation in family planning activities, projects and programme services with the aim of achieving gender equality and empowering women (Nelson et al., 1996).

As much as the above definitions attempt to highlight what male involvement in family planning initiatives entail, it is Mburu and Adam‟s (2011) definition that suffices in this study. The two scholars posit that male involvement involves all activities that are geared towards ensuring active participation and shared responsibility between both partners in family planning matters with the primary aim of providing joint decision-making on the use of contraceptives.

Presently, decision makers are looking for ways and programs to involve men in reproductive health decisions, including family planning and support for safe motherhood. Previous programs have established that a supportive partner facilitates women's reproductive health and contraceptive use. Contraceptive use has also been boosted by the advent of acquired immunodeficiency syndrome (AIDS) pandemic and the increasing rates of sexually transmitted diseases (STDs) which have given safer sex practices and the condom renewed importance (UNAIDS, 2009).

Women have for a long time been the main target of family planning campaigns at the expense of their male counterparts. Despite this, a greater percentage of women using contraception use a male contraceptive method or a contraceptive method that requires male cooperation. In 1988, 66 percent of married women aged 15-49 years who used contraception

utilized male methods or ones requiring male cooperation. However, by 1993, only 34 percent of married women in the same age range were using male methods or methods requiring male cooperation. In the Philippines, according to the Demographic Health Survey of 2008, 37 percent of all women who used contraception employed ones that require male participation, whereas 54.6 percent of married women, who used contraception, utilized ones that require male participation (DHS, 2008). According to the same survey 98.7 percent of married women reported that their husbands are aware of their use of contraception; however, it did not state whether the husbands participated in selection of the contraceptive method, which is the focus of this study (World Health Organization, 2012).

Noreen, (2012) found that men who were actively involved with Improving Maternal Neonatal and Child Survival (IMNCS) program were more likely to be involved in their partners' reproductive health issues compared to those not involved in the project. This project actively involved men in family planning training and activities urging them to accompany their partners to FP sessions, thus encouraging their involvement (Kamal et al., 2013).

Khan and Patel (2001) reported that the study of male's role and involvement in family planning is a widely neglected area in India. However, in the previous 30 years the country had recorded a significant change in contraceptive use. In the 1960s and 1970s, the main acceptors of family planning methods such as the condom and vasectomy were males contributing to about 50% of the total FP acceptors. However, technological advancement to other FP methods such as sterilization and laparoscopic contributed to the gradual shift towards women (Clark et al., 2008). Conversely, Wang & Mallick, (2019), after conducting a randomized study, found that there were lower contraception discontinuation rates in China. The study further indicated that there was an acceptable use of FP methods on partners who

were both educated about FP compared to women who were taught in the absence of their husbands.

Reproductive health programs around the world are increasingly recognizing that men are an important target for their services. Men not only have reproductive health concerns of their own, but their health status and behaviours also affect women's reproductive health. The need to include men in all matters that require joint spousal decisions is crucial in achieving key reproductive health goals. However, men have not been involved as they should and progress to involve them has been insufficient and uneven (United Nations Population Fund, 2010)

Evidence advocates for the involvement of men in reproductive health issues in general (Manaf, Ismail, & Latiff, 2012). In the Philippines, few studies on involvement of married men in family planning and responsible parenthood, sexual health and support for safe motherhood are available. The focus of the available studies is on young unmarried men's perception of male involvement in reproductive health (Achumbre, Deronia, Diaz , Llagas, & Torregoza, 2010).

2.4 Family planning in Ghana

Some studies have been conducted on family planning and reproductive health in Ghana. Adongo et al., (2006) tried to examine Men's Concerns about Reproductive Health Services in a rural Sahelian Setting of Northern Ghana whiles focusing on the Zurugelu and found out that Community mobilization and male outreach was not sufficient for introducing behavioural change.

Uptake of contraceptive services was greater and more sustained among the Zurugelu when combined with Community-Based Health Planning and Services (CHPS) and Community

Health Officers (CHO) services, than when Zurugelu lacked supporting CHO. Introducing CHPS and the services of CHO, to focus on men in the Zurugelu community, sustained and significant improved reproductive change among the Kassena-Nankana of northern Ghana (Adongo et al. 2007) According to the 2014 Ghana Demographic and Health Survey (GDHS), only 27% of married women use family planning with 22% using a modern method and 5% using traditional methods (GDHS, 2014).

Adongo et al. (1997) investigated elements of the social system of the KassenaNankana that influence reproductive beliefs and behaviour and found out that women opting to practice contraception must do so at considerable risk of social ostracism or familial conflict. Few women view personal decisions about contraceptives as theirs to make. Although children are highly valued for a variety of economic, social, and cultural reasons, mortality risks remain extremely high.

Schuier, (1999) worked with men's groups and male community leaders in a participatory fashion to overcome men's opposition to women using family planning and concluded that gender constraints to reproductive health are best addressed by working with men to change their situation, using participatory approaches which foster women's empowerment.

2.5 Knowledge and perceptions concerning family planning by men

According to a survey conducted by GDHS (2003), 99% of all men know at least one method of contraception and all women 98%, which means men are more Knowledgeable about family planning issues than women. This may be due to the fact that illiteracy level among women is higher than men. Other studies have proved that although men are well informed about family planning service, the same cannot be said of accessing and utilization of the service (NDHS Male Module, 2003).

It has further been established that one (1) in three (3) men consider contraception to be a woman's issue. This is the general view of the individual but the fact is that if the men were encouraged and motivated they will show interest in utilizing the family planning service in Ghana in particular and Africa as a hole. While half of the men felt that women who use contraceptive may become promiscuous, other men also perceive that although childbirth is a woman's business, husbands support is crucial on matters concerning usage of family planning service.

According to a survey conducted in Mpigi district in Uganda, it was revealed that, men have limited knowledge about family planning, that family planning service does not adequately meet the needs of men and that, spousal communication about family planning issues is generally poor (Kaida et al., 2005) Here, one can contribute to the fact that men, both adult and young have favourable knowledge and attitude related to family planning but very few report the use of contraceptives.

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

According to a study done to investigate men's knowledge, attitude and practice of family planning in Enugu Nigeria, it was revealed that males have some level of knowledge about family planning and modern contraceptives methods showed considerable opposition to their use among males on religious grounds (Obionu, 2013). In contrast, a survey done in Khartoum

Sudan showed a strong positive attitude towards family planning services by men, with few actually using a method. Similarly, a study in Danfa in Ghana came out that more than two thirds of rural men approved and accessed family planning services, and that men knew at least one modern method and they also prefer visiting mobile clinics for obtaining condoms rather than buying them in a chemical shop (IPPF, 2005/2006). This situation is common in most of the health centres due to the unconducive environment and the fact that the health facilities are not male user-friendly.

A survey conducted on men's approval and accessing family planning, Akafuah & Sossou, (2008) established that some factors have significant effect on access and utilization. Another study carried out in Kenya further supports the observation that men's knowledge about family planning correlate with its use. However, despite the fact that men's knowledge of contraceptives is quite high, contraceptive use by men remains uncommon.

Men who did not want to use family planning, perceived it to be bad for health, and that it was against their religion. Again,4 due to rumours and misconception about family planning, many men expressed fear about the safety and performance of modern methods. In addition, men perceived that contraceptive used by women could threaten their fidelity in marriage (Mcginn, 2016).

According to a research done on men's knowledge, attitude and practice of family planning in Enugu south-eastern Nigeria, the result showed that a high proportion of men had knowledge of and possessed positive attitude to family planning even though, a lesser proportion actually used the methods. The poor utilization pattern was due to many reasons, which includes consequences of such moves as being against God's wish, it also exposes both men and

women to sexual promiscuity, as well as exposing people to 'evils' of modernization which brought no respect to sexual and traditional values (Obionu, 2013).

A study done in Ouagadougou revealed that sizable number of men knew at least one modern contraceptive method, if they are prompted with a brief description of the method but surprisingly, due to some kind of perception they have about family planning, they failed to utilize it. Many other studies have showed that females are more knowledgeable than men about family planning issues. This information gap however, still poses relatively, low participation of men in family planning this indicate that only small proportion of men share fertility regulation responsibilities and prevention of sexually transmitted infections including AIDS. This is because of the fact that, men have a very limited choice of contraceptive methods (Population Council Dhaka, 1998).

A study in Pakistan on men involvement and use of family planning methods revealed that men's knowledge and contraceptive use has increased within a certain period.

Although men's knowledge about family planning has increased, utilization of the service is not encouraging (Kiani, 2003). Study on existing knowledge of male participation in reproductive health including family planning was done; the purpose of the study was to overcome specific obstacles, such as men's disapproval of contraceptive use by their partners and themselves, resulting in low utilization.

Also, pre-conceptions on the part of the service providers, that men are disinterested in taking responsibility for family planning, and inadequate information on male contraceptives and male attitude is also considerable (Green, Jackson, & Phillips, 1996). A study on men's perception done in Mwanza, Tanzania indicated that males are not using the family planning

service themselves because they believe it was bad for health, and condom was also perceived negatively for multiple reasons for instance, the method is associated with getting infected, becoming promiscuous and could reduce male sensation and sexual pleasure (Bongaarts, 2006).

Similarly, a study has shown that a male method such as vasectomy is considered a form of castration. This is preventing men from using it, but for men to use a particular method there should be intensification on effective information education and communication for men (Nzioka, 2000). Studies carried out in the sub-Saharan regions has shown that men hold certain traditional beliefs and misconceptions regarding modern contraception which act as barriers to them using these methods or even approving use by their sexual partners.

A study conducted on knowledge of and attitudes about family planning and its use by a convenience sample of men in Ghana indicates that increase in knowledge has significant effect on the respondents and identified socio-cultural misconceptions resulting from lack of knowledge and education as the main deterrents for the use of different family planning methods including vasectomy (Akafuah & Sossou, 2008).

2.6 Availability and Accessibility of Family Planning Service to Men

Despite the fact that men play an important role in reproductive health, studies have shown that there are certain hindrances to male utilization of family planning service. Range of family planning methods available to men is limited, and this as a result inhibits men's capacity to participate in fertility regulation (Green, Jackson, & Phillips, 1996). The inadequacy of male method of contraceptives has caused considerable media attention surrounding a recent breakthrough, in the development of a male birth-control pill (MBCP). The fact of the

issue is that, production of a new male method of contraceptive is still about 5-10 years away with some technical hurdles to overcome (Dvorsky, 2008).

