CHAPTER ONE-INTRODUCTION

1.0 BACKGROUND INFORMATION

The recent attention drawn to the issue of family planning by international bodies like the World Health Organization (WHO), United Nations Fund for Population Agency (UNFPA) cannot be over-emphasized. This is due to the socio economic implications and health hazards that high population growth rate have increasingly manifested in the economies of Developing Countries.

Inadequate family planning strategies have continuously exacerbated the vulnerability of developing countries, culminating into high maternal and infant mortality, increasing hard core poverty, disintegration of the extended family system, high incidence of HIV/AIDS and sexually transmitted infections and a high incidence of morbidity and mortality. At least 25% of all maternal deaths can be prevented by family planning. One in four infant deaths in developing countries can be prevented by spacing birth at least two years apart (Shane 1996).

Population growth rate has strong linkages with Economic Growth and Sustainable Social Development.

The above view points to the fact that rapid population growth as against scarce resources has been and is presently one of the major problems facing most countries in the world today. As a result, attempts are being made globally to create awareness and find ways of combating it. The widely accepted strategy is controlling or regulating fertility.

All this while, male involvement in family planning was not an issue on the platform. This is due to the fact that over the past few decades, there has been bias in the design of family planning programs, which almost excluded men simply because most of the services were

offered within maternal and child health clinics (MCH). Most research and information campaigns focused on women, reinforcing the belief that family planning is largely a woman's business with the man playing a peripheral role.

Many family planning programs have now recognized that involving men and obtaining their support and commitment in family planning is of crucial importance in Ghana 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 involvements 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. This study therefore seeks to investigate among others the level of male involvement in family planning in the Ga West District in the Greater Accra region and strategies to adopt in improving the levels of male involvement in this district.

1.1 Problem Statement

The Ministry of Health with the assistance from John Hopkins University launched educational campaign programs in all the regions of Ghana (1997) 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 attitude 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 male involvement in family planning nationwide, in areas such as the Ga West District, male involvement is not encouraging and a barrier to even females' acceptance and practice of family planning (GSS 1998). Ga West District, though located in the Greater Accra Region is fast growing in population with relatively low level sustainable development, hence making the district one of the poorest in Ghana. This has resulted in the people's inability to provide for themselves and their families the basic necessities of life. The study therefore seeks to ascertain why male involvement, approval and practice of family planning is still low in the Greater Accra Region and Ga West District in particular and how they can move from the high level of knowledge and awareness to a high level of support for and practice of family planning.

1.2 JUSTIFICATION /RATIONALE OF THE STUDY

According to GDHS 2003, the percentage distribution of currently married men who know a method of family planning by approval and of family planning in general, indicated that the Ga West district in the Greater Accra Region recorded among others the least in both approval and disapproval with figures of 62.1% and 27.0% respectively. Again, as indicated by the Ga West District Annual Report (2007) there is a progressive percentage increment of family planning acceptance rate, from 2005 to date with percentages of 15.0,17.6 and 18.1 respectively. However, this is far below both the Regional acceptance rate of 53.9% in 2007 and national target of 30% (GHS Annual Report, 2005). This poor Family Planning acceptance rate in the District could partly be due to the negative attitudes and ignorance of most men about Family Planning, seeing it as a strategy to deny them the right to bring forth the number of children desired. Practicing of Family Planning by women in this area often results in violence against them from their partners and most of them even hide to do it without their husbands notice. This has led to women giving birth to more children than they can cater for, as childcare is virtually in the hands of the women in most rural areas. They are also likely to face pregnancy and childbearing complications leading to high maternal mortality. This study would unravel the problems in males' involvement in family planning in this District and recommend measures to address them. The report would be useful to policy makers and other stakeholders to address the problem in the District.

1.2 RESEARCH QUESTIONS

- How supportive are men to their partners in the use of contraceptives and family Planning?
- What are the beliefs, perceptions and attitudes of men towards family planning
- What do people know about FP and its practice in this district?
- What strategies can be put in place to improve male involvement, approval, practice and support of family planning in the District?

1.3 GENERAL OBJECTIVE

The main aim of the study is to investigate the level of male involvement in family planning programs in the Ga West District.

1.4 SPECIFIC OBJECTIVES

The specific objectives of the study are:

a) To determine the level of male support to their partners in the use of contraceptives and family planning.

b) To investigate men's attitudes, beliefs and perceptions about family planning.

c) To investigate the knowledge, approval and practice of males in FP

d) To suggest strategies in improving male involvement in FP.

e) To recommend the findings to developing partners, public health practitioners, District assemblies, international communities to embark on comprehensive and participatory family planning programs in the Ga West District.

1.5 SCOPE OF THE AREA

The study covered part of the Greater Region but confined to Ga rural and other surrounding urban towns found within Amasaman, Obom and Weija district. Ten

communities from these three sub-districts were randomly selected for the study. The study was limited to the main study variables; thus partner support in the use of contraceptive and family planning, men's knowledge, men's attitude, their perceptions in family planning programs

1.6 CONCEPTUAL FRAMEWORKS ON THE FACTORS THAT HINDER MALE INVOLVEMENT IN FAMILY PLANNING

INADEQUATE FAMILY PLANNING SERVICES

- Focus on only female
- Done at only MCH.

EDUCATIONAL:

- Inadequate educational skills on the part of service providers
- Inadequate promotional activities
- Ambiguous messages, posters and flyers etc.

SOCIO-CULTURAL FACTORS

- Large families
- Beliefs and practices
- Promiscuity

- Stigma

ATTITUDE OF SERVICE PROVIDERS

- Inadequate training
- Inadequate motivation
- Pilfering of contraceptives

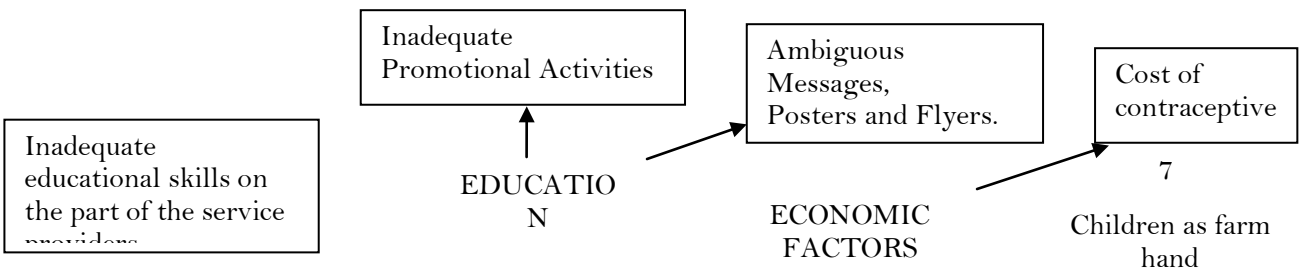
ECONOMIC FACTORS

- Cost of contraceptive
- Children as farm hands

SOURCE: Author 2008

CONCEPTUAL FRAME WORK

1.7 FIGURE 1.0 FACTORS HINDERING MALE INVOLVEMENT IN FAMILY PLANNING



1.8 EXPLANATION OF CONCEPTUAL FRAMEWORK

In investigating the level of male involvement in family planning in the Ga West district the following factors as illustrated from the above diagram (figure 1.0) have been identified to a large extent, as influencing the alienation of males from family planning programs. They include economic factors, attitude of service providers, socio – cultural factors, inadequate family planning services and educational factors.

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 programs. 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; male involvement also includes the number of men who encourage and support their partners in contraception and peers to use family planning and who influence the policy environment to be more conducive to developing male related programs. 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 was reviewed on various issues relating to the topic. These include; the state of family planning across the globe; the continent of Africa and Ghana. Also reviewed were 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 in the Ga West District.

2.1 INVOLVEMENT OF MALES IN FAMILY PLANNING INITIATIVES IN AFRICA

There has been considerable initiative in various forms to involve males in family planning programs in Africa. Programs 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 communications campaigns using 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 programs can have an impact on both male and female behaviors related to reproductive health

2.1.2 INVOLVEMENT OF MALES IN FAMILY PLANNING INITIATIVES IN GHANA

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, counseling skills among MOH service providers, and strengthen the MOH's ability to develop, implement, monitor, and evaluate communication programs in health.

A 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, Brong Ahafo 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 and 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 et al.., 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).

2.2 KNOWLEDGE, APPROVAL AND PRACTICES OF FP.

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 emphasizes that special efforts should be made to emphasize on men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, 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 interuptus) has been used as a contraceptive method since biblical times (PAI, 1991). And 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. World wide, one-third of the eligible couples using family planning rely on methods (vasectomy, Condom, Withdrawal and periodic abstinence) which require full male co-operation. In the developing countries the period 1970s and early 1980s, about one-fourth of the contraceptors relied on male methods (Population Report 1986). In the past decade (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.

that men and women do not necessarily have similar fertility attitudes and goals (Ezech 1993 and Bankole1995). Moreover, the scope of fertility and family planning research has.

According to (Awuni et al 2005) in his publication spousal communication and family planning in Amasaman, 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. 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), all revealed that, it is culturally acceptable for one to have a large family. Other economic factors include use of children as labor 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 programme to emphasize men's shared responsibility and promote their sexual and reproductive behavior, including family planning. 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. For example the sexual disease (i.e. sexually tract infections- STI's) is normally not stressed in national programs. There is also lack of information on responsible sexual behavior for the adolescents and the youth. Provider bias does affect male services. As one UNFPA report on male involvement summarizes, that;

Most reproductive health and family planning service delivery systems are almost entirely oriented to women and provide little or no information about male contraceptive methods. Health workers are sometimes poorly trained in counseling men about safer sexual practices and male methods and may communicate negative rumors about them (Green et, al. 1995)

Many family planning programs have now recognized that involving men and obtaining their support and commitments in family planning programs is of crucial importance in Ghana 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 involvements 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.

It is also noted that programmers have ignored the roles of men in the past, focusing only on women's behaviors 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. Furthermore, the level of contraceptive use among married men is such that men could participate in family planning activities if there were adequate programs 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.

In June 1995 study from North Gondar Ethiopia reveal that; Sixty one percent of men knew at least one method of family planning (FP) and 64.3% of them approved the use of FP. Forty one percent of these said that only women should use contraception. Involvement of couples on the choice of family planning methods and desired number of children in the family was approved by 58.3% of men. Only 47.2% of the study participants had heard about condoms. Misconceptions and negative attitudes towards condoms prevailed among men. Only 23.9% of married men have discussed family planning with their wives. Overall, 10.6% of men have ever used condoms in the past, and 6.1% are currently using condoms. Only 39.3% of current non-users of FP are planning to use FP in the future.

