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SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

MALE INVOLVEMENT IN FAMILY PLANNING: PERSPECTIVE OF MEN IN THE BAWKU WEST DISTRICT

BY

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DECLARATION

I, Ruby Ruhiamatu Sulley, hereby declare that with exception of references to literature and works of other researches, which have been duly acknowledged, this research is my own original work conducted under supervision. This work has not been presented to any other University or institution for any degree.

14TH AUGUST, 2022

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DEDICATION

I dedicate this work to the Almighty God, my grandmother, Madam Elizabeth Gaisie and the entire Gaisie family for their support.

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ACKNOWLEDGEMENTS

My sincere thanks go to the Almighty God for the wisdom and strength to help me pursue this program. I thank my supervisor Dr. Adom Manu for his guidance and support throughout my research work. I am also grateful to Dr. Samuel Sackey and Dr. Mawuli Dzodzomenyo for their immense support and advise. Special thanks go to my study participants for allowing themselves to be used for the study. Finally, I would like to express my appreciation and gratitude to all people who contributed in making this work successful.

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ABSTRACT

Background: An efficient way of managing fertility is through the practice of family planning. Low fertility results in slower population growth. Family planning has long been recognized as an efficient intervention in public health, extremely cost-effective in reducing the burden of disease on maternal and child health. Male involvement in family planning is not a new discovery to the field of public health. Even though contraceptive prevalence rate is high, 32% of women in the district wants to take up more methods. The women in Bawku West District are unable to assess family planning because male partners are not involved. This is a major public health concern and needs further investigation.

Methods: The study was a qualitative study using a phenomenology approach. Data were collected using focus group discussion and in-depth interviews. The study participant was made up of married and cohabiting men aged 18 to 59 years living in the Bawku West District. Purposive sampling technique was employed for the selection of participants. Two sub districts were chosen (1 urban and 1 rural, for fair distribution of participants) and the nature of the phenomenon examined among them. Interviews were audio-recorded, and the tape were transcribed verbatim and the resulting texts analysed using thematic analysis.

Results: Out of the 51 men that took part in the study, majority were young men between the ages of 18 to 32 years. Findings from the study revealed that health service factors such as accessible, distance to health facility and cost are major factors that deter men from participating in family planning services The study also revealed that though men were more knowledgeable about family planning and its methods did not reflect in their participation in family planning services in the district.

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Conclusion: Though men in the Bawku West district had appreciable knowledge on family planning, they are unwilling to practice it because of sociocultural, individual characteristics and health service factors. The study recommends that there should be variety of methods for men to choose from.

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LIST OF ABBREVIATIONS

CDC	-	Centre for Disease Control and Prevention
CHPS	-	Community Based Health Planning Services
DHIMS	-	District Health Information Management System
DHMT	-	District Health Management Team
FP	-	Family Planning
FGD	-	Focus Group Discussion
GDHS	-	Ghana Demographic and Health Survey
GSS	-	Ghana Statistical Service
ICPD	-	International Conference on Population and Development
MDG	-	Millennium Development Goals
MMDA	-	Metropolitan, Municipal and District Assemblies
MOH	-	Ministry of Health
SDM	-	Standard Days Method
SRH	-	Sexual and Reproductive Health
TFR	-	Total Fertility Rate
UNFPA	-	United Nations Fund for Population Activities
WHO	-	World Health Organization

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CHAPTHER ONE

INTRODUCTION

1.1 Background

An efficient way of managing fertility is through the practice of family planning. Low fertility results in slower population growth. Family planning over the years has been recognized as an efficient intervention and extremely cost-effective in reducing the burden of disease on maternal and child health (Bowie & Mwasw, 2011). Global estimates state that 222 million women have unmet needs for family planning. The phenomenon is particularly prevalent among low income areas of the world ((Sensoy, et al., 2018).

In their study of men and women's perceptions Bugiri and Mpigi districts in Uganda, found that decision-making on contraceptive use is the shared obligation of men and women and that effective development and implementation of male-involvement in family planning initiatives should address obstacles to men's reassuring participation in reproductive health, including addressing men's negative beliefs regarding contraceptive services which were prevalent in the study areas (Kabagenyi, et al., 2014). Similarly, Mosha, Ruben & Kakolo (2013), found that men showed little interest in participating in family planning issues in Mwanza, Tanzania.

Kriel, et al., (2019), found that culture influenced gender dynamics and adequate understanding of family planning and contraceptive information affected male attitudes and perceptions about contraceptive use, whether positively or negatively. Males reacted negatively to contraceptive use due to limited understanding, misunderstandings about side-effects; male dominance in relationships; and physical abuse in Kwazu-Natal, South Africa.

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However, there is still a great gap between the rich and the poor in accessing services, resulting in an extremely high unmet need for the poor (Prata, 2007). The reasons for unmet need are mainly due to worries about side effects, poor access to services, absence of right data and society disapproval to use contraceptive (Casterline & Sinding, 2000). Family planning advantages go beyond improvements in maternal and child health. For instance, family planning can lead to greater education, better job prospects, greater socioeconomic status and empowerment for girls and females (Casterline & Sinding, 2000).

The International Conference on Population and Development (ICPD) in 1994 emphasized the role of women in development process and the broadening of the scope of family Planning and intensifying male participation was a major recommendation at the conference. Communication between spouses enhances family planning techniques of use and continuation. However, in nations with elevated fertility rates and unmet need, males were often considered unsupportive of the use of family planning methods by their partners. There is the need to promote women's right in society as well as to encourage male participation in order to enhance reproductive health programs. Reproduction involves both male and female, but men have the least contraceptive methods and techniques.

Gender attention at the 1994 International Conference on Population and Development (ICPD) in Cairo led to a renewed call for males to actively involve themselves in reproductive health problems. In some developing nations, enhanced use of contraceptives has already decreased the annual amount of maternal deaths by 40% over the previous 20 years and decreased the percentage of maternal death per 100 000 live births by about 26% in just over a century. It was estimated that

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if the unmet need for contraception could be fulfilled, another 30% of the maternal deaths still occurring in these countries could be avoided (WHO, 2010).

1.2 Problem Statement

It has been two and half decades since the International Conference on Population and Development (ICPD) was held. There is still a 1.5% annual increase in global population. Most developed countries have completed their fertility transition and are now experiencing low levels of fertility.

Contrary to this, countries in the least developed regions, especially in sub-Saharan Africa and Asia are experiencing moderate to high levels of fertility. Africa fertility rate is estimated to be the global highest at 4.7 children per women and the least Europe at 1.6 children per women between 2010 and 2015. Most Africa countries face countless difficulties in reproductive health including elevated rates of unplanned and adolescent pregnancies (World Population Policies, 2013).

The uptake and use of family planning services and contemporary techniques of contraception rely on many variables (Knudse, 2006). In reproductive health problems, the male partner plays a main role. According to Hasna, (2006) men are required to increase the utilization of family planning services. But men are often being viewed as not supporting the use of family planning by their partners (Kabagenyi et al, 2014). Male involvement in family planning is not a new discovery in public health, although it is often ignored.

Male participation in family planning and reproductive health is a significant influence in the achievement of any program on sexual and reproductive health (SRH) (Char, 2011). Whiles in

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some nations in Africa contemporary family planning methods are restricted due to husband resistance, religious and health issues (Cleland et al, 2011). This is due to the reality that societal norms and religious views in developing countries such as Ghana often ensure that males are the main decision-makers on their spouses use of family planning and they decide on the number of children to have (Adelekan, Omoregie and Edoni, 2014). Many societies have a patriarchal system and females have very little option in contraception without men's permission. In spite of all these factors men have the limited contraceptive methods, namely condoms, vasectomy, withdrawal and the Standard Days Method (SDM) that requires their involvement, programming for family planning has concentrated mainly on females.

A programming evaluation demonstrates that programs do not especially serve males and children. Most programs work from the point of view that females are contraceptive users and that males should be careful enough to help their partners. The concept that family planning is the woman’s business is out-dated (Tilahum et al, 2013). Rapid population growth is a concern in Ghana that warrants attention. The issue, however, is still evident in societies where large families are valued. In their marriage pattern, religious beliefs and perceptions, this can readily be found.

According to GDHS, (2014), women's contraceptive use in Volta region is greater and northern region is lowest. Male involvement in family planning is more than just raising the amount of men who use condoms and have vasectomy. It involves reducing the gap in scientific evidence on the number of males encouraging their partners and colleagues to use family planning and influencing the poly climate to promote the creation of male-related family planning programs (Ngeh, 2017).

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The situation in Bawku West District is that male family planning involvement is low, and males do not enable their spouses to use any contemporary contraceptive to space their birth. The district reported 202 male family planning involvement in 2016 and dropped dramatically to 41 male involvement in 2017 (DHIMS, 2017).

Currently very limited evidence exists regarding male involvement in the Bawku West District. The main aim of this study is to explore how men in the District conceptualize male involvement, the way their individual factors affect their level of participation in family planning and develop programs that will increase effective participation.

1. 3 Research Questions

1. How do men conceptualize family planning?
2. In what ways do individual characteristics hinder male involvement in family planning?
3. Are there any health service factors that hinder male participation in family planning?
4. To what extent do socio cultural factors influence male involvement in family planning?

1.4 General Objective

To explore male involvement in family planning in the Bawku West District

1.4.1 Specific Objectives

1. To explore men's understanding of the concept of family planning.
2. To examine the extent to which sociocultural factors influence male involvement in female planning.
3. To describe ways individual characteristics hinders male involvement in family planning.
4. To explore health service factors hindering male involvement in family planning.