Men would prefer hormonal contraceptives, which are made in the form of injectable or implant, with these method men will show more interest in using family planning (Heinemann et al., 2005). Other studies have revealed that there are a lot of choices to make on family planning methods for male, including the traditional methods, but because of certain beliefs coupled with inadequate knowledge of certain methods of contraception some men are against their use with reasons best known to them (Nzoka, 2000). Here, the reality is that family planning services available for men are few and, besides, the facilities providing family planning services are also not enough, even the few available are not male user-friendly. According to a demographic health survey, done in Ilorin, Nigeria, family planning clinics are oriented to women, therefore, men often feel uncomfortable and unwelcome in these clinics (Akpamu et al., 2009).

According to a survey on approved contraceptive use, men's lack of access to the family planning service is a barrier to its use. Therefore, men cannot share their responsibility on reproductive health, including family planning if they cannot access the service. Most family planning clinics, according to a study mainly cater for women, so men are not comfortable visiting these clinics (Population Report, 1994). This contradicts the findings of a study done in Danfa, Ghana that showed that men can easily access family planning service (IPPF, 1984). The study shows that men even prefer buying the condoms from existing mobile outreach clinics than buying it from drug stores. Similarly, a case study conducted in Khaochakan district in Thailand showed that majority of males knew where the family planning service was available, some know about health centres, others, hospitals whiles some primary health

care units and drug stores. Majority of the male clients had to travel for the service at less cost (Eni, 2005). The real situation on the ground is that although men are aware of family planning service, access and utilization is low and poor.

2.7 Proportion of males who are involved in Family Planning Service by Men.

A survey conducted in the United States found out that on average; male comprise only

6% of all family planning clinic clientele, this compared to a research carried out in Danfa in Ghana revealed that males prefer visiting mobile clinics for obtaining condoms rather than buying it in a store (IPPF, 1984). This indicates that males patronized the service brought to them at their door step rather than going to the health centres.

Another survey revealed that even though there has been some success in trying to increase male utilization of family planning service, the reality remains that most males do not utilize the service and it is evident that while some positive strides have been taken, some negative influence act to inhibit male utilization of family planning service (Sonenstein and Pleck, 1995).

GDHS 2003 showed that married men and sexually active men who reported having ever used one or more male methods of contraception, which are male sterilization, male condom, periodic abstinence and withdrawal, the most popular male method, the condom has been used by few males, both married and unmarried males. Male sterilization however is practically non- existent in Ghana. What is known in literature is that most male methods are used by few males.

A study was conducted in northern Nigeria on the linkages between socio-economic characteristics, attitudes and familial contraceptive use. The result disclosed that there is high

knowledge of contraceptive but low rate of its utilization. The men who were willing to use contraceptives were more willing to use them for child spacing purposes than for limiting family size (African Journal Reproductive Health, 2006). Other studies were done on programming for men on family planning in Zimbabwe and Kenya. The study showed increased percentage of men who believed, they alone should be responsible for family planning decisions but increase in male approval of contraceptive use was lacking (Ntabona, 2002). This attitude among men is common particularly in sub- Saharan Africa including Ghana. What is known generally is that men are the heads of the family and, therefore, the decision makers, on health issues.

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

A study done on men's attitudes towards family planning in Ilorin in traditional urban Nigeria revealed that men are either not interested or concerned about family planning or are opposed to it. But the reality of the fact is that, men are really interested, not only allowing their wives, but they themselves participating in its practice (Kamla-Raj, 2006).

A case study was carried out to examine the extent of male use of family planning and the nature of men's role in family planning in the developing countries. The study showed that lack of supply and inadequate information were the two key reasons for insufficient use of

male contraception and low levels of utilization (Amin, 1994). In Ghana for instance, most males are well informed and knowledgeable in reproductive health issues including family planning. But because of certain beliefs, perception and misconceptions, they do not patronize the service.

2.8 Barriers to Male Involvement in Family Planning

2.8.1 Cultural Factors

Levy (2008) suggests that the ability of a woman to control her fertility level is strongly affected by the social constructs of gender roles and expectations. An assortment of researchers indicates that gender inequality has a tendency of who uses, accesses, and makes decisions of contraceptives. Moreover, gender inequality determines when to participate and withdraw sex (Levy, 2008).

Religion instigates different beliefs and norms surrounding sexuality issues. It is a powerful tool with the capability of swaying people's opinions as regards family planning. Most religions are against the use of modern contraceptives. According to Ali and Ushijima (2005), procreation is the primary purpose of marriages and sexual intercourse for Catholics. As such, the use of contraceptives violates the principal purpose of marriage. The majority of Islamic jurists in Swaziland indicate that the use of family planning is not forbidden. Others, on the other hand, suggest that family planning violates God's primary intention of marriage. Among fundamentalist Muslims, FP methods that are permitted are those that do not induce abortion and are reversible. Irreversible sterilization methods are not allowed. As such, this has left male Muslims with a condom as the only contraceptive, and it should strictly be used within marriage only (Ali & Ushijima, 2005). Sileo (2014) suggests that mobilization of family

planning in Uganda has been rendered difficult owing to the involvement of religious leaders. According to Izugbara et al. (2010), religious barriers are quite evident in African in that about 20% of the population is composed of Catholics whose doctrine emphasizes that sexual acts are for recreational purpose.

According to Korra (2002) and Abdel and Amira (2013), the desire for women to use contraceptives is brought about by the rapid population growth which is characterized by high fertility rates, high birth rates, and low male contraceptive prevalence rates. In India, a study conducted by the National Family Welfare Programme found that only 27% of males were aware of the modern methods. The remaining proportion used the traditional methods (Abdel & Amira, 2013). They further noted that a higher percentage of rural men are less knowledgeable about the modern contraceptive methods compared to their urban counterparts. The extent to which cultural factors impede male involvement in family planning differs based on the social and cultural background of married men.

Oyedokun (2008), posits that males have a limited choice of contraceptives due to their personal beliefs, dislike, and perception of contraceptive costs and their side effects. Cultural factors contribute to higher extent barriers to male involvement in family planning as a result of several couples' autonomy and age of the married couple. According to a study conducted in Nepal, there exists a significant association between male involvement in family planning and gender roles. An assortment of studies shows that a couple that increases their contraceptive use improve their social and cultural changes while at the same time reducing maternal and child mortality. Most studies indicate that culturally, most communities render it hard for a male to be involved in family planning because contraception would lead to sexual unfaithfulness among the taker. However, a study conducted in Lesotho among female

university students indicate that the 10% who were unaware of modern contraceptives and where their male counterparts were also non-knowledgeable, chances of the spread of STIs and HIV could be high. Therefore, WHO (2010) is concerned about the reluctantance of male involvement in family planning which may hinder its goal of reducing the AIDS epidemic by 26% by 2020.

In Kenya, Nzioka (2001) and Ngetich (2013) indicate that lack of male involvement may further increase maternal and child mortality rates making it hard for the government to achieve its Millennium Development Goal and Vision 2030 with regard to reproductive health and family planning.

2.8.2 Economic Factors

Developing nations have high poverty rates. Densily populated countries are no exception as the per capita income is relatively small owing to the large population. In India, for instance, a study by Balaiah (2005) indicates that only men earning at least Rs. 5000 were 2.3 times likely to use contraceptives. Kamal et al. (2013) found that in Bangladesh, the level of a couple‟s income influences male involvement in family planning. This study reports that about 45.5% of men whose income level was more than 10,000 takas per month would be involved in reproductive health and family planning. Oluwasanmi, Pengpid, & Peltzer, (2011) further indicate that unemployed men have high levels of not participating in contraceptive use compared to the employed ones. In Sudan and Uganda, the research found that male involvement in family planning declined with the decrease in the level of a household‟s income (Oluwasanmi Oluwasanmi, Pengpid, & Peltzer, 2011). In Kenya, Abdel and Amira (2013) posit that rural areas are associated with low-income levels and thus use of modern contraceptives is substituted with traditional methods of which does not always hold.

The unmet need for family planning is associated with education level. Studies conducted by Ferdousi et al. (2010) and Hossain (2003) in India and Bangladesh, respectively, found that the level of education couples have contributed to their use of contraceptives. As such, the higher the level of education, the higher the rate of contraceptive use. A study conducted in southern Sudan reported that the unmet need for family planning decreases with the level of a married couple‟s educational achievement and employment status. Abdel and Amira (2013) posit that this happens as men become more and more empowered. In Uganda, studies show that the unmet need for family planning is lower for men with better education. For example, a study by Assefa and Fikrewold (2011) found that in, unmet need was less for men with at least secondary education. In Kenya, the same study reported that men with incomplete primary education were two times more likely to experience an unmet need for family planning in comparison to those with complete primary education or higher education. Ojakaa (2008), however, reports that, in most times, a husband‟s education is insignificant and suggests that the level of a wife‟s education is the most important if couple‟s unmet need was to bereduced.

According to the World Population (2004), poorer couples have a tendency of having children at a relatively younger age as compared to the wealthy ones. Moreover, this study found that poorer couples have more children throughout their lives compared to wealthy couples. Conversely, the use of modern contraceptives is only evident among wealthy couples. Thus, poorer couples are left enshrined to the traditional contraceptive use where at most time's males are reluctant to adopt. Therefore, consequences that are associated with lack of male involvement in family planning persist in such households.

Acayo (2012) conducted a study in Uganda‟s Lamwo district to determine economic factors that affect men in family planning utilization with their partners. The study found that about 18% were students, 39% were unemployed and 24% were operating small businesses. Employed men in the study accounted for only 16%. Acayo (2012) concluded that a majority of men could not afford family planning services owing to their economic status. Thus, this makes it hard for male involvement in family planning initiatives. Moreover, the study found that poverty has an adverse effect of contributing to further unwanted pregnancies, as well as high maternal and child mortality rate.

Also, even for wealthy women whose husbands are not that rich, only one out of five married women have an unmet need for family planning. This is because, in patriarchal society, men feel that it is their responsibility to provide for their families and if they cannot afford to buy contraceptives, then they will prevent their wives from doing so.