Contrarily, about 90% of the men from the Ga West district knew of at least more than one method of family planning, with a relatively moderate (44%) approving Family Planning usage, reasons mostly based on religion and cultural values.

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 the 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 per cent) as the primary reason of non-use followed closely by infrequent sex relations/not having sex and fatalistic attitudes (9 per cent). Reasons for non-use however, differ considerably by age of women. Unfavorable attitude toward family planning (24 per cent) either by women themselves or by their husband, fatalistic attitudes (20 per cent) and religion (9 per cent) are the major reasons for the women below 30 years of age (53 per cent). Older women (30), on the other hand, normally report reasons such as in fecundity (including menopausal) or having no sex/infrequent sexual relations (68 per cent combined).

There are some significant differences in reasons for non use between married women and men. More men (11 per cent) than women (4 per cent) mention that they oppose family planning. Men are also less likely to cite the reason such as infrequent sex / having no sex than women (8 per cent versus 16 per cent). Religious prohibition, as the reason of non-use, varies little between men and women. Another reason is that most women in Ghana 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 mostly branded witches in their old age. Lack of desired communication between spouses about family planning may also be a serious barrier to contraceptive use. In the most recent years (1999-2000) over half (52 per cent) of the currently married women said they had not discussed with their husbands about family planning. Of the remaining, while 40 per cent had discussed it twice or less, only 8 per cent 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 2000 (GWDS) indicated a discouraging low proportion of wives who talks to their husbands about family planning and any other issue relating to reproductive health .

Use of the traditional method, that is withdrawal, rises with an increase in the level of education. Women with a secondary education and more report the highest use (6.4 per cent) of withdrawal. By age at very two extreme ends (at early young and old) women report the use at a higher rate. The level of current contraceptive use is higher in urban areas (60 per cent) than in rural areas (52 per cent) among women. There is a considerable difference in condom use reported by women in urban (10 per cent) and rural (3 per cent) areas, probably indicating easier availability of the method in urban than in rural areas.

Major factors believed to affect the attitudes of Ghanaians towards family planning and contraceptive use are, the socio economic well being of the people, religious and traditional-held values and beliefs and lastly lack of correct information about the side effects of modern contraceptives. These mentioned variables are not different from the Ga West District as per the findings from the various communities.

Many Ghanaian women, those who practice family planning and those who do not practice family planning have realized the need to limit size in order to improve upon the economic well-being of the family. When women participants were asked what the ideal number of family should be, those from Accra, Kumasi and Takoradi said three or four, one said "The way i want to educate my children, I need four or three years between them. I can't have more than three because the children will also be very healthy" Another said, "Not more than three, if both partners cooperate, they will be able to care for them and see to it that they are well developed"

Rogers 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 behavior deal with beliefs and values that are very independent to

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 Ga West and 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 rumors 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, but these have been so grossly exaggerated to the extent that, a lot of women are skeptical in using modern contraceptives.

Further more, 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 a pill user at one time or the other, it is blamed on the pill. In a survey conducted by Roger, a respondent referred to a 43years old neighbor who had a swollen stomach 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 ever 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 rumors and counter campaigns which family planning invariably provoke".

Several research works 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. For example a young woman goes to the family planning clinic for the first time and seeks advice on contraceptives. She is briefly told about the pills ,foaming tablets, and IUD but is finally convinced to adopt the IUD (because at the particular time the only contraceptive available is the IUD) She agrees to adopt the method and five minutes later walks out of the clinic with an over sized IUD in her womb(the only size of IUD available at the clinic, and therefore the preliminary examinations that must normally take place to decide on correct size before the IUD is inserted in the womb has not been necessary) Sooner or later, the young woman experiences severe cramps, bleeding, pains in her abdomen and knees and she is not able to stand up straight. She goes back to have her device removed, but not before she tells her friends about her experiences. Her friends tell her neighbors and co-workers the latter their neighbors and relatives and so on and where do we apportion blame for the exaggeration that accompanies the story at each stage of transmission? These are some of the reports given by participants at family planning clinics.

Another characteristic which distinguishes family planning communication as noted by Rogers 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 practicing family planning would have to practice it undercover to avoid being attacked by their husbands if they should find out later.

2.3 MALE SUPPORT AND FAMILY PLANNING PRACTICE

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 counseled (Tapsoba et al., 1993).

Spouse 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 to women, so men are uncomfortable about going to these clinics. Men must be reached in other ways. This testimony from a Kenyan man is a good illustration of that need: "After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with the natural methods we were using. Her blood pressure immediately shot up, and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty, too, to take part in family planning. One morning we went together to our local family-planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally lost." (Wambui, 1995). This confirms the assumption that no matter how many men want to know about and utilize contraception, most family-planning programs have not yet given adequate attention to serving them.

Findings from Focus Group Discussion from Weija community almost corroborated the Kenya man's story, where instinctively, a man who went to the Family Planning center for counseling, upon seeing only women, thought he was at the wrong place, though in actual sense that was the venue he was coming to. Again, almost all the care providers confirmed their inability to satisfy or encourage men to patronize their facilities due to lack of either male-friendly environment or personnel either male or female trained specially to attend to men only. These handicaps according to the health professional, makes it difficult to entice males to visit the facilities.

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. Programs 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, focused male-involvement programs can have an impact on both male and female behaviors related to reproductive health.

2.4 FACTORS INFLUENCING/HINDERING (ATTITUDES, BELIEFS AND PERCEPTIONS) OF MALE INVOLVEMENT IN FAMILY PLANNING

Rogers 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 behavior deal with beliefs and values that are very independent to 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 Ga West and 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 rumors 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 skeptical in using modern contraceptives.

Further more, many diseases which afflict people with age, especially beyond 45years are associated with the pill. If a victim of any these diseases (hypertension, diabetes, cancer etc) happen to be a woman and happened to have a pill user at one time or the other, it is blamed on the pill. In a survey conducted by Roger, a respondent referred to a 43years old neighbor who had a swollen stomach 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 ever 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

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 (Ringheium 1993 Leriden 1986 and UNFPA)

This view was also expressed by some group of men in the Obom sub district, where they claimed condom use interrupt 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. Currently married women who approved of family planning were four times more likely to use contraception than those who did not approve. Married women who discussed family

planning with their partners were three times more likely to be current contraceptive users. Currently married women with higher education were three times more likely than uneducated women to use contraception.

This finding holds true, in the Ga West District, where as the result indicated, majority of the respondent's only had formal education to the primary level. Also, a sizeable number of them also indicated their non-use of contraception due to them having inadequate knowledge about Family Planning, this to a larger extent could be attributed to their inability to appreciate, read or understand issues on Family Planning from health educators either through community health workers or the electronic and the print media

Also, 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 to women, so men are uncomfortable about going to these clinics. Men must be reached in other ways. This testimony from a Kenyan man is a good illustration of that need. Findings from Ga West District, revealed among other reasons why men do not accompany their spouses to the clinics as the fact that; Family Planning centres were far away from their place of residence and would have wished to attend but for time factor, other reasons were the fact that the facility lacks confidentiality, where they would have wished to have confident or private discussions on issues concerning Family Planning and reproductive health in general with care providers devoid of any interference from the general public.

As a policy measure, information, education and communication programs on family planning should be intensified, particularly in rural areas. Female education, at least up to secondary level, should be given top priority.

2.5 STRATEGIES TO IMPROVING INVOLVEMENT OF MALES IN FAMILY PLANNING

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 to 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 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, practice of male contraceptives share half of the current contraceptive rate in Turkey.

In addition, practicing family planning by males is now well recognized to have important implications on needs of couples. For example, use of the male methods (condom) may relieve women of various health risks posed by their prolonged use of oral contraceptives (Bruce 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 condom.

Also, on the grounds of gender equality, responsibility for birth control should be shouldered by men and women alike. It is therefore emphasized 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 gender oriented

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 posses 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 recognizes the need to encourage male contraception with increased efforts and also, important to enhance the sustainability of the family planning programs.

It is an accepted fact globally that when a variety 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 (Ringheium 1993 Leriden 1986 and UNFPA)

The government family planning programme continues to enjoy favorable 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 programme development in Ghana can augment the seemingly low level of male participation

CHAPTER THREE

METHODOLOGY

3.0 PROFILE OF STUDY AREA

The study area covers Ga West District in the Greater Accra Region with Amasaman as its district capital. It was carved out of the original Ga District in 2004 as part of

government decentralisation program. Ga West District is the third largest district in the Greater Accra Region after the Tema Municipality. The District is located in the Southern part of Ghana. It shares boundaries with Awutu-Afutu-Senya districts to the West, Akwapim South District to the north, Accra Metropolis to the South-East and the Atlantic Ocean to the south and has a total land space of 710.2sq km. It has over 300 scattered communities;

The study population is heterogeneous, comprising Gas, Akans, Ewes, Hausa etc. However, the Ga ethnic group owned the land and are in the majority. They are predominantly farmers, petty traders, fishmongers etc. Christians and Muslims dominate the district with few traditional believers. The area is densely populated. The common language spoken here are; Ga, Ewe and Akwapim Twi. Ga kenkey and hot pepper with fried fish is said to be the stable food for the Ga people.

Economically, members are not better off as they are mostly peasant farmers and fishmongers. Poverty is at its peak in the area, as a result, parents find it difficult in providing three square meals daily and to pay premium to enable them enrol into the district-wide mutual health insurance scheme. However, Plan Ghana and Action Aid International have come into the district with a number of interventions in the area of education, health and livelihood.

Quality of roads in the Ga West District is not good, especially during the rainy season. This makes undertaking out- reach programs very difficult during this period, denying most of the communities access to good health care services. The District has a total of 281.15 km road length, representing 8.5% of roads in the region. The major roads in the District include Accra-Nsawam and Mallam-Weija roads. Basically, all the roads in the District are classified as feeder. The feeder roads in the District are further divided into Engineered, Partially engineered and Non-Engineered. About 15.9% of the 291.15Km road length is engineered, while 8.4% constitute partially engineered. The remaining 75.7% is non-engineered.

The district can only boast of three health centres, five community initiated facilities with three CHPS compound. These facilities are manned by midwives and medical assistants.

