

KWAME NKRUMAH UNIVERSITY OF SCIENCE TECHNOLOGY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF POPULATION AND REPRODUCTIVE HEALTH



**THE INFLUENCE OF MALE INVOLVEMENT ON FAMILY PLANNING
USE IN
THE WEST MAMPRUSI DISTRICT OF THE NORTHERN REGION OF
GHANA**

BY:

ABUDU MALIK

JUNE, 2019

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,
KUMASI, GHANA**

**THE INFLUENCE OF MALE INVOLVEMENT ON FAMILY PLANNING
USE IN THE WEST MAMPRUSI DISTRICT OF THE NORTHERN REGION
OF GHANA**

ABUDU MALIK (BED. HEALTH EDUCATION)

**A THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION,
FAMILY AND REPRODUCTIVE HEALTH, KWAME NKRUMAH
UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI GHANA, IN
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF
A DEGREE OF MASTER OF PUBLIC HEALTH IN POPULATION AND
REPRODUCTIVE HEALTH.**

JUNE, 2019

DECLARATION

I, **ABUDU MALIK**, hereby declare that this thesis work is my own work towards the award of Master of Public Health Degree in Population and Reproductive Health and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been given.

ABUDU MALIK (PG6174016).....
STUDENT SIGNATURE DATE

CERTIFIED BY
DR. YEETHEY ENUAMEH.....
(SUPERVISOR) SIGNATURE DATE

CERTIFIED BY
DR. EASMON OTUPIRI.....
(HEAD OF DEPARTMENT) SIGNATURE DATE

DEDICATION

I dedicated this work to Almighty Allah, my wife Alimatu Sadia and my daughters Hajia, Mufidah and Ayisha.

KNUST



ACKNOWLEDGEMENTS

First of all, I will like to thank Almighty Allah for his love, guidance and protection, throughout the program. I would like to express my profound gratitude and appreciation to my supervisor Dr. Yeetey Enuameh for his support, patience, guidance, helpful suggestions and constant reminders throughout the duration of this project, without his support and guidance this project work wouldn't have been successfully. I am equally grateful to Mr. Titus Kpiinfaar for his assistance and support during the data analysis section and write up.

Also my special thanks to the Dean of school of public health, Head of Department, lectures and the entire staff of the Department of population, family and Reproductive health for guidance and support.

I would like to thank my wife Alimatu Sadia and my daughters Hajia, Mufida and Ayisha for their care and support and also a big thanks to Prof Thomas Akabzaa for his support and encouragement.

I wish to also acknowledge the support and contribution of the District Health management Team of west mamprusi District.

Finally I would like to extend my special thanks to all my friends and classmates.

TABLE OF CONTENTS

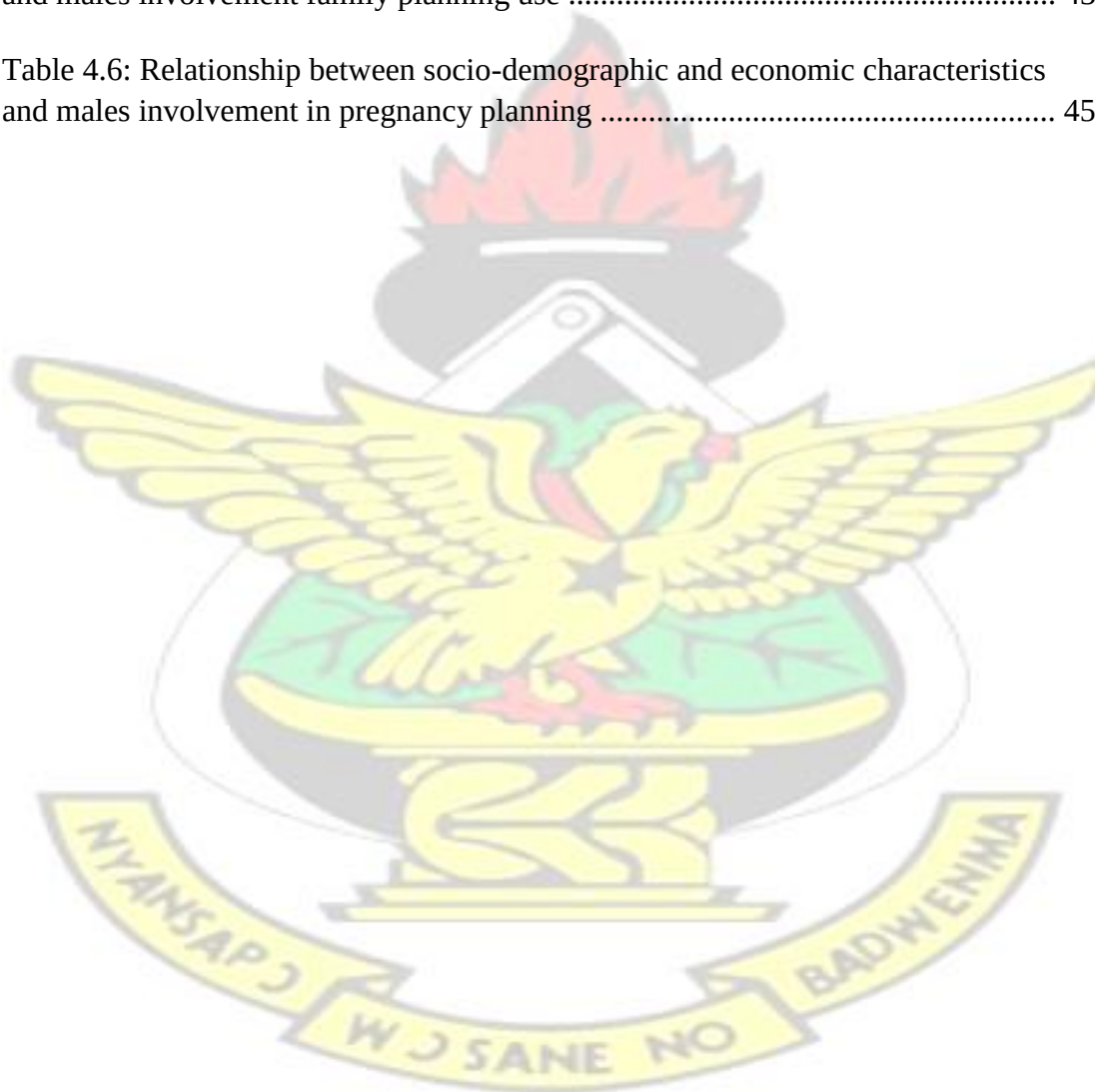
Contents	Page
DECLARATION	ii
DEDICATION	iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	vi
LIST OF TABLES	ix
LIST OF FIGURES	x
ABBREVIATIONS/ACRONYMS	xi
ABSTRACT	xii
CHAPTER ONE	1
INTRODUCTION	1
1.1 Background	1
1.2 Statement of Problem	3
1.3 Study Rationale	4
1.4 Conceptual Framework	5
1.5 Research Questions	5
1.6.0 Study Objectives	6
1.6.1 General Objectives	6
1.6.2 Specific Objectives	6
1.7 Profile of the Study Area	6
1.8 Scope of the study	8
1.9 Organization of the study	8
CHAPTER TWO	9
LITERATURE REVIEW.....	9
2.0 Introduction	9
2.1 Concept of family planning	9
2.2 Benefits of family planning	12
2.2.1 Benefits of family planning to the family	12
2.2.2 Benefits of family planning at the community level	13
2.2.3 Benefits of family planning at the national level	13
2.2.4 Benefits of family planning at the global level	14
2.3 Barriers and factors influencing males' involvement in family planning	15

2.3.1 Socio-demographics and economic factors	15
2.3.2 Socio-cultural factors	18
2.4 Males knowledge and patronage of family planning	19
2.4.1 Males perception and attitude towards family planning	21
2.5 Facilitators for males' involvement in family planning	23
CHAPTER THREE	25
METHODS AND MATERIALS	25
3.1 Study Design	25
3.2 Data Collection Techniques and Tools	25
3.3 Sampling Method	25
3.4 Study Population	25
3.5 Sample Size Determination	26
3.6 Inclusion Criteria	26
3.7 Exclusion Criteria.....	27
3.8 Sampling Procedures	27
3.9 Pre-testing	28
3.10 Study Variables	28
3.11 Data Handling and Analysis	28
3.12 Ethical Consideration	29
3.13 Assumptions	29
CHAPTER FOUR	29
RESULTS	30
4.0 Introduction	30
4.1 Respondents Socio-demographic and economic characteristics.....	30
4.2 Males patronage and support of partners Family Planning uptake	32
4.3 Barriers/facilitators to male involvement in family planning	35
4.4 Sources of FP/contraceptives information	38
4.5 Contraceptives/FP methods	39
4.6 Socio-demographic and economic characteristics and males involvement in planning the desired family size	40
4.7 Socio-demographic and economic characteristics and males involvement in family planning use	42
4.8 Socio-demographic and economic characteristics and males involvement in pregnancy planning	44
CHAPTER FIVE	47

DISCUSSION	47
5.0 Introduction	47
5.1 Males knowledge and patronage of family planning	47
5.2 Males’ perceptions and attitude toward family planning	49
5.3 Facilitators and barriers to males’ involvement in family planning	50
5.4 Socio-demographic and economic characteristics influence on males involvement in FP	51
5.5 Limitations of Study	53
CHAPTER SIX	54
CONCLUSIONS AND RECOMMENDATIONS	54
6.0 Introduction	54
6.1 Conclusions	54
6.2 Recommendations	55
6.2.1 Ghana health services	55
6.2.2 District health directorate	55
6.2.3 Individuals/NGOs and Civil society	56
REFERENCES	57
APPENDIX	64
Appendix 1: Gantt chart	64
Appendix 2: BUDGET	64
Appendix 3: Questionnaire	66

LIST OF TABLES

Table 4.1: Socio-demographic and economic characteristics	31
Table 4.2: Male patronage and support of partners FP uptake	34
Table 4.3: Barriers/facilitators to male involvement in family planning.....	37
Table 4.4: Relationship between socio-demographic and economic characteristics, and planning desired family size	41
Table 4.5: Relationship between socio-demographic and economic characteristics and males involvement family planning use	43
Table 4.6: Relationship between socio-demographic and economic characteristics and males involvement in pregnancy planning	45



LIST OF FIGURES

Fig 1.1: Framework for Male Involvement and its influence on Family Planning use . 5

Fig 4.1: Sources of FP/contraceptives information 39

Fig 4.2: Contraceptives/FP methods 39

KNUST



ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CHRPE	Committee on Human Research, and Publication Ethics
CI	Confidence Interval
CHPS	Community Health Planning Services
EPI	Expanded Programme on Immunization
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immune Virus
MDGs	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-Governmental Organization
OR	Odds Ratio
RTIs	Reproductive Tract Infections
SD	Standard Deviations
SDGs	Sustainable Development Goals
STIs	Sexually Transmitted Infections
WHO	World Health Organization

ABSTRACT

Background: Family planning involves the processes, activities, and practices to space births and limit family size through the prevention of unwanted pregnancies. Pregnancy is intended to occur by choice and not by chance. Family planning aims to assist couples and individuals at all ages to achieve their reproductive goals so as to improve their general reproductive health. Male involvement in the context of this study implies male support in decision taken on family planning issues and encouraging women in the service uptake. Data from the West Mamprusi District Health Directorate indicate low family acceptor rate over a three-year period as 7.3% for 2014, 4.3% in 2015 and 9.1% in 2016. The low coverage for family planning has been anecdotally attributed to poor males' involvement.

Aim: This study sought to determine male involvement and its influence on family planning use in the West Mamprusi District of the Northern region of Ghana.

Materials and method: The study employed a cross-sectional design with quantitative approach to data collection to determine male involvement and its influence on family planning use in the West Mamprusi District. A structured questionnaire was used to gather data from 140 respondents by simple random sampling. Data was checked for completeness and accuracy, and analyzed using STATA version 12.1 at a significant level of 5%.

Results: Average age of males interviewed was 28.52(SD $\pm$ 7.30), with over threequarters (87.1%) were married men and 83.8% had at least 4 children and 72.3% reported having intention for more children with major (41.3%) decision making regarding childbearing been determined by the husbands. Males' patronage and involvement in family planning indicates 38.6% of men to have accessed family planning with their partners, and 35% said they were stigmatized when involved in

family planning with partner. Overall males knowledge of family planning was 58.5% and negative perceptions and attitude of men towards vasectomy was 37.5% and facilitators and barriers to males involvement in family planning include time factor (32.1%), stigmatization/gossip (19.8%), and shyness (16.1%), prohibited by religion (13.6%) and cost/lack of monies to access the services. Major barrier affecting males involvement was contraceptives side effect (82.1%) and cited side effects to include; abdominal pains/heavy menstrual flow (33.3%), delayed pregnancy/menstruation (22.9%), weight gain/obesity (13.3%) and dizziness/headache 12.4%. Associated socio-demographic determinants influencing males involvement in family planning were; age category (OR=2.55; 95%CI 0.97-6.65; p=0.05), educational level (OR=0.19; 95%CI 0.39-0.94; p=0.04) and occupation (OR=0.37; 95%CI 0.15-0.84; p=0.02). In conclusion males' involvement in family planning was woefully low, with high awareness level and an average knowledge level of FP. Determinants of males' involvement in family planning was found to involve men age, educational level and occupation.

KNUST



CHAPTER ONE

INTRODUCTION

1.1 Background

Family planning involves the processes, activities, and practices to space births and limit family size through the prevention of unwanted pregnancies. Pregnancy is intended to occur by choice and not by chance (GSS, 2014; Morhe et al., 2014). Family planning aims to assist couples and individuals at all ages to achieve their reproductive goals so as to improve their general reproductive health (GSS, 2014; Morhe et al., 2014). Male involvement in the context of this study implies male support in decision taken on family planning issues and encouraging women in the service uptake (Mulatu et al, 2016).

The objectives of Ghana's family planning programme are to provide information, education, and counseling to individuals and couples, enabling them to decide freely and responsibly when to start childbearing and how to space the children they choose to have, to provide affordable contraceptive services and make available a full range of safe and effective methods; and to provide information on how to manage reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV and AIDS (GSS, 2014).

Male parents are also responsible for caring for children, as well as planning the size of the family, prevent sexually transmitted diseases and other health complications. The role of males in such matters is of great importance, because they are the sole decision-makers in a vast majority of families. Especially in the developing countries, women have a little or no say on matters which affect their reproductive health and child bearing (Jayalakshmi et al., 2002).