2.9 Conceptual Framework

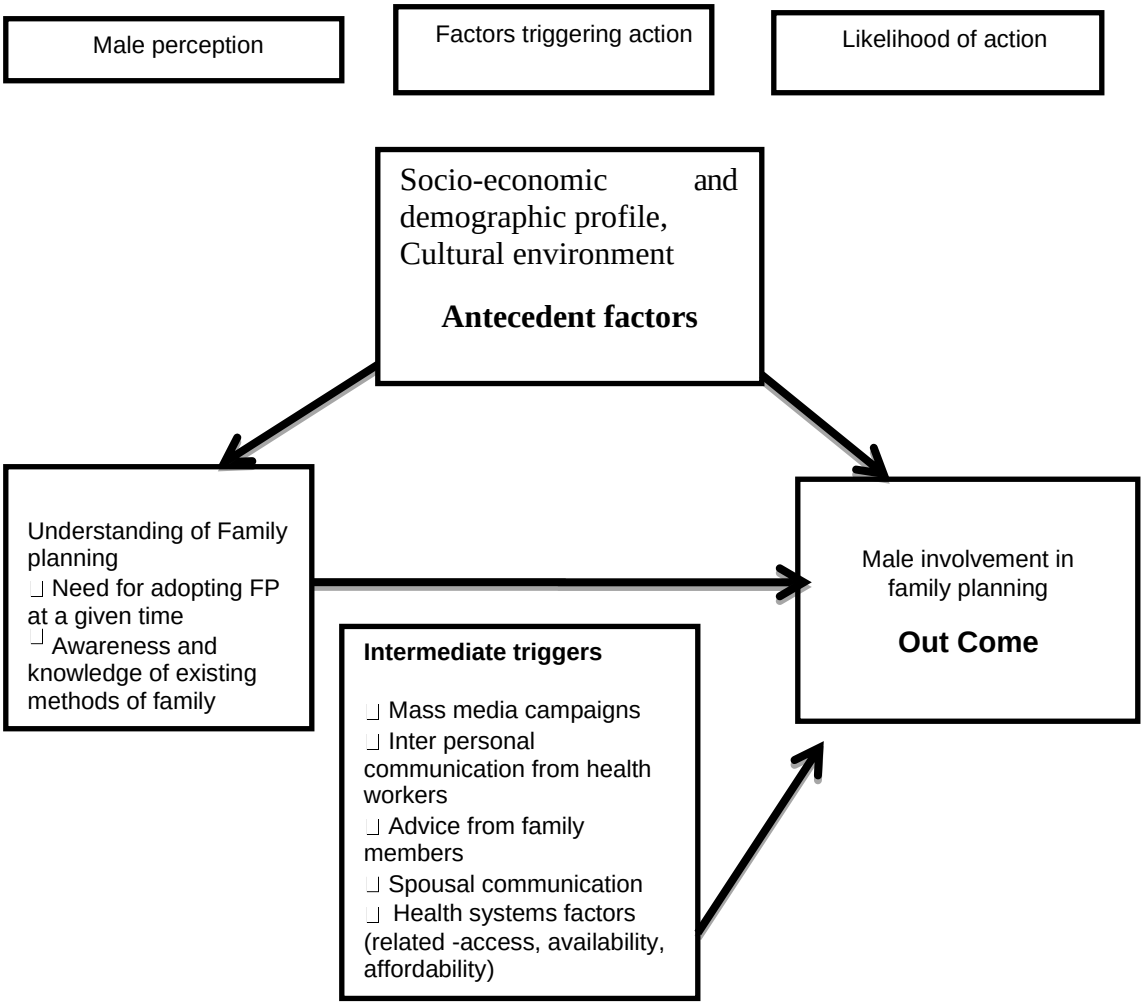

Figure 1.1 Framework for Male Involvement in Family Planning
Adopted from Bruijn(2004), with modifications

The framework was adapted from the de-Brujin model (2004) and modified. The model above illustrates the relationship between the outcome male involvement variable and the independent variables.

2.9.1 Male perception

Predictive variables included male understanding of family planning; the need to adopt family planning methods, awareness and knowledge of existing family planning methods and the motivation to adopt the behaviour of using family planning methods

2.9.2 Factors triggering actions

Factors triggering male involvement in family planning (socio-economic, demographic and cultural environment) and intermediate triggers to male involvement in family planning (media campaigns on family planning methods, spousal communications with males, interpersonal communication with health workers and the health systems in place) are all factors that would influence male involvement in family planning.

2.9.3 Likelihood for action

Actions are events, people, or things that move people to change their behaviour. The health behaviour model (HBM) persists that trigger, is necessary for prompting an individual to engage in a health-promotion behaviour. Men in general have negative perception about vasectomy. They belief once they undergo vasectomy there is the likelihood that they will have sexual dysfunctions (Adongo et al., 2014). Since their sexual desire will decrease, it will later lead to impotent. Men believe that the use of modern family planning methods for males will help them and their wives involved in family planning activities.

This model described above would enable the researcher to identify the possible antecedents, the basic reasons, for a specific effect, problem, or condition.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter devoted to the methods used in the study. It gives information about the research design, study area, population of study; sample size, sample selection, methods of data collection, data analysis, procedure, and problems that the researcher encountered during the study.

3.2 Research Design

This was a cross-sectional analytical study. A combination of qualitative and quantitative data collection methods was used to explore male involvement in family planning in the Bekwai Municipality.

3.3 Study Area

The study took place in the Bekwai Municipality, located in the southern part of the Ashanti Region. The Municipality is bordered to the North by Bosomtwe District, to the South by Adansi North District, to the East with Bosome-Freho District and to the West with Amansie Central and Amansie West Districts. The population of the Municipality is 134,850 (As projected from the 2010 population census) with males and females representing 47.1 percent and 52.9 percent respectively. The municipality has four (4) Sub-municipalities. One hundred and thirty-five (135) communities, one hundred and five (105) Outreach Sites fourty one (41) TBAs, thirteen (13) health facilities. The Bekwai Municipality can boost of rich cultural diversity. The Municipality covers seven paramouncies, which are Bekwai, Essumeja,

Kokofu, Denyase, Amoaful, Adankranja and Asamang. Economic Activities-The citizens are predominantly Farmers. Some are also traders

3.4 Study Population

The target population for the study were males of reproductive age between 18 to 59 years in the Bekwai municipality.

3.5 Sampling and Sample Size Calculation

3.5.1 Sample Size Calculation

The Cochran (1977) formula was used to estimate the sample size as follows:

$n= Z^2pq/d^2$

Where n = the desired sample size

z = 95% confidence interval (standard value 1.96)

p = the proportion of males in the target population estimated to be involved in family planning

q = 1.0-p

d = degree of accuracy desired at 0 .05

Similar studies by Wiafe, (2015) found that the proportion of males involved in family planning in Sunyani municipality was 34% and since Brong Ahafo region has similar characteristics like Ashanti region 34% prevalence rate was assumed.

Therefore, substituting, the sample size was computed as follows:

n = [(1.96)2x (0.34) x (0.66)]/ (0.05)2

n = 345.

3.5.2 Sample size adjustment

Using a Design effect of 1.5, sample size was computed as 345x 1.5 equals 518.

A non-respondent rate of 5 % was factored in to give the required sample size of 543.

3.5 Sampling Procedure

For the purposes of this study, only men living in the Bekwai municipality were selected. A multi-stage cluster sampling technique was used to select the subjects from all four sub- districts in the Bekwai municipality namely Bekwai, Dominase, Kokofu and Kortwia. Each of four sub-districts were divided into four clusters, clusters were randomly selected, and the total number of houses within each cluster was divided by the sample size to get the sampling interval. A list of the house numbers of the houses was obtained from the Bekwai Municipal assembly. A house was randomly selected within the interval and was used as the starting point. The interval was used to select subsequent houses. Within the selected houses, one male in each household was interviewed. In households with only one male, the individual automatically qualifies for interview. However, the simple random sampling technique was employed to select one respondent from households where more than one male qualified to be selected only one was randomly selected. In households where there was no respondent in a particular house, the next house was used and the counting continued from there. Adult males aged between 18 to 59 years who are sexually active in these communities were included in this study.

3.6 Inclusion and exclusion Criteria

All sexually active adult males aged between 18 to 59 years in the Bekwai municipality were included in this study. The study excluded all adult males between ages 18 to 59 years in the Bekwai municipality who were mentally retarded or could not speak either Twi or English.

3.7 Data collection technique and tools for quantitative component

Quantitative information was collected using a structured questionnaire in English which comprised of both open and close ended questions. The questionnaire was administered in the local language (Twi) on any respondent who did not understand English or chose to communicate in the local language. Data on socio-demographic characteristics of respondents, respondents' knowledge on family planning, and barriers hindering their family planning utilization was collected. Eight data collectors with at least a certificate in any tertiary education who were fluent in both English and Twi and who were familiar with the customs of the Bekwai Municipality were employed to assist in the data collection process. Four health workers with experience in family planning activities were assigned to supervise the data collection process. These assigned supervisors also performed checks on the completed questionnaire for quality. A three-day training was undertaken by the researcher for both data collectors and supervisors to ensure the quality of the field exercise. The training aimed at preparing the data collectors with in-depth understanding of the questions and interview process. The training was centered on interpreting the questions from English to Twi, filling of the questionnaire, and a field pre-test in a community outside the study district.

3.8 Data collection technique and tools for qualitative component

Focus group discussions (FGDs) were conducted among groups of adult males in the various communities to collect qualitative information on male involvement and barriers to male participation in family planning. The qualitative data were used to support the quantitative findings.

Focus group discussions were conducted in all four sub-districts (Bekwai, Dominase, Kokofu, Kortwia) and in each subdistrict, one community (Denyase, Poano, Essumaja, Kensere respectively) was selected and FGD held among participants to gather information on knowledge, perception and male involvement in family planning. The results realized from this focus group discussion was used to support the quantitative findings. Participants were grouped into two. One group was made of male participants who use Contraceptives and the other group were made of male participants who do not use Contraceptives. Each focus group consisted of 6 participants and discussions lasted for about 1-2 hours.

The interview guide included questions on factors hindering male involvement in family planning, knowledge on family planning and ways to increase male involvement in family planning. The focus group discussion was done in Twi and whole process was recorded using tape recorder.

3.9 Pre-testing and data collection tools

The quantitative questionnaire was pretested in a purposively selected community outside the study district among 53 males while the FGD guide was pre-tested on ten purposively sampled eligible males from the same community. The pre-test aimed at understanding the appropriateness, clarity and flow of questions of the data collection tools. Unclear questions

were reviewed. The information gathered from the pretesting process has been excluded in the final study results.