3.1 THE TOP TEN DISEASES IN THE DISTRICT

No.	2006			2007		
	Disease	**NO**	**%**	**Disease**	**No.**	**%**
1	Malaria	14825	39.9	Malaria	15859	39.5
2	Skin diseases	10326	27.8	Skin diseases	11531	28.7
3	Diarrhea diseases	2986	8.0	Diarrhea diseases	3484	8.7
4	Acute respiratory infections	3235	8.7	Acute respiratory infections	3325	8.3
5	Anemia	1890	5.0	Anemia	1870	4.7
6	Hypertension	1345	3.6	Hypertension	1544	3.9
7	Road traffic Accidents	870	2.3	Road traffic Accidents	810	2.0
8	Rheumatic & joint pains	590	1.6	Rheumatic & Joint pains	790	1.97
9	Intestinal worms	724	1.95	Intestinal worms	644	1.6
10	Pneumonia	356	0.95	Pneumonia	280	0.69

SOURCE: DHMT, GWD 2008

3.2 STUDY METHODS AND DESIGN

This study is to determine the level of male involvement in family planning among resident in the Ga West District and to investigate the socio-cultural barriers that militate against their acceptance and practice of family planning.

Descriptive method and cross sectional study was used as the study design. The study used different data collection techniques. The interview method was used to solicit information

on the background characteristics of respondents as well as their knowledge and family planning behaviors. A total of 244 respondents were interviewed using simple random, systematic and purposive sampling. The tools used were written questionnaires administered by six interviewers.

Also, key informant interviews were conducted to assess the effectiveness of the programs in involving males in family planning programs

3.3 STUDY POPULATION

The population included men and women in their reproductive age (17-56years) that are family/ household heads and are resident in the district with 3-8 children and married.

A total of four health providers at the family planning clinics were interviewed.

Participants for the FGD were selected with the assistance of some key informants in the various communities through non-probability sampling technique. In each community within the three sub-districts, discussions were held with each of these groups using focus group guide. Between five (5) to eight (8) discussants were selected per a FGD session, using such grouping criteria like marital status, gender, age and socio-economic status to ensure homogeneity. These groups were selected on the basis of their experience and knowledge on the topic of study

The in-depth knowledge these people provided was corroborated with the answers from the questionnaire to assess the extent of male involvement and the way forward.

3.4 TABLE OF STUDY VARIABLES

Variable	Operational Definition	Indicator	Scale of Measurement	Techniques
Education	Level of education	Primary, JSS, SSS, Tertiary	Nominal scale	Interview
Knowledge of FP	Ever heard and benefit of FP	Respond to questions	Ordinal scale	Interview

		asked		
Income of the household.	Monthly income of a household	Thousands of Ghanaian Cedi	Ordinal scale	Interview
Cost of contraceptive	Amount paid for contraceptive.	Very costly, costly, Moderate, cheap.	Nominal scale	Interview
Gender bias	Males deciding contraceptive in the household.	Decision making	Nominal	Interview
Value for children	Love for many children	Large family size	Nominal scale	Interview
Occupation	Type of work respondents do	Working, not working.	Nominal scale	Interview
Ignorance	Have no knowledge of contraceptive	Response to questions asked	Nominal scale	Interview
Fertility	Number of children desired	Response from Questions asked	Nominal scale	Interview
Male partner support	Men showing interest of their spouses on FP, also accompanying their partners to the health centre for FP advice	Responses to questions asked	Ordinal scale	Interview
Ideal family size and sex preference	The number of children to have and the preferred sex of the new born child.	Responses to questions asked	Ordinal scale	Interview

3.4 Data Collection Techniques and Tools

The study used different data collection techniques. The interview method was used to solicit information on the background characteristics of respondents as well as their knowledge and family planning behaviors.

Also, Focus Group Discussions and institutional (In-depth) interviews were conducted to assess the effectiveness of the programs in involving males in family planning programs.

3.5 SAMPLING TECHNIQUE

3.5.1 Selection of Communities

Ten communities were selected for the study. Simple random sampling was used to select the ten participating communities. All the communities in the District were listed to constitute the sample frame. The names of these communities were written on pieces of paper, folded, put in a container and closed. The contents of the container were shaken several times to ensure a good mix or randomization of the pieces of paper. The ten communities were then picked at random one after the other. These selected communities constituted the study communities.

3.5.2 Selection of Houses

Houses, within which households were resident, were selected by systematic sampling. A list of all houses in each community was collected from the District Directorate of Health Services. The first household was selected through simple random sampling followed by the selection of every other fifth house in that order. Thus house 1, 5, 10, 15, 20, 25, 30, 35, 40, 45, 50 and 55 until the number of houses that were satisfied to have contained the number of households to administer the questionnaire were obtained.

3.6.3 Selection of Respondents in Households

In each community twenty-four persons were contacted, at the household level. Purposive sampling technique was adopted in selecting respondents who were mainly married men and women who are heads of household since they are the focus of the study.

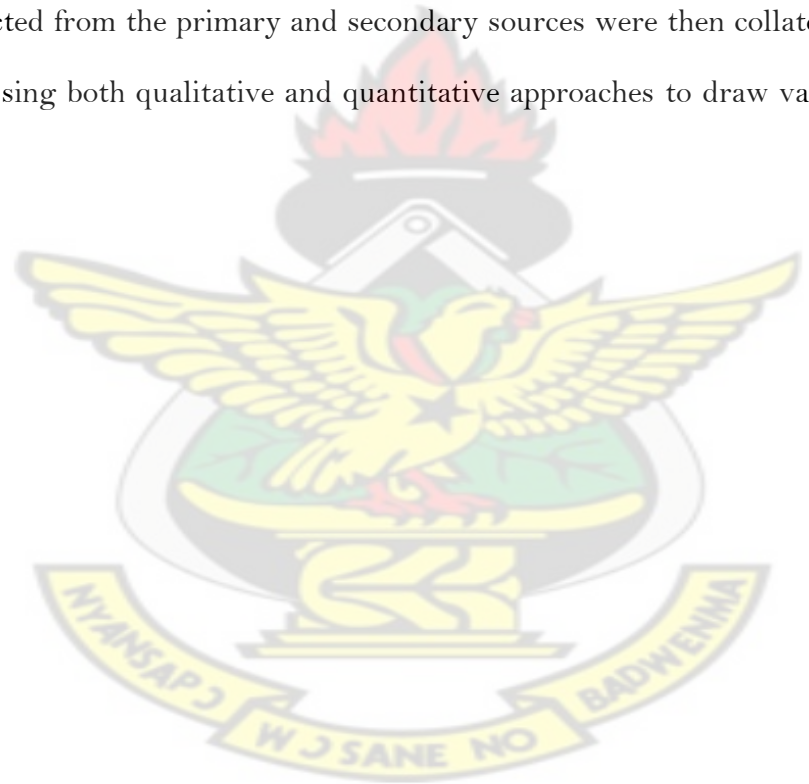
3.6.4 Selection of Respondents of focus groups (FGD)

Participants for the FGD were selected with the assistance of some key informants in the various communities through non-probability sampling technique. In each community, discussions were held with each of these groups using focus group guide. Between five (5) to eight (8) discussants were selected per a FGD session, using such grouping criteria like marital status, gender, age and socio-economic status to ensure homogeneity. These groups were selected on the basis of their experience and knowledge on the topic of study

3.6.5 Selection of Participants for In-depth interview

Participants for the In-depth interview were selected family planning providers.

The data collected from the primary and secondary sources were then collated, synthesized and analyzed using both qualitative and quantitative approaches to draw valid conclusions and inferences.



3.7 SAMPLE SIZE ESTIMATION

A total of eligible 244 candidates are sampled. This was based on the family planning acceptors, with the figure of 18% for the district. (The District Annual Report, 2007). Ten Communities were used, out of these, 24 respondents were selected from (9) communities and (28) from (1) community, totaling 244.

Sample size was calculated using the formula

$$N = z^2 (pq)/d^2$$

(Wayne 2006)

Where N = sample size

Z = Reliability Coefficient with 95 percent confidence certainty

P= Population variance available from previous data, where q = 1-p

D = the desired or the required size of standard error allowed

If the value of p is 0.18 (which gives the largest sample size) and the desired standard error chosen to be 0.05 with reliability coefficient of 95 % certainty (z = 1.96)

Then, $N = \frac{\lceil (1.96)^2 (0.18*0.82) \rceil}{(0.05)^2}$

N = **244**

3.8 PLANS FOR DATA HANDLING.

The safety of data to be collected was guaranteed by ensuring proper handling and maintaining data. All such data were retrieved from field assistants and kept at a secure location to prevent data from adverse weather conditions and damage from children. Responses from interviews and focal group discussions were recorded with the permission of respondents.

3.8.1 QUALITY CONTROL

Research Assistants were adequately prepared before they went into the field. This ensured quality of the data in terms of its reliability and validity. Training sessions were organized for research assistants; the purpose of which was to introduce them to methods of collecting accurate data and community entry skills. The student researcher personally supervised the research assistants to make sure that quality data is collected. Ensuring that interviewers go through their questionnaires to be sure that it is completed before the interview ends. The researcher again, did daily checks on the questionnaires submitted to make sure that questionnaires are completely filled and recorded information makes sense

3.9 PRE-TESTING OF RESEARCH INSTRUMENT

A pilot study using a sample of twenty (20) men was selected from Aborkobi in the Ga-East municipality. This was to assess the level of male involvement in family planning activities. The pretest afforded me the opportunity to assess the reactions of respondents to the research procedures, such as community entry and local protocols. The ability of respondents to accurately understand questions asked as well as the ability of interviewers to ask the right questions and record them accurately. Other factors that were taken into consideration included the appropriateness of the sequence in which the questions were arranged, time allocated to the interviews and the budgetary implications. All my research assistants were involved in the pretest that ensured adequate preparedness for the field work.

3.10 DATA ANALYSIS TOOLS

Data collected was summarized and stored in percentages and frequency distribution tables, which was used to group sample data.

3.11 STATISTICAL METHOD

Computer software's such as excel was used to create the database and other software's like, Statistical Package for Social Sciences (SPSS) was used for the statistical analysis

3.12 SELECTION AND TRAINING OF RESEARCH ASSISTANTS

Research assistants selected had the same educational background, which included among others, adequate knowledge in family planning issues, existing local conditions, having interest in family planning in general and male involvement in particular to reduce biases. Selected research assistants were trained on all areas covered in the field manual and interview techniques.

3.13 DISSEMINATION OF FINDINGS

With the help of the stakeholders particularly the GWDA and DHMT, a durbar of opinion leaders was organized in the district capital for the presentation of findings. This included representative from the District Assembly, the DHMT, chiefs, women and other influential leaders from all the communities in the district, NGOs and other decentralized department in the district. The eventual objective is the publication of the report.

