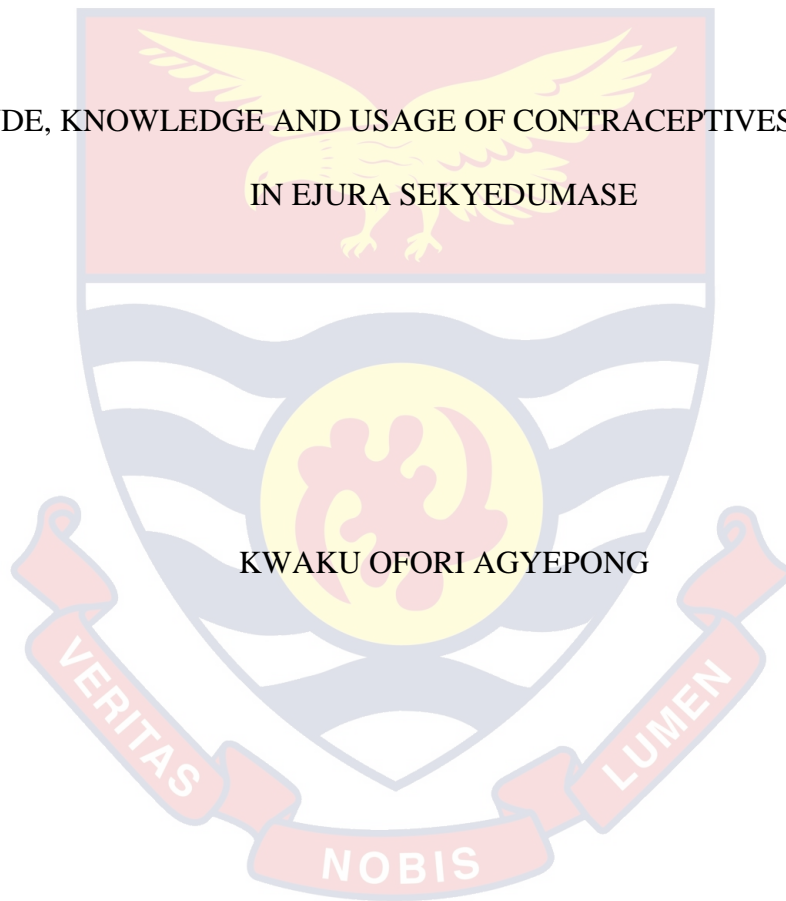


PRESBYTERIAN UNIVERSITY COLLEGE, GHANA
FACULTY OF DEVELOPMENT STUDIES

ATTITUDE, KNOWLEDGE AND USAGE OF CONTRACEPTIVES AMONG MEN
IN EJURA SEKYEDUMASE



2019

PRESBYTERIAN UNIVERSITY COLLEGE OF GHANA
FACULTY OF DEVELOPMENT STUDIES

ATTITUDE, KNOWLEDGE AND USAGE OF CONTRACEPTIVES AMONG MEN



A Dissertation submitted to the Department of Environment and Rural Development of the Faculty of the Rural Development Studies, Presbyterian University College, Ghana in partial fulfilment of the requirement for the award of Master Degree in International

SEPTEMBER 2019

DECLARATION

Candidate's Declaration

I hereby declare that this Dissertation is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Name: Kwaku Ofori Agyepong

Candidate's Signature:

Date:

Supervisor's Declaration

I hereby declare that the preparation and presentation of the Dissertation were supervised in accordance with the guidelines on supervision of project work laid down by the Presbyterian University College, Ghana.

Supervisor's Name: Ms Doris Fiasorgbor

Supervisor's Signature:

Date.....

ABSTRACT

The aim of this study is to assess the knowledge, attitude and usage of contraceptives among men in Ejura Sekyedumase Municipality. Hence, to improve the overall reproductive health status of men, it is important to encourage contraceptive use among men. The study employed both quantitative and qualitative methods of enquiry to extract information from respondents. Questionnaires, consisting of structured and unstructured questions, were used to collect data. A total of 234 respondents were used for the study. Statistical Package for Social Sciences (SPSS) was used to analyse the data which were presented in frequencies and percentages, and Microsoft Excel was used in plotting of graphs. Results indicated that most of the respondents were currently not using any family planning method. Healthcare providers were the most important source of information with regards to contraceptives or available family planning methods. Many respondents were aware of the use of condoms and vasectomy as family planning methods and had used a contraceptive less than a year ago. The pharmacy was the main source for contraceptive purchase and their privacy was fairly satisfactory. It is not a common occurrence to see men attending family planning clinics with their spouses or partners as almost 80 percent of respondents have never attended a family planning clinic before. Majority stated the family planning clinic was far from them. The respondents indicated that accessing family planning services was expensive. The most important factors that militate against the use of contraceptives by men are pressure from peers and negative community perception. The study recommended the need to set up “men” clinics to cater for the reproductive needs of men.

DEDICATION

This work is dedicated to my wife, Mrs. Josephine Kumi-Mensah and daughter, Nana Ama Gyanewaa Agyepong for their prayers and support.



ACKNOWLEDGEMENTS

I wish to express my profound and sincere gratitude to our maker and creator, the Almighty God for his care, blessing and guidance showered on me throughout the course of my education.

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I am highly indebted to my siblings Frank, Evelyn, Grace, Kofi and Kwame, and Emmanuel Kwatei Quartey for their encouragement and support.

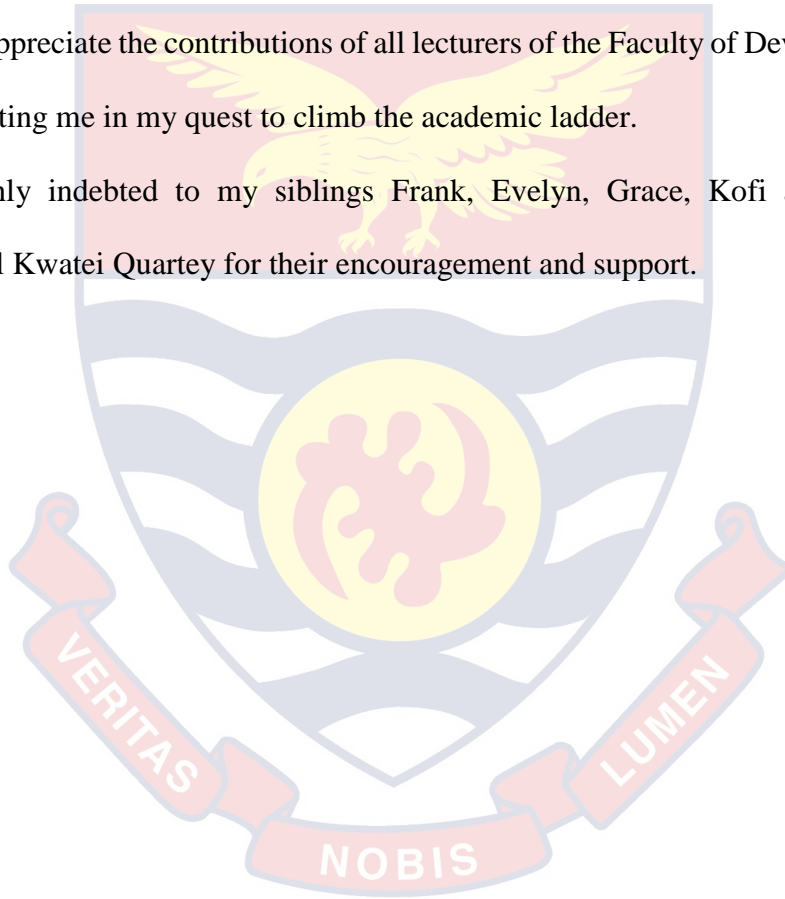


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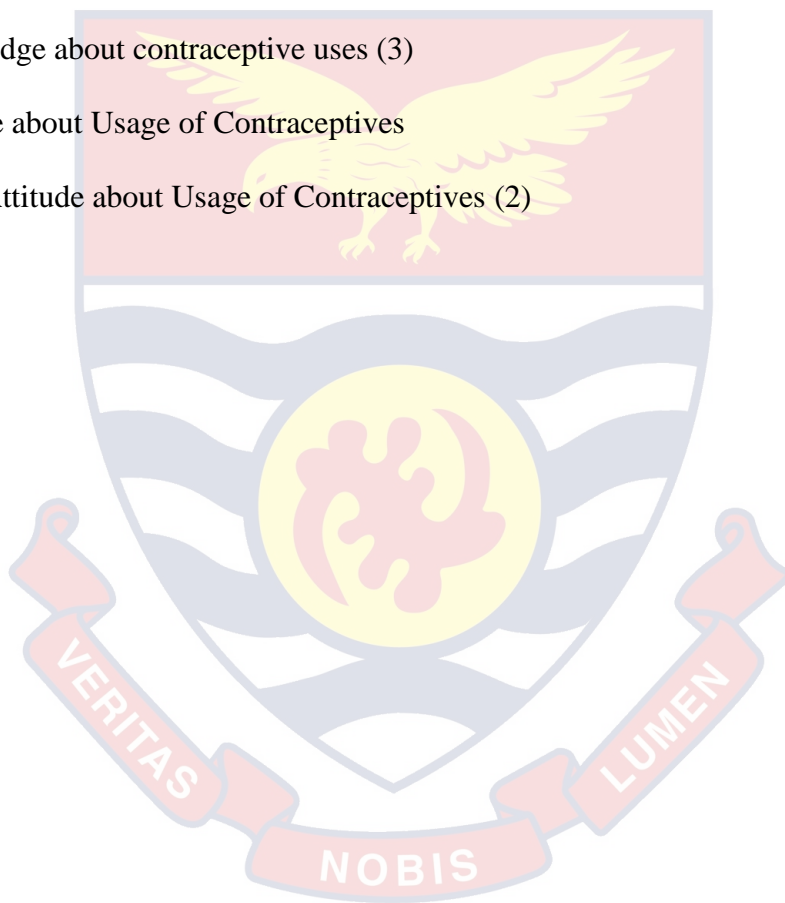
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CHAPTER ONE

INTRODUCTION

Background of the Study

Rapid population growth is one characteristic traced among most developing societies, as a result of high fertility (Khan *et al.*, 2007). In sub-Saharan Africa the rate of population growth is one of the highest in the world. This is a consequence of persistent high fertility, although infant mortality has declined in recent years and life expectancy has increased. In spite of an increased emphasis on family planning programmes in the region, the impact on fertility in sub-Saharan Africa compared to other regions of the world is low (Boateng, 2013).

One reason offered for why family planning in Asia has been relatively more successful than in sub-Saharan Africa is that Asia has experienced significant socioeconomic change. In addition, vigorous population campaigns in the region have involved local community leaders and other influential people. The campaigns were aimed at creating the desire to limit family size. Typically, concerted efforts were made to increase the desire for small families and then to provide contraceptives and family planning services as a means of controlling fertility (GHS/UNFPA, 2015). Similar efforts have gained momentum in sub-Saharan Africa but with little results. The economy in the region continues to be agriculture based, with populations that are predominantly rural. Early marriage and low levels of contraceptive use continue to be normative. In fact, until quite recently there was no apparent sign of fertility decline in the 45 countries of the region, with the exception of Zimbabwe, Botswana, and Kenya (Petro-Nustas, 1999). One factor that might contribute to the lack of success of the African population control programmes may be that they tend

to be directed toward women only, ignoring the role of men in contraceptive decisions (Boateng, 2013).

Millions of individuals and couples around the world are unable to plan their families as they wish, even with tremendous advances in the development of modern contraceptive services in recent years, according to the World Health Organisation (WHO) globally each year, close to 350,000 women die from pregnancy and childbirth complications (WHO, 2014).

Reports from Ghana Health Service (GHS) indicate that in 2014, approximately 376,657 pregnancies registered in 2013 were registered to young women aged 10-24 years. This represents 39% of a total of 971,268 registered pregnancies countrywide (GHS, 2014). There were 23,130 cases of spontaneous and induced abortions among young women (10-24 years) reported within the same period (Hamed *et al.*, 2018).