Although on males usually are the decision makers about sexual activity, and the desired number of children they often know very little about the health benefits of planning and spacing pregnancies for mothers and children (Jayalakshmi et al., 2002). Without accurate information on the benefits and various methods of family planning, they resist supporting family planning use because of misinformation that some methods may harm the woman's health, or because they believe that women using family planning are more likely to be promiscuous (Jayalakshmi et al., 2002). From the same study confirm that involving men can lead to better health outcomes including those specific to family planning knowledge, intra-spousal communication, and family planning use and continuation. Engaging male in family planning can foster a positive environment for the couple's broader sexual, emotional and spiritual health (Jayalakshmi et al., 2002).

It is well-documented that male's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions (Toure, 1996). However, fertility and family planning research and programs have ignored male's roles in family planning in the past, and have been focusing on women's alone in improving family planning services uptake (Toure, 1996). Every day, 1,600 women and more than 10,000 new-born die from preventable complications during pregnancy and childbirth. Almost 99% of these maternal and 90% of neonatal deaths occur in the developing countries (Demissie, 2016). In developing nations like Ghana, societal norms and religious beliefs permit male to be the primary decision makers in home and hence on the use of family planning methods by their partners and on family sizes (Wiafe, 2015).

Also, spousal disagreement on the use of family planning deters women from using it. As such, to exclude male from sexual reproductive health services means they are not able to access vital knowledge and counseling on the service, and they will fail to provide the needed support to women for the uptake of family planning and other reproductive health service (Wiafe, 2015).

Family planning is instrumental to reduce poverty, promote economic growth, increase female productivity and improve child and maternal health. Decreasing women's time on child rearing and increasing their enrolment in productivity and education to enhances their social status and decision-making power (Mulatu et al, 2016).

In Africa, males generally desire larger families than their wives. Gender norm, societal cultural expectations on behaviors of females and males often bound women's ability to negotiate in contraceptive use and active participation in efforts to improve their livelihoods (Morhe et al., 2014).

Investigating and identifying factors that influence how males are involved in family planning could facilitate their support for such programmes to the betterment of the health of the community.

1.2 Statement of Problem

Some studies have shown that males are much more interested in and have a positive view of family planning than is generally assumed (Ukeagu, 2014). Though their involvement is still low especially in developing countries like Ghana. This low involvement is endears by the fact that over the last three years, males' attendance to family planning in West Mamprusi district is declining. Data from the District Health

Directorate for family planning acceptor rate over a three-year period was 7.3% for 2014, 4.3% in 2015 and 9.1% in 2016. The low coverage for family planning has been anecdotally attributed to poor males' involvement (GHS, 2016).

There has been no major scientific research in the district in assessing male involvement and its influence on family planning use in the West Mamprusi district. Hence there is a gap in males' knowledge in understanding the reasons why they have to involve in family planning programmes. This study seeks to fill that gap and unearth certain factors influencing males' involvement in family planning and suggest ways to improve on male involvement in their partners' family planning uptake.

1.3 Study Rationale

The Northern Region of Ghana is one of the deprived and the poorest in the country. This study seeks to assess the influence of males' involvement in family planning service.

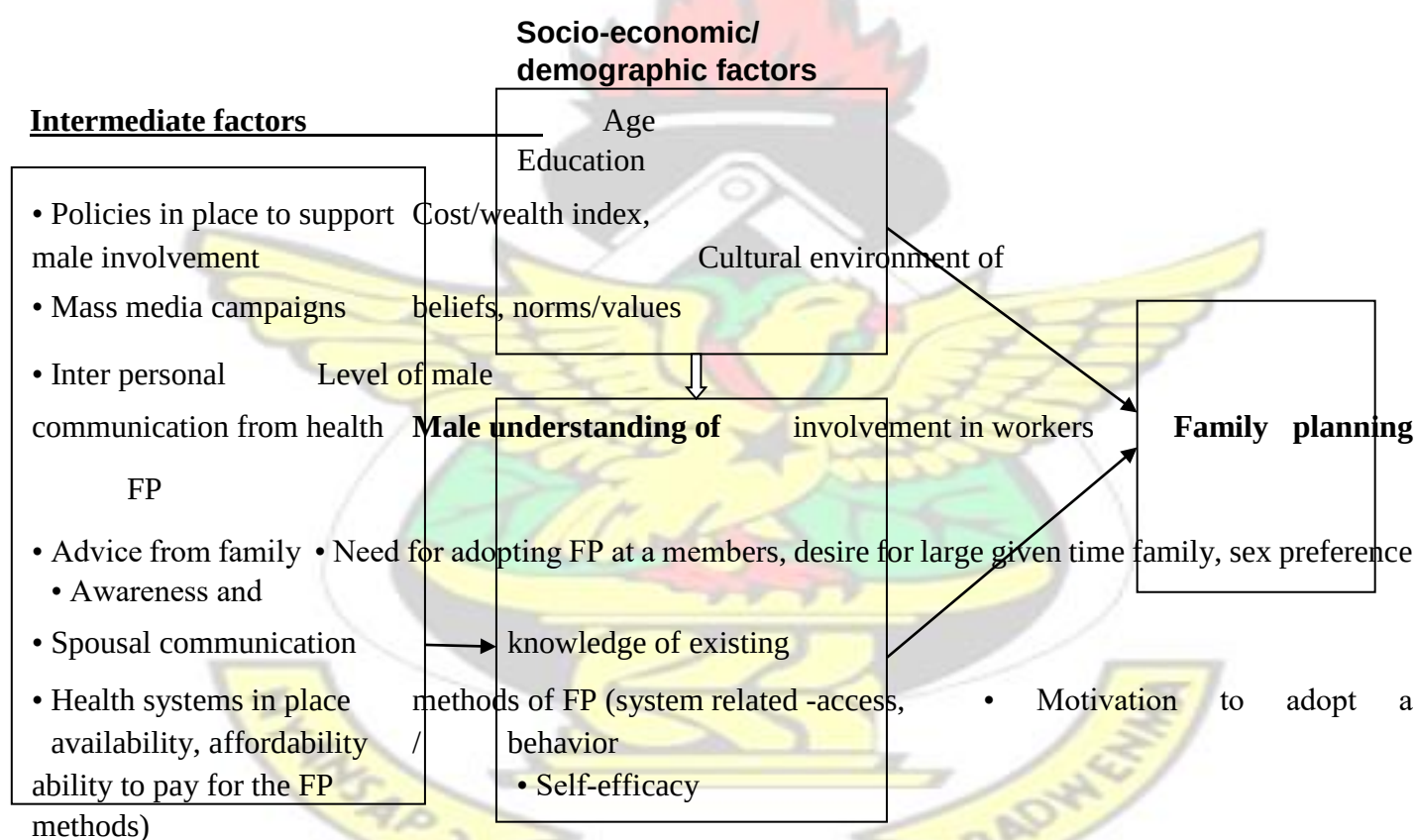
Male involvement in family planning can promote an increasing number of males using condoms and having vasectomies. Male involvement could also encourage number of males to influence support for their partner and their peers to use Family planning and, also influence the policy environment to be more conducive to the development of male-related programs.

Male involvement is therefore defined in a much broader sense to include male contraception, and as well refer to all organizational activities aimed at males as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice among either sex (Demissie, 2016).

This study therefore will contribute to increase knowledge and improve attitudes of males toward family planning and promote contraceptive use among males and females of reproductive age.

It will also provide the opportunity for Ghana Health Service staff to offer better family planning counseling service to males. It will also help the Ministry of health to strengthen and evaluate educational programmes on family planning to develop new ways toward improving males' involvement in family planning

1.4 Conceptual Framework



Source: Modified version of the de-Bruijn model) (Char, 2011) Fig 1.1: Framework for Male Involvement and its influence on Family Planning use

1.5 Research Questions

These include;

1. What is the patronage of family planning services by males?

2. What are the facilitators and barriers that affect male involvement in family planning use?
3. What is the knowledge and perception about male involvement in family planning?
4. What is relationship between the various factors including socio-demographic and male involvement in family planning?

1.6.0 Study Objectives

The objectives of the study include the study general and specific objectives as below, and they include;

1.6.1 General Objectives

The general objective of the study sought to determine male involvement and its influence on family planning use in West Mamprusi District of the Northern region of Ghana.

1.6.2 Specific Objectives

The specific objectives of this study include;

1. To assess the patronage of family planning services by males
2. To determine or identify the facilitators and barriers to male involvement in family planning use
3. To assess the knowledge and perception of males involved in family planning use
4. To assess the various determinants including socio-demographic and their association with male involvement in family planning

1.7 Profile of the Study Area

The study was conducted in West Mamprusi with its capital being Walewale. It is one of the twenty district of the Northern Region six districts in the northern region. It has a total population of 168,011 people (Ghana Statistical Service, 2010). The district covers a total area of 4,892 km

It has an under-five mortality rate of 175/1000 live births (Ghana Statistical Service, 2013). It was chosen because it is one of the poorest and deprived districts in Ghana. The district is located within longitudes 0°35'W and 1°45'W and Latitude 9°55'N and 10°35'N. It has a total land size area of 2610.44sq km and shares boundaries with East Mamprusi and Gushiegu Districts to the east North Gonja, Savelugu and Kumbungu Districts to the south; Builsa, Kassena-Nankana East Districts and Bolgatanga municipal (Upper East Region) to the north and; to the west. The West Mamprusi District is one of the 26 administrative assemblies in the Northern Region of Ghana. Administratively, the district lies within the Northern Region, although it has strong economic and functional linkages with some major settlements in the Upper East Region like Bolgatanga and Fumbisi in rural areas.

The district has an estimated population of 139,730 with 150 communities. The annual growth rate is 2.9% (2010 population and Housing Census). The ethnic composition of the population is about seventy five percent (75%) Mamprusi. The other minor groups are; the Builsa (4.7%), Frafra (2.7%), Kasena (2.2%), the Dagomba (1.8%), and some other ethnic groups in Ghana (2010 PHC, GSS). The main dominant religions are Islam (79.4%), Christianity (15.6%) and the Traditionalists (3.7%). The West Mamprusi District has one District Hospital, and a Polyclinic which serve the entire population. However, there are other smaller health facilities such as health centers, Community Health Planning Services (CHPS) compounds and so on dotted round the district to augment primary healthcare delivery. While most of these facilities are state-owned, others are owned and operated by faith-based organizations as well as private individuals. The district hospital therefore remains a major referral point for those in the sub-districts and beyond.

1.8 Scope of the study

This study was focused on determinants of males' involvement in family planning and its influence on involvement and support of their partner uptake of contraceptives and family planning using structured questionnaire with closed and opened-ended questions. Geographically, the study is limited to married men and men in intimate relationships and was residence of the West Mamprusi district in the Northern of Ghana. In this case, differences in socio-demographic factors were established, males' involvement in family planning was assessed and any other challenges associated with the involvement of men in family planning and contraceptives within the West Mamprusi district of the Northern region of Ghana.

1.9 Organization of the study

This study is organized into six chapters. Chapter one focused on introduction/background, problem statement; research objectives and questions; hypothesis, study rationale, brief methodology, scope of the study; study limitation and study organization. Chapter two will focused on review of relevant literature. Chapter three will address the research methodology including the study design, data collection techniques and instruments, study population, study variables, sample size and sampling technique among others and the health profile of the study area. Chapter four is comprised of data analysis, data analysis plan, statistical methods and presentation of results. Chapter five is comprised of discussion of the results with related literature reviewed and the last chapter six would comprise of conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section presents the literature review of the study based on the study topic and the related objectives of the study which sought to determine factors influencing male involvement in family planning in the West Mamprusi district in the Northern Region of Ghana. The reviewed literature has been categorized into sections which include; concept of family planning, benefits of family planning, demographic, socioeconomic, and cultural and other relevant factors that influence male involvement in family planning. Literatures were also reviewed knowledge and perceptions of males on family planning, males' patronage and involvement in family planning. Literature was reviewed using search engines such as Google scholar, Wikipedia, Pubmed, Research gate and other Google platforms and search engines.

2.1 Concept of family planning

Family planning (FP) in diverse literature has been defined in different ways, but more importantly it enables individuals or couples to attain their desire number of children by birth spacing and timing of their children through the use of modern contraceptives (implants, injectables, condoms) or traditional methods (periodic abstinence and withdrawal method) to the prevention of pregnancy (Shah, 2007). The synonym of FP is sometimes called birth control, which equally connotes the prevention of pregnancies and limiting family size of couples on planning their families. The term contraceptives or contraception refer to devices or medications that are used by couples to reduce the likelihood of ovum fertilization by the sperm cells

(Shah, 2007). Contraceptive methods could be either temporary or permanent. Temporary methods include: periodic abstinence during the fertile period, *coitus interruptus* (withdrawal), and lactational amenorrhea which are the natural occurring periods of infertility during breast-feeding and postpartum amenorrhea.

Contraceptives also involve the use of reproductive hormones such as oral pills and long-acting injections and implants, placement of a device in the uterus like copperbearing and hormone-releasing intrauterine devices. Also, interposing a barrier method that prevents the penetration of the sperm into the upper female genital tract such as condoms, diaphragms, and spermicidal.

Permanent methods of contraception include; male and female sterilization which are vasectomy and tubal ligation.

The concept of FP emerged when the world population by 1900 was estimated to be about 1.7 billion, and in 1999 it was reported to have risen to 6 billion according to World Health Organization (WHO), which triggered the need for people to plan their families. Presently, it is estimated that about 80% of the world's population live in developing countries, and was further pronounce to have risen to 90% by the year 2050 (Admasu, 2015). Alongside this population increase, and the limited amount of resources in each day about 1,600 women and more than 10,000 children who are newly borne die from preventable pregnancy and childbirth complications.