3.14 ETHICAL CONSIDERATION

Ethical clearance was first gotten from School of Graduate Studies, giving me an ethical backing for the research. Again, proper community entry was followed, respecting all community structures and protocols. This enabled me explain the purpose of the study to them, since FP issues are very sensitive within the traditional setup. Informed consent was also sought from community elders. This was done along-side some DHMT staff since they are most known in the study area. Again, conscious efforts were made to learn certain don'ts of the various communities before entering and when entered. All information that is gotten from the respondents was treated as confidential.

3.15 ASSUMPTIONS

Assuming that;

a. The study population is representative of the total population
b. Funding will be gotten for the study
c. The communities under study will be receptive and the information given by the respondents are true.
d. No chieftaincy or tribal conflict within the data collection period, hence reducing to a large extent the element of bias in the collection of the data.

3.16 LIMITATIONS OF THIS RESEARCH

- Language barrier may serve as a limitation to the research, since I would not be in the position to communicate directly with the respondents especially in the Ga spoken by them.
- The two hundred and forty four sample size may not be a good ground for extrapolation or generalization of study finding.
- The structured questionnaires to be used may be misunderstood and most likely to affect the true reflection of findings.
- The period for data collection may coincide with the busy schedules of respondents and may have little time for data collectors, since it would be in the rainy season. This may affect respondent's output and hence research finding

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Table 1. Demographic Characteristic of Respondents

VARIABLES	FREQUENCY	PERCENT
Age		
17-22	4	1.64
23-28	36	14.75
29-44	115	47.13
45-50	73	29.92
51-56	16	6.56
Total		
Occupation		
Farming	50	20.49
White color job	77	31.56
Artisan	107	43.85
Unemployed	9	3.69
Others	1	0.41
Total	244	100
Religion		
Islam	41	16.80
Christian	142	58.20
Tradition	38	15.57
Pagan	20	8.20
Others	3	1.23
Total	244	100
Ethnicity		
Ga	75	30.74
Ewe	77	31.56

Twi	64	26.23
Hausa	17	6.97
Others	11	4.51
Total	244	100
Marital Status		
Single	3	1.23
Married	223	91.39
Widowed	5	2.05
Cohabite	9	3.69
Divorced	4	1.64
Parity		
1-3	173	71.31
4-7	61	25.00
8-11	9	3.69
Total	244	100
Educational Level		
No schooling	31	12.70
Primary	33	13.52
JSS/Middle	77	31.56
Secondary	66	27.05
Tertiary	36	14.75
Others	1	0.41
Total	244	100

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Ages of respondents varied greatly, with majority of them coming from the age range of 29-45(47.13%) and 45-50(29.92%) with a minority age group of 17-22, 23-28, and 51-56 forming 1.6%, 14.75% and 6.56% respectively.

About 20.49% of the respondents as seen above were engaged in farming for their livelihood, 31.97% were found to be in the formal sector, majority of the respondents constituted 43.03% and were either artisans or traders, 3.68% were unemployed.

From the table it is also realized that, a total of 16.80% are practicing Islamic religion, a majority of them (58.20%) believed in Christianity, 15.57% were traditional worshippers, 8.20% said they were pagans whiles 1.23% were Ickiest and Buddhist.

The largest ethnic groups within the study area as seen from the table1 above were the Ewes, they formed 31.56%, followed closely by the Gas 30.74%, Twi 26.23%, Hausa 6.97%, with the other ethnic groups like Nzema, Krobo, Dagomba, Fulani and Guan forming about 4.51%.

A majority of the respondents interviewed preferred a parity of 1-3 (71.31%), 25.00% said they were interested in having 4-7 children, with only 3.69% preferring 8-11 children.

As can be seen from table1 only 1.23% of the respondents were found to be single, 91.39% of the respondents were married, 2.05% of them were widowed, 3.69% were cohabiting (living together though not legally married), 1.64% responded they were divorced.

On educational level, 12.70 % said they had never schooled or had any formal education,13.52% had primary education, 31.56% had education up to JSS or Middle school, respondents who had SSS, O/A Level or Technical education were 27.05%, 14.75% had tertiary education (Polytechnics/University level), 0.41% mentioned others.

4.1 Table2. Distribution (%) of respondents who have ever heard family planning.

Have you ever heard of family Planning	frequency	Percentages
Yes	129	52.87
No	115	47.13
TOTAL	244	100

From table2, it is observed that knowledge about FP was relatively high among respondents, with a proportion of 52.87% having ever heard of family planning, this can partly be attributed to the aggressive family planning campaigns on Radio and durbars being organized in the District by Health professionals and other development partners. 47.13% however, had never heard of any family planning methods.

4.2 Table3.What respondents know about family planning

Knowledge of family planning method	Frequency	Percentages
Family Planning gives couples the opportunity to plan the number and spacing of their children	221	90.57
Family Planning is a way of allowing women to deny their husband sex	15	6.15
Family Planning is a strategy designed by Whiteman to give power to women	6	2.24

Family Planning is a Whiteman's plan to kill all blacks by spreading HIV/AIDS to them	2	0.82
Total	244	100

To find out the depth of knowledge respondents had on FP, 91.57% said, family planning gives couples the opportunity to plan the number and spacing of their children, 6.15% said family planning is a strategy designed by the white man to give power to women, 2.24% responded that, family planning is a way of allowing women to deny their husbands sex, yet, 0.82% said family planning is a white man's plan to kill all blacks by easily spreading HIV/AIDS to them. Findings from the above reveal that, a large proportion of the respondents (91.57%) had accurate knowledge about FP by indicating that FP gives couples the opportunity to plan the number and spacing of their children.

4.2 In order to further investigate into the extent of male involvement in family planning within the district, a Focus Group Discussion (FGD) session was organized to determine participants (chiefs, opinion leaders, Assembly Men, women leaders and mother-in-laws and selected individuals in the community) knowledge base on FP, among other variables; The following were some of their responses;

4.2.1 Knowledge about family planning practice

To determine the participant's knowledge about FP, findings from all the FGD session conducted within the district responded that; Family Planning is used for pregnancy prevention, a mechanism for child spacing and FP being used to limit family size.

4.3 Table4.Distribution family planning approval

Do you approve of FP	Frequency	Percentages

Yes	108	44.26
No	136	55.74
Total	244	100

From the above table4, it is realized that, 44.26% of those interviewed indicated their approval of their partners to one family planning or the other, 55.74% said they do not approve of family planning, reasons being that, women would take advantage of FP to flirt with other men, the fact that some FP methods like the condom interrupts sexual satisfaction, quite a number of them also mentioned religion as reasons for non approval,

Also, finding from FGD reveal that, few of the participants approved of FP since to them it helps one to plan the number of children they would want to have in future, they also claim it helps improve the health status of mothers and their children and the fact that men's approval would to a large extent increase coverage of FP.

Majority however, disapprove of FP with the reason that, it is against their religion and the fact that, God said in the Holy books that we should multiply and fill the earth.

Other reasons were the fact that, it has severe side effects and the inability of one to enjoy sex to the fullest. They also, believed that approving to FP is like giving license to your wife to flirt with other men.

4.4 Table5.Distribution of respondents who have ever used any family planning method

Ever used FP methods	Frequency	Percentages
Yes	108	44.26
No	136	55.74
Total	244	100

From table5 above, 44.26% of respondents interviewed said they had ever used family planning, 55.74% responded they had never used any family planning method

before. The reasons given were not different from that given by those who do not approve of FP.

4.5 Table6.Distribution of respondents who have ever used any of these contraceptive methods

Ever use family Planning Method (Yes)	Frequency	Percentages
Pills	28	11.48
Condoms	195	80.92
Depo-Provera	12	4.92
Vasectomy/Tubal ligation	2	0.82
Others	7	2.87
Total	244	100

From table6 above, it is observed, 11.48% have ever used the pills, majority of them (80.95%), have used either the male or the female condoms, 4.92% had ever gone for Depo-Provera, 0.82% said they have gone to the clinic for vasectomy, 2.87% said they used other family planning methods like, calendar method, withdrawal method and temperature checking. The overwhelming proportions that have ever used condom indicated its easy accessibility and relatively moderate price as some of their reasons for use of the method.

4.6 Table7.Distribution of respondents who gave reasons for using a particular method

Reasons for using a particular method	Frequency	Percentages
Less costly	38	15.57
Easily accessible	170	69.67
Takes a longer period before use	13	5.33
Reliable	22	9.02
Others	1	0.4
Total	244	100

15.57% preferred a particular method because, it is less costly, 69.67% said they preferred that method because it is easily accessible, 5.33% also said they used those

methods because, it takes a longer time before re-use, 9.02% said they preferred the particular method because they are reliable, 0.4% said they used those methods due to other reasons (prevention of pregnancy and HIV/AIDS).

4.7 Table8.Distribution of those who gave reasons for not using family planning methods

Reason for not using FP		
Against my belief	40	16.39
Interrupts sex	175	71.72
Afraid of side effects	4	1.64
Inadequate Knowledge in FP	25	10.25
Total	244	100

When respondents were asked to find out from those who answered No to using any family planning method, the following responses were given; 16.39% said, they do not use family planning because it is against their religion, a large proportion (71.72%) did not practice family planning because, they believe it interrupts their sexual enjoyment, also 1.64% said, they do not use family planning because, they heard from their colleagues the side-effect they had experienced from using family planning methods, 10.25% of them said, they do not use family planning because, they do not have adequate knowledge about family planning methods.

4.8 Table9.Distribution of respondents who are aware of a place to get family planning method.

Do you know of a Place to get FP	**Frequency**	**Percentages**
Yes	216	88.52
No	28	11.48
Total	244	100

When respondents were asked whether they knew of a place to get family planning methods, 88.52% knew of where to get FP methods, 11.48% said they had no idea as to where to get family planning methods.

4.9 Table10.Distribution of respondents who knew of a number of places to get family planning methods

How many of these Places can one get FP services	Frequency	Percentages
1 place	40	16.39
2 place	175	71.72
3p lace	25	10.25
Others	4	1.64
Total	244	100

When respondents were asked to find out how many of these places they knew of; 16.39% were aware of only one place, 71.72% were aware of two places, 10.25% were aware of three places, 1.64% of the respondents indicated others(herbalist, fetish priest and from witch doctors)

4.10 Table11.Distribution of respondents whose spouses were currently using contraceptive methods.

Current use of Contraceptive	frequency	Percentages
Yes	48	19.67
No	176	80.53
Total	244	100

A total of 80.53% representing the majority indicated they were currently not using any family planning method or doing something to delay pregnancy. This again was attributed largely to interruption of sexual enjoyment, fear of side-effects, their

wives being promiscuous among others. 19.67% however, said they are doing something to delay pregnancy.