3.10 Study Variables

The variables used in this study are explained as follows.

3.10.1 Dependent variable

The dependent variable in this study was male involvement in family planning. It was created as a composite variable comprising five (5) questions covering respondents' interests and practical involvement in family planning. The questions were: Will you recommend family planning to a friend or family; Have you ever discussed FP with your wife; Do you get some time off work to attend FP clinic; Which FP method do you and your wife use; Will you provide financial support to your wife to attend FP; All the questions were dichotomous (Yes or No). 'Yes' was assigned a score of 1 whilst 'No' was assigned a 0 score. All the score for the five (5) questions were compute into one variable called "Male FP Involvement". The total score ranged from 0 to 5. An overall average score was computed for the five (5) scores. All respondents who attained a score below the expected average were labelled "Low Male Involvement" and respondents who attained a score greater or equal to the overall average score were labelled "High Male Involvement". Frequency was run to estimate the proportion male who are involved in family planning and a pie chart was used to display the proportion output in the results section.

3.10.2 Independent variable

The independent variables were demographic, socio economic, cultural environment of males; males' perception and knowledge of existing methods of family planning, barriers hindering male involvement in family planning.

All responses to knowledge and perceptions questions were scored to attain high and low level scores. All responses which the researcher deemed correct under these variables were scored '1' and all responses under these variables which the researcher deemed wrong were scored '0'. A total score was then computed for both variables with labels ('level of knowledge' and 'level of perception' respectively). An average score (mean) was computed for the overall score for these individual variables. All respondents total score below the mean score was scored poor and all respondents score which was equal or greater the than the mean score was scored good.

3.11 Data Processing and Analysis

Data were entered into the computer using the Statistical Package for Social Science (SPSS) version 20. All data entry inaccuracies were corrected before analysis. Data analysis was conducted using SPSS. The data was cleaned by running preliminary frequencies to detect entry errors. All non-responses were treated as missing. Frequencies were run for key variables and the results presented in tables and charts.

3.11.1 Quantitative data management and analysis

Data captured in completed questionnaire was regularly checked by the researcher to ensure that all fields were properly completed and there were no inconsistencies in responses. Inconsistencies identified were resolved immediately by returning to the respondent concerned by the interviewer to make the necessary amendment. The reviewed data were entered into Epi Info™ version 7 by the researcher to produce a data set. The data set was exported into the Statistical Package for Social Science (SPSS) version 20 for analysis. Data cleaning was done in SPSS version to check for data errors and missing values. Frequencies

were run for a key variables and the results were presented in table and charts. Pearson Chi-square ($\chi 2$) test was used to determine any statistically significant associations between the independent variables and the outcome variables at 95% confidence interval and the variables that were statistically significant ($p<0.05$) were included in a multivariate logistic regression analysis and adjusted odds ratio (AOR) was calculated to determine the strength of association. Results on the socio-demographic characteristics of the study participants were reported using descriptive statistics.

3.11.2 Qualitative data management and analysis

Qualitative data from focus group discussions were transcribed verbatim and analyzed thematically, typed edited and entered into a computer and summarized. The transcripts were read several times to identify recurring themes and patterns. Responses were interpreted by looking at patterns and formulating ideas which could account for those patterns. Results realized from the qualitative data was used to support the quantitative findings and in most cases quotes from the discussions were used.

3.11.3 Quality control

Quality control measures employed in this study to ensure quality of data included;

- A two-day training for research assistants on the questionnaire administration.
- Pre-testing of questionnaires before actual data collection on the field.
- Assigning of Supervisors to research data collectors on the field during data collection to ensure quality data.

3.12 Ethical Considerations

The following ethical issues were considered in the study:

1. Ethical approval was obtained from the Ghana Health Service Ethics Review Committee before commencement of the study.

2. Permission was obtained from the District Chief Executive and leaders of the communities where participants were selected.

3. Permission was also sought from the Municipal Health Directorate to use nurses as supervisors in this study.

4. The consent of participate in the study were sought prior to their inclusion in the study. Individuals who were eligible for the study was enrolled in the study only after they endorsed a written informed consent/assent form, either by signing or thumb-printing before they respond to the items on the questionnaire. Verbal explanation about the study was given to participants before the commencement of each Focus Group Discussion and they were told about their right to withdrawal.

5. Anonymity and confidentiality were strictly ensured in the study. Participants names were not linked with the data, and data analysis was performed in aggregate. Also all study-related materials were strictly kept confidential. Hardcopies were kept under lock and key and softcopies were password protected

CHAPTER FOUR

4.0 RESULTS

Introduction

This chapter presents the results the analyses of data collected. The aim of this study was to identify factors associated with male involvement in family planning in the Bekwai municipality.

4.1 Background characteristics

Table 4.1 presents respondents background characteristics. About 214 (40.1%) out of the 534 respondents were within the age group 30-39 years. 40 (7.1%) of the respondents were less than 20years. Of the 534 respondents, 233 (43.6%) had attained the SHS education whilst 17 (3.2%) had attained tertiary education. Majority of the respondents (75.8%) been married or co-habiting. The highest level of education attained by wives of male respondents in this study was Junior high (31.1%). Less than one-third (30.1%) of the wives received no formal education. Nearly all (96.3%) the men are married to one wife while a few (3.7%) of them are married to two. Table 4.1 also depicts that 198 (48.5%) of the male respondents' interview had 1-2 children whilst 7 (1.7%) had no child.

Majority (82.2%) of respondents were self-employed with only 5.1% employed into the formal sector. Of the 534 respondents, 179 (33.5%) were Christians followed by the Catholic group (21.7%) with the least (4.9%) belonging to the traditional religion as indicated in Table 4.1 below.

Table 4.1 Background characteristics of respondents

Variable	Frequency n=534	Percentage
Age (years)		
< 20	40	7.5
20-29	184	34.4
30-39	214	40.1
≥ 40	96	18.0
Educational level		
None	40	7.5
Primary	40	7.5
JHS	204	38.2
SHS	233	43.6
Tertiary	17	3.2
Marital status		
Married/Co-habiting	405	75.8
Single	129	24.2
Educational level of wife		
None	161	30.1
Primary	105	19.7
JHS	167	31.3
SHS	93	17.4
Tertiary	8	1.5
Number of wives		
1	386	96.3
2	15	3.7
Number of children		
0	7	1.7
1-2	198	48.5
3-4	160	39.2
5+	43	10.5
Employment status		
Formal sector	27	5.1
Unemployed	68	12.7
Self employed	439	82.2
Employment status of wife		
Formal sector	11	2.1
Unemployed	155	29.0
Self employed	368	68.9
Religion		
Catholic	116	21.7
Charismatic/Pentecostal	88	16.5
Orthodox churches	67	12.5
Other Christians	179	33.5
Muslim	58	10.9
Traditionalist	26	4.9

4.2 Knowledge of respondents on family planning

Table 4.2 presents information on participants' knowledge on family planning. Majority (96.3%) of respondents claimed they had ever heard of family planning.

Results from the focus group discussion indicates similar trend of ideas which was revealed by participants who took part in the discussion. Most of the participants in the discussion had an appreciable idea of family planning. Some participants indicated family planning is a means of preventing unwanted pregnancies, Others also reiterated that both male and female have their own methods of family planning. The following quotes support the above evidence;

> *"I heard family planning is a way of preventing any unwanted pregnancy" (Participants 2, Age:37, community 1)*

> *"What I can also say is, family planning is a how to plan your family" (Participants 2, Age:40, community 2)*

> *"I know family planning is a way of protecting yourself from getting pregnant when you are not ready" (Participants 3, Age:29, community 3)*

> *"I also think that family planning help prevent disease and pregnancy" (Participants 3, Age:35, community 4).*

About 64.4% of respondents agreed that family planning issues shouldn't be a concern for only women. Similar result was revealed during the focus group discussion, most participants agreed that, family planning should not be a concern for only women but men as well.

"Family planning issues should not only be for females; males are supposed to involve themselves because males are head of the family. And as such males are even supposed to spear head this family planning issues" (Participants 1, Age:25, community 2)

"Both male and females have their method as family planning is concerned. So when it comes to making decision about family planning, males are supposed to support females in making every decision about it" (Participants 1, Age:45, community 1)

However, 15.0% of the respondents claimed they do not know whether family planning issues should concern only women. Majority (79.4%) of respondents claimed condoms are not to be used more than once whilst 10.7% claimed they had no idea. About 60.5% of respondents agreed that periodic abstinence is a means of controlling pregnancy whilst 12.0% claimed they have no idea. Table 4.2: Knowledge of respondents on family planning

Variables	Frequency n=534	Percent
Ever heard of Family Planning		
No	20	3.7
Yes	514	96.3
Whether FP is an issue that should concern only women		
Don't know	80	15.0
No	344	64.4
Yes	110	20.6
Whether condoms can be used more than once		
Yes	53	9.9
No	424	79.4
Don't Know	57	10.7
Knowledge on Periodic Abstinence		
Yes	323	60.5
No	147	27.5
Don't Know	64	12.0

In general, more than half (53.2%) had good knowledge while 46.8% had poor knowledge on family planning (Figure 4.1)