Sexual and Reproductive Health (SRH) has been regarded mainly as ‘women’s issue’ and the responsibility of women traditionally (Hoga *et al.*, 2014). In the 1980s, the Demographic Health Survey collected standard data on women’s SRH and for the first time it added men as partners and husbands (Varga, 2001). Since the International Conference on Population and Development, men have become more involved in SRH programs on the premise that men who are educated on SRH issues are more likely to support their partners’ decisions on contraceptives (Hoga *et al.*, 2014) and family planning with the aim to improve women’s health (Sonenstein *et al.*, 2000). Since then men have been increasingly involved in fatherhood and childrearing as a means to increasing men’s participation in gender equality (Sonenstein *et al.*, 2000). More recently, efforts to push for

more gender-equitable behaviour and attitudes have been linked to men's involvement in SRH (Bayray, 2012).

Problem Statement

Infertility has traditionally been a source of pain, anxiety and shame and the more important children are to a fabric of a given society, the more important it is for couples to be fertile. A lot of factors including economic improvement in healthcare and nutrition just to mention a few have contributed to the present high birth rate in Ejura community. There is a psychology behind child bearing that when one gives birth to fewer children, the tendency of some dying at the adolescent age might be higher and since agriculture is the main source of livelihood for most of the people in Ejura community, more children are required to assist in cultivation of agricultural produce. Females are considered traditionally as a major cause of high population without given much emphasis on the male. Contraceptive usage especially among couples in Africa have mostly solely focused on the female and family planning issues have been centred usually, but not exclusively, on female's education and usage (Arowojolu *et al.*, 2014). Men as the main decision makers in the family have a role to play when it comes to fertility regulation and one of the main roles men are expected to play is by the use of contraceptives as a method to control the rate of population growth in the Municipality.

Family planning in Ghana dates as far back as 1956. However, studies have shown that acceptance of family planning in Ghana has not been encouraging. Although studies have shown that men are much more interested in and have a positive view of family planning than is generally assumed, their involvement is still low especially in the developing world

(Ijadunola *et al.*, 2010). This is also true in Ghana, studies show that although knowledge of at least one method of family planning is high among men, their involvement is low. This low involvement is keenly seen in the fact that over the last three years, male attendance of family planning in clinics has not seen any significant rise. This state of involvement has negative effects on the effectiveness of family planning programmes (Bayray, 2012).

This study is to find out whether males, especially and specifically in Ejura Sekyedumase in the Ashanti region of Ghana are given the necessary education on contraceptive, determining their knowledge and usage level towards the practice.

Objectives of the Study

The main objective of the study is to assess the knowledge, attitude and usage of contraceptives among men in Ejura Sekyedumase Municipality.

Specific Objectives

The study specifically seeks to:

- i. Assess men's level of knowledge on contraception.
- ii. Investigate men's attitude about contraceptives.
- iii. Assess the level of contraceptive usage among men in the community.
- iv. Determine the barriers that inhibit the use of contraceptives or adoption of family planning methods.

Research Questions

- i. What is the level of men's knowledge on contraception and family planning?
- ii. What are men's attitudes towards contraception and family planning?
- iii. What is the level of usage of contraceptives by men?
- iv. What are the barriers that inhibit the use of contraceptives or adoption of family planning methods by men?

Relevance of the Study

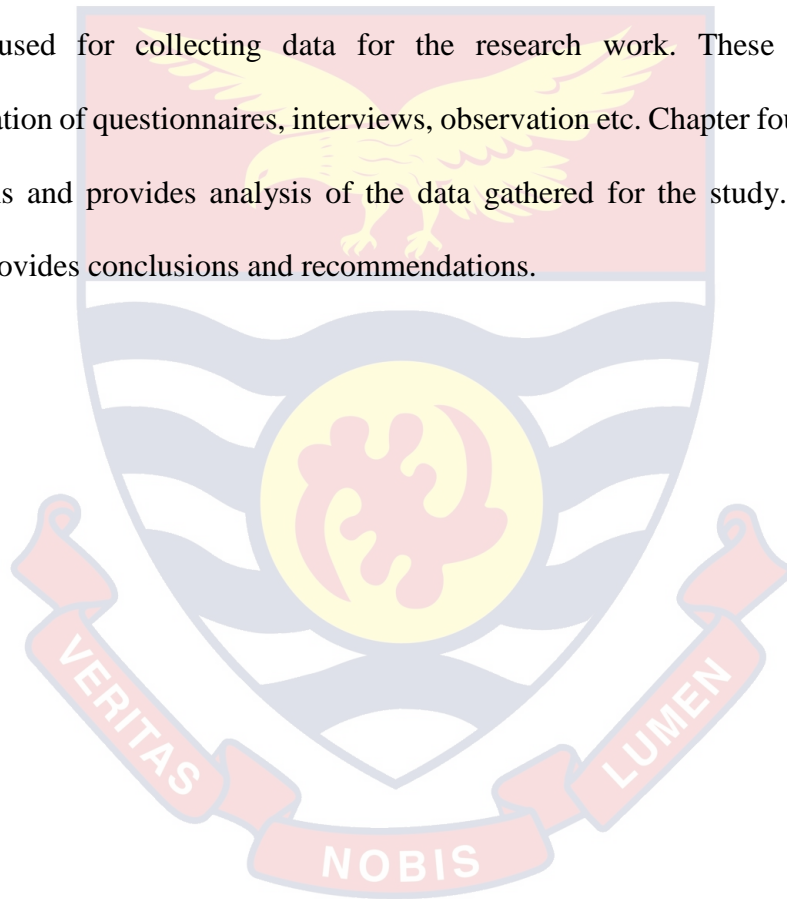
The study is worthwhile because it is a contribution to the debate and critique on contraceptive knowledge and usage, and it is only by such critiques that the perception of men on contraceptive can be studied to benefit both men and women in society. It will add to the literature on Ghanaian contraceptive usage and reproductive health. It must be noted that this attitude has not been adequately critiqued. Another significant factor to consider is that the findings of this study may enable governments and policy makers in Ghana to consider men's contraceptive usage and knowledge as they also play a major role in population policies. Finally, in future this research will serve as a reference material for individuals and students who are interested in human development studies and also would like to do further research on it.

Limitations of the Study

The most important limitation was time. Secondly the reluctance of respondents in disclosing information with the view that information provided will not be kept confidential was also a limitation.

Organization of the Study

The research work is in five (5) chapters. Chapter one concerns itself with the general introduction grouped under the following headings; Background to the study, Statement of the problem, Objectives of the study, Significance of the study, Research questions, Scope of the study and Organization of the study. Chapter two involves the review of the various related literature on the relevant subject under the study. Chapter three includes the various methods used for collecting data for the research work. These methods include administration of questionnaires, interviews, observation etc. Chapter four presents results, discussions and provides analysis of the data gathered for the study. Finally, the fifth chapter provides conclusions and recommendations.



CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents a review of literature on relevant topics such as a brief history on contraceptive use and family planning in Ghana, benefits of family planning and contraception, different methods of male contraception, attitudes and knowledge of male contraception use, etc. This chapter sets out the direction of the research.

History of Contraceptive Use and Family Planning in Ghana

Historically, no one knows how long family planning has been on-going in Ghana. Officially, family planning started far back in 1956, a year before Ghana had her independence (Adanu *et al.*, 2009). The Planned Parenthood Association of Ghana (PPAG) was formed around 1967. Ghana's first organized efforts towards scaling up family planning actually started in 1969 when an advisory team on population affairs led by Prof. Fred T. Sai helped to establish the Family Planning Council at the Ministry of Finance and Economic Planning. Ghana developed its first population policy in 1969, which aimed primarily at reducing the high rate of population growth to facilitate sustainable socio-economic development (GHS/UNFPA, 2015). Three years later after the PPAG was formed, the Ghana National Family Planning Programme (GNFPP) was launched in 1970 to implement the plans as outlined in the 1969 population policy. Evidence from data since 1988 paints a picture of both gains and stagnation in FP programming. The GNFPP achieved limited success due to a number of factors including poor institutional coordination, shortage of trained personnel, insufficient institutional support and

inadequate government funding (GHS/UNFPA, 2015). After 25 years, population growth still remained unacceptably high and so the Population Policy was revised in 1994 to include a systematic integration of population in development planning with renewed emphasis on fertility reduction to accelerate economic modernization, sustainable development and poverty eradication (Boateng, 2013).

Benefits of Family Planning and Contraception

Furtherance of family planning and ensuring access to ideal contraceptive methods for females and males, is important to securing the well-being and autonomy of both men and women, while supporting the health and development of communities (Kanakakis & Goulis, 2015).

Preventing Maternal Morbidity and Mortality

Contraception has clear health benefits, since the prevention of unintended pregnancies results in a subsequent decrease in maternal morbidity and mortality. Family planning allows spacing of pregnancies, delaying pregnancies in young girls who are at increased risk of health problems and death from early childbearing, and preventing pregnancies among older women who also face increased risks. Family planning enables women who wish to limit the size of their families to do so. By reducing rates of unintended pregnancies, contraception also reduces the need for unsafe abortion. Family planning is a low-cost and effective way to save lives (Nieschlag, 2010).

Reducing Unsafe Abortion from Unintended Pregnancies

An estimated 20 million unsafe abortions take place each year—resulting in 67,000 deaths annually, mostly in developing countries. Family planning can prevent many of these tragic deaths by reducing the number of unintended pregnancies with a higher risk of pregnancy complications and unsafe abortions (Waites, 2003).

Reducing Infant Mortality

Contraception can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Closely spaced births result in higher infant mortality: international survey data show that babies born less than two years after their next oldest brother or sister are twice as likely to die in the first year, as compared to those born after an interval of three years. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health (Campbell *et al.*, 2006).

Helping to Prevent HIV/AIDS

Contraception reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV. Contraception is an effective approach to reducing costs associated with HIV/AIDS: Savings are estimated at US\$25 at HIV/AIDS care and treatment facilities, for every dollar spent on family planning. Contraceptive use prevents more than 577,000 unintended pregnancies to HIV-infected women each year in sub-Saharan Africa; if all women in the

region who did not wish to get pregnant used contraception, another 533,000 (additional) unintended pregnancies to HIV-positive women could be averted annually (Chaudhuri, 1998).

Empowering People and Enhancing Education

Family planning and contraception enables people to make informed choices about their sexual and reproductive health, and creates an opportunity for women for enhanced education and participation in society, including paid employment. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (Rizvi *et al.*, 1995).

Reducing Adolescent Pregnancies

Pregnant adolescents are more likely to have preterm and low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities (GHS/UNFPA, 2015).

Slowing Population Growth

Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts (GHS/UNFPA, 2015).

Different Methods of Male Contraception

Before a method can be considered as effective, there are certain criteria that it must meet. It must first and foremost be effective as the corresponding female method. Secondly, it must be acceptable by both partners. Other desired attributes include not having significant adverse effects (especially in relation to virility, libido and erectile function). It must also not affect the offspring and be reversible as concerns fertility. Last but not the least, it must be readily available and affordable (Kanakis & Goulis, 2015).

Emerging approaches to male contraception can be broadly classified into two groups (Dey *et al.*, 2013). One direction does not directly affect spermatozoa production and early stages of development, but subsequently, during passage in the epididymis and the vas deferens, the functional character is altered and the number passing on the ejaculatory duct reduced. There is thus the possibility of localised intervention with virtually no systemic effect. The second class of method aims to suppress spermatozoa production generally by manipulating the hormonal status. Moreover, there is a requirement of regular intake of drugs orally or by injection (Dey *et al.*, 2013).

Natural Method

Withdrawal method (coitus interruptus) and periodical abstinence particularly in mid-cycle are the only two natural methods of contraception for males. Although discouraged and rightly so, by westerners because of high failure rates, these methods have been used for decades in Ghana and other developing countries. This method needs no special training (Dey *et al.*, 2013).