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1.5 Justification of the Study

About 44% of pregnancies worldwide are either unwanted or unplanned (Bearak et al, 2018). Unwanted pregnancy in Africa presents a significant and ongoing threat to societal health and growth, Africa accounts for more than a quarter of the 40million pregnancies occurring annually in the region, which could be due to contraceptive failure, non-use, and to lower extend due to rape (Gipson et al, 2008). Considering the implications, intensifying family planning practices in different households is crucial. Family planning is not the sole duty of females; their male counterparts must also take part in this practice or promote it to be efficient. According to Arundhati (2011), male participation in family planning and reproductive health is a very significant influence in the achievement of any program of sexual and reproductive (SRH), but the present scenario in the Bawku West District is that fathers as heads of nuclear families do not adopt the family planning agenda. In 2017 the district with about 30,115 males, reported only 41 male involvement in family planning (DHMIS,2017). In spite of the numerous advantages in family planning, family planning uptake in Bawku west district is quite low (30.2%) (GHS Annual Report, 2016). Observation made as a service provider indicates that women in the district want to come for the service but are afraid. Anecdotal evidence in the district suggest that men are the main obstacle to low uptake of family planning in the district. Although several works have been done on the level of male involvement in family planning, less has been performed to define the factors that hinder male participation in the program (Kiogora, 2016; Mukasa, 2009).

It is therefore important to explore the factors that hamper male involvement in the Bawku West District. Information on these will assist create programs and initiatives to enhance male involvement in family planning operations. Finally, this study's results will serve as a basic data for future studies on barriers to male involvement in family planning.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Family planning is a method of controlling the number of children one wants to have and the intervals between births. It includes the timing, spacing and limiting of pregnancy. Family planning also includes the age at which one wishes to give birth. The methods of family planning may involve sex education, the use of contraceptives and voluntary sterilization. Family planning is one of the achievements of public health (Sultan S,2018).

According to the World Health Organization (WHO), Family planning is defined as "the ability of individuals and couples to anticipate and reach their desired number of children, the spacing and timing of their births. This is accomplished through the use contraceptive methods and therapy of involuntary infertility" (WHO, 2008).

Increased child spacing and small family size have helped to reduce infant and child mortality rates, improve the economic and social conditions of women and also improve maternal health. Short birth intervals also reduce the preceding child's chances of survival. In the early part of the 20th century, contemporary family planning initiatives started in the United States. Ghana has been supporting the use of family planning since 1960 and several writers have given proof of contraceptive access and use and its effect on population reduction. Between 1987 to 1990 the government of Ghana initiated the Contraceptive Social Marketing. Then between 1990 to 1996 the Ghana Family Planning and Health Program was established and the Ghana Population and AIDS Project between 1996 to 2000 (Hong et al.,2005). In spite of all these projects and programs Ghana population increased from 18.9million in 2000 to 24.6million in 2010 (GSS,2012). The

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government realizing the linkage between increased population growth and economic development introduced nation policies and policy document on family planning, thus the National Population Policy and A Road Map for Reposition of Family Panning in Ghana (GHS,2006). Gribble (2008) Opined that achieving a manageable and reduced population rate is a vital integral component of the national strategy of government to accelerate the pace of economic development, enhance the quality of life of all citizen and accelerate the pace of economic development as outlined in the Action Plan Vision 2020 (GSS,1999; Hogue,2007)

A fundamental goal of the five-year job program (5YPOW) of the Ministry of Health is Improving human development, with importance on empowering individual and offering quality services, particularly females, to take control of their reproductive health, hence the Ministry combined the National Family Planning Program with Maternal and Child Health (MOH, 2007).

2.2 Male involvement in family planning

Family planning contributes significantly to the achievement of the Millennium Development Goals. In recent times, male involvement has gained considerable attention in family planning programs but its implementation remains a challenge. Studies show that male involvement in family planning activities has the potential to increase uptake and continuation of the methods by enhancing spousal communication through ways such as decreased male opposition or resistance or increased knowledge (Kim & Kols, 2002). Nevertheless, in many Sub-Saharan African countries, despite growing evidence of the benefits of engaging men i in decision-making on fertility rates, reproductive health and unmet need for family planning remain high. While several influencing factors exist, low prevalence of contraception were partially due to males' resistance to or non-involvement in family planning (Dudgeon & Inhorn, 2004).

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There is an increasing consent worldwide that a strong family planning policy would help achieve the MDG's (Abrejo et al, 2008).

Many developing nations such as North Africa, Asia, and Latin America has experienced a reproductive revolution, and this has led to a big decline in fertility. However, Sub-Sahara Africa has not witnessed this fast trend. The region in recent times still has a Total Fertility Rate of about five birth per female (Bongaarts,2011). Promoting family planning reduces poverty, speeds up socioeconomic growth, reduces infant and maternal mortality, improves child education and encourages gender equality (UNFPA,2010).

The decision on family planning is produced not only by spouses, but also by the husband's relatives, mainly in the context of developing nations. The function of husbands in decision making process of family planning is an issue that has lately received consideration as a significant factor of contraceptive use. The role of men in family planning involves decision making on contraceptive use (Allen et al, 2014). A study conducted by Berhane et al, (2011) revealed that serious efforts to reach the targeted family planning coverage are most successful when they involve men. A study in Uganda concluded that directing family planning towards men may significantly increase contraceptive uptake (Shattuck et al, 2010). Abraham et al, (2010) suggested that education, information, and communication be provided to change the behavior of men concerning contraceptive practice.

Recently the role of the husband in decision about family planning is an important determinant of contraceptive uptake that has gained much attention. Allen et al (2014) concluded that the role of

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men in family planning involves taking decisions on the use of contraceptives. Nonetheless, findings indicate that in less developed countries, male involvement is less popular.

In a study to assess men's practice and attitude about self-use of contraceptives in Nigeria by (Orji & Onwudiegwu,2008) majority of men agreed for their partners to use contraceptives. However, almost 65% disagreed of attending family planning clinics with their partners However almost two-thirds (65%) disapproved of attending family planning clinics with their spouses, while only 26% of partners had ever done so.

In a study to examine men and women's perceptions concerning obstacles to men's support and use of modern contraceptives. Kabagenyi et al, (2014) concluded that, Contraceptive use decision-making is the mutual responsibility of both men and women. Successful development and implementation of family planning programs affecting men will resolve obstacles to promoting men's involvement in reproductive health, including resolving the negative beliefs of males with respect to contraceptive services. In another study on the factors influencing the usage of family planning services in the Talensi District in the upper east region of Ghana, Apanga & Adam (2015), revealed that usage of family planning was low due to husband's opposition to the uptake of family planning services in the district as much as 90% of the respondents cited opposition from their husbands as a major factor that prevents them from taking up family planning services.

Awareness of family planning methods among men in a study by Adelekan et al (2014) was almost universal. However, it did not translate into actual use of these methods into actual use of these methods of family planning. In addition, male participation in family planning decision was poor. Generally, men have a higher knowledge on family planning than women do. However, the uptake

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of family planning by men is generally low as compared to the number of women. Religion, marital type, academic achievement, and occupation are the correlates of men's views on the role of men in family planning decision making. There is an immediate need to increase male participation in decision making in family planning if family planning is going to change (Ijadunola et al, 2010).

2.3 Men's understanding of the concept family planning

Family planning is not a new concept in Ghana. Over the years so much has been done by private and government institutions to create public awareness about family planning and its long-term benefits to families and the Ghanaian population at large. The uptake of any family planning method depends on the person's knowledge of the various types of methods available and the willingness of both partners to involve themselves in the family planning program. In a study to examine men's knowledge and attitudes about family planning and its use and in an attempt to establish participant's general knowledge of the various family planning approaches that they have been familiar with and the used on a regular basis.

All respondents interviewed confirmed that they had that learned about family planning services and were willing, in general terms, to clarify their understanding on the perception of family planning and its key objectives. The most common knowledge they had about family planning was that family planning practice helps to space and reduces the number of children couples want to have and help families to plan and cater for a small family size (Akafuah & Sossou, 2008).

There has been some more research in Ghana on reproductive health and family planning, Adongo et al (2006), attempted to examine Men's Concerns about Reproductive Health Services in a rural setting in Northern Ghana. While concentrating on Zurugelu they discovered that male outreach

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services and community mobilization were not community mobilization enough to introduce behavioral change. The findings of a research undertaken in the Kwabre district showed that the male use of family planning services in the Kwabre district is Kwabre district is relatively high compared to the national prevalence (25% against 32.8%). There is also a high level of knowledge among respondents about contemporary contraception (91.7% knew at least two techniques of contraception). However, in relation to the range of family planning methods available to clients, the quality of the services offered is quite low.

The key family planning methods provided are the injectable, pill and condom. Family planning services are readily available to clients but because of the high fertility preference expressed by most participant's utilization is low (Akyeah, 2007). A study also conducted by Kiana (2013) revealed that utilization of family planning services is not encouraging even though men have increasable knowledge about it.

Male involvement in family planning techniques or methods is essential for maternal and neonatal care in Ghana, but the amount of male participation in family Planning is very small in the nation, particularly in the northern portion of Ghana, where having many children is seen as family assets. Most of the time, the issue is not about the number of children, but about the spacing and the parent's ability to give them the care they need considering large-family homes. Study analysis revealed that most individuals, particularly males and females, have an understanding of the topic, yet only a few males engage or promote their spouses to engage in it. Understanding the role of male involvement in family planning could contribute to effort aimed at increasing family planning uptake (Dudgeon & Inhorn, 2014). Men's awareness of contraception and attitude towards modern

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contraception is now high in Bangladesh and factors such as education and socio-economic status, women's gender, number of children who have died and number of living children in a family, higher knowledge of men and positive attitudes towards contemporary contraceptives have influence on contraceptive usage (Islam, 2013).

