Male Perspectives of Family Planning: Evidence from La Dade Kotopon in Ghana

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Theory Article

Received date: August 14, 2020
Accepted date: August 28, 2020
Published date: September 4, 2020

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Keywords: Family Planning, Contraception, Diffusion of Innovations, Reproductive Health, Health Communications.

ABSTRACT

Achieving the Sustainable Development Goal (SDG) target of universal access to reproductive health will be difficult without the full involvement and participation of men. Family planning has a major role to play in reducing poverty, maintaining quality health and improving the livelihoods of nuclear families. Men are the traditional heads of households in Ghanaian communities, as such they have the power to influence their spouse's use family planning and what methods they chose. As such, this study sought to understand male perspectives on family planning in the La-Dade Kotopon Municipality in Ghana. A cross sectional descriptive study design was used amongst men who were chosen using the simple random method in the study area. The data was analyzed into inferential and descriptive statistics which helped to determine the perspectives of men in the La Dade Kotopon Municipality about family planning. One of the major findings of this study is that, about 60% of respondents do not think family planning is good thing which must be encouraged, the most preferred method of family planning amongst men in the study area is the withdrawal method. The study concludes that there must be a targeted, rigorous, aggressive education and dissemination of information on family planning, because the adoption of such healthy reproductive lifestyle benefits not just the individual, but the nation at large.

INTRODUCTION

The global hike in population has attracted a lot of attention because of its negative effects on the Socio-Economic Development of Nations (World Health Organization, 2019). In developing countries, governments, NGOs, and international organizations have paid critical attention in recent decades to the importance of family planning as a mechanism for improving people's wellbeing and enhancing not only the economic prosperity of families and individuals, but that of the nation. Senegal has recently moved the expansion of family planning to a higher priority status. This is on the grounds that it can improve the health and wellbeing of people, improve the national economy, and help Senegal develop further as a nation (MoH and Social Action 2012).

On the African continent, the rapid population growth has led to poverty, diseases and a degradation in public health and sanitation.

In most countries like Nigeria, Egypt and Ghana, the pattern is the same. The youth are pushed off the land because of degradation and poverty to migrate to big cities like Cairo, Lagos and Accra. where they find themselves in a trap because they can neither cope with life in the city nor go back to the village (Abiodun and Baloqun, 20009). In Ghana, reproductive health has widely been focused on providing access and choice in family planning, caring for women before, during, and after pregnancy, preventing and controlling sexually transmitted infections, including Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), preventing and treating cervical cancer breast cancer, promoting the health of adolescents, promoting positive communication between sexual partners, promoting special services (counseling, care, and education) to women that decrease the disparity of services between genders and supporting positive reproductive health related practices (WHO, 2011). This plan of action has helped Ghanaians understand that family planning is an integral part of health which must be given attention.

In Ghana, the rapid population growth from 1912-1960 led to a decline in the standard of living. There was extreme poverty, which resulted in what, is called "the vicious cycle of poverty". Consequently, in March 1969, the government published a document on Ghana's population policy under the title "Population Planning for National Progress and Prosperity". This was the forerunner to the Ghana National Family Planning Program that was officially launched in May 1970 (WHO, 2007).

In developing countries, one in three women will have a baby before the age of 20, evidently, pregnancy related deaths

during childbirth is two times higher in women under 20 years compared to women over 20 years (UNPF, 2004). A quarter of the estimated 20 million abortions which happen annually happens amongst women aged between fourteen and nineteen (UNPF, 2004). In Sub Saharan Africa, it is estimated that 14 million unintended pregnancies occur every year, with almost half occurring among women aged between fifteen and twenty-four (Hubacher et. Al, 2004). It is evident that the effective use of family planning methods will potentially prevent about 90% of unsafe abortions, 20% pregnancy related morbidity and a third (32%) of maternal deaths worldwide (Cleland et al, 2006).

In Ghana, family planning is mostly considered a female practice which excludes males because women are those who are biologically supposed to carry and bare children even though they are not the only producers of children, also, most contraceptives are basically designed for women. Contraceptives like, the diaphragm, the pill, injectable and IUD are all restricted to women whereas only a few like the sheath (condom) and vasectomy have been designed for mem.

In most traditional societies' females need the consent and approval of their male partners before choosing and/or using family planning. The consent of the male before family planning is important because it takes both the male and female to decide not only the number of children to have, but also the prescribed or appropriate contraception (Nalwadda et al, 2010).

In many African traditional societies like Ghana, pregnancy before marriage is often viewed as an abomination. As such, many unmarried females who get unintended pregnancies seek illegal abortion services for fear of societal judgement. Abortions in Ghana being illegal increases the risk of maternal deaths because it usually unsafe and mostly conducted by untrained/ unqualified personnel.

Findings from two major studies conducted amongst university students indicated that more than half of male students did not have access to sexual and reproductive health services and HIV/AIDS related programs despite their engagement in high risk sexual behaviors (Mayega, 2010). Findings from another survey also asserted that a quarter (25%) of male university students were sexually active and engaged in sexual high-risk sexual activity, yet their level of awareness about contraceptives was low (Rutherford et al, 2014).

Knowledge on the attitudes of males towards family planning and contraceptive use may inherently lead to better planning and execution of family planning and reproductive health campaigns, since males are heads of households and mostly play a key role in the health and reproductive decisions of their spouses. The results from this study will inform and enhance the design of family focused reproductive health campaigns which will in turn reduce illegal, unsafe abortions and unintended pregnancies, and their consequent adverse outcomes in Ghanaian communities.

The Research Problem

Research and public health interventions on the adoption and use of contraceptives and family planning have often focused on women and girls; however, it is important to consider men's attitudes and behaviors (UNFPA, 2016). More specifically, it is crucial to understand men and what they think when it comes to contraceptive use, this is because they have the power to influence their spouse's usage and adoption of family planning and contraceptive methods. In order to understand and improve the sexual and reproductive health of men, there is the need to study the reasons that lead to their choices in contraceptive and family planning use. Based on research gaps, this study explores men's perspectives on family planning and contraceptive use.