Physical Methods

Barrier Methods

Barrier methods place a physical impediment to the movement of sperm into the female reproductive tract (Chaudhuri, 1998). The most popular barrier method is the male condom, a latex or polyurethane sheath placed over the penis. The condom is the oldest method of contraception; however, it was not until 2004 that the WHO established the manufacturing specifications for condom production (Page *et al.*, 2008). There are about 50 million condoms users worldwide. Effectiveness can be improved with proper and consistent use and the use of spermicides. The condom has travelled a long way from what it was, to the coloured and flavoured forms, which exist presently. Condoms are now available at an optimal thickness and in a variety of sizes, shapes, widths, and lengths. The ever-increasing rate of sexually transmitted diseases, more specifically AIDS, and the rising figures of teenage pregnancy have restored the condom its previous importance (WHO, 2018).

Vasectomy

Vasectomy became popular as a male contraception method in the 1960s, particularly in the US (Dowbiggin, 2008). Nowadays, vasectomy is selected by 2.7% of couples seeking contraception (10% in the U.S.), totalling over 40 million men worldwide (Schwingl & Guess, 2000). It is more popular among advanced societies and more highly educated men due mainly to cultural and religious restrictions (Rizvi *et al.*, 1995). The operation procedure includes the dissection of the vas deferens followed by ligation and electrocoagulation of the two ends, a minimally invasive technique of high efficiency with failure rates lower than 1% and low complication rates (Trussell *et al.*, 1990). The

successful outcome of the operation should be confirmed by obtaining a sperm analysis at least 3 months postoperatively. The main disadvantage is its poor reversibility, a fact that should be emphasized preoperatively to the patient and which renders this option suitable for men who do not intend to father children in the future (Kanakis & Goulis, 2015). Short-term complications include bleeding and hematomas, wound infection and epididymitis, at rates of 1-6% (Schwingl & Guess, 2000). A major long-term complication is procedure failure due to recanalisation of the vas deferens (0-3% of cases) (Goldstein, 1983). Moreover, the rise of intraepididymal pressure as a result of the ligation of the distal end of the vas deferens may produce discomfort in the scrotum and can occasionally cause rupture of the epididymis and semen leakage, which in turn is associated with the formation of scrotal granulomas and the development of anti-sperm antibodies in the serum. Recently, concerns have been raised regarding an association of vasectomy with a modestly increased incidence of high-grade prostate cancer; however, a causal relation could not be established (Kanakis & Goulis, 2015).

Vas Occlusion

Newer "vas occlusive" methods offer alternatives to vasectomy with completely reversible effects. Vas occlusive devices block the flow of or render dysfunctional the sperm in the vas deferens. The most recent form of vas occlusive male contraception, called Reversible Inhibition of Sperm Under Guidance (RISUG), involves the use of a styrene that is combined with the chemical DMSO (dimethyl sulfoxide). The complex is injected into the vas deferens. The complex then partially occludes passage of sperm and also causes disruption of sperm cell membranes (Dey *et al.*, 2013; Kanakis & Goulis, 2015).

Hormonal Methods

Currently, attempts to develop male contraceptives are directed mainly towards: (i) development of antispermatogenic agents to suppress sperm production, (ii) prevention of sperm maturation, (iii) prevention of sperm transport through vas deferens (or rendering these sperm infertile) and (iv) prevention of sperm deposition. According to current knowledge, the pulsatile release of gonadotropin-releasing hormone (GnRH) from the hypothalamus stimulates the release of luteinizing hormone (LH) and follicle stimulating hormone (FSH) from the pituitary, which, in turn, stimulate Leydig cells to produce testosterone (T) and Sertoli cells to promote spermatogenesis, respectively. Conversely, circulating testosterone regulates gonadotropin production by exerting an inhibitory effect at the level of the hypothalamus and pituitary gland in the setting of a feedback circuit (Page *et al.*, 2008).

Consequently, the exogenous administration of testosterone is expected to suppress the gonadal axis, thereby inhibiting endogenous testosterone production and testicular spermatogenesis. These effects are completely reversible after the withdrawal of exogenous testosterone (Roth, 2012). Because the human spermatogenesis cycle lasts approximately 72 days, there is a delay of 2-3 months after the initiation of hormonal contraceptives until they achieve their full contraceptive effect. The ultimate goal of male hormonal contraception (MHC) is to reduce the number of sperms in the ejaculation so drastically that it is impossible to achieve fertilization. The ideal goal, therefore, is to achieve azoospermia. However, pregnancy rates as low as those attained with the female

contraceptive pill may be achieved with a concentration of up to 1 million sperm/ml, which may be considered acceptable (Hamed *et al.* 2018).

Androgen Monotherapy

The use of exogenous testosterone as a male contraception method was introduced in the 1970s; by the 1990s, the WHO had funded a number of clinical trials (Kanakakis & Goulis, 2015). Currently three main androgen monotherapies are being used. They include testosterone enanthate (TE), testosterone undecanoate (TU) and testosterone buciclate (TB) (Ramakrishnan, Kaur, & Rajalakshmi, 1989). The latter is the most effective of all these hormonal methods. T buciclate (TB) was developed in the 1970s via the collaboration of the WHO with the National Health Institute (NIH) in an effort to develop a form of testosterone with a prolonged time of action. The half-life of TB is 29.5 days compared to 4.5 days of TE, while the total duration of action is 3-4 months (Waites, 2003). A single intramuscular injection of TB can cause suppression of spermatogenesis comparable to that of weekly injections of TE (Behre *et al.*, 1995); however, this substance has not attracted any commercial interest as yet primarily because pharmaceutical companies do not see much profit in products that are not patronized frequently. The administration of testosterone in the form of subcutaneous implants can provide stable levels of circulating testosterone for many months, avoiding the spikes observed with injectable testosterone formulations, a possible cause of the “sperm rebound” phenomenon. A single application of implants totalling a dose of 1200 mg has an efficacy equal to that of weekly administration of TE and can be combined with a progestin for higher security (Handelsman *et al.*, 1992). Their placement can be applied on an outpatient basis through

a small incision of the skin. The oral administration of testosterone has not proven to be effective as a method of male contraception.

Side effects of Androgen Monotherapy

The fact that supernormal testosterone levels are necessary to achieve the desirable suppression of spermatogenesis has raised concern over the long-term effects of contraceptive treatment on men's health, especially as concerns the cardiovascular system and prostate-associated morbidity. So far there are no data to directly correlate the administration of androgens with increased cardiovascular events. A recent study involving T administration in cardiovascular compromised patients has been strongly criticized for methodological problems (Bhasin *et al.*, 2001). Exogenous administration of androgens in young healthy males correlates with weight gain, which mainly concerns fat free body mass, and decreases high-density (HDL) cholesterol. However, a parallel decrease in the concentration of total and low-density (LDL) cholesterol, which is mainly considered as atherogenic, is observed, ameliorating at least theoretically the cardiovascular risk (Nieschlag, 2010).

Data that correlate high levels of T to the development of prostate malignancy are conflicting (Raynaud, 2006). Moreover, existing clinical trials on male contraceptives generally concern young people and are too short in length to allow reliable conclusions. Nevertheless, given the large male population which will be affected and the long-term effects anticipated by the commercial use of a contraceptive method, the dose of administered androgens should be reduced to the minimum effective for achieving

contraception (Campagnoli *et al.*, 2005). A less severe side effect is the development of acne, whereas sexual function and overall satisfaction seem to slightly improve during androgen administration (Sjögren & Gottlieb, 2001). Additional concerns have been raised regarding the reversibility of MHC. However, no single case of permanent infertility as a result of MHC has been reported in any clinical study. In a recent study, it was observed that longer duration of androgen administration and the use of formulations with sustained action were associated with longer recovery time (Sjögren & Gottlieb, 2001).

Combination of Androgens with GnRH-analogues

The administration of GnRH-agonists, after an initial phase of stimulation (flare-up), eventually suppresses gonadotropin secretion by reducing GnRH receptors on the pituitary gland (down-regulation). On the other hand, in studies in which GnRH-agonists were co-administered with T as a means of MHC, adequate suppression of spermatogenesis could not be achieved, probably because of the lack of full FSH suppression (Dowbiggin, 2008). Unlike agonists, GnRH-antagonists can cause complete suppression of both LH and FSH, which is achieved within a few hours, avoiding the phenomenon of flare-up (Behre *et al.*, 1995). Nevertheless, the requirement for frequent parenteral administration and the high cost of such agents make them impractical as a MCM (Campagnoli *et al.*, 2005). The development of non-peptidic antagonists suitable for oral administration or slow-release implants (histrelin) may reignite interest in testing these substances.

Androgen - Progestin Combinations

Progestins, comprising an integral component of female contraception, have been studied extensively in women. A similar suppression of the reproductive axis by progestins has been observed in men and in combination with androgens they can achieve comparable suppression with androgen monotherapy, using lower doses of androgen (Sjögren & Gottlieb, 2001). Consequently, numerous studies combining androgens with progestins as means of MHC have been conducted. Progestins other than progesterone is of synthetic origin and are classified into 19-norsteroids, derived from T and 21-progestins or pregnanes derived from progesterone. They exist in forms such as Norethisterone, Levonorgestrel, Desogestrel, Medroxyprogesterone acetate, Cyproterone acetate (Page *et al.*, 2008).

Side Effects of Androgen – Progestin Combinations

The co-administration of progestin together with androgens appears to have no adverse effects on body weight and results in HDL-cholesterol concentrations similar to those of androgen monotherapy. The route of progestin administration seems to play an important role, as oral administration is associated with pro-atherogenic action, whereas transdermal administration (implants) is not, probably due to the bypassing of hepatic metabolism (Ref). In women, the administration of progestins appears to increase cardiovascular disease endpoints and inflammatory markers (IL-6, C-reactive protein); in men, however, the available evidence is inadequate to draw firm conclusions due to the much lower experience and the small size of clinical studies (Vogelsohn, 2005). The addition of progestin to the regimen does not seem to affect the time required for the recovery of spermatogenesis (Campagnoli *et al.*, 2005).

Knowledge and Attitude about Family Planning Methods and Contraceptive Use

Knowing about contraceptives is presumed to be a first step in stimulating the desire for its use. Assessment of knowledge about contraceptives therefore does not only determine the extent of awareness and sensitization (Takyi, 2000; Kongnyey *et al.*, 2007) but further provides the background for which use of the service is further evaluated. Evaluation in this sense relates with the background characteristics, principally social, of users that influence these awareness and sensitization levels. Oral contraceptives (OCs) were the most popular form of contraception for sexually active Canadian women surveyed in 1998 (Fisher *et al.*, 1998). Seventy-three percent users at the time of the survey expressed a high degree of satisfaction with the pill, although misperceptions were prevalent. Few women knew it was safe for non-smokers to take the pill after age 35, and that the pill reduces certain cancers. When asked whether taking the pill presented fewer health risks than pregnancy, just 4% strongly agreed.

Published literature on the efficacy of contraceptive counselling and education seems to reflect a significant gap between what providers think they offer and what consumers appear to receive. An audit of family planning users in Scotland revealed a 30% discrepancy between the number of women whom clinicians thought they had appropriately counselled and the number of patients who actually understood the teaching (Rajasekar *et al.*, 1999). Oakley estimated that up to one third of women require more individualized counselling to use OCs effectively (Oakley *et al.*, 1994). Getting the good news out about the many benefits of OCs will enable more women to take advantage of their positive health effects and may help increase compliance (Rosenberg *et al.*, 1998;

Shulman *et al.*, 2000) It was discovered that the knowledge of Canadian women on the pill regarding risks, benefits and side effects of the pill remains deficient in several key areas, but was increased by counselling. According to the recent Ghana Demographic Health Survey, 2003, knowledge of family planning was defined operationally as having heard of a method. The survey, which used an interviewer prompt method, showed that knowledge of contraceptive was known by 98 percent of women and 99 percent of men (GSS, 2003) considering that these proportions represented Ghanaians who knew at least one method of contraception.

Knowledge about modern and traditional contraceptive have changed over a decade and half ago. Whereas the latter was popular among Ghanaians, the former is now popular even though users of contraceptives use the traditional methods (Clement *et al.*, 2004). It is noted that contraceptive knowledge among unmarried women was found to be 100 percent. Condoms, diaphragm, the pill, implant, foam tablet and lactational amenorrhoea were among the methods commonly identified. In a cross-sectional survey in Kinshasa, Democratic Republic of Congo, condom was the most widely known modern contraceptive method since it was cited by 43% of women; the Pill was by only 28%, Injectables 16.2%, IUD 8%, spermicidal foam 2%, and the diaphragm by less than 2%. Teenagers and young adults (15–24 years) were less knowledgeable of modern methods (Kayembe *et al.*, 2003).