2.4 Sociocultural factors influencing male involvement in family planning

Sociocultural factors are customs, values and lifestyles that characterize as society. More precisely, cultural aspect include language, religion, attitudes and values.

Depending on the socio-cultural environment in which individuals live and communicate the factors that can affect the degree of male involvement in reproductive care differ. Based on national representative DHS data in Bangladesh, a study by Bishwajit et al (2017) concludes that years of education, access to television and radio and communication with health workers on contraceptives play a significant role in male participation in the country.

Northern Nigeria's culture is patrilineal with a strong male impact on many decisions in households including those of FP. (Duze & Mohammed, 2016) realized that historically, men in this area are heads of households, sole providers and also manage the economic resources of their communities. This makes males attitudes towards FP and contraceptive use an important factor which affects the desires and opinions of women in this area. For instance, there is evidence that, in many ways, husbands play important roles in reproductive health decision making. In most developing nations, men play the role of goalkeepers in health care (Shrestha et al, 2014). A study by Akafuah & Sossou (2008) in Dunkwa-on-offin Ghana to examine the attitude and knowledge of family planning among men revealed that factors influencing the interests of men and their participation

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in contraception in Ghana include literacy, successful dissemination of information in the mass media, spousal contact, religion and the nature of monogamous marital relationships. In this same study, the high participation of respondents who described themselves as Christians and used some form of family planning services could be due to the active involvement of the Ghana Christian Council which supports the country's family planning system. For example, the Christian Council, which is made up of Evangelical Christian organizations and other churches, has been heavily involved in the development and promotion of family planning initiatives and the coordination of services for church members and the general public since the program was launched in Ghana. As confirmed by Buor (2011). However, the low uptake of family planning services among respondents who identified themselves as traditional believers and Muslims could be due misconceptions about traditional religious beliefs and lack of adequate knowledge on services. Similarly, Wulfan & Bagah (2015) from their research report in a Muslim community in Ghana realized a low male participation family planning uptake and a higher non approval for partners contrary to perfect awareness and knowledge of contraceptive options.

In Burundi, there is a supposed "climate of fear" surrounding contraceptive uptake in the rural regions. This at least partially rooted in traditional religious doctrines condemning family planning. Mubita-Ngoma & Kadanta (2010) examined the relationship between religion and family planning uptake in Africa. The study yielded mix results. Religious beliefs accounted for 50% decline on the decision to use contraceptives in Zambia. Whereas other studies have indicated that church affiliation does not prevent contraceptive uptake (Nketiah-Amponsah et al, 2012). In Mozambique an analysis of religious involvement in family planning produced a net positive

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association between contraceptive usage and church attendance regardless of denominational affiliation (Agadjanian, 2013).

Contraceptives have been viewed culturally as a progressive tool for women because they have the ability to provide fertility control. Many people see this as empowering women and a tactic that challenges their right. In contrast, people see the use of contraception as an excuse for women to become promiscuous or unfaithful. The preference for a big family size, social value and socio-cultural factors describes the lack of support for male involvement in the family planning programme (Adongo & Binka, 1998). A study conducted in Mwanza, Tanzania, on the perception of men indicated that men do not use contraceptives themselves because they believe was bad for health and condoms were also perceived to be negative for several reasons (Bongaarts, 2006). The main reasons for men not discussing family planning with their partners were due to the religious objection of family planning and that it was a cultural taboo (Mandara, 2012). Cultural and religion, perception towards family planning as women's issue, sex preference for inheritance and considering children as measure of blessing of God, and fear of partner sexual promiscuity were identified as major barriers to male participation in family planning services utilization in Ethiopia (Tamiso et al, 2016).

2.5 Individual characteristics hindering male involvement in family planning

Individual characteristics are characteristics identified within an individual including their attitudes, skills, personal characteristics and genetics. These factors in one way or the other play a major role in the decision to take a family planning method by men. Studies show varying attitudes of men towards contraceptive use, male involvement in family planning is generally low and this

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serves as one the many obstacles to the delivery of quality reproductive health care. In a study to find out the reasons for such a poor attitude by Jordanian men towards family planning, it was concluded that, analysis of the role of men in family planning, however, must include their opinions on the ideal family size. Throughout men's understanding of the importance of family planning and the need for reproductive health services, men's fertility desires play a key role. The Higher Population Council stated in Jordan that couples prefer male children and that Jordanian families have the perception that male children men and women prefer male children represent the virility and authority of a person (Raju et. al., 2000).

A study conducted in Uganda revealed that men who had more years of education are more likely to be involved in family planning activities than those with less years. The same study also realized that, other individual factors such the type of profession determined how men participated in family planning. Taxi drivers were more likely to participate in family planning than farmers. Men with a well-paid job were also more likely to participate in family planning methods than those with less paying jobs (Mohlala et al, 2011). The age and marital status are some of the individual factors that determine male participation in family. Several studies have reported that older age and cohabiting reported higher male involvement (Byamugisha et. al., 2011). It was further realized that husbands whose partners were whose 25years or older were 1.2 times more likely to be involved in family planning. Monogamous spouses and cohabiting men were twice and 1.6 times more likely to participate in family planning. Female attitudes and considerations can also be seen as a reason for low male participation in reproductive health services. Many studies have shown that women are afraid of violence from their spouses who attend ANC clinics with them. These women fear that the detection of a positive STI test can lead to their husband's rejection,

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refusal or perception of the guilt for introducing STI into the relationship between couples (Kiarie et. al., 2006, Semrau et. al., 2005).

People avoid the methods of contraception that require minor surgery. It has been established that men generally avoid vasectomy as it needs minor surgery (Olaitan, 2011). A study conducted by Ndenzako et al., (2006) also established that contraceptive use depends mostly on the sexual satisfaction of men, many males do not want to use condoms because they feel it decreases their sexual pleasure. Shahjahan et al (2013) findings revealed that men with marital length of 5 to 10years are more likely to be active in reproductive health service that their counterparts. The longer duration of marriage increases the involvement of men in reproductive health service.

2.6 Health service factors hindering male involvement in family planning.

Unmet need for contraception results in several health challenges such as unplanned pregnancies, unwanted births and unsafe abortions. Slumber et al, (2018), realized that most interventions have been unable to positively address this unmet need due to various community and health system level factors. However, Starbird et al., (2016) in their work identified that one of the most prominent and strategic and investment areas in achieving sustainable development goals (SDGs), by the United Nations have been to prioritize and to increase and sustain the practice of family planning services.

To achieve greater male participation in family planning providers should motivate men and act as their confidents. In their study, all the family planning providers stressed on the fact that men play smaller role in issue of reproductive health and that their attendance to family planning clinics was low, however all but one service provider encourage a higher number of men to visit the clinic

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family planning services (Ijadunola et al., 2010). In India, local health workers, both those responsible for working in the field with the communities and those in administration had provider bias in their efforts to encourage male involvement male in family planning. This they explained as a local gender ideology and general male disinterest (Char et al., 2011).

Availability of supplies and methods, workload and lack of knowledge and skills of providers has been described as key organizational factors influencing quality of care. In a focus group discussion, the most frequently cited obstacle to quality family planning services is lack of supplies. The few providers who reported having adequate contraceptive supplies said they still needed cards for family planning and educational materials and disinfectant. Some contraceptive stock-outs and other supplies have been recorded to the past 3–6 months and have resulted in discontinuation (Mugisha & Reynolds, 2008.). Providers felt lack of supplies led to longer waiting time for client, unwanted pregnancies and difficulty in diagnosing and treating sexually transmitted infections (STIs). Interestingly, perceptions of the willingness of customers to pay for services has an effect on the type of care providers provided. Often care providers would not hesitate to make referrals for methods of contraception or medical treatment if they felt that there was a lack of financial aid and this results in many customers been referred for services (Mugisha & Reynolds, 2008). A study conducted in Misrikh on improving the attitude of men in family planning uptake revealed that male providers were able to improve attitudes about family planning and men's roles in reproductive decision making than women providers (Johri et al, 2005).

It has been identified that rural clients are less likely than urban clients to use modern contraceptive methods for a number of reasons including number poor family planning services and limited contraceptive choice (National Research Council, 2013). A study conducted in Navrongo

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highlighted the achievement in improving health to the doorstep of rural people is essential to improve access (NHRI, 2000). A work done by IFPP, 2002 confirmed that physical distance from client's home to family planning services point does not have an important effect on use of modern methods (IFPP,2002).

A research conducted in rural Burundi by Ndayizigiye et al., (2017), revealed that one of the major contributors to low uptake of contraceptive methods was refusal of services by providers. Providers who were affiliated to certain religions may refuse family planning services to clients citing inconsistencies with their religious beliefs. Clients who are refused services spread word of their experience to other clients and the demand and uptake drops further. In this same study, lack of fully trained health providers to administer contraceptive methods was also identified as a major reason for the low uptake of family planning services. The study concluded by recommending strengthening of the community distribution of contraceptives methods and the training of health professionals and community health workers that will include education on the economic and health benefits of family planning and strengthening their skills for safe and effective administration of contraceptive methods and improving the health infrastructure.

Privacy and confidentiality is key in family planning uptake. According to Austin et al, 2015 pre service training before they are posted help improve quality service. Providers and staff characteristics include specially trained staff, respect for young people, non-judgmental attitude, privacy and confidentiality honored (Boyd et al 2000).