With this, nearly 99% of maternal deaths and 90% of neonatal deaths have been reported to occur in less developed countries such as those in sub-Sahara Africa including Ghana (Butto and Mburu, 2015). The WHO estimated 287,000 maternal deaths to have occurred in 2010; in which sub-Saharan Africa constituted 56% of maternal deaths and 29% in Southern Asia with issues relating to pregnancy was found as the greatest contributor to the burden of maternal deaths globally (Marius et al, 2014). The burden of maternal and neonatal death can be reduced if human fertility rate is regulated through the use of FP in spacing children and limiting births. Fertility rate in Ghana has shown a declined rate in the number of children per woman from 6.4 in

1988 to 4.2 in 2014 according to the Ghana Demographic and Health Survey (GDHS). The decline in fertility rate over a decade in a decrease in neonatal and infant mortality to 41 deaths per 1,000 live births which is about 28% decline rate since 1998, through under-five mortality however saw an increase to 60 deaths per 1,000 live births to indicate 44% rate within the same period (GSS, 2014). Key drivers to the decline in infant and under-five mortality could be the use of contraception or FP in Ghana, through contraceptives and family planning are often seen as a business for women with low males' involvement in Ghana and within SubSahara Africa. Contraception and family planning use are perceived to make a woman promiscuous and about 73% of men in Ghana matters relating to contraceptives and family planning (GSS, 2014). According to Marius et al (2014), women's ill patronage in reproductive health/FP services has been cited to be influenced by lack of male involvement. The involvement of males in FP does not only help in the acceptance of FP or contraceptives but also ensure the effective use and continuation of the method. Ensuring male involvement in FP could have helped in the achievement of the post millennium development goals (MDGs) and the current Sustainable Development Goals (SDGs) in reducing maternal deaths and impact of HIV prevalence in the population (Kassa et al, 2014). To increase the use of contraceptives and FP among women, call for males involvement have been made, because males involvement in FP have greater health impact and ensure the reduction of maternal mortality, and infant and child mortality, and also help increased school enrolment among girls and women overall socioeconomic empowerment (United Nations, 2017). Therefore, this study sought to determine male involvement and its influence on family planning use in West Mamprusi District of the Northern region of Ghana.

2.2 Benefits of family planning

The benefits of FP are enormous to the socio-economic empowerment and health impacts of individuals, families, communities, societies and the nation as a whole.

Few of such benefits are outlined below.

2.2.1 Benefits of family planning to the family

The following are among the benefits of family planning to the socio-economic empowerment and health impacts of the family;

- ✓ Through FP, the basic necessities such as food, water, housing, education and clothing of each family member are achieved. It also helps families to spend less money and save over a period of time, and be able to make education for their children more affordable, and the children are better educated to the highest level and are able to take good care of their parents in the future (Marius et al, 2014).
- ✓ It reduces substantially the illness of mother and child and therefore boosts family incomes that could have been used in paying for hospital bills and treatment of ailments. Again, once the mother is healthy she will be able to engage in productive economic activities to support the family, and the family will live in harmony and peace (Marius et al, 2014).

2.2.2 Benefits of family planning at the community level

The use of FP in a community by women helps provide the following benefits;

- ✓ Helps reduce health risks to women and guarantees them more control over their sexual and reproductive lives. With better health and greater control over their lives, women can take advantage of education, employment and civic

opportunities in their communities and the overall well beings of the community been improved (Kassa et al, 2014).

- ✓ Maternal and child morbidity and mortality in the community will reduce, and issues of taking care of the sick will be avoided and peoples can engage in productive economic ventures. Also through family planning, women health in general will be improve, and prevent the spread of diseases in communities such as the sexually transmitted diseases like HIV/AIDS (Kassa et al, 2014).
- ✓ Through the use of FP, issues of abortions from unwanted pregnancy, and also a precursor of maternal deaths will be prevented. Also resources of the family and community will be well managed to enhances the social and economic lives of the people since the monies that will be use for health services are channel to improving the lives of the people (Kassa et al, 2014).

2.2.3 Benefits of family planning at the national level

Uptake of FP by women will contribute to improvement of health services issues like diarrhoea and pneumonia management of children at less cost and lessen national budget on procurement of logistics and provision of facility. National health programme such as nutrition programme, expanded programme on immunization (EPI), and family planning programmes become efficient and contribute directly to the improvement of maternal and child health and healthy growth and development in children (United Nations, 2017).

Also, with smaller population size, family and government will have reduced burden in the provision of infrastructure and logistics, and other essential equipment which are important to the social and economic growth and the general well being of the people in the country (Marius et al, 2014).

The education of the people will be improved and ensure a healthy nation, promote enhanced productivity in the country and self-sufficiency to building sustainable development in the country. Again, issues of unwanted pregnancies which lead to unsafe and induced abortions putting burden on the national health system could be prevented through the use of family planning. The uptake of family planning will contribute to the reduction of maternal and infant mortality in the country (Marius et al, 2014).

2.2.4 Benefits of family planning at the global level

At the global level, the uptake of FP by women and families will contribute greatly to the attainment of the sustainable development goals (SDGs) and targets on the reductions of maternal and infants mortality by the United Nations and target for HIV/AIDS prevalence and impacts around the globe (United Nations, 2017). The agenda 2020 on FP set up by the United Nations which focuses on the 69 poorest countries, and Every Woman, Every Child which seeks to outline broader strategies of accelerating the improvements of women, adolescents and children health by 2030 will equally be achieve (United Nations, 2017).

2.3 Barriers and factors influencing males' involvement in family planning

Among factors that have been identified to have greater impact on the utilization of reproductive health services by women is participation of males in FP services. This has been highlighted by the 1995 International Conference on Population and has called Development indicating the responsibilities of men in women reproductive health, and for men active involvement in women contraceptives uptake and other reproductive health services according to Hemaideh et al (2016). The involvement of males were reported to include the use of males FP methods and increase males involvement in

decision making concern women contraceptives uptake and planning family size (Hamaideh et al, 2016). Male involvement in FP also indicate their acceptance and support of their partners' wants, preferences of FP methods, and sexual and reproductive health rights of their wives to ensuring fairness (Kassa et al, 2014).

A number of these factors interfere with women FP uptake and the low coverage of FP services, and as well as the desire for more children to be underpinned by low level of knowledge on contraceptives and unavailability of the preferred method to use (Kassa et al, 2014).

In addition, others factors could be demographic, socio-economic, cultural and among others which could have significant influence on males involvement in family planning in the study area which are further discussed below;

2.3.1 Socio-demographics and economic factors

Various socio-demographic and economic factors influenced male involvement in FP.

In a study by Malkawi et al (2016) in Kenya found men's level of education and number of children a man has to have significant influence on male's involvement in FP.

The study also found demographic factors like age to affect male FP involvement whereby the elderly men were 2.1 times more likely to have involvement in FP than the younger in age. Again, those who had more than two children were found to have a lower rate of current contraceptives use. A similar study indicates previous contraceptives use to have association with men's attitudes towards FP. Men were found to have indicated that having more children as a man showed masculinity and earned a man more respected (Malkawi et al, 2016).

However, a study conducted in Ghana found no significant association between men's socio-demographic variables such as age, number of wives, level of education and ever had children to significantly influenced male's involvement in FP. With majority of men in Ghana aged between 15-59 years thinking that men should have responsibility towards family planning and support women FP uptake (GSS, 2014). In Ethiopia a Marius et al (2014) study found strong association between age, marital status and male's involvement in FP. It indicated older or aged men and cohabitation to have influence on FP uptake by men. Similarly, in Malawi the study had showed age and marital status to significantly influence male's support for their wives in FP uptake, and more men were found to have been in support of vasectomy as method for FP (Marius et al, 2014).

A study conducted by Butto & Mburu, (2015) in Kenya found 48% of men not involved in FP and 6% only was reported to have used family planning in Kenya, and have equally found respondents age, education, number of children, and type of marital relation to have significant influence on the male FP involvement. However, other studies by the same author found men with no formal education to be less likely to involve in family planning and support of their partners to uptake FP services (Butto and Mburu, 2015).

Aduayi et al (2017) study also found respondents age group and the number of children to have statistically significant association with the level of males' involvement in FP. The study also found men's level of education to have significant association with males' level of involvement in FP practices, and again indicate that men with no formal education made up of 89% and were less likely to involve in FP. In Butto & Mburu(2015) study found religion to have association with men contraceptives use ($p=0.003$), as well as type of marital relation to have equally influenced the level of

male involvement in FP. Again, the study found monogamous marriage men to have 3.8 increased chance of involving in FP and to have offered support to their wives FP services uptake.

Another study by Soremekun (2018) found men engagement in FP to have direct influence on their partners' uptake of reproductive health services with regard to FP choices, decision making on FP and contraceptives behavior of men (Soremekun, 2018).

In addition, Aduayi et al (2017) also found age, religion, education and occupation to have significant influence on overall male involvement in family planning practices, and males' perceptions towards FP services. A Soremekun (2018) study equally found age, religion, and education to significantly influence males overall FP practices and uptake of contraceptives. A multi-variable logistic regression analysis by Aryeetey et al (2010) in Ghana found age of respondents, occupation, marital status and religion to have significant influence on men uptake of modern contraceptives and an increased level of knowledge on FP methods (Aryeetey et al, 2010). With related study also in Uganda found age, place of residence, occupation, and marital status to have significant influence on males non-use of contraceptives and as well as the fear of side effects which were making men not to allow their wives to use contraceptives (Orach *et al.*, 2015).

2.3.2 Socio-cultural factors

Cultural beliefs and perceptions, as well as cultural standards of society serve as barriers to males' involvement in FP practices. In Marius et al (2014) study found males respondents to believed that males need to involve in FP services because they play dominant role in family decision-making in FP practices, and found men as heads of

the family to exert a lot of significant influence on women's decision making on FP uptake.

The study equally found decision pattern at home to include jointly decisions, males dominated decision and females dominated decision making by respondents in which males decision making was found to have dominated females decision making which was influenced by cultural norms of making the man the head of the family (Marius et al, 2014).

In Nigeria, similar study found men who followed their wives to FP clinic to have been perceived as being dominated by their wives or being controlled by their wives because men perceived FP to be the preserve of women. By this, 65% of men in Nigeria were found to have disapproved men attending FP clinic with their wives (Marius et al, 2014).

Soremekun (2018) indicates many men to believe the use of FP to limiting births and spacing of children to have encouraged promiscuity among women and so disapproved the use of FP. Also, the study found males uptake of FP and involvement to be associated with socio-cultural norms and a determinant of gender relations in society, and so can promote males involvement in FP activities in Nigeria (Soremekun, 2018).

In Zimbabwe, a study by Aduayi et al (2017) found 42% of married women believe that it was the responsibility of men to decide whether or not their wives will be allowed to use FP methods (Aduayi et al, 2017), and in Ethiopia women who were found to be at risk of unplanned pregnancies because they have had unprotected sex have reported to have been opposed by their husbands (Aduayi et al, 2017) in the use of FP.

In Ghana, women FP uptake was found to have been influenced by cultural norms and beliefs where women are required to obtain permission from their husbands before

using any contraceptive method. The cultural position of men being the head of the family influenced decision making regarding to women reproductive health and FP (GSS, 2014).

2.4 Males knowledge and patronage of family planning

The influence of males' involvement in FP and support of their wives to the uptake FP services is dependent on their knowledge level of the various contraceptive methods and the use of it. With regards to a study conducted by Aduayi et al (2017) found almost all men (99.7%) to be aware of FP with condoms being the most commonly known method and the least known FP method was vasectomy.

Major sources of FP methods were found as 54.2% through radio, 12.7% school, and 11.4% from friends and relatives, and the most commonly used FP methods were condoms (49.5%), and 19.8% been emergency contraceptive pills. Again, overall contraceptives use was found to 66.1%, with currently used contraceptive methods to involve condoms (49.5%), withdrawal/*coitus interruptus* (22.5%), contraceptive pills (19.8%), and the least used contraceptive methods to have similar proportions of 0.6% for implanon and vasectomy (Aduayi et al, 2017).

In Tlahun et al (2013) in Ethiopia usage of men's condoms was very low though there was a high level of contraceptives knowledge with about 96% aware of at least one form of contraceptive method. In related study by Duze & Mohammed (2006) found nearly two-third (63.6%) of males to have knowledge of contraceptive methods, and similar proportion to have known of at least one method of contraception. However, the study found that men's place of residence, age and education had significant influence on men contraceptives knowledge and use.

Kassa et al (2014) of Uganda found 91.6% of men to have knowledge of modern contraceptive methods and 99.2% to have said they have ever heard of FP methods. In Ghana, modern contraceptives knowledge (97%) of men was found to be universal, with 56% aware of more than one FP methods, and 65% of men to have ever used modern family planning method, while 82% of respondents thought contraceptives were effective for the control of births (Aryeetey et al, 2010). In Tanzania, men contraceptives awareness was reported to be equally universal, and about 99.7% knew more than one FP method and 67% were found to have ever used family planning methods (Mosha et al, 2017).

Among FP methods men have ever used were reported low patronage for methods such as injectables, oral contraceptives, except condom which was reported high among married men. With FP knowledge, it was universally reported in Tanzania (100%) and 82.3% were found to have ever used modern contraceptives method (Mosha et al, 2017).

In another study in Malawi found 50% condoms used among men and women, contraceptive pills was 36.3%, periodic abstinence/ rhythm was 33.4%, Injectables 23.4%, withdrawal method was 20.6%, Intra-Uterine Devices 13.5%, tubal ligation 12.3%, diaphragm was 12.2% and vasectomy as 10.6% (Akwenabuaye et al, 2013). And in similar study by Nzioka (2012) found an increased number of male to have knowledge and interest in FP, and this was reported among the young men and the educated men.

In Ghana, according to the Ghana Demographic and health Survey; contraceptives knowledge was reported universal among both men and women; with about 99% of men and women to have had knowledge of contraceptives regardless of their marital relation. Men aged 15-49 years about 99% have knowledge of modern methods and

81% knew of the traditional methods, and about 77% to have known withdrawal method, male condom was 99%, emergency pills 87%, female condom 88% and Injectables 83% (GSS, 2014).

In related study by Akafuah & Sossou (2008) in Ghana (Accra) found sociodemographic characteristics like education, religion, marital status, influence of education from the media to significantly affects men contraceptives knowledge and the involvement of it.

2.4.1 Males perception and attitude towards family planning

The involvement of males in FP could be influence by their attitude and perceptions towards the uptake of FP services. In Mosha et al (2017) found majority of men (96%) to have had positive attitude towards FP, with most of them to have had positive perceptions about FP as effective methods to the control of births, and some were found to have recommended FP to their friends and relatives as means of birth control in Tanzania.

In a related study by Kassa et al (2014) which assess men attitude towards FP and have found about 51.1% of men to have developed interest in knowing more about FP while 48.9% were found to have had no interest in FP, and however had believe in the natural birth control processes (Kassa, Abajobir and Gedefaw, 2014).

Again, Aduayi et al (2017) found 89.5% of men to have had good perception about FP and 82.9% beliefs FP to be good while 33.9% and 18.6% to have agreed that condom use doesn't reduce sexual satisfaction and vasectomy as the desirable method of practice. Overall assessment of men positive perceptions was 89.5% and negative perceptions of men towards FP was found to about 10.5% (Aduayi, 2017).