In an assessment of gender issues relating to contraceptive use in Ebo State, Nigeria, Osaemwenkha observed that educated and sexually active youth had wide spread knowledge of contraceptives and this background correlates with the number of methods

known (Osaemwenkha, 2004). Obviously, such wide knowledge does not necessarily mean that such persons have adequate exposure to the use of contraceptives because other decision-making influences could determine its use or otherwise. Even though Osaewenkha, perceived that his respondents, 800 university female students, may have had enough knowledge, he discovered that even among the enlightened, decision making on contraceptive use has the male involvement factor essential.

Modern contraceptive methods, by improving reproductive health, have a positive impact on women's overall health and quality of life. To exert this beneficial effect, correct and consistent use of the contraceptive method chosen by the clients is necessary. This is achieved by promoting correct knowledge via good quality family planning counselling. One of the factors which might affect efficacy of family planning counselling is the source of information or the counsellor (Bayray, 2012).

It has been reported that, the most adequate source of information on family planning is the general practitioner but other sources of information on this topic have also been cited (Topsever *et al.*, 2006). To help people make informed choices, communication can stress people's right to information about personal health and their ability to make family planning decisions for themselves. Messages can point to the range of contraceptive methods available, describe the characteristics of specific methods, and tell where and how to find out family planning information and service.

Communication can help people get the most out of family planning counselling by discussing the need and responsibility to ask questions and obtain answers from family planning providers (JHUCCP, 2001). The level of awareness of a range of contraceptive methods provides a rough measure of the availability of family planning information in the country. In countries where people have more exposure to family planning messages on radio and television, people are aware of more methods (JHUCCP, 2001). The purpose of family planning counselling is to help the client make informed choices about reproductive health and family planning issues. Informed choice, which should among other topics cover knowledge transfer about the mode of action of the chosen method, has been shown to improve efficiency and compliance to contraceptive method use. Thus, correct knowledge about the mode of action of the method chosen, can be considered an efficacy outcome for family planning counselling (Topsever *et al.*, 2006).

Family planning counselling which covers knowledge transfer about contraceptive mode of action, by enabling informed choice, improves compliance to and efficiency of contraceptive methods (Topsever *et al.*, 2006). Urban areas provide greater exposure to information about family planning through print and broadcast media, and they provide a greater range and supply of family planning services and distribution outlets than rural areas (IFPP, 2006).

A study conducted in Guatemala indicated that the levels of modern contraceptive knowledge and use among people living in rural areas of Guatemala differ substantially from those of people living in urban areas. The results suggest that lack of knowledge and

familiarity with modern contraceptive methods remain an important barrier to modern contraceptive use in Guatemala, particularly in the indigenous population (IFPP, 2006). Also, another study in the US have found that as black female teens age, their knowledge about contraceptives increases and they are more likely to report having ever used contraceptives and currently using contraceptives. In particular, black female teens who had received formal sex education (i.e., in school, a clinic, a community organization, or church) were more likely to have ever used contraceptives than black female teens who had not received such instruction (Topsever *et al.*, 2006).

According to a study conducted in Kwazulu Province in South Africa, Family planning clients are usually not provided with detailed information on family planning methods so that they can make an informed decision (USAID, 2002). Effectiveness, contraindications, advantages, disadvantages, possible side effects, and the managements of side effects are frequently not discussed with clients during FP counselling. More information is provided on advantages than on disadvantages, and less is provided on the management of side effects than on actual side effects. Providers do not mention the full range of contraceptives that are available to clients. That complete information on methods is not made available to clients (USAID, 2002).

Engaging men in family planning programs holds promise as a means to improve access and use of family planning. Contraceptive acceptability and use are related to method and user factors. Surveys have indicated that many men do believe that they should share responsibility of family planning and contraception with their partners, and men whose

wives have experienced side effects from female methods of contraception may be even more concerned about shared responsibility (Vogelsong, 2005). Indeed, many men who participate in male contraceptive clinical trials report that their main reason for participating was that the female partner had experienced problems with her method of contraception. Evidence also shows that addressing gender in family planning programs — for instance by engaging men — can improve program outcomes and increase gender equality (Vogelsong, 2005).

Ziyane & Ehlers (2007), who investigated Swazi men's contraceptive knowledge, attitudes, and practices, concluded that adult and adolescent Swazi men lacked knowledge about modern contraceptives. This lack of knowledge perpetuated negative attitudes, misconceptions, and fears about the use of contraceptives. Secondly, adult men could not discuss contraceptive issues with younger female nurses.

Bietsch (2015) examined male attitudes towards family planning in Sub-Saharan Africa, and concluded that positive attitudes towards family planning are increasing throughout Sub-Saharan Africa, and with decreasing desired number of children and increasing access to contraceptive services, positive attitudes may translate into increased contraceptive use and declines in fertility in a region with some of the highest fertility in the world.

In a study to assess the attitude and knowledge among men towards vasectomy in Bangalore *et al.* (2015) concluded that the myths and the attitude of men toward vasectomy can only be changed by intensive education and effective information.

Hamed *et al.* (2018) assessed the knowledge, attitude and practice of family planning among husbands in an Egyptian village and concluded that 60% of husbands gave their approval to family planning, while 28.5% had knowledge about family planning. The study also deduced that the current use of family planning methods was quite low.

A cross-sectional survey to gain understanding of men's knowledge of and attitude towards birthspacing and contraceptive use in Jordan threw light on the attitude of men towards contraceptives use in most states in the middle east. The study revealed that men's education greatly influenced their knowledge and attitudes about contraceptives. Again, religions played a great role in family planning decisions. Men, in particular, are interested in religious programs and the acceptability of various contraceptive methods within the confines of religious laws (Petro-Nustas, 1999).

Paudel & Acharya (2018) assessed whether number and sex composition of living children determine contraceptive use and method mix among Nepalese men who expressed not wanting to have more children. They concluded that son preference was found to be associated with family planning use and method mix in Nepal. In light of these findings, family planning service provision in Nepal needs to adopt multidimensional integrated approach. Therefore, in addition to improving the quality and reach of family planning services, national family planning programs must work in collaboration with efforts to promote the value of girl child. The study further concluded that men need to be involved

during family services and related activities as equal partners of their wives to promote shared decision making and spousal communication.

Tilahun *et al.* (2015) undertook a study aimed at measuring the effect of a six-month-long family planning education program on male involvement in family planning, as well as on couples' contraceptive practice. The study showed that family planning educational intervention, which includes both spouses and promotes spousal communication, might be useful to foster contraceptive practice among couples. The results also offer practical information on the benefits of male involvement in family planning as a best means to increase contraceptive use. Thus, providing opportunities to reinforce family planning education may strengthen the existing family planning service delivery system.

Similarly, (Bayray, 2012) undertook a study to assess male involvement in family planning use in an Ethiopian village. Conclusions indicated that men demonstrated lower knowledge on contraceptive methods that could be used by men. In addition, it was found out that there was low utilization of family planning methods and use of these methods for spacing rather than limiting child bearing. Level of discussion between a husband and a wife, husband support and approval found to be lower, lack of information, access to the services and the desire to have more children were some of the main reasons for not using and choosing family planning.

In a survey conducted by Heinemann *et al.* (2005) to investigate attitudes toward male fertility control in a multinational survey across four continents, they concluded that 55%

of the current survey respondents reported being willing, or very willing, to use a new method of male fertility control with favourable response rates ranging from 28.5% in Indonesia to 71.4% in Spain.

Unsurprisingly, as men have not been a part of family planning conversations, their knowledge about reproduction and family planning is generally low in certain areas. Gender norms also influence men's acceptance of family planning in general and of specific contraceptive options. Male methods, in particular, are surrounded by myths and misperceptions. In India and Nepal, many men resist vasectomy due to myths that the procedure causes physical weakness or impotence and reduces a man's capability to provide for his household (Char *et al.*, 2009). A common belief in some regions is that only women should be sterilized. As a result, stigma is often attached to men who undergo sterilization. Interestingly, these same myths and misconceptions can increase the use of male sterilization in other areas. For example, Rai (2012) reports that in the Karnali region of Nepal, women are considered harder workers than men, as women both work in the field and have household duties. Consequently, men may opt to receive vasectomy because they believe the weakness brought about by female sterilisation would inhibit household productivity.

Some men in Nepal opt to use male methods because they believe women who use contraception regularly become promiscuous (MOPH, 2012). In similar study, Shahjahan & Kabir (2007) report that resistance to condom use is also a barrier to men's engagement in family planning. Men in Bangladesh may resist using condoms for family planning

because of perceptions that condoms reduce sexual pleasure and because they fear condom failure during intercourse.

Extent of Influence of Socio-economic Characteristics on Decision to use Contraceptives

Deciding to use modern contraceptives is a difficult decision by most prospective users, especially women. The difficulties arise from the strength of the interplay of influences from close family relations. Furthermore, the economic dependency level of the woman on her close relations affect the decision process for the uptake of contraceptives (Benefo, 2005). The type of work and the amount of income earned by the woman in particular have a strong relation to use of contraceptives (Baiden, 2003; Sign *et al.*, 2003). Studies during the past few decades have established a close and significant relation between contraceptive use and fertility preferences. Das and Deka (1982) have considered the cultural factors in fertility as there is evidence that the fertility behaviour changes with different cultural settings. The economic value ascribed to children enhances fertility among those who are economically poor.

In several studies on modernity and fertility, education is found to be the prime influencing factor. Education may have a direct influence on fertility, since education affects the attitudinal and behavioural patterns of the individuals. Lactational amenorrhoea, which lasts for two to three years in some societies gives scope for longer birth intervals, thus affecting the fertility among such women (McNeilly, 1979). As Anand (1968) and Chandrasekhar (1972) put it, the family welfare programmes, their reception, impact and

utility have affected fertility in every society in this era of rapid population growth. Because of the government's policy on birth control, exhaustive efforts are made by the government to popularize the different family welfare methods. Results achieved so far in this direction can be attributed to the programme inputs. However, besides several cultural factors, non-availability and/or lack of knowledge, attitude towards desired family size, traditional beliefs and practices play an important role in family planning.

A number of KAP studies have been taken up covering different population groups. Gautam and Seth (2001) in their study among rural Rajputs and Scheduled Caste (SCs) found out that raise in education besides providing knowledge on the contraceptive methods helps in improving acceptance of family control devices. There are other studies also in similar lines taken up among tribal and rural populations (Meerambika *et al.*, 1999; Sushmita & Bhasin, 1998). However, the national programme should have group specific and area specific interventions with regard to family planning. In this background, an attempt was made in that paper to study 'knowledge and practice of contraception' among Racha Koyas, a tribal population from Andhra Pradesh. In this connection, it is pertinent to note that in the 'National Health Policy', the tribal groups need special attention as they are considered 'a special group'. These among others account for the emphasis on the concept that contraceptive is a human rights issue. This concept does not only empower women to take control of their reproductive life but also develop themselves to be independent of others, so as to ensure their total well-being and that of their children.

Many researchers have observed that, this concept is a borrowed one from the west and its adaptation in the African setting. Considering the complexity of influences on close and external relations on their lives, in addition to their socio-economic standing (White, 2002), needs extensive examination (RAND, 1998; White *et al.*, 2002; Awusabo-Asare, 2004; Solo *et al.*, 2005). Level of education and socio-economic status of women have been identified to affect fertility decision directly (White, 2002). In addressing the distribution of financial resources in relation to AIDS and family planning methods use in Offinso, Ghana, Duodo and others implied that the inequitable distribution of resources to the detriment of rural communities affects contraceptive use (Duodo *et al.*, 1998). In a study on empowering women in Navrongo and its environs, Ghana, Solo and others observed that health decision making including the use of contraceptive is influenced by traditional beliefs, men animist rights and poverty (Solo *et al.*, 2005).