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2.7 Conceptual Framework

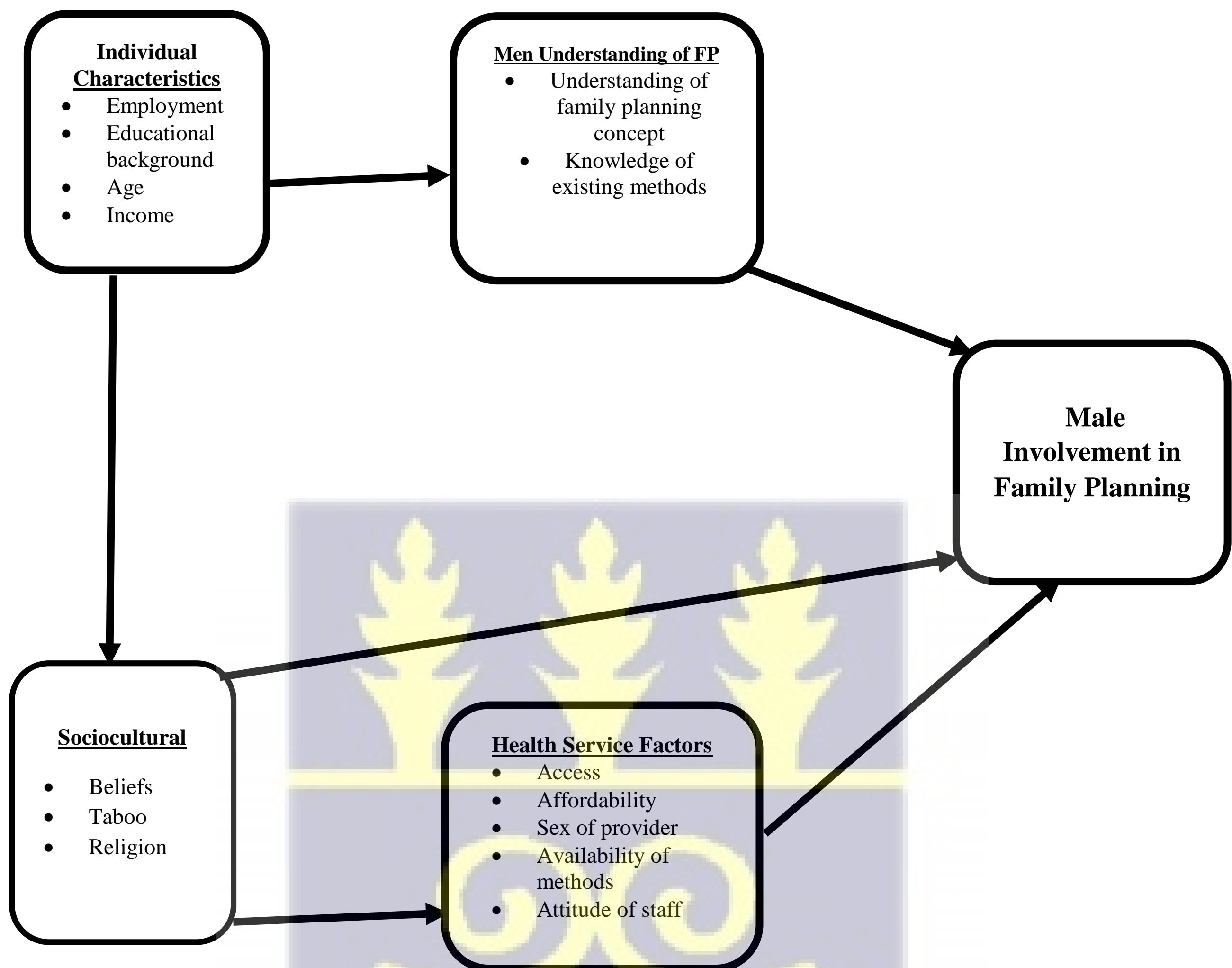

Figure 1: Conceptual framework on male involvement in family planning

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Conceptual Framework Narrative

The framework as displayed above explains the factors that determine male involvement in family planning. Achieving higher male involvement in family planning activities is dependent on the following factors: men understanding of family planning methods, sociocultural factors, individual factors, and health related factors.

It can be said that accepting to take up family planning methods depends on how much understanding the individual has on the method, therefore understanding of what family planning it and its benefits are and the various methods available could help increase male participation. More so, individual factors such as employment and income levels, educational background are all factors that determine male involvement in family planning.

Sociocultural factors also determine to a larger extent male involvement in family planning. Factors such as taboos, religious beliefs, and some cultural practices determine how well family planning will be accepted especially by males.

Health service factors such as availability and access to family planning, sex of providers and attitude of service providers to clients are all factors that determine male involvement in family planning activities.

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CHAPTHER THREE

METHODOLOGY

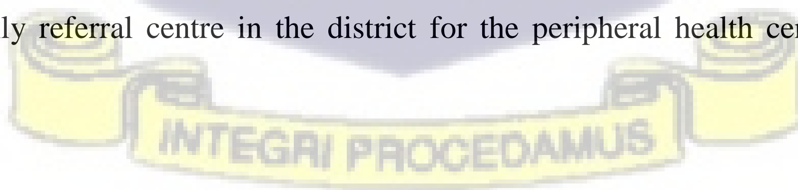
3.1 Introduction

This chapter discusses the research design, research setting, population, sample size and sampling procedure. It will also describe the instrument for data collection, ethical consideration and data analysis.

3.2 Study Area

The study was conducted in the Bawku West district. Bawku West forms part of the 15 of Municipalities and Districts in the Upper East Region. Bawku West District is located in the north-east section of the Upper East Region with Zebilla as the District administrative capital. It is bordered to the north by the Republic of Burkina Faso, to the West by Talensi and Nabdam District, to the West East by the Binduri District and to the south by East Mamprusi Municipal.

The 2010 population and housing census estimated population of Bawku West District is 94,034 with 45,114 being males and 48,920 females (Ghana Statistical Service, 2010). The major economic activity in the district is farming and rearing of livestock. The inhabitants are predominantly traditional worshippers although there is quite a number of Christians and Muslims in the district. There are eight sub districts, seven rural and one urban and a district hospital that serves as the only referral centre in the district for the peripheral health centres and (CHPS) compounds.



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3.3 Study Design

The study was a qualitative study, employing phenomenology approach. Data were collected through in-depth interview and focus group discussion. This examined the phenomenon and enabled men share their lived experience in their natural settings.

3.4 Study Population

The study population was married, and co-habiting men aged 18 -59 years having at least a child and living in the Bawku West District.

3.4.1 Sampling Strategy

3.4.2 Sample Size

A total of 5 focus group discussions were conducted in two sub-districts and each focus group had about 6-8 participants. Participants for the focus group discussion were put into groups, that is 18 to 25years in one group, 26 to 35 in another group then 36 to 59years also in a group. This grouping was done so that participants would feel comfortable to express themselves. Besides the focus group discussion,15 in-depth interviews were conducted among study participants. Data should be gathered until empirical saturation is reached as propounded by Baker & Edward 2012. Empirical saturation is the point where no new ideas emerge. As such our chosen sample size could at any point reduce as we reach saturation.

3.4.3 Sampling Technique

Purposive sampling technique was employed for the selection of participants. Bawku West District is made up of 8 sub-district: one urban, and seven rural. For fair distribution of participants, two sub-districts (1 urban and 1 rural) were chosen and study participants were selected from these sub-districts. Community volunteers and Assembly men identified and purposively selected

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married and cohabiting men aged 18-59years having at least a child and living in these communities and organized them for the interviews. Only participants who were willing to be audio-taped were recruited in the study.

3.4.4 Inclusion and Exclusion Criteria

3.4.4.1 Inclusion Criteria

Men aged 18-59 years who were married or co-habiting having at least a child and living in Bawku West District.

3.4.4.2 Exclusion Criteria

Men aged 18-59 years who are married or co-habiting but do not have at least one child, cannot communicate in the interviewer's language (English, Twi and Kusaal) and, those who are not mentally sound were excluded from the study.

3.4.5 Selection of Participants

A purposive sampling was used in selecting participants from Boya-Gbantongo and Zebilla South sub-district with the assistance of community volunteers and Assembly men for the in-depth interview and focus group discussion. These volunteers and Assemblymen identified married or co-habiting men aged 18 -59 years having at least a child and living in the study communities and informed them about the study. Participants were told their responds would be recorded.

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Only participants who voluntarily consent to take part in the study after explanation and agreeing to be audio-taped were recruited in the study. Men who met the inclusion criteria were then allowed to take part in the study.

3.4.6 Data Collection Tool

Focus group discussion and in-depth interview guides were developed to guide data collection. The guides covered information on participants understanding on male involvement in family planning, information on sociocultural factors that influence male involvement in family planning, individual characteristics hindering male involvement in family planning practices and health service factors hindering male involvement in family planning. With permission from the respondents, the interviews and discussions were audio-recorded. For confidentiality purposes, identity numbers rather than names were given to respondents and their information was coded.

3.5 Pre-testing

The study was pretested in Binaba a community in Bawku West District. One focus group discussion and two in-depth interviews were conducted. Pre-testing allowed for corrections to be made to the interview guide and also helped the researcher to improve her interviewing skills.

3.6 Data Collection Procedure

Community volunteers and assembly men visited the study communities and informed participants about the study before it began. Participants gave their consent before participating in the study. Focus group discussion and in-depth interviews were scheduled at a time that was convenient for participant and the venue was the choice of the participants.

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The interviews and discussions were conducted in English, Twi and kusaal using an interview guide to explore men's view on family planning. Participants were segmented according to ages for the focus group discussion to enable them freely express themselves. With permission from participant's interviews were audio-recorded. The audio-recordings were done by the research assistants while the principal investigator moderated the discussions and interviews. Identity numbers rather than names were given to respondents and their information was coded for confidentiality purposes. To ensure privacy interviews and discussions were conducted in a safe environment devoid of noise and intruders. The information that was gathered from participants were transcribed into English by the researcher and research assistance. Independent coders were used to corroborate the theme extracted from the data for credibility purposes.