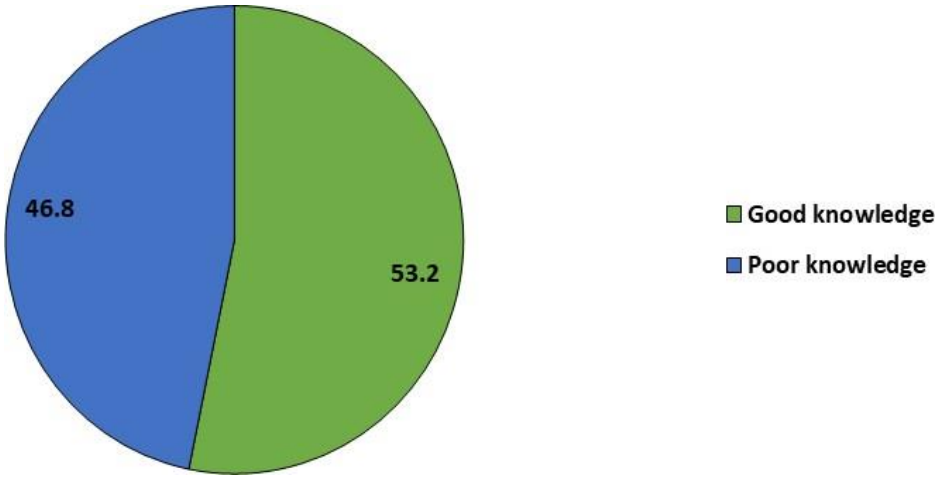

Figure 4.1: Knowledge of respondents on family planning

4.3 Perception of respondents on male involvement in Family Planning

Table 4.3 presents respondents' perceptions on male involvement in family planning in Bekwai municipality. Table 4.3 shows that, Majority (90.1% and 97.9%) of the respondents were of the view that their communities accept men accompanying their wives or partners to social events and to family planning clinics respectively. About one-third (36.1%) participants said family members finds it strange attending family planning clinic with wife or partner whilst 29.2% revealed that family members would praise them (men) for accompanying their wives or partners to family planning clinics. Majority (88.4%) of the respondents claimed there is no stigma from community on males who accompany their wives or partners to family planning clinic whilst 11.6% think there is stigma. Further, about 48.3% of respondents thinks indifferent on males who are involved in family planning. However, about 44.2% think community members would praise men who are involved in family planning. Similar result

was realized from the focus group discussion. A 40-year-old man, has this to say about community or friends' perception about males who are involve in family planning;

"*Some friends will praise me for getting myself involved in family planning activities. In fact, my family members will feel happy for me for involving myself in family planning activities". (Participant 8, from community 3)*

About 7.5% think community would think of males who are involve in family planning as very weak. Some quotes that arose from the focus group discussion and supports the community perception on male involvement in family planning are as follows;

"As for me, If I get involve in family planning activities, my family members will say I am encouraging bad behavior. Because my family sees all women involve in family planning as cheats or most likely to cheat on their husband". (Participants 9, Age:33, community 1)

"In my family, all men who involve themselves in family planning activities are seen as very different. They mostly refer to such men as adults who know not what they do". (Participants 3, Age:29, community 3)

"Most women who wants to fornicate use family planning to prevent any unwanted pregnancy. So some family members and friends think a man who want to womanize engages in family planning to prevent impregnating women they chase in the community". (Participants 8, Age:51, community 4)

"Master, in my house, if you are always seen involving yourself in family planning issues we will give you a beautiful name like "OTOO LEGE" which literary means a fool. (Participants 11, Age:28, community 3)

Table 4.1 Perception of respondents on male involvement in family planning

Variables	Frequency n=534	Percent
Acceptance for a man to accompany his wife for social events		
No	53	9.9
Yes	481	90.1
Acceptance for a man to accompany his wife/partner for family planning services		
No	11	2.1
Yes	523	97.9
Family react towards a man attending family planning with his wife/partner		
Indifferent	185	34.6
Praise him	156	29.2
Strange	193	36.1
Stigmatization associated with male involvement in FP in communities		
No	472	88.4
Yes	62	11.6
Description for male involvement in family planning		
Indifferent	258	48.3
Praise him	236	44.2
Very weak	40	7.5

In general, majority (86.7%) of the respondents perceived male involvement in good light. (Figure 4.2).

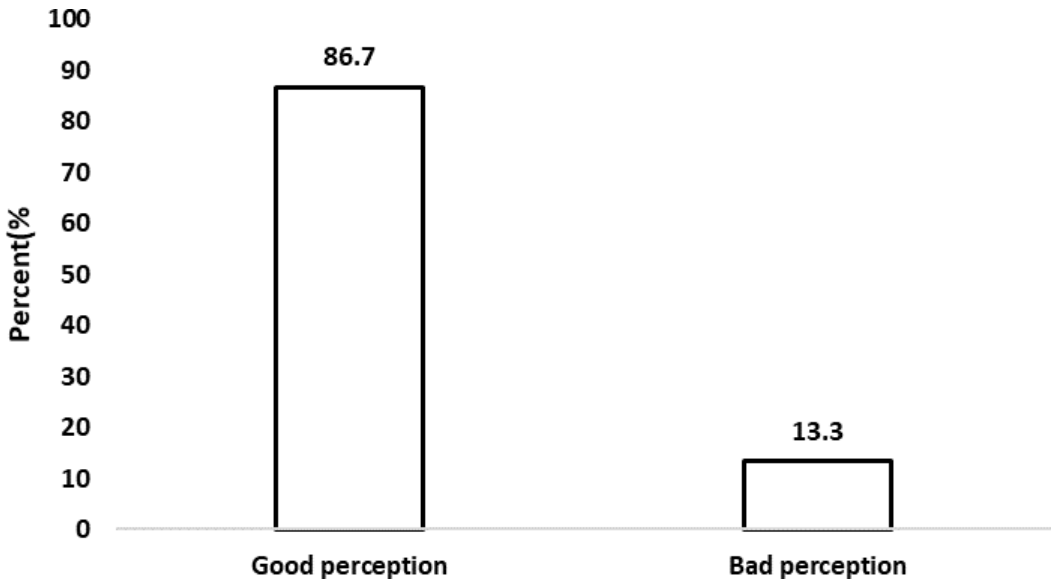

Figure 4.1 Overall Perception on Male Involvement in FP

4.4 Proportion of males involved in family planning activities.

Table 4.4 illustrates proportion of males involve in family planning activities. As indicated in Table 4.4, about two-thirds (65.0%) of respondent were of the view that, they would recommend family planning to a friend or a family member whilst 35.0% said they would not. The table further shows that, majority (82.2%) of the respondents revealed that there would not get some time off their work to attend family planning clinic whilst 17.8% claimed they would. Majority (93.4%) of the respondents were not using any family method. Majority (71.2%) of respondents had never discussed family planning with their wives whilst 28.8% of them said they had discussed family planning with their wives. Most (70.2%) respondents were of the view that, they would not continue to provide support to their wives if family planning fails whilst 29.8% said they would still provide support to their wives if family

planning fails. About 66.5% of respondents stated they would provide financial support to their wives to attend family planning clinic whilst 33.5% said they would not.

Result from the focus group discussion similarly revealed that most participants were of the view that, they would recommend family planning to their family members or friends. Furthermore, on issue of ever discussed family planning with their wives, most of the participants said no which was similar to results illustrated in table 4.4 below.

Among the reasons given by participants during the discussion for not ever discussing family planning with their wives which also back the evidence (71.2%) in table 4.4 below has been outlined in the quotes below;

"My wife hates the sound of family planning, so there is no need discussing family planning issues with her. She would not even have time to talk about family planning with me". (Participants 10, Age: 52, community 1)

"In my house, males take decision alone without consulting women. That is our tradition. So discussing family planning matters with women to solicit their views is prohibited". (Participants 12, Age: 38, community 4)

"As for me discussing family planning issues with my wife is out of the things I will do before I leave the face of this earth. She even suspects me already, not to talk of discussing family planning issues with her. She will conclude on her suspicions about me seeing another woman" (Participants 6, Age:43, community 3)

"My religion does not encourage men discussing issues with their wives before acting on them. Men always act alone to make decisions and women are to follow instructions from men" So no need for me to discuss family planning issues with her". (Participants 7, Age: 46, community 2)

Few of respondents claimed they had ever discussed family planning with their wives. The following quotes supports the above evidence;

"I have never done anything without consulting my wife. She always gives me all the advice I need when I am confused on which decision to take especially when it comes to my health and

business issues. I have ever discussed family planning with her". (Participants 4, Age:32, community 2)

"I really felt the need to space my child birth after my third born, so I discussed with my wife in order to decide on the best method to use. Thankfully, she chose one of the long term method which I was comfortable with". (Participants 5, Age:26, community 4)

"As we all know, family planning is not about only women, men are also involved, so in terms of making choices in family planning services, my wife and I have to discuss and come out with a method or services which we all prefer" (Participants 12, Age:35, community 3)

Table 4.4 Proportion of males involved in family planning activities

Variables	Frequency n=534	Percent
Recommend family planning to a friend or family		
No	187	35.0
Yes	347	65.0
Get some time off work to attend family planning clinic		
No	439	82.2
Yes	95	17.8
Family planning method do you and your wife use		
Condom	10	1.9
Implant	6	1.1
Injectable	6	1.1
IUD	10	1.9
Not using any method	499	93.4
Pills	3	0.6
Ever discussed family planning with your wife		
No	380	71.2
Yes	154	28.8
Still support your wife if a family planning method fails		
No	375	70.2
Yes	159	29.8
Provide financial support to your wife to attend family planning clinic		
No	179	33.5
Yes	355	66.5

The proportion of men been involved in family planning services was determined. Majority (65%) of respondents had low involvement in family planning services. (Figure 4.3)

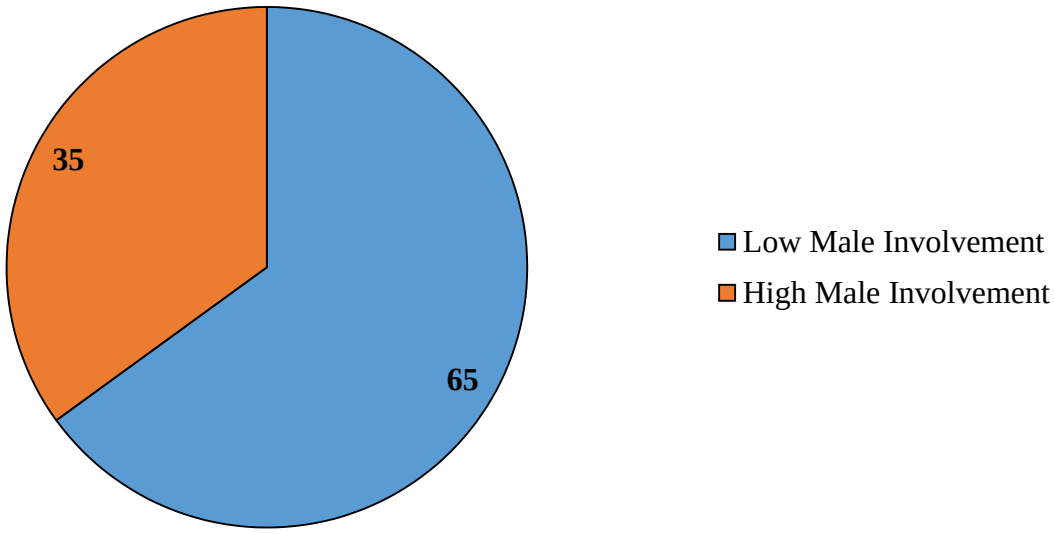

Figure 4.3: Overall Male involvement in family planning

4.5 Barriers to male involvement in family planning

Barriers hindering male involvement in family planning are presented in Table 4.5. Greater than two-thirds (68.4%) of the respondents reported that they had never attended a FP clinic. Out of the 534 respondents interviewed about one-fifth (21.2%) of the respondents had visited a family planning clinic once whilst less than one-tenth (0.6%) of the respondents had attended a family planning clinic four or more times. Majority (85.6%) of the respondents claimed family planning services are readily available whilst 14.4% said otherwise. About seven in ten (73.0%) of the respondents were of the view that family planning is important to them. However, only 2.8% of the respondents said family planning is of extreme important. Table 4.5 further indicates that about 35.6% of the respondents attributed challenges hindering

male involvement in family planning to negative community perceptions. 20.6% attributed challenges hindering male involvement to stigmatization whilst 20.8% said lack of knowledge is the cause of poor male involvement in family planning.