In Nigeria, about 89% of men were found to have approved of their spouses using FP while 11% disapproved of their wives using FP methods, with about 65% of males to have disapproved their wives attending family planning clinics and 26% to have been in support (Marius et al, 2014).

Again, in a qualitative study by Tilahun et al (2013) found more men to have positive attitude towards FP, and as well as more men were found to have been in support of their wives in the uptake of family planning services.

Notwithstanding, about 3% of men were found to have had negative attitude towards FP in which a 45 years old man have said “What will I do in a family planning clinic, contraception is women’s business, I will just give my wife the necessary financial support she needs” Overall, males attitudes and perceptions towards FP was found to be high (91%) and 64% to have ever used contraceptives (Tilahun et al, 2013).

In Duze & Mohammed (2006) study found 55% of men to have had unfavorable attitude towards family planning and 35.7% were found to have had favorable attitude towards the use of family planning by women. According to Aryeetey et al (2010) men perceptions about FP in Ghana was found to be associated with their use of modern family planning methods, and Mosha et al (2017) found 40% of men to have indicated that they will not discuss FP uptake with their wives. Kabagenyi et al (2014) study found social norms and health system support factors to significantly affect men involvement in FP and participation in other reproductive health services, and to have found some of the men who said the use of vasectomy make men to lose their masculinity and do not support uptake of vasectomy.

Orach et al (2015) study in Uganda found men who are the heads of families and been the sole decision-maker to significantly influence women FP use, for which most

women were found to have been expected their men to initiate the decision on the discussion of FP at home, and when the men failed to do so the woman is likely not to have used contraceptives. In Ghana, a study by Akafuah & Sossou (2008) found men attitude towards FP to have been influenced by their socio-demographic characteristics such as education, religion, marital status and exposure to the media to affects their involvement and support of their wives to the uptake of family planning services.

2.5 Facilitators for males' involvement in family planning

The level of males' involvement in FP in Ethiopia was found to be about 8.4%, and similar proportion to have participating in the use of FP, and more males were found to have reported in support of the use of male condoms (Kassa et al, 2014). Among the reasons/facilitators cited that could have accounted for the low involvement of males' in family planning to include men desire for more children, wife or partner refusal, fear of side effects, prohibition by religion, and lack of awareness on FP methods.

In the same study by Kassa et al (2014) found men who support their wives in FP services uptake to be more likely to have involve in FP services. Again, men who were found to have encouraged their wives to use FP were more likely to have involved in FP services, and as well as support their wives, motivates them and share their responsibility in reproductive health services uptake and encourages men to develop a supportive attitude towards FP. Other factors such as lack of FP information, and inaccessibility of the FP methods to have accounted for the low level of involvement males in family planning services (Kassa, Abajobir and Gedefaw,

2014). In Tanzania, a study by Mosha et al (2017) found low level of males' involvement in FP to have been influenced by educational level, contraceptives

information sources, occupation, level of household income, and distance from the health facility to have affected males' FP services.

In a related study by Akwenabuaye et al (2013) found spousal involvement in FP to have took place after having two or more children, and contraceptives use to have been found to always initiate by the husbands. It therefore require the needs to address barriers to males' involvement in FP to create the supportive environment for men to be able to partake in FP services of women, and as well as address men negative attitude towards FP (Kabagenyi *et al.*, 2014) in Uganda. In Ghana, overall male involvement in FP and the support of women uptake of FP services to be about 8.2% (GSS, 2014), which is woefully low and influenced by men level of education, knowledge, stigmatization and lack of social support for males involvement in family planning.

CHAPTER THREE

METHODS AND MATERIALS

3.1 Study Design

The study was a cross-sectional design to determine the level of male involvement in family planning and its influence on family planning use within a specific time period. Quantitative method of data collection was used to assess the factors affecting males' involvement and its influence in family planning use.

3.2 Data Collection Techniques and Tools

Quantitative method was use to collect data. A structured questionnaire was used to collect quantitative data among married male or men in intimate relationship. The questionnaire included both closed and open-ended questions which were comprised the knowledge and perceptions of males about family planning and also to identify barriers affect males' involvement in family planning use.

3.3 Sampling Method

The study was conducted among males' participants at West Mamprusi district. A Simple random sampling method was use to selected communities from each subdistrict and at the household level purposive sampling was used to select males' participants who fell within the inclusion criteria which aimed at reducing biases in the study results. A household refers to the group of people who lived together and share the same cooking pot (GSS, 2010).

3.4 Study Population

Data collected was mainly from primary sources. The study population involved males aged 15-49 years who were in intimate relationship or were married. The estimate population of males between 15-49years in West Mamprusi was 35,506 (GSS, 2010).

3.5 Sample Size Determination

The sample size was determined using the Cochran and Synedecor sample size determination formula below:

$$n = \frac{Z^2 P Q}{D^2}$$
$$1.96^2 * 0.091 * 0.909 / 0.05^2 = 0.31777331 / 0.0025 = 127.1$$

Where:

n = the desired sample size z = the reliability coefficient for 95% confidence level usually set at 1.96 p = District family planning acceptor rate 9.1% (0.091) (East Mamprusi District Health Directorate Annual report, 2016) q = is proportion of non-

acceptor rate in the district ($100 - 9.1 = 90.9\%$, (0.909)) d = the margin of error which has been set at 5%.

The determine sample size was 127 which was then adjusted by a non-response rate of 10% to have 140 participants.

3.6 Inclusion Criteria

The inclusion criteria for this study involved males who had lived in West Mamprusi for at least six months and were currently residence of West Mamprusi. It had also included males who were 15-49 years and were available on the day of the interview and willing to participate in the study.

3.7 Exclusion Criteria

Anyone who was not a resident of West Mamprusi and had not resided for at least six months was excluded from the study. Also those below 15 years and above 50 years were also excluded and as well those who were in the age range but were not present at the household during the interview day.

3.8 Sampling Procedures

The West Mamprusi district has four sub-districts, all of which were part of this study. The total number of communities within each sub district was obtained from the District Assembly and a number of communities were randomly chosen from each sub-district. The total number of men for each community was also obtained from the District Assembly through the Census report and by using population proportions a quota was assigned to each community or group. By population proportion method, the total number of males in each sub-district was obtained from the district assembly and divided by the overall total and then multiple by the determined sample size to get the number of males to be interview in each sub-district, and at each sub-district by simple

random sampling through balloting; a landmark such as school or church was identified as starting point and from the first household that was sampled. Subsequent households in the district was determined based on the previous house until all the require participants were achieve. In the community, in order to have a starting household, a landmark such as mosque was then identified to randomly select a household for the selection of males for interview.

At the household level permission was obtained from the household head and one male was randomly selected by balloting for interview. A subsequent household was selected by pen spinning until all the households are selected for interview in each community.

3.9 Pre-testing

The questionnaire was pre-tested in Langbinsi community in the East Mamprusi district. This enabled the clarification of issues that were not clear in the questionnaire; and helped to estimate the time needed to administer a questionnaire and also test the efficiency of the designed instrument.

3.10 Study Variables

The study variables involved dependent and independent variables. The dependent variable was the level of males' involvement in family planning use (the proportion of males who had supported their females partner to use family planning). The independent variables include socio-economic/demographic factors like age, education, cost/wealth index, and cultural environment of beliefs, norms/values. Factors influencing males involvement in Family planning were determined based on the need to adopt FP services at a given time, awareness and knowledge of existing methods of FP, and the motivation to adopt a behavior and self-efficacy.

3.11 Data Handling and Analysis

The data collection tool was first checked for accuracy of questions by pre-testing in the field and then corrected to have the final tool to ensure right responses from participants were received. After, collection of field data, it was then cleaned of typo errors, missing data, and duplications to checked for appropriateness, consistency and accuracy of the information that would be provided by the participants. Questionnaire was also given identification numbers to make it possible to contact some participants in case of wrong information, and when it became necessary for clarification of certain issues and also to complete certain questions that they have left unanswered. Serial numbers were assigned to the individual edited questionnaires for the purpose of easy identification during the recoding process and rechecking of information on the questionnaire during the data entering exercise. The opened ended questions were coded to create themes for their individual responses. STATA and excel software were use to analyze the quantitative data gathered. Data was first entered into Microsoft excel and then transported into STATA software for the analysis. Frequency tables, graphs and charts were generated with the categorical variables while also using odds ratios to determine the association between the dependent and independent variables. Variables that showed association with P-value less than the significant level of 0.05 (5%) were used through univariate and multivariate analysis to generate their respective crude and adjusted odd ratios with their 95% confident level.

3.12 Ethical Consideration

Ethical approval with number CHRPE/AP/031/18 for the study was sought and obtained from the University of Science and Technology Ethical Review committee board (Committee on Human Research, and Publication Ethics). A written consent was

obtained from all the participants of this study; confidentiality and privacy was maintained throughout the study.

3.13 Assumptions

It was assumed that all responses given by participants were accurate and they understood the questions posed to them before answering. It was also assumed that questionnaires were accurately administered to the best knowledge to the respondent. The outcome from their responses was akin to the opinion of all men in the district for their involvement in family plan.

CHAPTER FOUR

RESULTS

4.0 Introduction

This section presents the results of the study based on the set objectives of the study. A total of 140 participants were interviewed, and their results are hereby presented below;

4.1 Respondents Socio-demographic and economic characteristics

Table 4.1 presents the socio-demographic and economic characteristics of respondents. Majority (42.1%) of the respondents interviewed were between 26-32 years, 35% aged between 19-25 years and similar proportions (11.4%) of respondents aged between 33-39 years and above 40 years. Again, about 31.4% of men had no formal education, 22.8% had secondary education and 17.9% of respondents were found to have had tertiary education. With regards to educational attainment of the partners; similarly proportions were found as 32.1% had no formal education and 21.4% had secondary education and 6.4% had tertiary education. More than threequarters (87.1%) of respondents were married men and less than a tenth were never married, divorced and

widowed. In term of number of wives men were married to, about 65.7% had one wife, 29.2% were married to 2wives and 5.1% had more than 3wives, and with this; more than three-quarters (83.8%) of men had 1-4children, 15.4% had 5-8children and 0.9% had more than nine children. Also, about 50.7% of men were unemployed, 14.3% were civil servants and traders were 12.9%, and 35% of them were Christians, more than half (53.6%) were Muslim and11.4% were either traditionalist or spiritualist. Again, most men (42.0%) were found to have married less than 4 years, and about 55.2% of both partners took decision on the desired number of children and 41.3% of men were decision makers on children number, and majority

Variable		Frequency (N = 140)	Percentage (%)
Age category	19-25	49	35.0
	26-32	59	42.1
	33-39	16	11.4
	40+	16	11.4
Educational level	No formal education	44	31.4
	Primary	18	12.9
	JHS	21	15.0
	Secondary	32	22.8
	Tertiary	25	17.9
Educational level of partner	No formal education	45	32.1
	Primary	35	25.0
	JHS	21	15.0
	Secondary	30	21.4

Marital status	Tertiary	9	6.4
	Married	122	87.1
	Divorced	11	7.8
	Widowed	4	2.9
	Never married	3	2.1
Number of wives had (N=137)			
	1	90	65.7
	2	40	29.2
	3+ Number of children (N = 117)	7	5.1
	1—4	98	83.8
	5—8	18	15.4
	9+ Occupational status	1	0.9
	Unemployed	71	50.7
	Civil servant	20	14.3
	Artisan	19	13.6
	Trader	18	12.9
	Other specify	12	8.5

(72.3%) of men were found to have intended to have more children. **Table**

4.1: Socio-demographic and economic characteristics

Occupational status of partner			
	Unemployed	66	47.1
	Civil servant	8	5.7
	Artisan	2	1.4
	Trader	55	39.3
	Other specify Current	9	6.4
religion of respondents			
	Christian	49	35.0
	Islam	75	53.6
	Traditional/spiritualist	16	11.4
Number of years marriage (N=138)			
	<4	58	42.0
	4—13	56	40.6
	14—22	22	15.9

	>22 Desired	2	1.5
number of children of couple (N=136)			
	Husband	1	0.7
	Wife	24	17.7
	Both	75	55.2
	Husband parents	35	25.7
	God knows	1	0.7
Decision maker on children number (N=138)			
	Husband	57	41.3
	Wife	6	4.3
	Both	47	34.1
	Husband parents	18	13.0
	God knows	10	7.3
for more children (N=137)			
	Yes	99	72.3
	No Decision	38	27.7
maker to stop child bearing (137)			
	Husband	43	31.4
	Wife	4	2.9
	Both	45	32.8
	Husband parents	12	8.8
	God knows	33	24.1

Source: Author's construct, 2019 4.2 Males patronage and support of partners Family Planning uptake

Table 4.2 summarizes the males' patronage and support of partners' uptake of family planning and contraceptives use. With regards to the distance to family planning clinic; more than half (55.8%) of men had to cover a time length of 30minutes to

1hour and about 18.8% covered less than 30minutes to reach a family planning clinic.

However, more than three-quarters (83.3%) found it acceptable to accompany their partner to FP clinic, and about 46.4% of men disagreed that family planning issues should concern only women. Also, nearly two-third (59.9%) of men were found to have known very little about family planning and only 16.8% however had sufficient knowledge about family planning and contraceptives. More than half (54.4%) of men said, families and friends will react strangely when a man had accompanied his wife to

FP clinic and only 16.2% will praised a man who was found to have accompanied the wife to FP/contraceptives clinic. However, about 35% of men have said to have been stigmatized, and 56.2% said they have ever been influenced by in-laws and families to have more children. About 50.7% of men were influenced to have more children because, their extended family system does not have many children, and 32.5% said their current children were of one particular sex. Also, about 27.3% of community members will described a man who had accompanied the wife to FP clinic as a man who like sex or womanizer, 25.3% will described man as lazy or irresponsible and 23.2% will described such a man of been weak or foolish. About 38.6% of men were found to have ever access FP services with their partner, and with regards to cost of accessing the FP services; about 39.2% found the cost expensive and 33.8% said it was normal. Again, with regards to time spent at FP clinic; less than two-third (60.9%) said their wives spent 1-2hours and 24.1% spent less than 1hour in accessing FP services, with 27.8% found the time spent as too long and 62.4% said the time spent was normal.