Despite these others have observed contrary relations of use of contraceptive with socio-economic variables. In his study on factors affecting contraceptive use in Ghana, Tawiah, using a regression analysis modelling identified that, respondent's age, type of place of residence, religion, ethnicity, desire for more children, marital duration, availability of electricity in the household, husband's approval of contraception, husband's education and occupation, have no significant effects on current use of contraceptives (Tawiah, 1997).

In a cross-sectional survey of 21 countries in sub-saharan Africa, using demographic health survey data, Derose and others in 2004 established that discussions with partners on contraceptive informs women of their husbands' attitude towards contraceptive and

therefore the intention for its use. The study also established that women usually do not discuss sexual plans and desire with their husbands especially on matters relating to the number of children to have and spacing of birth (Derose *et. al.* 2004).



CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter covers the study area, research design, study population, sample and sampling procedures, research instrument, method of data collection, and data analysis.

Study Area

The study was conducted in Ejura, situated in the Ejura-Sekyedumase Municipality of the Ashanti region, Ghana. The municipality shares boundaries with the Atebubu- Amantin to the north, the Nkoranza District to the west (all in the recently established Ahafo Region), the Ashanti Mampong district to the east and Afigya Kwabre district to the south (all in the Ashanti Region). Hence, this district is in the transitional zone of the country. According to Ghana Statistical Service report on Ghana's Population and Housing Census conducted in 2010, it reviewed that Ejura Sekyedumase has a total population of eighty five thousand, four hundred and forty six (85,446) that constitute a distribution of twenty eight thousand, three hundred and twenty eight thousand, five hundred and eighty one (28581) male and female respectively. Agriculture is the main source of employment for almost 85% of the total population in the Municipality. The soil type helps to support the cultivation of food and cash crops. Root tubers as well as cereals do well in the study area and this explains why maize and yam are considered as the major chief crops grown in the area. Even though agriculture serves as the major occupation in the area, there are few people who are engaged in other artisanal professions which include carpentry, hairdressing, fitting and others in petty trading. In order to foster the growth in human skills and knowledge development,

Ejura community has a number of schools ranging from primary to secondary level. It has twenty primary schools which consist of four Islamic, five missions, five private and six municipal primary schools. It has also two secondary schools – one government and the other private, and one technical institute (Municipal Education Unit Ejura, 2013).

Research Design

Research design is the researcher's plan of action for answering research questions set (Babbie, 1990). Studies have affirmed that the central role of research design is to minimise the chance of drawing incorrect causal inferences from data. It therefore serves as a work guide. There are various types of research designs in the field of social sciences. These include descriptive research design, explorative research design, evaluative research design and experimental research design. However, the researcher adopted a cross-sectional and descriptive research design for this study. Descriptive research design describes the nature, characteristics, function, relationships and patterns of the study (Creswell, 2002).

Study Population

Study population, according to Neuman (2006), is a group of individual persons, objects or items from which samples are taken for measurement. Since men are the focus group of the study, the population consisted of men of reproductive age (15 – 59 years) in the community. However, a small population of females were added as they are partners in effective usage of birth control strategies.

Sample Size

A total sample size of two hundred and thirty – four (234) men served as a representation of the entire population.

Sample and Sampling Procedure

A sample is a suitable number or amount of people or objects taken out of a population for a study. Sampling is, thus, the principle of collecting information from part of a population in such a way that responses and characteristics reflect those of the population from which they are drawn, especially units with similar characteristics (Neuman, 2006). Random sampling technique was therefore used for this study. Five (5) geographical areas, namely, *Broadcasting, Ejurafie, Ejura, New Town, Saboline and Dagombaline* were selected for the study. These areas were selected because they contain all forms of the class structure of livelihood (higher, middle and lower class) among them. The total number of houses in the community was obtained from the Statistical Service Department in the Municipality. Study households were selected from the community through systematic sampling from a random start point.

The sampling interval of households in the community was determined by dividing the total number of households to the allocated sample size. The initial interviewed household was randomly selected by a lottery system from the community house number register. The subsequent households to be included in the study were identified systematically through house-to-house visits, each time adding the sampling interval to the previous number. One eligible male per household was interviewed. If more than one eligible man was

encountered in the household, a lottery method was used to determine the person to be interviewed.

Research Instrument

Questionnaire and interview guide were used as research instruments for collecting data. Questionnaire were used because they are very effective in extracting information from a target group. The research instrument was made of both close-ended and open-ended questions. The questionnaires consisted of semi-structured questions (containing both open-ended and close-ended questions) that led the respondents to provide clear and specific responses. The *closed-ended questions* helped in collecting the quantitative data. They allowed for easy coding and analysis that was used to draw comparisons in the study. Likewise, the *open ended-questions* enabled the author to register the views and opinions of respondents. This was very important since the close – ended questions limited the extent to which respondents could express themselves.

Data Pre-Testing

Data collection began with a pilot test during which the questionnaire was tested to determine the suitability of the research instrument (Creswell, 2009). The pilot study was conducted using 10 respondents (2 from each geographical area) to (i) determine whether the questions in the questionnaires were clear enough to elicit the appropriate responses, (ii) help make necessary changes to the questionnaire in order to solicit the needed data for the study, (iii) help to know the right time and occasion for administering the questionnaires.

Method of Collecting Data

Data for the study were collected from both primary and secondary sources. Qualitative and quantitative primary data were collected using interview and questionnaires. Secondary data, on the other hand, were data collected from readily available sources; obtained from both published and unpublished sources such as academic journals, electronic databases, internets, academic research works and books.

Data Analysis

Data collected were cleaned, edited and coded. The International Business Machine Statistical Package for Social Sciences (IBM-SPSS, version 20) programme was employed to analyse the coded data. Results from the analyses are illustrated with frequency tables and bars for the analyses.

Ethical Consideration

Anonymity and confidentiality of respondents were guaranteed, and their identities were not asked during data collection. Informed consent was obtained from all respondents.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This segment presents the analyses of the data gathered from the field study. Analyses were presented in two sections. The primary segment looked at the demographic characteristics of the respondents, while the second part examined the attitude, knowledge and usage of contraceptives among men.

Socio-Demographic Characteristics

Age, Marital Status and Educational Level of Respondents

Depicted in Table 1 are the gender, age, marital status and nationality of respondents. About 44.4 percent of the respondents could be found in the 36- 45-year age group. They were closely followed by those in the 26 – 35 years age group with 41.1 percent, while those in the 46 – 55 years age group were 11.1 percent of the population. The least number of respondents were observed in the 41-50 years age group. The age distribution shows that most of the participants were youth. All respondents were Ghanaians. Marital status of the respondents indicated that over 80 percent of the population were married. Single respondents made up about 12 percent of the population. Three (3%) of the population was divorced while about 1 percent was separated. With regards to education, respondents with university degrees was in the highest category (40%). Those with SHS certificates followed suit with 22.2 percent while HND holders were 20 percent of the study population. JHS certificate holders numbered 37 (15.6%). Post-graduate degree holders were in the minority with 2.2 percent. Hence, all respondents were literate.

Table 1: Demographic characteristics of Respondents

Characteristic	Frequency	Percent (%)
<i>Age (years)</i>		
15 – 25	8	3.3
26 – 35	96	41.1
36 – 45	104	44.4
46 – 35	26	11.1
Total	234	100
<i>Marital Status</i>		
Single	29	12.2
Married	195	83.3
Divorced	8	3.3
Separated	3	1.1
Total	234	100
<i>Level of Education</i>		
JHS	37	15.6
SHS	52	22.2
HND	47	20.0
Graduate	94	40.0
Post Graduate Degree	5	2.2
Total	234	100

Source: Field data (2019)

Religion, Number of Children, Occupation and Expected Income of Respondents

Table 2 shows respondents' religion, number of children, occupation and expected income levels. Religious beliefs play a major role in the acceptance of birth control methods. In this study, respondents who were Christians were in the majority (59%). Muslims comprised 28.6 percent of the population, while those who professed no religious affiliation were 7.7. Traditionalists were 4.7 percent. Majority of the respondents (38.9%) had 1 – 4 children, 32.2 percent had 5 – 8 children, while 28.9 percent of the respondents had no children. Regarding occupation, results indicate that most of the respondents were government employees (43.3%). Business owners comprised 35.5 percent of the population. Respondents who had other occupation not listed in the options were about 13 percent while those involved in petty trading were 4.4 percent. Income levels of respondents showed that most of the respondents (about 41.1%) earned between GhC501.00 – 1,000.00 monthly. 35.6 percent earned GhC1,001.00 – 1,500.00, while 17.8 percent earned above GhC1,501.00 – 2,000. The least amount of GhC500 and below was earned by 5.6 percent of the population on monthly basis.

Table 2: Religion, Number of Children, Occupation and Income of Respondents

Characteristic	Frequency	Percent (%)
<i>Religion</i>		
Christian	138	59.0
Muslim	67	28.6
Traditionalist	11	4.7
None	18	7.7
Total	234	100
<i>Number of Children</i>		
1 - 4	91	38.9
5 - 8	75	32.2
None	68	28.9
Total	234	100
<i>Occupation</i>		
Petty Trading	10	4.4
Government Employee	101	43.3
Business	91	38.9
Other	31	13.3
Total	234	100
<i>Income (GHC)</i>		
GHC 500 and above	13	5.6
GHC 501 - 1000	96	41.1
GHC 1001 - 1500	83	35.6
GHC 1501 - 2000	42	17.8
Total	234	100

Source: Field data (2019)

Preference for Sex (Gender) and Interval Between Two Successive Births

Figure 1 indicates respondents' preference for a particular sex (male or female child).

Eighty-three percent (83%) indicated their preference for a particular gender (either male

or female). Personal interaction with respondents showed that many preferred male children to females because in the Ghanaian setting, male children ensure the perpetuation of the family lineage. Seventeen percent (17%) however had no preference for the sex of their children. They indicated that children are gifts from God irrespective of the gender. Respondents also indicated their preference for the interval between successive births (Figure 2) and 2 years was the most preferred by 24.4% of the respondents, 23.3% preferred an interval of 1.5 years interval with 24.4%. Three (3) years interval was preferred by 21.1%, while an interval of 2.5 years was preferred by 17.8%. An interval of above 3 years was preferred by 13.4% respondents.

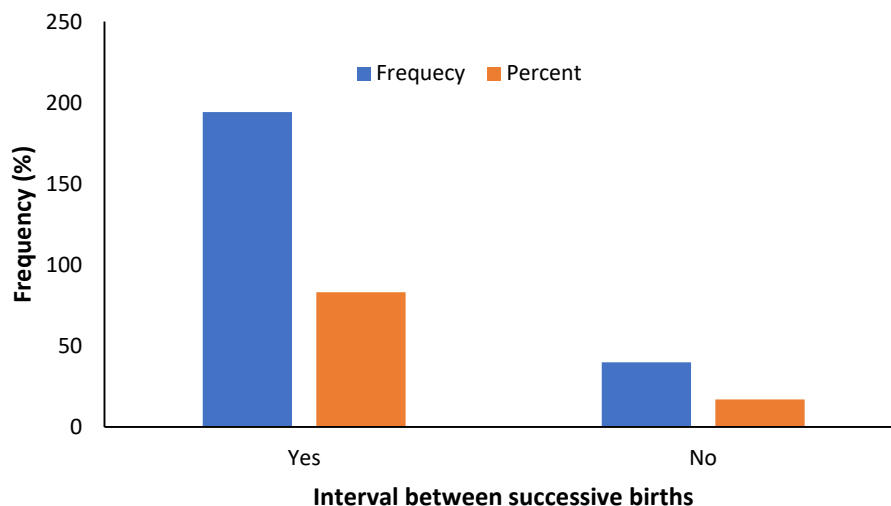


Figure 1: Preference for interval between two successive births?