3.7 Data Quality Control

Data collection was done in a conducive and safe environment which enabled free interaction of respondents. In-depth interview and focus group discussion were conducted in an environment devoid of noise in order to obtain a clear audio tape recording of interviews. The study was pre tested in Binaba a community in Bawku West District before proceeding to the field. Research assistants were given training on how to conduct focus group discussion and in-depth interview before going to the field. Data was collected within a period of three weeks The audio recordings were coded with a password and only the researcher and supervisor had access to it.

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3.8 Data Management and Analysis

The audio-taped interview from in-depth interview and focus group discussion were transcribe verbatim by the researcher and research assistance. The resulting texts were read over and over

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again to understand the world of the participants. Thereafter, the data analyzed manually using thematic analysis technique, where the data was coded into various themes in line with the study objectives. To ensure credibility and validity of findings, independent coders were used to corroborate the theme extracted from the data. According to Maynard and Purvis (1994), repeated listening to tapes of interviews is important, but yet often neglected during analysis phase.

3.9 Ethical Approval

1. Ethical approval was sought from the Ghana Health Service Ethics Review Committee (Protocol ID number GHS-ERC054/11/19).
2. Permission to enter the communities was obtained from Assembly men in the respective towns.

Informed Consent

Informed consent was obtained from all participants. Before obtaining consent, the study was thoroughly explained to participants. They were told that their participation in the study was voluntary, and that they were free to opt out at any point in time during the interview.

Anonymity

For anonymity purpose participants were given identity numbers rather than names.

Confidentiality

Participants were assured of confidentiality. They were told that any information they provide would be strictly confidential, and would be used for the purposes of this research only.

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Risk

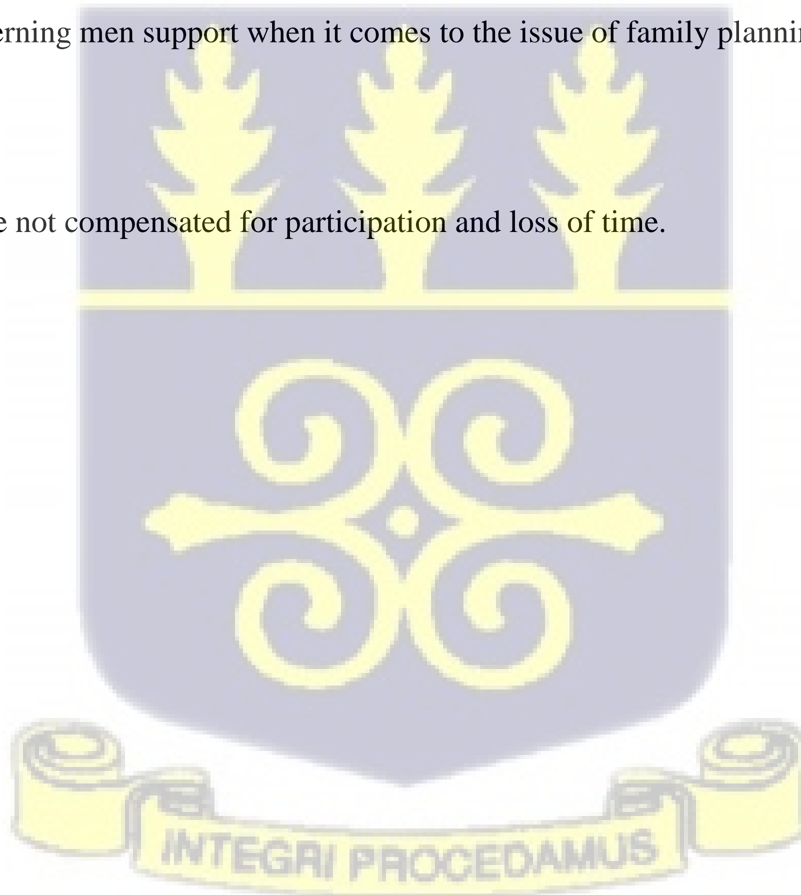
There were no risk or harm from the study however there were some level of discomfort since some of the questions were sensitive. In view of this, the design of the interview guide was well structured to facilitate the discourse. The respondents were informed about the general nature of the study and assured of no potential harm.

Benefit

Though participants may not have any immediate or direct benefits from the study, but their responses would be helpful in policy planning and formulation of recommendations to appropriate authorities concerning men support when it comes to the issue of family planning

Compensation

Participants were not compensated for participation and loss of time.



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CHAPTER FOUR

RESULTS

4.0 Introduction

This Chapter presents the finding from the study by way of analysis. The findings are from 51 respondents who were interviewed based on the interview guide which sought to explore male involvement in family planning in the Bawku West District of the Upper East Region. A total of 51 males between the ages of 18-64 participated in this study. In all, 5 focus group discussions with between 6-8 members and 15 in-depth interviews were conducted.

4.1 Demographic Characteristics of Respondents

Tabl4.1 presents the demographic characteristics of the respondents. Of the 51 males who participated in the study, majority (43%) were between the ages of 25 to 34 years with the least (2%) aged 55 to 59 years. Majority (61%) of participants were Christians with traditionalist being the least (18%). Majority (33%) of the participants Interviewed had attained tertiary education. Majority (57%) of the respondents were married with the least (43%) cohabitating.

Table 1: Demographic characteristics of respondents

Characteristic	Frequency (%)
Age	
18-24	20 (39)
25-34	22 (43)
35-54	7 (14)
55-64	2 (4)
Religion	
Christian	31 (61)
Muslim	11 (21)
Traditionalist	9 (18)
Level of Education	
Tertiary	17 (33)
Secondary	10 (20)
Junior high	5 (10)
Primary	7 (14)
None	12 (23)
Marital status	
Married	29 (57)
Cohabiting	22 (43)

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4.2 Men understanding of the concept of family planning

Generally, respondents interviewed had an appreciable understanding of family planning. Majority were able to explain the term family planning per their indigenous understanding. In terms of family planning methods, respondents were more knowledgeable on the female contraceptive methods compared with that of the males. With the extent to which men should involve themselves in family planning services, participants opined that men should discuss family planning with their partners, but women should rather choose which method to use.

The following quotations support the findings that men understand the concept of family planning:

> "*Family planning is the process where you and your partner decide on the number of children you want to have, the spacing so you will be able to take care of them.* Man aged 34, In-depth Interview, Yelwoko.
>
> "*Family planning help couples plan on the number of children to have and when to have them*. The benefit is that the mother's health is improved, and the husband is able to care for the family adequately*"*. From FDG Three
>
> "*Family planning is a method that help couples to decide on how many children to have, when to have them so as to cater for them well and also helps the mother recover from pregnancy and delivery*". Man aged 50, In-depth Interview, Kukori.

Another man had this to say.

"It is a method for women. The women do it to prevent them from getting pregnant. Man aged 23, In-depth interview, Zebilla.

The following quotations also confirm the position of men with regards to their preference for women using the family planning methods.

> *"I prefer my partner to rather use the family method since I do not get any pleasure when I use the condom.''* From FDG Two"

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''I will not waste this plenty money to buy cows to marry my wife and at the end of the day does not have any satisfaction when I sleep with her.'' From FDG one.*''*

"As a traditional man I will not involve myself in family planning, I have inherited my dead brother's wife and I have to continue his generation". Man aged 49, In-depth Interview, Zabzorga

4.3 Influence of Socio-cultural factors on male involvement in family planning

One of the objectives of the study was to explore the socio-cultural factors that influence family planning use. Participant were interviewed on their perception on multiple births, traditional believes and sex of the family planning providers as an influence on Family Planning uptake among males. Majority of the participants indicated their desire to have multiple children because it is prestigious to them. Others believed that, having multiple children will be a means and a guarantee for them to have 'big' and great funerals after their death. Nonetheless others expressed contrary view on this position.

One chief expressed his opinion as follows:

"*As a Naaba, it is a pride for me to have many children. It gives you social prestige, and its fulfilling when you die, and they are counting and introducing your children. Culturally, I will have a great funeral because each one of them will have to kill a goat or fowl for me*". Man aged 50, In-depth Interview, Yelwoko

Another man said,

"*Yes, it is an asset to have so many children, as a traditional man and a northerner, am proud when I see my children working and taking care of my properties. I know and am happy that I will get a great funeral when I die".* Man aged 56, In-depth Interview, Zabzorga.

However, some of the participants expressed a contrary view, and the following quotation illustrates this point.

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"It is an achievement to have few responsible children than plenty useless children". From FDG Three.

Some participants also indicated that, their religious or traditional affiliations have a major influence on their uptake of family planning services as men.

> *"It is against my tradition as a traditional man to use contraceptives, and I have inherited my late brother's wife, so I have to continue his generation".* Man aged 34, In-depth Interview, Kukori

> *"I help my father pour libation to the gods, therefore I can't use any family planning method".* Man aged 22, In-depth Interview, Yelwoko

> *"As a Muslim, Allah forbids us to use any form of contraceptives. Even condom is a great sin towards Allah".* From FDG Five

> *"The Bible tells us to multiple and fills the earth. That is exactly what I am doing since my church prevents us from using contraceptive".* From FDG Four

Others had contrary views, thus,

> *"Even though am a Christian my church doesn't prevents me so I use condoms".* Man Aged 19, In-depth Interview, Zebilla

In terms of the influence of sex of health provider on family planning uptake among men. Participants indicated they will also choose a male health service provider over a female health care provider. Nonetheless others indicated the sex of the health providers has no influence on their choice of family planning uptake

> *"I feel unease and a little bit shy when am being attended to by females".* From FDG Three.
> *"It is difficult discussing sex with the opposite sex and mostly after buying the condom the women have different perception about you".* From FDG Four.

> *"I don't have any problem with whoever attends to me, whether male or female am ok".* From FDG One.