Table 4.2: Male patronage and support of partners FP uptake

Variable	Frequency (N = 140)	Percentage (%)
Distance to the family planning clinic (N=138)		
Less than 30minutes	26	18.8
30minutes to 1hour	77	55.8
1-2hours	34	24.6
More than 2hours	1	0.7
Acceptable for man to accompany wife FP clinic (N=138)		
Yes	115	83.3
No Family Planning issues should concern only women	23	16.7
Strongly disagree	24	17.4
Disagree	64	46.4
Neutral	24	17.4
Strongly agree	16	11.6
Agree How much known about family planning (N=137)	10	7.2

	Knows nothing	23	16.8
	Knows very little	82	59.9
	Knows sufficiently	23	16.8
	Knows a lot	9	6.5
How friends/family react when man attend FP clinic			
	Strangely	74	54.4
	Praise him	22	16.2
	Indifferent	40	29.4
Are men who involved in FP stigmatized			
	Yes	48	35.0
No Ever been influenced by in-laws to have more children			
	Yes	77	56.2
	No	60	43.8
Reasons influenced to have more children			
	Children are of one particular sex	25	32.5
	Being the only child	13	16.9
	Not having many children in the extended family	39	50.7
How community people will described a man in FP who involved			
	Weak/foolish	23	23.2
	Lazy/irresponsible	25	25.3
	Indifferent/uncultured	10	10.1
	Disregarded/not respected	13	13.1
	Like sex/womanizer	27	27.3
	Doing well/good husband	1	1.0
Ever access FP services with partner			
	Yes	51	38.6
	No	81	61.4
Cost of accessing FP services			
	Expensive	52	38.2
	Normal	46	33.8
	Cheap	25	18.4
	No idea	13	9.6
Time off from work to attend FP clinic			
	Yes	47	36.4
	No	82	63.6
How long wife spend at FP clinic			
	Less than 1hour	32	24.1
	1-2hours	81	60.9

feel about time spent at FP clinic	2-3hours How	20	15.0
	Short	13	9.8
	Normal	83	62.4
	Too long How	37	27.8
describe attitude of FP staff	Very friendly	18	13.5
	Friendly	65	48.9
	Indifferent	32	24.1
	Unfriendly	14	10.5
Rude How describe the health talks at FP clinics		4	3.0
	Very helpful	29	21.6
	Helpful	79	59.0
	Unhelpful	15	11.2
	Complete waste of time	11	8.2

Source: Author's construct, 2019

4.3 Barriers/facilitators to male involvement in family planning

Table 4.3 indicates the barriers and facilitators to male involvement in family planning. Nearly two-third (62.2%) of men said there were barriers that prevented them from involving in family planning. Major barriers that prevented males' involvement in FP services were cited to include time factor (32.1%), stigmatization/gossip (19.8%), and shyness (16.1%), prohibited by religion (13.6%) and cost/lack of monies to access the services. Again, most (82.1%) men cited contraceptives side effect of been a major barrier, and cited the side effect to include; abdominal pains/heavy menstrual flow (33.3%), delayed pregnancy/menstruation (22.9%), weight gain/obesity (13.3%) and dizziness/headache 12.4%. With this, about 92.6% of men said they needed to know more about FP, 76.9% of men had approves FP use with their partner and 73.3% had ever discussed FP use with their partners. With regards to frequency of discussion, about 47.4% discussed once with their partner and

about 29.3% had never discussed FP use with their partner. And about 93.3% have ever heard of FP, and most (52.3%) men knew FP are use to prevent pregnancy, prevent HIV/AIDS and STI's was 13.3% and spacing out pregnancy and childbirth was 34.4%. With this, about 75.0% have ever used FP and contraceptives, and most access their FP services at health centres (70.5%), shops and pharmacy was 14.4% and government hospital was 15.2%. With regards to men attitude towards vasectomy indicate 37.5% to prevent pregnancy, reduced sexual feelings 35.3% and castration 19.1%. Overall contraceptives and family planning knowledge among men was 58.5%.

Variable	Frequency (N = 140)	Percentage (%)
Are there any barriers to accessing FP		
Yes	84	62.2
No Barriers to accessing FP services	51	37.8
Distance too far from provider	5	6.2
Shyness	13	16.1
Time factor	26	32.1
Cost/lack of monies	10	12.3
Stigmatization/gossip	16	19.8
My religion prohibited FP use	11	13.5
Most common challenges that prevent men		
Time factor/Cost	15	11.5
Distance	2	1.5
Lack of knowledge about FP	12	9.2
Contraceptive side effect	45	34.3
Negative community perceptions	23	17.6
Stigmatization/gossip	4	3.1
My religion prohibited FP use	10	7.6
Shyness	10	7.6
Lack of male FP providers	3	2.3
Fewer contraceptives choice for men	7	5.3
Do you know of any side effect of FP		
Yes	110	82.1
No Specify FP side effects known	24	17.9
Infertility	12	11.4

Delayed pregnancy/menstruation	24	22.9
Abdominal pains/heavy menstrual flow	35	33.3
Loss of weight/leanness	7	6.7
Becoming obese/breast big	14	13.3
Dizziness/headache	13	12.4
Need to know more about FP		
Yes	125	92.6
No Approve of couples using FP	10	7.4
Yes	103	76.9
No Ever discussed on FP with partner	31	23.1
Yes	99	73.3
No Frequency of discussion on FP	36	26.7

Table 4.3: Barriers/facilitators to male involvement in family planning

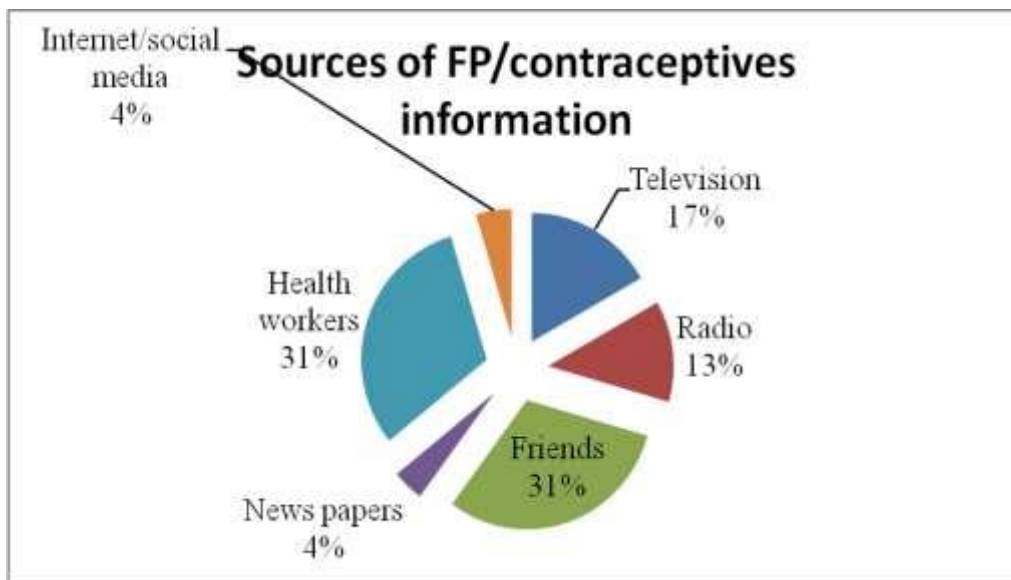


	Once	63	47.4
	Twice	19	14.3
	More often	12	9.0
heard of family planning	I don't remember Ever	39	29.3
	Yes	125	93.3
	No	9	6.7
What do you know about FP	Prevent HIV/AIDS and STIs	17	13.3
	Prevent pregnancies	67	52.3
	Space out pregnancies Ever	44	34.4
use FP/contraceptives	Yes	101	75.4
	No	33	24.6
Where access FP/contraceptives	Health center	93	70.4
	Shops/pharmacy	19	14.4
	Government hospital Attitude	20	15.2
towards vasectomy	Prevents pregnancy	51	37.5
	Reduce sexual feelings	48	35.3
	No effect	11	8.1
	Castration	26	19.1
Overall men knowledge of involvement FP use	Yes	76	58.5
	No	54	41.5

Source: Author's construct, 2019

4.4 Sources of FP/contraceptives information

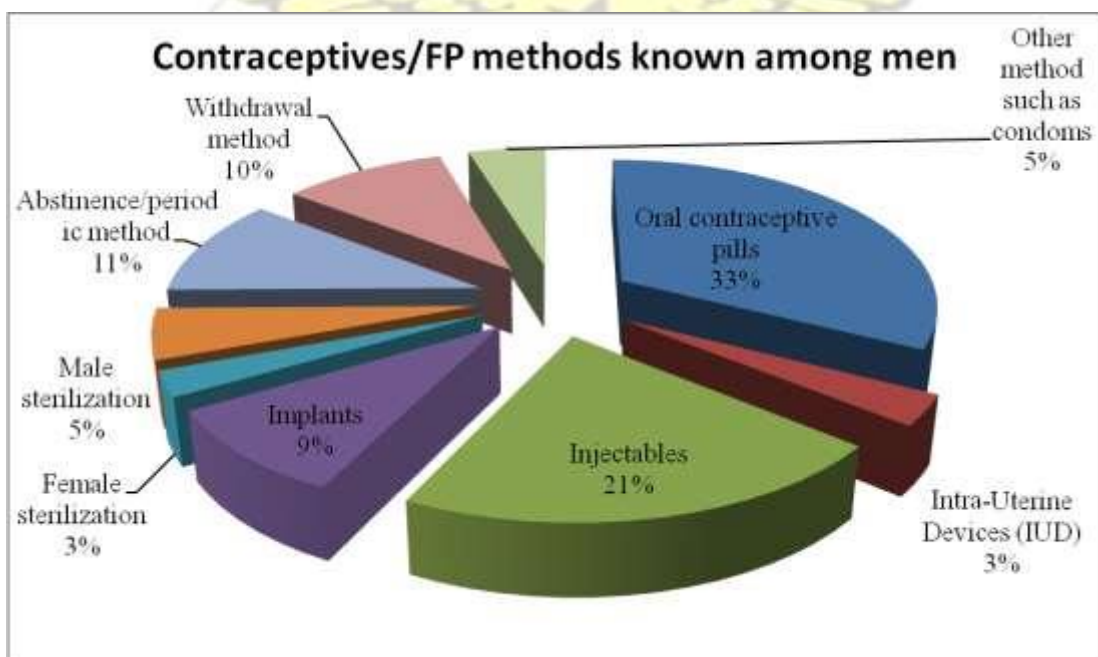
Fig 4.1 depicts the sources of FP/contraceptives information among men. Most men of about 31% had FP information from friends and health workers. The least sources of information was from newspapers, television and internet/social media.



Source: Author's construct, 2019 Fig 4.1: Sources of FP/contraceptives information

4.5 Contraceptives/FP methods

Fig 4.2 presents the contraceptives/FP methods known among men. About 33% of men knew oral contraceptive pills, 21% knew about injectables, and the least known methods include; withdrawal, IUD, implants, male and female sterilization, abstinence/periodic method and other methods such as condoms.



Source: Author's construct, 2019 Fig 4.2: Contraceptives/FP methods

4.6 Socio-demographic and economic characteristics and males involvement in planning the desired family size

Table 4.4 presents the univariate and multivariate analysis of respondents' sociodemographic and economic characteristics of males' involvement in planning the desired family size. From the univariate analysis, educational status of men was found to have a significant association with couple desired family size; as men who had tertiary education were more likely to have planned their desired family size (OR=0.13; 95%CI 0.03-0.48; $p=0.003$), as well as the educational status of the partner was equally likely to influenced the couple desired family size. Also, men who were civil servants were more to have planned their desired family size with a decreased number of children (OR= 0.20; 95% CI 0.06-0.63; $p=0.002$) as compared to those who were unemployed.



Relationship between socio-

Table 4.4: demographic and economic characteristics, and planning desired family size

Variable		Unadjusted OR (95% CI)	Pvalue	Adjusted OR (95% CI)	Pvalue
Age category	N (%)				
19-25	49 (35.0)	1.00			
26-32	59 (42.1)	0.89(0.38-2.05)	0.79	-	-
33-39	16(11.4)	2.96(0.57-15.39)	0.17	-	-
40+	16 (11.4)	1.69(0.46-7.08)	0.46	-	-
Educational level*					
No formal education	44 (31.4)	1.00		1.00	
Primary	18 (12.9)	1.82 (0.34-9.81)	0.47	3.34(0.85-13.11)	0.08
JHS	21 (15.0)	0.53(0.15-1.85)	0.31	0.48(0.15-1.49)	0.21
Secondary	32 (22.8)	0.81 (0.25-2.57)	0.73	0.56(0.20-1.52)	0.26
Tertiary	25 (17.9)	0.13 (0.03-0.48)	0.003	0.19(0.39-0.94)	0.04
Educational level of partner*					
No formal education	45 (32.1)	1.00		1.00	
Primary	35 (25.0)	3.34 (0.82-13.61)	0.07	1.83(0.34-9.60)	0.47
JHS	21 (15.0)	0.48 (0.15-1.53)	0.21	0.53(0.15-1.81)	0.32
Secondary	30 (21.4)	0.56 (0.20-1.55)	0.26	0.81(0.26-2.54)	0.73
Tertiary	9 (6.4)	0.19(0.03-1.03)	0.03	0.14(0.04-0.42)	0.001
Marital status					
Married	122 (87.1)	1.00			
Divorced	11 (7.8)	0.80(0.19-3.32)	0.76	-	-
Widowed	4 (2.9)	0.17 (0.01-2.03)	0.11	-	-
Never married	3 (2.1)	0.17(0.01-2.04)	0.11	-	-
Occupational status*					
Unemployed	71 (50.7)	1.00		1.00	
Civil servant	20 (14.3)	0.20 (0.06-0.63)	0.002	0.20(0.07-0.59)	0.004
Artisan	19 (13.6)	5.88(0.69-50.06)	0.06	5.88(0.73-47.42)	0.09
Trader	18 (12.9)	1.73(0.44-6.76)	0.42	1.73(0.45-6.68)	0.43
Other specify	12 (8.6)	0.69(0.18-2.60)	0.58	0.69(0.18-2.57)	0.58
Occupational status of partner*					
Unemployed	66 (47.1)	1.00		1.00	
Civil servant	8 (5.7)	0.30(0.05-1.58)	0.133	0.30(0.06-1.53)	0.15
Artisan	2 (1.4)			1	

Trader	55 (39.3)	0.36(0.15-0.86)	0.02	0.37(0.15-0.84)	0.02
Other specify	9 (6.4)	0.79(0.14-4.35)	0.78	0.79(0.15-4.30)	0.79
Current religion of respondents					
Christian	49 (35.0)	1.00		-	-
Islam	75 (53.6)	1.15(0.52-2.54)	0.71	-	-
Traditional/spiritualist	16 (11.4)			-	-
Number of years marriage					
(N=138)					
<4	58 (42.0)	1.00		-	-
4—13	56 (40.7)	0.53(0.23-1.21)	0.12	-	-
14—22	22 (15.9)	1.91(0.48-7.58)	0.34	-	-
>22	2 (1.5)			-	-

Source: Author's construct, 2019

4.7 Socio-demographic and economic characteristics and males involvement in family planning use

With regards to males' involvement in family planning use and their sociodemographic and economic characteristics; men with tertiary education were more likely to have involved in family use (OR=9.52; 95% CI 0.01-0.81; p=0.02) than those with no formal education in univariate analysis, however this was not the case when adjustments were made. Males with primary education were observed to be less likely involved in FP (AOR=0.21; 95% CI 0.05-0.85; p=0.03). Again, men religious affiliation was likely to influence their involvement in family planning use as men who were Muslim and Traditionalist/Spiritualist had a decreased chance of using family planning as compared to those who belong to the Christian religion (OR=0.23; 95% CI 0.06-0.84; p=0.02) but this was not the case after adjustment as religion was observed to have no influence on FP use. Also, men who were married less than four years were less likely to have use family planning than those who been in marriage for several years.