Therefore, the problem for this study is rested upon the presumption of the critical role of shared responsibility for family planning and contraceptive use amongst men and women and the need to target men adequately in family planning and contraceptive use campaigns.

Methodology

A cross sectional descriptive study design was used to document and present the attitudes of males towards family planning in the La Dade Kotopon Municipality in Ghana. The study population consisted of males in the La Dade Kotopon Municipality. For ethical and data validity reasons, the researcher decided not to include any participants who are below the age of 18. The researcher chose to use the simple random sampling method to choose respondents for the study. The reason was because, the simple random method offers all members of the population and equal chance of being included in the study, hence the results can be confidently generalized to fit the entire population (Neuman, 2012).

The sample for the study is calculated as

n= (Nz^2 pq)/ [E^2 (N-1) +z^2 pq] (Cochran, 1977)

Where n is the sample size

N is the population of men in the La Dade Kotopon Municipal which is 86,808

P is the expected proportion and is assumed to be 0.5 q=1-p=0.5

Z is 1.96

And E is the margin of error. It is equal to 0.05

The sample to be used is 383.

The study only made use of primary data as no secondary data was used, this means all data used in the analysis were collected by the researcher and his team. For the purpose of achieving the objective of this paper, the research employed the administration of survey questionnaires to gather primary data for analysis. Personal questionnaires were distributed to randomly sampled respondents in the study area, this afforded the respondents the opportunity to complete the questionnaires with minimal assistance from the researcher. By doing this, the researcher's influence is kept at a minimum to avoid bias during the completion of the questionnaire. For the purpose of this study, a closed-option questionnaire was personally distributed to selected respondents.

A total of three hundred and eighty-three questionnaires were sent out and all of them were completed and returned to the researcher for coding and analysis. The questionnaire approach was chosen based on what the study needs to achieve. The results assisted in finding out the attitudes of males in the La Dade Kotopon Municipality towards family planning. The employment of the survey questionnaires was a good way of collection data quickly and also a way of reducing the cost in data collection, as compared to other methods (Neuman, 2012).

Various descriptive statistical techniques were used to analyze data. These include simple percentages, charts and averages. Frequency distribution of respondent's opinions on the various issued are provided and discussed, and they fully offer an idea of the attitudes of males in the La Dade Kotopon Municipal towards family Planning

The Study Area

La Dade Kotopon Municipality

The population of La-Dade Kotopon Municipality, according to the 2010 Population and Housing Census, is 183,528 with females constituting 96,719 which make up 52.7% while the total of males is 86,808 which formed 47.3%. The Municipality is entirely urban (100%) and has a sex ratio of 90 which is lower than that of the region (93.6). It also has a youthful population (children under 15 years) (44.3%) depicting a broad base population pyramid which tapers off with a small number of elderly persons (60+ years) constituting 5.8 percent. The total age dependency ratio for the Municipality is 50.1 percent, the child dependency ratio is higher (44.3%) than that of old age dependency ratio (5.8) (GSS, 2014).

Of the employed population, only 1.5 percent are engaged as skilled agricultural, forestry and fishery workers, 34.8 percent in service and sales, 18.8 percent in craft and related trade, and 19.0 percent are engaged as managers, professionals, and technicians (GSS, 2014).

The population and demographic dynamics of the municipality make it ideal for the study. The municipality is one of the most densely populated municipalities within the Greater Accra Region, which by the official figures of the Ghana Aids Commission recorded the highest number of new HIV infections in 2018, with about 4,593 people contracting the disease (GAC, 2018). Currently, the greater Accra Region leads with the greatest number of persons living with HIV; 77,132, and out of this figure, about 28,000 people are on anti-retroviral therapy (ART), which is one of the services offered by the La General Hospital, the biggest health facility serving the municipality and other adjoining communities. The 2018 national estimates released by the Ghana Aids Commission, shows that 2.06% of the adult population are at risk of contracting the HIV virus (GAC, 2018).

Also about 10,000 teenage pregnancies were recorded in the Greater Accra Region in 2015 this is one of the highest ever recorded in the country, and shows evidence that people within the region may be involved in risky sexual behaviors, as such the municipalities within the region present an appropriate site to conduct a study like this (GSS, 2015).

Literature Review

Family Planning and Diffusion of Innovations

The Diffusion of Innovations Theory was propounded by Everett Rogers a professor of Rural Sociology in his 1962 book "Diffusion of Innovations". In his book he asserted that diffusion is the process by which an innovation or a new idea is communicated through certain channels overtime to target members of a particular social system. The theory of diffusion of innovations originated in the social science discipline of social communications, it explains how, overtime an idea or a product gains momentum and spreads through a specific population of social system. The end result of this diffusion is that, people, as part of a specific social system, adopt and start using a new behavior, idea or product (Rogers, 1962). Adoption means the people in the social system do something differently from what they were doing previously. The key adopting a new a behavior or product is that the person or user must perceive this new idea, or product as innovative, which means they must see an added advantage which they didn't have earlier. A typical example of diffusion of innovations in family planning is given when Moses et al (2002) recorded a higher use of condoms amongst men in Kenya because the men understood using a condom during sex will prevent the contraction and spread of HIV and other STDs and also stop unwanted pregnancies.

According to Murphy (2004) adoption of a new idea, behavior or innovation does not happen simultaneously in a social system. Instead, there is a process where certain groups of society may accept and adopt the innovation faster than others. Research has shown that the people who adopt an innovation early, usually have different characteristics from those who adopt the innovation later. When promoting a innovation to a particular population, it is important to study and understand the characteristics of the population which will help or hinder the adoption of the innovation (Murphy, 2004)

In Ghana, there has been a national drive to include family planning in the health delivery system. The government through its agencies and Non-Governmental Organizations (NGOs) have designed and used several methods in diffusing and getting people to accept family planning. In some social setting s such as rural areas, the government has adopted the use of Mobile Community Health Nurses and free-standing family planning clinics. In recent times, the Ghana Health Service (GHS), has integrated family planning into Maternal and Child Health Services (Adamchak, Bair, Barry and Olson, 1995). These organized steps of diffusing family planning amongst Ghanaian adults involved a massive number of capacity building workshops to train doctors and other health workers to offer modern family planning methods and to counsel clients in their use. Both interpersonal approaches and the mass media have been used to publicize the existence of family planning services, reassure potential clients of their harmlessness, and to encourage local women- and very rarely, men – to utilize them (Kabore, Tabsoba and Myers, 2003).