(Source: Field data, 2019)

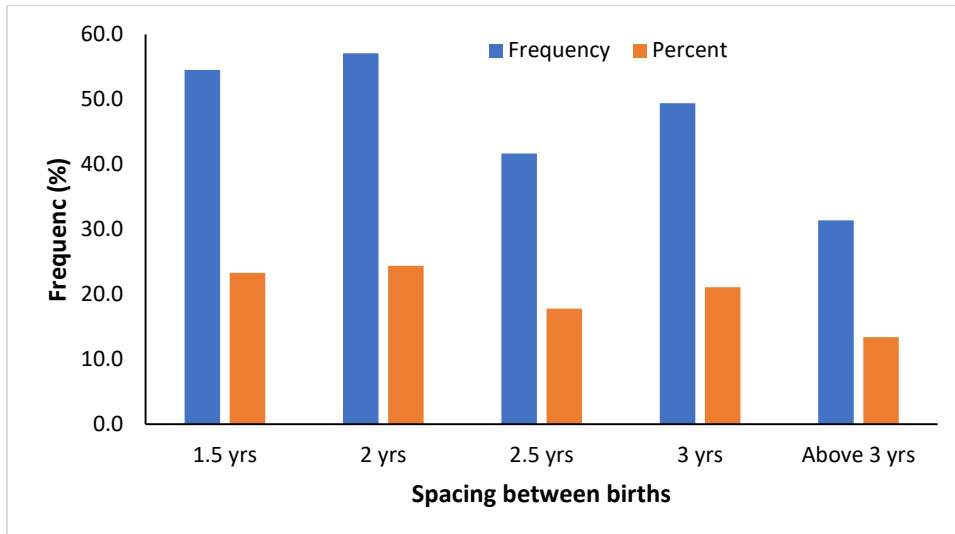


Figure 2: Preference for number of years before next birth

(Source: Field data, 2019)

Knowledge About Contraceptives Usage

Knowledge of contraceptives is key in determining its use, therefore, every attempt to assess barriers to contraceptive use ought to consider existing knowledge (Sedgh & Hussain, 2014). Low or no knowledge on contraception influences its use in one way or the other. Generally, global contraceptive knowledge is high. Table 3 presents the views of respondents with respect to their knowledge about contraceptives and their usage. With regards to whether respondents were currently using a family planning method, most (67.8%) of them answered in the negative (32.2%) however, responded in the affirmative. Respondents who answered in the negative were asked their reasons for not using contraceptives. Answers indicated that most respondents (53.3%) believed contraceptives or family planning methods have negative side effects. The second most important reason was attributed to financial difficulties (32.2%) while religious restriction was mentioned by 10 percent. Opposition from partners was indicated by a few respondents (4.4%) as

reasons for not using contraceptives. With regards to which contraceptive respondents or their spouses/partners have used before, the oral pill was the most patronized (35.6%). The calendar method, also known as the natural method, was the second most used method (25.6%). About 23.3 percent patronised condoms while the implant was least used by 15.6 percent of respondents.

The main reason respondents used the contraceptives was to prevent unwanted pregnancies (45.6%). As high as 41.1 percent indicated that they adopted the family planning method to limit birth while 13.3 percent also mentioned birth spacing as the reason for using contraceptives or adopting family planning methods. This is in line with the findings by Tuloro *et al.*, (2009) which had an association with of exposure to unintended pregnancy with contraceptive use.

Peers, healthcare providers, and the media were the main sources of information on contraceptives or family planning methods. Healthcare providers were the most important source of information with regards to contraceptives or available family planning methods (58.9%). Almost 23.3 percent heard about contraceptives through the mass media. Respondents who heard about contraceptives or family planning methods through peers were 17.8 percent. Only two main effective male family planning methods or contraceptives were known to the respondents. 65.6 percent of respondents indicated they were aware of the use of condom while 34.4 percent knew about vasectomy. The USAID demographic and health survey declared contraception knowledge almost universal (Khan *et al.*, 2007). This conforms to the findings of this study which realized that contraception

knowledge was universal among respondents. On the question of whether they are having side effects related to the method they are using; 73.3 percent were affirmative while 26.7 percent were in denial. Regarding the last time they used a contraceptive, most of the respondents (40% plus), had used a contraceptive less than a year ago. As many as 23.3 percent had used it over a year ago while 22.2 percent had used it less than a month ago. Ten percent (10%) had used a contraceptive less than 6 months ago while those who had used it less than a week were 1.1 percent. Pertaining to how long respondents have been using the current family planning method, 53.3 percent indicated it had been a year, while 28.9 percent mentioned they have been using it for a month. 17.8 percent said they had used it only for a week.

Irrespective of the fact that respondents knew about male contraceptive methods, most did not use them often. It was surprising to find that the high levels of knowledge on contraceptives did not reflect in its current use, as only 57.4 percent used them. This confirms by a study by Sedgh & Hussain (2014) that the high knowledge on contraceptives in developing countries do not always result to high usage.

When asked where they obtain their preferred contraceptive from, 60 percent mentioned the pharmacy as their source, 38.9 percent purchased them from health centres while 1.1 percent did so at grocery shops. About 76.7 percent rated how their privacy was respected as fairly satisfactory. Only 18.9 percent were not satisfied while 4.4 percent were very satisfied. Most respondents however described the attitude of the provider as friendly (58.9%), while 27.8 percent described the attitude of providers as being hostile. 13.3

percent felt the provider was disrespectful. The study found that service providers' attitude towards choice of method was a barrier. It is backed by a study which discovered that service providers impede contraceptive use (Save *et al.*, 2004). They introduce bias by dictating the method to be useful to clients either clearly or by implications is an attitude which also affects contraceptive use (Nalwadda *et al.*, 2010). Edh & El-Zanaty (2014) similarly reported that even though males were aware of contraceptives, there was a low rate of usage. In the current study 65 percent of respondents have knowledge about male contraceptives, this finding is similar to a study conducted in Uganda which declared that about 60 percent of the study participants had knowledge on family planning. Likewise, in a study in Egypt, Hamed *et al.*, (2018) reported 60 percent male respondents had knowledge about contraceptives and family planning methods. Also, this is consistent with a study conducted in Pakistan where about 97 percent of respondents had knowledge about contraceptives methods.

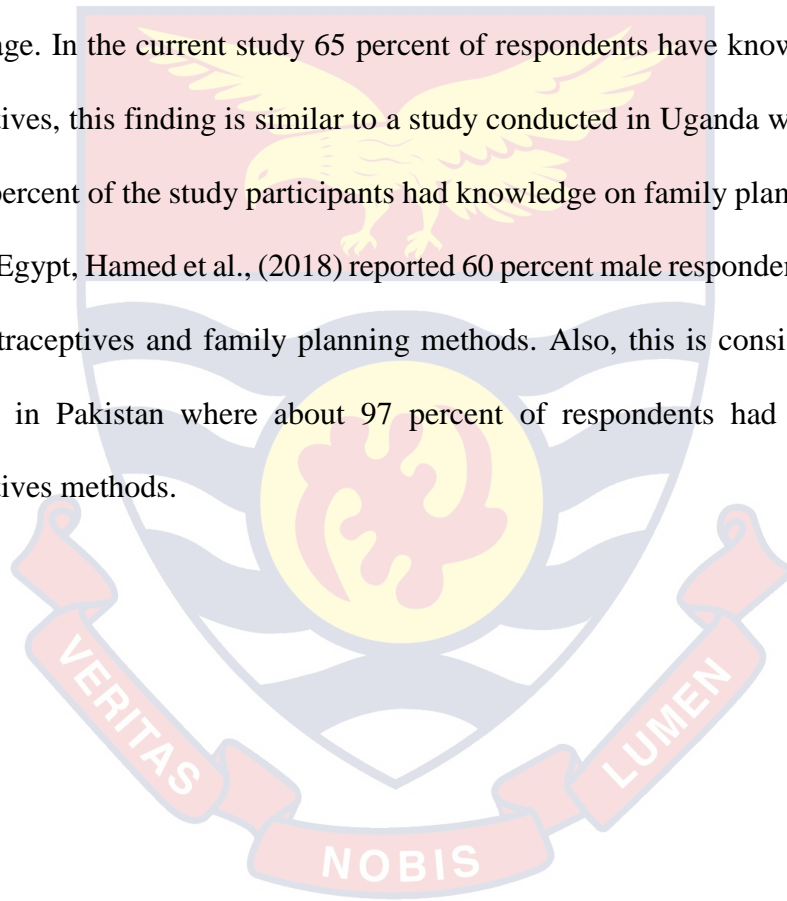


Table 3: Knowledge about contraceptive uses (1)

Views and Opinions about contraceptive usage	Frequency	Percent (%)
(N=234)		
<i>Are you currently using a family planning method?</i>		
Yes	75	32.2
No	159	67.8
Total	234	100
<i>Reasons for not using birth control methods</i>		
Side effects	125	53.3
Opposition from partner	10	4.4
Financial problem	75	32.2
Religious restriction	23	10
Total	234	100
<i>Which of the family planning methods mentioned below have either you or your partner used before?</i>		
Oral pill	83	35.6
Condom	55	23.3
Implant	37	15.6
Calendar method	60	25.5
Total	234	100

Source: Field data (2019)

Table 4: Knowledge about contraceptive uses (2)

Views and Opinions about contraceptive usage	Frequency (N=234)	Percent (%)
<i>What was the purpose of using the contraception or family planning method?</i>		
Birth spacing	31	13.3
Limiting birth	96	41.1
Prevent unwanted pregnancy	107	45.6
Total	234	100
<i>Sources of information about contraceptives</i>		
Peers	42	17.8
Healthcare providers	138	58.9
Mass media	55	23.3
Total	234	100
<i>What type of male contraceptives are you aware of?</i>		
Condom	154	65.6
Vasectomy	80	34.4
Total	234	100
<i>Do you have any side effects related to the method you're using?</i>		
Yes	172	73.3
No	62	26.7
Total	234	100
<i>When was the last time you used a contraceptive?</i>		
Less than a week	3	1.1
Less than a month	52	22.2
Less than 6 months ago	23	10
Less than a year ago	101	43.3
Over a year ago	55	23.3
Total	234	100
<i>For how long have you been using the current method?</i>		
Some few weeks	42	17.8
One month	68	28.9
One year	125	53.3
Total	234	100
<i>Where do you obtain your preferred contraceptive from?</i>		
Pharmacy / drug store	140	60
Provision stores	3	1.1
Health centres	91	38.9
Total	234	100

Source: Field data (2019)

Table 5: Knowledge about contraceptive uses (3)

Views and Opinions about contraceptive usage	Frequency (N=234)	Percent (%)
<i>How would you rate the way your privacy was respected by the provider during your visit?</i>		
Very satisfactory	10	4.4
Fairly Satisfactory	179	76.7
Not Satisfactory	44	18.9
Total	234	100
<i>How would you describe the attitude of the provider?</i>		
Friendly	138	58.9
Disrespectful	31	13.3
Hostile	65	27.8
Total	234	100

Source: Field data (2019)

Attitude Towards Contraceptives Usage

Table 4 presents the attitude of respondents to contraceptive use or family planning methods. With regards to how much respondents knew about family planning, majority (41.1%) indicated they knew little about family planning. About 37 percent knew sufficiently about family planning, while 22.2 percent knew absolutely nothing about family planning or the use of contraceptives. This is alarming and deserves much effort to sensitize people on family planning issues. The study sought to determine how

family/friends reacted towards a man who attends family planning with his spouse/partner. Most (62.2%) respondents were indifferent in their response. Twenty two percent (22.2%) indicated they will view such an action as strange. Fifteen percent (15.6%) however, said they will admire and congratulate such a man.

Also, respondents were asked if they discuss contraceptive use or family planning with their friends, and 60 percent affirmed they did while 40 percent did not. Respondents had to affirm or negate whether their spouses/partners, health workers and friends have discussed family planning with them, 65 percent have had their spouse/partner speak to them about family planning while 35 percent had not. About 59 percent indicated that health professionals have not discussed family planning with them. Nearly 51.7 percent of the respondents indicated that they have discussed family planning with their friends and 81.1 percent indicated they felt normal or nothing untoward during the conversation bordering on family planning.

With regards to respondents knowing any man who attends family planning with his wife/partner, 61.1 percent were negative in their response. Apparently, it is not a common occurrence for male partners to accompany their spouses. Almost 80 percent of respondents have never attended a family planning clinic before. Among those who claimed to have visited a family planning clinic before, formed a majority of 35.6 percent and they made have visited for about four or more times while only 13.3 percent have visited only once.