Relationship between socio-

Table 4.5: demographic and economic characteristics and males involvement family planning use

Variable	N (%)	Unadjusted OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
Age category					
19-25	49 (35.0)	1.00	-	-	-
26-32	59 (42.1)	0.67(0.26-1.71)	0.40	-	-
33-39	16(11.4)	0.62 (0.15-2.50)	0.50	-	-
40+	16 (11.4)	0.75(0.19-2.92)	0.67	-	-
Educational level*					
No formal education	44 (31.4)	1.00		1.00	
Primary	18 (12.9)	0.33(0.10-1.09)	0.06	0.21(0.05-0.85)	0.03
JHS	21 (15.0)	1.65(0.45-6.09)	0.44	1.46(0.27-7.74)	0.65
Secondary	32 (22.8)	1.72(0.56-5.35)	0.33	1.23(0.31-4.92)	0.76
Tertiary	25 (17.9)	9.52(1.01-88.81)	0.02	12.59(0.74-14.21)	0.08
Educational level of partner*					
No formal education	45 (32.1)	1.00		1.00	
Primary	35 (25.0)	2.57(0.89-7.41)	0.06	3.12(0.88-11.08)	0.08
JHS	21 (15.0)	2.59(0.71-9.43)	0.13	0.95(0.18-4.88)	0.96
Secondary	30 (21.4)	6.23(1.49-25.98)	0.004	2.07(0.31-4.92)	0.41
Tertiary	9 (6.4)	4.84(0.51-46.10)	0.12	0.56(0.02-13.62)	0.72
Marital status					
Married	122 (87.1)	1.00		1.00	
Divorced	11 (7.8)	2.57(0.30-21.81)	0.37	1.55(0.17-14.38)	0.69
Widowed	4 (2.9)	0.16(0.01-1.91)	0.09	0.24(0.01-3.59)	0.30
Never married	3 (2.1)	0.64(0.06-7.45)	0.72	0.19(0.01-3.08)	0.24
Occupational status					
Unemployed	71 (50.7)	1.00		-	-
Civil servant	20 (14.3)	3.46(0.71-16.98)	0.10	-	-
Artisan	19 (13.6)	0.89(0.27-2.93)	0.85	-	-
Trader	18 (12.9)	1.43(0.41-4.91)	0.56	-	-
Other specify	12 (8.6)	2.04(0.40-10.34)	0.38	-	-

Occupational status of partner					
Unemployed	66 (47.1)	1.00		-	-
Civil servant	8 (5.7)			-	-
Artisan	2 (1.4)			-	-
Trader	55 (39.3)	1.95(0.81-4.71)	0.13	-	-
Other specify	9 (6.4)	0.91(0.20-4.05)	0.90	-	-
Current religion of respondents*					
Christian	49 (35.0)	1.00		1.00	
Islam	75 (53.6)	0.98(0.39-2.43)	0.96	1.05(0.37-2.96)	0.92
Traditional/spiritualist	16 (11.4)	0.23(0.06-0.84)	0.02	0.39(0.09-1.76)	0.22
Number of years marriage					
(N=138)					
<4	58 (42.0)	1.00		1.00	
4—13	56 (40.7)	0.45(0.18-1.08)	0.06	0.29(0.10-0.87)	0.03
14—22	22 (15.9)	1.54(0.38-6.26)	0.53	1.28(0.23-7.06)	0.77
>22	2 (1.5)			1	

Source: Author's constructed, 2019

4.8 Socio-demographic and economic characteristics and males involvement in pregnancy planning

With regarding men involvement in pregnancy and their socio-demographic and economic characteristics, men who were aged between 26-32years were 2.55 times more likely to be involved in pregnancy planning with their wives as compared to those who aged between 19-25years (AOR=2.55; 95%CI 0.65-0.97; p=0.05). Again, men whose wives were found to have had secondary education had 2.86 times increased chance of using family planning methods with the support and involvement of their male partner (OR=2.86; 95% CI 0.97-8.45; p=0.04) as compared to those who had no formal education in univariate analysis, but this did not hold after adjustments were

Relationship between socio-

made. All other variables showed no statistically significant relationship with the outcome variable.

Table 4.6: demographic and economic characteristics and males involvement in pregnancy planning

Variable	N (%)	Unadjusted OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
Age category*					
19-25	49 (35.0)	1.00		1.00	
26-32	59 (42.1)	2.34(1.02-5.38)	0.03	2.55(0.65-0.97)	0.05
33-39	16(11.4)	3.00(0.77-11.54)	0.09	2.46(0.52-11.53)	0.25
40+	16 (11.4)	1.54(0.48-4.95)	0.46	3.35(0.81-13.97)	0.09
Educational level					
No formal education	44 (31.4)	1.00		1.00	
Primary	18 (12.9)	0.44(0.13-1.43)	0.16	0.49(0.13-1.88)	0.30
JHS	21 (15.0)	0.85(0.28-2.55)	0.77	0.46(0.11-2.02)	0.31
Secondary	32 (22.8)	0.89(0.34-2.31)	0.82	0.53(0.14-1.92)	0.34
Tertiary	25 (17.9)	2.95(0.80-10.91)	0.09	0.60(0.06-5.29)	0.64
Educational level of partner*					
No formal education	45 (32.1)	1.00		1.00	
Primary	35 (25.0)	0.79(0.31-1.98)	0.32	0.83(0.29-2.37)	0.74
JHS	21 (15.0)	2.06(0.64-6.60)	0.64	2.83(0.62-12.85)	0.17
Secondary	30 (21.4)	2.86(0.97-8.45)	0.04	3.17(0.71-14.22)	0.13
Tertiary	9 (6.4)	2.38(0.40-14.16)	0.32	1.93(0.17-21.78)	0.59
Marital status*					
Married	122 (87.1)	1.00		1.00	
Divorced	11 (7.8)	0.83(0.21-3.28)	0.79	0.73(0.16-3.34)	0.69
Widowed	4 (2.9)	0.0	0.03	1	

Never married	3 (2.1)	1.33(0.12-15.30)	0.82	1.59(0.12-21.58)	0.72
Occupational status*					
Unemployed	71 (50.7)	1.00		1.00	
Civil servant	20 (14.3)	4.53(1.13-18.14)	0.02	2.30(0.41-12.98)	0.34
Artisan	19 (13.6)	1.61(0.52-5.00)	0.39	2.01(0.58-6.90)	0.26
Trader	18 (12.9)	1.78(0.58-5.42)	0.30	1.87(0.52-6.71)	0.34
Other specify	12 (8.6)	1.16(0.32-4.22)	0.82	0.83(0.18-3.64)	0.81
Occupational status of partner					
Unemployed	66 (47.1)	1.00		-	-
Civil servant	8 (5.7)	3.75(0.39-35.43)	0.22	-	-
Artisan	2 (1.4)	0.0	0.25	-	-
Trader	55 (39.3)	1.11(0.52-2.34)	0.78	-	-
Other specify	9 (6.4)	0.75(0.16-3.31)	0.70	-	-
Current religion of respondents					
Christian	49 (35.0)	1.00		-	-
Islam	75 (53.6)	0.65(0.30-1.42)	0.28	-	-
Traditional/spiritualist	16 (11.4)	0.61(0.18-2.02)	0.41	-	-
Number of years marriage					
(N=138)					
<4	58 (42.0)	1.00		-	-
4--13	56 (40.7)	1.01(0.46-2.19)	0.97	-	-
14--22	22 (15.9)	1.29(0.46-3.64)	0.62	-	-
>22	2 (1.5)	0.74(0.04-12.83)	0.83	-	-

Source: Author's construct, 2019

KNUST



CHAPTER FIVE

DISCUSSION

5.0 Introduction

This section presents the discussion of the results based on the literature reviewed from other scholars. The discussion has been segmented into various sections based on the objectives of the study.

5.1 Males knowledge and patronage of family planning

Males' patronage of family planning services play a key role to enhance their sexual partner uptake of contraceptives and family planning services, and also contribute to males' uptake of responsibility. From the study, more than half of men covered about 30minutes to 1hour length of distance before they could access family planning, and this was however found to relate to Mosha et al (2017) study in Tanzania which indicates women had to covered long distance before getting their choice of contraceptive methods, and if this happened might serve as a dislike to males patronage and involvement in the family planning service.

Again, from the current more than three-quarters (83.3%) found it acceptable to accompany their partner to FP clinic, with about 46.4% of men to have disagreed that family planning issues should concern only women and however agreed that men should get involve in family planning and support their wives uptake of family planning and contraceptives. Similarly, Aduayi et al (2017) and Tlahun et al (2013) reported such views of men and said men are becoming more aware of family planning and contraceptives and cited the need for men to support their partner in the uptake of family planning and planning their family size.

Again, it was established from the current study nearly two-third (59.9%) of men said to have little knowledge about family planning and only 16.8% were found to have had sufficient knowledge about family planning and contraceptives. Also, more than half (54.4%) of men said, families and friends will react strangely to a man who had accompanied his wife to FP clinic, with only 16.2% will praised such a man. Family and friends reacting strangely could be a disincentive to males' patronage of family planning and contraceptives, and this might be attributed to low level of knowledge of families and friends regarding men roles toward to their partner in family planning. It might also be due to societal and cultural definition of man masculinity and family planning issues which at most time been perceived as women business could have made family and friends to react strangely towards a man who accompanied the partner to FP clinic. These findings were equally found to have been cited by Duze & Mohammed (2006); Kassa et al (2014) of Uganda; Aryeetey et al (2010) of Ghana and Mosha et al (2017) of Tanzania said males knowledge level regarding family planning, and family and societal reactions toward to a man who involved himself in family planning to affect their patronage and support of partner FP uptake.

In addition, with regards to males' patronage and involvement in family planning, about 35% said to have been stigmatized and in-laws and families were cited to be key players regarding the number of children the couples should have. More than three-quarters of men were found to have ever heard about FP, with more than half of men to have known that contraceptives/family planning are used to prevent pregnancy, prevent HIV/AIDS and STI's and spacing out pregnancy and childbirth. Related literatures to these were found to include studies by Mosha et al (2017); Akwenabuaye et al (2013); Nzioka (2012); GSS (2014) and Akafuah & Sossou (2008) all cited these to have influence on males' family planning patronage and involvement. Males involvement in family

planning use as regarding those who have ever use FP and contraceptives was about three-quarters, and most were found to have access contraceptives and family planning at health centres, shops and pharmacy and government hospital. Overall males contraceptives and family planning knowledge on pregnancy planning was more than half, and cited reasons for male knowledge could be attributed to public education on family planning and contraceptives via the media platforms and other public places.

5.2 Males' perceptions and attitude toward family planning

Males' perceptions and attitude towards family planning influence their involvement and patronage of family planning and contraceptives. From the study about 19.1% perceived vasectomy as a form of castration and 35.3% have negative attitude toward vasectomy as a form of reducing men sexual feelings which could have negative implications on men uptake of vasectomy and involvement in family planning and contraceptives use.

Men's negative attitude and perceptions toward vasectomy and family planning could be due to inadequate information and education regarding the use of vasectomy and contraceptives/family planning methods in general. In related studies by Mosha et al (2017); Kassa et al (2014); Aduayi et al (2017) found contrary views and opinions and said most men agreed that condom use doesn't reduce sexual satisfaction and that vasectomy was their desirable method of practice. Notwithstanding this, Tilahun et al (2013) equally found more men to have positive attitude towards FP, and however found more men to have been in support of their wives in the uptake of family planning services. But in the same study found 3% of men to have had negative attitude towards FP in which a 45 years old man said "What will I do in a family planning clinic, contraception is women's business, I will just give my wife the necessary financial

support she needs''. However, from the current study 27.8% of men feel the time spend at the FP clinic was too long, and major described the attitude of health workers toward them as friendly. Also, most men found health education given them at FP clinic has been helpful, with only 3% of men to have found the attitude of health workers of been rude. This could be related to studies by Duze & Mohammed (2006); Aryeetey et al (2010); and Kabagenyi et al (2014).

Again, most decision regarding family planning use was made by the husband, with 13% parental influence on decision making and majority of decision to stop childbearing was found to taken by both couples. This was found to relate to Orach et al (2015) study in Uganda and Akafuah & Sossou (2008) study in Ghana cited men to be sole decision makers regarding family planning and contraceptives use simply because men are often the heads of the family.

5.3 Facilitators and barriers to males' involvement in family planning

Males' involvement in family planning could be affected by barriers and equally triggered by facilitators that might support men uptake and involvement in family planning. From the study, barriers that affect men involvement in family planning was cited to include; lack of time on the part of men, stigmatization/gossip from families and community members, and shyness, prohibited by religion and cost/lack of monies to access the services. These findings could be related to GSS (2014) study which cited males' involvement in family planning to be woefully low and were attributed to low knowledge level resulting from lack of men involvement in contraceptives and family planning education, stigmatization and lack of social support for males' involvement in family planning. Also, Kassa et al (2014) relate low male involvement in family planning to be due to fear of health effects, and opposition by religious bodies as

barriers contributing to low males involvement in family planning. In addition, from the study facilitators for males' involvement in family planning were found to relate to men level of knowledge on family planning and frequency of discussion of family planning and contraceptives with partner. About 47.4% had discussed family planning and contraceptives use with partner once and 29.3% had never discussed contraceptives with their partner and more than three-quarters cited to have ever heard of family planning and contraceptives. This could be attributed to health education given at FP clinic and through the media might have contributed to men discussing contraceptives use with their partner. Similar findings from Kassa et al (2014) cited lack of FP information, and inaccessibility of the FP methods to have accounted for the low level of involvement males in family planning services. Again, other barriers from the current study cited to affect men involvement in family planning include contraceptives side effect such as abdominal pains/heavy menstrual flow, delayed pregnancy/menstruation, weight gain/obesity and dizziness/headache, and this related to studies by Mosha et al (2017); Akwenabuaye et al (2013); and GSS (2014).