4.11 Table12.Distribution of respondents on how long their spouses been using a particular method.

How long spouse been using a particular method	frequency	Percentages
One - five months	1	0.41
Six – ten months	23	9.43
Eleven - fifteen months	31	12.70
Seventeen – twenty months	19	7.79
Twenty-one months and above	170	69.67
Total	244	100

When respondents were interviewed to find out when their spouses started using a particular method, 0.41% said, they started only about one-five months, 9.43% six-ten months, 12.70% eleven-fifteen months,7.79% sixteen-twenty months, however, about 69.67% had used the family planning method for over twenty one and above months now.

4.12 Table13.Distribution of spouses and attendance to family planning clinics.

Does your spouse attend FP Clinic	frequency	Percentages
Yes	61	25.00
No	183	75.00
Total	244	100

When respondents were asked whether their spouses or partners attend any family planning clinic, 75.00% had never attended any family planning clinic before. This according to them was due to the fact that, they could get FP methods or

contraceptives easily at the various chemical shops around their vicinities. They also mentioned lack of confidentiality at the various FP clinics, being mishandled by some health professionals, religious and cultural beliefs among many others. 25% however, attend the FP clinics.

4.13 Table14.Distribution of reasons given by respondents who do not attend family planning clinic.

Reason for not Attending FP clinic	Frequency	Percentages
No Confidentiality at the facility	62	25.41
Being mishandled by the nurses	11	4.51
Too much time spent on the facility	148	57.79
Too far from my home	9	3.69
Others	21	8.61
Total	244	100

A question was asked those who had never attended family planning clinics to find out reasons why they do not attend the clinics. The following were their responses; 25.41% said they do not attend family planning clinics because there is no confidentiality at the clinics, 4.51% said they hear stories that, the nurses sometimes mishandle them anytime they visited the facility, 3.69% do not visit the clinics because they claimed the clinics were far away from their residence, a majority of them (57.79%) do not attend family planning clinics because, they claimed too much time is spent at the facility, 8.61% of the respondents indicated other reasons different from the ones mentioned above. Some of the reasons were menopause, widowed, religious beliefs and finally some also said they could easily get from chemical shops.

4.14 Table15.Distribution of respondents on accompanying their spouses to family planning clinic

Do You Accompany spouse to FP clinic	frequency	Percentages
Yes	21	8.61
No	223	91.40
Total	244	100

91.40% do not accompany their partners to the family planning clinics, partly because they believed not only is it time consuming but also they see FP as women's business not theirs. Only 8.61% do accompany their wives to the FP clinics.

4.15 Table16.Distribution of respondents on whether their spouses showed interest after they return from family planning clinics.

Do you show interest after return from FP clinic	Frequency	Percentages
Yes	60	24.59
No	184	75.41
Total	244	100

Respondents who said they showed interest after their spouses return from the clinics constituted 24.59%, whereas a large number (75.41%) of them said they had never shown interest after their spouses return from FP clinics.

4.16 Table17.Distribution of respondents on spousal support in family planning

Do You support Spouse in family Planning	frequency	Percentages
Yes	6	2.46
No	238	97.54
Total	244	100

A question to determine the level of support to partners as revealed from table17 above, showed that; overwhelming proportion(97.54%) of the respondents do not support their spouses or partners in family planning, only 2.46% support their partners in family planning. Arguments advanced by respondents for the abysmal male support was based on the basic reason that FP is the business of the woman whiles the man's responsibility is to concentrate on how to make money to feed the family and to provide for other needs.

4.17 Table18.Distribution of respondents on the ways they support their spouses

What ways does your Partner support you in FP	Frequency	Percentages
Planning number of offspring	95	38.93
Approving contraceptive Use	20	8.20
Taking Care of new born	104	42.62
Seeking skill healthcare	24	9.86
Others	1	0.41
Total	244	100

A follow-up question was asked respondent who said they supported their partners in family planning to find out specifically what support they give to their partners. The responses gotten were; 38.93% said they supported their partners in planning the number of offspring to have, 8.20% said they support their partners by approving of contraceptive use and using themselves, a majority of them (42.62%) said they support their partners by taking good care of their new born and also being responsible, 2.87% supported their partners through helping to seek skilled healthcare in case of sickness, 0.41%, however, supported their partners in other ways, like providing financial support to their partners to practice family planning.

Again, findings from the Focus Group Discussion (FGD) were not different from the above. The following were some of the responses;

Few participants mention that they took care of the young ones anytime their partners were busy, they also find out from their partners what discussion they had with care providers on issues bordering on FP on their return from the clinic. The rest said, their partners do not care about anything that has to do with FP matters. They believed it is the responsibility of the woman to seek and protect herself through FP and the role of the man being working hard to take care of the family.

4.18 Table19.Distribution of respondents as to whether they discuss the number of children they would like to have with spouse

Do u discuss No. of Children to have with spouse	Frequency	Percentages
Yes	26	10.66
No	218	88.34
Total	244	100

To determine the level of male involvement in family planning, a question was asked to find out how many of them discussed with their partners the number of children they would like to have; 88.34% respondents said they do not discuss with their spouses on the number of children to have in future, 10.66% said they do discuss with their partners the number of children to have.

4.19 **Table20.Distribution on what prevented respondents from discussing the number of children with their spouses**.

What prevents Discussing number of children	frequency	Percentages
Prerogative of men	230	94.27
God provides	6	2.46
man must bring forth all children in her stomach	8	3.28
Total	244	100

In finding out what factors/reasons made them not discuss with their partners the number of children they would want to have in future, the responses were; 94.27% believed having children is the sole prerogative of the man and therefore do not see any need discussing with his partner, 2.46% said they do not see the need to discuss with partners because they believe it is God who gives children and therefore any number given to them by God is okay with them, 3.28% also said women are expected to bring forth all the children she had in her stomach and therefore there is no need to discuss the number of children.

4.20 Table21.Distribution on whether family planning should be the sole responsibility of men.

Sole Decision-making by males	Frequency	Percentages
Yes	228	93.44
No	16	6.56
Total	244	100

A total of 93.44% believed using contraception should be the sole decision of males, whiles, and 6.65% believed it should be a shared responsibility between males and females.

Also, findings from a FGD came out with the following responses;

4.20.1 Views on whether males should be involved in FP

According to them, male involvement is necessary because men are the breadwinners of many homes; there is the need for their involvement so as to support their partners financially in terms of giving women money to go for FP methods or counseling services.

Again, through discussing FP issues with their partners, women would be in the position to choose the best method to suit them hence, women who hitherto would have hidden to practice FP, would instead feel comfortable to consult their husbands in matters relating to FP methods hence, leading to its effective and appropriate use. Others also think that involving men in FP would help improve FP coverage, since men are the decision makers in most families. This influence could be used to impress upon their partners to adopt FP methods. Yet others do not agree to men's involvement in FP issues, they contended that, it is a woman's business.

Also, just like the above, majority of the participants in this group ,asserted that, giving the man's role in our traditional homes as the head of the family and the fact that, he is the decision- maker in the family, it would not be out of place to involve them in matters bordering FP issues

4.21 Table22. Distribution on whether family planning is the responsibility of both male and female.

FP is a responsibility of both male and female	**frequency**	**Percentages**
Agree	14	5.74
Disagree	228	93.44
Don't know	2	0.82
Total	244	100

Again, on the issue of involvement, a question was asked whether contraceptive use should be the responsibility of males and female, 93.44% said they disagree that, it should be the responsibility of both males and females, 5.74% said they agree that family planning should be the responsibility of both males and female. 0.82% said they don't know.

4.22 Table 23.Distribution on cost of contraceptive

Cost of contraceptive (¢)	Frequency	Percentages
100 – 10,000	41	16.80
11,000 – 20,000	156	63.93
21,000 – 30,000	45	18.44
31,000 – 40,000	1	0.41
40,000 and above	1	0.41
Total	244	100

From table23 above, respondents were interviewed to find out much money they spend in acquiring family planning methods; 16.80% said it cost them about 100-10,000 in old Ghanaian currency to acquire a contraceptive, 63.93% said they spend about 11,000-20,000 cedis, 18.44% responded they spend about 21,000-30,000 cedis, 0.41% representing one person said he spent between 31,000-40,000 to acquire a contraceptive, again 0.41% also said he spent 40,000 and above cedis to buy a contraceptive.

4.23 Table24.Distribution of how respondents describe cost of contraceptive

How would you describe cost of contraceptives services	**frequency**	**Percentages**
Expensive	36	14.75
Moderate	171	70.08
Less expensive	37	15.16
Total	244	100

In finding out how contraceptive cost would have effect on usage, 14.75% described the cost of contraception as expensive, 70.08% said prices are moderate ,15.16% said it is less expensive.

4.24 Table25.Distribution of respondents on the benefit of family planning

Benefits of Family Planning	Frequency	Percentages
Yes	227	93.03
No	17	6.97
Total	244	100

From table25, respondents were interviewed to determine from them whether family planning has any benefit to at all; 93.03% responded they benefit from family planning, 6.97% said they do not benefit from family planning.

4.25 Table26.Distribution of benefits respondents stand to gain from family planning

Benefit to gain from family planning	frequency	Percentages
Women and children enjoy improved health	37	15.16
Experienced fewer unplanned pregnancies	106	43.45
Women attain more education and employment	52	21.31
Enhances socio-economic status	49	20.08
Total	244	100

To explore their knowledge in family planning, questions were asked on the benefits one stands to gain when practicing family planning, the response were; 15.16% said,

practicing family planning would enabled women and children enjoy improved health,34.43% said, practicing family planning would enable them experience fewer unplanned pregnancies and births and also lower rate of abortion, 21.31% said, planning ones family would help women control their fertility, hence being in the position to attain higher education and employment, 20.08% also said, family planning would enhance both socio-economic status and improve well-being of their families.

4.26 Table27.Distribution (%) of views on what would motivate one to practice FP

Strategies to motivation Family Planning practice	Frequency	Percentages
When couples are free to communicate issues on FP	67	27.46
When FP device are accessible and affordable	90	36.89
When couples are assured of their child's survival	36	14.75
When couples have knowledge about FP	51	20.90
Total	244	100

When respondents were asked of their opinions on what strategies will encourage them to practice family planning; 27.46% said, they would be motivated to use family planning if they were free to communicate and discuss family planning with their couples, 36.89% said, when family planning devices are accessible and affordable, 14.75% also said when couples are assured of the survival of their children, lastly, 20.90% said they would be encouraged to practice family planning if they had adequate knowledge in family planning.