Results from the focus group discussion reveals similar pattern as revealed in the outcome of the responses from the questionnaires administered. Most participants were of the view that, community perception of males involved in family planning stood out as the major cause of hindrances to male involvement. The following quotes support the above evidence;

"My community has a bad perception about males who are involved in family planning services, so I normally feel shy to discuss family planning issues with people outside my house. But when I am with my wife in the house, we normally talk about family planning". (Participants 2, Age:37, community 1)

"Some of the men do not have any knowledge about family planning. This makes it very difficult to accept their families most especially their wives taken part in family planning activities or services. I think effective education about the importance of family planning should be intensify especially in this town". (Participants 5, Age:28, community 3)

"I think the major reason why most people are not interested in the family planning things is the side effect associated with family planning. I know of a woman who had serious bleeding after using a family planning method. So I will not allow my wife go through such trouble". (Participants 10, Age:52, community 1)

"Some of the women actually do not like condom during sex. They can even tell you to take the condom off before they would allow you to have sex with them. So if women do not accept condom, how should I a man, engage in this family planning thing?" (Participants 8, Age:51, community 4)

"I think the education about family planning is not effective, as a result most men have not been reach with the true facts about family planning. Because till now, some men still think that family planning is for only women" (Participants 5, Age:29, community 3)

"Because of the community's bad perception about family planning, some men including myself feel shy to discussing family planning issues with others especially in public or even in front of my family members". (Participants 9, Age:39, community 2)

Table 4.5 Barriers hindering male involvement in family planning

Variable	Frequency n=534	Percent
Number of times respondents had attend clinic FP services		
Four or more times	3	0.6
Never	365	68.4
Once	113	21.2
Thrice	7	1.3
Twice	46	8.6
Whether family planning services readily available		
No	77	14.4
Yes	457	85.6
How important family planning is to respondents		
Extremely important	15	2.8
Important	390	73.0
Not important	74	13.9
Very important	55	10.3
Challenges preventing males from patronizing FP services		
Fewer contraceptive choice for men	12	2.2
lack of knowledge	111	20.8
Masculinity power	7	1.3
Negative community perception	190	35.6
Peer pressure	15	2.8
Shyness	35	6.6
Stigmatization	110	20.6
Wives are unsupportive	54	10.1

4.6 Association between Male involvement in family planning, background characteristics, knowledge and perception on family planning

Association was tested between male involvement in family planning, background characteristics, knowledge and perception on family planning. The study found an association between age [$\chi2=13.32$, $p = 0.038$], marital status [$\chi2= 9.02$, $p= 0.003$], educational level of wife [$\chi2= 14.77$, $p= 0.005$], employment status [$\chi2=17.90$, $p <0.001$], employment status of

wife [$\chi 2$=8.35, p=0.015] and good male involvement. In addition, there was an association between knowledge on FP [$\chi 2$=6.06, p= 0.014], importance of family planning [$\chi 2$= 30.77, p value <0.001], distance to get FP services [$\chi 2$= 5.22, p=0.022], means of access to FP services [$\chi 2$= 15.67, p<0.000] and good male involvement. There was no association between educational level, number of wives, religious belief and good male involvement in FP services.

Table 4.6: Association between Male involvement in family planning, background characteristics, knowledge and perception on family planning

	Male involvement in family planning		
Variable	**Poor male involvement n (%) [n=347]**	**Good male involvement n (%) [n=187]**	**χ^2 (p-value)**
Age (years)			13.32(0.038)
<20yrs	34(9.8)	6(3.2)	
20-29yrs	120(34.6)	64(34.2)	
30-39yrs	115(33.1)	99(52.9)	
≥ 40yrs	78(22.5)	18(9.6)	

Variable	**Poor male involvement n (%) [n=347]**	**Good male involvement n (%) [n=187]**	**χ^2 (p-value)**
			8.59(0.072)
Educational level			
None	26(7.5)	14(7.5)	
Primary	27(7.8)	13(6.9)	
JHS	141(40.6)	63(33.7)	
SHS	147(42.4)	86(46.0)	
Tertiary	6(1.7)	11(5.9)	
Marital status			9.02(0.003)
Married/Co-habiting	249(71.8)	156(83.4)	
Single	98(28.2)	31(16.6)	
Educational level of wife			14.77(0.005)
None	116(33.4)	45(24.1)	
Primary	74(21.3)	31(16.6)	

JHS	96(27.7)	71(38.0)	
SHS	59(17.0)	34(18.2)	
Tertiary	2(0.6)	6(3.2)	
Number of wives			0.17(0.681)
1	237(95.9)	149(96.8)	
2	10(4.1)	5(3.2)	
Number of children			3.09(0.377)
0	5(1.9)	2(1.3)	
1-2	131(51.2)	67(44.1)	
3-4	97(37.9)	63(41.4)	
5+	23(8.9)	20(13.2)	
Employment status			17.90(<0.001)
Formal sector	8(2.3)	19(10.2)	
Unemployed	51(14.7)	179(9.1)	
Self employed	288(83.0)	151(80.7)	
Employment status of wife			8.35(0.015)
Formal sector	4(1.2)	7(3.7)	
Unemployed	112(32.3)	43(23.0)	
Self employed	231(66.6)	137(73.3)	
Religion			3.37(0.642)
Catholic	76(21.9)	40(21.4)	
Charismatic/Pentecostal	54(15.6)	34(18.2)	
Orthodox churches	39(11.2)	28(15.0)	
Other Christians	121(34.9)	58(31.0)	
Muslim	41(11.8)	17(9.1)	
Traditionalist	16(4.61)	10(5.4)	
Knowledge on FP			6.06(0.014)
Poor knowledge	176(50.7)	74(39.6)	
Good knowledge	171(49.3)	113(60.4)	
Variable	**Poor male involvement n (%) [n=347]**	**Good male involvement n (%) [n=187]**	**χ^2 (p-value)**
Perception on Male involvement			0.01(0.971)
Bad perception	46(13.3)	25(13.4)	
Good perception	301(86.7)	162(86.6)	
Convenient to access family planning services			0.88(0.347)
No	51(14.7)	22(11.8)	
Yes	296(85.3)	165(88.2)	
Pay for family planning			0.053
No	52(15.0)	17(9.1)	
Yes	295(85.0)	170(90.9)	
Importance of family planning			30.77(<0.001)

Extremely important	6(1.7)	9(4.8)	
Important	246(70.9)	144(77.0)	
Very important	28(8.1)	27(14.4)	
Not important	67(19.3)	7(3.7)	
Challenges accessing family planning			0.35(0.554)
No	296(85.3)	163(87.2)	
Yes	51(14.7)	24(12.8)	
Does distance affect ability to get FP			5.22(0.022)
No	304(87.6)	150(80.2)	
Yes	43(12.4)	37(19.8)	
Does ability to get to the facility prevent you from accessing family planning			1.45(0.229)
No	301(86.7)	155(82.9)	
Yes	46(13.3)	32(17.1)	
Means of transport to access FP			15.67(<0.000
Walk	41(11.8)	47(25.1)	
Transport	306(88.2)	140(74.9)	

4.7 Factors associated with male involvement in family planning

A multivariate logistic regression model was used to predict factors that influence male involvement in family planning services. Employment status, importance of family planning and means of transport were found to influence male involvement in family planning services. The logistic regression showed that men who are unemployed are 75% less likely to be more involved in family planning service compared to men who are employed in the formal sector [AOR=0.25, 95% CI: 0.01-0.78), p= 0.017]. Also, men who are self-employed are 75% less likely to be involved in family planning services than men employed in the formal sector [AOR= 0.25, 95% CI: 0.01-0.64, p= 0.004]. The model also revealed that men who think family planning is not important are 93% less likely to be more involved in family planning services compared to men who think otherwise [AOR =0.07, 95% CI: 0.01-0.28, p <0.001]. In

addition, men who use any transport medium are 64% likely to be more involved in family planning services compared to men who walk [AOR = 0.36, 95% CI: 0.22-0.61, p<0.001].