While newspapers, magazines and television reached the elite opinion leaders with messages about the negative effects of rapid population growth, radio documentaries and advertisements, posters and billboards reached millions of poor and often illiterate or low literate audiences. Documentaries and drama with family planning themes were broadcast on television during prime time and as television coverage grew, it reached most of the population, helping to educate people and change norms. In the rural areas and poor city neighborhoods, trained promoters gave group talks, showed films and used folk entertainment to get across their messages on the desirability of family planning (Rogers, Vaughan, Swalehe et al, 1999; Yoder, Hornik and Chirwa, 1996).

Reproduction involves both men and women, and although the range of family planning methods include methods for men, namely, condoms, vasectomy and withdrawal, and the Standard Days Method which requires the participation of men, the diffusion strategy and communications surrounding family planning programming has primarily focused on women. PPAG Ghana's 2025 goal is to reach an additional 5 million women and girls in Ghana with family planning. Attention to gender at the 1994 International Conference on Population and Development (ICPD) in Cairo resulted in a renewed call to involve men more actively in reproductive health (Ringheim, 1999; Boender et al, 2004). In order for family planning programs to succeed, there is the need to recognize men as partners, to support the autonomous decisions of women, with equal regard for the reproductive and health needs of men (Wentzell and Inhorn, 2014). Nowadays, the efforts at expanding the vision for constructive male engagement in family planning and reproductive health are evolving from encouraging men to be supportive partners of women's reproductive health decisions to also being change agents within their families and communities and also meeting their own reproductive health needs, by adopting and practicing family planning methods which are targeted at men (IGWC, 2009).

Moreover, the use of any method of family planning by women is usually influenced by their husbands (Okwor and Olaseha, 2010). Men have rarely been involved in either receiving or giving information on birth spacing, sexuality or reproductive health. Men have almost always been excluded from family planning and reproductive health communications and innovations, because family planning is viewed as a women's affair (Wambui, Ek and Alehagen, 2009). In Ghana, men are the traditional heads of households, and decision makers in all issues in their respective households. Men therefore decide on family planning and the number of children their wives can have. In developing countries, men are considered the sole providers of the needs of their families.

Most women are not considered decision makers but implementers of what has been decided by men hence, it is important for men to be targeted in the communications that surround the diffusion of family planning (Wambui, EK and Alehagen, 2009). Studies in Nigeria, have established a high level of awareness about family planning but very low use of male targeted family planning methods has been recorded (Obisesan, Adeyemo and Fakokunde, 1998). There are several obstacles to the use of contraceptives in Ghana. Studies in Sub Saharan Africa have shown that major obstacles that hamper the diffusion of family planning include myths and misinformation or rumors and unconfirmed information passed within social connection (Ankomah, Oladosu and Anyanti, 2011), Other reasons for this lack of interest in family planning are fear of complications, lack of understanding of methods and fear and opposition from husbands (Diamond-Smith, Campbell and Madan, 2012). A fear of the side effects of family planning amongst the males in India, Nepal and Nigeria was identified by Hartmann et. al (2012).

According to Rogers (2003), diffusion of health innovations occurs through knowledge acquisition, persuasion, implementation and confirmation. If an innovation is adopted, it spreads through various communication channels. During communication, the idea is rarely evaluated from a scientific standpoint; but rather, subjective perceptions of the innovation influences its diffusion and acceptance overtime.

Finally, with particular reference to family planning, social systems determine diffusion and these are mostly influenced by the role of opinion leaders, change agents, types of innovation decisions and the consequences of the innovation. To use Rogers

model in health innovation requires us to assume that the innovations in family planning are equivalent to scientific research findings in the context of practice (Rogers, 2003).

Male Involvement in Family Planning

Reproductive and family planning campaigns in Ghana have traditionally ignored men and focused on women through Maternal and Child Health Services. The most visible indicator of the lack of male involvement in family planning in Ghana is the low use of male methods of contraception, e.g. condom, vasectomy, withdrawal and periodic abstinence (GSS; MOH and CDCP, 2015). A common assumption regarding traditional societies is that men have little to do and say about family planning. This assumption is perhaps the one most strongly held about men in Africa, where patriarchy has a long history and families have traditionally been very large (Mbrugu and Adams, 2004).

Men in most communities are socialized in exercising overall authority on family matters, including the reproductive health of their spouses. Traditionally men, exercise preponderant power in all issues, yet current population and reproductive health campaigns make little provision for male involvement. One of the reasons for this is the limitation in the number of male methods of fertility regulation, and the fact that most reproductive health services are provided in settings which are predominantly women oriented.

Historically, the predominant methods of preventing unwanted pregnancies in most parts of the world were methods used by or requiring the co-operation of men. The oldest of these, coitus interruptus or withdrawal, was known to at least three ancient religious traditions, and historical demography reveals that it was the principal method responsible for the demographic transition of Europe in the last century. In the 1990s, it was still used by an estimated 35 million couples worldwide, and is the most widely used method in Turkey, a country that has reasonable access to modern methods (Ringheim, 2000).

The condom or sheath dates back to roman times when the bladder of certain animals was used to stop the spread of sexually transmitted diseases. In family planning, the condom, the major non-permanent male method, was promoted and used as a barrier method. Currently, the condom is the most effective barrier method because it can be used for disease prevention in conjunction with other methods or alone, for the dual purpose of protection from disease and unwanted pregnancies (Bauni and Jarabi, 2003).

The condom as a contraceptive, usually has a higher failure rate than the pill, and would be more likely to be discontinued for the following reasons: a desire to switch to a more effective family planning method; the male's refusal to use and inconvenience. In countries with generalized HIV pandemics, there is the need to enormously increase condom use. Condom use within marriage is rare, and those who try the method abandon it within a period of twelve months (Ali et. al, 2006).