4.26 Efforts made by Service Providers to involve Males in the Family Planning

In assessing the level of male involvement in family planning programs, service providers from the three sub-districts were engaged in in-depth interviews to ascertain the activities they have been engaged in to ensure effective male involvement in family planning. The service providers who were engaged in the in-depth interviews included Community Health Officers, Midwives, and Public Health Nurses. The interactions revealed the following strategies;

4.26.1 Family Planning Services Available.

The following were mentioned by all the service providers; counseling for couples, Health Education and services such as Injectables, Oral Pills, Condoms, Norplant, Thelma, IUD, and emergency contraceptives are provided to clients after examinations.

4.26.2 Strategies to Enhance Male Involvement by Service Providers

There have been considerable efforts in addressing the issues of male involvement in family planning. According to the service providers at the Ga West District the strategies that they are engaged in include the following;

Public Health Education has been introduced in the local dialect on the local FM stations emphasizing on the need for men to be involved in the family planning and exposing the benefits of family planning to the populace

Again, community durbars have been going on which chiefs and opinion leaders involved through-out the sub-districts. The economic and health benefits of family

planning are explained to them. Also, misconceptions are explained to the people and their fears and anxieties allayed. According to the Public Health Nurse at the Weija sub-district, the people of Weija hold the belief that using contraceptives makes a woman barren, it also makes a woman become more promiscuous and the tendency to cheat on her husband is high.

Moreover, they hold the misconception that condom does not give the required satisfaction during sex.

Another strategy is the use of men support groups which have been established in the communities, work places and fellowships to educate their colleagues on the need to accept and practice family planning. This strategy if carried out effectively has the chance of sending family planning messages to friends and households and it's subsequent use and acceptance of contraceptives.

Lastly, an enactment of a national policy on FP, which seeks to give incentives to families who limit their family size, as is done in china, would to some extent help men to come for follow-up and other services on FP matters.

4.26.3 Recommendations to Further Involve Males in the Family Planning by Service Providers

The following were the recommendations that were established by the service providers among others.

First, males' family planning clinics should be established so that males could feel comfortable and visit the clinic to access family planning services. This is because family planning services are currently offered mainly throughout the District in maternal and child health Clinics, the facility as a female health facility.

Furthermore, logistics are inadequate for service providers. It was therefore, the opinion of the service providers that vehicles, motorbikes, office equipment should be

provided to enhance their movement to inaccessible areas to embark on educational campaigns.

Equally important are the Volunteers who need to be given incentives like motorbikes and fuel to enable them reach out to people in the hinterland

4.27 Table28.Distribution of monthly income of respondents

Monthly Income(Cedi)	Frequency	Percentages
51,000-100,000	7	2.87
101,000-150,000	50	20.49
201,000 and above	187	76.64
Total	244	100

Finally respondents were asked how much they earn monthly as income in cedis to determine whether it would have any effects on either usage or support, the responses were; 2.87% said, they earn an income range of 10,000-50,000, 20.49% of them earned around101,000-150,000, a majority of the respondents (76.64%) earned 201,000 and above.

CHAPTER FIVE

5.0 FINDINGS AND DISCUSSION

5.1 MALE SUPPORT IN FP PRACTICE IN THE GA WEST DISTRICT

From the research findings it is evidenced that majority of the men do not support their spouses when it comes to family planning activities. This is clearly indicated through the following variables; Number of respondents who do not support their partners (97.54%), Number of respondents who do not show interest after their spouses return from FP clinics (75.41%), Number of respondents who not

accompany their spouses to FP clinics (91.40%) , Number of respondents never discussed FP with spouse (89.34%) among others.

These overwhelming proportion of males who do not support their spouses in FP practices in the district gave among other reasons as the fact that, FP is women's business, again most of the respondents mentioned that, family planning practitioners always concentrate on women to the neglect of their male counterparts, thereby making it unattractive for men to accompany their spouses to these clinics. This assertion was corroborated with one of the discussants in one of the FGD held in Obom sub-district.

Others also responded that, much time is wasted at the facility as one needs to spend several hours waiting for their turn to be attended to. Bearing in mind that they have to be at work to make ends meet. This according to them has made it impossible even if they had wished to accompany their spouses to the FP clinic.

The abysmal support of many men in FP practices was also, largely based on their socio-cultural and religious orientation. Culturally, matters concerning sexual issues, in traditional Ghanaian certain are mostly considered as sacred and therefore, Ga rural where this research was undertaken is not an exception. This has therefore made it highly difficult for men to openly discuss issues on FP.

As already known, religion forms an essential component of the individual's life and therefore has enormous influence on their decisions, depending on the type of religion they belong to, and the doctrine of their religion. For instance, the research findings from the district indicated that, majority of Moslems, traditional believers, pagans and the Catholics among the Christian sect, mentioned emphatically the fact

that their religion abhors FP in any form and therefore do not see any reason for either supporting or accompanying their spouses to any FP clinic.

From the above reasons given and the overwhelming percentages shown, it is evidenced that, men in Ga-West district do not give much support to their spouses in FP practices, these attitudes of the men one way or the other affect the uptake of FP even among women in the district, to extent that some of them, had to hide behind their husbands to do it.

On the negative attitudes of men on spousal support in the district, a public health nurse I interviewed to solicit her views on male involvement in FP within the Amasaman sub-district, cited a very intriguing experience she had with a client who came for Norplant, apparently without the husband being in the known. Unfortunately for her the husband got to know of it later. Surprisingly the husband brought her back to the facility early the following morning for it to be removed. According to the nurse, she tried in vain to let her understand that it is very dangerous to remove it. According to nurse, she tried in vain to convince this woman to change her decision. The woman was therefore made to sign a document indicating her consent, which she readily agreed.

Again, when asked, averagely the number of males who visited her facility for counseling on issues concerning FP in a month, her answer gave an indication that male involvement is not encouraging. She therefore agreed with the general views held by many in the district that, men are adamant in issues pertaining to FP.

In Weija sub-district however, the public health practitioner showed me FP folders of most clients at the centre. This practice according to her is done to prevent their husbands from finding out they (partners), are involved in FP practices.

5.2 KNOWLEDGE, APPROVAL AND PRACTICE IN FP IN THE GA WEST DISTRICT.

The second objective of this study was to examine the level of knowledge, approval and practice of FP in Ga-west district. The research revealed that an appreciable number of the respondents (52.87%) interviewed had ever heard of at least one FP method or the order. In investigating their level of knowledge in FP, an overwhelming number (90.57%) indicated correctly that, Family Planning gives couples the opportunity to plan the number and spacing of their children. To further explore their knowledge base, respondents were asked the benefits they could get from family planning and the findings were; 15.16% said, practicing family planning would help women and children enjoy improved health, 34.43% said, practicing

family planning would enable them experience fewer unplanned pregnancies and births and also lower the rate of abortion, 21.31% said, planning family would help women control their fertility, hence being in the position to attain higher education and employment, 20.08% also said, family planning would enhance both their socio-economic status and improve well-being of their families.

These remarkable achievements were made possible, due to the relentless efforts put in place by the DHMT and other NGOs in and around the districts. For instance according to publications by Awuni et al (2005), the DHMT in their efforts to widen the knowledge base of FP within the district adopted a 3-prong strategy. Firstly, a team was charged with the responsibility of educating the public on issues pertaining to FP on the various local FM stations at least once a week in three local dialect being Ewe, Ga and Akan. These languages are believed to be understood and spoken by many in the district. The second strategy was moving with mobile cinema vans into the various communities to use the cinema to attract people. In between scenes the team took advantage to educate the gathering on the need for one to practice FP. The third team was charged with the task of educating patients who visited the OPD everyday for treatment especially men who come for diabetes counseling.

Other agencies like World Vision International and plan Ghana also contributed to the success.

However, on FP approval, 44.26% indicated their approval to FP methods, whiles a moderate proportion (55.75%) said they disapprove of any FP methods. Reasons they gave for their disapproval stem mainly on, socio-cultural, perceptions of side effects and religion. Culturally, the belief of people in this district is that the more the children one has the more respect he commands among his peers hence, would

not want to do anything to stop his spouse from bringing forth children. On the issue of religion, they all indicated that, once it is spelt out clearly in the Holy books to bring forth and fill the world, they do not see any reason why they should approve of any FP, whose ultimate aim is to cut down the number of birth.

The above findings agreed with reviewed literature by Odu, O.O, K .T. Ijadunola, et al (2006) who also contended that major reasons for non-approval of FP by men were the fear of side-effects and perception of FP as being against religion.

The practice of FP by men has for some time now been a subject for concern among FP activists all over the world. This concern has brought about a paradigm shift on men and women in FP programs. The argument advance for the inclusion of males in FP programs was the fact that men would not only encourage and support their partner's in contraception, but also would influence the policy environment to be more conducive to developing male related programs. As rightly put by Toure (1996), 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.

However, it is evidenced from the research findings that, Ga West district where this study is undertaken, needs much to be done on issues relating to male involvement, if they are to move along with the rest of the world in trying to get many men taking active roles in FP programs. This is because the findings from the district reveals that FP practice is not encouraging, since a large proportion(80.53%) of respondents interviewed asserted that, currently they were not using any FP method to either delay or avoid pregnancy, with only 19.67%, agreeing to practicing FP. Also when asked whether respondents had ever used any

FP method, 44.26% indicated they have ever used a FP method, however, a moderate proportion of 55.74% said they had never used any FP method. A further probe into the low and relatively low in FP practices among current users and ever used FP respectively revealed that; 71.72% said they do not enjoy normal sex anytime they use a FP method.

This assertion was once again reiterated in a FGD conducted in one of the communities, under Weija sub-district, where a male participant said " Using the condom as a FP method to him is as if putting a toffee together with the wrapper into your mouth", for this reason he would rather not have sex than to use any FP method.

Other reasons given were; being afraid of side effects (1.64%), religious beliefs (16.39%) and inadequate knowledge about FP (10.25%).

However, the information gathered from respondents on low FP practice apart from those mentioned above, was the fact that most of them also complained that, they would have used FP methods if they had other alternatives apart from the condoms and vasectomy, as is available to their women counterparts as reported by Ringheium 1993 Leriden 1986 and UNFPA in the literature.

They suggested among others that a more robust research should be conducted into coming out with male-specific FP methods.

Globally, men have not shared equally with women the responsibility for fertility regulation. While family planning efforts have been directed almost exclusively towards 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. New male methods, particularly if

reversible, may alter men's willingness to accept or share responsibility for the control of fertility. 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. E.O. Orji, U.Onwudiega (1999)

5.3 FACTORS (ATTITUDES, BELIEFS AND PERCEPTIONS) HINDERING MALE INVOLVEMENT IN FAMILY PLANNING IN THE GA WEST DISTRICT.

The third objective of this study was to look into certain factors that militate against the use of family planning in the Ga West. To be in the better position to assess this objective, the following variables were considered, these were; reasons given for not using FP method, reasons for not attending FP clinics, finally, what prevent them from discussing the number of children to have in future.