Table 4.7: Factors associated with male involvement in family planning

	Crude odds ratio	Adjusted odds ratio
Variable	**OR (95% CI) p-value**	**OR (95% CI) p-value**
Age (years)		
<20		
20-29		
30-39		
≥ 40	1.09(0.98-1.22) 0.100	
Educational level		
None		
Primary	1.16(0.96-1.42) 0.130	
JHS		
SHS		
Tertiary		
Marital status		
Married/Co-habiting	0.50(0.32-0.79) 0.003	Reference
Single		0.58(0.30-1.12) 0.109
Educational level of wife		
None		Reference
Primary	1.26(1.08-1.48) 0.004	0.60(0.30-1.19) 0.144
JHS		1.25(0.67-2.31) 0.471
SHS		1.11(0.57-2.16) 0.763
Tertiary		5.65(0.86-36.75) 0.070
Number of wives		
1	0.79(0.27-2.37) 0.681	
2		
Number of children		
0		
1-2	1.29(0.97-1.72) 0.080	
3-4		
5+		
Employment status		
Formal sector	0.71(0.51-0.98) 0.036	Reference
Unemployed		0.25(0.01-0.78) 0.017
Self employed		0.25(0.01-0.64) 0.004

Employment status of wife		
Formal sector	1.17(0.82-1.67) 0.378	
Unemployed		
Self employed		

	Crude odds ratio	Adjusted odds ratio
Variable	**OR (95% CI) p-value**	**OR (95% CI) p-value**
Religion		
Catholic		
Charismatic/Pentecostal		
Orthodox churches		
Other Christians	0.96(0.85-1.08) 0.521	
Muslim		
Traditionalist		
Knowledge on FP		
Poor knowledge	1.57(1.09-2.25) 0.014	Reference
Good knowledge		1.41(0.94-2.09) 0.089
Perception on Male involvement		
Bad perception	0.99(0.59-1.67) 0.971	
Good perception		
Convenient to access family planning services	1.29(0.76-2.21) 0.348	
No		
Yes		
Pay for family planning		
No	1.76(0.99-3.14) 0.055	
Yes		
Importance of family planning		
Extremely important		Reference
Important	0.57(0.43-0.75) <0.001	0.46(0.15-1.45) 0.184
Very important		0.69(0.19-2.42) 0.560
Not important		0.07(0.01-0.28) <0.001
Challenges accessing family planning		
No	0.85(0.50-1.44) 0.533	
Yes		
Does distance affect ability to get FP		
No	1.74(1.08-2.82) 0.023	Reference
Yes		1.71(0.99-2.92) 0.490
Does ability to get to the facility prevent you from accessing family planning	1.35(0.83-2.21) 0.230	
No		

Yes			
Means of transport to access FP			
Walk	0.40(0.25-0.63)	<0.001	Reference

CHAPTER FIVE

5.1 Discussion

The current study was conducted to identify factors associated with male involvement in family planning services in the Bekwai municipality. In general, the study found low level of male involvement in family planning (65%) than high male involvement (35%) in family planning services. Nevertheless, more than half (53.2%) of the respondents were having appreciable knowledge on family planning services. However, the logistic regression found only three factors: employment status of men, knowledge on importance of family planning and proper means of transport to family planning facilities to influence male involvement and patronage of family planning services.

5.2 Knowledge of males concerning family planning

Findings from this study suggest that most males (96.3%) knew what family planning was about. This fact was also revealed in the focus group discussion as most participants had an appreciated idea of what family planning was. Views of some participants during the focus group discussion had outlined in the quotes below to support the above evidence;

"I heard family planning is a way of preventing any unwanted pregnancy" (Participants 2, Age: 37, community 1)

"What I can also say is, family planning is a how to plan your family" (Participants 2, Age: 40, community 2)

"I know family planning is a way of protecting yourself from getting pregnant when you are not ready" (Participants 3, Age:29, community 3)

"I also think that family planning help prevent disease and pregnancy" (Participants 3, Age:35, community 4)

This study further revealed that, nearly two-thirds (64.4%) of the respondents were of the view that family planning issues should not be a concern for only women.

This study further revealed that about 60.5% of male knew periodic abstinence a means of prevent unwanted pregnancies. This finding conform to a study in the service area of the Jawaharlal institute urban Health Centre which showed that most men were aware of at least one of the family planning methods such as permanent method of sterilization, condoms, abstinence and the other contraceptive devices (Kumahikupam, 2003). The finding revealed in this study again, conform to another study done in Danfa in Ghana which concluded that men, knew at least one modern method (IPPF, 2005/2006).

The current study found that more than half (53.2%) of the participants had good knowledge on family planning. This resonates with data published on a similar study conducted among Iranian men. That study reported that awareness of family planning among study participants was 52.8% (Bani, Hosseini, Hasanpour, Valizadeh, & Abedi, 2014). This finding further contradicts a survey conducted in Mpigi district in Uganda, which revealed that, men have limited knowledge about family planning (Kaida et al., 2005). A plausible reason for this observation in this study could be attributed to the good perception about family planning among study participants. It could mean that good perception about family planning translated into good knowledge. Additionally, the education level of study participants could have been a major contributor to the good knowledge of the men involved in this study. More than two thirds of the study participants had various forms of education. Suffice it to say that, these varying forms of education may have provided the study participants with understanding about family planning messages they may have heard or read about.

5.3 Perception of males concerning family planning

The study revealed that majority (88.4%) of the males interviewed claimed there is no stigma from community on males who accompany family planning clinic with their wives or partners but about 11.6% think there is a stigma with male involvement in family planning. The study revealed that, less than 10% of males are usually referred to as being very weak as a result of their involvement in family planning.

A study conducted on knowledge of and attitudes about family planning and its use by a convenience sample of men in Ghana identified socio-cultural misconceptions resulting from lack of knowledge and education as the main deterrents for the use of different family planning methods including vasectomy (Akafuah & Sossou, 2008).

Butto & Mburu opined that family planning is not only restricted to the uptake of male family planning methods but also includes the number of men who encourage and support their partners and peers to use family planning. Failure to involve men in family planning programs therefore is likely to have serious consequences even if women are motivated to practice contraceptives because of opposition they may face from their spouse. In most African settlements, the man is the head of the family and so also is their decisions highly respected by their spouse. Subsequently, the likelihood of a women whose husband strongly objects to use of family planning to use such services is very low. By this reason, it is very essential male involvement in family planning is highly considered to unravel some of these challenges faced by some women. This study found that a large proportion of participants have good perception about family planning. This could mean that there is a paradigm shift on the notion that family planning is a woman's issue. The advent of modernity has helped to change some

stereotypical connotations such as family planning being a woman's issue. This may have resulted in the large proportion of study participants having good perception about family planning.

5.4 Proportion of males who are involved in family planning

The study revealed that about 65.0% of males interviewed agreed that they would recommend family planning to a friend or family member. The study further revealed that, majority (82.2%) of respondents had no time to spare to involve themselves in family planning services. Furthermore, it was revealed that, most (93.4%) males were not using any family planning method at the time of interview. There is the need to actively involved men in family planning training and activities urging them to accompany their partners to FP sessions, thus encouraging their involvement (Kamal et al., 2013). Most (70.2%) respondents revealed that they had never discussed family planning issues with their wives.

Similar result was revealed in the focus group discussion as most participants stated that they had never discussed any family planning issues with their wives. The quotes illustrated below supports the above evidence;

"As for me discussing family planning issues with my wife is out of the things I will do before I leave the face of this earth. She even suspects me already, not to talk of discussing family planning issues with her. She will conclude on her suspicions about me seeing another woman" (Participants 6, Age:43, community 3)

Findings in this study also revealed that, most (70.2%) respondents were of the view that, they would not continue to provide support to their wives if family planning fails. About 66.5% of respondents revealed that, they are ever ready to provide financial support to their wives to attend family planning clinic. Despite low involvement of male in family planning services,

some actions taken by some males to support their wives financially in line with the definition of male involvement by Greene (2000) who defines male involvement as all organizational activities targeted at men with the objective of increasing the number of men that encourage and inspire their wives to use family planning services. (Greene, 2000).

Report from some studies have indicated that active male involvement in reproductive healthcare positively influences maternal and child health outcomes (Bishwajit et al., 2017). Nevertheless, male involvement in family planning remain low as Bishwaji et al. (2017) found from their study done in Bangladesh that only 40% of men were actively involved in family planning services. Similarly, Butto & Mburu found from their cross-sectional study in Kenya that 48% of their respondents were not involved at all in family planning and that only 6% of men were using family planning method. In addition, Adelekan et al. (2014) did found low family planning intake among men where it was indicated that only 4.8% of their respondents had ever been involved in family pinning. All these findings are in consonance with findings of this study where only 35% of men were involved in family planning. This brings to light that male involvement in family planning remain low and interventions to promote male involvement in family planning must take different direction.

5.5 Barriers hindering male involvement in family planning

This study revealed that, most (68.4%) males interviewed had never attended family planning clinic though majority (85.6%) attest to the fact that family planning services are readily available to them. This study finding contradicts a study that concluded that family planning methods available to men is limited, and this as a result inhibits men's capacity to participate in fertility regulation (Green, Jackson, & Phillips, 1996). The finding in this study also confirms

a study done in Danfa, Ghana that showed that men can easily access family planning service (IPPF, 1984).

The study also revealed that most (73.0%) of the respondents in this study claimed family planning is of important to them. There are several challenges associated with male involvement in family planning especially those of social-cultural descends. This study revealed various challenges or barriers hindering male involvement in family planning services which include negative community perception (35.6%) about the males who indulged themselves in family planning activities. Others hindrances identified in this study included; stigmatization (20.6%), lack of knowledge (20.8%). The findings in this study conforms to other studies which revealed that there are a lot of choices to make on family planning methods for male, including the traditional methods, but because of certain beliefs coupled with inadequate knowledge of certain methods of contraception some men are against their use (Nzoka, 2000).

5.6 Factors associated with male involvement in family planning

Undoubtedly, the cause of low male involvement in family planning services is ascribed to wide range of factors stretching from demographic to cultural factors.

This study found a strong link between knowledge on importance of family planning among men and male involvement. This indicates that men who perceived FP to be important are more likely to engage in FP services.

This result concurs with a similar cross sectional study conducted in Cameroon where it was found that knowledge level on the importance of family planning was one of the barriers precluding male involvement (Egbe et al., 2016). Knowledge on the importance of an

intervention is very necessary as demonstrated by this and other studies. Men with less knowledge on FP are likely to hold misconceptions about the intervention.

In addition, some societies in the Ghanaian geographical area are deep rooted in culture where women with more children are revered in the society. By this reason, low knowledge level coupled with traditional belief are strong barriers to FP among some men. This is in consonant with findings of Finlayson K & Downe S. (2013) who found form their qualitative study the role of culture in family size and why some men turn to form large family size.

Egbe et al. (2016) noted that insufficient information on family planning is one of the barriers to male involvement. There is the need to breech this gap through constant community entry and sensitization by health personnel on family planning and its importance.

The study also found an association between employment status and male involvement in family planning. Men who are unemployed are 25% less likely to be more involved in family planning service compared to men who are employed in the formal sector and the same applies with the self-employed men. This finding suggest that income is a factor that could influence uptake of family planning services among men. Thus, men with good employment turn to use family planning services because they easily get access to information on FP through the media.

Finally, the study found that men who use any transport medium are 36% likely to be more involved in family planning services compared to men who walk. This goes to support the finding with regards to employment status. Geographical access to family planning clinics is therefore necessary to allow for easy patronage of FP services. The finding suggests that men who lived long kilometers away from FP clinics and whose primary means of transport is by

foot may be adamant in accessing these facilities because of distance.