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4.4 Individual Characteristics hindering male involvement in family planning

According to men in the Bawku West district, individual factors such as Age and income level has no influence on their involvement in family planning service. Most of the men interviewed highlighted that the age factor affects women rather than men. Others opined that family planning uptake should be for older men.

> *"As for we men at any age at all we can impregnate a lady, now we have small boys at the age of 9years reaching puberty so for us at any age we can be on a family planning method provided we have reached puberty, unlike the women that can reach their menopause, we men don't experience that.*" Man aged 39, In-depth Interview, Zebilla

> *"Men who are 50years and above should be on family planning method since at that age they will not be having the resources to take care of the children they give birth to."* Man aged 25 In-depth Interview, Kukori

With regards to influence of income level on uptake of family planning, majority of the men interviewed voiced family planning should be practiced by all notwithstanding ones' level of income. However, others had contrary views.

> *"Family planning is for birth spacing and giving birth to the number of children you can take care of and not for limiting birth. Therefore, whether you receive high income a month or not you can practice family planning*". From FDG One.

> *"Family planning is for the poor and the man that receives small income so that he will be able to limit his birth and take care of the few children he gives birth to. Therefore, I don't think the rich or someone who receives high income should practice family planning since they have the resources to care of plenty children*". Man aged 37 In-depth Interview, Zabzorga
>
> *"God is the one that take care of children not money"*. Man aged 57, In-depth Interview, Yelwoko

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4.5 Health service factors hindering male involvement in family planning

This objective looked at where family planning services should be accessed , availability of methods, distances to the nearest health facility, cost and attitude of family planning providers. Majority of the participants were of the view that family planning services should be done only at the hospital. Even though availability of methods plays an important role in family planning uptake, most men expressed that there are few methods for men, with the rest of the method focusing on women.

> *"Family planning should be done at the Hospitals because that is where the specialists are, but aside the hospital it should be done at the chemical shops*". From FDG Two

> *"It should be done at the hospitals and drug stores to control fake and expired drugs*". Man age 18, In-depth Interview, Kukori

Few had contrary view. They stated that family planning services should be included in the outreach service to prevent stigmatization at the health facilities.

> "*There is a lot of stigmatization at the hospital so it should be done at the market and other places convenient to us"*. Man aged 30, In-depth Interview, Zebilla

> *"I feel shy when I go to the hospital, so I prefer it to be done like how the community nurse do their outreach programs or even allow TBAs to provide the services"*. From FDG Three

> "*The male methods are not enough, and the three methods are suicidal. It takes a real man to do the withdrawal method. Vasectomy is even worse of. There should be more variety for the method*". Man aged 36, In-depth Interview, Yelwoko

> *"The male methods are not good at all, and even the ones available are not favourable. There should be injections and pills for men*". Man aged 27, In-depth Interview, Zebilla

Other participants insisted that the male methods are enough and that there should be no variety of method to choose from.

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"The reason why the male methods are not enough is that family planning is for women. That is why they have more methods than us. Men should not involve themselves in it, period." Man 38, In-depth Interview, Zebilla

Cost of family planning service is a major determinant in family planning service, especially in rural areas. Most of the participants interviewed remarked that family planning services should be factored onto the National health insurance to increase patronage of the service.

"*It is affordable but it should be free so everybody can participate in the service*". Man aged 22, In-depth Interview, Yelwoko

"Family planning services are not expensive, but it should be totally free or be included in Health insurance." Man aged 19 In-depth Interview, Zabzorga

"Oh, condoms are very cheap but not everybody can afford it therefore it should be supplied freely to every man or should be covered under Health insurance." From FDG One.

"For condoms the good ones and the ones that gives pleasure are very expensive, but the cheap ones are the ones that doesn't give pleasure". Man aged 20, In-depth Interview, Zabzorga

Some opined that the prices should be increased to reduce patronage.

"The price is too cheap it should be increased so that people will not use family planning". Man aged 33, In-depth Interview, Zebilla

Privacy and confidentiality, distance to nearest health facility and attitude of health service providers are key factors when accessing family planning services. Majority opined that they do not receive the necessary privacy and confidentiality when accessing family planning services. Though distance from participant to the nearest health facility is not far, men still do not patronize the service. Most men expressed that the attitude of family planning providers are not encouraging.

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"There is no privacy when you are accessing family planning, you only get privacy when you are the only one in the room. It takes a real man to buy condoms". Man aged 22, In-depth Interview, Yelwoko

"No privacy and confidentiality at all this is because most of the health workers here don't speak the local language and they consult through interpreters. So, when you go there everybody in the community will know your story". Man aged 43, In-depth Interview, Kukori

Some were of the view that they get a little bit of privacy when accessing family planning.

"Sometimes you get a little bit of privacy because they speak to you undertone". From FDG Five.

"I can't best tell if there is privacy or confidentiality because I don't use those things since it's against my tradition". Man aged 50, In-depth Interview, Yelwoko

Majority of the men interviewed were of the view that the distance does not affect participation.

They stated,

"Oh the clinic is not far, it's just a stone throw so it doesn't affect my participation". Man aged 20, In-depth Interview, Zabzorga

"With a motor bike I can use 10minutes to reach the clinic, it not far at all ". From FDG Four

"I stay just behind the clinic but I don't practice family planning". Man aged 40, In-depth Interview, Yelwoko

Majority of men interviewed stated that the unfriendly attitude of healthcare providers, prevents participation.

"*Health care workers should work on their attitudes, it affects participation. Some are very rude and can even shout and embarrass you.*" From FGD One.

"Some of them are unfriendly and gossips. They will gossip about you immediately you leave their presence". Man aged 19, In-depth Interview, Zebilla

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Few were of the view that the attitudes of healthcare workers are friendly.
"Some are friendly and others are not". From FDG Five

"Some are extremely good". Man aged 20, In-depth Interview, Yelwoko

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CHAPTER FIVE

DISCUSSION

5.0 Introduction

5.1 Demography of respondents

Out of the 51 men that took part in the study majority were young men aged between 18 and 32 years. Majority was Christians. Most of the participants interviewed had attained tertiary education and also most of the respondents were married.

5.2 Men understanding of the concept of family planning

Generally, respondents interviewed had an appreciable understanding of family planning. Majority were able to explain the term family planning per their indigenous understanding. In terms of family planning methods, respondents were more knowledgeable on the female family planning methods as compared with that of the male contraceptives.

Results from both in in-depth interview and focus discussion shows that respondents had much understanding of family planning During the interview respondents were able to explain what family planning is about. Majority stated that family planning helps space birth. This is in line with a study conducted by Akafuah & Sossou (2008) which they mentioned that, family planning helps space and reduces the number of children couples want to have. The study further revealed that most men were informed on the methods of family planning, respondents were aware of at least three methods of family planning. When respondents were asked about the methods of contraceptives for men, most of them mentioned at least two methods of contraceptives for men. Only a few were not aware of any contraception. Implying that, their Knowledge level on family planning is relatively high. They were however few of them who were not informed about family planning but were able to mention some methods of family planning as well. This speak to the fact

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that family planning education is going down well and contributing to the reason respondents were able to differentiate between the male and female methods. This finding agrees with what was found by Adongo et al (2006) which indicated that, there is high level of knowledge among men about contemporary contraceptive.

In spite of the high knowledge of modern contraception, most of the respondents were not using any form of contraception. These findings suggest that knowledge and awareness with modern contraception alone does not translate to the actual use of modern contraception in the Bawku West District; hence use of contraception should have been high. This finding is similar to a study conducted by Kiana (2013). In his study he established that utilization of family planning services is not encouraging even though men have increasable knowledge about it.

It is an acceptable fact that, the level of awareness of variety of contraceptive methods provides a rough measure of availability of family planning information in a district and the level of contraception uptake by men in general. Though this study was conducted in both urban and rural areas and although respondent's knowledge level about contraception was quite high, it should have translated to high prevalence of contraceptive uptake in the district, this was not the case.

With the extent to which men should involve themselves in family planning services, participants opined that men should discuss family planning but women should rather choose a method because they believe that the methods for men are unfavourable to them especially the vasectomy and the use of the condom. This is reflected in the work done by Bongaarts, 2006, in his study which he conducted in Mwanza, Tanzania, on the perception of men on family planning. The study revealed

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that men do not use contraceptives themselves because they believe it was bad for health and condoms were also perceived to be negative for several reasons. It has been found that males usually avoid vasectomy as it needs minor surgery, (Olaitan, 2011). Most men in Bawku west were of the view that they do not use condom because they do not get the needed pleasure. This finding is similar to a study conducted by Ndenzako et al (2006) which they established that contraceptive use depends mostly on the sexual satisfaction of men, many males do not want to use condoms because they feel it decreases their sexual pleasure. Due to these reasons majority of the men interviewed prefer their partners rather take up a method. It is interesting to note that one of the reasons the married men were not using any family planning method was that they consider the money for their wives' bride prides to be huge and therefore they demand right to sexual pleasure.

5.3 Influence of sociocultural factors on male involvement in family planning

The study revealed that majority of the participants indicated their desire to have multiple children because it is prestigious to them, and also believed that, having multiple children will make them have great funerals after their death. This justifies what was found by Adongo & Binka (1998) which they specified that, preference for a large family size, social values and socio-culture factors explain the lack of support for male participation in the family planning programme. It is also in line with a study conducted by IFPP, 1998 throughout Sub-Saharan Africa, which suggested that husband and wives who are having similar fertility goals generally want more children. It therefore, support the finding that a high proportion of both husbands and wives want a large family in Sub-Saharan Africa. Also, a study conducted by Tamiso et al, 2016 indicated that due to cultural and religion, perception towards family planning is seen as women's issue, sex preference for inheritance and considering children as measure of blessing of God, and fear of partner

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unfaithfulness were identified as a major obstacle to male involvement in family planning services in Ethiopia.