5.4 Socio-demographic and economic characteristics influence on males involvement in FP

Males' involvement in family planning with regarding desired family size, pregnancy planning and family planning and contraceptives use could be influence by their socio-demographic and economic characteristics. From the study, men educational status was found to have a significant association with desired family size as well as the educational status of their partner as those who had tertiary education were more likely to have planned their desired family size in the univariate analysis but was not the case after the adjustment. Also, men who were civil servants were more to have planned

their desired number of children as compared to those who were unemployed. Mosha et al (2017) found men educational level, contraceptives information sources, occupation, level of household income, and distance from the health facility to have affected males' involvement in FP services.

Again, in the current study socio-demographic and economic characteristics such as educational level, religion, and marital status were found to have significant influence on males' involvement in family planning. Men who had tertiary education were more likely to have involved in family use in the univariate analysis as compared to those who had no formal education, however this was not the case when adjustments was made. Also, men religious affiliation was likely to influence their involvement in family planning use in the univariate analysis as men who were Muslim and Traditionalist/Spiritualist had a decreased chance of using family planning as compared to those who belong to the Christian religion but this was not the case after the adjustment as religion was observed to have no influence on FP use. Also, men who were married less than four years were less likely to have use family planning than those who been in marriage for several years. These findings were found to positively relate to Akafuah & Sossou (2008) in Ghana in which socio-demographic characteristics such as education, religion, marital status and exposure to the media were found to affects their involvement and support of their wives to the uptake of family planning services. Other related studies by Aduayi et al (2017); Soremekun (2018); Aryeetey et al (2010); and Orach et al (2015) however found men age, place of residence, occupation, and marital status to have significant influence on males involvement in family planning.

Additionally, from the current study men involvement in pregnancy planning show socio-demographic and economic characteristics such as age, and educational level to

have significant influence on male involvement in family planning. Men who aged between 26-32years were having 2.55 times more likely to have of involved in pregnancy planning with their wives as compared to those who aged between 19-25years.

Again, men whose wives were found to have had secondary education were 2.86 times increased chance of using family planning methods with the support and involvement of their male partner in the univariate analysis but this did not hold after the adjustments were made as compared to those who had no formal education. These findings were in relation to studies by Butto & Mburu (2015); Aduayi et al (2017); Marius et al (2014); GSS (2014); Malkawi et al(2016); Hemaideh et al (2016); and Kassa et al (2014) all cited similar related factors to have significant influence on males involvement in family planning and contraceptives use.

5.5 Limitations of Study

The limitation of study, which the study encountered, was in the administration of the questionnaires because the field assistants were likely to be challenged with the local language in explaining the various questions for the respondents to understand but they were given adequate training to ensure that, the questions were well asked. Also the respondents' personality traits and beliefs about certain questions since the study related to one's sexual life and contraceptives use in responding to them was likely to be a limitation to this study but effort was put in place to assure them of strict confidentiality and enhance data validity and reliability.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the conclusions and recommendations of the study based on the results and discussions of the study.

6.1 Conclusions

From the results over three-quarters (87.1%) were married men and 83.8% had at least 4 children and 72.3% reported having intended for more children with major (41.3%) decision making regarding childbearing been determined by the husbands. With males patronage and involvement in family planning indicates 38.6% of men to have access family planning with their partners, and 35% cited been stigmatized when involved in family planning with partner. Overall males knowledge of family planning was 58.5% and perceptions and attitude of men towards vasectomy was 37.5% and facilitators and barriers to males involvement in family planning include time factor (32.1%), stigmatization/gossip (19.8%), and shyness (16.1%), prohibited by religion (13.6%) and cost/lack of monies to access the services. Major barriers affecting males involvement relate to contraceptives side effect (82.1%) and cited side effects include; abdominal pains/heavy menstrual flow (33.3%), delayed pregnancy/menstruation (22.9%), weight gain/obesity (13.3%) and dizziness/headache 12.4%. Associated socio-demographic and economic factors influencing males' involvement in family planning were found to include; age category, educational level and occupation.

6.2 Recommendations

The recommendations for the study were segmented to target institutions and stakeholders, and these include the following;

6.2.1 Ghana health services

1. The Ghana health services should collaborate with the Ministry of health to develop a policy that will ensure contraceptives and family planning availability and free family planning services to men and their partner as cost was a barriers.
2. They should also collaborate to designed educational programmes to improve contraceptives and family planning education to enhance men involvement in family planning.
3. The Ghana Health Services should come out with an FP educational plan which will target men in the high educational level, civil servants and men within the age bracket 26-32 to train them as peer educators to support their colleagues as these were having significant influence.

6.2.2 District health directorate

1. The district health directorates should intensify health education on contraceptives and family planning through the media such as local radio station to increase contraceptives uptake
2. They should also undertake communities' sensitization programmes and education on men roles and support of their partners on contraceptives and family planning. As contraceptives use was perceived as women business and eradicates the forms of stigmatization on men who accompanied their wives to FP clinics.
3. The district health directorate should also collaborate with local nongovernmental organizations and civil society institutions to support in the provision of family planning methods to make it available and accessible to men and their partners whenever they go to FP clinics

4. The district health directorate should again organize in-services training to reproductive health personnel and other health workers on clients/customers relationship and FP education to help them positively or in a friendly matter handle their clients well.
5. Also, the district health directorate should use men who had high education as well as those in the civil service as FP ambassadors to help educate their colleagues and also share their testimonies and benefits to them and their families for involving in FP use.

6.2.3 Individuals/NGOs and Civil society

1. Individuals should be willing to cooperate with the health workers on contraceptives and family planning education and the services they will offer to them
2. Non-governmental and civil society organizations should support by providing contraceptives and family planning methods free to the health facilities to enhance service availability and accessibility to potential clients.
3. They should support in community education on family planning and contraceptives use to clear certain misconceptions and misinformation regarding family planning and contraceptives use.

REFERENCES

Admasu, K. (2015). Family Planning; Blended Learning Module for the Health Extension Programme.

Aduayi, V., Deji, S., Eyitayo, E. E. (2017). Men's Perception and Practice of Family

Planning in Ede South Local Government Area.

www.researchgate.net/publication/315925707, 10 (January), 5 of 11.

Akafuah, R.A. and Sossou, M.A., (2008). Attitudes toward and use of knowledge about family planning among Ghanaian men. *International Journal of Men's Health*, 7(2).

Akwenabuaye, V., Kalu, O., & Anake, M. (2013). Family Planning Behaviours and Decision-Making among Couples in Cross River State , Nigeria. *International Journal of Learning & Development*, 3(1), 100–120.

<https://doi.org/10.5296/ijld.v3i1.3146>

Aryeetey, R., Kotoh, A. M., & Hindin, M. J. (2010). Knowledge , Perceptions and Ever Use of Modern Contraception among Women in the Ga East District , Ghana. *African Journal of Reproductive Health*, 14(December), 27–32.

Butto, D., & Mburu, S. (2015). Factors Associated with Male Involvement in Family Planning in West Pokot County , Kenya. *Universal Journal of Public Health*, 3(4), 160–168. <https://doi.org/10.13189/ujph.2015.030404>

Admasu, K. (2015) *Family Planning; Blended Learning Module for the Health Extension Programme*.

Aduayi, V. and Deji, Samson Eyitayo, E. E. (2017) ‘Men ’ s Perception and Practice of Family Planning in Ede South Local Government Area Men ’ s Perception and Practice of Family Planning in Ede South Local Government Area Osun State ’, <https://www.researchgate.net/publication/315925707> Men's, 10(January), p. 5 of 11. doi: 10.9734/BJMMR/2017/32408.

Akwenabuaye, V., Kalu, O. and Anake, M. (2013) ‘Family Planning Behaviours and

- Decision-Making among Couples in Cross River State , Nigeria', *International Journal of Learning & Development*, 3(1), pp. 100–120. doi: 10.5296/ijld.v3i1.3146.
- Aryeetey, R., Kotoh, A. M. and Hindin, M. J. (2010) 'Knowledge , Perceptions and Ever Use of Modern Contraception among Women in the Ga East District , Ghana', *African Journal of Reproductive Health*, 14(December), pp. 27–32.
- Butto, D. and Mburu, S. (2015) 'Factors Associated with Male Involvement in Family Planning in West Pokot County , Kenya', *Universal Journal of Public Health*, 3(4), pp. 160–168. doi: 10.13189/ujph.2015.030404.
- Char, A. (2011) *Male Involvement in Family Planning and Reproductive Health in Rural Central India*.
- Demissie, D. B. (2016) 'Male Involvement in Family Planning and Associated Factors among Married in Malegedo Town West Shoa Zone , Oromia ,Ethiopia', 15(3), pp. 11–18.
- Kabagenyi, A. *et al.* (2014) 'Barriers to male involvement in contraceptive uptake and reproductive health services : a qualitative study of men and women ' s perceptions in two rural districts in Uganda', *Reproductive Health*. Reproductive Health, 11(1), pp. 1–9. doi: 10.1186/1742-4755-11-21.
- Kassa, M., Abajobir, A. A. and Gedefaw, M. (2014) 'Level of male involvement and associated factors in family planning services utilization among married men in Debremarkos town , Northwest Ethiopia', *BMC International Health & Human Rights*, 14(33), pp. 1–8.

- Malkawi, A. O. *et al.* (2016) 'Men ' s perceptions of and participation in family planning in Aqaba and Ma ' an governorates , Jordan', *Eastern Mediterranean Health Journal*, 22(2).
- Marius Zambou Vouking, Christine Danielle Evina, C. N. T. (2014) 'Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests', *PanAfrican Medical Journal*, 8688, pp. 1–5. doi: 10.11604/pamj.2014.19.349.5090.
- Mosha, P. E., Mgimwa, C. A. and Msuya, S. M. (2017) 'Assessment of Knowledge and Perception Towards Modern Contraceptives Use Among Women of Reproductive Age in Mtwivila , Tanzania', *Science Journal of Public health*, 5(4), pp. 335–340. doi: 10.11648/j.sjph.20170504.19.
- Mulatu, Keadnew, Mekonnen, W. (2016) 'iMedPub Journals Men ' s Involvement in Long Acting and Permanent Contraceptive Use in Mizan-Aman District Southwestern Ethiopia : A Community Based Cross-Sectional Study Abstract', *Health Science Journal* , Vol. 10(ISSN 1791-809X), pp. 1–9.
- Nations, U. (2017) 'World Family Planning 2017 Highlights', *Department of Economic and Affairs, Population Division*, 1(212 963 2147), p. 9 of 43.
- Orach, C. G. *et al.* (2015) 'Perceptions , attitude and use of family planning services in post conflict Gulu district , northern Uganda', *Conflict and Health Journal*. Conflict and Health, 9(24), pp. 1–11. doi: 10.1186/s13031-015-0050-9.
- Shah, I. H. (2007) 'Family Planning and Reproductive Health', *Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland*, I, p. 3 of 11.

- Soremekun, O. (2018) 'Factors that Influence Male Involvement in Family planning: A Qualitative study of men of reproductive age in Ibadan North East and North-West', *European Journal of Public Health*, 24(May), p. 2838879.
- Tilahun, T. *et al.* (2013) 'Family Planning Knowledge , Attitude and Practice among Married Couples in Jimma Zone , Ethiopia', *PLOS ONE, OPEN ACCESS*, 8(4), pp. 1–8. doi: 10.1371/journal.pone.0061335.
- Toure, L. (1996) 'Male Involvement in Family Planning A Review of Selected Program Initiatives in Africa Male Involvement in Family Planning', (May).
- Ukeagu, C. (2014) 'Male Involvement in Family Planning in Some'.
- Wiafe, E. (2015) 'University of Ghana <http://ugspace.ug.edu.gh> School of Public Health College of Health Sciences University of Ghana , Legon Male Involvement in Family Planning in The Sunyani Municipality by this Dissertation is Submitted to the University of Ghana , Lego', (10262364).
- Admasu, K. (2015) Family Planning; Blended Learning Module for the Health Extension Programme.
- Aduayi, V. and Deji, Samson Eyitayo, E. E. (2017) 'Men ' s Perception and Practice of Family Planning in Ede South Local Government Area Men ' s Perception and Practice of Family Planning in Ede South Local Government Area Osun State ', [https://www.researchgate.net/publication/315925707 Men's](https://www.researchgate.net/publication/315925707_Men's), 10(January), p. 5 of 11. doi: 10.9734/BJMMR/2017/32408.
- Akwenabuaye, V., Kalu, O. and Anake, M. (2013) 'Family Planning Behaviours and

- Decision-Making among Couples in Cross River State , Nigeria', *International Journal of Learning & Development*, 3(1), pp. 100–120. doi: 10.5296/ijld.v3i1.3146.
- Aryeetey, R., Kotoh, A. M. and Hindin, M. J. (2010) 'Knowledge , Perceptions and Ever Use of Modern Contraception among Women in the Ga East District , Ghana', *African Journal of Reproductive Health*, 14(December), pp. 27–32.
- Butto, D. and Mburu, S. (2015) 'Factors Associated with Male Involvement in Family Planning in West Pokot County , Kenya', *Universal Journal of Public Health*, 3(4), pp. 160–168. doi: 10.13189/ujph.2015.030404.
- Char, A. (2011) Male Involvement in Family Planning and Reproductive Health in Rural Central India.
- Demissie, D. B. (2016) 'Male Involvement in Family Planning and Associated Factors among Married in Malegedo Town West Shoa Zone , Oromia ,Ethiopia', 15(3), pp. 11–18.
- Kabagenyi, A. *et al.* (2014) 'Barriers to male involvement in contraceptive uptake and reproductive health services : a qualitative study of men and women ' s perceptions in two rural districts in Uganda', *Reproductive Health*. *Reproductive Health*, 11(1), pp. 1–9. doi: 10.1186/1742-4755-11-21.
- Kassa, M., Abajobir, A. A. and Gedefaw, M. (2014) 'Level of male involvement and associated factors in family planning services utilization among married men in Debre markos town , Northwest Ethiopia', *BMC International Health & Human Rights*, 14(33), pp. 1–8.