Distance is often a great disincentive to visiting the family planning clinic. Respondents were asked how close the family planning clinic is to them. Majority (44.4%) stated the family planning clinic was far from them, while about 34% claimed it was a little distant from their abode. About 21.1 percent indicated it was far from their location. The study also sought to know how important family planning was to respondents. Close to 48 percent said family planning was important to them, while 30 percent were of the view, it is very important. About 13.3 percent made it known it was extremely important, and 8.9 percent thought family planning was not important. In that vein, 84.4 percent indicated in their response they would gladly recommend family planning to friends and relatives.

Figure 3 presents respondents' views on cost of accessing family planning services. Majority (45.6%) of the respondent indicated that accessing family planning services was expensive. About 37.8 percent of respondent were of the view that the fees charged were normal, while 16.7 percent simply had no idea.

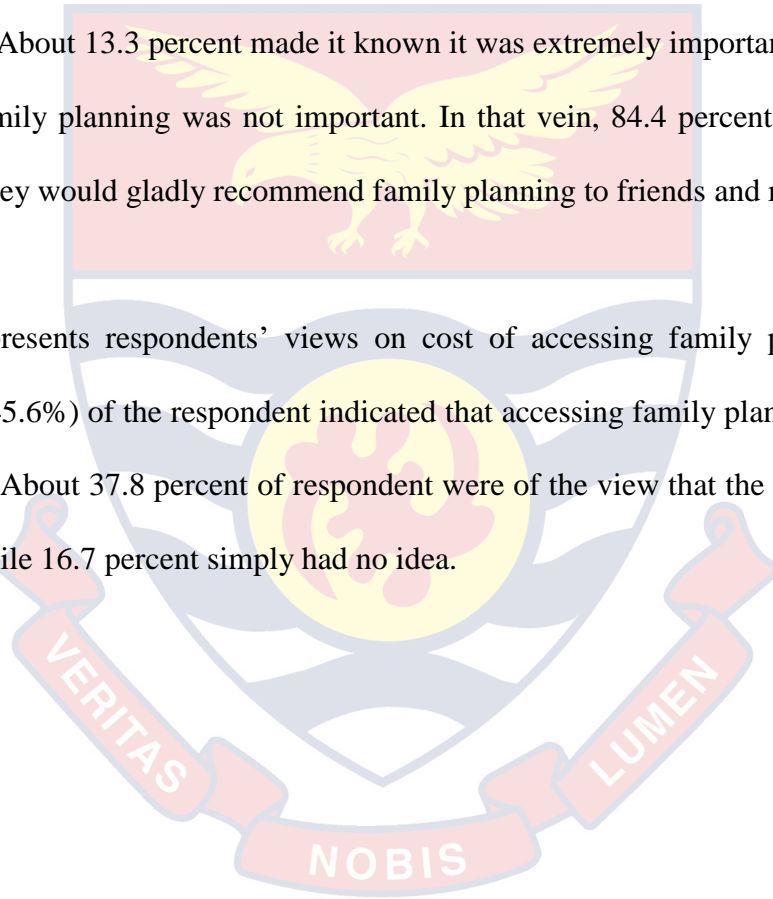


Table 6: Attitude about Usage of Contraceptives

Views and Opinions about contraceptive usage	Frequency (N=234)	Percent (%)
<i>How much do you know about family planning?</i>		
Know nothing	52	22.2
Know very little	96	41.1
Know sufficiently	86	36.7
Total	234	100
<i>How do your family /friends react towards a man who attends family planning with his wife /partner?</i>		
Strangely	52	22.2
Praise him	37	15.6
Indifferent	146	62.2
Total	234	100
<i>Do you discuss Contraceptive use or family planning methods with your friends?</i>		
Yes	140	60
No	94	40
Total	234	100
<i>Has any of the following people ever discussed family planning with you?</i>		
<u>Your spouse/partner</u>		
Yes	152	65
No	82	35
Total	234	100
<u>Health workers</u>		
Yes	96	41
No	138	59
Total	234	100
<u>Your friends</u>		
Yes	121	51.7
No	113	48.3
Total	234	100

Table 7: Attitude about Usage of Contraceptives (2)

<i>What was your reaction when they talked to you about family planning?</i>		
Normal	190	81.1
Shy	44	18.9
Total	234	100
<i>Do you know of any man who attends family planning with his wife /partner?</i>		
Yes	91	38.9
No	143	61.1
Total	234	100
<i>Have you ever attended family planning clinic?</i>		
Yes	49	21.1
No	185	78.9
Total	234	100
<i>If yes , how many times have you attended family planning clinic?</i>		
Once	31	13.3
Twice	42	17.8
Thrice	78	33.3
Four or more times	83	35.6
Total	234	100
<i>How close is the family planning facility to you?</i>		
A little distant	80	34.4
Far	104	44.4
Very far	49	21.1
Total	234	100
<i>How important is family planning to you?</i>		
Extremely important	31	13.3
Important	112	47.8
Very important	70	30
Not important	21	8.9
Total	234	100
<i>Would you recommend family planning to a friend /relative?</i>		
Yes	197	84.4
No	37	15.6
Total	234	100

Source: Field data (2019)

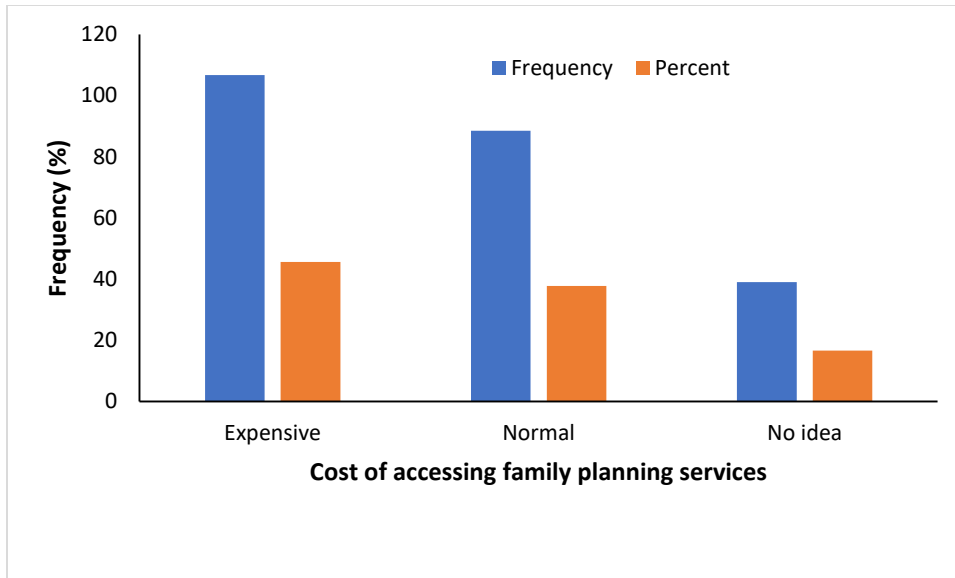


Figure 3: Cost of accessing family planning services

(Source: Field data, 2019)

Barriers that Inhibit the Use of Contraceptives or Adoption of Family Planning Methods

Acceptance and use of contraceptives have without doubt faced severe challenges in their adoption rate, especially in sub-Saharan Africa. An objective of this present section is to identify the key barriers that influence the use of contraceptives or adoption of family planning methods. Barriers, according to Thummalachetty *et al.* (2017) are practices or reasons that deny people from accessing family planning services despite their wish for it.

Figure 4 presents results on whether respondents or their spouses/partners have had problems with the usage of contraceptives. Most respondents (63.3%) were affirmative in their response. About 36.7 percent have not had any issues with the use of contraceptives. Information about side effects dictates contraceptive use (Sedgh & Hussain, 2014) although studies have shown that clients who received counselling on side effects were

more likely to use contraceptives (Sedgh & Hussain, 2014). This also supports the findings of the 2014 Ghana Demographic and Health Survey which stated fear of side effects as a reason for contraceptive non-use (Ghana Statistical Service, 2015). It has similarly been stated that the fear of side effects or experienced side effects is a barrier to contraceptive use (Campbell *et al.*, 2006). Figure 5 depicts the barriers that prevent men from getting involved in family planning. Many respondents (23.3%) mentioned peer pressure as the foremost factor inhibiting the involvement of men in family planning. Negative community perception was also paramount as it was mentioned by 22.2 percent of the respondents.

Lack of male family planning providers also followed suit (15.6%). Similarly, masculinity power (14.4%) was also important. Again, fewer choices of family planning methods for men is a big barrier as 12.2 percent indicated it was a hindrance to usage. A small percentage of 6.7 percent reported shyness as one of the major hindrances to the adoption of male family planning methods. Last but not the least, lack of knowledge about family planning methods also play a crucial role in preventing men from being involved in family planning.

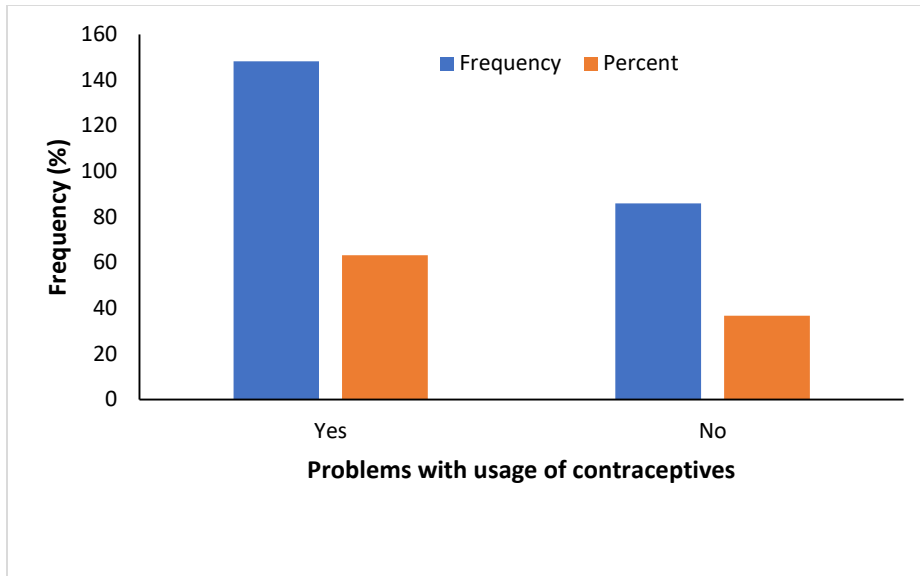


Figure 4: Respondents' or spouses problematic encounters with contraceptives

(Source: Field data, 2019)

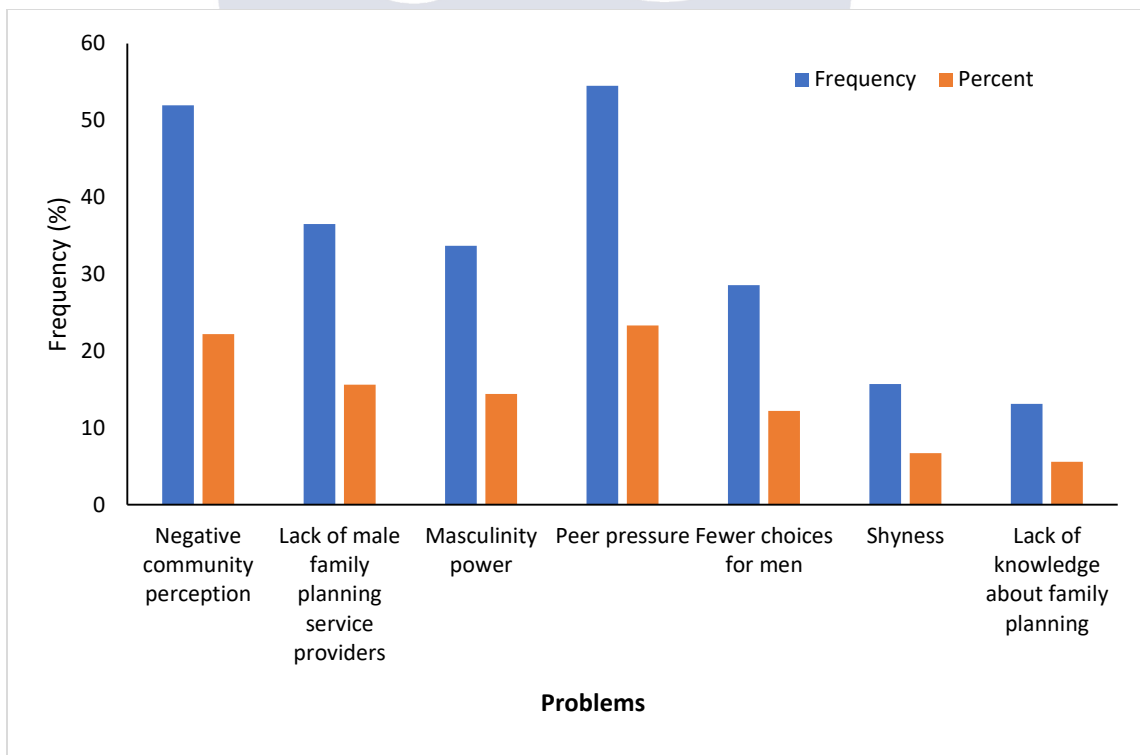


Figure 5: Main challenges preventing men from being involved in family planning

(Source: Field data, 2019)

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

Introduction

This chapter provides a summary of the major findings; and also provides conclusions and recommendations on the use of contraceptives by men.