The study found that, participants indicated that their religious or traditional affiliations have a major influence on their uptake of family planning services as men. This finding is similar to what was found by Wulfan & Bagah (2015) where they established that, a Muslim community in Ghana realized a low male involvement in family planning uptake and a higher non approval for partners contrary to perfect knowledge and awareness of contraception options due to religious believe. It also agrees with what was identified by Mandara (2012) which indicated that men did not discuss family planning with their partners due to religious objection and cultural taboos.

Some of the respondents were of the view that, even though their religion frowns on the use of contraceptives, they still use it. A study conducted in Mozambique to analysis religious involvement in family planning produced a linkage between the use of contraceptives and church attendance regardless of denominational affiliation (Agadjanian, 2013). It also agrees with what was found by Nketia Amponsah et al (2012) which they pointed out that church affiliation does not prevent contraceptive use.

The perception of the men interviewed was that family planning uptake is based on the decision to have a big or small funeral when one dies. Majority of participants had the notion that the use of contraception prevents men from having many children. Moreover, some men reported, having many children is well respected in the traditional setting and it guarantees a man would have a great funeral when he dies. Therefore, for these participants, family planning uptake was not a priority for them.

In terms of the influence of sex of the health care provider on family planning uptake among men. Participants indicated they will also choose a male health service provider over a female health

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care provider. A study conducted by Johri et al 2005 in Misrikh on improving the attitude of men in family planning uptake revealed that male providers were able to improve attitude about family planning and men's role in reproductive decision making than women providers. Also, male providers helped to reduce male opposition to contraceptive use, since men were more relaxed discussion sexual issues with other men. The study further revealed that male providers played a key role in encouraging continuation of family planning services in the male focus group compared to the female focused group. Nonetheless, others men in the Bawku west district indicated that sex of the health providers have no influence on their choice of family planning uptake.

5.4 Individual characteristics hindering male involvement in family planning

According to the men interviewed in the Bawku west district for this study, individual factors such as age and income level has no influence on their participation in family planning services. Most of the men interviewed highlighted that the age factor affects women and not men because after menopause women cannot participate in family planning services. Others opined that family planning uptake should be for older men. The age and marital status are some of the individual factors that determine male participation in family. A study according to Byamugisha et.al (2011) reported that older age and cohabiting men reported higher male participation.

With regards to influence of income level on uptake of family planning, majority of the men interviewed voiced family planning should be practiced by all notwithstanding ones' level of income. However, others had contrary views. Men with a well-paid job were also more likely to involve in family planning services than those with less paying jobs (Mohlala et al, 2011)

Participants were of the view that, caring for children does not depend on the money a person has. This reflected in their responses in relation to individual factors such as influence of income level

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on family planning services. Majority explained that, God takes care of children and not human beings, therefore, a person can be poor and give birth to so many children.

5.5 Health service factors hindering male involvement in family planning

This objective looked at where family planning services should be accessed, availability of methods, distances to the nearest health facility, cost and attitude of family planning providers. Majority of the participants were of the view that family planning services should be done only at the hospital. This finding is contrary to a study conducted in rural Pakistan, using control group and experimental group. The study shown that increasing contraceptive access through doorstep delivery increased contraceptive use by 50% in the experimental group as compared to those in the control group. Few of the men interviewed had contrary views to the majority view held above. They stated that it should be done at pharmacy shops and also be included in outreach service to prevent stigmatizations at the health facilities which is in line with a study conducted by NHRI, 2000 in Navrongo highlighted the achievement in improving health to the doorstep of people in rural areas is essential to increase access. Because of social constraints there is the need to bring services as close to the clients for family planning.

Even though availability of methods plays an important role in family planning uptake, most men expressed the view that there are few methods for men, with the rest of the method focusing on women. According to Hatcher et al, 2001 for family planning services to be effective, it should be able to offer a range of methods and commodities so that the method most suitable for a client can be provided. They also stated that choice in family planning methods increases the level of uptake and continuation of service by clients.

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Most participants explained that the two methods namely vasectomy and condom which was the only method available in the district limited their participation in family planning uptake. Vasectomy to them was not the best option since it involves surgery and also irreservsible. The use of condom they perceived reduces sexual pleasure.Other participants insisted that the male methods are enough and that there should be no variety of method for the men to choose from since enough methods do not have any influence in their participation. This finding is in contrast with what was found by Mugisha & Reynolds, 2008, where after conducting a study using a focus group discussion established that the obstacle to quality family planning service is due to lack of methods.

Cost of family planning services is a major determinant in family planning service delivery, especially in rural areas within Bawku West district. Most of the respondents interviewed remarked that family planning services should be factored onto the National health insurance to increase patronage of the service. This was in relation to the fact that the female contraceptives have been enrolled onto the National health insurance scheme. Majority of participants stated that, there should be equity in service delivery to increase their participation in family planning uptake. This implies that men should be given proper attention in the national family planning program.

Generally, accessibility is a multidimensional concept that does not only mean physical distance and travel time to services, but also involves economic, psychological and attitudinal cost and the perceptions of potential clients. A study in Vietnam revealed that accessibility was clearly associated with contraceptive use for several subgroups of women (Singh et al.,2000).

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Majority of the men interviewed were of the view that the distance does not affect participation. Though distance from participant's home to the nearest health facility is not far, men still do not

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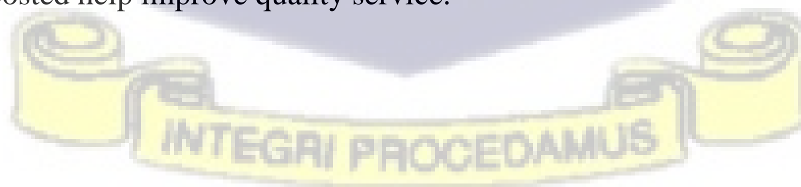
patronize the service. A study conducted by IFPP, 2002 confirmed that physical distance from client's home to family planning service point has no influence on the family planning services point has no influence on use of contemporary methods since the percentage of women using contemporary methods in rural setting did not vary much among women in urban settings.

Privacy and confidentiality, are key factors when accessing family planning services. Lack of privacy and confidentiality can restrict and make it very difficult to actively participate in family planning services. Results from the study revealed that majority of men both from in-depth interview and focus group discussion opined that they do not receive the necessary privacy and confidentiality when accessing family planning services. Men between 18 to 25years stated that their information about them buying condoms reaches their spouse and community members, and this negatively affects their participation in family planning activity.

Most men expressed that the attitude of family planning providers are not encouraging. They stated staff are not friendly and welcoming and this affects their participation. This attitude of staff in Bawku west district contradict with a finding that providers and staff individualities consist of specifically trained staff, respect for the youth, non-judgmental attitude, privacy and confidentiality honored (Boyd et al 2000). According to Austin et al, 2015 pre service training before they are posted help improve quality service.



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CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Conclusions

Based on the findings of the study the following conclusions are made in relations to the study objectives:

1. Men have appreciable knowledge on family planning and the various contraceptive methods, but they are unwilling to practice it themselves. Rather they will advise their wives to take up a method since they see it to be non-beneficial to them.
2. Sociocultural factors such as traditional norms and religion are great determinants involvement of males in family planning.
3. Concerning individual factors that hinders male involvement in family planning, the perspective of men in Bawku west district is that age and income level has no influence on their participation in family planning services.
4. Where family planning services should be accessed and availability of methods, distance to the nearest health facility, cost and attitude of family planning providers are a major health service factors that deter men from involving themselves in family planning services. The study found that men want variety of methods to choose from since they perceive their methods to be relatively fewer

6.1 Recommendations

1. There should be desired number of modern contraceptive for men since they perceive their participation in family planning services is hindered by paucity of desired number of modern contraceptives.

2. There should be future studies to examine the level of participation of men in family planning services if it included in outreach services.

3. Family planning service providers in the district should be trained on good customer care to encourage men attend the family planning clinic.
4. . Men should be given attention in the national family planning program.

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APPENDIX A: PARTICIPANTS INFORMATION SHEET

This information sheet provides information about the research for men at the Bawku West District to make an informed decision of whether to participate in the study or not. It outlines the nature of the research, what the research involves, risks, benefits and compensation.

Title of Study: "Male Involvement in Family Planning: Perspective of Men in the Bawku West District"

Introduction: I am Ruby Rahimatu Sulley a Master of Public Health (MPH) student at the School of Public Health of the University of Ghana, Legon. My email address is ewuraesiamblessed14@gmail.com and my telephone number is 0244920810. I am conducting a research on the topic: Male involvement in Family Planning: Perspective of men in the Bawku West District of the Upper West Region.

Nature of research: This study is a qualitative research study, focusing on male involvement in family planning in the Bawku West District of the Upper East Region of Ghana. I am interested in finding male involvement in family planning in the District and 60 number of men will be consented in this study. The study will take place in this district.

Participants Involvement: I would like to invite you to participate in this study because you are a man who is at least married or cohabiting and have visited this facility. I believe that you can help me by providing the appropriate responses.

Duration /what is involved: A focus group discussion and in depth interview will be conducted for men to obtain information on their understanding on male involvement, sociocultural factors, individual characteristics and health service factors. This information will then be entered into a statistical software for analysis. If you are interested in participating in this study, you can go ahead and fill in a consent form. Well trained research assistance will be around to assist you if you need any clarifications. The discussion and interview will take 50-60minutes and 45minutes-60minutes respectively of your time.

Potential Risks: There would be no anticipated risk or harm from the study however there will be discomfort since some of the questions are sensitive. In view of this, the design of the interview

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guide is well structured to facilitate the discourse. The respondents will be informed about the general nature of the study and assured of no potential harm during the study.