- Malkawi, A. O. *et al.* (2016) 'Men ' s perceptions of and participation in family planning in Aqaba and Ma ' an governorates , Jordan', *Eastern Mediterranean Health Journal*, 22(2).
- Marius Zambou Vouking, Christine Danielle Evina, C. N. T. (2014) 'Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests', *PanAfrican Medical Journal*, 8688, pp. 1–5. doi: 10.11604/pamj.2014.19.349.5090.
- Mosha, P. E., Mgimwa, C. A. and Msuya, S. M. (2017) 'Assessment of Knowledge and Perception Towards Modern Contraceptives Use Among Women of Reproductive Age in Mtwivila , Tanzania', *Science Journal of Public health*, 5(4), pp. 335–340. doi: 10.11648/j.sjph.20170504.19.
- Mulatu, Keadnew, Mekonnen, W. (2016) 'iMedPub Journals Men ' s Involvement in Long Acting and Permanent Contraceptive Use in Mizan-Aman District Southwestern Ethiopia : A Community Based Cross-Sectional Study Abstract', *Health Science Journal* , Vol. 10(ISSN 1791-809X), pp. 1–9.
- Nations, U. (2017) 'World Family Planning 2017 Highlights', *Department of Economic and Affairs, Population Division*, 1(212 963 2147), p. 9 of 43.
- Orach, C. G. *et al.* (2015) 'Perceptions , attitude and use of family planning services in post conflict Gulu district , northern Uganda', *Conflict and Health Journal*. *Conflict and Health*, 9(24), pp. 1–11. doi: 10.1186/s13031-015-0050-9.
- Shah, I. H. (2007) 'Family Planning and Reproductive Health', *Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland*, I, p. 3 of 11.

Soremekun, O. (2018) 'Factors that Influence Male Involvement in Family planning: A Qualitative study of men of reproductive age in Ibadan North East and North-West', *European Journal of Public Health*, 24(May), p. 2838879.

Tilahun, T. *et al.* (2013) 'Family Planning Knowledge , Attitude and Practice among Married Couples in Jimma Zone , Ethiopia', *PLOS ONE*, OPEN ACCESS, 8(4), pp. 1–8. doi: 10.1371/journal.pone.0061335.

Toure, L. (1996) 'Male Involvement in Family Planning A Review of Selected Program Initiatives in Africa Male Involvement in Family Planning', (May).

Ukeagu, C. (2014) 'Male Involvement in Family Planning in Some'.

Wiafe, E. (2015) 'University of Ghana <http://ugspace.ug.edu.gh> School of Public Health College of Health Sciences University of Ghana , Legon Male Involvement in Family Planning in The Sunyani Municipality by this Dissertation is Submitted to the University of Ghana , Lego', (10262364).

APPENDIX

Appendix 1: Gantt chart

PROJECT EXECUTION PLAN (GANNT CHART)										
ACTIVITY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Reconnaissance visit										
Project planning										

Questionnaire development										
Ethical clearance										
Pre-testing of questionnaire										
Training of Research Assistants										
Data collection and entry										
Data analysis										
Report writing										
Dissemination										
Submission of report to Graduate school										

Appendix 2: Budget

This budget has been prepared based on specific activity lines. The total cost of the study will be six thousand, seven hundred and five Ghana cedis (GHS 6,705) as detailed in table 5.1.

Table 5.1 Project execution budget

ACTIVITY	ITEMS REQUIRED	UNIT COST IN GHS	FREQUENCY	TOTAL COST IN GHS
Reconnaissance visit	T & T	200	1	200
Project planning	Lap –Top	1500	1	1500
	Internet data	400		400
	Printing and photocopies	30		30
Questionnaire design	printing and photocopies	100		100
Ethical clearance		100		100
Pilot study	printing and photocopies	30		30
	T & T	100		100
Training of research assistants	A4 sheet	25	1 ream	25
	printing and photocopies	50		50
	Pens	2	10	20

	Flip chart	20	1	20
	Markers	50	1	50
	Note pads	10	4	40
	Venue	200	1	200
	Snacks and lunch	20	4	80
	T & T	20	3	60
Data collection	Allowance	300	3	900
Data management and analysis	Statistician	400	1	400
Report writing	Printing and photocopies	50		40
Dissemination	Venue	200		200
	Snacks and lunch	20	50	1000
Submission of report to Graduate School	Printing and photocopies	60	4	240
	CD copy	5	4	20
Researcher's Allowance		900	1	900
TOTAL				6,705

Appendix 3: Questionnaire

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY (KNUST), KUMASI – GHANA
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH
QUESTIONNAIRE ON MALE INVOLVEMENT AND ITS INFLUENCE ON FAMILY PLANNING USE IN THE WEST MAMPRUSI DISTRICT OF NORTHERN REGION, GHANA

Introduction: Hello. My name is _____ and I am a student of KNUST. I am conducting a study on “**Male Involvement and Its Influence on Family Planning Use in the West Mamprusi District**”.

I would be very grateful, if you could participate in the interview process. The interview process will take about **25-30 minutes**. You are guaranteed that whatever information you provide, will be kept strictly confidential. Your participation in this interview exercise is voluntary and thus, you could stop the interview at any time. However, we hope that you will kindly participate in the interview process, since your views are important.

MAY I START NOW? 1. ☐ YES, PERMISSION IS GIVEN. START INTERVIEW 2. ☐ NO, PERMISSION IS NOT GIVEN. STOP AND PROCEED

A01	Respondent ID.....	Date Interview.....
A02	Sub-district.....	Interviewer ID.....
A03	Community:	

SECTIONA: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND ITS DETERMINANTS OF RESPONDENTS

Please, tick as applicable in this part of the questionnaire			
NO	QUESTION	CATEGORIES	CODE
A04	Age of respondent in complete years:		
A05	Educational level:	01 = No, Formal Education	[][]
		02 = Primary	
		03= JHS	
		04 = Secondary	
		05 = Tertiary	
		06 = other specify	
A06	Educational level of partner:	01 = No, Formal Education	[][]
		02 = Primary	
		03= JHS	
		04 = Secondary	
		05 = Tertiary	

		06 = other specify	
A07	What is your current marital status:	01= Married /living together	[][]
		02 = Divorced/separated	
		03 = Widowed	
		04 = Never married/never lived together	

A08	If married or not, how many wives/sexual partners do you have currently?	01 = 1	[][]
		02 = 2	
		03 = 3+	
A09	Number of children:		[][]
A10	Male's occupational status:	01 = unemployed	[][]
		02 = civil servant	
		03 = Artisan	
		04 = Trader	
		05 = other specify	
A11	Partner's occupational status:	01 = Unemployed	[][]
		02 = Civil servant	
		03 = Artisans	
		04 = Traders	
		05 = Other specify	
A12	What is your current religion?	01 = Christian	[][]
		02 = Islam	
		03 = Traditionalist/spiritualist	
		04 = No religion	
		05 = Other specify	
A13	Number of years lived with marriage	01 = <4	[][]
		02 = 4-13	
		03 = 14- 22	
		04 = >22	
A14	Desired number of children	01 = None	[][]
		02 = 1-2	
		03 = 3-4	
		04 = >5+	
A15	Who made the decision on the number of children	01 = Husband	[][]
		02 = Wife	
		03 = Both	
		04 = Husbands parents	
		05 = God knows	
A16	Do you intend to have more children?	01 = Yes	[][]
		02 = No	
A17	Decision on when to stop child bearing	01 = Husband	
		02 = Wife	

		03 = Both	[][]		
		04 = Husbands parents			
		05 = God knows			
No.	Question	Response			
SECTION B: MALES PATRONAGE AND SUPPORT FOR PARTNERS FAMILY PLANNING SERVICES USE					
B01	If you were to go to the FP clinic at the health facility, how long will it take you to get there?	01= Less than 30minutes 02 = 30minutes - 1 hour 03 = 1-2 hours 0 4 = More than 2 hours	[][]		
B02	In this community, is it acceptable for a man to accompany his wife/ partner for Family Planning?	01 = Yes 02 = No		[][]	
B03	Family planning is an issue that should concern only women	01 = Strongly disagree 02 = Disagree 03 = Neutral 04 = Strongly Agree 05 = Agree			[][]
B04	How much do you know about family planning?	01 = Knows nothing 02 = Knows very little 03 = Knows sufficiently 04 = Knows a lot		[][]	
B05	How do your family/friends react towards a man attend family planning with his wife/partner?	01 = Strangely 02 = Praise him 03 = Indifferent	[][]		
B06	Are men who are involved in family planning activities stigmatized in this community?	01 = Yes 02 = No			
B07	Have you ever been influenced by your parents/ in-laws/ relations to have more children?	01 = Yes 02 = No	[][]		
B08	If yes give reasons.	01 = Children are of one particular sex 02 = Being an only child 03 = Not having many children in the		[][]	

		extended family	
		04 = Other (specify)	
B09	How would members of this community describe a man who is seen to be involved in family planning?		
	Have you ever assessed FP services with your partner?	01 = Yes 02 = No	
B10	How would you describe the cost of accessing family planning services?	01 = Expensive 02 = Normal 03 = Cheap 04 = No idea	[][]
B11	Do you get time off from work to attend family planning clinic?	01 = Yes 02 = No	[][]
B12	Typically, how long do you/your wife spend at the family planning clinic?	01 = Less than 1 hour 5 02 = 1-2hours 03 = 2-3hours 04 = 3-5 hours 05 = More than 5hour	[][]
B13	How do you feel about time spent at the family planning?	01= Short 02 = Normal 03 = Too long	[][]
B14	How will you describe the attitude of family planning staff?	01= Very friendly 02 = Friendly 03 = Indifferent 04 = Unfriendly 05 = Rude	[][]
B15	How will you describe the health talks given at the family planning?	01= Very helpful 02 = Helpful 03 = Unhelpful 04 = Complete waste of time	[][]
SECTION C:/FACILITATORS/BARRIERS TO MALE INVOLVEMENT IN FAMILY PLANNING			
C1	Are there any barriers to accessing family planning services?	01 = Yes 02 = No	If no, skip the next
	If yes please state those barriers		[][]

C02	What are the main challenges prevent men from involving themselves in family planning?	01 = Negative community perception 02 = Lack of male FP service providers	[][]
	(Circle all that apply)	03 = Stigmatization 04 = Masculinity power 05 = Wives are unsupportive 06 = Peer pressure 07 = Fewer contraceptive choices for men 08 = Lack of knowledge 09 = Shyness 10 = Lack of knowledge about FP 11 = Against my religion 12 = Time 13 = Cost 14 = Distance 15 = Side effect	
C03	Of these challenges you have listed, which one do you think is the very common?		[][]
C04	Do you know of any side effect of family planning?	01 = Yes 02 = No	If know skip the next
C05	If yes, please specify the effect		
C06	Need to know more about FP	01 = Yes 02 = No	[][]
C07	Approve of couples using FP	01 = Yes 02 = No	[][]
C08	Ever discussed on FP with partner	01 = Yes 02 = No	[][]
C09	Frequency of discussion on FP	01 = Once 02 = Twice 03 = More often 04 = I don't member	[][]
SECTION D: MALES KNOWLEDGE AND PERCEPTION ABOUT FAMILY PLANNING			
D01	Have you ever heard of family planning?	01 = Yes 02 = No	[][]

D02	If yes, what do you know about family planning?	01 = To prevent HIV/AIDS or STIs 02 = To prevent pregnancies 03 = To space out pregnancies	[][]
D03	Sources of family planning/contraceptives information?	01= Television 02 = Radio	
		03 = Friends 04 = News paper 05 = health workers 06 = internet/social media	
D04	Ever know of any family planning method to delay/avoid pregnancy?	01 = Yes 02 = No	
D05	Knows where to access contraceptives/family planning?	01= Health center 02 = Shops/pharmacy 03 = Government hospital	[][]
D06	Which of the following contraceptives/family planning methods do you know off? (Circle all that apply)	01= Oral contraceptive pills 02 = Intra-Uterine Devices (IUD) 03 = Injectables 04 = Implant 05 = female sterilization 06 = Male sterilization 07 = Abstinence/periodic method 08 = Withdrawal method 09 = Other specify	[][]
D07	What is the attitude towards vasectomy	01 = Prevents Pregnancy 02 = Reduce sexual feeling 03 = No effect 04 = Castration	[][]
D08	Over all knowledge of contraceptive use	01 = Yes 02 = No	
SECTION E: RECOMMENDATION STRATEGIES OF IMPROVING THE EXISTING SITUATION			
E01	In your opinion, what will you recommend to improve on males' involvement in family planning?	1..... 2.....	

Appendix 4: Ethical Clearance Approval

Appendix 5: Consent form





KWAME NKURUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES



SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Ref: CHRPE/AP/031/18

5th February, 2018.

Mr. Abudu Malik
District Health Administration
Post Office Box 18
BONGO.

Dear Sir,

LETTER OF APPROVAL

Protocol Title: *"Male Involvement and its Influence on Family Planning Use in the West Mamprusi District of Northern Region of Ghana."*

Proposed Site: *West Mamprusi District, Northern Region, Ghana.*

Sponsor: *Principal Investigator.*

Your submission to the Committee on Human Research, Publications and Ethics on the above named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 23rd June, 2017 from the West Mamprusi District Health Directorate (study site) indicating approval for the conduct of the study in the District.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Protocol.
- Questionnaire.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, beginning 5th February, 2018 to 4th February, 2019 renewable thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Yours faithfully,


Rev. Prof. John Appiah-Poku
Honorary Secretary
FOR: CHAIRMAN

Room 7 Block J, School of Medical Sciences, KNUST, University Post Office, Kumasi, Ghana
Phone: +233 3220 63248 Mobile: +233 20 5453785 Email: chrpe.knust.kath@gmail.com / chrpe@knust.edu.gh



CONSENT FORM

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information about the study, including that on procedures, risks and benefits, to enable the prospective participant make an informed decision to or not to participate.

DATE: _____ NAME: _____

Statement of person giving consent:

I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction.

I understand that my participation is voluntary (not compulsory).

I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it.

I understand that I may freely stop being part of this study at any time without having to explain myself.

I have received a copy of this information leaflet and consent form to keep for myself.

NAME: _____

DATE: _____ SIGNATURE/THUMB PRINT: _____

Statement of person witnessing consent (Process for Non-Literate Participants):

I _____ (Name of Witness) certify that information given to _____ (Name of Participant), in the local language, is a true reflection of what I have read from the study Participant Information Leaflet, attached.

WITNESS' SIGNATURE (maintain if participant is non-literate): _____

MOTHER'S SIGNATURE (maintain if participant is under 18 years): _____

MOTHER'S NAME: _____

FATHER'S SIGNATURE (maintain if participant is under 18 years): _____

FATHER'S NAME: _____