Firstly, a large proportion (71.72%) of the sample do not use FP, because they perceive it interrupts sexual satisfaction, 1.64% also had the perception that, FP practice leads to side effects and therefore are not always comfortable using any FP methods. 10.25% do not practice FP simply because they do not have adequate

knowledge about FP practice, however, 16.39% do not use FP methods because of their religious affiliations and beliefs.

Secondly, 57.79% of men do not attend any FP clinic because; they believe that too much time is spent at the facility in trying to get any FP counseling from FP practitioners. 25.41% do not attend FP clinics because they believe that, there is no confidentiality at the facilities, and that, almost all gathered are most likely to hear what you would have wished was discussed in confidence. 3.69% cited inaccessibility as reasons for not attending any FP clinic. They indicated that the facilities were far away from their residency. Lastly, 4.51% do not attend FP clinic due to the attitudes of some health professionals. They claim some of the nurses exhibit certain negative behaviors which sometimes put them completely away from the facility.

A participant in one of the communities under Amasaman in a FGD organized, shared his experience at one facility he ever visited. According to him, he went there very early so as he could be attended to in good time, so as to go to work afterwards. After waiting for a long time, though official opening hours was far past, the nurse suddenly appeared. According to him, they happy, confident they would be attended to by the nurse soon. Surprisingly, not only did the nurse refuse to greet them, nor apologize for her lateness, she also sat on her desk reading news paper believed to have been an Ebony magazine. According to the participant, he gathered the courage to approach her and to make her understand that have been waiting for her for quite sometime now. According to him no sooner did he finish his submission, than the nurse retorting," gentleman if you think you are in a hurry you can go away". He therefore exchanged words with the nurse and vowed from that day onwards, never to step foot in any FP facility.

On what prevents them in discussing the number of children they intend to have in future, majority (94.27%) mentioned that, they believed having children is the prerogative of the man and therefore need not seek the opinion of his spouse, 2.46% also believed children are gift from God and therefore mere mortals like them can not change the will of God, hence their reason for not discussing amongst themselves. Lastly, 3.28% believe a woman must have all the children from her womb; therefore there is no need in discussing the number of children to have with spouse.

5.4 WAY FORWARD TO IMPROVING MALE INVOLVEMENT IN FP IN THE GA WEST DISTRICT.

Previous studies have shown that the use of multiple channels of communication yields positive results for male involvement in family planning (Kim et al, 1992). Radio has been noted to be especially effective. This channel though already adopted by the DHMT as number one on their 3-prong strategy would need to be intensified by introducing phone-in session to either serve as an avenue for further clarification or as a form of soliciting feedbacks from listeners. Again, the radio as an effective means of disseminating information in rural communities such as Ga-rural is necessary because almost all the households the research team interviewed had at least a radio.

Also, Community Health Nurses, Village Health Volunteers should begin to address their FP and health messages to men and also women. Whiles at the same time, assuring women_that they would have the opportunity for secret contraceptive use. In addition, field-workers including Community Health Officers, Public Health

Nurses and Village Health Volunteers should approach men to explain and answer questions about health and family planning services. Occasionally, family planning sessions should be organized for the men and to encourage open discussion of family planning among men groups.

Equally important targets are the male Village Associations such as drumming and farming groups which are particularly common in most communities throughout the district. Members of these groups are usually organized for cooperative farm labor and other projects. These occasions provide useful opportunities for Community Health Officers (CHO), Community Health Nurses and male Village Health Volunteers to reach out to groups of men to discuss family planning with them. This effective measure shall help increase their appreciation of family planning whiles decreasing the perceived disadvantages or misconceptions, fears and their anxieties.

Also, many men should be encouraged to enroll in the various nursing training colleges, by dispelling the notion that nursing as a profession is only for women. It is believed that when many men are encouraged into the various Nursing Training Colleges, it would help increase the number of male health providers who would attend to the needs of men especially on issues concerning reproductive health and family planning. This has become necessary because all the health facilities I conducted the in-depth interview, lamented on lack of male care providers with whom men would have been comfortable to confide with.

Finally, when men who embrace family planning are portrayed in national television and the FM stations are made to appear as heroes It is believed, would encourage more men to be involved in FP practice.

Again, when the government institute a national population policy which seeks to give some incentive package to couples who give birth to one child, it is also believed would serve as a motivator to men in practicing FP.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The level of male involvement in family planning programs has been poor in the Ga west district. According to the findings of the research, male support in FP practice is discouraging with an overwhelming average proportion of (90%) not doing anything to support their partners in FP practices. This has led to most women secretly going to the maternal and child health clinic to meet the public health Nurses without the approval of their husbands. This most often than not generate a lot of tension in the marriage and sometimes leading to divorce when their husbands later discover their spouses hide to do it.

However, as found from the research, knowledge of respondents in the district is moderately high with a proportion of (55.57%) with only (44.46%) approving of

family planning. Again, as observed from the findings, a high proportion (80.53%), is not currently practicing FP as compared to only (19.67%) practicing FP in the Ga west district.

Yet, from the research findings men's attitudes, beliefs and perceptions about FP in the Ga west district is nothing to write home about, majority of them (71.72%) have the perception that FP especially the condom interrupt their sexual enjoyment, also quite a number also mentioned religious and cultural beliefs as reasons for non-approval or non-use of FP methods, others also mentioned negative attitudes of some health professionals as reasons for non attendance to FP clinic. Finally (10.25%) indicated their inability to appreciate what FP is, hence their reluctance in supporting their spouses in FP.

Generally, as can be seen from the above, it is evidenced that male involvement has not been encouraging in the district, hence the need for family planning programmers within the district to come up with special package for FP, targeting specifically on male involvement, this time bringing on board community leaders like chiefs, elders, Assemblymen and lineage heads, whose views are normally known to be respected in our various traditional settings. These measures when meticulously carried out would, to some extent, help attain some appreciable level of success in increasing the level of male involvement in the district.

6.3 RECOMMENDATIONS

The following recommendations may further enhance the level of male involvement in family planning programs in the Ga west district

6.3.1 DISTRICT HEALTH MANAGEMENT TEAM (DHMT)

The District Health Management Team (DHMT) should provide resources and motivate Public Health Nurses, Nurse Midwives, Community Health Officers and Village Health Volunteers to effectively mobilize the chiefs, elders and lineage heads to participate and cooperate in family planning programs. When the concept is accepted by the community leaders, it would be easier for other men and women to accept and practice without any hindrances. Also outreach programs directed towards men should be encouraged through the provision of education, communication and family planning services.

6.3.2 POLICY MAKERS

It is important that policy makers use the mass media in creating awareness and motivation for family planning. In previous efforts, message content has been inadequate and this is why the inter personnel channels have had the opportunity to fill the gap with misinformation. There is an urgent need for contraceptive advertising to contain more information on male family planning methods and facilities.

Participation in community durbars builds collaboration with traditional leaders and establishes open discussions on family planning and other health related issues. Community drama programs should emphasize on "Responsible manhood" which can further lead to internalizing of the male involvement in family planning concept.

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KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
SCHOOL OF MEDICAL SCIENCES
DEPARTMENT OF COMMUNITY HEALTH

MALE INVOLVEMENT IN FAMILY PLANNING IN THE GA WEST DISTRICT

QUESTIONNAIRS FOR HEADS OF HOUSEHOLDS

Introduction

Good morning/afternoon and thank you in advance for being ready to give us a hearing. We are from the Dept. of Community Health, KNUST. My name is …….. ……..
We are conducting several meetings with people like you in the Ga West District to find out views and ideas about male involvement in Family Planning. Your opinions are highly essential at the same time vital and they will help us to improve the kind of family planning services we provides. Whatever you say will be treated confidential, so feel at ease to express your candid opinion.

SECTION A

BACKGROUND CHARACTERISTICS

1. How old are you?

   A. 17 - 22 years B.23- 28 years C. 29 - 44 years D.45- 50 years E. 51-56 years

2. Level of Education: A. No Schooling B. Primary C.Middle/JSS D. Secondary / SSS/Technical E. Tertiary F.? Others (Specify) ----------

3. What work do you do? A. Farming B. White colour job C. Artisan/Trading D. Unemployed E. Others (Specify)----------

4. Which Religion do you practice? A. Islam B. Christianity C. Traditional worshiper D. Pagan E. Others (Specify)----------

5. To which ethnic group do you belong?

   A. Ga B. Ewe C. Twi D. Hausa E.Others (Specify)…….

6. How long have you stayed in the community?

   A. 1-10 years B. 11-20 years C. 21- 30 years D.31-40 E. 40 >

7. What is your marital status?

   A. S ingle B. Married C. widowed D. Cohabitating E. Divorced

8. Have you ever given birth? Yes ( ) No ( )

9. How many children do you have at this time, if any?

   A. 3 - 4 Children B.5-6 Children C. 7-8 Children

SECTION B

I would like to discuss issues on family planning with you

10. a. Have you ever heard of family Planning? : Yes ( ) NO ( )

    b. If yes, what do you know about family planning?

A. Family planning gives couples the opportunity to plan the number and Spacing of their children

B. Family planning is a strategy designed by the white man to give power to women

C. Family planning is a way of allowing women to deny their husbands sex

D. Family planning is a white man plan to kill all blacks by easily Spreading HIV/AIDS to them

E. Others (Specify)……..

11. a. Have you ever used any family planning methods? Yes ( ) No ( )

b. Which of these contraceptives have you ever used?

A. Pills B.Male / Female condom C. Depovera. D.Vasectomy / Tubal ligation

E.Others

(specify)……...

c. What is the main reason for choosing that particular method?

A. It is less costly B.It is easily accessible C. takes a longer period before re-us

D. It is reliable E. Others(Specify)…….

d. Why don't you use any family planning method?

A. It is against my belief B. I do not have knowledge about family planning

C. It interrupts sexual satisfaction. D. Am afraid of side effects E. Others (specify)

e. What is the main reason for choosing a particular method?

A. It is less costly B.It is easily accessible C. takes a longer period before re-use

D. It is reliable E. Others (Specify)…….

12. Do you as the man of the house approve of family planning? Yes( ) No ( )

13. a. Do you know of a place where a person can get male family planning services?

Yes ( ) No ( )

b. If yes, how many of these places can one get family planning services?

At the clinic, At the hospital, At the chemical shop, At the nurse's house

E. Others

(Specify)…….