This brings to bare the essence of building such clinics closer to community members. In addition, periodic outreach session on FP can be organized in communities to allow ease of access to every community member irrespective of the means of transportation.

To this end, community sensitization programmes aimed at improving male involvement in FP should be provided by government through community-based health facilities and willing non-governmental organizations.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

In line with study objectives, the study concludes as follows:

1. The study found that the knowledge level of men about family planning was good as revealed in the study.
2. As revealed in this study, respondents greatly agreed that, there is no stigma attached to male involvement in family planning services. Though a greater proportion of study participants had good perception on family planning, male involvement in family planning in the Bekwai District was low.
3. The study further revealed low male involvement in Family Planning services in the district.
4. Knowledge on importance of family planning among men, distance to family planning clinics and means of access to Family Planning services were the major factors identified in this study to be contributing to low male involvement in family planning.

5.2 Recommendations

Based on the findings, the following recommendations are made.

- The Municipal Health Management Team should intensify health education and promotion activities about the importance of male involvement in family planning by targeting opinion leaders (religious leaders and community elders) to ensure community participation in the education and promotion of male involvement in FP.
- Municipal Health Management Team should also designe a tailored health education and promotion activity which will reward men who will be much involved in family

planning issues in quarterly durbar.

- The Municipal Health Management Team should liaise with community health volunteers to form community based groups on family planning for only males to reduce shyness in discussing male involvement in FP.
- The Municipal Health Management Team should liaise with the District Assembly to construct family planning and reproductive health clinics in communities close to community members. This is likely to reduce the cost of travelling that prevents some men from patronizing family planning services.

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APPENDIX

1. Questionnaire

STUDY TITLE: MALE INVOLVEMENT IN FAMILY PLANNING IN THE BEKWAI MUNICIPALITY

Date of Interview:

NO.	QUESTIONS	RESPONSES	SKIP
SECTION A: DEMOGRAPHIC DATA			
A1.	Age (as at last birthday):	[ ] [ ]	
A2.	Educational level:	1) None 2) Primary 3) JSS/JHS 4) Secondary 5) Tertiary 6) Other please specify.....	
A2a.	Educational level of wife:	1) None 2) Primary 3) JSS/JHS 4) Secondary 5) Tertiary 6) Other please specify.....	
A3.	Marital status:	1) Married /Cohabiting 2) Not married	If not married skip to A4

A3a.	If married, how many wives:	1 2 3+	
A4.	Number of children:	[ ] [ ]	
A5.	Employment status:	1) Employed – formal 2) Unemployed 3) Self employed 4) Others specify.....	
NO.	**QUESTIONS**	**RESPONSES**	**SKIP**
A5a.	Wife's employment status:	1) Employed – formal 2) Unemployed 3) Self employed 4) Others specify.....	
A6.	Religion:	1) Catholic 2) Charismatic / Pentecostal 3) Orthodox churches 4) Other Christians 5) Muslim 6) Traditionalist 7) Other please specify.....	
SECTION B: KNOWLEDGE AND PERCEPTION			

B7.	Have you ever heard of Family Planning?	1) Yes 2) No	
B7a.	In this community is it acceptable for a man to accompany his wife for social events?	1) Yes 2) No	
B7b.	In this community, is it acceptable for a man to accompany his wife/partner for Family Planning?	1) Yes 2) No	
NO.	**QUESTIONS**	**RESPONSES**	**SKIP**
B8.	Family planning is an issue that should concern only women	1) Yes 2) No	

	B9-B23 is about contraception- I mean ways in which men and women can avoid getting pregnant. Which methods have you heard of? What others?	Yes	No	Don't Know
B9	Pill (female can take a pill everyday)	1	2	3
B10	Injection (females can have an injection every 2 or	1	2	3

	every 3 months)			
B11	Condom (a boy can put a rubber device on his penis during intercourse)	1	2	3
B12	Emergency contraceptive pills (a woman can take pills soon after intercourse)	1	2	3
B13	Withdrawal (a man can pull out of a woman before climax)	1	2	3
B14	Periodic Abstinence (a couple can avoid sex on days when pregnancy is most likely to occur)	1	2	3
B15	Condoms are an effective method of preventing pregnancy	1	2	3
B16	Condoms can be used more than once	1	2	3
B17	Condoms can slip off the male and disappear inside the females body	1	2	3
B18	It is a good idea to use hand lotion for lubrication when using a condom	1	2	3
B19	A condom should be unrolled before putting it on a male's penis	1	2	3
B20	The male should hold unto the end of the condom when withdrawing after ejaculation	1	2	3
B21	The Implant is can be used for both men a nd women	1	2	3
B22	IUD is taken as a pill by women three times a day?	1	2	3
	B23-B34 Female sterilisation is a permanent	1	2	3

	method of contraception?			
B23	Male sterilisation is a surgical procedure?	1	2	3

NO.	QUESTIONS	RESPONSES	SKIP
B25.	How will your family react towards a man attending family planning with his wife/partner?	1) Strangely 2) Praise him 3) Indifferent	
B25a.	How will your friends react towards a man attending family planning with his wife/partner?	1) Strangely 2) Praise him 3) Indifferent	
B26.	Are men who are involved in family planning activities stigmatized in this community?	1) Yes 2) No	
B27.	How would members of this community describe a man who is seen to be involved in family planning?	1 Very weak 2 Praise him 3 Indifferent	
B28.	Where do people go for family planning services in this community	1) Hospital 2) Health centre 3) Private clinic 4) Maternity homes 5) Pharmacy shops	

B29.	Do you get time off from work to attend family planning clinic?	1) Yes 2) No	
B30.	Typically, how long do you / your wife spend at the family planning clinic?	1) Within 30 minutes 2) 30-1 hour 3) 1-2 hours 4) 2+ hours	
B31a.	How do you feel about the time spent at the family planning?	1) Short 2) Normal 3) Too long	
NO.	**QUESTIONS**	**RESPONSES**	**SKIP**
B32.	How will you describe the attitude of family planning staff?	1) Very friendly 2) Friendly 3) Indifferent 4) Unfriendly 5) Rude	
B33.	How will you describe the health talks given at the family planning?	1) Very helpful 2) Helpful 3) Unhelpful 4) Complete waste of time	
SECTION C: PROPORTION OF MALES			
C33.	Where do people go for family planning?	1) Hospital 2) Clinic 3) Chemist shop 4) RCH	

		5) CWC	
C34.	Have you and your wife ever used any family planning method?	1) Yes 2) No	
C34.	What was your impression about the service?	1) Excellent 2) Good 3) Bad	
C36.	Are you currently using any family planning method?	1) Yes 2) No	
C37.	Have you ever attended family planning clinic?	1) Yes 2) No	
NO.	**QUESTIONS**	**RESPONSES**	**SKIP**
C38	How many times have you attended family planning clinic?	1) Never 2) Once 3) Twice 4) Thrice 5) Four or more times	
C39.	Do you know any man who attends family planning with the wife/partner?	1) Yes 2) No	
C40.	Are family planning services available when needed?	1) Yes 2) No	

C41.	Does the family planning clinic in this community have special arrangements for providing services to men?	1) Yes 2) No	
SECTION D: FACTORS ASSOCIATED WITH MALE INVOLVEMENT			
D42.	Is it convenient to access family planning services?	1) Yes 2) No	
D43.	Do you pay for family planning service?	1) Yes 2) No	
D44.	How important is family planning to you?	1) Extremely important 2) Important 3) Very important 4) Not important	
NO.	**QUESTIONS**	**RESPONSES**	**SKIP**
D45.	Would you recommend family planning to a friend / relative?	1) Yes 2) No	
D46.	Are there any challenges accessing family planning services?	1) Yes 2) No	If no skip to D36
D47.	If yes please state the challenges		

D48.	In your opinion, what are the main challenges preventing men from involving themselves in family planning? (Circle all that apply)	1. Negative community perception 2. Lack of male FP service providers 3. Stigmatization 4. Masculinity power 5. Wives are unsupportive 6. Peer pressure 7. Fewer contraceptive choices for men 8. Lack of knowledge 9. Shyness 10. Lack of knowledge about FP
D50.	Of the problem you have listed, which one do you think is the very common?	
D51.	Does distance affect your ability to go for family planning services?	1) Yes 2) No
NO.	**QUESTIONS**	**RESPONSES**
D52.	Does ability to get to the facility prevent you from accessing family planning?	1) Yes 2) No
D53.	Do you walk or transport to the facility?	1) Walk 2) Transport

SECTION E: To recommend strategies of improving the existing situation		
E54.	In your opinion, why is it that male generally do not attend family planning?	

NO	MALE INVOLVEMENT	RESPONSES	SKIP
F 55	Will you recommend family planning to a friend or family	1 Yes 2 No	
F56	Do you get some time off work to attend family planning clinic	1 Yes 2 No	
F57	Which family planning method do you and your wife use	1 Yes 2 No	
F58	Have you ever discussed family planning with your wife	1 Yes 2 No	
F59	Will you still support your wife if a family planning method fails	1 Yes 2 No	
F60	Will you provide financial support to your wife to attend family planning clinic	1 Yes 2 No	

2. Focus Group Discussion Guide

INTERVIEW GUIDE ON VIEWS OF SELECTED MALES ON MALE INVOLVEMENT IN FAMILY PLANNING.

I am a Master of Public Health student at the Department of Population Family and Reproductive Health, School of Public Health, University of Ghana. As part of my Masters studies, I am conducting a study titled **Male Involvement in Family Planning in the Bekwai Municipality.** It would be highly appreciated if you respond to the questions in a short interview. All information provided would be strictly confidential and would be used strictly for research purposes only. Thank you.

1. How would you describe male involvement in family planning in this community?
2. How do your family/friends feel about a man attending family planning services with his wife/partner?
3. In this community, it is acceptable for a man to accompany his wife/ partner for Family Planning?
4. What do you think prevents some men from participating in family planning issues?
5. Have you ever discussed family planning with your wife/partner?
6. Why did you discuss family planning with your wife?
7. Why did you not discuss family planning with your wife?
8. How many times have you attended family planning clinic?

9. Would you recommend family planning to a friend?

10. Can you identify any shortfalls/ challenges with the family planning services?

11. How can family planning services in this community be improved?

12. What do you think can be done in the health facilities to increase male involvement in family planning?

3. Consent form

4. Ethical Clearance Letter