In Sub Saharan Africa, the prevalence of HIV is increasing. Therefore, promoting condom use for sexually active young men is one of the most effective ways of curtailing the spread of HIV and AIDS. The correct and consistent use of condoms can help prevent both HIV and unwanted pregnancies, both of which are risk factors for sexually active young people (Bankole et. al, 2008).

Despite great improvements in its clinical technique, vasectomy- a simple, safe and cost-effective method of fertility regulation for men- has lagged behind the prevalence rates of female sterilization in the world (Bunce et. al, 2007).

Over the past decade, the Demographic and Health Survey conducted in 21 confirmed that one of the family planning methods that is the least known, understood and used is vasectomy (Jacobstein and Pile, 2007). According to Jacobstein and Pile, (2007) with the exception of Ghana, Kenya, Malawi, and Uganda, majority of men in Sub Saharan Africa had not heard of Vasectomy. According to the writers, the use of vasectomy varies significantly by country and region, almost three quarters of the 37 million couples who use vasectomy live in Asia, with china and India alone accounting for more than two thirds of this total (Jacobstein and Pile 2007). Vasectomy use in Latin America has increased four-fold in the past ten years. While prevalence remains less than 1% in most parts of the region, vasectomy rates in almost all of Africa stands at 0.1% or less, despite the fact that vasectomy services are provided in post clinics which offer Maternal and Child Care Services (Jacobstein and Pile, 2007).

Men and the Prevention of Sexually Transmitted Diseases

Unprotected sex, leads to the risk of either an STD infection or an unwanted pregnancy. Estimates by the World Health Organization (WHO), presume that more than 340 million new cases of syphilis, gonorrhea, chlamydia and trichomoniasis occur in men and women aged between 15 and 49 annually. On the average, STI rates continue to rise in developing countries (WHO, 2011). Many STIs have long term consequences, in 2017 WHO reported that 25% of pregnancies result still birth and neonatal deaths because of early, untreated syphilis in pregnant women. According to WHO the overall perinatal mortality of syphilis in women is around 40% (WHO, 2007).

STDs have been one of the major causes of reproductive morbidity in Sub Saharan Africa, and their high prevalence facilitates HIV transmission (Sri Devi and Swarnalatha, 2007). STDs are usually contracted among core groups sch as female sex workers, characterized by a high number of partners, high risk sexual behaviors and poor health care seeking behavior (Thomas and

Tucker, 1996). With the exception of HIV, most STIs and other reproductive tract infections account for a significant proportion of outpatient hospital visits among adults of reproductive age. In most nations, it is ranked amongst the top reason individuals visit the hospital (Dallabetta et. al, 2006).

Moses et. al. (2002), write that, men are often likely to have more than one sexual partner, these partners may be commercial or noncommercial. The most important predictor of STD risk for men is the reported number of sexual partners. The most significant predictor of STD amongst men are: purchase of sex and being unmarried or being married but not living with their spouse (Moses et. al, 2002). In Ghana the prevalence of HIV among adults aged 15-49 as at July 2018 was estimated at 1.6% (GAC, 2019). The Ahafo Region has the highest prevalence of 2.66% and the North East Region recorded the lowest prevalence of 0.39%. The Greater Accra region has the highest estimated number of people with new HIV infections at 4,593 (GAC, 2019). Data from the Ghana Aids Commission an indicates that there is an estimated 334,713 people living with HIV in Ghana, out of that figure, 117,199 which represents 35% are male, and 217,514, which represents 65% are females. Adults 15 years and above were 305,199, representing 91%. The estimated number of new infections in 2018 was 19,931 (GAC, 2019).

The World Health Organization also estimates 100,000 new cases of HIV infections could be prevented if data on prevention and treatment intervention involving sex workers were to be used in peer education and prevention campaigns (WHO, 2014).

In Ghana, there have been few STD prevention campaigns which have targeted adult heterosexual men as a distinct client group. Unlike women who are able to take advantage of fertility clinics and Maternal and Child Health Services, most STD/HIV prevention initiatives which target men have been those which have been broadcast through TV and radio (Jackson et. al, 1997).

A 2004 study by Wilson highlighted a prevention program targeted at fishermen in Kenya, but the report contains little information about the impact of the program (Wilson, 2004). Laukamm-Josten et. al. (200) analyzed a peer education project which had Tanzanian truck drivers as the main target. An 18-month intensive phase of peer education about condom use followed by a 24-month maintenance phase showed a trend which indicated that condom use had increased from 56% to 76% amongst men (Laukamm-Josten et. al. 200). A study by Leonard et. al (2000) asserted that on HIV and STD prevention and condom promotion peer education program amongst Senegalese men found significant increase in men's HIV and STD related knowledge and use of condoms.

The study by Jackson et. al. (1997) found a significant increase in condom use amongst men, a decrease in the percentage of men who had been in involved in extramarital affairs before the study as well as a decline in the number of men who had had sex with sex workers, following their cognitive behavioral intervention.

RESULTS AND DISCUSSION

Demographic Characteristics

In order for the researcher to make adequate and substantial inferences from collected field data, it was important to collect demographic characteristics such as age, highest level of formal education completed and source of employment. This data helps the researcher to understand and use the social economic status of respondents in the discussions in this section.

Table 1: Age of Respondents

Age Group	18-27	28-37	38-47	48-57	Above 57
Frequency	133	114	56	58	22
Percentage %	34	29	15	16	6

Table 1, shows the frequency and percentage table for the age of the respondents as mention earlier, the researcher decided to not include any participant below the age of 18 because of ethical and data validity reasons. There are five age groups with "18-27" being the lowest, the highest age grouping was "Above 57". Age group "18-27" had the highest frequency with one hundred and thirty-three respondents, representing 34%. Age group "28-37" came next with a frequency of one hundred and four-teen respondents making up 29%. Age group 38-47 came next with 15% which represented a frequency of fifty-six. Age group 48-57 had a frequency of fifty-eight which represented 16%. Respondents who said they are above 57 years, had the lowest frequency with a representation of twenty-two, which made up 6%.