SECTION C:

14. a. Is your spouse currently using any family planning method or doing something to delay or avoid pregnancy? Yes ( ) No ( )

b. if Yes, which one?

A. Pills B.Male / Female condom C. Depovera D.Vasectomy / Tubal ligation

E. Others (specify)……

c. If No, what prevents or hinders her from doing something or using a Family planning method?

A. It is against our beliefs B. I need more children C. My partner will **not** allow me

D. We do **not** have adequate knowledge on family planning

E. Others

(Specify)……

15. How long has your spouse been using this particular method?

A. One - five month B. Six - ten months C. Eleven - fifteen months

D. Sixteen- twenty month E.Twenty one months and above

16. a. Does your spouse/partner attend the family planning clinic? Yes ( ) No ( )

b. If No, is there any reason?

A. No confidentiality at the facility B. Being mishandled by the nurses

C. Too much time spent at the facility D. Too far from my home

E. Others (Specify)……

17. a. Do you accompany your spouse to the family planning clinic? Yes ( ) No ( )

b. If yes, how were you handled by the health workers?

A. Excellent B. Very good C. Good D. Poorly E. Very poorly

18. a. Do you find out or show interest after your spouse returns from the clinic?

Yes ( ) No ( )

b. If No, is there any reason?

……

……..

19. a. Do you support your spouse in family planning? Yes ( ) No ( )

b. If yes, in what ways does your spouse support you in family planning?

A. Planning the number of offspring to have with you

B. Approving of contraceptive use and using him self

C. Taking care of our new born and being responsible

D. Seeking skill healthcare when I am sick

E. Others

(Specify)……

20. a. Have you ever discussed with your spouse on the number of children you may want

to give birth to and at what interval or frequency? Yes ( ) No ( )

20. b. If Yes, how many and at what interval?

A.1-3 children -

B. 4-7 children -

C. 8 children and above -

20. c. If No, what prevents you?

A. It is the prerogative of the man B. God provides and therefore any number goes

C. A woman must bring forth all the babies in her stomach

D. Who nose the child that will safe you

E. Others (Specify)……

21. a. Out of the number chosen above (**Q20b**), if two are living would you practice family Planning? Yes ( ) No ( )

21. b. If No what is the reason?

A. The chances of loosing the two is greater

B. God has His share, so if you give more births he will take his living your own

C. Good ones are gotten from many D. You cannot guarantee the life of the two

E. Others (Specify)…….

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

d. How many would you like to be girls? ……..

22. How much does it cost you to get contraceptive services (for condoms / other methods)? A. 100 – 10,000 cedis B.11, 000-20,000 C. 21,000- 30,000 D. 31,000-40,000 E. 41,000 and above

23. How would you describe the cost of getting contraceptive services (for condoms / other methods)? A. Very expensive B. Expensive C. Moderate D. Less expensive

24. a. Would you say that using contraceptives should be the sole decision of the male?

Yes ( ) No ( )

b. If Yes, is there any reasons?

……

……

25. a. Do you think practicing family planning would give you any benefits? Yes ( ) No ( )

25. b. If yes, what are some of the benefits you stand to gain?

A. Women and children enjoy improved health

B. Experience fewer unplanned pregnancies and births, and have lower rates of abortion.

C. Women who have control over their fertility have a chance to attain more education and find employment

D. It enhances both socio- economic status and improve well-being of their families.

E. Others (Specify)……..

26. In your opinion, what would encourage or motivate couples to practice family planning or using a contraceptive method?

A. When couples are freely to communicate and discuss issues on family planning

B. When family planning devices are accessible and affordable

C. When couples can be assured of the survival of their children

D. When couples has adequate knowledge on family planning

E. Others (Specify)……..

27. You said you are doing something to earn a living, may I know your monthly income?

a.10, 000-50,000 b. 51,000-100,000 c.101, 000-150,000 d.201, 000 and above

28. Averagely, how much do you spend in a day from your month fully income mentioned above? ……

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MALE INVOLVEMENT IN FAMILY PLANNING IN THE GA WEST DISTRICT

FOCUS GROUP DISCUSSION (FGD) INTERVIEW GUIDE FOR RELIGIOUS AND OPINION LEADERS, WOMEN LEADERS AND SOME HEADS OF HOUSEHOLDS

Introduction

Good morning/afternoon and thank you all for coming. We are from the Dept. of Community Health, KNUST. My name is …….. and these are my colleagues …….. (Let them introduce themselves). We are conducting several meetings with people like you in the Ga West District to find out views and ideas about Male Involvement Family Planning. Your opinions are very important and they will help us to improve the kind of services we provide.

There is no right or wrong answer and you do not have to agree with what someone else says. Everyone's contribution is valuable and accepted. In order not to lose any important information we would like to tape record the discussion. Whatever you say will be confidential so feel at ease to express your opinion. But please talk one at a time.

SECTION A:

Knowledge and Practice

1. Have you ever heard about family planning? Probe further on what they know about family planning

2. What are some of the family planning methods that you know of and ever used it? Probe: What types of traditional methods are used in this community? Which is the preferred method in the community? How much do these different methods cost? Where do you get them and their impression about the cost

3. What are your views about family planning ? Should men be involved in family planning at all? Would you be more inclined to use modern methods of family planning, or the traditional ones?_Probe: What are the reasons for this? (i.e. tradition, social acceptability, finances or religion)

4. Do you approve or disapprove the use of family planning? If Yes ( ) No ( ), why do you approve or disapprove of family planning.

5. What are some of the reasons why some men do not intend to use family planning at all? (Probe further on whether he or she support those who do not intend to use Family Planning)

SECTION B:

Beliefs Attitudes and Perception

6. Different tribes have different perceptions about the ideal number of children to have;

How many children do people in this community want to have and who is the decision maker on the number of children a couple should have in a relationship (in this locality)?_Do people prefer boys or girls? Probe further on the reasons why they prefer either boys or girls

7. What do you think about the attitude of the family planning providers? Probe further on the regularity and quality of services provided, what they like about the service providers work, what they want them to do differently and whether the service delivery points promote confidentiality

SECTION C:

Partner Support

8. Do you approve or disapprove the use of family planning? Probe on the reasons behind their approval or disapproval of family planning

9. How supportive is your spouse on issues concerning family planning?

10. Mention at least four of the support given that are cardinal to you and would promote your health

11. Do your spouse find out or show any interest when you returned from clinic?. Probe on she returned from antenatal or post natal services

SECTION D:

Influencing factors

12. Have you ever discussed with your spouse on the number of children to bring forth and the frequency to do that? Dig further on the frequency and how to do that

13. What is the position of your mother or mother- in- law on family planning? Probe further to elicit more information on whether they are in support of their daughter-in-law in practicing family planning

14. Do you think practicing family planning would give you any benefits? Probe on the benefits they stands to gain

15. Seek their opinions on what would encourage or motivate couples to practice family planning or using a contraceptive method? Probe further to elicit more views

16. What are some of the challenges or barriers you face from your spouse on the choice of a family planning method?

THANK YOU FOR THE GOOD TIME SPENT WITH US

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MALE INVOLVEMENT IN FAMILY PLANNING IN GA WEST DISTRICT IN-DEPTH INTERVIEW GUIDE (FOR SERVICE PROVIDERS)

Introduction

Good morning/afternoon and thank you in advance for being ready to give us a hearing. We are from the Dept. of Community Health, KNUST. My name is …….. ……

We are conducting several meetings with people like you in the Ga West District to find out views and ideas about male involvement in Family Planning. Your opinions are highly essential at the same time vital and they will help us to improve the kind of family planning services we provides. Whatever you say will be treated confidential, so feel at ease to express your candid opinion.

Educational level of care provider

A. General Nursing B. Community Health C. Public Health D. Midwife

E. Others [Specify]

……

1. What reproductive services does your facility provide for men ?

……

….

……
…..

……
…..

2. Are these patronized by men? Yes ( ) No ( )

3. What range of family planning needs do you provide in the clinic?

A.Pills B.Male / Female condom C. Depovera A. Pills D.Vasectomy

E.Others (specify)……

4. What is the proportion of women who utilized your family planning services?
……

5. What is the proportion of men who utilized your family planning services……

6. Which methods of family planning do men usually prefer? (For themselves/spouses)

A. Pills B.Male / Female condom C. Depo D.Vasectomy / Turbal ligation

E.Others (specify)……

7. a. Do men often accompany their spouses to the clinic? Yes ( ) No ( )

b. If No, What in your views accounts for this?

A. No confidentiality at the facility B. Being mishandled by the nurses

C. Too much time spent at the facility D. The facility is not male friendly

E. Others

(Specify)…….

8. Do you provide separate room for male clients? Yes ( ) No ( )

9. a. Are you satisfied with the level of male involvement? Yes ( ) No ( )

b. If No, what would you suggest?

……
..

……
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……
.

10.What is your position on male participation in family planning?

A. They should be actively involved B.They should not be involved

C. Their involvement would derailed the progress of family planning

D. Their involvement will help expand family planning coverage

E. Other

(Specify)……

11. a. Do you think that their involvement would help expand your family planning coverage? Yes ( ) No ( )

b. If Yes/No explain

……
……

……..

12. What new strategy do you put in place to motivate or encourage male clients come to the clinic for follow-ups & other services?

……
…….

……
……

……

……...

13. If a client defaults what do you do?

……

……...

……

……...

14. How much does it cost to provide contraceptive services (for condoms/ other methods)?

A. 100 – 10,000 cedis B.11, 000-20,000 C. 21,000- 30,000 D. 31,000-40,000

E.Others (Specify)……

15. What reactions do you receive from men on the cost of contraceptive services? (for Condoms / other methods) A. Very expensive B. Expensive C. Moderate D. Less expensive

16. How long does the clinic operate each day to provide family planning or reproductive Healthcare for men?

DAY	OPEN	CLOSE
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

17. On average, how many clients visit your facility every day?

a. Female

……

b.

Men…….

18. Can a client pick up reproductive supplies (condoms) at any time? Yes ( ) No ( )

19. If you were a young man and walked into one of your family planning clinics, How would you like the clinic environment to be ?

……

……

……

20. Is your clinic environment male-friendly? Yes ( ) No ( )

21. What things, in your mind, make it either male-friendly or not male-friendly?

……

……

……

22. a. Do you employ male staff or have male volunteers that provide education to? Yes ( ) No ( ) If yes , skip Q 22(b)

22. b. If no, can you think of reasons that might inhibit you doing so in the future?

……

……

……

23. As a health worker interested in family planning issues, do you ever received

information or training on male reproductive health? Yes ( ) No ( )

24. What is the future of family planning in your area?

……

……

……

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