Benefits: Though you may not have any immediate or direct benefits from the study, your responses would be helpful in policy planning and formulation of recommendations to appropriate authorities concerning men support when it comes to the issue of family planning.

Costs: Participation in this study will not cost you any money. You will also not receive any money/incentives for participating in this research.

Compensation: You will not be compensated for your participation and loss of time

Declaration of Conflict of Interest: The researcher has noconflict of interest in this study.

Confidentiality: Your name and identity will not be taken in this study. However, the information you are going to provide will be coded and will be treated strictly confidential. You are assured of total confidentiality to the information you will give. Apart from the researcher and supervisor of this research, no one else will have access to information provided whether in part or whole. Data files would be kept for six months after which they will be destroyed or discarded.

Voluntary participation/withdrawal: Participation is voluntary. You are free to choose if you want to take part in this study. Also, you can withdraw your consent at any time without further explanation, and without any adverse consequences.

Outcome and Feedback: Data gathered will help to improve policy formulation on men involvement in family planning.

Feedback to participant: No feedback will be given to you as an individual but a report will be given to the various stakeholders involved in formulating policies on family planning in Ghana (GHS, MOH just to mention a few).

Funding information: The principal investigator is funding this study.

Sharing of participants Information/Data: Data gathered will be kept in my possession and will not be shared with any other organization(s) or individuals. It will be solely mine.

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Storage of samples: Data files would be kept for six months after which they will be destroyed or discarded. Clearance will be sought from the Ethics Review Committee before it would be used for any other purpose.

Provision of Information and Consent for participants: You will be given copy of the Information sheet and Consent after it has been signed or thumb-printed to keep.

Who to Contact for Further Clarification/Questions: If you have a concern about any aspect of this research, please contact Ruby Rahimatu Sulley at the School of Public Health, Legon or speak to me on telephone number 0244920810. For further clarification on ethical issues please contact Madam Abena Apadu, the administrator at the Ghana Health Service Ethics Review Committee on telephone 0503539896.

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APPENDIX B: CONSENT FORM FOR STUDY PARTICIPANTS

I want to thank you for taking the time to meet with me today. My name is Ruby Ruhaimatu Sulley and I would like to talk to you about your knowledge on male involvement in family planning in the Bawku West District. The interview should take less than an hour. I will be taping the session because I do not want to miss any of your comments. Although I will be taking some notes during the session, I cannot possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don't miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may end the interview at any time.

Are there any questions about what I have just explained? Are you willing to participate in this interview? YES / NO

Interviewee Witness Date ____

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (English, ☐ Twi, ☐ Kusaal ☐). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant………………………….. ID Code ……………………………..

Participants' Signature ………OR Thumb Print………. OR Mark (Please specify)…………

Date:………………………………….

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INTERPRETERS' STATEMENT (where applicable)

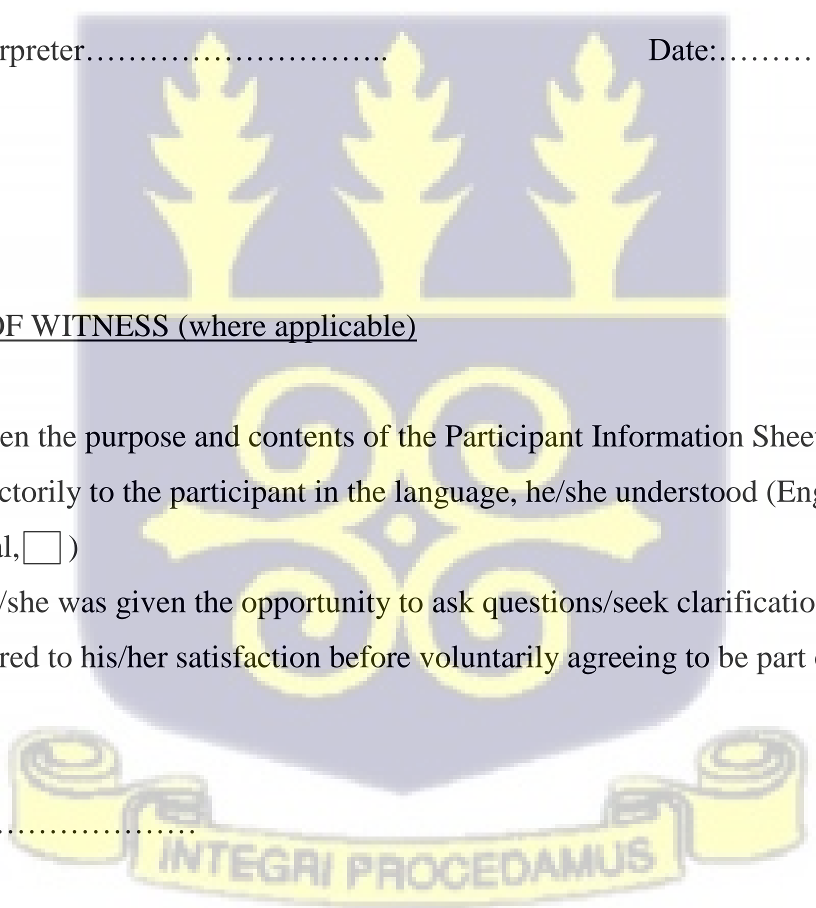
I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (English,☐ Twi, ☐ Kusaal, ☐) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……………………………

Signature of Interpreter……………………….. Date:………………………

Contact Details



STATEMENT OF WITNESS (where applicable)

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language, he/she understood (English, ☐ Twi,☐ Kusaal,☐)
I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name: …………………………

Signature……………. OR Thumb Print ……….... OR Mark (please specify) ………………..

Date: ……………………………

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INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name……………………………………….

Signature ………………………………………………….

Date……………………………………………………….

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APPENDIX C: INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION

1. How old are you?
2. What is your level of education?
3. What is your marital status?
4. Which religion do you belong to?
5. In what way do you think the age of men affect their involvement if family planning activities?
6. How does income level affect family planning services?
7. What is your understanding of the term 'family planning'? In what ways has your understanding of family planning influenced your participation in family planning?
8. To what extent do you think men should involve themselves in family planning services?
9. Can you mention some of the family planning methods that you are aware of and which of these methods would you prefer to undertake?
10. It is believed that having many children in this community is an asset. To what extent does this notion affect men's involvement in family planning activities?
11. Traditional beliefs play a very important role in decision making in this community, explain how this influences your decision to take up a family planning method.
12. Family planning is carried out only in the hospitals, is there any other way you think it should be done?
13. How long do you have to travel before you reach the nearest health facility? And how does this affect your interest in seeking family planning services.
14. Cost of health care is on the rise, is family planning services affordable now? How affordable do you thing family planning services should be?
15. Does the sex of the health care provider affect male involvement in family planning? To what extent does it influence your decision in family activities
16. Are there enough male family planning methods? Do you think there should be wider variety of methods to choose from?
17. Do you get the needed privacy when accessing family planning services and to what extent do you think confidentiality and privacy will influence your decision to involve in family planning activities?

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18. To what extent do you think the attitude of the health care providers can influence male involvement in family planning?

Is there anything more you would like to add? Do we missed something you thing is important or what else should we talk about regarding this topic? I will be analyzing the information you and others gave me in one month. I will be happy to send you a copy to review at that time, if you are interested. Thank you for your time.

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APPENDIX D: INTERVIEW GUIDE FOR IN-DEPTH INTERVIEW

1. How old are you?
2. What is your level of education?
3. What is your marital status?
4. Which religion do you belong to?
5. In what way do you think the age of men affect their involvement if family planning activities?
6. How does income level affect family planning services?
7. What is your understanding of the term 'family planning'? In what ways has your understanding of family planning influenced your participation in family planning?
8. To what extent do you think men should involve themselves in family planning services?
9. Can you mention some of the family planning methods that you are aware of and which of these methods would you prefer to undertake?
10. It is believed that having many children in this community is an asset. To what extent does this notion affect men's involvement in family planning activities?
11. Traditional beliefs play a very important role in decision making in this community, explain how this influences your decision to take up a family planning method.
12. Family planning is carried out only in the hospitals, is there any other way you think it should be done?
13. How long do you have to travel before you reach the nearest health facility? And how does this affect your interest in seeking family planning services.
14. Cost of health care is on the rise, is family planning services affordable now? How affordable do you thing family planning services should be?
15. Does the sex of the health care provider affect male involvement in family planning? To what extent does it influence your decision in family activities
16. Are there enough male family planning methods? Do you think there should be wider variety of methods to choose from?
17. Do you get the needed privacy when accessing family planning services and to what extent do you think confidentiality and privacy will influence your decision to involve in family planning activities?
18. To what extent do you think the attitude of the health care providers can influence male involvement in family planning?

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Is there anything more you would like to add? Do we missed something you thing is important or what else should we talk about regarding this topic? I will be analyzing the information you and others gave me in one month. I will be happy to send you a copy to review at that time, if you are interested.

Thank You for your time

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APPENDIX E: ETHICAL APPROVAL LETTER

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
Tel: +233-302-681109
Fax + 233-302-685424
Mob + 233- 050-3539896
Email: ethics.research@ghsmail.org

MyRef. GHS/RDD/ERC/Admin/App 19/650
Your Ref. No.

21st November, 2019

Ruby Ruhaimatu Sulley
P. O. Box 110
Tamale

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC054/11/19**
Project Title	Male Involvement in Family Planning: Perspective of Men in the Bawku West District
Approval Date	21st November, 2019
Expiry Date	20th November, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

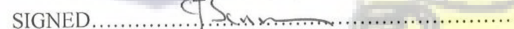
- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...



Dr. Cynthia Bannerman
(GHS-ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra