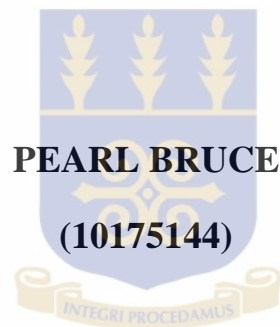


**THE INVOLVEMENT OF MEN IN FAMILY PLANNING:
A CASE OF 37 MILITARY HOSPITAL**

BY



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT
FOR THE AWARD OF MPhil SOCIOLOGY DEGREE**

JUNE 2013

DECLARATION

I hereby declare that this thesis is the result of my own research work, carried out in the Department of Sociology, University of Ghana, under the supervision of Dr. Akosua Darkwah and Professor Clara Fayorsey. All references in this work have been duly acknowledged and all errors found in this work are solely mine

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DEDICATION

This work is dedicated to my daughter Perella, for the many inconveniences she had to go through in the course of my study.

My parents of blessed memory for the love and care they gave that have shaped me into the person I am today.

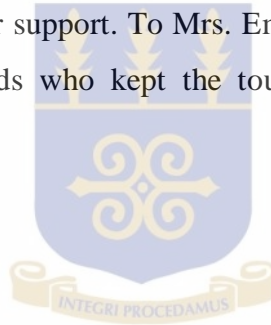


ACKNOWLEDGEMENT

Dr. Akosua Darkwah would forever be in my memory for her time, support, guidance and encouragement during the preparation of this thesis. I am most grateful. I would also like to extend gratitude to Professor Clare Fayorsey for the role she played in this write up.

I would like to send genuine appreciation to the command of 37 Military Hospital, the staff of public health for the friendly atmosphere they created while I carried out the study in their institution. I am also thankful to all those respondents who took time off their busy schedule to complete the questionnaire presented.

My appreciation goes to Mr. E. K. Y. Amegbe who offered valuable advice as he read through this work. I extend special thanks to Miss Cynthia Botchway who solely typed this manuscript. I am thankful to these persons: Mr. Emmanuel Addey, Mr. Reginald Quartey and Mr. Kojo Tawiah Baah-Nuakoh who gave their support. To Mrs. Emily Pinto I say thank you for the role played. Thank you to all my friends who kept the touch burning while I was faced with challenges.



ABSTRACT

Until recently, fertility and family planning research in developing countries, as well as policy and programme formulation, has generally relied on data collected from women. Increasingly, however, attention is being paid to the inclusion of men. Although women bear children and most modern contraceptives are female centered, childbearing has an impact on men's lives too. This impact may be felt financially, if men accept the responsibility of supporting their children, and in a range of other ways, including the health and well-being of their wives and children.

This main aim of the study was to explore involvement of men in family planning programmes. The specific objectives included identifying couples' preferred family size; determining the level of male support to their partners in the use of contraceptives and family planning, investigating the socio-demographic characteristics of men who are involved in family planning and exploring the relationship between preferred family size and male involvement in family planning.

Using both qualitative and quantitative methods, 91 respondents were sampled for the study. The findings of the study suggest that men usually perform supportive roles to their partners instead of using family planning methods themselves. In addition, the preferred family size is influenced by spousal communication even though the men usually had an upper hand in deciding the number of children a couple would have. Involving men and obtaining their support and commitment to family planning is of crucial importance in the African region, given their elevated position in the African society.

TABLE OF CONTENT	Page
Declaration	ii
Dedication	iii
Acknowledgements	iv
Abstract	v
Chapter One: Background to the Study	1
1.0 Introduction and background	1
1.1 Statement of Problem	3
1.2 Objectives of Study	4
1.3 Research Questions	5
1.4 Justification of Study	5
1.5 Research Method	6
1.5.1 Research Design	7
1.5.2 Population	7
1.5.3 Sampling size	7
1.5.4 Sampling procedure	8
1.5.5 Data source	8
1.5.6 Instrument for Data Collection	8
1.5.7 Pre-Test	9
1.5.8 Reliability and Validity of Instrument	9
1.5.9 Data Handling and Analysis	10
1.5.10 Ethical Considerations	10
1.5.11 Limitations of the Study	11

Chapter Two: Literature Review	12
2.0 Introduction	12
2.1 Issues affecting male involvement in family planning	30
2.2 Benefits of family planning	34
2.3 Getting men involved in family planning	35
2.4 Theoretical Framework	37
2.4.1 Power Relations in the Family	37
Chapter Three: Family Planning Policy in Ghana	40
3.0 Introduction	40
3.1 National Population Policy	40
3.2 Family Planning in Ghana	41
3.3 Birth Control Methods	44
3.4.1 Natural Family Planning	44
3.4.2 Calendar Based Method	45
3.4.3 Withdrawal	47
3.5 Barrier Methods of Birth Control	47
3.5.1 Condom	48
3.6 Hormonal Method of Birth Control	50
3.6.1 Oral Contraceptives	50

3.6.2 Depo-Provera	51
3.6.3 Jadelle	52
3.6.4 Intrauterine Device	53
3.7 Sterilization	54
3.8 Conclusion	56
Chapter Four: Data Analysis, Presentation of Findings and	
Discussion of Findings	
4.0 Introduction	57
4.1 Demographic Data	57
4.2 Preferred Family Size	63
4.3 Spousal Communication on family size	64
4.4 Type of contraceptive used by respondents	67
4.5 How respondents got introduced to contraceptives	71
4.6 Male support in contraceptive usage and family planning	72
4.7 Cultural characteristics and family planning	76
4.8 Reasons for engaging in family planning	80
4.9 Conclusion	81

Chapter Five: Summary, Conclusion and Recommendation	82
5.0 Introduction	82
5.1 Conclusion	82
5.2 Recommendation	84
Reference	85
Appendix I: Questionnaire	94
Appendix II: Interview Guide	104

List of Tables		Page
Table 1	Age Distribution of Respondents	58
Table 2	Religious Distribution of Respondents	58
Table 3	Ethnic Distribution of Respondents	61
Table 4	Marital Status Distribution of Respondents	61
Table 5	Educational Level of Respondents	62
Table 6	Educational Level of Partners	62
Table 7	Preferred Family Size	64
Table 8	Preferred Family Size and Spousal Communication	66
Table 9	Types of Contraceptive ever used by respondents/partners	68
Table 10	Types of Contraceptives currently being used by respondents	70
Table 11	Duration of Contraceptive usage	70
Table 12	Introduction to Family Planning	71
Table 13	Frequency of partners accompanying respondents to the family planning clinic	73

Table 14	Reasons for partner accompanying respondents	74
Table 15	Payment of Family Planning Services	74
Table 16	Male support in contraceptive replacement	75
Table 17	Cultural Characteristics	78
Table 18	Reasons for Utilising Family Planning	80

List of Figures	Page
Figure 1: Excerpts from the 1994 National Population Policy	40
Figure 2: Excerpts from the 1996 National Reproductive Health Service Policy and Standard by the Ministry of Health	43
Figure 3: Cycle beads	46
Figure 4: Male and Female Condoms	49
Figure 5: Oral Contraceptive	51
Figure 6: Depo-Provera	52
Figure 7: Jadelle	53
Figure 8: Intrauterine Device	54
Figure 9: Tubal Ligation	55
Figure 10: Vasectomy	56

CHAPTER ONE

1.0 Introduction and Background

Until recently, fertility and family planning research in developing countries, as well as policy and program formulation, have generally relied on data collected from women. Increasingly, however, attention is being paid to the inclusion of men. The reasons for the new interest in men are not hard to find. First, information that has become available from surveys conducted over the past decade suggests that men and women do not necessarily have similar fertility attitudes and goals (Ezeh, 1993; Bankole, 1995). Second, the scope of fertility and family planning research has expanded to include such broader reproductive health issues as sexually transmitted diseases, on which data from both men and women are needed (Degraff and de Silva, 1996).

Although women bear children and most modern contraceptives are female centred, childbearing has an impact on the lives of men too. This impact may be felt financially, if men accept the responsibility of supporting their children, and in a range of other ways, including the health and well-being of their wives and children. Often, a man's social status is also affected when he becomes a father (Frank and McNicoll, 1987).

The male partner may play an important role in decision-making regarding contraceptive use and the number of children they would like to have. In some countries or among some social groups, according to Lasee and Becker (1997), the male partner has greater influence than his spouse. In Ghana, the wife's attitude toward contraception is strongly influenced by her husband's attitude and background characteristics, especially education, but the husband's views are not similarly influenced by his wife (Ezeh, 1993).

On the other hand, the perception that men will necessarily have more influence on reproductive decisions because they typically control the family's assets, and are accepted as the household head and are older, may be an exaggeration. The actual situation is likely to depend on other factors which vary over time and by location. For instance, among the Yoruba of Nigeria, the fertility desires of both marriage partners are important predictors of the couple's fertility. However, whereas the husband's desire is dominant in predicting the couple's behaviour when the number of living children is small, the wife's desire becomes more important as the number of children grows (Bankole, 1995). In Taiwan, when spouses disagree over whether to have another child, the wife tends to prevail (Coombs and Chang, 1981).

Efforts to promote family planning in developing countries have often been criticized for their exclusion of men. The consequence of the female-only approach has been that some men view family planning with suspicion, regarding it as being aimed at undermining their authority in the family. For instance, men in Nigeria typically believe that contraception makes it easy for their wives to engage in extra-marital sexual relationships (Bankole, 1994). While men's attitudes toward family planning are generally positive, some studies show that men believe that they should be in control if or when a couple should use contraceptives (Mbizvo and Adamchak, 1991; Mustafa and Mumford, 1984).

Failure to involve men in family planning programs can have serious implications. Even when women are educated and motivated to practise contraception, they may not do so because of opposition from their husbands. Individuals interviewed in urban Sudan believed that the male partner decides if a couple will use contraceptives and, if they do, choose the method (Khalifa, 1988).

The important role of men in reproductive decision-making and its effect on contraceptive use as well as behaviour of couples has been increasingly recognised as subject of interest in the global context (Bankole and Sing, 1993; Omandi-Odhiambo, 1997; Karra et al., 1997). The ICPD-POA (1) and the 1995 Beijing Conference on Women and Reproductive Health reaffirmed the importance of responsible parenthood and the need to include men in family planning and reproductive health programmes and actions (Piet-Pelon et al., 1999; U.N, 1994).

It is widely accepted that family planning services are essential to fertility decline. The proximate determinant of ongoing fertility decline in the developing world has been the widespread adoption of contraception. Previous studies have shown that the availability and accessibility of family planning services is an important determinant of contraceptive use (Tsui and Ochoa, 1992). In Vietnam, the ease of obtaining contraceptives has been shown to be an important factor in the success of family planning programs (U.N, 1997).

1.1 Statement of Problem

The Ministry of Health, with the assistance from John Hopkins University in 1997 launched educational campaign programmes in all the regions of Ghana focusing on male involvement in family planning. The post-campaign findings indicated a significant increase in men's family planning knowledge and practice. The issue now is how to move them beyond mere increased knowledge to changed attitudes and increased practice. Even though family planning awareness is high, its uptake is as low as 15% in 2004 (GDHS, 2006). There are barriers that may impede male involvement in family planning such as poverty, unemployment, religion, cultural and societal norms and education (Engle, 2000). Men may be deeply and psychologically involved in family planning but these barriers may not allow them to demonstrate their involvement.

Inadequate male involvement in family planning has been identified as the major factor affecting family planning acceptance in Africa in general (Nukunya, 1992). Despite a reported appreciable knowledge in family planning nationwide, in some areas, male involvement is not encouraging and a barrier to even females' acceptance and practice of family planning (GSS, 1998). The study therefore seeks to ascertain why male involvement, approval and practice of family planning are low and how men can move from the high level of knowledge and awareness to a high level of support for and practice of family planning.

1.2 Objectives of the Study

The general objective of this study is to explore the involvement of men in family planning programmes.

In pursuance of this, the study would be guided by the following specific objectives:

- a) To identify couples' preferred family size.
- b) To determine the level of male support to their partners in the use of contraceptives and family planning.
- c) To investigate the socio-demographic characteristics of men who are involved in family planning.
- d) To explore the relationship between preferred family size and male involvement in family planning.

1.3 Research Questions

In order to arrive at any reasonable and meaningful conclusion, the following research questions would be useful.

1. What are the demographic characteristics of men involved in family planning?
2. What is the level of the involvement of men in family planning procedures?
3. What relationship does the preferred family size of a couple have with the involvement of men in family planning procedures?

1.4 Justification of the Study

In sub-Saharan Africa, family planning and reproductive health care research and interventions place a disproportionate emphasis on women and largely ignore the role of men (Mbizvo and Adamchak, 1991; Fakeye and Babaniyi, 1989; Odhiambo, 1992; Ringheim, 1993). As a result, male participation in family planning and reproductive health has been low (WHO, 1995).

Men in Africa, who are heads of their households, are often key figures in domestic decision making, particularly about fertility behaviour and preferences (Isiugo-Abanihe 1994), and that authority is supported by tradition. They are also the main link between the family and the prevailing culture and are the major players in bringing development to the home. Fapohunda and Todaro (1988) observed that African family structure shapes spousal perceptions of fertility and that, men and women do not necessarily have the same views about family planning and reproduction because their interests are shaped by expectations which are determined by the social structure of their households and community. Therefore, the failure to include men in

reproductive research could reduce coverage, bias findings, and undermine applicability of findings for policy and programmes.

Indeed, an understanding of men's perspectives on family planning and reproductive health could provide more insights than are possible by studying women because men have more power than women in reproductive decision making, including the number of children and whether or not to use family planning. As such, their views need more careful and systematic analysis (see also Isiugo-Abanihe, 1994), especially since those views are important determinants of women's reproductive attitude and behaviour (Rutenberg and Watkins, 1997; Ezeh, 1993; Renne, 1993). Additionally, men dominate decisions and policies in the public domain. Therefore, an understanding of their reproductive perspectives could identify programme interventions to promote the use of services by men both as family planning clients and as partners to women clients and this, in turn, would influence family planning and reproductive health policies.

1.5 Research Method

The techniques employed and the ways they are applied in conducting any research, can considerably affect the result of a study. Therefore, a judicious choice of research method and how these methods are used can simplify and facilitate the collection and analysis of data Kumekpor (2002). It is therefore imperative that reliable methods are devised to obtain information in such a way as to make the results tenable, dependable and predictive. This section describes the sources of data and the methods employed to gather data. Description of the procedures used in collecting data will enable readers of this study appreciate the particular strengths and limitations of the study.

1.5.1 Research Design

The research design for this study was based on a survey. The survey research makes it possible for researchers to collect information about target audience without having to deal with the entire population. Surveys also allow a small proportion of the sample to be selected and findings generalized to the larger group. This makes the research less expensive but still efficient. The data presented however, is descriptive in nature.

1.5.2 Population

The population for this study consisted of all couples and individuals who access family planning facilities and service providers of health facilities who provide family planning services. However, this study was limited to only couples and individuals who access family planning services and a service provider of health facilities who provide family planning services at the 37 Military Hospital.

1.5.3 Sampling Size

A total of ninety-one (91) respondents were used for this study. Ninety of these respondents were individuals who access family planning facilities whereas one was a service provider of the health facility which provide family planning services at the 37 Military Hospital. The ninety respondents were given questionnaires to fill whereas the one service provider was engaged in an in-depth interview. This sample size was chosen due to financial constraints and because of the fact that the researcher was not able to hire assistants to help in the collection of data. The researcher was also faced with time limitation since the work was to be undertaken within a specific period. Therefore using a large sample size meant that the work would not be completed within the specific time frame.

1.5.4 Sampling Procedure

The selection of respondents was done using a combination of probability and non probability sampling methods. This method is the simple random sampling and purposive sampling. These two sampling methods were used to select respondents from the health facility. Care was however taken to avoid double representation of the sample. The simple random and purposive sampling methods were used to select respondents, who use the family planning facility at the study area. Some of the respondents, who were purposively selected because of their visits to the medical facility and their use of family planning procedures, refused to take part in the research half way through the questionnaires.

1.5.5 Data Source

Data were collected from both primary and secondary sources. According to Kumekpor (2002), secondary data is information that has been gathered previously for some purpose other than the current research project. The secondary data for this study was sourced from the internet, textbooks, news print and articles in journals. The primary data are for a specific purpose or for a specific research study. The primary data was collected from respondents from the field of study.

1.5.6 Instrument for Data Collection

Questionnaires were used to collect data from respondents. This instrument was chosen due to the fact that it is easy to administer and also makes it possible for much data to be collected within a short time. According to Kumekpor (2002), questionnaires organise the project and give it direction and coherence; they delimit the project showing its boundaries, keep the researcher focused during the project and point to the data that will be needed. Questionnaires are very easy to use, score and code for analysis on a computer. The questionnaire was made up of both open

and close-ended questions. The open-ended questions were to make room for respondents to express their opinion on some of the issues stated in the questionnaire. The questionnaire was organised into four sections; some were self-administered by those respondents who could read and write, while the researcher assisted those respondents who could not. Despite the fact that the researcher's bias may come to play in the line of questioning, utmost care was taken to avoid the situation where the researcher influenced the type of responses that were provided by the respondents.

1.5.7 Pre-Test

The questionnaire was pre-tested on 10 patients of the 37 Military Hospital. The purpose of the pre-test was to remove ambiguities, and unnecessary items in the questionnaire. Pilot testing of the questionnaire helped to unearth the face and content validity and reliability of the questions in measuring what it was intended for the questionnaire was then amended accordingly for use in the field. The refining of the items in the questionnaire was also intended to make the items very simple for the respondents to understand so that they could provide the appropriate response to the items. The pre-test also gave a fair idea of the responses to be obtained from the field.

1.5.8 Reliability and Validity of Instrument

The researcher ensured that the instrument developed was reliable. The result of the pre-test conducted aided in ascertaining the dependability and the consistency of the items in the questionnaire.

1.5.9 Data Handling and Analysis:

The data handling exercise started with field editing to check the appropriateness, consistency and accuracy of the information provided by respondents. This exercise made it possible to contact some respondents afresh, when it became necessary for clarification of certain issues and some also to complete certain questions that they left unanswered. Serial numbers were then assigned to the individual edited questionnaires for the purpose of easy identification during the coding process and rechecking of information on the questionnaire during the data entering exercise. The open-ended questions were extracted, after which they were coded. The computer software Statistical Package for the Social Sciences (SPSS) was used to analyze the data. This is because SPSS is the most widely used statistical Software in the Social Sciences. This package provides users with substantial increase in the ease and flexibility with which they can approach their day-to-day use of the computer to generate frequencies and percentages for easy interpretation. Frequency tables were used in the analysis and interpretation of the data.

1.5.10 Ethical Considerations

Ethical issues confront every researcher who embarks on a study involving humans as subjects. Some general agreements have been shared by researchers about what is proper and improper in the conduct of scientific inquiry. The most important ethical considerations that prevail in social research include, harm to participants, voluntary participation, anonymity and confidentiality and deception. I dealt with these concerns in the course of data collection. Firstly, I ensured that no participant was harmed through the revelation of information that would embarrass him/her. Secondly, the respondents were adequately educated about what was being investigated and thus enhance the chances of their participation. They were particularly informed about how the questions in the questionnaire will intrude into their sexual lives and for that reason they have

every right to refuse to participate in the research or discontinue participation when they feel uncomfortable about the kind of questions asked. Further, I assured the respondents of their complete anonymity and confidentiality. This would be achieved by concealing their true identities through the use of code words to represent their names. Finally, I convinced my respondents that I was pursuing a genuine intellectual exercise devoid of any deception by showing them a letter from the head of my department and my student's identity card. By the above method the researcher ensured her neutrality and objectivity so that the findings are representative views of the respondents.

1.5.11 Limitation of the study

Since all the respondents were females, it was statistically impossible to conduct any of the sophisticated statistical tests to test for hypothesis to support the claim of male involvement in family planning even though the descriptive statistics (frequency tables) show that. There is, therefore, a limitation in the extent to which the findings represent the population.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Family planning is a deliberate effort by couples to regulate the number of children and spacing of births. It aims at improving family life at the micro level and contributing to sustainable development at the macro level. This is through fertility decline among other mechanisms. However, variables such as education, religion, socio – economic as well as cultural factors affect the effectiveness of family planning programmes. One factor that deserves attention is the involvement of males in family planning. Male involvement in family planning means more than increasing the number of men using condoms and having vasectomies; it also includes the number of men who encourage and support their partners in contraception and encourage peers to use family planning and who influence the policy environment to be more conducive to developing male related programmes. In this context, male involvement should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group, which has the effect of increasing the acceptability and prevalence of family planning practice of either sex (Toure, 1996).

Conducting a social research such as this one requires that one reads through works done by authorities, relevant documents and publications to gain more insight into the problem under study since works done previously might shed more light on the subject. Thus, in the ongoing study, literature is reviewed on various issues relating to the topic. These include the state of family planning across the globe. Also reviewed are the factors that were responsible for male involvement, knowledge, attitudes, perceptions and practice of family planning, partner support and achievements so far and the way forward in increasing male participation.

There has been considerable initiative in various forms to involve males in family planning programmes in Africa. Programmes to encourage men's involvement in family planning are now gradually gaining prominence due to interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using the mass media, interventions to increase access and use of family planning services by men such as community based distribution condom sales and promoting work place programs, and a few male clinic and vasectomy services. Some of the field experiences have shown that well – targeted focused male involvement programmes can have an impact on both male and female behaviours related to reproductive health.

There have been several decades of neglect of male role in family planning dating back to the 1960s with the development of modern contraceptive methods for women. One of the reasons why family planning programmes in the past focused on women instead of men was the assumption by many providers that women have the greatest stake and interest in protecting their own reproductive health (Toure, 1996). But growing numbers of family planning research are facing challenges on the isolated focus on the woman and are focusing on the influence of her male partner in protecting women reproductive health. This is especially true in sub Saharan Africa where men influence decision making in many ways (Ezeh, 1992; 1997; MARRIDA and Ulla, 2004).

Recently, family planning programmes and providers have seen that involving men in addition to women in family planning results in an improved programme effectiveness. The 1994 International Conference on Population and Development also encouraged family planning programmes and providers to consider both men and women jointly. This new interest in men is

based on the consideration that although most reproductive health burdens are borne by the women, the majority of the decisions that affect both women and men reproductive health are made by men or by men and women jointly. And also if men are involved they may be a potential partner as well as advocates for good reproductive health rather than bystanders, barriers, or adversaries (Toure, 1996; Terefe and Larson, 1993).

In some regions, the achieved impact of family planning is attributed to both male and female factors. For example, a study in Tanzania showed that the fertility decline in the Pare community was attributed to the high education of the man and the wife. The effect of wife's education was stronger. The same study showed that the younger the husband and the higher the educational levels of both husband and wife, the more positive the determinants for fertility regulation (Marrida and Ulla, 2004).

In September 1987, the Health Education Division of Ghana's Ministry of Health (MOH / HED) began a systematic family planning IEC project, with funding from USAID and technical assistance from John Hopkins University. Drama, a theme song, community audiovisual material, and community activities formed part of the first phase. The second phase of the project highlighted male involvement in family planning. The goals of the first phase of the project were to increase knowledge of and improve attitude towards, family planning and promote contraceptive use among men and women of reproductive age, enhance family planning, counselling skills among MOH service providers, and strengthen the MOH's ability to develop, implement, monitor, and evaluate communication programs on health.

November 1991 study of the project found that almost all males surveyed in six regions had seen or heard of at least one IEC family planning campaign medium. In the Ashanti, BrongAhafo and Central regions, where intensive campaign run, more men were reached than in other

regions. Findings indicate a significant increase in men's family planning knowledge, practice and improvement in attitude with the increasing length of the project. Also, among those men exposed to the intensive campaign, 47 percent had discussed family planning with their partners and 26 percent stated that their partners were using modern contraceptive method (Kim, Kumah and Piotrow, 1992) The project used situational analysis, service provider training, and IEC material development and mobilization for two campaigns in three regions before expanding the campaign to remaining areas. The project used a wide variety of IEC material, media and activities, including leaflets and booklets, motivational posters, national radio and television to broadcast modern contraceptive method (Kim et al., 1992).

The concept of male involvement in family planning is broad in nature. The programme of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 emphasised that special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; pre-natal, maternal and child health prevention of sexually transmitted Diseases (STD's); and prevention of unwanted and high risk pregnancies. Use of male methods is one important aspect of male involvement in family planning. Historically, the traditional method of withdrawal (coitus interruptus) has been used as a contraceptive method since biblical times (PAI, 1991).

The use of condom dates back 400years ago (Ross and Frankenberg, 1993). Despite the pioneering role played by the age-old male methods in the evolution of family planning, the present contribution of male methods (traditional and modern) to the total contraceptive prevalence rate is strikingly low. Worldwide, one-third of the eligible couples using family

planning rely on methods (Vasectomy, Condom, Withdrawal and periodic Abstinence) which require full male co-operation, and in the developing countries in the period 1970s and early 1980s, about one-fourth of those who use the contraceptives relied on male methods (Population Report, 1986).

Since the 1990s, although there has been overall increase in the level of contraceptive prevalence, low use of male methods is likely to remain static in most of the developing countries, so that men and women do not necessarily have similar fertility attitudes and goals (Ezech 1993; Bankole, 1995). According to Awuni et al (2005) the low level of practice of family planning among the people is due to inadequate spousal communication. Other social factors that deter male involvement among the people of Amasaman include the belief, among others that if a woman uses contraceptive she will become promiscuous (Awuni et al, 2005). Many men also think that contraception is a woman's business and therefore men need not be involved.

Focus group discussion findings from Amasaman, Obom and Weija, according to Touré (1996), all revealed that it is culturally acceptable for one to have a large family. Economic factors include use of children as labour for agriculture. An equally important reason is inadequate concern of men's reproductive health needs. In Ghana no effective measures have been adopted in the national family planning programmes to emphasise men's shared responsibility and promote their sexual and reproductive behaviour, including family planning (Touré, 1996). It is noticed that men often have a poor understanding of their reproductive health because they are approached with a female focused family planning programme (Touré, 1996). For example, the sexual disease (i.e. sexually transmitted infections- STI's) is normally not stressed in national

programs. There is also lack of information on responsible sexual behaviour for the adolescents and the youth. Provider bias does affect male services.

A UNFPA report on male involvement observed that most reproductive health and family planning service delivery systems are almost entirely oriented toward women and provide little or no information about male contraceptive methods (UNFPA, 1997). Health workers are sometimes poorly trained in counselling men about safer sexual practices and male methods and may communicate negative rumours about them (Green et al., 1995) Many family planning programmes have now recognised that involving men and obtaining their support and commitments in family planning programmes is of crucial importance because most decisions affecting family and political life are made by men. Men hold positions of leadership and influence from the family unit right through national level. Their involvement in family planning matters would therefore not only ease the responsibility borne by women in terms of decision making but would also accelerate the understanding and practice of family planning in general.

Many men are poorly informed regarding sexuality and reproduction and need guidance on how to share decision-making and negotiate on how to make choices with their partners. In the recent national DHS surveys in 15 countries (most in sub-Saharan Africa), three of four married men recognised at least one modern method of contraception. The pill was the most recognised method, followed by the condom and female sterilisation. Except in a few countries, most men had not heard of vasectomy (Akinrinola and Sasheela, 1998;UNFPA, 1995).

Approximately one-third of women surveyed in developing countries reported that they are using a contraceptive method involving male participation or co-operation. About 5 percent of married couples in the developing world rely on vasectomy for pregnancy prevention, and an equivalent

proportion relies on condoms. Usage of these two methods is highest in Asia. Periodic abstinence and withdrawal are not widely used in most developing countries. About 10% of Kenyan married couples are using a method that requires male participation, such as condom, periodic abstinence, withdrawal or vasectomy (Akinrinola and Sasheela, 1998; Toure, 1996).

Women are either under collective decision making with their husbands or completely rely on the husbands' decision on issues that affect their reproductive life. Earlier studies found out that most women are forced to have more children by their male partner. In some other cases, women reported the need for husbands' permission for practising family planning; some are unable to use family planning service due to opposition by their husbands (Ezeh, 1997; Berhane et al., 1999).

It is also noted that programmers have ignored the roles of men in the past, focusing only on women's behaviour and reproductive needs. However, since the 1994 International Conference on Population and Development (ICPD), interest in men's involvement in reproductive health has increased. Unfortunately, data on their knowledge and use of contraception are generally scanty. Findings from Ondo State, Nigeria revealed that men's level of contraceptive knowledge is high in the study areas. About 90% knew at least one method of family planning (Ross, Stover and Willard, 1999).

Furthermore, the level of contraceptive use among married men is such that men could participate in family planning activities if there were adequate programmes to involve them. Men in the sample areas were found not only to support their spouses' use of contraceptives, but were actually using condoms to delay or prevent pregnancy. Despite the fact that women have positive attitudes towards family planning and have also more exposure to the family planning messages, the current prevalence rate of the female methods is still very low. The reasons for not currently

using family planning by married women and also their unwillingness to use in the future can be attributed to a number of factors.

In 1999-2000 a study was conducted in Bangladesh to unearth the reasons for non contraceptive use by women. Reasons for non-use of contraception among the currently married women show that in fecundity (either “menopausal” had hysterectomy or sub fecund) is mentioned by the non-contraception women (44 percent) as the primary reason of non-use followed closely by infrequent sex relations/not having sex and fatalistic attitudes (9 percent) (Hoque, Nazrul and Murdock, 1997). The reasons for non-use however, differ considerably by age of women. One of such reasons for the non-use of contraceptives is unfavourable attitude toward family planning (24 percent) either by women themselves or by their husband. In addition, fatalistic attitudes (20 percent) and religion (9 percent) are the major reasons for the women below 30 years of age (53 percent). Older women (above 30 years of age), on the other hand, normally report reasons such as infertility (including menopausal) or having no sex/infrequent sexual relations (68 percent combined) (Hoque et al, 1997).

There are however, some significant differences in reasons for non-use between married women and men. More men (11 percent) than women (4 percent) mentioned that they oppose family planning. Men are also less likely to cite reasons such as infrequent sex / having no sex (8 percent) whereas more women cited these reasons (16 percent). Religious prohibition, as the reason of non-use, varies little between men and women. Another reason is that most women in Ghana according to Kim et al(1992) want more children because of the socio-economic reasons attached to having more children; hence the use of contraceptive is seen as a hindrance. Again, women who do not have children are often branded witches in their old age.

Hoque et al (1997) argues that the lack of desired communication between spouses about family planning may also be a serious barrier to contraceptive use. In most recent years (1999-2000) over half (52 percent) of the currently married women said they had not discussed with their husbands about family planning. Of the remaining, while 40 percent had discussed it twice or less, only 8 percent had discussed it more than twice. Inter-spousal communication about family planning was less frequent among the very young women (10-14) and the older women. Spousal communication according to GWDS (2000) a discouraging low proportion of wives talk to their husbands about family planning and any other issue relating to reproductive health.

Men who have opposed FP have reported a variety of reasons, including fear that it will undermine their authority as head of the family, concern that their wives will be unfaithful, assumptions that it is against their religious teachings, worry about contraceptive side effects, erroneous beliefs about physiology and the mode of action of contraceptives and a desire to prove their fertility. Research conducted in Nigeria revealed socio-cultural factors accounting for the differences between men's and women's preferences with respect to fertility. The motivation of Nigerian men to have many children is related to the value and benefits of children (Toure, 1996). In Ethiopia, although the ideal number of children preferred by men is higher than women, large family sizes are currently not needed by couples as described by a study in a remote community of south Ethiopia. The same study showed that women are forced to have more children by their male partners (Berhane et al, 1999).

Major factors believed to affect the attitude of Ghanaians towards family planning and contraceptive use are the socio economic well being of the people, religious and traditionally held values and beliefs and lastly lack of correct information about the side effects of modern contraceptives. Many Ghanaian women, those who practise family planning and those who do

not, have realized the need to limit the size in order to improve upon the economic well-being of the family.

Communication between partners is a key factor in joint decision-making and contraceptive use. Talking with one's partner about reproductive and contraceptive decisions making is likely to increase understanding and help support one's partner's decision. According to the Demographic and Health Survey data in West Africa, about three quarters of the men and women had not discussed family planning with their partners in the year preceding the survey. In Tanzania, 45 percent of married women did not know what their husbands thought about FP or thought their husbands disapproved of family planning, when in fact many of the husbands approved (Toure, 1996; Ezeh et al., 1996).

In line with the above, a study in Tigray region revealed that the frequency of discussion between partners and contraceptive utilization by the couples are positively associated.

But by the same study, more than a third of the couples had no discussion on these issues (Gebrekidan, 2002). The Ethiopian Demographic and Health Survey (DHS) 2000 also showed that there are minimal couple discussions on matters related to family planning. For example, 67% of women who know at least one method of contraception had not discussed issues of family planning with their husbands in the twelve months prior to the DHS, and one third of the women reported that they didn't know about their husbands' attitude towards family planning (Central Statistical Authority, 2001). Spousal communication is only one element of support to one's partner choices of preference. Other indicators of the extent of men's support to women's choices include: Male views of gender roles; whether husbands report using family planning with their wives; and whether men are engaged in monogamous relationships (UNFPA, 1995).

Family planning programme planners tend to assume that men are opposed to family planning and will, if involved in reproductive decision making, prevent women from regulating their fertility. Available data, however, suggest that the most successful family planning programs target men as well as women and promote communications about contraception between spouses (Toure, 1996; Terefe and Larson 1993; Kaba, 2000).

Involving men in family planning could increase contraceptive prevalence in several ways: By providing alternatives to couples dissatisfied with their current method; by increasing male contraceptive use; by promoting greater discussion between sexual partners; and by changing male attitudes regarding contraception. A study in Ethiopia found that couple, in which the husband participated in discussions during home visits, were more likely to initiate and maintain contraceptive use (Terefe and Larson, 1993).

A study that examined fertility decision- making and observed decline in fertility across five generations of one middle class family in South, India indicated that fertility level dropped during the period of greatest male involvement in reproductive decision making. Such male involvement has resulted in fertility decline and long-term benefits for women. Individual motivation rather than choice of methods was more important for positive male participation in the family planning (Kaba, 2000).

Rogers (1973) in his article, “communication strategies for family planning”, makes a distinction between family planning, communication and other forms of communications that family planning and fertility behaviour deal with beliefs and values that are very independent of individuals. A decision on family planning affects his manhood, his sex life, his family and religion. Religions and traditionally held beliefs are of utmost concern to the people of Ghana as

a whole. They do also realize the importance and need for family planning in contemporary times but nevertheless, to them, the ideal number of children a family should have is six, eight or more.

On the issue of use, inadequate information and the spread of rumours have affected many women's attitude towards adopting modern family planning methods. There are mild effects experienced with the use of contraceptives but these are not serious and are usually short lived. However, these have been so grossly exaggerated to the extent that, a lot of women are sceptical in using modern contraceptives. Furthermore, many diseases which afflict people with age, especially beyond 45years are associated with the pill. If a victim of any of these diseases (hypertension, diabetes, cancer etc) happens to be a woman and happened to be a pill user at one time or the other, it is blamed on the pill.

In a survey conducted by Roger (1973), a respondent referred to a 43year old neighbour who had a swollen stomach that it was because she had been taking the pill. In a related development, participants reported having heard about side effects from friends but none of them knew of any case that had been confirmed medically. A lady who had the IUD inserted for her in a competent Health care facility got pregnant whilst wearing the IUD. She believed that the device got lost or swallowed up in her body. These side effects are of great concern to women because they view them as serious health hazards. Even the reduction in menstrual flow, experienced with the use of the pill is perceived as a serious abnormality. In reference to the proper mix for family planning communication campaign, Opia-Mensah stated that "an important interpersonal component is essential to counteract the rumours and counter campaigns which family planning invariably provoke".

Several research works such as Ezeh (1992) and Toure (1996) revealed that the paramedical staffs who are actively engaged in the information on education of family planning among the local population are by and large consciously or unconsciously responsible for the misinformation flow. Another characteristic which distinguishes family planning communication as noted by Rogers (1973) is that family planning decisions are collective decisions rather than individual decisions, couples are involved in the discussions and deliberations in family planning issues.

Unfortunately, findings from both survey (analysis of the questionnaires administered) and Focus Group Discussions did not confirm this. Among users of contraceptive, it was only those who were users of foaming tablet who said the decisions had been taken jointly with their husbands and partners. For the rest of the female respondents, the decisions had been solely theirs and almost all of them have been using contraceptive for more than a year without their husband's knowledge. This means that women who do not want their spouses to detect that they are practising family planning would have to practise it undercover to avoid being attacked by their husbands if they should find out later.

The husband's support is found to be a good predictor of future practice and continued use. There are studies done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984). In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (Population Reports, 1994).

In Madagascar, Norplant continuation rates were higher after one year among couples in which the husband had been involved in the decision-making process, and among these couples both wives and husbands were more satisfied with Norplant than those in which only the wife was counselled (Tapsoba et al., 1993). Spousal communication is positively associated with contraceptive use: DHS data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) show that the percentage of women using modern contraceptives is consistently higher in the group that had discussed Family Planning with their husbands in the year before the interview than in the group that had not (JHU/PIP, 1994).

Because of lack of communication, many women do not know what their husbands think about Family Planning. Many women think that their husbands disapprove of Family Planning, when in fact the husband approves. In West Africa, about three quarters of the men and women had not discussed family planning with their spouse in the year preceding the survey, except in Ghana and Cameroon where the proportions were about one-half and two-thirds respectively. In East Africa, the figure is less than 40 percent, except in Burundi and Tanzania (Ezeh et al., 1996). In Burundi, 94 percent of men surveyed approved of contraceptive use, but only 48 percent had discussed it with their wives in the preceding year (Population Reports, 1994).

According to a 1993 DHS survey, 45 percent of married women in Tanzania either did not know what their husbands thought about Family Planning or thought their husbands disapproved of family planning, when in fact many of the husbands approved. Men's lack of access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most Family Planning clinics cater for women, so men are uncomfortable about going to these clinics (Wambui, 1995). This confirms the assumption that no matter how many men want to know about and utilize

contraception, most family-planning programmes have not yet given adequate attention to serving them. There are some examples of experience and initiatives in various forms which illustrate a genuine concern and creative approach toward achieving greater male involvement in family planning in Africa. Programmes to encourage men's involvement in family planning are expanding, especially through interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using mass media, and interventions to increase access and use of Family Planning services by men such as community-based distribution, condom sales and promotion, workplace programs, and a few male clinics and vasectomy services. Some of the field experiences have shown that well targeted and focused male-involvement programs can have an impact on both male and female behaviour related to reproductive health.

On the issue of use, inadequate information and the spread of rumours have affected many women's attitude towards adopting modern planning methods. There are mild effects experienced with the use of contraceptives but these are not that serious and are usually short lived, but these have been so grossly exaggerated to the extent that, a lot of women are sceptical in using modern contraceptives. Furthermore, many diseases which afflict people with age, especially beyond 45years are associated with the pill. If a victim of any of these diseases (hypertension, diabetes, cancer etc) happens to be a woman and happened to have been pill user at one time or the other, it is blamed on the pill.

Among contraceptive users, some husbands are concerned with family size (for economic, child welfare, and health reasons) and encourage their wives to seek information about the use of modern contraceptives. A discrepancy in attitudes exists between spouses: men's positive attitude toward modern contraception contrasts with women's traditional desire for a large family.

Villagers do not use modern contraceptives because of barriers created by FP services that do not take into account the lifestyle of these people (e.g. language, work hours, respect for privacy), disturbing and poorly explained side-effects, especially of pills and injected Depo-Provera, insufficient knowledge of human physiology, contraception failures due to inappropriate use (often because of poor explanations by health post staff), comments from dissatisfied users, and women's reliance on their reproductive role for self-esteem. Globally, men have not shared equally with women the responsibility for fertility regulation. While family planning efforts have been directed almost exclusively toward women, the lack of male involvement may also reflect the limited options available to men. Current methods for men are either coitus-dependent, such as the condom or withdrawal, or permanent, such as vasectomy.

The 20-year history of social science research on male contraceptive methods is examined here in terms of the human and method factors related to the acceptability of hypothetical methods and the prevalence of use of existing methods. The introduction of new safe and improved male methods will ultimately lead to an increase in contraceptive use (Ringheim 1993 Leriden 1986 and UNFPA) This view was also expressed by some group of men in the Obom sub-district of the Ga south district in Ghana, where they claimed condom use interrupts sexual satisfaction and that they would be more inclined to use other contraceptive methods if there were new male methods like the pills, injectables etc, just as their female counterparts are privileged to have.

Research opportunities in the areas of gender, decision-making, communication, health education, and service delivery will be enhanced when methods for women and men are comparable. In the 1988 Ghana Demographic and Health Survey, respondents' approval of

family planning emerged as the most important predictor of current contraceptive use, followed by discussion of family planning with partner and level of education.

Male participation in family planning is seriously hindered by paucity of a desired number of modern male methods of contraception. In addition message about the use of “Natural” methods is conveyed in the national Family Planning program. At the field level efforts directed towards motivating the large population in rural areas to use male methods (i.e. Condom and Vasectomy) are discouragingly low. More importantly, the special role of condom use to check the transmission of infection of HIV virus causing AIDS is not explained at all to the vast rural masses, who have little knowledge of the targeted disease. All these imply that targeting men actively in family planning should be given proper attention in the national family programme. There is now a realization of the growing importance of male participation in family planning which emerges from the fact that the females now shoulder largely the contraceptive burden. To ease the burden, men should therefore, play a greater role in contraceptive use as a joint and equal responsibility.

A high level of contraceptive prevalence in most of the developing countries can be achieved through increased involvement of men in family planning. For example, the practice of male contraceptives is about half of the current contraceptive rate in Turkey. In addition, practising family planning by males is now well recognised to have important implications on needs of couples. For example, use of male methods (condom) may relieve women of various health risks posed by their prolonged use of oral contraceptives (Stokes, 1980). Despite the recognition that condom can serve as a means of contraception; their primary association is with sexually transmitted diseases (STD's) prevention. Moreover, the most effective technology against the spread of HIV/AIDS is still the condom.

Also, on the grounds of gender equality, responsibility for birth control should be shouldered by men and women alike. It is therefore emphasised that further increases in the existing level of contraceptive prevalence must come progressively from use of methods, which require male participation. The ultimate success of family planning based on total family welfare rests on maintaining a balance in the choice of mix of the gender oriented 27 contraceptives. In the developed countries high contraceptive prevalence rate demonstrates (though not always) the compliance of equity in the use of gender-specific contraceptives. In general, men possess a higher potential contribution to family planning service delivery as well as in the extension of relationship between partners and improved communication regarding reproductive goals within the present patriarchal system (Green et al., 1995). This fact recognises the need to encourage male contraception with increased efforts and also, to enhance the sustainability of the family planning programs. It is an accepted fact globally that when varieties of methods are available for men, male participation in family planning is likely to increase. New methods of male fertility regulation currently undergoing clinical trials have the potential of being effective as well as reversible, (WHO, 1990; Gates 1992). The introduction of new safe and improved male methods will ultimately lead to an increase in contraceptive use (Ringheim, 1993; Leriden, 1986). The government family planning programmes continue to enjoy favourable and stable political support in the country. This immense opportunity can be utilized to place the important issue of male involvement in family planning at the national level in an egalitarian manner to gain emphatic public support. It therefore, implies that exploring various potential avenues of male contraceptive programme development in Ghana can augment the seemingly low level of male participation.

2.1 Issues affecting Male Involvement in Family Planning

The lack of interest by men in family planning can be attributed to several factors including spousal communication. Men have a major role in the decision to use family planning methods and determining the number of children a couple should have. Spousal disagreement on reproductive matters relates to the ways in which men and women communicate their preferences. Spousal disagreement can be due more to the lack of communication between spouses than to be articulated opposition of one spouse to the other's desires (Omondi – Odhiambo, 1997).

In West Africa, nearly 75 percent of men reported that they had never discussed family planning with their wives; in East Africa fewer than 40 percent of men said they had never discussed it and in North Africa the percentage was even lower (Becker 1996; Ezeh, Seroussi and Raggars, 1996). Communication can also be non-verbal, especially where there is no tradition of discussion between spouses about sexual intercourse or contraception (Balmer et al, 1995). Failure to communicate about sex and other reproductive matters can lead to a failure to act on commonly held preferences (Van de Walle and Maiga, 1991).

Many societies have a patriarchal structure and without approval of men, women have very little choice in their contraception. Decision making is another issue affecting the family planning. Men in Africa, who are heads of their households, are often key figures in domestic decision making, particularly about fertility behaviour and preferences (Isiugo-Abanihe, 1994) and that authority is supported by tradition. They are also the main link between the family and the prevailing culture and are major players in bringing development to the home. Fapohunda and Todano (1988), observed that the African family structure shapes spousal perception of fertility and that men and women do not necessarily have the same views about family planning and

reproduction because their interests are shaped by expectations which are determined by the social structure of their households and community.

Additionally, men dominate decisions and policies in the public domain. An understanding of their reproductive perspectives could identify programme intervention to promote the use of services by men both as family planning clients and as partners to women clients and this, in turn, would influence family planning and reproductive health decisions. From the historical point of view, a lot of men do not agree with family planning programmes and consider them as irrelevant and therefore they have little awareness of family planning.

Furthermore, there are false beliefs about male contraceptive methods especially in terms of vasectomy and condom which lead to doubt and non-response. Vasectomy has been equated with one of myths which maintain that vasectomy is equal to castration. Another misconception is that vasectomy impairs sexual function. Still more misconception includes the ideas that vasectomy will make a man fat or weak or less productive (Grillo, 2009)

Usman Gwarzo as cited in Grillo (2009) comments that men are not the ones against vasectomy, but the myths are that vasectomy is castration and can lead to impotency. He further reiterated that the resistance to family planning is men, but vasectomy can be easily accepted so that the man does not have to worry about what happens to your children when you have more than you can support (Grillo, 2009). In Bangladesh a pilot distribution project found that most couples who received free condoms did not use them. The reason was that they thought that condom use could cause impotence (Population reports, 1982).

Moreover, men fail to communicate sex with their partners and men have strong beliefs in sexual myths, often blaming women for having only daughters or being infertile. The introduction of family planning as a woman's issue has made men suspicious of family planning activities.

The limited availability of male contraceptive methods and societal attitude make it unfavourable to elicit support for equality of men and women (Ormel, 1997). Male methods used include condom, withdrawal, periodic abstinence and the Billings method remain a relatively insignificant part of the mix. Many men directly assume responsibility for preventing pregnancy through coital – dependent method such as condoms, withdrawal and periodic abstinence. Despite the widespread use of traditional methods (some of which require men's involvement) over generations, less attention has been devoted to understanding men's use of methods such as withdrawal and periodic and postpartum abstinence.

In a number of sub-Saharan African countries more than 50 percent of current contraceptive practice is recourse to "traditional" methods, periodic abstinence being predominant (Ezeh, Seroussi, and Raggars, 1996). Withdrawal accounts for 9 percent of overall contraceptive practice in developing countries and is widely used in some countries (eg. 26 percent of all married women of reproductive age in Turkey report withdrawal as their current method: Rogow and Horowitz, 1995).

It is sometimes argued that the use of male methods is necessary to assume responsibility for contraception, and that the programmatic and contraceptive development emphasis on female methods has reinforced men's ability to avoid connection between sexual behaviour and reproductive responsibility. Prior to the 1960s, most of the available contraceptive methods (the condom, vasectomy and withdrawal) were all male controlled. Since then contraceptive

technology has advanced with respect to female – controlled methods, but male methods remain the same (Csillag, 1996; Ringheim, 1993; 1996). While the call for more investment in male contraceptive method is not new (Diller and Hembree, 1977), only about 8 percent of the world's contraceptive budget is allotted for the development of new male contraceptives (Sachs 1994). A lively debate exists as to whether or not contraceptive development should shift attention to male controlled methods (eg. Harrison and Rosenfield, 1996).

Men's lack of access to services has been a barrier to family planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. In the past, family planning programmes have focused on women because of the need to free women from excessive child bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family planning services were offered within maternal and child health (MCH) centres. Most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role. In view of this, men are so uncomfortable about going to these clinics. Thus, most family planning programmes have not yet given adequate attention to serving men.

In traditional societies of Africa, children mean the sustenance of the lineage. The ancestors determine the maintenance of the tradition by as many descendants as possible. Families with few children refuse themselves the right of the fore bearers in the continuation of the line of descent (Caldwel, 1987). Men are not familiar with their health care system as women, due to the fact that males are less likely to see a doctor or confide in providers about their medical problems than females. They are reluctant to seek medical treatment for conditions associated with social

stigma (such as impotency and infertility). The attitude of men towards involvement in family planning and reproductive health affects their participation. One of the glaring gaps is the fact that men themselves have not been asked what they seek in a provider and the types of services that would entice them to participate in family planning.

Forest (1987), sees negative staff attitude as one of the barriers prohibiting males from accessing family planning services. Barriers to male involvement in family planning programmes are also caused by service providers who assume that men have no interest in reproductive health (Alexis 1996). Lack of training on men's reproductive health issues to care providers contributes to the negative attitude demonstrated by staff. Forest, (1987) had documented that resource restrictions, predominantly female staff, negative staff attitudes and lack of staff training seemed to be major barriers to including men in family planning services. It appears very little is known about how to deliver reproductive health services for men and as a result, training was designed specifically on how to incorporate men's reproduction.

2.2 Benefits of Family Planning

Family planning allows people to attain their deserved number of children and determine the spacing of pregnancies. It is achieved through contraceptive methods and treatment of fertility. It helps women to achieve life goals and when they decide to become mothers. The World Health Organization (WHO) and the United Nations Population Fund (UNPF) have identified some benefits to family planning and they include preventing pregnancy related health risk in women, reducing infant mortality, helping prevent HIV/AIDS, empowering people and enhancing education, reducing adolescent pregnancies and slowing population growth. Other benefits include reductions in anaemia and dysmenorrhoea, reduced risk of ectopic pregnancy, less

demand for abortion, decreased need for surgical sterilization, reduced maternal mortality and fibrocystic breast changes (Burkman et al., 2004).

2.3 Getting men involved in family planning

In the past, family planning programmes had focused on women because of the need to free women from excessive child bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family planning services were offered within maternal and child health (MCH) centers. Most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing peripheral role. But in a patriarchal society which still prevails in most countries, husbands make most of the important decisions for their families. It is necessary to have effective communication between husband and wife in order to ensure equal roles in matters of reproductive health. Such communication can also bring many advantages for growth of men's consideration to participate in family planning (Population Council 1998, pp.27-28).

Male motivation campaigns can build up male support for family planning, persuade men to discuss family planning with their partners and encourage couples to adopt modern contraception (Kim et al., 1992; Protrow et al., 1992; Yun et al., 1989). To reach men, however, such campaigns must select suitable communication channels and must tailor their messages to fit male concerns and information needs. Men may respond more to the economic benefits of family planning than to the health benefits, which commonly appeal to women.

Changes in society cannot happen by working with half of the population alone, and men must be engaged to create an environment of gender equality and better health. Men should be engaged in family planning-sharing power to make family planning decisions with their wives

and partners. It also means sharing the responsibility for using contraception and participating in maternal and child health care.

Research on male involvement demonstrated that men are more likely to support family planning and to use a method themselves if services and educational programmes are targeted at them. Because men fear that contraception reduces their control over their lives sexually, male-friendly approaches can enhance gender equality in reproductive health decision (Omuodo, 1996). In Swaziland, males are targeted for family planning education. In Togo, the media is being used to encourage positive attitudes toward family planning among particular groups. In Sierra Leone, men have met in groups to learn about how to prevent sexually transmitted diseases and about the benefits of family planning. In Ghana, family planning services targeted at men have increased male involvement.

Health facilities should have certain characteristics. For example, such facilities should offer predominantly family planning and sexually transmitted diseases services, a range of methods beyond condoms and vasectomy and guarantee configuration, privacy and comfort. There should be adequate access to information on choice and merits of family planning method and side effects. Flexible hours and short waiting time would be helpful. Services should also be affordable.

Service providers should be knowledgeable, patient, polite, persuasive, warm, and discreet and trust worthy. Efforts should be made to create a male-friendly service delivery system at the existing service delivery centres.

Research indicates that when men communicate with their wives and partners about planning their next child family planning use increases. Given the right opportunities, changes in gender equality and family planning can happen in a short time, improving women's health, family health, enabling women's contributions to the country and building the development potential for the nation

To ensure effective male participation in the family planning programme, it will be necessary to provide men with adequate information on family planning and contraception methods through designing and appropriate IEC materials. Programmes must work towards overcoming the perception among males that acceptance of contraceptive methods is a threat to their status. Outreach programmes for men should use men as educators, promoters and providers. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision making for family planning matters, but would also accelerate the understanding and practice of family planning in general (Ibid).

2.4 Theoretical Framework

2.4.1 Power Relations in the Family

Feminists provide a rich account or analysis of power relations in the family. Like Marxists, feminists tend to see society as divided into different social groups. However, they see the major division as being between men and women rather than between different classes characterised by exploitation and unequal power relations. Radical feminists characterize contemporary societies as patriarchal, arguing that men have much of the power in families.

One approach to studying conjugal roles is to examine power within marriage. This has usually been attempted through examination of who makes the most crucial decisions. To this end, a

study conducted by Hardill et al (1997) provides a useful reference. They examined power in dual-earner households in Nottingham and came out with four main patterns of money management.

The first common pattern was the husband-controlling pooling. In this system especially where the wife did not work, money was shared but the husband had the dominant role in deciding how it was spent. This system tended to give more power to the men. The second most common category was where the wife was working and better-paid, the money was shared but the wife had the dominant role in deciding how it was spent. This tended to be the most egalitarian system of decision-making on finances.

The third pattern observed was husband control where the husband was the main or only wage-earner. Sometimes the women worked, but their earnings largely went into housekeeping. This system tended to lead to male dominance. The least frequent pattern was wife control where in some instances neither of the partners worked and both received their income from welfare benefits. Although this system appeared to give women more power than men, it was most common in poorer households where the responsibility for managing finances was more of a burden than a privilege. In conclusion, the evidence suggests that women are still a long way from achieving equality within marriage even in advanced societies like Britain. They are still primarily responsible for domestic tasks and they have less power than their husbands or partners within marriage.

The norms and practices that describe women as substandard to men, inflict controls on-them exist everywhere and there is the ideology that men are superior to women and women are a part of the properties of men (Sultana, 2011).

The feminist perspective on power relations in the family was used to examine male involvement in family planning in relation to the support that they give to their wives and the decision making process (family size and family planning programmes).

CHAPTER THREE

FAMILY PLANNING POLICY IN GHANA

3.0 Introduction

This section is devoted to Family planning policy in Ghana. The section begins with a look at the National Population Policy of Ghana which was revised in 1994 and how family planning became the needed requirement to deal with the rapid population growth in the country.

3.1 National Population Policy

Twelve years after Ghana received its independence (1969), the government established a national population policy. The policy was meant to improve the quality of life for all Ghanaians through the promotion of economic growth and the management of population growth (Harvard University, 1994). This policy was however revised in 1994 since the 1969 policy did not have the required impact on the population growth rate. Figure 1 below shows excerpts from the revised National Population policy.

Figure 1: Excerpts from the 1994 National Population Policy

Reduce the total fertility rate (TFR) from 5.5. to 5.0 by 2000 and then to 3.0 by 2020;

Achieve a contraceptive prevalence rate (CPR) of 15 percent for modern Family Planning methods by 2000 and 50 percent by 2020;

Reduce the current annual population growth rate of about 3 percent to 1.5 percent by 2020

Source: (Harvard University, 1994;
<http://www.npc.gov.gh/assets/NationalPopulationPolicyataGlance.pdf>)

The preliminary goal set by the government was to reduce the population growth rate from 3% in 1969 to 1.7% by 2000. However, as at 1993, the rate was still near 3% and thus the policy failed to show the desired decrease in growth hence its revision in 1994 (Harvard University, 1994).

To achieve the set objectives in the 1994 National Population Policy, the Reproductive and Child Health Unit (RCHU) of the Ghana Health Service (GHS), which is accountable for family planning services, made increasing accessibility and suitable utilisation of family planning services precedence (Hong et al., 2005).

3.2 Family Planning in Ghana

The government support of family planning programmes began in 1969, with some of the major programme initiatives being the Contraceptive Social Marketing (CSM) project (1987- 1990), the Ghana Family Planning and Health Programme (FPHP) (1990-1996) and more recently, the Ghana Population and AIDS Project (GHANAPA) (1996-2000) (Hong et al., 2005). In 1970, the Ghana National Family Planning Programme was established under the Ministry of Finance and Economic Planning with the belief that it is a fundamental human right that couples should have the opportunity to decide freely the number and spacing of their children (Odoi-Agyarko, 2003).

The primary focus of these projects was to augment demand and use of modern methods for family planning through the use of social marketing strategies Miller et al., 1998; Adamchak et al., 1995). The main goal of the Family Planning Programme is to aid couples and individuals of all ages to attain their reproductive goals and advance their general reproductive health through

information and counselling on contraception and other reproductive health services (Odoi-Agyarko, 2003).

The FPHP continued social marketing strategies and toiled to enlarge the capacity of the public and private sectors to provide family planning services, supplies and information, including the ability of these sectors in addressing sexually transmitted infections (STIs) and HIV infections (Miller et al., 1998; Adamchak et al., 1995).

Afterwards Maternal and Child Health (MCH) and the Ghana National Family Planning Programme were combined under the Ministry of Health. It then became MCH/FP. In the 1994, the International Conference on Population and Development (ICPD) was held in Cairo. As an outcome of the conference, Ghana endorsed the Programme of Action of ICPD and adopted the ICPD definition of reproductive health. The components of the ICPD are “safe motherhood, family planning, prevention and management of unsafe abortion and post abortion care, prevention and management of reproductive tract infections including sexually transmitted diseases (STI) and HIV/AIDS, prevention and management of infertility, prevention and management of cancers of female and male reproductive system, responding to concerns about menopause, discouragement of harmful traditional practices, gender based violence and reproductive health care, sexual health and information, education and communication” (Odoi-Agyarko, 2003).

In 1983, the Ministry of Health took over the accountability for organising the information and education phase of the family planning programme. The personnel of the Ministry and its facilities were used for the design, creation and circulation of educational materials, the development of materials for the media, outdoor publicity and group discussions. The Ministry of Mobilisation and Social Welfare also contributed to the interpersonal communications

programme and the mobilization of new family planning clients. Family planning formed an integral part of the programme of the Department of Social Welfare and Community Department (Odoi-Agyarko, 2003)

Between 1993 and 1996, there was a particular focus on increasing access to permanent (mini-laparotomies and vasectomies) or long-term methods (intrauterine devices [IUDs] and implants). In-service training was then being provided by the RCHU to nurses to provide the monthly injectables and emergency contraception and by Engender Health, a nongovernmental organisation (NGO), to medical officers and doctor-nurse teams in the vasectomy procedure. This has increased the variety of methods that can be safely offered at facilities (Hong et al., 2005).

The private sector was not left out in the family planning campaign in the country. Organisations like Planned Parenthood Association of Ghana and the Christian Council of Ghana partook actively in the activities of the National Family Planning Programme. The Catholic Secretariat placed more importance on the rhythm /ovulation method. Volunteers from the community were also employed in some projects for the circulation of contraceptives and private medical practitioners offered family planning services (Odoi-Agyarko, 2003).

Figure 2: Excerpts from the 1996 National Reproductive Health Service Policy and Standards by the Ministry of Health

Adolescents- Sexually active adolescents who seek contraceptive services shall be counselled and served. Information and counselling shall be provided to adolescents. For adolescents, in general, emphasis will be on abstinence.

Spousal consent- For married couples, spousal consent for contraceptive use is not required

Mental disability- In case of mental disability or serious psychiatric disease where the nature of the disease does not allow for informed choice, contraceptives shall be provided in consultation with all parties including persons in loco parentis and trained service providers

Source: (Odoi-Agyarko, 2003; Ministry of Health, 1996)

3.3 Birth Control Methods

According to the World Book Encyclopaedia (1994), birth control is a term that includes all methods used to regulate or prevent the birth of children. Other terms with a similar meaning are birth planning, family planning, fertility control and Planned Parenthood. Family planning plays a key role in the prevention of unintended pregnancy, including adolescent pregnancy. Preventing unintended pregnancy also reduces the incidence of abortion and improves birth outcomes.

Similarly, family planning information, education and services reduce both the incident and impact of sexually transmitted infections through screening and treatment. Birth control techniques can either be traditional or modern. Traditional techniques involved natural family planning safe periods, abstinence and withdrawal. Modern techniques include barrier method, hormonal method and sterilisation.

According to the family planning service provider at the 37 Military Hospital, Ghana currently provides a constellation of family planning commodities: short-term methods, long-term methods and permanent methods. However, in this research, the methods have been grouped under natural family planning methods, barrier methods, hormonal methods and sterilisation.

3.4 Natural Family Planning

Natural family planning (NFP) is a scientific method for determining human fertility through observation of a woman's biological cycles. Natural family planning is a method used to help a couple determine when sexual intercourse can and cannot result in pregnancy. During the menstrual cycle, a number of changes occur in the woman's body. By keeping track of these

changes, couples can plan when to have intercourse and when to avoid intercourse, depending on whether they are trying to achieve or avoid pregnancy. Periodic abstinence is the only method deemed moral by the Catholic Church for avoiding pregnancy. When used, natural family planning limits sexual intercourse to naturally infertile days. Various methods are used to identify whether a woman is likely to be fertile; this information may be used in attempts to either avoid or achieve pregnancy.

Methods of the natural family planning are: the Symptoms – Based Methods, the Calendar – Based Methods and the Lactational Amenorrhea Method. The symptoms based method track biological signs of fertility. This is dependent on her basal body temperature, cervical mucus and cervical position Wikipedia, (2013). The lactational amenorrhea method (LAM) is a method of avoiding pregnancy based on the natural postpartum infertility that occurs when a woman is amenorrheic and fully breast feeding. The rules of the method help a woman identify and possibly lengthen her infertile period.

3.4.1 Calendar Based Method

The calendar based method determines fertility based on a record of the length of previous menstrual cycles and the standard days method. A cycle bead, unaffiliated with the religious teachings, is a usual tool based on the Standard Days Methods.

Figure 3: Cycle Beads

is

Source: Author's Field Survey, May 2013.

A cycle bead is a colour-coded string of beads representing a woman's menstrual cycle. The cycle beads are used to determine the safe period in the woman's menstrual cycle. The method is most effective for women with menstrual cycles that are regularly between 26 and 32 days long. Women with cycles outside this range should use a different method of family planning to prevent pregnancy. It helps a woman track her cycle, identify when are fertile days and non-fertile days and monitor that her cycles are in a range for effective use of this family planning method. If you are hoping to get pregnant, you can determine the best days to have sex. Similarly, if you are hoping to avoid pregnancy, you can also determine which days to avoid unprotected sex. The method is inexpensive; it does not include chemical birth control that may cause abortion. However, it limits sexual intercourse to naturally infertile periods. There are no side effects, and does not offer protection from sexually transmitted infections.

3.4.2 Withdrawal

Withdrawal, also known as coitus interruptus or the pull out method is the world's oldest way to practise birth control. In today's world, about 35 million couples rely on withdrawal. With this method, the male partner ejaculates outside the vagina and external genitalia of the female, thus preventing any possibility of conception. As a method of birth control, withdrawal has distinct advantages over most other methods. It requires no devices, involves no chemicals and is available at no cost. It does, however, have one strong disadvantage. The failure rate of withdrawal ranges from 10% pregnancies per 100 women per year, (if withdrawal is used consistently) to 23 pregnancies per 100 women per year among actual users (Free and Alexander, 1976). This failure rate is as a result of several factors. There is a small possibility that preliminary ejaculatory fluid can escape before the penis is withdrawn. There is no cost and it is available in any situation. Chances of getting pregnant with this method are much higher than with any other method since some men have difficulty telling when they will ejaculate.

3.5 Barrier Methods of Birth Control

Barrier methods of birth control prevent fertilisation by creating a physical barrier between sperm and egg cells. Barrier methods of contraception generally do not have any side effects.

The most common forms of barrier contraception include male and female condoms.

3.5.1 Condoms

A Condom is a type of birth control used during intercourse to prevent pregnancy and the spread of sexually transmitted diseases. Condoms are usually made of latex or polyurethane. Condoms contraception can either be a male or a female. According to the USA Department of Health and Human Services (2011) a male condom is a sheath or covering which is closed at one end and fits over a man's penis. Other than vasectomy the condom is the only available method of birth control for men. A condom blocks sperm from coming into contact with the inside of the vagina. A female condom is a vaginal sheath that is used by a woman and fits inside the vagina. Female condom is a good last minute alternative when dealing with a partner who does not have a condom or would not wear one. It is a polyurethane pouch with rings at the front and end-side.

Condoms are relatively inexpensive birth control method and they can be made readily available to most people. They can be purchased in the market, drug stores and family planning clinics or from distributors. The health person interviewed asserted that men use condoms a lot. This basically provides some protection from sexually transmitted diseases and HIV. It is a reliable method for people who cannot use hormonal birth control methods. The major complaint of condom users is that the condom reduces sensitivity. Drum, Piotrow and Dalsimer (1974), say to increase sensitivity, natural skin – textured or lubricated condoms may be used. They further identified that a very small number of people are allergic to rubber condoms; they should try using natural skin condoms instead.

In addition to providing protection against pregnancy, other benefits of the condoms are; sex therapists occasionally recommend the use of condoms in treatment of premature ejaculation, as they reduce sensitivity of the glands during intercourse (Masters and Johnson, (1966);) it has been found that in some infertile couples desiring pregnancy, the woman's body makes

antibodies to her partner's sperm. In such couples the use of condoms for 3 – 6 months can prevent the release of sperm antigens into the vagina, (Damm, Piotrow and Dalsimer (1974).)

Condoms may however cause irritation of the vagina or the penis.

Figure 4: Male and Female Condoms



Male Condoms



Female Condoms

Source: Author's Field Survey, May 2013.

3.6 Hormonal Methods of Birth Control

Hormonal birth control methods work by releasing hormones that prevent ovulation. They also thicken the mucus in the cervix making it hard for the sperm to reach the egg. On the other hand the endometrium thins, making it less likely for the fertilised egg to get attached to it. The different types of hormonal birth control methods are oral contraceptives (pill), injection and implant. These work by releasing progestin, while the vaginal ring and patch works by releasing both estrogen and progestin. However, hormonal birth control methods do not provide protection against sexually transmitted diseases (STDs) like human immunodeficiency virus (HIV).

3.6.1 Oral Contraceptive (Pill)

Oral contraceptives also known as birth-control pills are used for the prevention of pregnancy. The birth control is a common method of family planning that women can use to regulate fertility. Depending on the type of pill you use, you may have a menstrual period once a month or every four months. Birth control pills contain the hormones progesterone and estrogen and prevent ovulation or the release of an egg. The pill also thickens cervical mucus making it hard for the sperm to enter the uterus. Pregnancy cannot occur after unprotected sex.

Figure 5: Oral Contraceptive

Source: Author's Field Survey, May 2013.

3.6.2 Depo-Provera

Depo-Provera according to Camilleri (2012) is a well known brand name for medroxy progesterone acetate, a contraceptive injection for women that contains the hormone progesterone. Depo-Provera is an injection given every three (3) months. It is injected deep into the muscle just beneath the skin. It suppresses ovulation, and/or thickens the cervical mucus to prevent sperm from passing through. It is a reversible method of birth control given only by prescription. It does not interfere with sex and reduces the risk of ovarian and endometrial cancer. It may delay your chances of getting pregnant after the shots are stopped and will lead to possible hair loss. The health person again stated that the short term contraceptives are what most women prefer. These are able to meet the expectations of lactating mothers as well as other clients

Figure 6: Depo Provera

Source: Author's Field Survey, May 2013.

3.6.3 Jadelle

Jadelle is an implant system that provides effective, long acting reversible contraception for women. Two thin, flexible rods made of silicon tubing and filled with levonorgestrel, a synthetic progestin, are inserted just under the skin of a woman's upper inner arm in a minor surgical procedure. Protection from pregnancy is provided within 24 hours, when insertion is performed during the first week of a woman's menstrual cycle.

The woman rapidly returns to her normal fertility when the implants are removed. Since Jadelle contains no estrogen, the most common side effects are change in menstrual bleeding patterns.

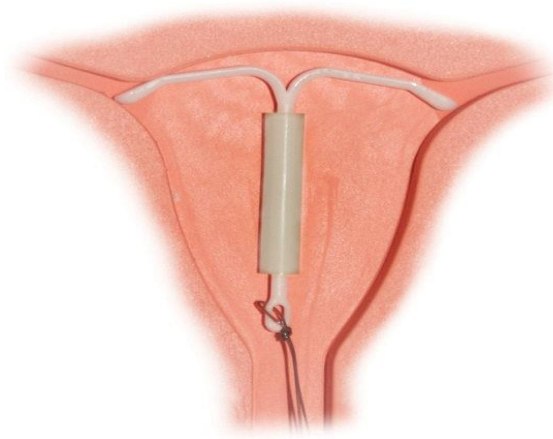
Figure 7: Jadelle

Source: Author's Field Survey, May 2013.

3.6.4 Intrauterine Device (IUD)

Intrauterine devices also known as IUD can prevent a woman from getting pregnant. It is a small plastic device which is placed in the uterus by a clinician. The T-shaped device keep the sperm from fertilising egg. Some contain synthetic progesterone, others have copper on them. It is a reversible method of birth control given only by prescription. IUD (non-hormonal) is a preferred choice for women since it does not release any chemical into the system. It is easy to use and has a low maintenance method. It does not interfere with breast – feeding. The woman may experience spotting between periods. The device does not protect against sexually transmitted infections.

Figure 8: Intrauterine Device



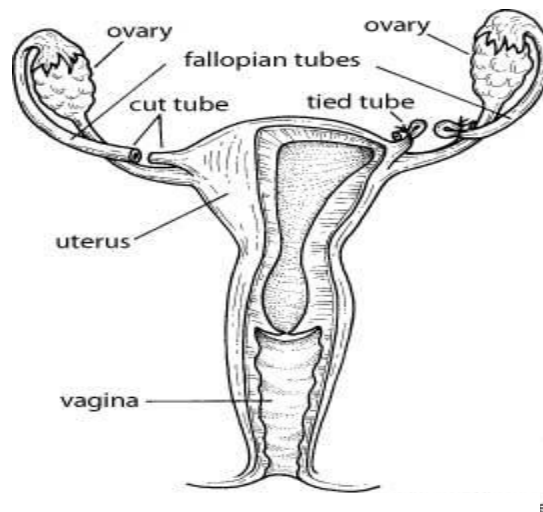
Source: Author's Field Survey, May 2013.

3.7 Sterilisation (Permanent Method)

Sterilisation is a permanent method of contraception. In certain cases it can be reversed, but the success of this procedure is not guaranteed. Due to this, sterilisation is meant for only for men and women who do not intend to have children in the future. The effect of sterilisation operation on the hormonal feedback between the pituitary and the gonads has been studied extensively

Rosemberg et al., (1974), Johnsonbaugh et al., (1975). Levels of luteinising hormone, testosterone and estrogen remain within the normal range after sterilisation. Levels of serum progesterone are slightly reduced after tubal sterilisation Redwanska, Berger and Hammond, (1979), Donnez, Wauters and Thomas (1981). Sterilisation procedures can be for both men and women. Female sterilisation can be tubal ligation, which closes the fallopian tubes by using a clip, cutting and tying, or cauterising (burning) the tubes. The procedure takes anywhere from 10 to 45 minutes or hysterectomy, which is the surgical removal of a woman's uterus. Sterilisation is a very reliable and effective method of contraception with no long term side effects. However, it gives no protection against sexually transmitted diseases.

Figure 9: Tubal Ligation

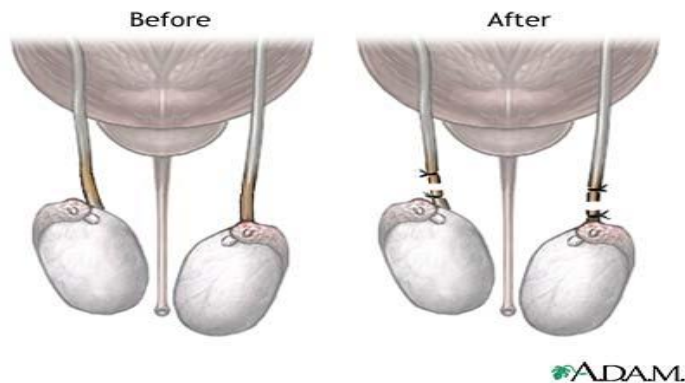


Source: Author's Field Survey, May 2013.

Vasectomy is sterilisation for men. A vasectomy is an operation that makes a man permanently unable to make a woman pregnant. It involves cutting the two tubes called vas deferens so that the sperm can no longer get into the semen. The surgery is carried out by a doctor specialised in

vasectomy. This ensures that no sperm exit from the penis during ejaculation. The method is highly effective but usually irreversible

Figure 10` : Vasectomy



Source: Author's Field Survey, May 2013.

3.8 Conclusion

This chapter has outlined the various family planning methods available in the 37 Military hospital based on an in-depth interview conducted with one of the service providers. These various methods of family planning discussed above give us a good idea of what these methods are so as to aid us in understanding the discussion that will be done in the next chapter, which will look at why women go in for family planning and the method that they are likely to choose and engage in.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents the data analysis of the data collected in order to meet the research objectives. As discussed earlier the objectives include identifying couples' preferred family size, determining the level of male support to their partners in the use of contraceptives and family planning, investigating the socio-demographic characteristics of men who are involved in family planning and exploring the relationship between preferred family size and male involvement in family planning. The data presentation and analysis are undertaken in the following order:

- The demographic characteristics of the respondents
- Preferred family size
- Contraceptive use
- How culture affects family planning
- Reasons for family planning use

4.1 Demographic Data

All the ninety respondents who participated in the study and filled the questionnaire administered were females. This is because the male partners were reluctant to participate in the research with the excuse that their wives are capable of providing all the answers to the questions.

In terms of age, table 1 show that many of the respondents (30%) were between the ages of 25-29 whereas 26.7% and 23.3% are between the ages of 30-34 and 35-39 respectively. This implies that those who are in their reproductive age are the ones more likely to engage in family planning

methods. However, 3.3% and 2.2% are between the ages of 45-49 and 50-54 respectively. This shows that people of these ages are not likely to engage in family planning because they are likely to have reached the end of their reproductive age for women.

Table 1: Age Distribution of Respondents

Age Distribution	Percentage
20-24	6.7
25-29	30.0
30-34	26.7
35-39	23.3
40-44	7.8
45-49	3.3
50-54	2.2
Total	100

Source: Author's Field Survey, May 2013.

Majority of the respondents (88.9%) are Christians whereas 10.0 % and 1.1% are Muslims and Traditionalist respectively (table 2).

Table 2: Religious Distribution of Respondents

Religious Distribution	Percentage
Christianity	88.9
Islam	10.0
Traditional Worship	1.1
Total	100

Source: Author's Field Survey, May 2013

The high number of Christian women in the study relates with the findings of Addai (1999) when he argued that religion is a strong determinant of contraceptive use among Other Christian women in urban areas and suggests that for these women, religious norms, doctrines, beliefs and ideals may be important in their reproductive regulation decision making process. The Catholic Church is overt and regular in its stand against the use of contraception and abortion. This

pronatalist stance generally ties women of this faith to the use of an inefficient method of birth control. Unlike Traditional and Catholic faiths, Protestant and Other Christian churches do not directly or indirectly oppose contraceptive use. Therefore the higher contraceptive use among Protestant and Other Christian faiths may be influenced by their lack of opposition to contraception, abortion, and sterilization (Addai, 1999).

Caldwell & Caldwell (1987) argue that within the Traditional African religion, ancestors are honoured and their spirits appeased through the bearing of children as descendants. Within such a faith, they argue, high fertility is morally correct and attracts divine approval. Childlessness and sub fecundity deny the rights of ancestors to be born and/or for the lineage to be reproduced, and are associated with evil. Therefore, the likelihood of use of modern contraceptive methods among traditional women may be shaped by members' perception of the side effects of modern contraception on reproductive capabilities. Also, traditional African religion tends to identify large family size with virtue. This reason can be used to account for the low number of traditional religious women in this study.

The low patronage of family planning services by Muslim women is related to the findings of Sharman et al. (2011). According to them large percentages of Muslim women fail to use modern contraceptives, and the trend in the last decade is not encouraging and this is due to the fact that other studies have found that women affiliated with Muslim faith are less likely to use contraception because of this faith's stance on procreation (Chamie, 1981; Caldwell, 1968; Fagley, 1967; Kirk, 1967).

The data revealed that 37.8% of the respondents, are Akan whilst the rest are Guan (5.6%), Ewe (25.6%), Ga (12.2%); 3.3% were each represented by Dagomba and Grushi; Hausa, Kasem and

Frafra represented 2.2% respectively; Yoruba, Bulisa, Chamba, Sisala and Busanga represented 1.1% each.

According to the Ghana Statistical Survey (2012) some ethnic groups have better contraceptive use than others in Ghana. Ewes tend to have a better contraceptive use than all the other ethnic groups. The Akan and other ethnic groups classified as others came second to the Ewes. The Gruma and Mande ethnic groups had the lowest use of contraceptive among the ethnic groups in Ghana. The findings for this study however put the Akan as the majority ethnic group that are engaged in the use of family planning services. Sharman et al (2011) posited that ethnicity does have a significant effect on contraceptive use and for that matter the use of family planning services.

Again, previous studies conducted in United States of America (USA) and Sub-Saharan Africa have shown that contraceptive use patterns vary among ethnic groups (Christman and Zawacki 2009; Raine et al. 2002; Addai 1999). Bennett and Dahal (2008) argue that the Government of Nepal has failed to provide equal access to public services to people lower in the ethnic hierarchy, to women and to the Teraimadhesi ethnic group and that illiteracy, poverty and low socioeconomic status are the reasons for the exclusion.

However, Borrero et al. (2009) found that ethnicity and race has no significant effect on the use of family planning services. A possible explanation, according to Tawiah (1997) is that, once a woman experiences higher education, her ethnicity and religious affiliation do not significantly affect her current contraceptive use.

Table 3: Ethnic Distribution of Respondents

Ethnicity	Percentage
Akan	37.8
Guan	5.6
Ewe	25.6
Ga	12.2
Dagomba	3.3
Yoruba	1.1
Hausa	2.2
Bulisa	1.1
Chamba	1.1
Grushi	3.3
Kasem	2.2
Busanga	1.1
Frafra	2.2
Total	100

Source: Author's Field Survey, May 2013.

Table 4 represents the marital status of the respondents. 83.3% of the respondents are married whilst 6.7% are not married. In addition, 2.2% are separated and 7.8% are cohabiting.

Table 4: Marital Status Distribution of Respondents

Marital Status	Percent
Single	6.7
Married	83.3
Separated	2.2
Cohabiting	7.8
Total	100

Source: Author's Field Survey, May 2013.

In relation to education of both the respondents and their partners (table 5 and 6) 1.1% of the respondents and their partners have no education. However, there is a disparity in the level of education for both the respondents and their partners in relation to primary (respondent 4.4%; partner 1.1%); JHS (respondent 22.2%; partner 14.4%); SHS (respondent 30.0%; partner 28.9%); tertiary (respondents 42.2%; partners 54.4%). This shows that the highly educated are more

likely to engage in family planning compared to those who are not highly educated. This finding supports the arguments that the level of education of both partners, especially the man, influences the use of family planning and fertility regulation (Ezeh, 1993; Marrida and Ulla, 2004). Contrary, Tehrani et al. (2001) argues that a husband's illiteracy increased the risk of non usage of contraceptives by 1.8 times.

Also according to the Ghana Demographic and Health Survey Report (2003) women's education is strongly associated with lower fertility such that women who are highly educated had less children compared to those with less education and these educated women are more than twice as likely to use contraception as women with no or less education. Tawiah (1997) also argues that married women who have higher education are more likely to be contraceptive users, the odds ratio being three times higher for such women, compared with their uneducated counterparts.

Table 5: Educational Level of Respondents

Educational Level	Percentage
No formal education	1.1
Primary	4.4
JHS	22.2
SHS	30.0
Tertiary	42.2
Total	100

Source: Author's Field Survey, May 2013.

Table 6: Educational Level of Partners

Educational Level	Percentage
No formal education	1.1
Primary	1.1
JHS	14.4
SHS	28.9
Tertiary	54.4
Total	100

Source: Author's Field Survey, May 2013.

4.2 Preferred Family Size

Most of the respondents (50%) preferred a family size of three whereas others preferred a family size of one (2.2%), two and four (21.1% respectively), and five (3.3%). Concerning the gender ratio of the family size of respondents, 40% of the respondents reported that they preferred only one male child; 36.7% preferred two boys; whereas 5.6% preferred to three boys. However, 7.8% of the respondents reported that they wanted all their children to be boys with the reason that they loved the company of boys compared to girls (see tables 3 and 4).

When it comes to the preference for a female child (42.2%) of the respondents reported that they would prefer to have two girls compared to boys. One of the reasons given for this preference is that girls are helpful at home. Some of the respondents (37.8% and 3.3%) reported that they preferred one or two female children respectively. However, some of the respondents reported that they wanted to have a balance in the sex of their children and as such wanted to have either a boy and a girl or two boys and two girls. All these reasons notwithstanding, some of the respondents (40.0%) reported that they do not have any sex preference for their children (tables 7 and 8).

Table 7: Preferred Family Size

Characteristic	N=90	Percent
Preferred Number of Children		
One		2.2
Two		21.1
Three		50.0
Four		21.1
Five		3.3
Six		2.2
Total		100
Preferred Number of Boys		
One		40.0
Two		36.7
Three		5.6
All		7.8
None ¹		10.0
Total		100
Preferred Number of Girls		
One		37.8
Two		42.2
Three		3.3
None ²		16.7
Total		100

Source: Author's Field Survey, May 2013.

4.3 Spousal Communication on Family Size

¹This refers to the respondents who do not have any special preference for boys and those who preferred one child, which they would like to be a girl.

²This refers to the respondents who do not have any special preference for girls and those who preferred one child which they would like to be a boy.

Communication between partners is a key factor in joint decision-making and contraceptive use. Talking with one's partner about reproductive and contraceptive decisions making is likely to increase understanding and help support one's partner's decision. According to the Demographic and Health Survey data on West Africa, about three quarters of the men and women had not discussed family planning with their partners in the year preceding the survey. In Tanzania, 45 percent of married women did not know what their husbands thought about FP or thought their husbands disapproved of family planning, when in fact many of the husbands approved (Toure, 1996; Ezeh, Seroussi and Raggars, 1996). Research has shown that discussion of family planning with partner or husband–wife communication and decision making, was positively associated with contraceptive use. Married women who discussed family planning with their partners were three times as likely to be current users of contraception as compared to their counterparts who had never had such discussion (Tawiah, 1997).

Majority of the respondents, 94.4%, reported that they communicated with their partners in relation to their family size (see table 7). The communication between spouses on preferred family size according to Lasee and Becker (1997) has an influence on the use of family planning procedures and the type of contraceptives that the couples would use although the male partner may play an important role in decision-making regarding contraceptive use and the number of children. This finding is in agreement with other studies (Oni and McCarthy, 1991; Salway, 1994).

However, 5.6% reported that they did not communicate with their partners on family size because of the fear of hostility from the partner. The fear of a hostile reaction from the man supports the argument that men play an important role in reproductive decision-making and its effect on contraceptive use as well as behaviour of couples (Bankole and Sing, 1993; Omandi-

Odhiambo 1997; Karra, et al. 1997). In addition, it is generally believed that in Ghana, the wife's attitude toward contraception is strongly influenced by her husband's attitude and background characteristics, especially education, but the husband's views are not similarly influenced by his wife (Ezeh, 1993).

In addition, the fear of hostility goes a long way to show the power relations that exist in the family. According to Hardill et al. (1997), women are still primarily responsible for domestic tasks and they have less power than their husbands or partners within marriage. There is always male dominance, especially, when it comes to decisions such as family size and the use of family planning methods.

Table 8: Preferred Family Size and Spousal Communication

Characteristic	N=90	Percent
Reasons for Preference for Particular Sex		
Boys would bring children into the family		2.2
To balance the sex of the children		26.7
Love the company of boys		5.6
Girls are helpful at home		13.3
Boys would protect their sisters		2.2
None ³		40.0
No Response ⁴		10.0
Total		100

³ This refers to the respondents who do not have any special preference for their child/children's sex and those who could not assign any special reason for their preference.

⁴This refers to the category of respondents who did not answer the question.

Actual Number of Respondents' Children	
One	33.3
Two	34.4
Three	15.6
Four	11.1
Five	1.1
None ⁵	4.4
Total	100
Discussed Number of Children with Partner	
Yes	94.4
No	5.6
Total	100
Reasons for not Discussing Number of Children with Partner	
Fear of hostile reaction from the man	5.6
Not Applicable ⁶	94.4
Total	100

Source: Author's Field Survey, May 2013.

4.4 Types of Contraceptive used by Respondents

Most of the respondents preferred to use two main types of contraceptives and they are the condoms (26.7%) and the injective (28.9%). These methods are preferred due to the fact that

⁵This refers to the category of respondents who are yet to have children but are already attending family planning clinic.

⁶This refers to the respondents who gave a positive response to an earlier question on whether they had discussions with their partners with regard to the number of children they would bring forth. They were therefore, not required to respond to this question.

they bring about less side effects and immediate fertility is restored when one ceases to use them (U.S.A. Department of Health and Human Services, 2011).

Table 9 shows the usage of contraceptives by respondents. Respondents were required to indicate type ever used. In response to the type of contraceptives were used by respondents, 28.9% of the respondents asserted the injection as the one ever used. Condom was the second highest choice of respondents as ever used; this was indicated by 26.7%. The use of IUD was 17.8%, the Pill represented by 11.1%. Cycle beads and jadelle were both represented by 6.7% while tubal ligation and LAM was 1.1% respectively.

Table 9: Type of Contraceptive ever used by Respondents/Partners

Type of contraceptive	Percentage
Pill	11.1
Condom	26.7
IUD	18.9
Cycle beads	6.7
Injection	28.9
Jadelle	6.7
Tubal ligation	1.1
LAM	1.1
Total	100

Source: Author's Field Survey, May 2013.

In respect of contraceptives currently in use, the majority of the respondents (42.2%) are using injection and this can be affiliated to the fact that an injection provide highly effective protection against pregnancy and does not require daily or post-coital vigilance on the part of the user or her partner. This method allows women to avoid the potential health risks and adverse events associated with estrogen containing contraceptives and, unlike sterilization, allow a return to fertility after discontinuation (Blumenthal et al., 2011)

The second highest contraceptive used among respondents (18.9%) is IUD. This is because research has shown that IUDs is 99% effective and can aid in the prevention of pregnancy especially in the case of unprotected intercourse or after a contraceptive accident such as a torn condom. (Wellbery, 2000). However, studies have shown that the use of the IUD is avoided because of perceived risk of pelvic inflammatory disease associated with sexually transmitted infections (Shelton, 2001).

In an era of HIV infection, use of the condom as protection against STIs in addition to its use as a family planning method has become important (Awusabo-Asare et al., 2004). Condom use is the third method that the respondents (16.7%) reported that they preferred and are currently using. This could be due to the fact that condoms have no side effects, can easily be obtained when needed (in terms of time for replacement), it helps to increase sexual satisfaction and it does not have any use related problems (Population Council, 1998). Other may choose to use condoms to prevent HIV infection (Marindo et al., 2003) and that condoms are an integral and essential part of comprehensive prevention and care programmes (WHO, 2004). In addition, Adetunji (2000) argues that condoms have lead to an increase of male participation in family planning.

Moreover, Meekers and Richer (2005) argue that the perceived affordability and ease of use of the female condom and prior use of the male condom are strong predictors of female-condom use for both male and female consumers. Furthermore, in marital unions, the female condom is largely used as a mechanism for pregnancy prevention, which is consistent with the way the product has been marketed. In non-marital relationships, however, the female condom appears to be used for both pregnancy and STI prevention. All these reasons can account for the use of condoms among respondents.

The use of jadelle, cycle beads, the pill and tubal ligation are 7.8%, 6.7%, 5.6% and 2.2% respectively.

Table 10: Type of Contraceptive currently being used by Respondents

Type of contraceptive	Percentage
Pill	5.6
Condom	16.7
IUD	17.8
Cycle beads	6.7
Injection	42.2
Jadelle	7.8
Tubal ligation	2.2
Total	100

Source: Author's Field Survey, May 2013.

In response to the duration of contraceptive usage, most of the respondents 54.4% documented one year and above, 16.7% stated 3 – 4 months, whilst 10.0% fell into the duration of 0 – 1 month. Furthermore, 7.8% had used the product for 2 – 3 months, whilst 5.6% of the respondents had used the products for 1 – 2 months or 5 – 6 months, respectively (tables 11).

Table 11: Duration of Contraceptive Usage

Duration	Percentage
0-1 month	10.0
1-2 months	5.6
2-3 months	7.8
3-4 months	16.7
5-6 months	5.6
One year and above	54.4
Total	100

Source: Author's Field Survey, May 2013

According to the UNPA (2013), a study by the Guttmacher Institute confirmed that women's ability to use contraceptives and to determine whether and when to have children enhances their chances of effective family planning. This in turn improves their incomes, family stability,

mental happiness as well as the well being of their children. Thus, it helps women to achieve their life goals and o decides on when to become mothers.

4.5 Introduction to Contraceptives

Most of the respondents (55.6%) reported that they got the information on family planning and the types of contraceptives available from the clinic. Other respondents, 44.4%, reported that they had information on family planning and the types of contraceptives available from friends, relatives, (mother), work, media, school, partner (who have been informed about family planning and the various contraceptives available) and from seminars (see table 12).

Table 12: Introduction to family planning

Source of Introduction	Percentage
At the clinic	55.6
At the work place	6.7
Through a friend	13.3
Adverts in the media	17.8
Through my mother	1.1
At school	13.3
At a seminar	1.1
Through my partner	1.1
Total	100

Source: Author's Field Survey, May 2013.

The example of the respondent who reported that her partner informed her about family planning and contraceptive goes to support the notion that involving men in family planning could increase contraceptive prevalence in several ways. They include providing alternatives to couples dissatisfied with their current method; increasing male contraceptive use; promoting greater discussion between sexual partners; and changing male attitudes regarding contraception (Toure, 1996; Terefe and Larson, 1993; Kaba, 2000). .

According to Toure (1996), Terefe and Larson (1993) and Kaba (2000) family planning programme planners tend to assume that men are opposed to family planning and will, if involved in reproductive decision making, prevent women from regulating their fertility. Available data, however, suggest that the most successful family planning programs target men as well as women and promote communications about contraception between spouses. It is worth noting that the Ghanaian society is largely male-dominated, even with regard to female reproductive health, so men's involvement in family planning can therefore hardly be over-emphasised (Tawiah, 1997). Therefore, men need to be involved in family planning as a mechanism to ensure its success.

4.6 Male Support for Contraceptive Usage and Family Planning

The husband's support is found to be a good predictor of future practice and continued use. There are studies done in the Philippines, which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984). In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23% of women whose husbands did not approve (Population Reports, 1994).

Male support in this research is determined by three factors. These are, the frequency with which the partner accompanies the respondent to the clinic; the role the partner plays in the payment for the service provided; and the role the partner plays in replacement of the contraceptive (see tables 6 and 7). In terms of the visitation to the clinic, majority of the respondents (64.4%) reported that their partners do not play any role since they have never accompanied them to the

clinic. Some of these respondents gave the excuse that the time for the family planning sessions are not conducive for their partners due to their work schedules.

On the other hand, 24.4% and 2.2% of the respondents reported that their partners accompany them sometimes and every time respectively (table 13).

Table 13: Frequency of Partners Accompanying Respondents to the Family Planning Clinic

Frequency of Partner's accompaniment	Percentage
First time	8.9
Every time	2.2
Sometimes	24.4
Never	64.4
Total	100

Source: Author's Field Survey, May 2013

The respondents who reported that their partners accompany them to the hospital gave two main reasons for this support: the desire to ensure that respondents take the contraceptive (7.8%) and the desire to get more information/education (27.8%). These reasons depict the Feminist conception of power relations in the home. The consent of the male partner is even requested for by the service providers before a woman is allowed to patronage these family planning services. The belief that the man is the head of the house and he must be involved in every decision in the home can serve as a barrier to most women especially when the man has no interest in the use of contraceptives.

However, 8.9% of the respondent also reported that at the time of the interview that was their first time of coming to the clinic for family planning sessions (table 14).

Table 14: Reasons for Partners Accompanying Respondents

Reasons	Percentage
To ensure I take the contraceptive	7.8
To get more information/education	27.8
Not Applicable ⁷	64.4
Total	100

Source: Author's Field Survey, May 2013.

The second factor in relation to the determination of male support is the payment of the family planning services rendered. Most of the respondents (71.1%) reported that even though their partners are not with them for the family planning sessions, they provide the support in terms of finances and pay for the family planning services rendered to the respondents. However, 26.7% of respondents stated that they pay for the services themselves whereas 1.1% respondents reported that their job pays for the service. Furthermore, another group of respondents (1.1%) stated that both they and their partners jointly pay for the service.

Table 15: Payment of Family Planning Services

Who Pays	Percentage
The Man	71.1
The Woman	26.7
Both	1.1
My Work Place	1.1
Total	100

Source: Author's Field Survey, May 2013

The third form of support that the partners of respondents offer is in the form of the partner reminding respondents when the date of replacement of contraceptive devices approach. A significant percentage of respondents (72.2%) stated that their partners reminded them. On the

⁷ This refers to the respondents whose partners had never accompanied them to family planning clinic. They were therefore not required to assign reasons why their partners accompanied them. That notwithstanding, some of them gave the reason that their partner's work schedule was not permissive and was therefore not a sign of rejection.

contrary, 27.8% of respondents reported that their partners do not provide this form of support. These respondents gave three main reasons for this. These include the fact that some of the respondents (1.1%) do not live in the same localities as their partners. In addition, others (25.6%) reported that they knew the date for the replacement and as such did not need the partner to remind them of it. Yet another group (1.1%) reported that their partners have no idea of the date of replacement and that is why they do not provide that support.

Table 16: Male Support in Contraceptive Replacement

Characteristic	N=90	Percent
Frequency of Contraceptive Replacement		
Don't Know		7.8
Monthly		12.2
Every three months		33.3
Yearly		5.6
Five Years		18.9
No Replacement		6.7
Not Applicable ⁸		15.6
Total		100
Role of Partner in Contraceptive Replacement		
Yes		72.2
No		27.8
Total		100
Explain Why Your Partner Plays No Role in the Replacement		

⁸ This refers to the respondents who use male/female condoms which are replaced after every individual sexual activity but which the options provided did not make room for. It also represents those who chose cycle beads which some of them claim was not replaceable.

We live in separate localities	1.1
I Know the date	25.6
He does not know the date	1.1
Not Applicable ⁹	72.2
Total	100

Source: Author's Field Survey, May 2013.

4.7 Cultural Characteristics and Family Planning

According to Stephenson et al., (2007), the decision of a woman to adopt a modern method of contraceptive is strongly influenced by how she perceived other community members would judge her actions. Previous studies showed that women may choose to adopt family planning, or indeed choose a particular method, as a result of the methods adopted by other women in the community. The association between contraceptive use and the levels of approval by women in the community may also reflect various underlying community processes, such as prevailing cultural norms surrounding the expected roles of women.

Bertrand et al (1995) have highlighted the importance of looking beyond physical access to examine barriers that arise from the socio-economic and cultural environment in which an individual lives when looking into the barriers to family planning service use. Both demographic and socioeconomic determinant of reproductive health service utilization are affected by cultural influences on health-seeking service behaviour (Basu 1990; Goodburn, Gazi and Chowdhury 1995). The health behaviour of individuals is often influenced by community beliefs and norms,

⁹ This refers to the respondents whose partners played an active role in contraceptive replacement and were therefore not required to respond to the question demanding reasons for their partners' non-involvement.

such that individual behaviour is influenced by community perceptions of individual actions (Rutenberg and Watkins 1997). This argument is reflected in the responses of respondent in relation to the awareness of family members and friends of the use of family planning. Majority of the respondents (64.4% for relatives and 71.1% for friends) reported that family members and friends are not aware of their decision to use family planning methods.

Deciding to use modern contraceptives is a difficult decision by most prospective users, especially women. The difficulties arise from the strength of the interplay of influences from close family relations. Furthermore, the economic dependency level of the woman on her close relations affects the decision process for the uptake of contraceptives (Benefo, 2005). The type of work and the amount of income earned by the woman in particular have a strong relation to use of contraceptives (Baiden, 2003)

This notwithstanding, 35.6% of the respondents took the bold step of informing relatives and 28.9% of respondents informed friends about their decision to utilise family planning. Some of the respondents (16.7% for relatives and 22.2% for friends) reported that their decision was met with encouraging words whereas 8.9% (relatives) and 24.4% (friends) discouraged them with their pronouncements. Moreover, some of the respondents reported that a certain percentage of relatives (3.3%) and friends (2.2%) were indifferent (see tables 8 and 9).

Table 17: Cultural Characteristics

Characteristic	N=90	Percent
Who takes the Decision on Family Planning		
The man		18.9
The woman		16.7
Both		64.4
Total		100
Awareness of Relatives with respect to Respondents' Usage of Contraceptives		
Yes		35.6
No		64.4
Total		100
Response of Relatives to Respondents' Usage of Contraceptives		
Encouraging		16.7
Discouraging because of side effects		8.9
Indifferent		3.3
No Response ¹⁰		6.7
Not Applicable ¹¹		64.4
Total		100
Respondents' Reaction to Relatives' Response		
Felt motivated		21.1
Felt discouraged		3.3
Indifferent		4.4

¹⁰ This represents the category of respondents who responded in the affirmative but did not provide an answer to the question on the reaction of their relatives to the knowledge of their usage of contraceptives.

¹¹ This refers to the respondents who responded in the negative when asked earlier on as to whether their relatives were aware that they are using contraceptives to plan their families. They were therefore not required to answer this question.

No Response ¹²	6.7
Not Applicable ¹³	64.4
Total	100

Source: Author's Field Survey, May 2013.

Respondents who were encouraged by both family and friends felt motivated whereas those whose relatives and friends discouraged them or showed no sign of interest were discouraged. Such discouragement can be affiliated to the cultural belief that it is usually culturally acceptable for women to have a large family (Touré, 1996) is likely to play a role in the discouraging responses that relatives gave to respondents. However, a section of the respondents reacted indifferently towards the negative responses that came from both family (4.4%) and friends (1.1%). Respondents reported that relatives made those discouraging remarks due to the numerous rumours of the various side effects of these methods (see table 8). Although there are mild effects experienced with the use of contraceptives, these are not serious and are usually short lived. However, these have been so grossly exaggerated to the extent that, many women are sceptical in using modern contraceptives. Furthermore, many diseases, which afflict people with age, especially beyond 45years, are associated with the pill. If a victim of any of these diseases (hypertension, diabetes, cancer etc) happens to be a woman who happened to be a pill user at one time or the other, it is blamed on the pill.

¹² This represents the category of respondents who responded in the affirmative but did not provide an answer to the question on their subsequent reaction to that of their relatives in respect of the latter's knowledge of their usage of contraceptives.

¹³ This refers to the respondents who responded in the negative when asked earlier on as to whether their relatives were aware that they are using contraceptives to plan their families. They were therefore not required to answer this question.

4.8 Reasons for engaging in Family Planning

Majority of the respondents (73.3%) reported that the need to space their children is the main reason and motivation for engaging in family planning methods. This is because child spacing is greatly valued and women in particular prize it (Ezeh 1991). Another category of respondents reported that they engage in family planning methods because of the desire to stop having children (16.7%). However, for some of the respondents (10.0%) economic reasons are paramount in their decision to engage in family planning. For these respondents, they engage in family planning because they cannot afford to have a large family (table 17). According to Frost and Lindberg (2012), majority of women perceive that using birth control allows them to better care for themselves and their families, either directly or indirectly through facilitating their education and career. For example, not being able to pay for a baby, not being prepared for children, feeling that children would disrupt goals, not having a partner and wanting better care for children already born were all considered very important reasons by the majority of women. These individual-level assessments of the advantages of personal contraceptive use are mainly consistent with the findings of broader economic research examining the role that contraceptive have played in improvements in social and economic conditions for women, particularly through greater education and more workforce participation (Goldin and Katz, 2000; Ananat and Hungerman, 2012).

Table 18: Reasons for Utilising Family Planning

Reasons	Percentage
To space children	73.3
Cannot afford to cater for many children	10.0
To stop having children	16.7

Source: Author's Field Survey, May 2013.

Due to these decisions, some of these respondents (17.8) have gone through a series of pressuring moments from their relatives to quit the family planning process and have more children. It is interesting to note that one of the reasons given for these pressures is that most of the respondents who are going through the pressure are the only child of their parents (5.6%). Others report that they are being pressured to have more children because the children that they have currently are of the same sex (5.6%) and also because there are few children in the extended family (6.7%).

4.9 Conclusion

From the above discussion of the findings of the study, it can be concluded that the educational level of the couple can determine whether they will go in for family planning or not. In addition, the ability for couples to communicate about the number of children they would like to have also helps in determining whether they will engage in family planning practices as well as the particular family planning method they would like to use. Moreover, the support those male partners provide for their female counterparts motivate these females to engage in family planning processes. In addition, the desires to properly care for children and space the years of childbirth are some of the reasons for the usage of contraceptives among respondents.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.0 Introduction

This study sought to explore involvement of men in family planning programmes. This was achieved through the identification of women's preferred family size, exploring the level of male support to their partners in the use of contraceptives and family planning, investigating the socio-demographic characteristics of women who are involved in family planning and exploring the relationship between preferred family size and male involvement in family planning.

5.1 Conclusion

Family planning programme planners have not actively developed programmes that would require the involvement of men in family planning. One main family planning method for men that is widely accepted is the use of the condom. However, males can prevent unwanted and unplanned for pregnancies if they employ Vasectomy. The study found that:

- **Male Involvement**

The physical involvement of the male partners is not felt although they provide their support both financially and serves as reminders of their wives. Also the insistence on the presence and consent of the male partners at least for the first visit to the health center by service providers sometimes restricts the use of the service since most of the male partners seem to show no interest in the use of contraceptives.

- **Spousal Communication**

Spousal communication is a key factor that helps to increase the possibility of family planning and can have a bearing on the type of contraceptive that a person uses. When spouses communicate about the use of family planning methods it helps to draw the attention and participation of the male partners.

- **Educational level**

The educational level of spouses also affects the decision to engage in family planning. Those who have a high level of education are more comfortable with family planning methods and are likely to adopt the use of contraceptives compared to those who do not have a high level of education.

- **Cultural norms**

Contraceptive users are most likely not to inform relatives and friends about their decision to use contraceptives due to the many cultural norms surrounding child bearing and the rumours of the side effects of these contraceptives. Moreover, the rumours of the perceived side effects associated with the use of contraceptives can also prevent the patronage of family planning methods.

- **Reasons for the use of contraceptives**

People mostly engage in family planning as a means to space their children, whereas others engage in family planning because of economic reasons. Yet another group of respondents engages in family planning because of the desire to stop having children altogether.

5.2 Recommendation

The research has provided some insight into contraceptive usage among Ghanaians. Based on the findings of the study the following recommendations are made

- Since all respondents in this study were females, it would be insightful for future studies to capture male opinions in order to establish the extent of support and usage of contraceptives among that population.
- Also, it would be insightful for future studies to investigate the level of trust in family planning procedures from both the perspective of the service providers and the extended families of users.
- Futures studies can also investigate why some women are still not engaged in family planning process after its long years of introduction into the Ghanaian society.
- There is the need for inter-sectoral collaboration to empower women so that to a large extent they can take control over their lives in terms of the use of the FP methods. This is necessary because it appears that their overdependence on the male counterparts and closed relative economically has over the years limited them from using family planning methods.
- In addition, the service providers should embark on a sensitization programme to educate people on the side effects of these contraceptives and how the side effects can be handled to prevent any damage to the patient.

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APPENDIX I: QUESTIONNAIRE**UNIVERSITY OF GHANA****DEPARTMENT OF SOCIOLOGY****TOPIC : THE INVOLVEMENT OF MEN IN FAMILY PLANNING: A CASE STUDY
OF 37 MILITARY HOSPITAL**

I am a final year student of the Department of Sociology, University of Ghana, Legon writing a thesis on “The Involvement of Men in Family Planning: A Case Study of 37 Military Hospital”, as part of my master of philosophy degree in Sociology. The finding of this research will be presented to the Department of Sociology in the form of thesis. The data will be confidential and used for statistical purpose only and identity of sources of information will not be disclosed. I would therefore be very grateful if you could spare some time to respond to this questionnaire.

SECTION A – (Socio- Demographic)

1. Age:

- a. 20 – 24 years
- b. 25 – 29 years
- c. 30 – 34 years
- d. 35 – 39 years
- e. Other (specify).....

2. Religion:

- a. Christianity
- b. Islam
- c. Traditional Worship

- d. Other (specify).....
3. Ethnicity
- a. Akan
 - b. Guan
 - c. Ewe
 - d. Ga
 - e. Dagomba
 - f. Other (specify).....
4. Marital Status
- a. Single
 - b. Married
 - c. Divorced
 - d. Separated
 - e. Widowed
 - f. Cohabiting
5. Highest level of education:
- a. No education
 - b. Basic
 - c. JHS
 - d. Secondary/Technical
 - e. Tertiary
 - f. Other (specify).....
6. Education level of partner

- a. No education
- b. Basic
- c. JHS
- d. Secondary/Technical
- e. Tertiary
- f. Other (specify).....

7. Occupation

- a. Bank official
- b. Teacher
- c. Driver
- d. Carpenter
- e. Auto – mechanic
- f. Shop attendant
- g. Tailor
- h. Security officer
- i. chef
- j. Other (specify).....

8. Occupation of partner

- a. Bank official
- b. Teacher
- c. Driver
- d. Carpenter
- e. Auto – mechanic

- f. Tailor
- g. Security officer
- h. Chef
- i. Other (specify).....

SECTION B: PREFERRED FAMILY SIZE

9. How many children would you like to give birth to?

- a. 1
- b. 2
- c. 3
- d. Other (specify).....

10. How many of these children would you like to be boys?

- a. 1
- b. 2
- c. 3
- d. Other (specify).....

11. How many would you like to be girls?

- a. 1
- b. 2
- c. 3
- d. Other (specify).....

12. What is the reason for the preferred sex of children.....

.....
.....

.....
.....

13. How many children do you have?

- a. 1
- b. 2
- c. 3

d. other (specify).....

14. Have you ever discussed with your partner the number of children you may want to give birth to?

- a. Yes
- b. No

15. If No explain.....

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

SECTION C: MALE SUPPORT IN THE USE OF CONTRACEPTIVES AND FAMILY PLANNING.

16. How were you introduced to contraceptives?

- a. At the clinic
- b. At the work place
- c. Through a friend

d. Other (specify).....

17. How often do your partner accompany you to the family planning clinic?

a. This is my first time

b. Every time

c. Sometimes

d. Other (specify).....

18. What is the reason for accompanying you?

.....

.....

.....

.....

.....

19. Who usually pays for the services?

a. The man

b. The woman

20. Which of these family planning methods have you/your partner ever used? (**tick as many as apply**)

a. Pill

b. Male/Female condom

c. IUD

d. Cycle beads

e. Injection

f. Jadelle

- g. Vasectomy
- h. Tubal ligation
- i. Other (specify).....

21. Which one are you using now?

- a. Pill
- b. Male/Female condom
- c. IUD
- d. Cycle beads
- e. Injection
- f. Jadelle
- g. Vasectomy
- h. Tubal ligation
- i. Other (specify).....

22. How long have been using it?

- a. 0-1 month
- b. 1-2 months
- c. 2-3 months
- d. 3-4 months
- e. Other (specify).....

23. How often does it need replacement?

- a. Don't know
- b. Daily
- c. Monthly

- d. Yearly
- e. Other (specify).....

24. Are you reminded by your partner about this replacement?

- a. Yes
- b. No

25. If no explain.....
.....
.....
.....
.....

SECTION D – CULTURAL CHARACTERISTICS OF MEN INVOLVED IN FAMILY PLANNING

26. Who makes the decision on family planning?

- a. The man
- b. The woman
- c. Both

27. Do family relations know that you are using family planning?

- a. Yes
- b. No, if No skip to 30

28. What was their response?
.....
.....

29. How did you take it?

.....

.....

30. Do friends know about it?

a. Yes

b. No, if no skip to 33

31. What was their response?

.....

.....

32. How did you take it.....

.....

33. Why did you decide to use family planning

a. To space children

b. Cannot afford to look after many children

c. To stop having children

d. Other (specify).....

34. Where do you live?

35. Is there no other clinic in your residential area that can render the service?

.....

.....

36. Why is this a preferred clinic?

- a. I always receive medical treatment here
- b. It was recommended by a friend
- c. I do not want to be seen in the community as controlling birth
- d. Other (specify).....

37. Have you ever been pressed by your parents/ in-laws/ relations to have more children?

- a. Yes
- b. No

38. If yes give reasons.

- a. Children are of one particular sex
- b. Being an only child
- c. Not having many children in the extended family
- d. Other (specify).....

THANK YOU

APPENDIX II: QUESTIONNAIRE**UNIVERSITY OF GHANA****DEPARTMENT OF SOCIOLOGY****TOPIC: THE INVOLVEMENT OF MEN IN FAMILY PLANNING: A CASE STUDY OF
37 MILITARY HOSPITAL
IN-DEPTH INTERVIEW GUIDE (FOR SERVICE PROVIDERS)**

I am a final year student of the Department of Sociology, University of Ghana, Legon writing a thesis on “The Involvement of Men in Family Planning: A Case Study of 37 Military Hospital”, as part of my master of philosophy degree in Sociology. The finding of this research will be presented to the Department of Sociology in the form of thesis. The data will be confidential and used for statistical purposes only and identity of sources of information will not be disclosed. I would therefore be very grateful if you could spare some time to respond to this questionnaire.

Qualification of care provider

- a) General Nursing
- b) Community Health
- c) Public Health
- d) Midwife
- e) Others (Specify)

1. What is your position on male participation in family planning?
2. What range of family planning needs do you provide in the clinic?
3. What reproductive services does your facility provide for men?
4. Which methods of family planning do men usually prefer? (For themselves/partner)
5. How do you select a method of family planning for your client?

6. What is the composition of your advisory board/committee?
7. How much does it cost to provide contraceptive services?
8. What reactions do you receive from men on the cost of contraceptives?
9. Can a client pick up reproductive supplies at any time?
10. If a client defaults, what do you do?
11. How do you carry out follow up service?
12. Do you provide separate rooms for male clients?
13. How long does the clinic operate each day to provide family planning or reproductive health care?

DAY	OPEN	CLOSE
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

14. Are there special days or hours for men? What are these?
15. How do you protect your male clients?
16. Do men often accompany their partners to the clinic?
17. On the average, how many clients visit your facility every day?
 - a. Female.....
 - b. Male.....

18. How many employees/ volunteers work in the clinic?

	Female	Male
Employees		
Volunteers		

19. What is the nature of relationship between staff and clients?

20. Do you have a special hotline for men to call for more information?

21. How do you assess the level of male involvement in family planning?

22. As a health worker interested in family planning issues how do you receive information and training on male reproductive health?

23. Give suggestion to help motivate men into family planning

24. What is the future of family planning for your clinic?

THANK YOU