Summary of Main Findings

The purpose of this study was to assess the knowledge, attitude and usage of contraceptives among men in Ejura Sekyedumase Municipality. The following findings have been made at the end of the study:

Most of the respondents were currently not using any family planning method. Responses indicated that most respondents believed contraceptives or family planning methods had negative side effects. The second most important reason was attributed to financial difficulties while religious restriction was mentioned by 10%. Opposition from partners was indicated by a number of respondents as reasons for not using contraceptives. Contraceptives was mostly used to prevent pregnancies. Healthcare providers were the most important source of information with regards to contraceptives or available family planning methods. Most respondents were aware of the use of condoms and vasectomy as family planning methods and had used a contraceptive less than a year ago. The pharmacy was the main source for contraceptive purchase and privacy was fairly satisfactory at these points.

With regards to how much respondents knew about family planning, majority indicated they knew little about family planning. Family/friends reacted indifferently towards a man who attends family planning with his spouse/partner. Most respondents discuss contraceptive use or family planning with their friends. It is not a common occurrence to see men attending family planning clinics with their spouses or partners as almost 80% of respondents have never attended family planning clinics before. Majority stated the family planning clinic was far from them. Majority of the respondent indicated that accessing family planning services were expensive.

Most respondents or their spouses/partners have had problems with the usage of contraceptives. Major pressing challenges inhibiting men from using contraceptives or adopting family planning methods include – in order of importance, peer pressure, negative community perception, lack of male family planning service providers, male chauvinism, fewer choices for men, shyness and lack of knowledge about family planning methods.

Conclusion

From the results of the study, it can be concluded that that most men were aware of condoms or vasectomy as the main contraceptives available to men. However, majority do not use any form of birth control. The pharmacy proved to be the main source for the purchase of contraceptives. Men's attitude towards contraceptives or family planning was mostly indifferent. Contraceptive usage was expensive. Peer pressure and negative community perception were the most barriers militating against the use of contraceptives or family planning methods.

Recommendations

Based on the findings of this study, it is important that different approaches be used to improve contraceptive use among men of reproductive age. The following recommendations are made:

Practice

- i. Fear of side effects was a major barrier identified in the study. Messages should be developed and circulated to men by the District Health Directorate to reduce the level of fear about contraceptive use.
- ii. There is the need for periodic surveys to identify some attitude of service providers which discourage men from accessing contraceptives. This would help address negative provider attitude and increase the use of contraceptives.

Policies

- i. Health care providers, friends and mass media are the major sources from which awareness on contraceptives is obtained, therefore, the Ghana Health Service (GHS) should have a policy on how to reach out to people with in-depth knowledge on the benefits of contraceptive use and barriers to contraceptive use through these groups.
- ii. There is the need to encourage the setting up of “men” clinics by the government in specific hospitals. This will encourage men to patronize family planning clinics.
- iii. In view of the above, men who are seen as the head of the family should be involved in family planning issues so far as population growth is concerned.

Research

- i. Further research on contraceptive use among men should be conducted extensively and should involve a larger sample size so as to make it possible to generalize findings to all men of reproductive age.



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APPENDIX
PRESBYTERIAN UNIVERSITY COLLEGE OF GHANA
KUMASI CAMPUS
FACULTY OF DEVELOPMENT STUDIES
ATTITUDE, KNOWLEDGE AND USAGE OF CONTRACEPTIVES AMONG
MEN IN THE EJURA SEKYEDUMASE

My name is Kwaku Ofori Agyepong, a student of the Presbyterian University College of Ghana. I am conducting a study on the above topic and we will be grateful if you could spare me a few minutes of your time to answer a few questions on the subject. While it serves as an MA dissertation, it will contribute to knowledge on attitude, knowledge and usage of contraceptives among men. Your contribution will be greatly appreciated though you are not under any obligation to participate. THIS IS PURELY AN ACADEMIC EXERCISE, HENCE ANY INFORMATION GIVEN WOULD BE TREATED STRICTLY AS CONFIDENTIAL.

INSTRUCTION: Please fill the spaces provided. Mark (√) where applicable and specify where necessary. Thank you

1. 1. Sex:

a. Male []

b. Female []

2. Age: a. 15 – 25 [] b. 26 – 35 years [] c. 36 – 45 years [] d. 46 – 55 years []
] d. 56 – 65 years e. 66 – 75 years []
3. Nationality : a. Ghanaian [] b. Non-Ghanaian []
4. Marital status: a. single [] b. married [] c. divorced [] d. separated [] e.
Widow/widower []
5. Number of Children: a. 1 – 4 [] b. 5 – 8 [] c. 9 – 12 [] d. 13 and above []
e. None []
6. What is your highest level of education? Please select the most appropriate.
a. JHS [] b. SHS [] c. HND [] d. Graduate Degree [] e. Post Graduate Degree []
] f. Other (Please Specify)
7. Expected income per month: a. GHC 500 and below [] b. GHC 501-1000 [] c.
GHC 1001 – 1500 [] d. GHC 1501-2000 [] e. GHC 2001 and above []
8. Occupation: a. Farming [] b. Petty Trading [] c. Government employee [] d. Dress
making [] e. Apprentice [] f. Business [] g. Other (Please Specify)
.....
9. Ethnic group:
10. Religion: a. Muslim [] b. Christian [] c. Traditionalist/Spiritualist [] d. No
religion []

11. If a Christian, which denomination? a. Catholic [] b. Pentecostal [] c. Protestant [] d. Spiritual []
12. Do you consider sex preference (male or female)
13. Would you continue giving birth if you have not obtained the desired number of male and female children?
14. How wide an interval would you prefer between two successive births? a. 1.5 years [] b. 2 years [] c. 2.5 years [] d. 3 years [] e. Above 3 years []
15. Are you currently using a family planning method? a. Yes [] b. No []
16. If *No* to question 15, why? a. To plan pregnancy [] b. Not sexually active [] c. Side effects [] d. Opposition from partner [] e. Financial problem [] f. Lack of knowledge [] g. Religious restrictions [] h. Lack of access [] i. Others (Specify).....
17. Which of the family planning methods mentioned below have either you or your partner used before? Tick as many as apply. a. Oral pill [] b. Emergency pill [] c. Condom [] d. IUD [] e. Implant [] f. Injectable [] g. Sterilization [] h. Calendar method [] i. Withdrawal []
18. Which of these family planning methods do you and your partner use most or have signed on to?
- a. Oral pill []
- b. Emergency Pill []
- c. Condom []
- d. IUD []
- e. Implant []

- f. Injectable []
- g. Sterilization (Vasectomy/tubal ligation) []
- h. Calendar Method []
- i. Withdrawal method []
19. What was the purpose of using the contraception or family planning method?
- a. Birth spacing [] b. Limiting birth [] c. prevent unwanted pregnancy [] d. prevent STDs [] e. Others (Kindly specify)
20. Sources of information about contraceptives: a. Peers [] b. Healthcare providers [] c. Mass Media [] d. Partners []
21. If (d), what were the partners sources of information? a. Partners experiences of side effects [] b. Knowledge from peers or hearsay [] c. Knowledge from health providers [] d. Knowledge from healthcare providers
22. What type of male contraceptives are you aware of? a. Condom [] b. Vasectomy [] c. Hormonal injections d. None
23. Do you know of any side effects related to the method you are using? a. Yes [] b. No []
24. When was the last time you used a contraceptive? a. Less than 24hrs [] b. Less than 1 week [] c. Less than a month [] d. Less than 6 months ago [] e. Less than a year ago [] f. Over a year ago []
25. For how long have you been using the current method,? a. Some few weeks [] b. One month [] c. One year
26. Where do you obtain your preferred contraceptive from? a. Pharmacy/drug store [] b. Provision stores [] c. Fuel station shops [] d. Health centres []

27. How would you rate the way your privacy was respected by the provider during your visit? a. Very satisfactory [] b. Satisfactory [] c. Fairly satisfactory [] d. Not satisfactory []

28. How would you describe the attitude of the provider? a. Friendly [] b. Disrespectful [] c. Hostile [] d. indifference []

29. Do you discuss contraceptive use or family planning methods with your friends? a. Yes [] b. No []

30. Have you heard of any problems associated with the use of any contraceptive method? a. Yes [] b. No []

31. Has your spouse or partner had problems with any of the methods you or she has been using? a. Yes [] b. No []

32. If Yes to question 31, kindly state
.....
.....
.....

33. What are some of the factors that prevent you and your spouse or partners from accessing family planning services?.....
.....
.....
.....

34. Do you believe that family planning is an issue that should concern only women?

35. How much do you know about family planning? a. Know nothing [] b. Know very little [] c. Know sufficiently [] d. Know a lot []
36. How do your family/friends react towards a man who attends family planning with his wife/partner? a. Strangely [] b. Praise him [] c. Indifferent []
37. How would members of this community describe a man who is seen to be involved in family planning services?
-
-
-
38. Are men who are involved in family planning activities stigmatised in this community?
39. How would you describe the cost of accessing family planning services? a. Expensive [] b. Normal [] c. Cheap [] d. No idea []
40. Typically, how long do you/your wife spend at the family planning clinic? a. Less than 1 hour [] b. 1 – 2 hours [] c. 2 – 3 hours [] d. 3 – 5 hours [] e. More than 5 hours []
41. Has any of the following people ever discussed family planning with you?
- i. Your spouse/partner a. Yes [] b. No []
- ii. Health worker a. Yes [] b. No []
- iii. Your friend a. Yes [] b. No []
42. What was your reaction when they talked to you about family planning? a. Normal [] b. Shy [] c. Embarrassed []
43. Do you know of any man who attends family planning with the wife/partner? a. Yes [] b. No []

44. How close is the family planning facility to you? a. Very close [] b. A little distant [] c. Far [] d. Very far []
45. Does the family clinic in this community have special arrangements for providing services to men? a. Yes [] b. No []
46. Have you ever attended family planning clinic? a. Yes [] b. No []
47. If yes to question 47, how many times have you attended family planning clinic? a. Once [] b. Twice [] c. Thrice [] d. Four or more times []
48. How important is family planning to you? a. Extremely important [] b. Important [] c. Very important [] d. Not important []
49. Would you recommend family planning to a friend/relative? a. Yes [] b. No []
50. Are there any challenges accessing family planning services? a. Yes [] b. No []
51. If Yes to question 51, please state these challenges
-
-
-
52. Which of the following would you assume to be the main challenges preventing men from being involved in family planning? Please tick all that apply.
- a. Negative community perception []
 - b. Lack of male family planning service providers []
 - c. Stigmatization []
 - d. Masculinity power []
 - e. Wives are unsupportive []
 - f. Peer Pressure []

- g. Fewer choices for men []
 - h. Lack of knowledge []
 - i. Shyness []
 - j. Lack of knowledge about family planning []
53. Of the problems listed above, which do you think is the most common?
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