Table 2, displays the frequency of the highest completed educational level of the respondents. The lowest represented option was those who said they had never been to school, which had a frequency of six and a percentage of 1.5. respondents who had completed post graduate training came in next with a frequency of 20, which made up 5.3%. People who had completed Basic/Middle were 22%, and had a frequency of 84. 117 respondents which make up 30.5% said they had completed secondary or vocational education. Polytechnic, University, Nursing and people who have had some sort of tertiary education, topped the list with a frequency of 156, which makes up 40.7%.

Table 2: Highest Level of Education

Level of Education	Frequency	Percentage %
Never Been to School	6	1.5
Basic School/ Middle School	84	22
Secondary/ Vocational Sch	117	30.5
Tertiary/University/Poly	156	40.7
Post Graduate	20	5.3

Table 3: Employment of Respondents

Employment Group	Frequency	Percentage
Unemployed	48	12.5
Self Employed (Agriculture)	56	14.7
Self Employed (Non-Agriculture)	175	45.6
Employed (Corporate or Civil Service)	94	24.6
Unemployed/Inactive	10	2.6

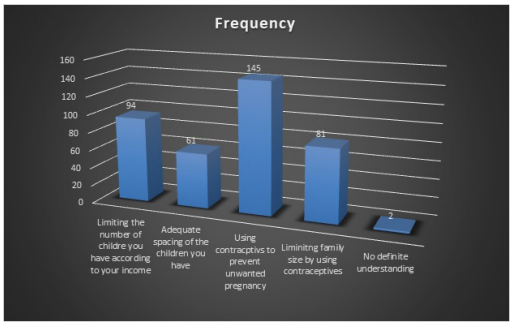
The employment status of the study participants is shown above in table 3. Ten of the study participants, a percentage of 2.6 said they were retired or inactive. Unemployed members of the respondents had a frequency of forty-eight and made up 12.5%. fifty-six respondents about 14.7% said they are self employed in agriculture related activities. Respondents who work in the corporate or civil service were ninety-four, making 24.6%. respondents who are self employed in non-agriculture related activities were one hundred and seventy-five, which formed a total of 45.6%.

Knowledge of Family Planning

According to Rogers (2003), the diffusion and spread of an idea, product or innovation is usually influenced by the thoughts and idealization of the perceived beneficiaries about the product or idea. Most of the time, these ideas and thoughts, serve as the premise for making opinions about the idea or product and how and when they eventually adopt it. In this regard, the survey examined the thoughts and opinions of the respondents on family planning.

As displayed in Figure 1, two respondents who represent 0.5% said they had no definite understanding of family planning. Sixty-one respondents making up 15.9% said they understand family planning to be adequate spacing of the children you have, eighty-one respondents which is equal to 21.1% said their understanding of family planning is limiting the size of your family by using contraceptives. A total of ninety-four (24.5%) respondents said family means limiting the number of children you have according to your income, whiles one hundred and forty-five respondents who make up 38% said their idea about family planning is using contraceptives to prevent unwanted pregnancies

Figure 1: Understanding and Idealization of Respondents on Family Planning



The researcher sought to find out the personal sentiments the respondents have about family planning, as this will allow for proper conclusion and recommendations to be made about men and family planning in the La Dade Kotopon Municipal. Twenty-two respondents (5.8%) said they feel it is a thing for the rich people in society. Thirty people (7.9%) said family planning is a threat to tradition and must not be encouraged. Forty-three respondents (11.3%) said they saw family planning as a thing targeted at the poor in society. Also, sixty-eight respondents who make up 17.8% said family planning is a source of rebellion in women or wives, whilst seventy-two people (18.7%) of respondents said family planning is the source of promiscuity in society. Lastly, one hundred and forty-eight people who form a total of 38.6% respondents said they saw family planning as a good thing which must be encouraged because its puts people in charge of the lives. The distribution is shown in Figure 2.

Figure 2: Personal Sentiments About Family Planning

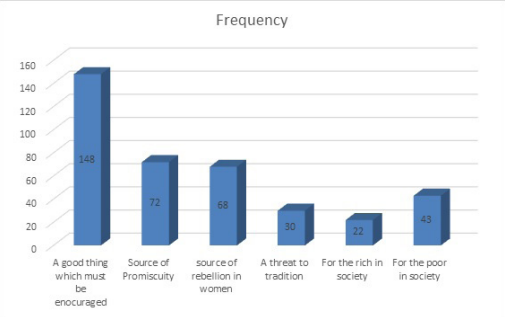


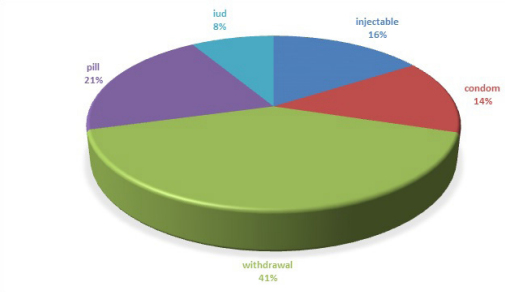
Table 4 presents a bivariate chi square analysis between age groups and the personal sentiments of respondents towards family planning. The test shows a strong relationship between age and sentiments towards family planning. The test scored highest between age group "18-27" and those who said family planning was a good thing and must be encouraged. The test had 12 degrees of freedom (Pearson Chi2{12}) and a probability ratio of (Pr = 0.000), this confirms that there exists a significant statistical relationship between the two variables and the possibility that someone who is within the age group of "18-27" thinks family planning is a good thing and must be encouraged is not due to chance.

Table 4: Bivariate Analysis of Age Groups and Personal Sentiment About Family Planning

Personal Sentiment	**18-27 Yrs**	**28-37 Yrs**	**38-47 Yrs**	**48-57 Yrs**	**Above 57 Yrs**	**Total**
A good thing which must be Encouraged	74	58	11	4	1	**148**
Source of Promiscuity	10	10	17	23	12	**72**
Source of Rebellion in women/wives	19	30	7	9	3	**68**
Threat to tradition	3	4	10	9	4	**30**
For the rich in society	7	4	6	4	1	**22**
For the poor in Society	20	8	5	9	1	**43**
Total	**133**	**114**	**56**	**58**	**22**	**383**

Pearson chi2(12) = 330.6463 Pr = 0.000

Figure 3: Respondents Preferred Practice of Family Planning



On preferred method of family planning, the data from the survey indicates that one hundred and fifty-seven respondents representing 41%, chose the withdrawal method as their preferred family planning method. 21% of respondents, who are seventy-nine indicated the pill to be their family planning method of choice. The injectable was chosen by sixty-one respondents who make up 16% of the sample. On the other hand, fifty-three (14%) respondents chose the condom as their preferred family planning method whiles the Inter Uterine Device (IUD) was chosen by thirty-three (8%) respondents as their family planning method.

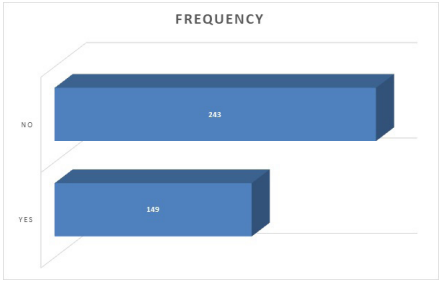
Table 5, shows a bi variate chi square comparison between the variables, "age group" and "preferred method of family planning". The analysis shows a strong statistical relationship between "age group" and "preferred family planning method", the test had 12 degrees of freedom (Pearson Chi2{12}) and a probability ratio of (Pr = 0.000). This confirms that there exists a significant statistical relationship between the two variables. One of the highlights of the test is that, no on in the age group "above 50", chose the injectable as their preferred method of family planning, also no one in the age group "48-57" chose the Inter Uterine Device (IUD) as their preferred method of family planning. According to the results of this chi square test, the possibility that a respondent within an age group, prefers a particular method of family planning is not based on chance.

Table 5: Bivariate Analysis of Age Group and Preferred Method of Family Planning

Preferred method of Family planning	**18-27 Yrs**	**28-37 Yrs**	**38-47 Yrs**	**48-57 Yrs**	**Above 57**	**Total**
Injectable	30	15	8	8	0	**61**
Condoms	15	11	11	10	6	**53**
Withdrawal	30	71	21	29	6	**157**
Pill	43	10	8	11	7	**79**
IUD	15	7	8	0	3	**33**
Total	**133**	**114**	**56**	**58**	**22**	**383**

Most methods of family planning target women, as such the researcher wanted to know if the men sampled for this study would use new family planning methods which target men if there are any. Out of the three hundred and eighty-three respondents, two hundred and thirty-four (61%) responded no, but one hundred and forty-nine (39%) responded in the affirmative that they will willingly try new family planning methods which target men if there are any. The distribution is presented in figure 4.

Figure 4: Willingness to Try a New Male Family Planning Method



Discussion

In Africa, the penetration of family planning and contraception services has been slow, mainly because of political, social, moral and cultural obstacles (Richey, 2008). These obstacles are embedded in a complex web of socio-cultural belief systems, values and practices (DeGraft, 2005). The demand for family planning in Africa is driven by a wish to postpone and space births rather than a desire to control population or family size (Caldwell and Caldwell, 2002). Findings from this study, support this assertion by Caldwell and Caldwell, (2002), because 38% of respondents believe the purpose of family planning is "using contraceptive to prevent unwanted pregnancies". Findings from this study indicate that one hundred and thirty-eight respondents believe family planning and contraceptive use is a good thing which must be encouraged, this confirms the findings of a study in 2001 which asserted that about 40% of respondents are aware of family planning and believe it is a good thing which must be encouraged across genders (Onwuzurike and Uzoxhkwu 2001).

On the downside, it is important to make mention that, a total of more than 50% of respondents believe family planning is a source of promiscuity, source of rebellion in women, for the rich in society, or for the poor in society this corroborates a study in East Africa which concluded that, many people do not have enough information about family planning and do not know the benefits or advantages they gain from the use of contraceptives, that is why the use of the use and penetration of contraceptives and family planning amongst males is low (Dangat and Njau, 2013). A high proportion of respondents in this study (41%) choose the withdrawal method as their family planning method of choice. About 122 respondents between the ages of "18-47", chose the withdrawal as their family planning method of choice, this goes a long way to support the assertion by Hagan and Buxton (2012), that even though most youth engage in risky sexual behaviors, they rarely practice contraception which can adequately prevent pregnancy and protect them from STDs and AIDS (Hagan and Buxton, 2012).

Like some earlier studies, this study found that most men are unwilling to try new contraceptives or family planning methods even if they target men directly (Morrison 2000). From the survey questionnaires, it was obvious that sociological and cultural reasons affect male's acceptability of family planning. The results from the survey also indicate that the choice of condoms as a preferred method of family planning is low and unconvincing, despite its ability to prevent sexually transmitted diseases and also serve as a contraceptive concurrently. About ninety-four respondents believe that family planning means limiting the number of children you have because of your income. This indicates an understanding that, the size of your family should reflect your income and resources, in order to be able to give them a good life (Sedgh and Hussain, 2014).

Also, it is surprising to note that, even though more than 70% of respondents have completed senior high school or higher, the most preferred method of family planning is the withdrawal method, which according to UNHCR (2004) is the least dependable family planning method, because it doesn't protect against STDs and has very little success rate as a form of contraception (UNHCR, 2004).

Conclusion and Recommendations

Family planning has been in Ghana since the 1960s, but there are still societal misconceptions that surround contraception and family planning in Ghana, sometimes these misconceptions prevent men from fully being involved in the family planning process or making informed family planning choices. A high proportion of respondents in this study believe family planning is good thing which must be encouraged but only a small size of the sample is willing to try new family planning methods which target men. While age group is the only predictor used in this study to determine the preferred methods of family planning and willingness of respondents to try new family planning methods which target only men, there is the need for aggressive advocacy, education and dissemination of information on family planning amongst men of all ages, as increasing adoption of such healthy behavior is critical to enabling individuals, households and communities achieve improved health outcomes which go a long way to improve the livelihoods of people (Sedgh and Hussain 2014).

It is recommended for community health personnel to involve men in outreach programs, this is because, the involvement of men in reproductive outreach programs will serve as a source of education and an avenue for them to clear all misconceptions about the methods and safe practice of family planning.

Finally, it is recommended that the educational curricula in basic schools must include education on reproductive health. This will enable young males to have knowledge about contraception and family planning before they become sexually active Knowledge about family planning and contraceptive use will not only help prevent unwanted pregnancies but will also teach ways of protecting themselves from HIV/AIDS and other sexually transmitted diseases.

REFERENCES

1. Abiodun, O. M., and Baloqun, O. R. (2009). Sexual activity and contraceptive use among young female students of tertiary educational institutions in Ilorin, Nigeria. Contraception. 79(2):146–9.
2. Adamchak, S. E., Bair, W. D., Barry, S. and Olson, C., (1995). Final evaluation of the Ghana Family Planning and Health Project (FPHP). POPTECH Report No. 95-045-031. Arlington, Virginia: Population Technical Assistance Project.

3. Ali, M.M., Cleland, J. Bernstein, S, Ezeh, A, Faundes, A, Glaiser, A., & Innis, J. (2006). Family planning: the unfinished agenda. Lancet, 368 (9549), 1810-1827.
4. Ankoman, A., Oladosu, M. and Anyanti, J. (2011). Myths, misinformation and communication about family planning and contraceptive use in Nigeria. Open Access Journal of Contraception. Vol. 2, PP. 95-105.
5. Bankole, A., Singh S., Hussein R., & Oestreicher G. (2008). Condom use for Preventing STI/HIV and Unintended Pregnancy among Young Men in Sub-Saharan Africa. American Journal of Men's Health, 3(1), 60-78.
6. Bauni, E.K., & Jarabi B.O. (2003). The Low Acceptability and Use of Condoms within Marriage: Evidence from Nakuru District in Kenya. African Population Studies vol. 18 n□1/Etude de la population africaine. 18 n□1, 52-65.
7. Boender, C., Santana, D., Hardee, K., Greene M. E., Schuler, S. (2004). The "so what?" report: a look at whether integrating a gender focus to programs makes a difference to outcomes. Washington DC: Interagency Gender Working Group.
8. Bunce, A., Guest G., Searing H., Frajzyngier V., Riwa P., Kanama J., & Achwal, C. (2007). Factors Affecting Vasectomy Acceptability in Tanzania. International Family Planning Perspectives, 33(1), 13-21.
9. Caldwell, J. C. and Caldwell, P. (2002). Is intergration the answer for Africa? International Family Planning Perspectives. 28(2): pp 108-110.
10. Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A. and Innis, J. (2006). Family planning: the unfinished agenda. Lancet. 368(9549): 1810–1827.
11. Cochran, W. G. (1977). Sampling Techniques, Third Edition. New York; John Wiley.

- Dallabetta, G., Field M.L., Lage M., & Islam Q.M. (2006). STDS: Global burden and
- challenges for control of sexually transmitted diseases: A handbook for design and
- management of programmes. Durham, North Carolina, Family Health International/
- the AIDS Control and Prevention Project (AIDSCAR), 23-52.

12. Dangat, C.M and Njau, B. (2013). Knowledge attitude and practices on family planning services among adolescents in secondary schools in Hai District, Northern Tanzania. Tanzania Journal of Health Research. 15(1): 98-111.
13. De-Graft, A. (2005). Healer shopping in Africa: New evidence from a rural urban qualitative study of Ghanaian diabetes experience. British Medical Journal. 331-737.
14. Diamond-Smith, N., Campbell, M. and Madan, S. (2012). Misinformation and fear of side effects of family planning. Culture, Health and Sexuality. Vol. 14. No. 4: pp. 421-433.
15. Ghana Aids Commission (2018). Annual Report. Accra, Ghana: Ghana Publishing Company.
16. Ghana Statistical Service. (2014). 2010 population and housing census report. Accra: Ghana Publishing Company.
17. Ghana Statistical Service, Ministry of Health, Centre for Disease Control & Prevention (2015). Ghana Demographic and Health Survey. Preliminary Report., Accra, Ghana.
18. Hagan, J. E. and Buxton, C. (2012). Contraceptive knowledge, perception and use amongadolescents in selected senior high schools in the Central Region of Ghana. Journal of Sociological Research. 3(2). ISSN 1948-5468.
19. Hartmann, K., Gilles, K., Shattuck, D., Kerner, D., and Guest G, (2012). Changes in couples: communication as a result of a male-involvement family planning intervention. Journal of Health Communications. Vol. 17. No. 7: pp 802-819.
20. Hubacher, D., Mavranezouli, I. and McGinn, E. (2008) Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it. Contraception. 78(1): 73–78.
21. Interagency Gender Working Group. (2009). Engaging men for gender equality and improved reproductive health. Washington DC: IGWG.
22. Jackson, D.J., Rakwar, J.P., Richardson, B.A., Mandaliya, K., Chohan, B.H., Bwayo, J.J., Ndinya-Achola, J.O., Martin, JR, H.L., Moses, S., & Kreiss, J.K (1997). Decreased incidence of sexually transmitted diseases among trucking company workers in Kenya: results of a behavioral risk-reduction programmes. AIDS, 11, 903-909.
23. Jacobstein, R., & Pile J.M. (2007). Vasectomy: The Unfinished Agenda; ACQUIRE Project Working Paper. Engender Health. New York: USAID.
24. Kaboré, I., P. Tapsoba, I. Askew, and J. Myers. (2003). New approaches to integrating STIs, HIV/AIDS, family planning, and reproductive health in Bazèga, Burkina Faso. Washington, D.C.: U.S. Agency for International Development. http://www.dec.org/pdf_docs/PNACS139.pdf.
25. Laukamm-Josten, U., Mwizarubi, B.K., Outwater, A., Mwaijonga, C.L., Valadez, J.J.,Nyamwaya, D., Swai, R., Saidel, T., & Nyamuryekung'e, K. (2000). Preventing HIV infection through peer education and condom promotion among truck drivers and their sexual partners in Tanzania, 1990-1993. AIDS Care, 12, 27-40.

26. Leonard, L., Ndiaye, I., Kapadia, A., Eisen, G., Diop, O., Mboup, S., & Kanki, P. (2000). HIV prevention among male clients of female sex workers in Kaolack, Senagal: results of a peer education programme. AIDS Education and Prevention, 12, 2-37
27. Miller, K. R., Askew, I. Horn, Marjorie, C. and Ndhlovu, L. (1998). Clinic based family planning and reproductive health services in Africa: findings from situation analysis studies. New York: Population Council.
28. Mayega, R.W. (2010). HIV/AIDS Sero-behavioral Survey in Six Universities in Uganda. In: East Afrcian Community-African Medical and Research Foundation, AMREF.
29. Mburugu, E., & Adams, B.N. (2004). Chapter 1: Families in Kenya. In B.N. Adams & J. Trost (Eds.) Handbook of World Families. (3-24). Thousand Oaks CA: Sage Publications.
30. Ministry of Health and Social Action. (2012). "Plan d'action national de Planification Familiale 2012-2015." Division of Health and Reproduction, Republic of Senegal.
31. Morrison, V. (2000). Contraceptive needs among Cambodian refugees in Khao Phlu camp. International Family Planning Perspectives, Vol. 26 No. 4: PP 188-192.
32. Moses, S., Ngugi, E.N., Costigen, A., Kariuki, C., Maclean, I., Brunham, R.C., & Plummer, F.A. (2002). Response of sexually transmitted infections epidemic to a treatment and prevention programme in Nairobi Kenya. Sexually Transmitted Infections, April: 789SUPPL 1) i114-i12o doi: 10.1136/sti.78.SUPPL_1.i114 Pub Med Central
33.
34. Murphy, E. (2004). Diffusion of Innovations: Family Planning in Developing Countries. Journal of Health Communication, 9:sup1, 123-129, DOI: 10.1080/10810730490271566 Neuman, W. (2012). Basics of social research. Whitewater: University of Wisconsin Press.
35. Nalwadda, G., Mirembe, F., Byamugisha, J., and Faxelid, E. (2010). Persistent high fertility in Uganda: young people recount obstacles and enabling factors to use of contraceptives. BMC public health. 10:530.
36. Obisesan, K. A., Adeyemo, A. A. and Fakokunde, B. O. (1998). Awareness and use of family planning methods among married women in Ibadan, Nigeria. East African Medical Journal. Vol. 75, No. 3: pp. 135-138.
37. Okwor. E. and Olashea, I. (2010). Married men's perception about spousal use of modern contraceptives: a qualitative study in Ibadan northwest local government area, South West Nigeria. International Quarterly of Community Health Education. Vol. 30, No. 3: pp. 223 238.
38. Richey L. A. (2008). Population politics and development: from the politics to the clinics. Kampala, Uganda: Fountain Publishers Ltd.
39. Ringheim, K. (1999). Revising the downward trend in men's share of contraceptive use. Reproductive Health Matters. 7(9): 83-96.
40. Ringheim, K. (2000). Male involvement and contraceptive methods for men. Present and Future Social Shange, September-December 1996, 26(3-4), 88-99.
41. Rogers, E. M. (1962). Diffusion of innovations. New York: Free Press of Glencoe.
42. Rogers, E. M. (2003). Diffusion of Innovations (5th ed.). New York: Free Press.
43. Rogers, E., Vaughan, P., Swalehe, R., Rao, N., Svenkerud, P., and Sood, S. (1999). A radio soap opera's effect on family planning behavior in Tanzania. Studies in Family Planning. 30(3): 193-221.
44. Rutherford, G. W., Anglemyer, A., Bagenda, D., Muyonga, M., Lindan, C. P. and Barker, J. L. (2014). University students and the risk of HIV and other sexually transmitted infections in Uganda: The Crane survey. International journal of adolescent medicine and health. 26(2):209–215.
45. Sedgh, G and Hussain R. (2014). Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries. Studies in family planning, 45(2): pp. 151 169.
46. Sri Devi., B & Swarnalatha, N. (2007). Prevalence of RTI/STI Among Reproductive Age Women (15-49) In Urban Slums of Tirupati Town, Andhra Pradesh. Health and Population-Perspective and Issues, 30(1), 56-70.
47. Thomas, J.C., and Tucker M.J. (1996). The development and use of the concept of a Sexually transmitted disease core. Journal of Infectious Diseases, 174(S2), 134-143.
48. United Nations Commission for Refugees (2004). Reproductive health services for internally displaced persons: Report of an inter-agency global evaluation. Geneva: UNHCR.
49. UNFPA. (2016). Universal Access to Reproductive Health: Progress and Challenges. Available at: http://www.unfpa.org/publications/universal-access-reproductive-health-progress-and challenges.

50. Wambui, T., Ek, A. C. and Alehagen, s. (2009). Perception of family planning among low income men in Western Kenya. International Nursing Review. Vol. 56(3): pp 340-345.
51. Wentzell, E. A. and Inhorn, M. C. (2014) Reconceiving masculinity and and men as partners for ICPD beyond 2014: insights from a Mexican HPV study. Global Public Health. 9(6): 691 705.
52. Wilson, W. (2004). Partner reduction and the prevention of HIV/AIDS: The most effective strategies come from the communities. British Medical Journal, 328, 848-849.
53. World Health Organization. (2004). Defining Sexual health. Report of a Technical Consultation on Sexual Health 28-31 January, Geneva. Available at: www.who.int. Accessed November 1, 2019.
54. World Health Organization. (2007). Family Planning: A Global Handbook for Providers. John Hopkins Bloomberg School of Public Health/Centre for Communication and World Health Organization.
55. World Health Organization. (2011). Millennium Development Goals: 20 Ways that World Health Organization helps countries reach the Millennium Development Goals. Available at: www.who.int/mdg/en/ . Accessed October 15, 2019.
56. World Health organization. (2011). Global prevalence and incidences of selected curable sexually transmitted infections: Overviews and estimates. Geneva: WHO.
57. World Health Organization (WHO). 2019. “Family Planning Fact Sheet.” World Health Organization Media Center, May. Accessed Nov 12, 2019. http://www.who.int/mediacentre/factsheets/fs351/en/index.html
58. Yoder, S., Hornik, R., and Chirwa, B. (1996). Evaluating the program effects of a radio drama about AIDS in Zambia. Studies in Family Planning. 27(4): 188-203.